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Policy, Power, Stigma and Silence: Exploring the Complexities of a Primary Mental Health Care Model in a Rural South African Setting

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Abstract

The movement for global mental health's (MGMH) efforts to scale up the availability of mental health services have been moderately successful. Investigations from resource poor countries like South Africa have pointed towards the value of an integrated primary mental health care model and multi-disciplinary collaborations to support mental health needs in underserved and under-resourced communities. However, there remains a need to explore how these policies play out within the daily realities of communities marked by varied environmental and relational complexities. Arguably, the lived realities of mental health policy and service delivery processes are best viewed through ethnographic approaches, which remain underutilised in the field of global mental health. This paper reports on findings from a case study of mental health services for HIV-affected women in a rural South African setting, which employed a motivated ethnography in order to explore the lived realities of primary mental health care model and related policies in South Africa. Findings highlighted the influence of three key symbolic (intangible) factors that impact on the efficacy of the primary mental health care model: power dynamics – which shaped relationships within multi-disciplinary teams, stigma – which limited the efficacy of task-shifting strategies, and a silencing of women's narratives of distress within services. The resultant gap between policy ideals and the reality of practice is discussed. The paper concludes with recommendations for building on existing successes in the delivery of primary mental health care in South Africa.

Key words: Global mental health; ethnography; primary health care; women's mental health; South Africa

Introduction

The Movement for Global Mental Health (MGMH) has made strides in exposing the 'treatment gap' between the burden of mental and neurological and disorders and services in material poor countries worldwide (Patel & Prince, 2010). Recent efforts by the movement have been driven by figures such as those citing mental and neurological conditions as leading contributors to the global burden of disease in the next fifteen years (Patel & Thornicroft, 2009), alongside reports citing numbers as high as 90 per cent of mental illnesses as untreated in low and middle income countries (Saxena et al, 2007).

At the heart of the movement resides an impassioned advocacy for scaling up mental health services in countries where as little as 1% of health budgets are devoted to mental health (Sarceno et al., 2007). Following the release of the movement's 2007 Lancet special issue, additional collections in PLoS Medicine (Patel and Thornicroft, 2009; Patel et al., 2013) explored cost-effective treatment strategies for resource poor settings. These collections asserted the value of a primary health care model as the foundation of community mental health services, given its ability to work as a foundation for task shifting or sharing initiatives to tackle resource deficits. Integrated services combining low-cost pharmaceutical and psychological interventions such as counselling (Van't Hof Cuijpers, Waheed & Stein, 2011) delivered using task-sharing and shifting strategies (Padmanathan & De Silva, 2013), as well as combined interventions alongside treatment for other non-communicable conditions (Ngo et al., 2013) are among the leading recommendations informing the shape of mental health care in many low-income settings (See WHO 2010; 2013).

However, many global movement recommendations have faced many critiques from. ethnographic and similar social constructivist disciplines. This is to be expected, given that a social constructivist approach allows a larger space for emotional responses to adverse social realities to be seen as normal, rather than grounds for illness (Summerfield 2008; 2012). Global movement efforts have been

labelled as medical imperialism at its worst (Summerfield, 2012), and mismatched to local reality at best (Skovdal, 2012) by critics. However, this does not negate the positive contributions rendered by the movement's efforts (Swartz, 2012). For example, increased international attention to mental health has created opportunities for local action against social injustices facing mental health service user groups in numerous contexts (Patel & Prince 2010). In Zambia, the service user movement MHUNZA has successfully drawn on discourses made popular by the MGMH in lobbying for revisions to outdated and discriminatory mental health legislation (WHO, 2008). Furthermore, the recent release of the World Health Organisation (WHO) action plan on mental health (2013) can be directly linked to successes of the MGMH (Eaton, Kauma, Wright & Minas, 2014). However, achieving the lofty aims of the global action plan, which includes the implementation of mental health legislation globally by 2020, will likely require deeper understandings of the local contextual realities that may influence the implementation of policy and delivery of services (Whyte, 2009), re-asserting the value of ethnographic approaches within the global mental health field. To date, much global mental health research has prioritised the pragmatics of biomedical service delivery (Swartz, 2012). Studies exploring the impacts of political, cultural and economic realities on mental health services in the global mental health field are scarce, with recent calls for studies exploring the realities of service delivery in complex settings (Patel, Jenkins, Lund, Tol, 2012). It is at this juncture that this paper makes its contribution. It explores the realities facing the implementation of 'global movement' recommended policy – specifically a primary mental health care (PMHC) model- in response to the following research question:

- What are the factors that shape the everyday delivery and outcomes of a primary mental health care model in resource poor settings?

The paper reports on ethnographic findings from an in-depth case study of community mental health services delivered using a primary mental health care model in rural South Africa. It focuses on the intersection of global mental health recommendations with the economic, historical and relational forces that shape life in everyday South Africa.

Background: A policy for primary mental health care in South Africa

Global mental health recommendations for services in resource poor countries like South Africa argue for approaches that target community level engagement around mental health. For example, the 'balanced care' model (WHO 2010; Thornicroft and Tansella, 2013) balances the availability of hospital and community-based mental health services. In resource-poor settings, the model focuses on improving the recognition and treatment of people with mental illnesses within primary health care clinics, alongside the treatment of more complicated cases at specialised centres. Other approaches include community collaborative models that feature multi-sectoral collaborations between health services, user and family groups, NGOs and multi-sectoral collaborative forums that draw on participation from social welfare sectors, as well as the general community (Petersen & Ssebunnya, 2011). Community collaborative approaches rely on task shifting and sharing strategies, which increases access to treatment for selected priority illnesses, such as psychotic disorders, or common mental disorders (CMD).

