Section 16. Human Rights and Mental Health

Human Rights and Mental Health

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“The most deadly criticism one could make of modern civilization is that apart from its man-made crises and catastrophes, it is not humanly interesting... In the end, such a civilization can produce only a mass man: incapable of spontaneous, self-directed activities: at best patient, docile, disciplined to monotonous work to an almost pathetic degree... Ultimately such a society produces only two groups of men: the conditioners and the conditioned, the active and passive barbarians.”

Lewis Mumford, 1951

Bruce Levine PHD; Why the Rise of Mental Illness? Pathologizing Normal, Adverse Drug Effects, a Peculiar Rebellion; Mad in America

“The bees were continually rebuilding unsatisfactory cells as the comb grew outwards.”

CC Pollen Co The Importance of Bees http://www.beepollen.com/the-importance-of-bees/

Many people are scared of diversity because they think it’s somehow the opposite of teamness. This is a fallacy.

In searching for a fresh idea, the best teams I’ve worked with have been the most diverse.... but that collective should be eclectic and not an excuse to join an intellectual club.

John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009
This section, like the others, is prepared in such a way that the experts in their fields primarily tell the story. The sources are clearly displayed and the reader can seek them out for further interrogation of the subject matter.

Note 2: PsySSA, SASOP, SADAG and SAFMH were invited to contribute to this section. Only SAFMH responded. This is a ‘living document’ and contributions are welcome at all times. There is nothing like the other side of the story to change opinions.

Max du Preez; A Rumour of Spring; Chap. 1 Multiply wounded, multiply traumatised; 2013; Zebra Press

‘It’s all very complex, contradictory and schizophrenic.

But however much whites contributed to development in this country and however decent many of them may have been, the stark reality remains that they and their ancestors inflicted immeasurable psychological and developmental damage on generations of black people and that we are still feeling the effects of this in 2013.

I don’t think white South Africans who had no active, direct role in apartheid should grovel or be paralysed with guilt. But we should acknowledge the hurt and damage it caused, and the direct and indirect ways we benefited from white domination; we should acknowledge that the legacy of apartheid still affects our communities; we should communicate that to the people who were so hurt and damaged; and we should take responsibility for our past and that of our ancestors.’

Sadly, the South African population has struggled to close the Human Rights gap between the legacy of our euro-centric past and our ambitious constitution. Mental Health in South Africa, when taken in conjunction with what has been referred to in Section 1 of this proposal as the “Health Gang” (Substance Abuse, HIV/Aids, Poverty and Violence), is sorely deprived of Human Rights value. What is so frustrating is that the resources that do exist could be doing so much more with what they have. Unfortunately there appear to be too many vested interests at play, and the very organisations that should be at the forefront of solutions are in fact, part of the problem.

Undoubtedly South Africa has made Human Rights progress, modernising its Mental Health/Illness legislation. Potentially, for the most part, this legislation should enable service providers to both become more effective and to move toward the envisaged goal of integrated Health Care. Unfortunately this has been slow in gaining traction. There appear to be a number of reasons for this:

1. Government finance has not exactly been gushing from the coffers
2. A absence of effective leadership in all sectors
3. The only representation the Psychology and Psychiatry sectors have are Guilds/Unions whose primary interest is the enhancement of their membership
4. Advocacy is only in an embryonic state
5. Activism has played second fiddle to Climate Change and Wildlife issues

State Finance: This proposal does not debate the relative prioritisation of government expenditure. The only note is the ‘stuck record’ which applies to most economies world-wide — if appropriate expenditure is not forthcoming society as a whole will continue to suffer. From a South African point of view, the Trauma lens provides us with the most important barometer of those ills. In our case it’s a Trauma magnifier on Human Rights that is required. PTSD is the only Trauma paradigm that even gets a mention in our public discourse on Mental Illness and Mental Health. This, as much of this document is devoted to, ignores the Community and Cultural Trauma that pervades our social landscape on a massive intergenerational scale.

Hollywood always reminds us that staring at peeling wallpaper from your mattress on the floor, while desperation sucks at your soul, often produces the goods. But once survival mode has been transcended and there’s food on the table, things tend to change a little.

John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009

Leadership: If we had committed leadership in Mental Health we would have had the change we needed and increased momentum by now. For a variety of reasons leadership practice has confined itself to narrow personal and
'professional' parameters. Leaders have found no compelling reasons to go beyond their contracted walls and take risks in the interest of progress. The Ekurhuleni Declaration was probably necessary but possibly a convenient 'guilt blanket' for leaders to hide behind. Instead of taking ownership of the declaration, leaders now appear to defer to it as their actual level of commitment.

**PsySSA and SASOP:** Neither of these organisations participates in solution thinking. This statement may come as a shock or be simply dismissed with scorn by these organisations, but as Einstein concluded, you cannot produce solutions without identifying the real problems. PsySSA and SASOP seem to overlook the fact that they are part of the problem. No problem identification, no solution thinking.

**SASOP**

This Section does feature well thought out SASOP responses to our national strategic plan and legislation; providing very logical argument – if you are a SASOP member. Supply of psychiatrists is minimal and demand is great. All these SASOP submissions take advantage of that. Of course we need Psychiatrists in critical roles going forward, but just where are they going to come from? We have less than 400 active psychiatrists in South Africa and the personal sacrifices it’s going to take to make a public Human Rights difference are not going to come from this generation of SASOP leaders—or they would have done so already. SASOP has no publically available answers as to how they would supply the much needed shortfall. Their position seems to be that the Government must throw money at the problem and the resources will somehow materialise.

It remains an extraordinary mystery as to how come our Mental Health Act does not define “diagnosis” nor does it give any indication as to what authority ‘diagnosis’ has to defer. It’s a critical issue in psychiatry so it can only be deduced that the omission is deliberate and not an oversight. The legal implications are profound. So are the Human Rights issues. The people need to know what guides the hand of the ‘caregiver’.

In Section 8 of this proposal, SASOP’s Treatment Guidelines are introduced to the public outside world, probably for the first time. It’s so very encouraging to know about the efforts of some of SASOP’s members to make ‘diagnostics’ locally relevant. Why the secrecy? Perhaps SASOP believes it’s not in the public interest, or the public does not have a need to know. If either of these possibilities are found to be true, then there potentially damaging legal and Human Rights consequences for SASOP and South Africa. When the next Oscar Pretorius is standing on the global court room stage, how will SASOP defend a psychiatric evaluation? DSM? ICD? TGPD?

An informed Criminal Justice system could be thrown into chaos if (as they could be) the DSM was presented as ‘unworthy’, the ICD ‘unready’ and the TGPD ‘incomplete’. At the very least, our Criminal Justice System needs to be informed of either a single source in law, or that there are options – options that have very real, very critical differences between them. Relying on Peer Review is simply inadequate in Human Rights terms, as many opinions exist within Psychiatry itself. Pity the poor as they have even less redress to professional in/competence levels of psychiatric assessors in the courts. This is SASOP’s patch. It’s their Human Rights obligation to fix this.

The SASOP slogan – “There is no complete mental health without psychiatry” speaks volumes in innuendo which readers can deduce for themselves.

**PsySSA**

It’s imperative for a Psychiatrist to belong to SASOP but that is not the case with of psychologists and PsySSA. Many psychologists who are not members of PsySSA privately express dissatisfaction with their lack of progress, yet continue to benefit from the Union efforts in terms of the fees they can charge. From time to time alternative organisations have been formed without sustained success, possibly due to passion and enthusiasm being dampened in a Health economy characterised by demand so greatly exceeding supply.

Whilst on platform after platform Psychologists debate the relevance of their profession in a modern world, the point is continually missed that psychology faces redundancy because it fails to identify customer needs and supply appropriate solutions. Psychology is primarily method driven, not needs driven. What this so often results in, is a customer only being methodologically measured by their Mental Health behaviour and not, additionally, by their more natural human consumption behavior. Choice becomes the realm of the therapist and not the patient.

This Section highlights an interview with South African legend Saths Cooper. Herewith an additional extract:
'There has been a burgeoning of psychology over the last 18 months because, post ICP2012, people have seen that the psychology that exists in South Africa can hold its own. Despite the heavy practice orientation, there is serious attempt to ground psychology in the sciences. In the next few years, we are going to be inundated with conferences like we have already been. South Africa is a firm member of the International Union, but it is amazing how many other countries, both western and from the global south, have looked to South Africa to unpack issues that have just been stalemated in a sense.

We have access to a veritable human laboratory of behaviors that we have not come to understand. And we have to take advantage of that in its multicultural richness, in its violence and daily stress ridden conditions but also in its propensity for resilience. So a lot of people will, I think, start taking lessons from South Africa if we continue to play those leadership roles. Already, we have sizeable bodies of thought in psychology that are ground breaking. We need to extend those to other areas, for example, development in education, in policy, in new interventions through our understanding of fellow South Africans.

We should also make psychology more in tune with the realities we face. I am not saying find a different psychology, but the psychology we end up with should have an element of proudly South African . . . South Africa, warts and all . . . so that we are not presenting only the negatives. It is easier to do research on the negatives. There are positives too. For example, we are the only country I know of where the salaries of psychologists are on par with doctors and dentists in the public sector. There are so many other firsts that we’ve got despite the terrible history of apartheid.’

Even though Saths Cooper is calling for many of the same things that TRISI is proposing, unless there is an appreciation of the consequences of everything that is said in this extract, psychology will not be able to just sweep away the fact that it is currently part of the problem. If we do have “sizeable bodies of thought in psychology that are ground breaking” then we need to see where that ground is being broken in South Africa and how it is supported and how it is rolled out. Unfortunately the ‘broken ground’ is simply not available for evaluation in the public domain, even if one’s cyber sources are sophisticated and the definition of ‘public’ is stretched. Where breakthrough thinking is prevalent it appears to be in small pockets and small samples. There is no evidence of this specifically being shared, organised and applied across the nation. We need to celebrate these achievements, but first we, the public, need to know about them. Honestly, a public barometer of goals and achievements would do wonders for public morale.

