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THE IMPLEMENTATION OF MENTAL HEALTH POLICY AND LEGISLATION: IS DEINSTITUTIONALISATION A PREDICAMENT FOR SOCIAL WORKERS AND FAMILIES?

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ABSTRACT

Globally, policy and legislation on mental health have shifted towards deinstitutionalisation. South African policy and legislation were adapted to adhere to international policy directives, resulting in a strong emphasis on reintegrating people with mental illness into their families and communities. The practical implementation of this shift depends on the existence of community-based organisations to support families and persons with mental illness. However, no research is available on the view of social workers on the implementation of mental health policy and legislation and the possible challenges experienced with deinstitutionalisation. To investigate if deinstitutionalisation presented a predicament for social workers and families, a qualitative approach – with exploratory and descriptive research designs – was employed with social workers and their supervisors working at selected psychiatric hospitals. These participants were approached specifically because they are often at the frontline of implementing mental health policy and legislation. It was concluded that existing legislation was superficial, unknown and patient-driven, and that deinstitutionalisation was viewed as an ineffective reintegration strategy. Recommendations are that policymakers must reassess the implications of this legislation and address community-based resources to support the proper deinstitutionalisation of and care for people with mental illness and their families.

Keywords: deinstitutionalisation; families; mental health; social workers

INTRODUCTION

Internationally, mental health policy and legislation have shifted from caring for people with mental illness in institutions to caring for them in their communities. This deinstitutionalisation approach indicates that people with mental illness must reintegrate with their families and communities (World Health Organization [WHO], 2014). In line with the international shift, South African mental health legislation and policies were adapted to require that people with mental illness should be deinstitutionalised and treated in their communities after being stabilised at a psychiatric hospital. However, in South Africa, where the implementation of social work policy and legislation is challenging as a result of structural constraints, such as a lack of workforce, funds and community resources, this shift towards deinstitutionalisation adds to existing challenges within the social work context (Uys & Middelton, 2014).

This article presents social workers' views about existing mental health policy, legislation and deinstitutionalisation in the South African context and the challenges experienced in their implementation at government psychiatric institutions in the Cape Metropole region of the Western Cape.

POLICY AND LEGISLATION ON MENTAL HEALTH IN THE SOUTH AFRICAN CONTEXT

The South African government indicated its commitment to mental health care when it implemented the Mental Health Care Act (MHCA) 17 of 2002 (Republic of South Africa [RSA], 2002) and adopted the United Nations Convention on the Rights of Persons with Disabilities in 2006 (Burns *et al*., 2011; United Nations [UN], 2006) and the National Mental Health Policy Framework and Strategic Plan 2013-2020 (Department of Health. 2012). The Act and these policies are discussed next.

The Mental Health Care Act 17 of 2002

In 2002, the South African National Assembly and the National Council of Provinces passed the MHCA 17 of 2002. The MHCA replaced the Mental Health Act 18 of 1973 to align the provisions of mental health services with South Africa's Constitution, which prioritises protecting human rights. The MHCA was promulgated and implemented with its regulations in December 2004 (RSA, 2004). This Act is regarded as one of the world's most progressive mental health laws, as it explicitly affirms the rights of everyone within its ambit and significantly limits the potential for substitute decision-making and involuntary treatment (Booyens, 2022). The MHCA further recognises that mental health services must promote the maximum mental wellbeing of patients and communities in which patients reside (WHO, 2011; 2014). In line with the Bill of Rights (RSA, 1996), Chapter 3 of the MHCA emphasises the rights of persons with mental illness to be treated with respect, human dignity, privacy, fair discrimination, and not to be exploited or abused.

This chapter also focuses on ways to provide the best access for patients with mental illness to mental healthcare, treatment and rehabilitation services (Madlala & Sokudela, 2014; Parker, 2012). Services include supporting families caring for relatives with mental illness, delivering essential medication, developing human resources, promoting mental health and public

education, and involving the government, NGOs and private sector in service delivery (Math *et al.,* 2019).

Among other things, the MHCA's regulations contain provisions about the role of the national and provincial governments in developing quality norms and standards and the regulation of processes, such as transferring and discharging patients to families and community-based organisations. For instance, regulation 48 of the MHCA (RSA, 2002) provides that provincial health departments must issue licences to NGOs and community-based organisations to facilitate caring for people with mental illness. In line with the focus on community-based organisations, Regulation 6 of the MHCA obliges the government to subsidise NGO-run residential homes and day-care centres within the government's available resources to provide care, treatment and rehabilitation for persons with mental illness (RSA, 2016).

Although the MHCA recognises families as a resource in caring for people with mental illness, Mokwena and Ngoveni (2020) suggest that the Act focused on patients without recognising the importance of rendering support services to their families. The lack of focus on families was already confirmed by the research of Faydi *et al.* (2011) more than 20 years ago, when the authors found that empowering and advocating for people with mental illness and their families were insufficiently addressed in Ghana, South Africa, Uganda and Zambia. Faydi *et al.* (2011) further confirmed that addressing the needs of family caregivers and their patients sufficiently required a collaborative approach between healthcare providers and governments. Nevertheless, a step was made in the right direction by including families in the National Mental Health Policy Framework (NMHPF) and Strategic Plan of 2013-2020.

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

The National Mental Health Policy Framework (NMHPF) and Strategic Plan 2013-2020 is a policy based on the Mental Health Action Plan 2013-2020 of the World Health Organisation (Department of Health, 2012; WHO, 2013). The NMHPF 2013-2020 aimed to improve mental health services for everyone, including affected families in South Africa, by 2020. After a significant consultative process, including provincial and national mental health summits held in 2012, the National Health Council integrated the Mental Health Action Plan of South Africa, which resulted in the NMHPF and Strategic Plan 2013-2020 (Department of Health, 2012) in 2013.