In South Africa, a district health model provides the overarching framework for the delivery of PMHC services. District hospitals form a bridge between primary care clinics (often referred to as satellite clinics), and specialised centres at regional and tertiary levels. The roots of this model date back to the 1997 South African white paper on health (Government of South Africa, 1997), which sought to desegregate health services through an Alma-Ata (WHO, 1978) style approach that prioritised equity, social justice, and the delivery of services to the poorest individuals (Bhatia and Rifkin, 2010).

Mental health services are coordinated through the implementation of the Mental Health Care Act (2002), replacing earlier apartheid era policy that enabled the misuse of psychiatric centres as pseudo detention centres for anti-apartheid activists (Hayes, 2000; Burns, 2010). The 2002 Act

emphasises the rights of patients, and establishes new monitoring frameworks to oversee admissions procedures.

Under the new Act, district level hospitals operate as 72-hour observation sites. At these centres, patients receive emergency care and treatment before being discharged for out-patient treatment (through visits to primary care or satellite clinics), or further referrals for observation or admission at regional and tertiary centres. Three criteria are required prior to long-term admissions: 1) patients and families are notified of the procedure and treatment plan 2) the local case is monitored and signed off by district medical staff prior to transfer and 3) a review of cases by a centralised review board is completed before the transfer or admittance of patients at long term facilities.

While researching in KwaZulu Natal, the province of focus in this paper, daily service delivery and implementation of the 2002 Act was guided by three policy documents. While a new national policy framework for mental health services was recently released (Department of Health, 2013), the following section will focus on the policy documents framing action at the time of research. The 2003 implementation guide focuses on community level implementation of the 2002 act. It outlines roles for community actors – in supporting continuity of care through monitoring and supporting medical compliance. It also outlines flows of power and resources through the PMHC system – with a chain of referral from lower tier community workers, such as primary care clinic nurses, to tertiary services at specialist hospitals, who are responsible for supervising treatment delivered at lower tiers of care. The Standard Treatment Guidelines for Common Mental Conditions (Department of Health, 2006) outlines the delivery of psychopharmalogical interventions for conditions prevalent within primary care settings. Guidelines outline treatment for depression, anxiety, schizophrenia and substance abuse disorders. Finally, the Psychosocial Rehabilitation for Common Mental Disorders policy (Department of health, 2010) targets community care and rehabilitation. It attends to the social needs of patients through the promotion of life skills training and vocational support. Development of rehabilitation plans depends on multi-disciplinary collaboration across health and social welfare sectors, following initial assessment at

district hospitals by a multi-disciplinary team (MDT) including social workers, allied health staff and medical practitioners.

Studies of primary mental health care services in South Africa have largely focused on structural service concerns such as human resources (Lund et al, 2010), and costing of services and practitioners (Petersen et al., 2012). Fewer studies have focused on the experiences of specific cadres of staff working within the system. Existing research has explored the experiences of nurses (Petersen,1999), and staff participating in the community service placement programme, which was launched by the South African Government to address human resource challenges facing many peri-urban and rural districts by placing early career health professionals in mandatory rural placements for one year (Pillay & Harvey, 2006). Collectively, the aforementioned studies paint a picture of an under resourced sector– and the urgent need to increase funding and resource allocations to the sector (Burns, 2010).

However, recent studies from the general South African health sector suggest the need to explore factors beyond the structural. For example, Lehmann and Gilson's (2012) study of general primary health care (PHC) services in South Africa asserts that different access to and uses of power among service actors within the PHC system impacted on the implementation of community health worker policy. Interactions between actors were governed by their social status in a hierarchical public health setting, and undermined the potential for lower level personnel – such as the volunteers and lower cadre staff (who would assume new roles under task-shifting in PMHC)- to influence service provision in meaningful ways. An earlier study of primary health nurses in mental health (Petersen, 2000) reflects this problematic. Nurses identified a culture of subordination in relationships between nurses and doctors and linked their reduced motivation in delivering care to a lack of positional power. Given widespread calls for multi-disciplinary approaches to mental health (WHO, 2010), the need to explore dynamics of these modes of intervention is clear. Whilst studies exploring the impacts of power and relational dynamics in multi-disciplinary collaborations for mental health care in African settings are

slim, recent work from high-income countries such as Australia have highlighted the complexities involved in multi-disciplinary care. Recent work by Nugus and colleagues (2010) highlight that doctor's use of positional power within MDTs impacted the efforts of lower-tiered staff to contribute to care plans. Findings also highlighted that working relationships were mediated by the expectation that doctors assumed responsibility for patient management.