Without a single hesitation, every support must be given to the principle of a ‘proudly South African’, Psychology work force. However, with respect, the salaries of Psychologists equalling Dentists, in isolation, is not a symbol of a profession we should be proud of. In fact it’s more akin to the tactics of COSATU who have driven wages up and employment down. If the profession was actively marketing the benefits of a career in psychology in the public space and if the profession was actively building the skills sets of an intermediary therapy resource, then perhaps this would be something to be proud of. In isolation it is simply the efficiency of a guild for the benefit of a very few. South Africa desperately needs greater on-the-ground numbers in all levels of Mental Health recovery. Where are the public campaigns by PsySSA? Why aren’t the advantages of a career in psychology plastered all over PsySSA’s web site? Why isn’t such career promotion supported by innovative education funding mechanisms? None of this is expensive.

If we should be so proud of South African psychology’s contribution to global solutions then why is this not in the public domain; celebrated widely? We so badly need good news stories as South African’s and for the morale of all who work in Mental Health.

Sadly we do still have “a veritable human laboratory of behaviors that we have not come to understand”. Great strides have been made by New Zealand, Australia, Canada and even the US in dealing with both Trauma and mental Health Cultural needs amongst ‘minorities’ yet we have buried discourse on Trauma and made no notable Cultural progress with the Mental Health Care of our ‘majority-minorities’. Why are we not leaders in the field of Cultural Trauma and Community Trauma? What is our reluctance to even enter the “laboratory” (sic)? There are many in the real world of human suffering, who will say it’s simply a continuation of the racial inequity of apartheid. Others will say it’s a deliberate Human Rights prejudice against the poor. Who is to prove them wrong when nothing is being done at home? Apathy is far worse than discrimination!
Assuming this international contribution by South African psychology to be validated – and we certainly continually produce innovative intellect across all human fields of endeavour so we can believe that it is possibly true even if it has not been revealed to the public – how come we have not also used this leadership platform to listen to what others have to offer us? Or are we doing all the talking?

Whilst the global progress in dealing with Trauma across all Mental Health domains and co-existent Health issues of Substance Abuse, HIV/Aids, Poverty and Violence, we in South Africa have simply buried the public discourse on the subject since 1997 and walked away from the challenges that grow exponentially and daily. Naturally, the psychology profession cannot raise the already packaged, progressive, culturally sensitive and extremely promising concept of Trauma-Informed Care if Trauma in our country is itself denied.

Huge strides have come from Mental Health systems around the world collaborating on the solutions-centred work that has arisen from the much publicised Adverse Childhood Study, originally published in 1997 and replicated over 80 times in many diverse settings and across many diverse samples. Yet, tragically, mention ACEs in a South African discourse with the profession and the response is a blank stare. (Please see Section 5 of this proposal).

Despite the fact that Psychological First Aid was adopted in 2007, by the WHO and 260 countries, as the only viable disaster incident intervention, there has not been a single official attempt to deploy PFA in South Africa where we still utilize the much maligned Critical Incident Stress Debriefing, or some home baked methodologies that have no contribution to global advancement in that field.

If we focused our collective psychology intellect on just ACE’s, T-IC and PFA (which is expertise freely or very cheaply available to us) we would be “proudly South African” in a very short space of time – as we do have the “laboratory” (sic) full of human lab rats that desperately need this expertise – and like counterparts in Emergency Medicine – our South African ingenuity and dedication would soon make us global leaders in these fields. If only we had the will!

Advocacy: Advocacy in South Africa is in a very immature phase. It’s probably logical that in this phase “voice” is only given through conduit representation. Unfortunately that has just as many dangers as no voice at all and it’s time for us to move to actually empowering the customer voice.

Standing in the way of that progression, are advocacy conduits that have built their reputations on being the ‘voice’ of others. It’s all very well for an organisation to call itself an advocate for change, but you cannot be an advocate for ‘voice’ and the voice as well. If you become the customers only mouthpiece, very little can be achieved. Much can be learned from the young student advocates, engaging the University Fee system, as this document is being written. They have had enough of the lack of progress made by those who speak on their behalf.

Continuous grandstanding and ‘brand building’ by the advocacy conduit, will eventually become wallpaper. Same noise, same response. Advocacy must be delivered by the very people it is designed to add value to. It must be allowed to be radical and critical when it wishes to be. If appropriate voice is to be given to customer needs, 50% of the time and space cannot be given to the ‘advocate’ – the individuals or groups message will just be lost in the not so pretty floral wallpaper.

Additionally when an organisation has a vested interest in its own narrative this can lead to all sorts of unfortunate consequences. Whilst there is no denying that Depression and Anxiety need every bit of attention they can get, SADAG made the mistake of following the DSM IV and classifying PTSD as an Anxiety Disorder. Thankfully the much maligned DSM 5 got something right and hauled it out of there. Yet, in a society that has denied the existence of Trauma for nearly 20 years, how many traumatised people have SADAG convinced that what they are experiencing is Anxiety and Depression and not the consequences of Trauma – PTSD or not? How many depression medications have been prescribed to those never in need? Having effectively built a large customer base on this narrative, how does SADAG change its advocacy narrative profile?

No, the customer needs to be guided in matter of ‘voice’ by advocates without a vested interest. The advocate itself should be silent and not seek to build brand reputation on the disability of others.

The approach taken by SAFMH is much more encouraging. Their strategy is to empower groups to speak on their own behalf and all efforts should be made to support these endeavours by professional groups and the media alike.
One area of advocacy that is so badly neglected is the rights and needs of those at the South African front line - social care givers. Understaffed, underpaid – if at all. They are at continuous risk of secondary trauma and burnout which, in turn, places those in their care at great risk. Not only do we desperately need to keep these folk operating optimally we need to attract many more suitable candidates to a very fulfilling occupation. Social workers are also the conduit to many other ‘voices’ in their care. So, if ‘voice’ is given to the social worker then they in turn need to guide those in their care who wish to express themselves; toward organised advocacy (ala SAFMH) where their needs can form part of a collective impact.

However, it may be that social workers are often inhibited by their NGO employers. NGO’s are desperate for funds and when they are available, they are invariably come with strings attached – the private objectives and will of the donor. Thus, those social workers in the employ of the NGO will be diverted to fulfilling the donor needs, as opposed to the holistic customer needs.

There is an urgent requirement to give voice to social workers, throughout the spectrum of caregiving: from psychiatrists to devoted volunteers.

Activism: To satirically paraphrase SASOP – “Without Advocacy there is very little chance of Activism.” There are very, very few Activists and most of those have vested interests that inhibit free and open speech. It seems South Africans are more perplexed by Climate Change and Animal Rights than Human Rights. Or perhaps, in the case of the former at least, that is where the money is.

This Section is not saying that there are not dedicated people in our Mental Illness and Mental Health economies. Of course there are - many. Even those who bear the brunt of this criticism should probably all be lauded for their commitment and dedication. However, far from being under-resourced intellectually, there are too many vested interests at stake that drain the potential impact our intelligentsia could be having on Mental Health and Mental Illness challenges in our country. Even the reformers of yesteryear, despite South Africa falling way behind their original vision in Mental Health progress, appear happy and comfortable with where they are now – is there no more fight in the old dogs?

In order for our South African population to achieve anything approximating a reasonable Human Rights yield in Mental Health, certain organisations like PsySSA and SASOP must be radically overhauled to operate in a manner which puts the interest of the country first.

We have far more resources than we are admitting to. The problem is that the resources are being squandered a leadership that has self-interest as its primary goal. It’s time for a younger generation to take over. This is urgent.

Mental Health and Disability - Department of Health; No health without mental health; A cross-government mental health outcomes strategy for people of all ages; HM Government

‘The mental health and resilience of individuals, families and communities is fundamental to building a fair and free society which protects people’s human and civil rights. This can only be achieved if we all work together in partnership. We know that, being in control of our own lives, good relationships, purposeful activities and participation in our communities improve our mental health.’

Better mental health, mental wellbeing and better services must be better for all – whatever people’s age, race, religion or belief, sex, sexual orientation, disability, marital or civil partnership, pregnancy or maternity, or gender reassignment status.

Any mental health outcomes strategy is a strategy for equality and human rights. This is because reducing inequality and promoting individuals’ human rights reduces the risk of mental illness and promotes wellbeing.

Personalisation is about respecting a person’s human rights, dignity and autonomy, and their right to shape and determine the way they lead their life. Personalised support and services are designed for the purposes of independence, wellbeing and dignity. Every person who receives support should have choice and control, regardless of the care setting. This is of critical importance for people with mental health problems – we know that feeling in control leads to better mental health. Choice and control over their support services is just as important for ex-offenders, drug users and other socially excluded groups.’
Mental Health, Human Rights & Legislation


‘A global human rights emergency in mental health

We are facing a global human rights emergency in mental health. All over the world people with mental disabilities experience a wide range of human rights violations.

The UN convention on the rights of persons with disabilities - new hope for rights protection

The work of the WHO is informed by the Convention of the Rights of Persons with Disabilities. In 2008 the UN Convention on the Rights of Persons with Disabilities (CRPD) came into force. The Convention sets out a wide range of rights including, among others, civil and political rights, the right to live in the community, participation and inclusion, education, health, employment and social protection. Its coming into force marks a major milestone in efforts to promote, protect and ensure the full and equal enjoyment of all human rights of persons with disabilities.

What can be done?