The NMHPF and Strategic Plan (2013-2020) endeavoured to provide effective mental health services by promoting prevention, treatment and rehabilitation services in South Africa (Department of Health, 2012). An important directive for social work service delivery was that service providers, people with mental illness, their caregivers, families and communities had to form partnerships to address service delivery. This included integrating people with mental illness into everyday community life (Department of Health, 2012; Kaminer, Owen & Schwartz, 2017), emphasising the shift to deinstitutionalisation.

The NMHPF and Strategic Plan 2013-2020 included specific objectives related to deinstitutionalisation, focusing on developing community-based resources and protecting the human rights of people with mental illness (Department of Health, 2012; Janse van Rensburg, 2012; 2013). One of these objectives was to promote decentralised primary health services in

communities and districts, including community-based care, primary healthcare clinics and district hospitals. A further objective promotes the participation of mental health patients and their carers (families) to promote patients' mental well-being and recovery and empower their communities. Another objective focuses on the issues of stigma and discrimination that go hand in hand with mental illness, for which it was proposed to implement measures to increase public awareness and reduce stigma and discrimination. Promoting and protecting the human rights of people with mental illness and adopting a multi-sectoral approach to address the vicious cycle of poverty and mental illness were furthermore listed as objectives (Department of Health, 2012; Kaminer *et al.,* 2017).

The MHCA (RSA, 2002) and the NMHPF and Strategic Plan (Department of Health, 2012) align with international trends, strongly emphasising developing community-based health care to deinstitutionalise patients with mental illnesses. The NMHPF and Strategic Plan (2013-2020) and the MHCA (RSA, 2002) state that mentally ill patients should be discharged as soon as possible to prevent them from being institutionalised and instead be treated in their communities. Thus, most patients must be treated in communities while living with their families (Hall, Raitakari & Juhila, 2021).

Community-based care and support are explained as services rendered by community-based organisations (CBOs) to patients with mental illness and their families within the patients' social environments (Vitale, Mannix-McNamara & Cullinan, 2015). The practical implication is that families must often care for their relatives with mental illness after they are discharged. This may be problematic for families, especially if there are no community-based resources. This is confirmed by South African scholars Tomlinson and Lund (2012) and Docrat, Lund and Chisholm (2019), who indicated that it might be challenging to implement effective community-based mental health services because of under-developed provincial mental healthcare plans.

Possible impact of policy changes on people with a mental illness and their families

Before the MHCA (RSA, 2002) was amended, people with mental illness used to be assessed at community health clinics. The amended MHCA (RSA, 2002) provides that patients must be admitted to a district hospital for a 72-hour observation period before being referred to a psychiatric hospital. Should patients be unstable, they must be admitted to a psychiatric hospital. However, Mbedzi (2018) indicates that, after 72 hours of observation, patients were often discharged from the district hospital to the care of their families, even though they were unstable. This is often the outcome of deinstitutionalisation – as general hospitals would face a shortage of suitable care facilities, such as beds and acute admission wards for patients with mental illness (Burns, 2011).

The outcome of patients being discharged early is that families would often have to care for their relatives with mental illness. This caregiving role is a burden because families are often uneducated or ignorant about the mental illness of the patient (Thom, 2007; Tranvag & Kristoffersen, 2008). In this context, burden can be defined as the impact of the mental illness of one family member on the emotional wellbeing of other family members, the family's time and finances, and general living conditions. Low-income families in neighbourhoods with

insufficient resources concerning housing, schools and services are likely to experience poor health and no occupational attainment, contributing to their burden of caring (Heinonen & Metteri, 2005; Uys & Middelton, 2014).

Caring for persons with mental illness can cause tremendous stress for their families and could further contribute to the burden of care. In South Africa, the MHCA rapidly shifted to community-based services without considering the implications of the transition. This shift, combined with poor support services, drastically escalated the burden of care on families (Lund *et al*., 2008; Mfoafo-M'Carthy & Grischow, 2022).

Apart from the adverse effects caregiving has on families, family burden has also been correlated with poorer clinical outcomes for family members with mental health issues. Furthermore, issues such as rendering support services to families caring for relatives with mental illness remain a concern in communities (Chow, Ajaz & Priebe, 2019). Thus, even though global policy recommends moving from institutionalisation to community-based care, support services for mentally ill patients and their families from admission to discharge are still lacking (Leech & Dolamo, 2016; Wong *et al*., 2022).

Social work in mental health

Social workers in psychiatric institutions render services to families to facilitate an understanding of the mental illness of the relative, as well as to ensure support and treatment services after discharge (Aldersey & Whitley, 2015). Thus, social workers in mental health care in South Africa work with patients and their families to ensure effective communication between families and professionals as well as adequate community-based support services (Gehlert & Browne, 2012). Social work practice is primarily shaped by the context in which it is practised. Therefore, social workers must have a good understanding of legislation and policy when delivering services to individuals affected by mental health conditions. Mugisha *et al.* (2017) believe that equitable and efficient services in the best interest of mentally ill patients and their families must be delivered within the available resources.

In South Africa, the available resources, such as community mental health and psychosocial rehabilitation for people with mental illness in support of the patient and their families, remain underdeveloped and may lead to implementation challenges. These challenges can be related to having little or inferior services available to address the physical, emotional and social needs of people with mental illness and their families (Burns, 2011; Flemming, Booth, Garside, Tunçalp & Noyes, 2019; Gehlert & Browne, 2012). South African authors believe that the social work profession has been experiencing significant challenges, such as having limited knowledge and skills to respond to rapidly changing mental health work environments and implementing amended policies and legislation (Bland *et al*., 2021).