Issues of power also shape spaces of treatment, with impacts on the provider-patient relationship (Foucault, 1976/2008), and, more specifically, on the ability for a patient to be 'heard' (Laing, 1960; Speed, 2006). Longstanding critiques describe a 'silencing' of patient voice that may occur within mental health treatment spaces, linked to the objectification of patients as ill bodies within the framework of psychiatry (Rissmiller & Rissmiller, 2006). Women are presented as particularly marginalised within treatment encounters, with research highlighting a history of women's oppression and discrimination within mental health services (Appignanesi, 2011), often enduring treatment that has failed to reflect their changing roles in society (McKay, 2010; Stoppard, 2000)

Over the years however, service user movements have increased the presence and power of patient voice (Crossley & Crossley, 2001), leading to shifts in discourses that call for greater patient participation within mental health treatment spaces. For example, the expansion of the recovery movement, which foregrounds person centred care (Fullagar & O'Brien, 1982) has increased the space for patients to be included in their treatment planning. However, much research in this area is from high-income country settings, with limited evidence able to articulate how far such movements have advanced the contributions of patients to their own care within in low income country settings (Kleintjes, Lund, & Swartz, 2012). Recent findings from a minority of studies in South Africa highlight a growing movement of users who are contributing to policy and campaigns to address stigma and discrimination in communities (Kleintjes, Lund, & Swartz, 2010; Kleintjes et al., 2012)

The delivery of primary mental health care services will also likely be complicated by the presence of stigma, defined by Dovidio, Major, and Crocker (2003) as the blend of affective, cognitive and behavioural responses directed towards those bearing discrediting attributes.. The presence of stigma among mental health care professionals across levels of care is well known, and has been linked to poorer quality care in high income country settings (Thornicroft, Rose, & Kassam, 2007). Whilst relatively few studies discuss the impact of stigma on the operation of primary mental health care services in South Africa (Kakuma, Kleintjes, Lund, et al., 2010), two older studies acknowledge the presence of mental health stigma amongst nurses working in general hospitals in KwaZulu-Natal (Mavundla, 2000; Mavundla & Uys, 1997). Efforts to address stigma have focused on public awareness and education campaigns, delivered through media campaigns and community outreach targeting the general population, children and adolescents, women (Kakuma et al, 2010). However, there is an absence of studies reporting on anti-stigma programs that target health care professionals.

The primary health care model has been argued as a route to reducing the negative impacts of varying knowledge systems that can often lead to such stigma. For example, health professionals in lower-tiered service centres (i.e. primary care clinics) are expected to hold better understandings of the local community and social realities framing patient wellbeing (McWhinney, 1998), increasing the likelihood that patient understandings of their distress are incorporated into treatment plans (Burgess, 2014). It has been argued that by drawing on practitioners closer to local realities, (such as those who live and work within the community itself) services can become more locally relevant (Wright, Common, Kauye & Chiwandira, 2013). The extent to which power relations and stigma influence the operations of primary mental health care in South Africa presents a gap in understandings of services, and an area which this study seeks to make a contribution.

Research Design and Methods

The study site is a rural South African sub-district in northern KwaZulu-Natal, in the Umkhanyakude health district. The community, which remains anonymous to protect the identity of local staff, is marked

by a high prevalence of HIV (37% - see Kuo et al., 2011). Violence and poverty mark the everyday narratives of community members and patients (see Burgess& Campbell, 2014). The town is near the Mozambique border, eight hours drive from the capital city and the nearest tertiary service centre for mental health.

Service delivery revolved around the district hospital (name withheld). It is one of five district hospitals, a 300 bed institution that supports 11 satellite clinics run by primary care nurses. The hospital operates as a 72-hour observation site for mental health patients, where in instances of emergency, patients are brought in and given access to treatment. During this period, patients are diagnosed and discharged back to their communities. Patients follow-up with nurses at satellite clinics. During the observation period, some patients gain access to social welfare support through referrals to a social worker, coordinated during MDT meetings.

Methodology

This paper reports on data from a larger case study of mental health services in the contexts of HIV and poverty. Data was collected from November 2010 to January 2011. While additional findings have been reported in detail elsewhere (Burgess, 2014; Burgess & Campbell 2014) this paper focuses on a five week 'motivated ethnography' of community mental health services.

Motivated ethnography

This study departs from conventional ethnographic investigations in its use of ethnography as one of many methods, rather than an overarching approach. The method was first described by social psychologists Duveen and Lloyd (1993). Similar to what has been defined as focused ethnography more recently (see Knoblaugh 2005), their method approaches a study setting with a focused aim, gathering evidence from the perspective of 'natives' with regards to a specific situation and activity, focusing on relevant elements of knowledge. Duveen & Lloyd's (1993 applied ethnography in order to develop a description of how gender operated as an organising dimension in classrooms. The form of ethnography utilised within this study is similarly streamlined in its approach - exploring the complexities

of managing community mental health within a primary care model. Direct participant observation and engagement in activities related directly to mental health services as they operated in the study community helped to portray the 'reality' of policies implemented within a primary mental health care model.

Data was collected using a series of 'ethnographic exercises' including:

1) Formal observations of services relating to the implementation of mental health policies in KwaZulu Natal.

2) Informal observations of community contexts linked to experience and responses to 'mental ill-health'

3) Semi-structured interviews with frontline practitioners working across tiers of the PMHC model as it operated on a day-to-day basis

76 hours of formal (structured) observation of clinic settings were conducted. Observational data was recorded using three strategies (see table 1). Structured field notes taken during clinic sessions were parsed into four sections: participant demographic information, patient history, key information from patient files, and presenting issue (see box 1 for an example). Informal daily observations were recorded in a field note diary kept throughout the study.

TABLE 1 ABOUT HERE

The limited time spent in field was supplemented by attention to data analysis and intensity, as suggested by Knoblauch (2005). Transcripts of interviews with health professionals were transcribed verbatim. Field note data – including observational notes, and field diary was typed up using word processing software, and subjected to coding and sequential analysis to identify key themes.

Data Analysis

A grounded thematic analysis was conducted. Braun and Clarke (2006) define thematic analyses as a procedure that works to identify, analyse and report patterns across an entire data set,

extending them to interpret particular aspects of a research project. Given its ability to sit as a contextualist method (between pure essentialism and constructivism) they argue the method's ability to acknowledge how social contexts impinge on the way individuals make sense of their environments, which allows findings to reflect reality and, "unravel the surface of reality" (Braun& Clarke, p.82).