- Raise awareness and advocate for change
- Develop mental health policies and laws that promote human rights
- Create mechanisms to assess and improve human rights conditions
- Train key stakeholders on the rights of people with mental disabilities

Department of Health; Republic of South Africa; NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013-2020

7.6 Human rights

‘By 2014:

1. The human rights of people living with mental illness will be promoted and protected, through the active implementation of the Mental Health Care Act (2002).
2. The Department of Health will work closely with the Ministry for Women, Children and Persons with Disability to ensure that provisions of the UN Convention on the Rights of Persons with Disabilities (2007) are actively implemented for persons with mental disability in South Africa.”¹⁷⁸

- Human rights

The human rights of people with mental illness should be promoted and protected
- The rights to equality, non-discrimination, dignity, respect, privacy, autonomy, information and participation should be upheld in the provision of mental health care.
- The rights to education, access to land, adequate housing, health care services, sufficient food, water and social security, including social assistance for the poor, and environmental rights for adult mental health care users should be pursued on a basis of progressive realisation. The non-conditional rights of mental health care users under the age of 18 years, including basic nutrition, shelter, basic health care services and social services, should be promoted and protected.’

Health Professions Council of South Africa; Human Rights, Ethics & Professional Practice Committee; http://www.hpcsa.co.za/Committees/HumanRights

‘The Human Rights, Ethics & Professional Practice Committee is set up primarily to promote respect for human rights and the rights of patients amongst persons registered with Council and to accordingly advise the Council and Professional Boards on such matters.

Responsibilities and functions

- advise the Council and Professional Boards on all matters pertaining to human and patient rights and dignity, and to promote respect for the human rights and rights of patients amongst persons registered with Council;
- advise the Council and Professional Boards on the establishment of appropriate guidelines of ethical conduct and behaviour and the maintenance of high standards of professional practice amongst persons registered with Council;
• initiate the formulation of policies, rules and rulings for approval by the Council and Professional Boards on appropriate professional and ethical behaviour and conduct of persons registered with Council;
• analyse issues raised by Committees of Preliminary Inquiry and Professional Conduct Committees regarding the treatment and care of patients and to advise the Council and Professional Boards on how to deal with such matters within the framework of professional practice;
• provide guidance to the professions with regard to the interpretation of the policies, rules and rulings on ethical and professional conduct made by Council and the Professional Boards, in relation to the human rights and dignity of patients;
• advise the Council and Professional Boards on any matter pertaining to Ethics, Health and Human Rights applicable to person registered with Council;
• Handle all other matters that management desires to have reviewed by the Committee;
• Regularly review and make recommendations about changes to the charter of the Committee;
• Obtain or perform an annual evaluation of the Committee’s performance and make applicable recommendations.’

The South African Medical Association; Human Rights, Law and Ethics Unit; https://www.samedical.org/links/law

‘The Human Rights, Law and Ethics Unit interacts with and co-ordinates liaison between SAMA and the Health Professions Council of South Africa and its Medical and Dental Professional Board on ethical guidelines and rules of Council. It plays a major role in advising individuals and institutions in the health care environment and assists members and 9 standing committees and other SAMA structures on human rights, legal and ethical issues within the medical field.’

HSPCS; PROFESSIONAL BOARD FOR PSYCHOLOGY RULES OF CONDUCT PERTAINING SPECIFICALLY TO PSYCHOLOGY; http://www.psyssa.com/documents/HPCSA%20Ethical%20Code%20of%20Professional%20Conduct.pdf

‘CHAPTER 2 PROFESSIONAL RELATIONS 10. Respect for human rights and others

(1) A psychologist shall respect the dignity and worth of a client and shall strive for the preservation and protection of fundamental human rights in all professional conduct.
(2) A psychologist shall respect the right of a client to hold values, attitudes, beliefs, and opinions that differ from their own.
(3) A psychologist shall recognise the inalienable human right to bodily and psychological integrity, including security in and control over his or her body and person, and the right not to be subjected to any procedure or experiment without his or her informed consent which shall be in a language that is easily understood by him or her.
(4) A psychologist shall never coerce a recipient of a psychological service into complying with the provision of such service nor shall he or she compel a client to give self-incriminating evidence via the use of psychological techniques or otherwise.’
What is Mental Health?

*Mental Health and Disability - Department of Health;* **No health without mental health: A cross-government mental health outcomes strategy for people of all ages;** **HM Government**

‘Mental health problems are common, and vary in their nature and severity and in their impact on an individual over time. They can be long lasting and can have a serious impact on quality of life for individuals and their families and carers. Again, we know a great deal about what works to improve outcomes; for example, we know that by intervening early we can prevent problems becoming more serious and long lasting. Different approaches are required for children, young people, adults of working age, adults with complex multiple needs and older people, but some approaches are effective in reducing distress and improving functioning across all protected groups. For instance, the principles of the recovery approach, which emphasises the importance of good relationships, education, employment and purpose alongside reductions in clinical symptoms, can apply to all age groups. Mental health services also need to recognise that it might be necessary to respond differently to some groups, particularly those with protected characteristics, in order to achieve similar outcomes.’

*WHO Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health; Investing in MENTAL HEALTH;* **2003**

‘Mental health is more than the mere lack of mental disorders. The positive dimension of mental health is stressed in WHO’s definition of health as contained in its constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one’s intellectual and emotional potential. It has also been defined as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined goals.’


‘A major obstacle for integrating mental health initiatives into global health programmes and primary healthcare services is lack of consensus on a definition of mental health. There is little agreement on a general definition of ‘mental health’ and currently there is widespread use of the term ‘mental health’ as a euphemism for ‘mental illness’. Mental health can be defined as the absence of mental disease or it can be defined as a state of being that also includes the biological, psychological or social factors which contribute to an individual’s mental state and ability to function within the environment.

For example, the WHO includes realising one’s potential, the ability to cope with normal life stresses and community contributions as core components of mental health. Other definitions extend beyond this to also include intellectual, emotional and spiritual development, positive self-perception, feelings of self-worth and physical health, and intrapersonal harmony. Prevention strategies may aim to decrease the rates of mental illness but promotion strategies aim at improving mental health. The possible scope of promotion initiatives depends on the definition of mental health.’

‘The purpose of this paper is to begin a global, interdisciplinary, interactive and inclusive series of dialogues leading to a consensus definition of mental health. It has been stimulated and informed by a recent debate about the need to redefine the term health. Huber et al emphasised that health should encompass an individual’s “ability to adapt and to self-manage” in response to challenges, rather than achieving “a state of complete wellbeing” as stated in current WHO definitions. They also argued that a new definition must consider the demographics of stakeholders involved and future advances in science. Responses to the article suggested the process of reconceptualising health be extended “beyond the esoteric world of academia and the pragmatic world of policy” 16 to include a “much wider lens to the aetiology of health” along with patients and lay members of the public. Huber et al’s definition of health could include mental health but it is not clear that this would be satisfactory to patients, practitioners or researchers.’
A pool of 25 researchers in mental health was identified through literature/internet searches to capture expertise in (1) ‘community mental health’ and ‘public mental health’, (2) ‘human rights’ and ‘global mental health’, (3) ‘positive mental health’ and ‘resilience’, (4) ‘recovery’ and ‘mental health’, and (5) ‘natural selection’ and ‘evolutionary origins’ of ‘mental health’.

The ‘What is Mental Health?’ survey was created and distributed electronically using the SurveyMonkey platform. Respondents were asked to describe their areas of expertise, and list or describe the core concepts of mental health. Respondents ranked four definitions (without citations) of mental health.

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<th>Definition of mental health</th>
<th>Most preferred (%)</th>
<th>Second most preferred (%)</th>
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| Public Health Agency of Canada
  *Mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity*
  WHO 19
  *Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*
  McKenzie K (personal communication, 2014)
  *A mentally healthy community offers people the ability to thrive. It is one in which people feel a sense of connectedness and there are also networks which link people from all walks of life to each other. There is a strong community identity but despite this the community is welcoming of diversity. People participate in their community, organize to combat common threats and offer support and aid for those in need*
  Huber et al. 20
  Mental health is the “ability to adapt and self-manage”
  Mental health is the “ability to adapt and self-manage”
  *None of the existing definitions are satisfactory* |
| 48                                                                                           | 24                                                             |
| 20                                                                                           | 26                                                             |
| 14                                                                                           | 28                                                             |
| 6                                                                                             | 8                                                              |
| 30                                                                                           | 6                                                              |
'The survey found dissatisfaction with current definitions of mental health. There was no consensus among this group on a common definition. However, there was significant agreement among subcomponents of the definitions, specifically factors beyond the ‘ability to adapt and selfmanage’, such as ‘diversity and community identity’ and creating distinct definitions, “one for individual and a parallel for community and society.”

‘...we propose a transdomain model of health (figure 4) to inform the development of a comprehensive definition for all aspects of health. This model builds on the three domains of health as described by WHO and Huber et al, and expands these definitions to include four specific overlapping areas and the empirical, moral and legal considerations discussed in the current study. First, all three domains of health should have a basic legal standard of functioning and adaptation. Our findings suggest that for physical health, a standard level of biological functioning and adaptation would include allostasis (ie, homeostatic maintenance in response to stress), whereas for mental health, a standard level of cognitive–emotional functioning and adaptation would include sense of coherence (ie, subjective experience of understanding and managing stressors), similar to Huber et al’s15 proposal. However, for social health, a standard level of interpersonal functioning and adaptation would include interdependence (ie, mutual reliance on, and responsibility to, others within society), rather than Huber et al’s15 focus on social participation (ie, balancing social and environmental challenges).’

Figure 4 - Transdomain Model of Health. This model builds on the three domains of health as described by WHO and Huber et al and expands these definitions to include four specific overlapping areas and the empirical, moral and legal considerations discussed in the current study. There are three domains of health (ie, physical, mental, and social), each of which would be defined in terms of a basic (human rights) standard of functioning and adaptation. There are four dynamic areas of integration or synergy between domains and examples of how the core concepts of mental health could be used to define them.


‘Mental health is different from the absence of mental illness, and is integral to our overall health. Mental health is a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community.
Good mental health buffers us from the stresses and hardships that are part of life for us all, and can help to reduce the risk of developing mental health problems and illnesses. Even when someone develops a mental health problem or illness, they can nevertheless experience good mental health and this can contribute to their journey of recovery.’