Because of the lack of research on challenges experienced by social workers in implementing mental health policy and legislation in South Africa, the views of social workers on this topic were explored and described. Frontline social workers employed at government psychiatric institutions within the Cape Metropole region of the Western Cape, where they utilised and implemented mental health policy and legislation daily, were included in this study. This study group had expert knowledge, as it was their role to ensure treatment and provide support to

persons with mental illness and their families during hospitalisation and after discharge.

AIM AND OBJECTIVE OF THE STUDY

This study aimed to understand the views and challenges faced by social workers when implementing mental health policy and legislation in the Cape Metropole region of the Western Cape.

The research objectives were to:

- explore the views of social workers about mental health policy and legislation in South Africa; and
- describe the challenges experienced by social workers in implementing mental health policy and legislation in South Africa.

RESEARCH METHODOLOGY

An empirical investigation was done in the Cape Metropole region of Western Cape. A qualitative approach was used to understand social workers' views and challenges in implementing mental health policy and legislation in South Africa (Creswell & Creswell, 2018). Both exploratory (social workers' views about mental health policy and legislation) and descriptive (challenges experienced by social workers in implementing mental health policy and legislation) research designs were used to approach and execute this study (Fouche, 2021; Rubin & Babbie, 2017).

The population of this study consisted of social workers and social work supervisors employed at government psychiatric hospitals in South Africa. For sampling, participants employed at psychiatric hospitals in the Cape Metropole region of Western Cape were purposively selected based on their roles, knowledge and skills in rendering social work services to families caring for adult relatives with mental illness (Maree, 2020).

Non-probability purposive sampling allowed participants to provide rich information on social work services rendered to families caring for adult relatives with mental illness (Creswell & Creswell, 2018). This social work study sample included social workers employed by the Western Cape Department of Health and those based at psychiatric hospitals within the Cape Metropole Region of Western Cape. The participants had to be social workers who had been rendering support services to patients with mental illness and their families for at least two years. The social work supervisor study group sample consisted of social work supervisors employed at psychiatric hospitals within the Cape Metropole Region of Western Cape. These participants had to be social work supervisors with at least two years of experience in psychiatric hospital positions.

During this study, some COVID-19 restrictions were still enforced in South Africa. Thus, data were collected from both study groups through semi-structured interview schedules using Microsoft Teams and Zoom. This allowed for an in-depth understanding of social workers' views and challenges experienced in implementing mental health policy and legislation (Maree, 2020; Rubin & Babbie, 2017). Social workers and social work supervisors at the psychiatric hospitals were informed about the aim of the study, while uncertainties about the

study were clarified before data collection. Virtual interviews and focus group discussions were conducted until data saturation was reached and participants provided no new information (Fouché, 2021). Interviews were conducted with social workers who worked with patients and families and facilitated effective communication between patients, families and multi-disciplinary teams. The participants also handled case management in in- and outpatient and community-based care, employment support, residential care, psychosocial support, family therapy and support, and assistance with basic reintegration of patients with mental illnesses into society while addressing needs associated with reintegration.

A virtual focus group discussion was held to obtain views of the social work supervisor's study group about social work programmes at psychiatric institutions. The focus group participants provided holistic views about challenges social workers might experience in delivering community-based support services. Working with a focus group in a group interview allowed for data generation by capitalising on communication between research participants.

Stellenbosch University's Research and Ethics Committee provided ethical clearance (Ethical Clearance Number: 8479). In line with Fouché's (2021) recommendations, the researcher also asked for written permission from the National and Provincial Department of Health to conduct the study (Ethical Clearance Number: WC_202110_028). The latter approved that research could be conducted at four psychiatric hospitals rendering social work services to families caring for adult relatives with mental illness in the Cape Metropole region of Western Cape. After obtaining approval from the identified psychiatric hospitals that social workers in their employment could be approached for research, informed consent was obtained from the social workers identified, as proposed by Fouché (2021). All information was treated with confidentiality in terms of the ethical code of conduct of the social work profession.

The researcher wanted to gain an understanding of social workers' views and challenges in implementing mental health policy and legislation while rendering social work support services to families caring for adult relatives with mental illness. The data obtained were grouped into themes, subthemes and categories following a seven-step process developed by Lincoln and Guba (1985) (Creswell, 2013; Fouché, 2021). The findings were then integrated and compared with the relevant literature.

RESULTS OF THE RESEARCH

The results of the research study are discussed below.

Biographical profile of social work participants in the first study group

The biographical details of the 17 social worker study group participants were given numbers to protect their identities and ensure confidentiality. Table 1 indicates the personal details of the participants, such as their gender, age range, years of working experience, level of education, and years working at their current employer.

Table 1: **Biographical details of participants (social workers study group)**

Participant	Gender	Age	Years of experience	Level of education	Years at current employer
1	Female	30-39	12 years	Bachelor of Social Work (BSW)	3 years
2	Female	50-60	23 years	Bachelor of Social Work (BSW)	3 years
3	Female	30-39	11 years	Postgraduate Diploma in Addiction	2 years
4	Male	60+	32 years	Bachelor of Arts (BA) + Honours in Social Work	28 years
5	Female	60+	44 years	Bachelor of Arts (BA) + Honours in Social Work	8 years
6	Male	30-39	16 years	Bachelor of Social Work (BSW)	14 years
7	Female	40-49	20 years	Bachelor of Arts (BA) + Honours in Social Work	7 years
8	Female	50-60	28 years	Master of Clinical Social Work (MCSW)	22 years
9	Female	30-39	12 years	Postgraduate Diploma in Addiction	9 years
10	Male	30-39	8 years	Bachelor of Social Work (BSW)	2 years
11	Female	40-49	17 years	Bachelor of Social Work (BSW)	16 years
12	Female	40-49	21 years	Master of Clinical Social Work (MCSW)	16 years
13	Female	50-60	18 years	Postgraduate Diploma in Addiction	6 years
14	Female	40-49	28 years	Master of Clinical Social Work (MCSW)	6 years
15	Male	50-60	30 years	Bachelor of Arts in Social Science	7 years
16	Female	50-60	29 years	B. Diac. Social Work	3 years
17	Female	20-29	3 years	Bachelor of Social Work	2 years