Following multiple readings of the data, computer coding software (Atlas-ti version 6.0) was used to develop a data driven coding framework. Large chunks of data (minimum length of two paragraphs) formed each analytical unit, in order to maintain the richness of contexts informing a particular code. This paper reports on findings related to the global theme *mental health services*. An organisational theme - *reality of policies in practice* was informed by the following emergent basic themes: stigma, power and silence.

Ethics

Ethics approval was granted by three sources: (i) The London School of Economics, (ii) the University of KwaZulu-Natal and (iii) the KwaZulu-Natal Department of Health.

Findings

Encountering stigma in services: "*You need doctors who don't look at a psych patient and say "but you're crazy man! You're crazy!*"

Visits and observations were conducted at satellite clinics with the highest number of mental health outpatients. According to policy implementation guidelines (KZN Department of health, 2003), patient follow-up is to be handled by primary care (satellite) clinic nurses who are to be supported locally by community actors such as NGOs, and family members in monitoring of patient treatment adherence. However, observations highlighted that mental health patients were only reviewed by district hospital staff during their scheduled monthly visits to primary care clinics. Mental health outpatients would be told to wait to see 'their doctors', the mental health nurses who visited in the company of a social worker. Policy guidance stipulates that the purpose of district staff's monthly visits is to identify new patients and support problematic cases. Instead, these visits focused on ensuring the

general care and wellbeing of outpatients who were otherwise overlooked. Analysis pointed to stigma

towards patients by nurses and NGO staff as the key contributing factor:

> *…Nurses who are working at community clinics no longer see the mental health care users… When we go to clinics we are supposed to see new cases, or ones with problems who are referred to us by the nurse…but when the clinic nurse sees [any] mental health care users [who come for refills] she says "I can't deal with these people" … and tells them to come back [when we are at clinic]… they will say wait for your doctor, or your nurses. So [because of] that stigma – they didn't catch up with (pills) from those clinics. – Psych Nurse 2*

Collaboration between NGOs, satellite clinics and district health staff in managing outpatients is

a mainstay of the South African primary mental health care model. The NGO in the study community

was located next door to the district hospital. The working relationship revolved around the NGO's

home-based care (HBC) team, collaborated with hospital HBC staff to target the hardest to reach

families who often failed to return for follow up.

Observations of MDT meetings highlighted that responding to patient's broader psychosocial needs,

such as family conflicts, poverty and unemployment depended heavily on the district mental health

team's ability to refer patients to the NGO. Given the complicated bureaucratic processes often

required to navigate social services, NGO referrals provided more immediate access to social support

and food parcels to tackle isolation and food insecurity.

However, following a mental health patient's discharge from the district hospital the likelihood of

being seen by an NGO HBC staff was slim– impacted by the presence of stigma that was reported by

district health services and observed during observations:

> *We don't use the word 'insane'… but they (NGO HBC workers) say "You are so insane, you are so insane" to the patients [and that causes patients] to become aggressive (which deters the NGO staff from helping patients). So we tell them (NGO workers), that even if you are mentally disturbed, if you comply with the treatment, you can be alright… but this does not always work…. So they just leave them to us [at the hospital] - **Psychiatric nurse 1***

> *Another referral for the NGO HBC team, and this time I receive a surprising answer – [the HBC nurse] informed me that because [participant's name] is an identified mental health care user, it's likely that the HBC volunteers will not want to work with her, especially in the summer. She describes a local belief that the summer is worse for people in the community who are mentally ill – that they have more episodes and are violent with volunteers because a certain tree is in bloom. We discuss this for some time, when she says she'll do the visit herself to make sure*

the woman gets seen. But the whole thing is worrying…what exactly is happening with these women who are now considered 'mental health users'? (Fieldnote excerpt, November 22, 2010)

Stigmatising attitudes towards mental health patients was also reported among higher power district level medical officers (general doctors), with some described as displaying a lack of respect for the mental health discipline within the hierarchy of medical services. More active district level staff linked the difficulties they faced in coordinating services to the reluctance of higher ranking medical officials to participate and take responsibility during treatment proceedings.

You need doctors who don't look at a psych patient and say "but you're crazy man! You're crazy!" Or doctors who hear a woman that has thought of committing suicide recently, and has had a previous episode where she attempted (suicide), look at the chart and say 'ok, well you're not crazy now, it's fine, we'll send her home …. support from the doctors is non-existent, mental health care is not a fashionable thing to go into… it's something that you can buck and turf, and it's not going to affect you as a doctor… you may end up with them for three days or something in your ward, and then you can just dope…them and then they won't bug you. There's incentive from a therapy side to sort it out because we end up dealing with the crap, but a therapist is never going to be the head of a [MDT]because you are not in the hierarchy to do so. – Therapy department Assistant manager

Power and position in primary mental health care services

Ethnographic observations highlighted that the distribution of responsibility across the PMHC system was weighted most heavily on district hospital staff: mental health nurses, occupational therapists, physical therapists and social work staff. Staff at lower ranks within the medical hierarchy – such as nurses, physio and occupational therapist, absorbed the bulk of responsibility over patient care. Figure 1 (adapted from the mental health care model included in the 2003 implementation guidelines) depicts the distribution of tasks and responsibilities among different levels of staff within the study site at the time of research. The figure highlights that district level staff absorbed responsibilities from higher and lower tiered actors who did not participate in services. In the 2003 recommended model, screening, treatment, mental health promotion and engagement are equally distributed across all tiers.