Government of Western Australia Mental Health Commission;  

‘Good mental health is a sense of wellbeing, confidence and self-esteem. It enables us to fully enjoy and appreciate other people, day-to-day life and our environment. When we are mentally healthy we can:

• form positive relationships
• use our abilities to reach our potential
• deal with life’s challenges’

US Department of Health and Human Services; What is Mental Health? http://www.mentalhealth.gov/basics/what-is-mental-health/

‘Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Over the course of your life, if you experience mental health problems, your thinking, mood, and behaviour could be affected. Many factors contribute to mental health problems, including:

• Biological factors, such as genes or brain chemistry
• Life experiences, such as trauma or abuse
• Family history of mental health problems

Mental health problems are common but help is available. People with mental health problems can get better and many recover completely.’

The Impact of Mental Illness

WHO Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health; Investing in Mental Health; 2003

‘Mental health has been hidden behind a curtain of stigma and discrimination for too long. It is time to bring it out into the open. The magnitude, suffering and burden in terms of disability and costs for individuals, families and societies are staggering. In the last few years, the world has become more aware of this enormous burden and the potential for mental health gains. We can make a difference using existing knowledge ready to be applied. We need to enhance our investment in mental health substantially and we need to do it now.’

The magnitude and burdens of the problem:

• As many as 450 million people suffer from a mental or behavioural disorder.
• Nearly 1 million people commit suicide every year.
• Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder).
• One in four families has at least one member with a mental disorder. Family members are often the primary caregivers of people with mental disorders. The extent of the burden of mental disorders on family members is difficult to assess and quantify, and is consequently often ignored. However, it does have a significant impact on the family’s quality of life.
In addition to the health and social costs, those suffering from mental illnesses are also victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions.

Mental and behavioural problems as risk factors for morbidity and mortality

‘It is becoming increasingly clear that mental functioning is fundamentally interconnected with physical and social functioning and health outcomes. For example, depression is a risk factor for cancer and heart diseases. And mental disorders such as depression, anxiety and substance-use disorders in patients who also suffer from physical disorders may result in poor compliance and failure to adhere to their treatment schedules. Furthermore, a number of behaviours such as smoking and sexual activities have been linked to the development of physical disorders such as carcinoma and HIV/AIDS. Among the 10 leading risk factors for the global burden of disease measured in DALYs, as identified in the World Health Report 2002, three were mental/behavioural (unsafe sex, tobacco use, alcohol use) and three others were significantly affected by mental/behavioural factors (overweight, blood pressure and cholesterol).’

‘Comorbidity, which signifies the simultaneous occurrence in a person of two or more disorders, is a topic of considerable and growing interest in the context of health care. Research supports the view that a number of mental disorders (e.g. depression, anxiety, substance abuse) occur in people suffering from both non-communicable and communicable diseases more often than would be expected by chance. And people suffering from chronic physical conditions have a greater probability of developing mental disorders such as depression. Rates of suicide are higher among people with physical disorders than among other people. Comorbidity results in lower adherence to medical treatment, an increase in disability and mortality, and higher health costs. However, comorbid mental disorders are often under-recognized and not always effectively treated. Increased awareness and understanding, as well as comprehensive integrated management may alleviate the burden caused by comorbid mental disorders on the individual, society and the health services.’

How much does mental illness cost?

‘Estimates of costs are not available for all the various disorders, and certainly not for all the countries in the world. Most methodologically sound studies have been conducted in the United States and the United Kingdom. At 1990 prices, mental health problems accounted for about 2.5% of GNP in the United States (Rice et al., 1990). In the
Member States of the European Union the cost of mental health problems is estimated to be between 3% and 4% of GNP (ILO, 2000), of which health-care costs account for an average of 2% of GNP.

Mental health problems in childhood generate additional costs in adulthood

The costs of childhood disorders can be both large and largely hidden (Knapp et al., 1999). Early onset of mental disorders disrupts education and early careers (Kessler et al., 1995). The consequences in adulthood can be enormous if effective treatment is not provided (Maughan & Rutter, 1998). Knapp shows in figure 4 that children with conduct disorders generate substantial additional costs from ages 10 to 27 years. These are not mainly related to health, as one would expect, but to education and criminal justice, creating a serious challenge for the social capital as a whole.

High costs of mental disorders compared to other major chronic conditions

A recent comparative study of the burdens of disease carried out within the United Kingdom’s National Health Service (NHS) demonstrated the relative and absolute costs of care for a wide range of disorders, including the comparatively high annual expenditure associated with chronic disease conditions such as psychosis and neurosis (NHS Executive, 1996; Figure 5 below).

The burden of substance abuse....
• 76.3 million persons are diagnosed with alcohol disorders;
• At least 15.3 million persons are affected by disorders related to drug use;
• Between 5 and 10 million people currently inject drugs;
• 5%–10% of all new HIV infections globally result from injecting drugs;
• More than 1.8 million deaths in 2000 were attributed to alcoholrelated risks; • 205,000 deaths in 2000 were attributed to illicit drug use (Figure 8);
• The government, drug abusers and their families shoulder the main economic burden of drug abuse; and • For every dollar invested in drug treatment, seven dollars are saved in health and social costs.’
'In South Africa, 25%–30% of general hospital admissions are directly or indirectly related to alcohol abuse (Albertyn & McCann, 1993), and 60%–75% of admissions in specialized substance abuse treatment centres are for alcohol-related problems and dependence. Almost 80% of all assault patients (both males and females) presenting to an urban trauma unit in Cape Town were either under the influence of alcohol, or injured because of alcohol-related violence (Steyn, 1996). The majority of victims of train-related accidents, traffic accidents – both pedestrians and drivers – had blood alcohol levels exceeding the legal limits (Van Kralingen et al, 1991). Foetal alcohol syndrome is by far the most common cause of mental disability in the country (Department of Trade and Industry, 1997).'

Talking about mental disorders means talking about poverty: the two are linked in a vicious circle

'Since mental disorders generate costs in terms of long-term treatment and lost productivity, it can be argued that such disorders contribute significantly to poverty. At the same time, insecurity, low educational levels, inadequate housing and malnutrition have all been recognized as contributing to common mental disorders. There is scientific evidence that depression is 1.5 to 2 times more prevalent among the low-income groups of a population. Poverty could therefore be considered a significant contributor to mental disorders, and vice-versa.'

The gap between the burden of mental disorders and resources...
What Causes Mental Illness?

Mayo Clinic [http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/definition/con-20033813]

‘2.2 Determinants of mental health and illness

Mental health has multiple biological, psychological and social determinants. These determinants interact in a complex manner, to provide protection of mental health or increase the risk for the development of mental illness. For example, a combination of genetic vulnerability, childhood trauma and adverse living circumstances brought about by poverty may predispose a particular woman to a major depressive episode. Conversely, a combination of genetic resilience, supportive and stimulating childhood environment, and opportunities for learning, work and fulfilment of social roles are protective of a particular person’s mental health. A person with mental illness may experience episodes of mental ill-health, which interrupt that person’s capacity to fulfil their work, family, social, academic and community roles. The mental disorder might follow a chronic, episodic course, or may resolve after one or more episodes.

Most mental disorders have their origins in childhood and adolescence. Approximately 50% of mental disorders begin before the age of 14 years. In South Africa, childhood adversity has been significantly associated with mood disorders, and posttraumatic stress disorder, major depression and substance-related disorders each significantly increased the chances that students did not complete secondary school.’

‘Mental illnesses, in general, are thought to be caused by a variety of genetic and environmental factors:

- **Inherited traits.** Mental illness is more common in people whose biological (blood) relatives also have a mental illness. Certain genes may increase your risk of developing a mental illness, and your life situation may trigger it.
- **Environmental exposures before birth.** Exposure to viruses, toxins, alcohol or drugs while in the womb can sometimes be linked to mental illness.
Brain chemistry. Biochemical changes in the brain are thought to affect mood and other aspects of mental health. Naturally occurring brain chemicals called neurotransmitters play a role in some mental illnesses. In some cases, hormonal imbalances affect mental health.”¹⁸¹ Mayo Clinic

MedicineNet.com http://www.medicinenet.com/mental_illness/article.htm

‘Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of genetic, biological, psychological, and environmental factors -- not personal weakness or a character defect -- and recovery from a mental illness is not simply a matter of will and self-discipline.

• Heredity (genetics): Many mental illnesses run in families, suggesting they may be passed on from parents to children through genes. Genes contain instructions for the function of each cell in the body and are responsible for how we look, act, think, etc. However, just because your mother or father may have or had a mental illness doesn't mean you will have one. Hereditary just means that you are more likely to get the condition than if you didn't have an affected family member. Experts believe that many mental conditions are linked to problems in multiple genes -- not just one, as with many diseases -- which is why a person inherits a susceptibility to a mental disorder but doesn't always develop the condition. The disorder itself occurs from the interaction of these genes and other factors -- such as psychological trauma and environmental stressors -- which can influence, or trigger, the illness in a person who has inherited a susceptibility to it.

• Biology: Some mental illnesses have been linked to an abnormal balance of brain chemicals called neurotransmitters. Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness. In addition, defects in or injury to certain areas of the brain also have been linked to some mental conditions.

• Psychological trauma: Some mental illnesses may be triggered by psychological trauma suffered as a child, such as severe emotional, physical, or sexual abuse; a significant early loss, such as the loss of a parent; and neglect.

• Environmental stressors: Certain stressors -- such as a death or divorce, a dysfunctional family life, changing jobs or schools, and substance abuse -- can trigger a disorder in a person who may be at risk for developing a mental illness.’


‘Mental health problems can have a wide range of causes. In most cases, no one is sure precisely what the cause of a particular problem is. We can often point to things that trigger a period of poor mental health but some people tend to be more deeply affected by these things than others.