Biographical profile of social work supervisors in the focus group discussion

The biographical details of this study's selected focus group participants are shown in Table 2 below. The biographical details of the seven focus group participants were given numbers to protect their identity and ensure confidentiality. Biographic details of the participants, namely their gender, age range, years of working experience, level of education, and years at their current employer are presented in Table 2.

***Table 2*: Biographical details of focus group participants (social work supervisors)**

Participant	Gender	Age	Years of experience	Level of education	Years at current employer
FGP 1	Male	60+	40 years	Master of Social Work (MSW)	33 years
FGP 2	Female	50-60	35 years	Master of Social Work (MSW)	3 years
FGP 3	Female	50-60	28 years	Master of Social Work (MSW)	19 years
FGP 4	Female	60+	39 years	Master of Social Work (MSW)	31 years
FGP 5	Female	50-60	29 years	Master of Social Work (MSW)	10 years
FGP 6	Female	50-60	28 years	Master of Social Work (MSW)	16 years
FGP 7	Male	60+	35 years	Bachelor of Social Work (BSW)	35 years

VIEWS AND CHALLENGES REGARDING THE IMPLEMENTATION OF MENTAL HEALTH POLICY AND LEGISLATION

Interviews and focus group discussions were conducted with social workers and social work supervisors, who had extensive experience in supporting patients with mental illness and their families with the basic reintegration of patients into society and addressing the needs associated with the reintegration process. These social workers had a holistic view of the challenges in delivering community-based support services. The collected data are presented in a qualitative thematic analysis using themes, subthemes and categories. The views about mental health policy and legislation in South Africa were the point of departure, followed by the challenges experienced by social workers with the implementation of mental health policy and legislation. Two themes emerged and were grouped into four subthemes and 10 categories. The participants' narratives were presented as data, followed by a literature control. The themes, subthemes and categories that emerged from the data analysis are presented in Table 3 below.

***Table 3:* Themes, subthemes and categories emerging from the data analysis**

Themes	Subthemes	Categories
Theme 1: **Views on mental health policy and legislation**	1.1 Policy and legislation are comprehensive, but there are challenges	1.1.1 Policy and legislation are inclusive 1.1.2 Policy and legislation have advanced since apartheid, but implementation is challenging
	1.2 Deinstitutionalisation is an appropriate concept but not necessarily practical	1.2.1 Deinstitionalisation as a reintegration strategy 1.2.2 Deinstitionalisation protects human rights 1.2.3 Deinstitionalisation is ineffective in the SA context
Theme 2: **Challenges with the implementation of policy and legislation**	2.1 The mental health system does not include families in the care and treatment of their relatives with mental illness	2.1.1 Lack of clarity on the role of the family
	2.2 Challenges with the implementation of the MHCA	2.2.1 Lack of knowledge about the MHCA 2.2.2 Guidelines for service delivery in the MHCA not clear 2.2.3 Ineffectiveness of Mental Health Review Boards

Theme 1: Views about mental health policy and legislation

Theme 1 refers to the views of participants of the social worker and social work supervisor's group about mental health policy and legislation and is discussed according to two subthemes: that policy and legislation are ineffective, and that deinstitutionalisation is an appropriate but not necessarily practical concept. These subthemes have been divided into five respective categories.

Subtheme 1.1: Policy and legislation are comprehensive, but there are challenges

The first subtheme is that existing policy and legislation were comprehensive but challenging. Two categories emerged from this subtheme: that policy and legislation were inclusive, and that policy and legislation have advanced since apartheid, but that implementation was challenging.

Category 1.1.1: Policy and legislation are inclusive

Most participants viewed South African mental health policy and legislation to be inclusive, meaning, as indicated in the literature, that participation, social and economic development, micro-, meso- and macro-practice, and partnerships were equally important, and were integrated and inclusive in promoting and protecting mental health (Lombard & Bila, 2020). The social worker study group participants reported that mental health policy and legislation in South Africa were inclusive and called for holistic services to be delivered. Participants commented:

> *I see the policy as holistic, addressing many facets of mental health. It addresses many.* (Participant 2)

> *The Mental Health Care Act focus on holistic service to patients and families. The Act is clear for care and rehabilitation … it's an all-inclusive Act.* (Participant 4)

These views are confirmed by Regulation 6 of the MHCA (RSA, 2002), which aims to provide care, treatment and rehabilitation to persons with mental illness (Madlala & Sokudela, 2014).

Category 1.1.2: Policy and legislation have advanced since apartheid, but implementation is challenging

Participants also felt that, although policy and legislation have advanced since apartheid, the implementation was challenging. The social work study participants thought the current mental health legislation was better than the legislation implemented during apartheid.