FIGURE 1 ABOUT HERE

In order to provide holistic mental health care, the psychosocial rehabilitation policy (2010) states that MDT meetings are to be held weekly, by representatives from the mental health team (a district nurse), therapy department (occupational or physical therapy) social work, and a medical officer. Medical officers are required to oversee meetings and signoff on any treatment plans and prescriptions of care.

Over the course of the study period, only two MDT meetings were held, each in the absence of a medical officer. The absence of doctors was attributed in part to stigma described in the previous section, and the severe resource constraints facing the rural sub-district. At the time of the study the hospital was staffed daily by 11 doctors, 3 Social Workers, 8 therapy department staff (split between occupational and physical therapy), and nurses[1]. However, medical doctors were also required to support satellite clinics, meaning that what few doctors remained on the premises fulfilled multiple roles. For example, at the time of the study, the mental health doctor – who was responsible for supporting the multi-disciplinary clinic, was also responsible for the HIV and the drug resistant TB (XR-TB) ward.

We had a meeting after the nurses' strike, about two or three weeks into [my] post, and they requested someone to take on the responsibilities of the mental health post, and people weren't very... forthcoming [laughs]… because I am also responsible for the XR-TB and HIV wards I haven't been able to make it to many [MDT] meetings. But the mental health nurses are brilliant – they know the community, the diagnoses, they know what is going on better than I do – Visiting mental health doctor

As alluded to above, a stretching of resources meant that the bulk of the responsibilities for mental health services fell on the shoulders of district mental health nurses and allied health staff. These practitioners had a deep understanding of patient needs, and as described in detail elsewhere (Burgess, 2014) developed a series of strategic practices to ensure that patients were being supported as best as possible. For example, mental health nurses who understood the complex social nature of patient's mental health symptoms, often tried to put off or limit the administration of medications, viewing social response as more important to changing patterns of mental distress. Despite the

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[1] Due to the poor record keeping at the study hospital, the total number of nurses on staff was not available at the time of the study.

substantial responsibility assumed by district practitioners, their within the primary mental health model often limited their ability to shape the content of patient care. For example, many allied health and nursing staff were interested in reassessing, reducing or stopping the medication of patients, but found themselves blocked in this regard:

> *I don't think it (MDTclinics) works very well –we need a doctor to be there. Because you can review a patient for months and months on end, but if you cannot change the meds then what are you doing? I think it's good in the sense that social work, O.T. and the psych nurse know what's going on in the community, know at which clinics most of the problem cases are … but it's so frustrating…. –Sr.occupational therapist*

Frustration at being powerless within the ranks of the primary mental health care system indicates that issues linked to role-related power in PHC identified elsewhere (Lawn et al., 2014; Lehmann & Gilson,2012) remain a concern in mental health care. Within the PMHC model, power resides with more senior officials (Thornicroft & Tansella, 2013). However, within this site, more senior officials were either reluctant to participate, or are flown in for monthly monitoring visits. Such professionals are furthest away from the realities of the community, and in some cases, have more biomedical world views that are distant to those of patients, which have been linked to the mismanagement in other low-income settings (Jain & Jadhav, 2009).

The reliance on specialists at distant geographical locations resulted in a discontinuity in services. For example, visiting psychologists and psychiatrists were not always reliable, despite best efforts:

> *Visiting psychologists and psychiatrists come here once a month and the lists are full for months in advance… they transport via helicopter… which is weather dependant and sometimes they don't even show up – Psychiatric Nurse 2*

The use of early career staff on community service placements is a specific policy initiative designed to tackle the above issues. Whilst the policy has increased availability of services in hard to reach areas (Pillay & Harvey, 2006), practitioners in this study reported that the use of these staff also contributed to the discontinuity in mental health services, as noted by the regional psychiatrist:

> *So we have a community service psychiatrist or psychologist (at regional level) who comes to us on a one year contract…what happens then is that you have to wait [for them] and you train them and so on and so forth. After a few months or a year then they leave or they either move from that particular placement and they're placed in another part of the hospital. So that contributes to the fluctuations in the effectiveness and level of engagement in mental health services – Regional psychiatrist*

The 2003 implementation policy stipulates that in the absence of specialised practitioners, onsite medical officers are responsible for confirming diagnosis and signing off on treatment plans established during MDT meetings or during ward assessments. On occasions where medical doctors did participate, the nursing and allied health staff asserted that many times they lacked an adequate knowledge base to explore conditions – resulting in misdiagnosis or treatment plans that were ill suited to a patient's needs. One of the psychiatric nurses on staff at the time of the study spoke of the difficulties in trying to question the opinions of practitioners.

> *Some of the doctors they don't understand what schizophrenia actually means, so then patients will be on chronic medication for rest of their life…. if I discover that somebody maybe has been misdiagnosed, first I have to consult the doctor who did that consultation, but sometimes it's difficult, because doctors say " You're undermining my integrity –you think you are superior?" So sometimes it's difficult – but we try.*

Seen but not heard: the unintentional silencing of women's voices?

The third theme identified in the analysis refers to women as a special case within PMHC services. Over the course of observations and interviews, descriptions of and narratives from female patients were unified by a single thread: a 'muting' of women's voices and their contributions to planning their treatment.