The following factors could potentially trigger a period of poor mental health:

• childhood abuse, trauma, violence or neglect
• social isolation, loneliness or discrimination
• the death of someone close to you
• stress
• homelessness or poor housing
• social disadvantage, poverty or debt
• unemployment
• caring for a family member or friend
• a long-term physical health condition
• significant trauma as an adult, such as military combat, being involved in a serious accident or being the victim of a violent crime
• physical causes -- for example, a head injury or a condition such as epilepsy can have an impact on behaviour and mood (it is important to rule out causes such as this before seeking further treatment for a mental health problem)
• genetic factors -- there are genes that cause physical illnesses, so there may be genes that play a role in the development of mental health problems.
Why is Mental Illness on the rise?

Bruce Levine PHD; Why the Rise of Mental Illness? Pathologizing Normal, Adverse Drug Effects, and a Peculiar Rebellion; Mad in America

‘Severe, disabling mental illness has dramatically increased in the United States. Marcia Angell, in her 2011 New York Review of Books piece, summarizes: “The tally of those who are so disabled by mental disorders that they qualify for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) increased nearly two and a half times between 1987 and 2007—from 1 in 184 Americans to 1 in 76. For children, the rise is even more startling—a thirty-five-fold increase in the same two decades.”

Angell also reports that a large survey of adults conducted between 2001 and 2003 sponsored by the National Institute of Mental Health found that at some point in their lives, 46% of Americans met the criteria established by the American Psychiatric Association for at least one mental illness.’

‘Once it was routine for many respected social critics such as Lewis Mumford and Erich Fromm to express concern about the impact of modern civilization on our mental health. But today the idea that the mental illness epidemic is also being caused by a peculiar rebellion against a dehumanizing society has been, for the most part, removed from the mainstream map. When a societal problem grows to become all-encompassing, we often no longer even notice it.’

‘Underlying many of psychiatry’s nearly 400 diagnoses is the experience of helplessness, hopelessness, passivity, boredom, fear, isolation, and dehumanization - culminating in a loss of autonomy and community-connectedness. Do our societal institutions promote:

- Enthusiasm — or passivity?
- Respectful personal relationships — or manipulative impersonal ones?
- Community, trust, and confidence — or isolation, fear and paranoia?
- Empowerment — or helplessness?
- Autonomy (self-direction) — or heteronomy (institutional-direction)?
- Participatory democracy — or authoritarian hierarchies?
- Diversity and stimulation — or homogeneity and boredom?’

‘The reality is that with enough helplessness, hopelessness, passivity, boredom, fear, isolation, and dehumanization, we rebel and refuse to comply. Some of us rebel by becoming inattentive. Others become aggressive. In large numbers we eat, drink, and gamble too much. Still others become addicted to drugs — illicit and prescription. Millions work slavishly at dissatisfying jobs, become depressed and passive-aggressive, while no small number of us can’t cut it and become homeless and appear crazy. Feeling misunderstood and uncared about, millions of us ultimately rebel against societal demands, however; given our wherewithal, our rebellions are often passive and disorganized, and routinely futile and self-destructive.’

‘When we have hope, energy, and friends, we can choose to rebel against societal oppression with, for example, a wildcat strike or a back-to-the-land commune. But when we lack hope, energy, and friends, we routinely rebel without consciousness of rebellion and in a manner in which we today commonly call mental illness.’

Neil O’Brien; The remarkable rise of mental illness in Britain; The Telegraph; October, 2012

‘What’s going on? Did lots of people suddenly develop mental health problems in the 1990s? It’s difficult to compare statistics from before Incapacity Benefit replaced Invalidity Benefit and Sickness Benefit in 1995. But if we look at the proportion of working days lost to different types of illness shows that the rising importance of mental illness started in the 1970s or 1980s. (shown in the graph below). The number of claims for Invalidity Benefit for a mental illness went up about 47 per cent in the seventies, and 57 per cent in the 1980s.'
Younger people are much more likely to be incapacitated by mental illness rather than other causes. In fact 60 per cent of young (25-34) men claiming IB or ESA are doing so for a mental illness, compared to 31 per cent of 55-59 year olds.

‘If, over time, we could reduce the number of people suffering from mental health problems, it would obviously reduce a lot of real misery. And the problem is so now large that it would also make a real difference to the economy too. The numbers who can’t work because of mental health problems (1.1 million) are not much off the total number claiming unemployment benefits (1.5 million), and the mental health charity mind argue that it mental health problems cost the economy £77 billion per year in England alone.

So we’re talking serious misery, but serious money too. Hopefully politicians will keep interested, and keep searching for solutions.’

‘Countries across the globe have shifted to far more industrialized processed and devitalized foods that rely heavily on the use of genetically engineered corn and soy. This denatured Western diet has spread its pernicious influence into the developing world as well.

I simply cannot overstate the importance of your food choices when it comes to your mental health. In a very real sense, you have TWO brains—one in your head, and one in your gut—both of which are created from the same tissue during fetal development.’

‘The Gut-Brain Connection Will Profoundly Influence Your Mental Health

The impact of your microflora on your brain function was recently reconfirmed by UCLA researchers who, in a proof-of-concept study, found that probiotics (beneficial bacteria) indeed altered the brain function in the participants. As reported by UCLA:

“Researchers have known that the brain sends signals to your gut, which is why stress and other emotions can contribute to gastrointestinal symptoms. This study shows what has been suspected but until now had been proved only in animal studies: that signals travel the opposite way as well. ‘Time and time again, we hear from patients that they never felt depressed or anxious until they started experiencing problems with their gut,’ [Dr. Kirsten] Tillisch said. ‘Our study shows that the gut–brain connection is a two-way street.’”

‘There’s a Strong Link Between Sugar Consumption and Mental Disorders

“A higher national dietary intake of refined sugar and dairy products predicted a worse 2-year outcome of schizophrenia. A high national prevalence of depression was predicted by a low dietary intake of fish and seafood. The dietary predictors of... prevalence of depression are similar to those that predict illnesses such as coronary heart disease and diabetes, which are more common in people with mental health problems and in which nutritional approaches are widely recommended. Dietary intervention studies are indicated in schizophrenia and depression.”"
Mental Health Promotion

HMG/DH; No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages; 02 Feb 2011

‘Any mental health outcomes strategy is a strategy for equality and human rights. This is because reducing inequality and promoting individuals’ human rights reduces the risk of mental illness and promotes wellbeing. Moreover, there is clear evidence that mental health services do not always meet the needs of certain groups, particularly black and minority ethnic communities and older people.’

‘Mental health is everyone’s business – individuals, families, employers, educators and communities all need to play their part. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential.’

‘We all need to take responsibility for caring for our own mental health and that of others, and to challenge the blight of stigma and discrimination. Our objectives for employment, for education, for training, for safety and crime reduction, for reducing drug and alcohol dependence and homelessness cannot be achieved without improvements in mental health.’

‘Mental health is everyone’s business – a call to action

A wide range of partner organisations, including user and carer representatives, providers, local government and government departments, have worked with the Department of Health to agree a set of shared objectives to improve mental health outcomes for individuals and the population as a whole. The six shared objectives are as follows:

(i) More people will have good mental health
(ii) More people with mental health problems will recover
(iii) More people with mental health problems will have good physical health
(iv) More people will have a positive experience of care and support
(v) Fewer people will suffer avoidable harm
(vi) Fewer people will experience stigma and discrimination’

WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM in SOUTH AFRICA; A report of the assessment of the mental health system in South Africa using the World Health Organization – Assessment Instrument for Mental Health Systems (WHO-AIMS). For the Ministry of Health South Africa; September 2007

‘Public education and links with other sectors Public education and awareness campaigns on mental health There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders in South Africa, namely the Department of Health. The Department is assisted by various NGOs, including the South African Federation for Mental Health, the South African Depression and Anxiety Group (SADAG) and other professional, consumer and advocacy bodies. Government agencies and NGOs have promoted public education and awareness campaigns in the last five years in all provinces. However, only the Western Cape, Free State and Gauteng reported the involvement of professional associations in these campaigns, and only the Western Cape reported the involvement of private trusts, foundations and international agencies.’

WHO Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health; Investing in MENTAL HEALTH; 2003

‘Is it possible to promote mental health and prevent mental disorders?

Within the spectrum of mental health interventions, prevention and promotion have become realistic and evidence based, supported by a fastgrowing body of knowledge from fields as divergent as developmental psychopathology, psychobiology, prevention, and health promotion sciences (WHO, 2002). Prevention and promotion programmes have also been shown to result in considerable economic savings to society (Rutz et al., 1992).’

‘The economic burden of mental disorders Given the prevalence of mental health and substance-dependence problems in adults and children, it is not surprising that there is an enormous emotional as well as financial burden on individuals, their families and society as a whole. The economic impacts of mental illness affect personal income, the ability of ill persons – and often their caregivers – to work, productivity in the workplace and contributions to the
national economy, as well as the utilization of treatment and support services. The cost of mental health problems in developed countries is estimated to be between 3% and 4% of GNP. However, mental disorders cost national economies several billion dollars, both in terms of expenditures incurred and loss of productivity. The average annual costs, including medical, pharmaceutical and disability costs, for employees with depression may be 4.2 times higher than those incurred by a typical beneficiary. However, the cost of treatment is often completely offset by a reduction in the number of days of absenteeism and productivity lost while at work.’

‘Alleviating the problem: prevention, promotion and management programmes A combination of well-targeted treatment and prevention programmes in the field of mental health, within overall public strategies, could avoid years lived with disability and deaths, reduce the stigma attached to mental disorders, increase considerably the social capital, help reduce poverty and promote a country’s development. Studies provide examples of effective programmes targeted at different age groups – from prenatal and early infancy programmes, through adolescence to old age – and different situations, such as post-traumatic stress following accidents, marital stress, work-related stress, and depression or anxiety due to job loss, widowhood or adjustment to retirement. Many more studies need to be conducted in this area, particularly in low- and middle-income countries. There is strong evidence to show that successful interventions for schizophrenia, depression and other mental disorders are not only available, but are also affordable and cost-effective.’