> *Since apartheid, I do think that development in terms of policy and legislation has improved. If you are speaking about involuntary admission previously, there used to be no clear direction in terms of who can do what.* (Participant 3)

> *The current Mental Health Care Act. It's much better than the one before.* (Participant 4)

Janse van Rensburg *et al.* (2018) confirmed that the current mental health legislation has improved significantly since the apartheid era. The authors state that there was advocacy to

develop a policy that allowed for and encouraged personalised care closer to the patient's environment to minimise institutional dependence. According to Trilsch (2009), previous legislation, influenced by South Africa's history of apartheid, did not acknowledge the human rights of mentally ill patients and would, for instance, emphasise that persons with a mental illness should be removed from society and institutionalised with limited freedom.

However, some participants mentioned that, although the current legislation was comprehensive, implementing mental health policy and legislation failed people. Participants added that only the educated understood the current policy and legislation. This was expressed as follows:

> *I think these acts, especially in South Africa, don't correctly deal with our problems because the acts are there, but for me, it's just the interventions that go with these acts. These interventions aren't in place.* (Participant 12)

> *These policies tend to be superficial. They are good on paper* [but] *when it comes to implementation, it's very difficult to implement them. You must simplify these policies for the understanding of your client system, and mind you, our client system is quite broad. It entails those that are well-educated and those that are less educated or not educated at all.* (Participant 14)

Some focus group participants indicated that policies must change, and legislation must be implemented more effectively. These participants mentioned that the MHCA must be clear regarding the roles and responsibilities of mental health professionals, such as who was eligible to complete certain MHCA forms. An example is Form 4 – an application for assisted or involuntary care, treatment, and rehabilitation, which a medical doctor must complete. These participants said:

> *We need to change policies, and we need to implement the policies better.* (Focus group participant 1)

> *We have an issue with the doctors sometimes here at the hospital as they refuse to complete Form 4 (Involuntary and or assisted admission to a psychiatric institution), which is the implementation of the Act because they feel that it's not their duty. So that is one of the challenges we have about implementing the Mental Health Care Act and reporting or getting people admitted.* (Focus group participant 5)

The view that the MHCA was comprehensive but challenging to implement and that client systems often did not understand the Act is echoed by South African researchers, such as Salize, Schanda and Dressing (2008) and Daniels (2018), who indicated that despite good policy development, implementation of mental health policy and legislation was poor. It can be deduced that the overall implementation of mental health policy and legislation is challenging. Although some services were in place, less-educated patients and families found the policies and legislation challenging to understand.

Subtheme 1.2: Deinstitionalisation is an appropriate concept but not necessarily practical

The second subtheme about policy and legislation in the mental health context in South Africa, as referred to in the MHCA, was that participants thought deinstitutionalisation was an appropriate but not necessarily practical concept. Three categories derived from this subtheme are discussed below.

Category 1.2.1: Deinstitutionalisation as a reintegration strategy

Participants reported that deinstitutionalisation promoted the reintegration of patients with mental illness into communities. Participants from the social worker study group indicated that deinstitutionalisation enabled and prepared patients with mental illness to stay with their families in a place where they could continue their lives regardless of mental illness. These participants said:

> *Patients need to be prepared to be deinstitutionalised and reintegrated into the community and to find a place and purpose in a specific area of the patient's choice where he or she can be happy and treated well regardless of the impairment that was caused by the psychiatric illness.* (Participant 4)

> *It's a place for treatment and rehabilitation, so reintegration should happen; deinstitutionalisation goes hand in hand with integration back home.* (Participant 11)

The social worker study group viewed favourably the requirement in national mental health legislation and policies that people with a mental illness should be deinstitutionalised, reintegrated and treated in their communities with their families. The finding that deinstitutionalisation was a reintegration strategy is confirmed in the literature, which regards deinstitutionalisation as a process that should primarily focus on structuring and implementing community-based rehabilitation and reintegration services (Petersen *et al*., 2009).

Category 1.2.2: Deinstitutionalisation protects human rights

The social worker study group mentioned that deinstitutionalisation formed part of the process of protecting human rights. South Africa's apartheid history has negatively influenced the country's national policy and legislation on mental health services. After 1994, the policy and legislation changed to reflect the values of the South African Constitution, such as protecting the human rights of people with mental illness and ensuring the implementation of mental health service delivery (Brand, 2005). Participants stated:

> *Deinstitutionalised individuals' human rights should be protected and accepted into the community. I think the concept is good…* (Participant 3)

> *It's good for patients with mental illness to go back into the community and their human rights to be protected.* (Participant 17)

These participants indicated that, with the implementation of deinstitutionalisation, people's human rights are enhanced in line with one of the objectives of the NMHPF and Strategic Plan (2013-2020). The participants reported that current mental health legislation and policies have a positive effect on patients with mental illness who were reintegrated into communities to stay

with their families and live everyday lives like any other citizen (Mahdanian *et al.,* 2023; Mezzina *et al.,* 2019).

Category 1.2.3: Deinstitionalisation is ineffective in the South African context

However, deinstitutionalisation was ineffective in South Africa and emerged as a strong participant view. The social worker's group participants indicated that the concept was ineffective in South Africa because of various challenges, such as the lack of adequate community-based resources and structural factors such as poverty in communities. Thus, in South Africa, this policy shift was challenging because of limited community-based facilities and communities being unprepared to reintegrate patients. Participants from the social worker study group indicated the following:

> *I think the deinstitutionalisation doesn't work; it was the model of overseas. Overseas, they have many resources and structures in place. But if you look at the South African context, we come from an area where even our communities are struggling in terms of economic factors, poverty, there's not a lot of resources in the community, there's not a lot of funding.* (Participant 12)

> *I don't think that our resources and structures in South Africa support people with mental health individuals who have chronic mental illness; communities cannot accommodate them.* (Participant 3)

Participants from both study groups mentioned that communities were unprepared for deinstitutionalisation because of a lack of proper planning for sufficient community facilities to accommodate patients. They stated:

> *The deinstitutionalisation policy was implemented without proper planning. I don't think it was thought through; I suppose they were in institutions because families weren't coping. Families are still not coping, but what support systems have been put in place to support those families in the communities?* (Participant 8)

> *Patients shouldn't be in hospitals; they should be in the community, but the communities are not ready or have the resources to care for them.* (Focus group participant 3)

Participants of both study groups thought that support to communities to activate different resources had not materialised and that no practical structures and resources were in place to support patients correctly. They said:

> *Activating resources to ensure institutionalised people are correctly supported and sustained has never happened.* (Focus group participant 2)

> *That deinstitutionalisation concept is like the theory. There is a theory, but there are no practical structures.* (Participant 11)

Participants from the social workers' study group further reported that limiting hospital beds and deinstitutionalising patients caused a strain and burden for families, as families were ill-

prepared for this policy change and could not cope because of a lack of support structures in their communities.

> *There's an escalation in terms of admissions, but there's nowhere for people to go as deinstitutionalisation has put this pressure on not only the hospital beds but also on the very few available community facilities.* (Participant 5)

> *The 2010 Mental Health Action Plan wanted to downsize the tertiary hospitals, to make it smaller, but would provide more resources in the community, but they just didn't fulfil that, and it manifests in crisis discharges which is one of the very big problems that is an extra burden on families.* (Participant 4)

> *Our system is not ready to cater for deinstitutionalisation as there are no resources out there, because if the family cannot look after the patient. There is no group home; there are no resources in the community.* (Participant 11)

One participant from the supervisor group reported that deinstitutionalisation would not work if families were unprepared to care for their relatives with mental illness, because the sudden return of a patient from an institution would result in families feeling burdened. The participant said:

> *We can't just deinstitutionalise patients without preparation. Deinstitutionalisation won't work because we didn't prepare families and because they thought this person was gone for good and suddenly now, they must look after this person again, which is a burden for families.* (Focus group participant 11)

This feedback indicates that the process of deinstitutionalisation, as envisioned by the MHCA, focused more on the emergency management of patients and less on the development of long-term, sustainable community resources and proper planning aimed at rehabilitating patients with mental illness to live with their families and communities. Here, the views of authors such as Chow and Priebe (2013) and Kramers-Olen (2014) might be considered. They reported that it was irresponsible to assume that deinstitutionalisation was the most appropriate approach to care for people with mental illness, or that it was a less expensive alternative to institutionalisation. They argued that the latter view is a myth that infuses decision-making and policy development. According to this study group, although deinstitutionalisation theory is ethical, it might not be as effective in practice in South Africa, as families and communities have not been prepared to reintegrate and care for patients with mental illness. This means that the appropriateness of deinstitutionalisation in the South African context should be considered in terms of the lack of focus on developing sustainable community resources, as it might be considered irresponsible.

Theme 2: Challenges with implementation of mental health policy and legislation

Theme 2 refers to the challenges that social workers and social work supervisors experience in implementing policy and legislation when rendering social work support services to families caring for relatives with mental illness. Glanz *et al*. (2008) believe that the challenges regarding implementing mental health policy and legislation have a cascading influence on the interactions between families and communities. Two subthemes emerged from theme 2: that

the mental health system does not include families in the care and treatment of their relative with a mental illness, and that challenges were experienced with the implementation of the MHCA.

Subtheme 2.1: The mental health system does not include families in the care and treatment of their relatives with mental illness

Participants from the social work group and social work supervisors indicated that families were not included in the care and treatment of their relatives with mental illness and that support for those families was limited. This lack of meaningful inclusion of families in the treatment and care of their relatives with mental illness was highlighted more than 10 years ago as the experience of many families who had to rely on the mental health system (Funk *et al*., 2010; Kleintjes *et al*., 2013). This lack of inclusion of families in treatment could still be linked to participants' views in this study, who indicated that the role the family was expected to fulfil in the deinstitutionalisation of relatives with a mental illness was unclear.

Category 2.1.1: Lack of clarity on the role of the family

The lack of clarity on the roles of families emerged as a critical view, as participants of both study groups confirmed that families' roles were not clearly defined. Participants added that the focus of support services during the care and treatment of the patient was mostly patient-related and not family-related – even though families were regarded as the primary custodians of their relatives with mental illness as they were essential role players in the implementation of deinstitutionalisation. Participants also mentioned that families were the experts in caring for their relatives and had to be involved in policy formulation, which would be one way of acknowledging them. These participants said:

> *The guidelines and the framework acknowledge that there's a family system. Legislation and framework are being aimed at mentally ill individuals, but not aimed at family members. From a government perspective, if they go in that direction of having a family framework guideline, that's one of the ways of hearing them and acknowledging families.* (Participant 3)

> *Families need to be involved in terms of policy formulation from the outset because, ultimately, families are the best experts because they are taking care of the relative with a mental illness 24/7.* (Participant 6)

> *I think the Mental Health Care Act for me, does not work well in terms of our families. When it comes to the carer and or families, they are not involved in the treatment and care of the patient, the Act mainly focuses on the patient.* (Participant 12)

> *We do need to focus on the family, and I think the policies should include them as they are the ones taking care of the patient.* (Focus group participant 1)

This lack of focus on families in the MHCA was confirmed by the research of Faydi *et al.* (2011), which found that implementing mental health policies and legislation in Ghana, South Africa, Uganda and Zambia was ineffective. It was also found that the empowerment and

advocacy of people with mental illness and their families, as well as intersectoral collaboration, were not sufficiently addressed.