The following field note excerpt highlights difficulties faced in encouraging women to unpack often complicated life stories in rooms where, due to space limitations patients were seen two at a time, accompanied by family members:

> *During psych clinics, the office operates in the strangest of ways, dictated by the space limitations at the hospital. The two nurses hold a clinic, where each meet with a separate patient who comes in, often with family, carrying their medical cards. People have been lining up for hours before hand, and between 8 am and 4 pm they will have to see everyone. Today,*

everyone equals 40 people on my very rough count... Inside the office where we see patients, there is no privacy and less space. Sometimes, men are asked to leave if women are talking about social or family histories, albeit rarely –but other than that, you just keep on going. A woman I took a particular interested in because of the large gaps in her diagnostic history embodied this. She kept making sideways glances at the husband of another client, refusing to give more than uncomfortable nodding in response to our questions. Finally M (mental health nurse) asked the husband to step outside so she could have a bit more privacy, after which she opened up a great deal. - Field note excerpt, Nov 24th, 2010

In discussions with therapy department staff, the root of women's silence was linked back to cultural norms surrounding women's behaviour. Zulu culture, which dominates the region where the study was completed – contributed a series of norms about women's roles in community life. Women's access to power has been limited throughout history, and despite advances in many low income countries women's exercise of power often remains linked to the successes and failures of the men in their lives (Mikell, 1997) Demographic and economic transitions in post-apartheid South Africa have undoubtedly changed women's access to certain forms of power, particularly in more urban settings (Hunter, 2010). In rural areas however, where women's access to education and independent economic power remains limited, women's power is still ultimately established through relations to men. Many South African communities maintain strong patriarchal lines that often limit the voices of women (Kehler, 2001; Neves & Toit, 2013), and the study site was one such community (See Burgess and Campbell 2014 for a more detailed account of these issues). Beyond this women who are accepting of hardship and continue in the face of adversity are celebrated (Hunter, 2010; Burgess, 2014), creating a receptive environment where silent, committed women gain a form of social capital and value.

A second case (see box 1) further highlights the permeation of the patient-client relationship by power and cultural norms, impacting the ability of a women's voice to be taken account of in services. The patient in question was called in for a special appointment with the regional psychiatrist who was scheduled for his bi-monthly visit. The district mental health nurse hoped that they would have a chance to review the patient's diagnostic history, as she feared that the patient was incorrectly diagnosed with schizophrenia and had been incorrectly prescribed anti-psychotic medication. Unfortunately, a last minute cancellation due to inclement weather meant the patient only met with the nurse.

Cancellations were common given that regional specialists had to be flown in for visits given the distance to the rural district hospital.

The patient's narrative of distress emerged as a product of her difficult familial relations that included abandonment by her partner, complicated by severe economic deprivation. Her first episode of psychosis occurred in 2006, and was linked to her abandonment by her husband which resulted in the loss of her children.   At the time of the study she was unemployed, unsupported by her former husband and now adult children, and struggled with food-insecurity. In line with her diagnosis of Schizophrenia (recognised as a chronic condition qualifying for welfare support), the patient described numerous attempts to apply for a disability grant. In previous efforts to process her grant application, she was also reviewed by medical practitioners at social welfare offices. Her encounter prior to the observed consultation involved a senior medical practitioner native to the study community who recommended that to solve her problems she find 'a boyfriend' rather than seek a grant for support.

BOX 1 ABOUT HERE

Such a suggestion from a local male medical practitioner mirrors the more traditional view of gender relations in Zulu culture that positions women as objects to be cared for by individual men and families (Krige, 1936; Hunter, 2010). The community at the heart of the study is dominated by Zulu cultural ideals, and the ongoing importance of traditional views to everyday life is confirmed by local women themselves who articulated the presence of a widely held view of men as the primary breadwinners and figures in families (Burgess, 2013; Burgess and Campbell, 2014). As reliance on local community partners increases with the solidification of a task shifting approach within primary mental health care (Department of Health, 2013), the potential silencing of women's voices by practitioners whose limiting views of women are validated by local culture bears further attention.

Practitioners also linked the limited attention given to women's social needs to resource scarcity. Existing outlets of support such as food parcels available through the social welfare

department (which last for a maximum of three years), and support from the local NGO – are temporary. By increasing the availability of supports to tackle the social challenges linked to distress in poor settings, silencing of women's needs due to scarcity could be reduced bringing responses more in line with women's social realities. For example, through increased provision of consistent funding to district hospitals, community mental health support groups (who were also linked to income generating opportunities), could be facilitated by permanent staff, rather than transitional staff such as community service placements. Whilst there is an obvious need to adjust funding in these areas, this would have a limited impact on how gendered power dynamics operating within other service spaces may lead to a silencing of women's own voiced concerns.

Discussion

Findings from the motivated ethnography identified three areas of concern within the delivery of primary mental health care services in South Africa that are often overshadowed by interests in addressing structural resource scarcity. Stigma among health care practitioners integral to community care, – NGO staff and primary care clinic nurses - created bottle necks in services that shifted the burden of care to district health professionals. Unfortunately, power dynamics between active district level staff and higher positioned providers limited the reach of more engaged practitioners. Findings also highlighted an unintentional silencing of women's narratives that occurs upon their entry into the service sector – exacerbated by resource limitations and social norms that limit attention to the broader contextual drivers of women's mental health needs.