‘WHO’s Mental Health Global Action Programme (mhGAP) To overcome barriers to closing the gap between resources and the need for treatment of mental disorders, and to reduce the number of years lived with disability and deaths associated with such disorders, the World Health Organization has created the Mental Health Global Action Programme (mhGAP) as part of a major effort to implement the recommendations of the World Health Report 2001 on mental health.’

‘Health promotion is the process of enabling people to gain increasing control over their health and improve it (WHO, 1986). It is therefore related to improving the quality of life and the potential for good health, rather than only an amelioration of symptoms (Secker, 1998). Psychosocial factors influence a number of health behaviours (e.g. proper diet, adequate exercise, and avoiding cigarettes, drugs, excessive alcohol and risky sexual practices) that have a wide-ranging impact in the domain of health (WHO, 2002). A growing body of cross-cultural evidence indicates that various psychological, social and behavioural factors can protect health and support positive mental health. Such protection facilitates resistance (resilience) to disease, minimizes and delays the emergence of disabilities and promotes more rapid recovery from illness (WHO, 2002). The following studies are illustrative. Breast-feeding (advocated by the joint WHO/UNICEF Baby-Friendly Hospital Initiative, Naylor, 2001) improves bonding and attachment between infants and mothers, and significantly improves child development. Promotive interventions in schools improve self-esteem, life skills, pro-social behaviour, scholastic performance and the overall climate. Among various psychosocial factors linked to protection and promotion in adults are secure attachment; an optimistic outlook on life, with a sense of purpose and direction; effective strategies for coping with challenge; perceived control over life outcomes; emotionally rewarding social relationships; expression of positive emotion; and social integration.’
South African Mental Health Care

SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH (SAFMH); [http://www.safmh.org/index.php/who-we-are/what-we-do/what-is-mental-health#sthash.vbiJ8et4.dpuf]

‘Human rights became a global focus after the Universal Declaration of Human Rights was adopted by the UN General Assembly in 1948.

In the early 1960’s deinstitutionalisation was implemented in the US and parts of Europe, acknowledging the rights of mental health care users. South Africa implemented the same, officially in 2004 when the new Mental Health Care Act 17 of 2002 came into effect.

There are also few organizations that represent the interests of those who suffer from severe Mental Illness. In 2007 South Africa became one of the first 10 signatories of the UN Convention on the Rights of Persons with Disabilities. Article 5 of the UNCRPD, which deals with equality and non-discrimination, states that all signatories shall “Prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all ground”.

The report also states that: “Further compounding the lack of access to justice is the high instance of undiagnosed intellectual impairment and mental illness in impoverished and rural communities. A system to avoid wrongful criminal convictions in the absence of assessment to distinguish between intellectual disability and criminal capacity, is urgently required”. Lastly, it also states that: “It is acknowledged that, as so eloquently illustrated through numerous case studies and submissions presented during the consultative process in drafting this report, that laws and policies cannot, in and of themselves, change the lives of persons with disabilities, but that it requires coordinated planning, provisioning and enforcement by Government to ensure that persons with disabilities have access to the services that the law provides. This is particularly relevant in relation to equal access to justice for children with sensory, communication, intellectual and psychosocial disabilities from poor and/or rural households.”

Rowe and Moodley; Patients as consumers of health care in South Africa: the ethical and legal implications; BMC Medical Ethics 2013, 14:15 [http://www.biomedcentral.com/1472-6939/14/15]

‘If the patient is considered a ‘consumer’ of health care, there are various implications. The doctor takes on the role of ‘provider’ or ‘supplier’ of the ‘commodity’ or ‘product’ of health care. This role-shifting could result in the replacement of professional ethics with marketplace or business ethics. Plato makes it clear in The Republic that a doctor is firstly a healer of the sick, not a moneymaker.’

‘In the public health sector of South Africa, there is such a high turnover of doctors that it is almost inevitable that doctors become interchangeable. In specific circumstances, a continuous doctor-patient relationship is definitely preferable, particularly in fields such as Family Medicine and Psychiatry.’

‘In reality, modern medical practice calls for different models to be adopted in different contexts, as is appropriate to the particular clinical situation. There is fluidity present in the doctor-patient relationship, as we need to adapt to the complexity and diversity that characterise modern medicine. A paternalistic model may be more appropriate in the Emergency Department, whereas the mutual relationship model will often work best in a general practice context.’

‘Viewing patients as consumers may be detrimental to the doctor-patient relationship. While it facilitates an emphasis on respect for patient autonomy, it inadvertently results in the commodification of health care. The new
legislative environment in South Africa promotes the protection of patient rights. It may, however, contribute to increased medical litigation.’

MENTAL HEALTH CARE ACT 17 OF 2002 [Assented To: 28 October 2002] [Commencement Date: 15 December 2004] [Proc. R61 / GG 27116 / 20041215]

‘ACT
To provide for the care, treatment and rehabilitation of persons who are mentally ill; to set out different procedures to be followed in the admission of such persons; to establish Review Boards in respect of every health establishment; to determine their powers and functions; to provide for the care and administration of the property of mentally ill persons; to repeal certain laws; and to provide for matters connected therewith.

PREAMBLE
RECOGNISING that health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services;
RECOGNISING that the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), prohibits against unfair discrimination of people with mental or other disabilities;
RECOGNISING that the person and property of a person with mental disorders or mental disabilities, may at times require protection and that members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities; and
RECOGNISING further that there is a need to promote the provision of mental health care services in a manner which promotes the maximum mental well-being of users of mental health care services and communities in which they reside;

‘Objects of Act
The objects of this Act are to-
(a) regulate the mental health care in a manner that-
   (i) makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources;
   (ii) co-ordinates access to mental health care, treatment and rehabilitation services to various categories of mental health care users; and
   (iii) integrates the provision of mental health care services into the general health services environment;

(b) regulate access to and provide mental health care, treatment and rehabilitation services to-
   (i) voluntary, assisted and involuntary mental health care users;
   (ii) State patients; and
   (iii) mentally ill prisoners;
(c) clarify the rights and obligations of mental health care users and the obligations of mental health care providers; and
(d) regulate the manner in which the property of persons with mental illness and persons with severe or profound intellectual disability may be dealt with by a court of law.’

‘CHAPTER III
12. Determinations concerning mental health status
(1) Any determination concerning the mental health status of any person must be based on factors exclusively relevant to that person’s mental health status or, for the purposes of giving effect to the Criminal Procedure Act, and not on socio-political or economic status, cultural or religious background or affinity.
(2) A determination concerning the mental health status of a user may only be made or referred to for purposes directly relevant to the mental health status of that user.’
The Ekurhuleni Declaration on Mental Health

Martha Cabrera; Essay: Living and Surviving in a Multiply Wounded Country; http://siyathanda.org.za/index.php/resources2/83-multiply-wounded-country

‘One of the questions we asked ourselves back then, and are still asking, is what has happened to the millions invested in training in Nicaragua and what good has it left behind, because there isn’t a community in this country that hasn’t received a workshop on something. Everybody has been “workshopped.” There have been workshops on gender, on environment, on civic participation, to name just a few. All the realities, not to mention all the voug'es that international cooperation suggests and at times imposes have been topics of workshops all over the country. But with so much effort put into so many workshops and seminars, why were the results so poor? Why, despite so much training, were people not responding to the seriousness of the problems? Why weren’t they mobilizing and making demands?’

The Ekurhuleni Declaration on Mental Health - April 2012; Afr J Psychiatry 2012;15:381-383

THE EKURHULENI DECLARATION ON MENTAL HEALTH - APRIL 2012

We, the participants in the National Mental Health Summit held on 12-13 April 2012, consisting of representatives of government departments, non-governmental organizations, the World Health Organization, academic institutions, research organizations, professional bodies, traditional health practitioners, clinicians and advocacy and user organizations, gathered around the strategic theme ‘Scaling up investment in mental health for a long and healthy life for all South Africans’:-

Recognising that health is a state of mental, physical and social wellbeing and not just the absence of infirmity and that there can be no health without mental health; human rights of people with mental disabilities are entrenched in South African and International law;

Realizing that primary health care is the foundation of the health care system and that there is a need to fully integrate mental health care into primary health care in South Africa with the view to increasing prevention, screening, self-management, care, treatment and rehabilitation; in order to achieve equitable, efficient and quality health services, South Africa is in the process of implementing a National Health Insurance System and mental health must form an integral part of this system.

Hereby commit to:-

1. Promoting mental health as an important development objective;
2. Eliminating stigma and discrimination based on mental disability and promoting the realisation of the United Nations Convention on the Rights of Persons with Disabilities (2006);
3. Full implementation of the Mental Health Care Act, 2002 (Act No. 17 of 2002) and changing the legislation where this is needed;
4. Ensure collaboration across sectors and between governmental and non-governmental organizations, academics and with other stakeholders to improve mental health services;
5. Providing equitable, cost-effective and evidence based interventions and thereby ensure that mental health is available to all who need it, including people in rural areas and from disadvantaged communities.
6. Integrating mental health and substance abuse services into the general health service environment.
7. Providing mental health and substance abuse care to people within communities while referring to higher health care levels where clinically required.
8. Ensuring that all users of mental health services participate in the planning, implementation, monitoring and evaluation of mental health services and programmes.
9. Fostering person-centred recovery paradigm that respects the autonomy and dignity of all persons;
10. Increasing human resources to address mental health needs throughout the country through additional training across sectors, integration into general health care and through the National Health Insurance System;
11. Developing and strengthening human capacity for prevention, detection, care treatment and rehabilitation of mental and substance use disorders and build links with traditional and complementary health practitioners.
12. Providing physical infrastructure that is conducive to the needs and human rights of people with mental disorders and disabilities;
13. Reducing costs and increase the efficiency of mental health interventions, including making medicines more affordable, in order to provide essential health services;
14. Establishing comprehensive mental health surveillance mechanisms, health information systems and dissemination processes to assist policy and planning.
15. Developing and supporting research and innovation in mental health.
16. Using the outputs from the summit to finalise the Mental Health Policy Framework 2012-2016 and to assist with its implementation and monitoring;

And consequently to:

1. Develop and implement a mental health service delivery platform based on community and district based models to ensure that prevention, promotion, treatment and rehabilitation services meet the needs of all;
2. Implement with vigour the Health Sector Mini Drug Master Plan;
3. Establish at least one specialist mental health team in each district;
4. Adequately fund mental health services as per WHO recommendations;
5. Embed and increase mental health human resources within the National Human Resource Plan;
6. Develop a fit for purpose plan for mental health infrastructure at all levels;
7. Revise norms and standards in line with the service delivery platform;
8. Strengthen Mental Health Review Boards;
9. Establish a national surveillance system and appropriate monitoring and evaluation systems for mental health care integrated into the National Health Information System;
10. Establish a national suicide prevention programme;
11. Strengthen links with traditional, complementary and faith based healers and non-governmental organizations.’