Subtheme 2.2: Challenges with the implementation of the MHCA

The last subtheme of Theme 2 – challenges experienced in service rendering was identified as challenges in implementing the MHCA. Three categories emerged from this subtheme: a lack of knowledge about the MHCA, unclear guidelines for service delivery in the MHCA, and the ineffectiveness of the Mental Health Review Boards (MHRBs).

Category 2.2.1: Lack of knowledge about the MHCA

In this category, it became evident that participants from the social work study group lacked knowledge about the MHCA. The participants indicated:

> *I'm not sure whether it's 1983 or because I haven't really, you know… Lately, I went to revisit the policy because I didn't know the questions would touch on policy.* (Participant 2)

> *The Mental Health Care Act for me is not a well-known Act. We, as people who are working with the policy itself, are not clued up with everything that is going on in the Mental Health Care Act.* (Participant 11)

Participants from both study groups experienced that service providers, such as community-based organisations and the Department of Social Development, felt uncomfortable working in mental health settings or with families affected by mental illness because they were uninformed or lacked the knowledge or skills to render mental health services. Participants said:

> *There is a lot of ignorance amongst community-based resources on how to implement the Act, to put the Act into practice and how to render a service optimally.* (Participant 16)

> *The Department of Social Development has a complete lack of information about mental illness, a lack of understanding of the MHCA, and a lack of education for the families.* (Focus group participant 5)

Maharaj (2021) cautioned that the lack of knowledge and general ignorance regarding the MHCA's implementation prevented social workers and other service providers from rendering optimal services to families caring for relatives with mental illness, which correlates with the study participants' views. Anand (2024) confirmed that limited knowledge about the MHCA could also be linked to community social workers, who did not view rendering mental health services as part of the scope of their practice. Nearly a decade ago, some South African scholars highlighted the lack of knowledge and skills in dealing with social work mental health. Ornellas (2014) clarified that community social workers did not equip themselves with the necessary knowledge and skills to render services within the mental health field. This situation was also highlighted by Olckers (2013), who stated that social workers were rendering mental health services without sufficient training and knowledge of the MHCA, which was a serious concern.

Category 2.2.2: Guidelines for service delivery in the MHCA not clear

In exploring further challenges experienced with implementing the MHCA, guidelines for service delivery as stipulated in the MHCA emerged as a challenge. Although many participants felt policies were essentially good on paper, the guidelines for service delivery were vague and poorly implemented, in their view. This was confirmed by the following participant, who stated that the MHCA was not well known and had vague guidelines.

> *The Mental Health Care Act for me is not a well-known Act. I don't know if it's because of negligence from myself but it is not well-known, and the guidelines are not clear and not being followed.* (Participant 11)

Another participant echoed this and stated that mental health policies and legislation were not implemented effectively.

> *These policies tend to be superficial. They are good on paper, but when it comes to implementation, it's very difficult to implement them because, at the end of the day, the information stops with you as a service provider because of not being trained on these policies to implement them effectively.* (Participant 14)

According to these participants, the MHCA and its guidelines are considered superficial, relatively unknown, vague and difficult to implement. However, this could be ascribed to a lack of knowledge, as Ornellas (2014) confirmed.

Category 2.2.3: The Ineffectiveness of Mental Health Review Boards

The Mental Health Review Boards (MHRBs) have been identified as a further obstacle in implementing the MHCA. Since 2005, the Provincial Executive Councils of South Africa established these quasi-judicial structures in terms of the MHCA. By April 2019, more than 20 MHRBs had been established in South Africa's provinces. When it comes to mental health issues, the MHRBs are 'watchdogs' that must regulate to ensure that mental institutions comply with the MHCA and that the rights of individuals with mental illness are protected (Lund, 2016; Swanepoel & Mahomed, 2021). Participants from the social worker group and social work supervisors group questioned the functionality and effectiveness of the MHRBs. Participants indicated that communication on MHRBs' expectations of social workers was vague. They continued that MHRBs were mostly dictating to and underestimating the roles of social workers. The participants reported:

> *In the last two years, the Mental Health Review Board has become redundant, there was no visits, in the period of COVID-19. Never clear communication from their side regarding the fact that they're not going to be doing visits. So, these complaints or concerns and appeals went to their offices, and nobody acted.* (Participant 5)

> *You know, the Review Boards I think from a social point of view, I really think there's an underestimation of our roles. I think they solely perceive our roles to be administrative in nature. Uhm... it's very dictated most of the time because they think what social workers ought to be doing what they can do. They think they have an idea of the scope of practice or social work. So, I think this is something that we are*

> *battling with for a couple of years now is the underestimation of our roles. Because they just zoom in from a legal perspective, but without having a social work background as well. So yeah, this is technical, as their only aim is to protect the patients, but we should work in conjunction with them, and they shouldn't perceive us as a separate body. How can we strengthen this partnership to make it better for our patients?* (Participant 6)

A participant from the social work supervisor's focus group mentioned that the MHRBs would demand that certain investigations be conducted by social workers instead of reporting the case to the police.

> *Mental health review board oversee that the rights of patients are taken care of, and they will ask questions about things such as abuse, but then I think also they cannot just come to us and say we need to investigate a case about abuse because we work in a hospital as social workers, we need to refer the case to the police…*(Focus group participant 3)

Based on the participants' contributions, it was apparent that social workers thought that MHRBs were redundant. MHRBs mostly dictated to social workers what they had to do in psychiatric hospitals, without the boards performing their allocated functions. These participants thought that the MHRBs underestimated social workers' roles and the scope of social work practice regarding services rendered to patients with mental illness and their families and communities. Participants further pointed out that communication from MHRBs was vague, for example, on what was expected from social workers regarding investigations into allegations of patients' rights being violated.