The ability for negative gender norms to permeate patient spaces can also be linked to spatial limitations. Female patients often do not feel comfortable discussing sensitive issues in the presence of other men, given the propensity for women who speak up to be judged negatively (Hunter, 2010). Furthermore, cultural norms which circulate in the community reduce the likelihood that women who do speak will be listened to, and they are consistently at risk of being silenced or dismissed by more powerful agents who maintain limiting views of women. The influence of negative representations of

women on patient care has been acknowledged elsewhere. For example, a recent study in Ghana reported that practitioner understandings of women's mental distress were informed by beliefs that biological differences such as a 'weaker constitution' made women more susceptible to depression (Ofori-atta et al., 2010).

Findings from the study point to a need to consider routes for services to overcome, or work around cultural norms that can contribute to health-limiting behaviours. At a minimum, spatial allocations in treatment settings should enable patients to be seen independently during counselling and screening sessions, by practitioners who are sensitive to the gendered realities of many patients (Burgess, 2014). Whilst the process of tackling gendered power dynamics in care will likely reside in small scale efforts that shift gender norms more broadly, an interim policy response could establish 'alternative spheres' for the assessment and delivery of treatment to women. One such route may reside in church settings. Many studies in low-income African-American communities have explored the role of faith and church groups for the delivery of mental health services, citing positive results (Hankerson & Weissman, 2012). Furthermore, church groups have been identified as providing important coping strategies for women with mental health problems in South African settings (Jewkes, 2013; Burgess & Campbell, 2014).   In South Africa, churches often represent spaces where women can gain access to increased power (though leadership roles) in ways that are accepted and respected. Utilising churches as spaces and collaborators for mental health treatment in this way could potentially provide further spaces for women to express and debate the complex realities surrounding their experiences of mental distress. The use of churches in relation to treatment, education and anti-stigma spaces has been supported in HIV-related work (Campbell, Skovdal & Gibbs, 2012), and provides a potential model that could be expanded on for mental health.

Overall, findings from this study highlight that in this deep rural setting, the implementation of the primary mental health care model is fraught with complications. Patients did not enter services through the outlined pathways of primary health care clinics for screening and referral. Instead, entry

was often through emergency care and 72 hour observations. The impacts of this on an already overburdened district health services are problematic. Existing staff and bed shortages in these centres, combined with limited ability to deal with mental health patients resulted in physical or medicalised restraints such as heavy doping as articulated by service providers in this study. Furthermore, general nurses at primary health care centres had limited engagement with mental health patients during clinics - an absence accounted for by other staff as the result of stigma. The outcome of these challenges was a collapsing of the primary mental health care model towards the centre – placing the brunt of the work on the shoulders of a rural district level health centre, already limited by broader structural limitations.

Dependence on higher tier staff within the primary mental health care model is limited by factors beyond the control of local staff. In this study, the temporality of community service staff, and weather conditions which result in cancellations of long awaited visits from specialists were particularly problematic. Unfortunately, findings from this study also suggest that the newly argued response to such issues – task shifting – may not automatically achieve meaningful improvements in the outcome of patient's lives in contexts where lower cadre staff are not adequately supported. Novel approaches to ensuring the availability of senior support in light of environmental barriers such as inclement weather would be of great use to similar rural settings. The use of telephone consultations was mentioned as an available, but often unused option by some practitioners. However recent advances in the application of mHealth (mobile technologies used within screening and treatment management settings) for mental health in South Africa present an opportunity to ensure access to support for lower-tiered staff (Tomlinson et al., 2013; Tsai et al., 2014; van Heerden, Tomlinson, & Swartz, 2012). However, given that task-shifting approaches tend to target structural pragmatics of care (i.e. – increasing access to screening, or facilitating outpatient management), attending to symbolic and relational barriers to care may be lower on the list of priorities. For example, the ability for power dynamics to influence the actions and efforts of more engaged and locally knowledgeable local practitioners – across disciplines –

was evident in this study, and highlights a need to consider expanding the decision making power and remit of local staff, particularly at district level.

It is important to note that an alternative explanation for the disengagement of lowest teir practitioners may reside in the limited capacities of general practitioners to handle mental health conditions. A recent study of task shifting for mental health care in South Africa highlighted that nurses welcomed the insertion of specialised counsellors, preferring them to handle mental health conditions in primary care clinics (Petersen et al., 2012). However, the insertion of a new cadre of worker does not tackle other issues identified by patients in this study – who often had difficulty in receiving general care beyond mental health concerns. Furthermore, the social impacts of this stigma on patients whose health narratives and identities are physically transported with them everywhere in medical cards that detail diagnosis and medical histories – are worth considering. Patients who are denied care or avoided by general practitioners potentially puts them at risk of isolation which has impacts on recovery processes. Findings point to the continued need to work on tackling mental health related stigma, not only within communities, but with health practitioners. Training programmes that focus on issues such as gender sensitivity and stigma reducing exercises, would be well suited to communities such as the one at the heart of this study. Recent studies in Kenya (Jenkins et al., 2013) report on the positive outcome of mental health training programmes with general health care workers at primary care (community) settings, which resulted in their increased tolerance, and capacities in dealing with mental health patients in primary care settings. Programmes of this nature could be replicated elsewhere, and delivered by specialist staff (or existing mental health volunteers) already employed within the primary mental health care model.