SA Mental Health Strategic Plan

A B R Janse van Rensburg, MB ChB, DCH, FC Psych (SA), MMed, PhD; Contributions from the South African Society of Psychiatrists (SASOP) to the National Mental Health Action Plan

‘Following the NMHS, a task team was established under the stewardship of Deputy Health Minister Gwen Ramakgopa, to develop a strategic action plan for implementing the resolutions from the NMHS and from the draft policy framework.[2] This task team was comprised of the NMHS’s organising committee. It was chaired by Prof. S Rataemane, with Prof. C Lund as vice chair. The team met in Pretoria in December 2012 and February 2013 and produced the first draft MHAP, which listed all the key actions identified in the Ekurhuleni Declaration and the draft policy framework. The second draft included eight objectives with ‘catalytic’ key activities – that is, requiring the most effective resource inputs for the maximum results.

Following further comments from role players and inputs from the NMHS organising committee, a final draft of the MHAP was completed in line with key mental health policy and legislation, including: the South African Constitution;[6] the National Health Act;[7] the Mental Health Care Act;[8] the Criminal Procedure Act;[9] the Children’s and Child Justice Act;[10] and the Prevention and Treatment of Substance Dependency Act.[11] The final draft MHAP also took cognizance of the National Service Delivery Agreement,[12] the Integrated School Health Policy,[13] the National Development Plan,[14] the Human Resources Strategy,[15] the Non-Communicable Diseases Strategy,[16] the National Drug Master Plan,[17] and the National Strategic Plan on HIV, Sexually Transmitted Infections (STIs) and TB.[18] Lastly, the MHAP was aligned with the activities regarding the planned national health
insurance (NHI) system.[19] The final MHAP draft was scheduled for submission to the NHC, and expected to be approved in the second half of 2013.’

Department of Health; Republic of South Africa; NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013-2020

‘6. Values and Principles

Values
- Mental health is part of general health

Principles
- Mental health care should be integrated into general health care
- People with mental disorders should be treated in primary health care clinics and in general hospitals in most cases
- Mental health services should be planned at all levels of the health Service.’

‘1. Introduction

Mental health care continues to be under-funded and under-resourced compared to other health priorities in the country, despite the fact that neuropsychiatric disorders are ranked third in their contribution to the burden of disease in South Africa, after HIV&AIDS and other infectious diseases;

There is a lack of public awareness of mental health and widespread stigma against those who suffer from mental illness;
- There is a lack of accurate routinely collected data regarding mental health service provision;
- Mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on psychiatric hospitals; and

While the integration of mental health into PHC is enshrined in the White Paper and the Mental Health Care Act, in practice mental health care is usually confined to management of medication for those with severe mental disorders, and does not include detection and treatment of other mental disorders, such as depression and anxiety disorders.’

‘2.3 Costs of mental illness

Mental health problems have serious economic and social costs. These include direct costs related to the provision of health care, and indirect costs, such as reduced productivity at home and work, loss of income and loss of employment. These costs have a direct effect on the mental health care user and their families’ financial situation. The indirect cost of mental disorders outweighs direct treatment cost by two to six times in developed countries and may be even higher in developing countries. In the first nationally representative survey of mental disorders in South Africa, lost earnings among adults with severe mental illness during the previous 12 months amounted to R28.8 billion. This represented 2.2% of GDP in 2002, and far outweighs the direct spending on mental health care for adults (of approximately R472 million). In short, it costs South Africa more to not treat mental illness than to treat it.

Social costs of mental illness can include disrupted families and social networks, stigma, discrimination, loss of future opportunities, marginalization and decreased quality of life. Stigmatizing beliefs reported in South Africa include beliefs that a people with mental illness are bewitched, weak, lazy, mad, insane, not capable of doing anything or unable to think. The consequences of such inaccurate beliefs are that individuals who have been labelled as having mental illnesses are feared, ridiculed or exploited. Many individuals have also been neglected, isolated, rejected by family and peers, abused or excluded from social engagement and basic rights. Stigma can thus act as a barrier to accessing education, employment, adequate housing and other basic needs.’

‘7.1 Organisation of services

In line with the World Health Organisation recommendations regarding organisation of mental health services, the mental health systems will include an array of settings and levels that include primary care, community based settings, general hospitals and specialised psychiatric hospitals.’
7.2 Financing
By 2014:
1. Mental health will be financed according to the principles adopted for all health financing in South Africa, and people will be protected from the catastrophic financial consequences of mental ill-health.
2. In the financing of the National Health Insurance system, mental health services will be given parity with other health conditions, in proportion to the burden of disease and evidence for cost-effective interventions.
3. Private medical aids should also be required to offer parity in their cover between mental health and other health conditions.
4. The limited financial resources available for mental health care will be used efficiently, and informed by evidence of cost-effectiveness where possible.
5. At national level, budget will be allocated to meet targets set for the implementation of areas of action within the policy and regular discussions will be held with provinces to discuss strategies and monitor progress with implementation. At provincial level, mental health budgets will be reviewed annually to align mental health with national priorities, for each of the areas for action in 2011 and annually thereafter.
6. All provinces will develop provincial strategic plans for mental health, in keeping with national policy, which outline specific strategies, targets, timelines, budgets and indicators in 2011 and annually thereafter.”
"7.4 Intersectoral collaboration
By 2013:
1. The Department of Health will engage non-health sectors (such as Education, Social Development, Labour, Criminal Justice, South African Police Service, Housing, Agriculture and NPOs), as well as for-profit organisations, to ensure that an inter-sectoral approach to mental health is followed in planning and service development.’

7.10 Human resources and training
‘By 2015:
• All health staff working in general health settings will receive basic mental health training, and ongoing routine supervision and mentoring.
• The expansion of the mental health workforce will be actively pursued by all provincial Departments of Health.
• A task-shifting approach will be used in the development of the mental health workforce, whereby trained non-specialist workers deliver evidence-based psychosocial interventions, with supervision and support from specialists.’

‘8.1 Minister of Health
4. Evaluating the prevalence and incidence of mental illness.
5. Identifying and driving the implementation of key priority areas, namely:
• Child and adolescent mental health;
• Community-based services within a psychosocial rehabilitation and recovery framework;
• Detection and management of common mental disorders (e.g., depression and anxiety disorders) at PHC level;
• Mental health promotion and prevention.
6. Promoting research in priority areas, and utilising research evidence to inform policy, legislation and planning.
7. Coordinating an intersectoral approach to mental health, through engagement of other sectors, and providing technical support to other sectors.’

Department of Health; Republic of South Africa, National Mental Health Policy Framework and Strategic Plan 2013-2020
‘The Department of Health will engage with a range of stakeholders who lobby for political support for mental health on the public agenda. This will include discussion regarding the importance and place of mental health within the broader disability agenda, and within other development priorities and public concerns will be better articulated.

The Department of Health will also engage with consumer and family associations in policy development and implementation, as well as the planning and monitoring of services. Emphasis will be placed on ensuring representation of people with mental disability on the broader disability agenda, and developing capacity to place mental health user concerns on the political, development and public health agenda.’

‘The human rights of people living with mental illness will be promoted and protected, through the active implementation of the Mental Health Care Act (2002).

The Department of Health will work closely with the Ministry for Women, Children and Persons with Disability to ensure that provisions of the UN Convention on the Rights of Persons with Disabilities (2007) are actively implemented for persons with mental disability in South Africa.’
**Informed Consent**

Informed consent

*Rowe and Moodley; Patients as consumers of health care in South Africa: the ethical and legal implications; BMC Medical Ethics 2013, 14:15*

http://www.biomedcentral.com/1472-6939/14/15

‘Chapter 2 of The National Health Act No 61 of 2003 details the rights and duties of users (patients) and health care personnel. According to Section 6(1), users have the right to full knowledge of their health status, the range of options available to them, and the consequences of each option. They have the right to refuse health services. Section 6(2) states that the health care provider has the duty to inform the user in a language the user understands and in a way that takes the user’s level of literacy into account. Apart from certain special circumstances detailed in Section 7, a user must provide informed consent in order to receive a health service. Section 8(1) makes it clear that a user has the right to participate in any decision-making affecting his or her personal health and treatment [5]. Particularly in rural African settings, the communitarian ethic abounds and other members of the family or community may need to be consulted and give consent to the patient before he or she is able to make a health-related decision and give informed consent.’

‘Part F of the CPA (Consumer Protection Act) describes the right to fair and honest dealings. Section 40 prohibits the use of coercion or other such means to convince a consumer or patient to accept a particular product or service. This will truly encourage the notion of patient autonomy and choice. Allowing the patient to make the decision and obtaining informed consent is vital because consumers have the right to choose. The consent should be truly ‘informed’ and this should be ensured by communication and documentation (including the informed consent form) in plain language easily understandable to the consumer. All agreements and policies such as a billing policy in private practice need to have fair terms and conditions as stipulated in the Act. The paying patient should also be informed of prices up front.’