Thus, to ensure that quality care and human rights conditions in mental health and social care facilities are aligned with best practice and human rights standards Marais and Petersen (2015) suggest that optimal services are delivered to patients with mental illness and their families, and that social workers and the MHRBs must improve and strengthen their working relationships.

DISCUSSION

Ever since South Africa became a democracy, legislation and policies dealing with mental health issues have improved and developed significantly. Today, many legislative acts and policies are inclusive and address several facets of mental health service delivery. One of these pieces of legislation is the comprehensive MHCA (RSA, 2002). This study indicated that the MHCA, among other things, focused on deinstitutionalisation, which is regarded as an acceptable reintegration strategy in South Africa as it protects and enhances the human rights of people with mental illness. Deinstitutionalisation also enables patients with mental illness to remain with their families in a place where they can continue with their lives, regardless of their mental illness.

However, according to the findings of this study, and although the MHCA is theoretically comprehensive, its implementation has been ineffective in serving patients with mental illness and those rendering services to patients with mental illness, their families and their

communities. Participants of this study emphasised that the MHCA's policy of deinstitutionalisation focused more on the treatment of patients with mental illness than on their effective reintegration with their families and communities. These participants also believed that the MHCA and its guidelines were not clear about service delivery to families of patients with mental illness and that there was an overall lack of training about service delivery to families and communities.

The participants identified a further obstacle to deinstitutionalisation: the absence of clear guidelines for deinstitutionalisation that accommodate mental health policy and legislation. Participants thought that not sufficient consideration was given to the infrastructure requirements of the deinstitutionalisation process the MHCA proposed. The process of deinstitutionalisation meant that hospitals were faced with insufficient care facilities for patients with mental illness. Burns (2011) and Maparura (2017) further highlighted a shortage of beds, the non-existence of acute admission wards for patients with chronic mental illness who posed severe health and safety hazards, not being able to separate male and female patients, and not being able to offer facilities for isolation of patients as current issues. These challenges compromised the ability of general healthcare workers to honour the standards and values enshrined in the MHCA, namely, to render effective services within their available resources.

The basis of deinstitutionalisation, as emphasised in policy and legislation, is that patients with mental illness should be enabled to join their families and communities to live as much of everyday life as possible (Jones & Gallus, 2016). In this process, the families of patients with mental illness are key role players as they must take on the responsibility of looking after their relatives with mental illness. The MHCA's lack of clarity about the role of families in taking care of their relatives with mental illness was concerning for the study group participants even though, as stated by Mabunda (2018), the MHCA acknowledged families to be the primary custodians of patients with mental illness. The participants agreed that the focus of social work services was mainly on patients and not on families, which are some of the most important role players in effectively implementing the shift to deinstitutionalisation. Therefore, families must be involved in formulating policy – which would be one way of acknowledging them.

Participants were also concerned about community service providers who felt uncomfortable working in the mental health context or were ignorant or lacked knowledge and skills about the MHCA and providing services according to its terms. The misinterpretation of the MHCA, which in theory is a good act, emerged as another result of poorly implemented policies.

Other challenges that could be tied to the implementation of the MHCA included a lack of knowledge about the Act amongst social workers and their supervisors and the vague guidelines for the delivery of services. The results of this study highlighted that the MHCA was not as well known among social work professionals as it should be, with many acknowledging that they had not read the document. The perception is that their views on the Act are based on experiences with implementation and not on actual knowledge of its content.

The ineffectiveness of the MHRBs has also been identified as a challenge as there was no clear communication on what these MHRBs expected from social workers, as they were mostly

dictating to social workers rendering support services to patients with mental illness and their families and communities, and at the same time underestimating the roles and functions of these social workers.

RECOMMENDATIONS

Although South Africa's mental health policy and legislation have improved since apartheid, implementation has been poor. The shift to deinstitutionalisation aimed to better protect the human rights of patients with mental illness because, in theory, these patients could stay with their families instead of having to be institutionalised (Spamers, 2016). However, deinstitutionalisation has not necessarily been implemented effectively, as families and communities were not ready or prepared to care for patients with mental illness because of a lack of development of sufficient community-based resources.

It is recommended that:

- the Department of Health should provide intensive education to all social work professionals on the provisions and Regulations of the MHCA to expand their knowledge about providing social services to families affected by having to care for relatives with mental illness; and
- policymakers should review and reassess the implications of the MHCA and address the lack of community-based resources to support the successful implementation of deinstitutionalisation.

With the focus on deinstitutionalisation and on caring for and treating patients with mental illness, the importance of rendering social work services to families caring for relatives with mental illness was not included in the mental healthcare system. Despite this challenge, optimal service delivery to families is difficult, because social workers are uninformed about implementing the MHCA, which may cause them to misinterpret the Act. In addition, the MHRBs, established in terms of the MHCA, are ineffective as they mostly dictate what social workers should do, while underestimating the roles of social workers.

It is recommended that:

- the MHCA must be reviewed and reassessed regarding the role of families, as the focus is more on patient care, treatment and rehabilitation without considering that implementing deinstitutionalisation specifically relates to an increased burden on families who were caring for their relatives with mental illness;
- in-service training on mental health had to be offered regularly by psychiatric social workers to community-based organisations to equip social workers with new information and developments to improve their knowledge and skills in community-based service rendering;
- the Department of Health should increase training on the MHCA for all social work professionals working with families who look after relatives with mental illness to increase an understanding of the implementation of the Act; and

- social workers must educate MHRBs on social work practice and their role in rendering services to families of patients with mental illness, as well as finding ways to streamline clear communication regarding the expectations of the MHRBs.

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