Conclusion and policy recommendations

Findings from this paper have highlighted the impact of social and relational dynamics on the delivery of mental health services in a resource-limited community, enabled by the ethnographic

approach taken by the study. This approach helped to illuminate often 'unseen' issues in health services – in this case, the complex interplay between systemic social issues facing primary mental health care, and relational dynamics such as power and stigma within MDTs. A growing interest in the insights provided by ethnographic approaches is well placed during a time of investment in mental health systems in globally. The recently established National Mental Health Policy Framework and Strategic Plan for South Africa (2013-2020) presents a renewed commitment to primary health care, multi-sector collaboration, and attention to symbolic and relational issues flagged up by this study, particularly stigma and gender. Identification of how such issues shape services can best be explored through ethnography vis a vis its attention context and its ability to shape realities (Lambert & McKevitt, 2002)

The framework outlines a set of promising plans for strengthening and expansion of care at the district health level, including the construction of inpatient units at district and regional hospitals, the use of task shifting approaches to train non-specialist works to deliver psychosocial interventions, and expansion of mental health training for general health staff (Department of health, 2013). This will involve the establishment of further permanent posts for mental health at district level health centres, which will go a long way to addressing some of the structural issues described in this study. However, this study illuminates that further work needs to be done to ensure the smooth operation of multi-disciplinary work for mental health. The establishment of training programmes that focus on sensitising practitioners to the issues of gender, alongside safe spaces for practitioners to tackle their own stigma will be valuable for communities such as the one in this study.

Though still in its infancy, the new national policy framework provides reason for hope. However, the scope of the policy recommendations could also contribute to inaction in the face of such changes, particularly in the current environment of human resource limitations. In future, use of ethnographic approaches within the monitoring and evaluation of newly implemented policies will be important to keep abreast of the real life outcomes of policy efforts. Ethnography could be utilised within process evaluations that run-alongside pilot studies and the implementation process of the new policy

framework. This would ensure that complex dynamics of space, relationships and power could be dealt with more imminently, rather than after they have derailed policy aims (Burgess, 2013).

The MGMH has created enough momentum that governments in countries like South Africa have begun to make commitments to addressing the mental health needs of its citizens. It remains to be seen how such efforts will further efforts to achieve mental health for all.

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Tables and figures

Table 1: Observational data from motivated ethnography

Location of structured observation	Number of observations	Type of data recorded
Hospital clinics	In-patient MH clinics (24 hrs)	Patient profiles/hx (n = 6 patients)
	Multi-disciplinary team meetings (6 hrs)	Reflective diaries on clinic setting/experience
Remote clinics (community)	Mental health/social work clinic (32 hrs)	Patient profiles/hx (n = 12 patients)
		Reflexive diaries on clinic setting/experience
NGO	Meeting w/HBC and therapy dept. (2 hours)	New Patient profiles/hx (N= 5)
		Reflexive diaries on clinic setting/experience
	HBC monitoring visit (9 hrs)	Patient profiles/hx (n=7)
		Reflexive diaries on setting/experience
	Community HIV support group meeting (3 hours)	Transcript of meeting
		Reflective diaries on clinic setting/experience

Box 1: Patient case notes - visiting psychiatrist special referral

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Female (S), Age 54

<u>Social history</u>: *S described a long history of problems with her ex-husband. He abandoned her, which resulted in the loss of custody of her children. She experienced depression and sadness related to the loss of her children. Depression did not respond to counselling sessions with the social worker on staff. She continues to argue with her children about them not supporting her – she currently has no job and no income.*

<u>Medical history</u>: *S was prescribed haloperidol (by community nurses) to manage audio hallucinatory symptoms (hearing voices) in 2006. When asked to describe what the voices say, she was unable to be very clear – and stated that that she can't really identify what they are assaying but it comes across like they are preaching to her. She says that she also feels an 'electrical shock' that isn't scary to her, but that's' what she feels when she hears them.*

<u>Chart notes:</u> *(history from visiting psychologist from 2006, prior to initiation of haloperidol). The psychologist describes that S's obsession with the grant is something that will only exacerbate her symptoms, but that he didn't' feel that she warranted receiving it at that time.*

M (Psych nurse) notes assert that based on the psychologist's findings that she may be malingering to gain access to a grant.

<u>Presenting issue:</u> *Her current complaint is linked to problems with her memory (forgetting where she puts things) and on-going psychosocial depression that is related to her unemployment, lack of support systems and on-going difficulties in accessing a disability grant. She described her most recent attempt to apply for a disability grant, which involved an encounter with the signatory doctor in the social welfare department who claimed that she didn't need a grant, she needed a boyfriend. Although she doesn't describe side effects from the psychotic medication that she is on, she asks – "If I'm not sick then why am I taking all of these medicines? And why do other patients who receive these medicines also get grants, but I cannot?"*

Level of care		Actual role
Tertiary specialist services: Psychiatrist, medical office, Psychologist, Social Worker, Psychiatric Nurse, Occupational Therapist	→	Specialised treatment; acute inpatient care; long-term in-patient care; out-patient care; support to regional hospitals; alcohol and drug rehabilitation; community outreach
Regional hospital: Psychiatrist, psychologist, social worker, psychiatric nurse, occupational therapist	→	Short-term acute in-patient care; outpatient care; support to district hospital; consultation liaison psychiatry; community outreach
District hospital: Psychiatrist (visiting) ; medical officer, psychologist (visiting) social worker, psychiatric nurse, occupational therapist, Physical Therapy	→	Assessment and admissions; 72-hour hospital admissions; outpatient care; training, support and supervision of PHC staff and counsellors; programme initiation and coordination; identification and management of mental disorders; referral; support and supervision to community; psychosocial rehabilitation and education; prevention and promotion programmes
Primary health clinics: Primary health care nurse	→	Identification and management of mental disorders; referral
Community: Traditional healers, spiritual leaders, police, community health workers, CBOs/NGOs, Teachers	→	Poverty alleviation programmes; identification and referral of mental health problems