‘The importance of clear instructions and warnings to patients as well as drawing the patient’s attention to any unusual or serious risks and obtaining written consent cannot be over-emphasised if the doctor is to avoid litigation. Additionally, South African common law recognises the offence of injuria - the unlawful infliction of bodily harm or violation of physical integrity. Lack of consent therefore equates to assault. Informed consent is not only a legal, but also an ethical imperative.’

*Mikki van Zyl; Jeanelle de Gruchy; Sheila Lapinsky; Simon Lewin; Graeme Reid; THE AVERSION PROJECT; Human rights abuses of gays and lesbians in the South African Defence Force by health workers during the apartheid era*

‘One of the most contested concepts in medical treatment is the notion of ‘informed consent’.

Consent is understood differently by various disciplines and professions, and also in various theoretical models.

*Alderson and Goody 1998:1*

How does a patient consent to a certain treatment?

In medicine and law, the notion of consent is based on the exchange of apparently ‘measurable’ information, with knowledge and skill as a central criterion, and the freedom of the subject to make a choice as the second.’

‘In South African law the following elements are deemed necessary requirements for valid consent.

a) The consent must be given voluntarily, without any coercion.

b) The consent may be given expressly or tacitly.

c) Consent must be given before the ... act is committed. Consent remains revocable, provided the act has not yet been committed.

d) The person giving the consent must be capable of forming a will. ... It means that the person has the mental capacity not only to know the nature of the act to which he consents, but also to appreciate its consequences.

e) The consenting person must be aware of the true and material facts regarding the act to which he consents. Mere submission is not consent.

f) In principle, consent must be given by the complainant, but in exceptional circumstances someone else may give consent on his or her behalf, such as where a parent consents to an operation to be performed on his or her child.’

*Snyman 1989:124–6*
‘Some people believe that patients should be protected against unscrupulous medical practitioners, and that the process of signing or giving consent should protect the patient against useless, harmful and unwanted interventions; an occasion when doctors have to be accountable; and an essential constraint on the more powerful profession.’ 

*Alderson and Goody 1998:5*

‘In practice, giving consent is mostly a formality, ... a polite ceremony, a token of respect that is hardly necessary because benign, expert doctors contribute to the smooth functioning of society; refusal and non-compliance are irrational. Consent is, however, a convenient means of transferring responsibility for risk from the clinician or researcher to the informed patient, thus enabling treatment and the research to proceed without serious risk of costly litigation.’ *Alderson and Goody 1998:5*

‘Doctors are bound to adhere to international standards of consent which are supposed to be enforced by the statutory councils. These protect both them and their patients. Within the judicial framework, it would require that the legal elements of consent are present. From a humane point of view, it also implies that a patient is given an explanation about the methods and consequences of treatment, in a language that the person understands. Time should be allowed for questions, and their questions answered as truthfully and as completely as possible. Alternatives to the treatment should be pointed out, as well as the consequences of not undergoing treatment.’

‘Finally, there should be no coercion or pressure on the patient to consent, as legally this constitutes ‘submission’ and not consent.’

‘Psychiatrists are in a powerful legal position. As acknowledged ‘experts’ on mental conditions, unscrupulous psychiatrists can rely on their medical status to ‘diagnose’ that certain people do not have the ‘mental capacity’ to consent to treatment because ‘they are suffering from mental stress’.’

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**Mental Health Organisations in RSA**

“The purpose of all of this (left hemisphere’s way of choosing denial or repression over considering an anomaly) is to impose stability on behavior and to prevent vacillation because indecisiveness doesn’t serve any purpose. Any decision, so long as it is probably correct, is better than no decision at all. A perpetually fickle general will never win a war.”

*V.S. Ramachandran, Phantoms in the Brain: Probing the Mysteries of the Human Mind; Harper Collins*

*Martha Cabrera; Essay: Living and Surviving in a Multiply Wounded Country; http://siyathanda.org.za/index.php/resources2/83-multiply-wounded-country*

‘How do we create a holistic, attractive development approach that provides results? We have discovered the importance of understanding the unity of mind, body and spirit to achieve this. Unfortunately, Western tradition has created three separate professions—psychologists, physicians and religious personnel—to deal with what is really a single reality. The fact is that we are one thing: mind, body and spirit.’

*Brendon Barnes and Saths Cooper; Reflections; on South African psychology with Saths Cooper; South African Journal of Psychology; September 2014 vol. 44 no. 3 326-332*

‘Globally, psychology is booming. In my stint now as president of IUPsS, I have had the opportunity to visit many places, and psychology is alive and well. In places like Colombia, where the similarities with South Africa are high, to become a clinical psychologist you need 5 years of university study and then only do a further degree. Most countries have a 4-year undergraduate degree, and we have 3. If we were to look at reconfiguring that, and then looking at creating other levels of service providers, we won’t find psychologists doing the frenetic things that a
small minority are doing now to get more money. We have also reached an agreement with the Department of Education to create a pilot program for school counselors and that is in the offing.

I think there will be a new era in psychology globally, and what Mao did not succeed to do to “allow 100 flowers to blossom” psychology can, in that no one theory is true and correct. No theory has the necessary and sufficient conditions to describe all of human behavior. But it is also a time that the divide between science and practice is being narrowed so that the old bifurcation doesn’t haunt us in the future. Because that is where we’ve lost the prize on impacting on policy makers and changing policy makers to make decisions. So what they (policy makers) do is rely on economists who have failed the world, rely on medicine and other areas to explain behavior which we should be leading. So we’ve given up that place which we must reclaim.

In the International Union, my mission now is to say that psychology underpins everything else in society. The Union is the global voice of psychology which is now 125 years old, and we should be developing psychology in parts of the world, where, if we don’t participate, if we ignore it, it will assume a Hindu or a Muslim or a Buddhist or narrow Christian face, which is not psychology. There is no area of human endeavor which does not rely on psychology.’

Advocacy

“For me, the question “Who should speak?” is less crucial than “Who will listen?”
“I will speak for myself as a Third World person” is an important position for political mobilization today. But the real demand is that, when I speak from that position, I should be listened to seriously; not with that kind of benevolent imperialism . . . (Spivak, 1990, pp. 59–60)”

World Health Organization, ADVOCACY FOR MENTAL HEALTH; Mental Health Policy and Service Guidance Package

“Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development.”

Martha Cabrera; Essay: Living and Surviving in a Multiply Wounded Country; http://siyathanda.org.za/index.php/resources2/83-multiply-wounded-country

‘All this led us to another issue: the organizational one. In Nicaragua, a great many organizations want to do “open heart surgery with a machete,” as one observer quipped. They want to “change the world,” but do nothing to change an old-fashioned model within the organization itself and thus reproduce a leadership style that blocks any real change. Daniel Ortega and Arnoldo Alemán are far from the only caudillos in this country. That political boss syndrome is reproduced in social organizations, in NGOs, in all sectors of our society.’

Rowe and Moodley; Patients as consumers of health care in South Africa: the ethical and legal implications; BMC Medical Ethics 2013, 14:15 http://www.biomedcentral.com/1472-6939/14/15

‘A dominant metaphor in medical ethics and law today is the ‘fiduciary’ metaphor where the doctor is regarded as a fiduciary for his patient. A fiduciary role relates to the Biblical concept of stewardship and originates from the law of trusts and agency. A fiduciary is defined as ‘someone with power or property to be used for the benefit of another and legally held to the highest standard of conduct’. It implies a relationship based on dependence and trust. A fiduciary may not promote his own interests or those of a third party. If he has divided loyalties or a conflict of interest, there is an increased risk of this ‘trust’ relationship being breached.’

‘The professional ethic describes health care as a moral obligation in a good society where it represents a sense of caring for the community. It emphasises the principle of beneficence rather than just non-maleficence. Health care is patient-orientated and demands an altruistic, even self-effacing attitude. This is part and parcel of being a professional, in the traditional sense of the word. Traditionally, a profession is committed to providing services for the common good. Professionals have a ‘calling’ and are not motivated only by personal interest and financial gain.’
Liz Fenton; ADVOCATES CODE OF PRACTICE; SEAP advocacy;

‘Definition of Advocacy

Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.’

‘People are entitled to be in control of their own lives but sometimes, whether through disability, financial circumstances or social attitudes, they may find themselves in a position where their ability to exercise choice or represent their own interests is limited. In these circumstances, independent advocates can help ensure that an individual’s rights are upheld and that views, wishes and needs are heard, respected and acted upon.’

Jane Dalrymple and Jane Boylan 2013; What is Advocacy and How do we Use it in Social Work; Sage; Library of Congress Control Number: 2013935593

‘Advocacy has been described as being ‘at the heart of social work’ (Sheafor and Horejsi, 2003: 57), a key function of social work practice in terms of helping service users and carers become independent from service providers and in the process developing the skills to advocate for themselves (Haynes and Mickleston, 1997) and an important element of social work practice (Payne, 2000a). Advocacy can be defined in many ways, but the following definition is a useful starting point. This definition is part of the guidance for Independent Mental Capacity Advocates introduced through the Mental Capacity Act 2005 in England. It relates to people who use mental health services and are deemed to lack capacity — a group who can struggle to have a voice in the systems and structures that impact on their lives:

Advocacy ... promotes equality, social justice and social inclusion. It can empower people to speak up for themselves. Advocacy can help people become more aware of their own rights, to exercise those rights and be involved in and influence decisions that are being made about their future. (Lee, 2007: 7)

SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH (SAFMH);
http://www.safmh.org/index.php/who-we-are/what-we-do/what-is-mental-health#sthash.vbiJ8et4.dpuf

‘South Africa’s National Mental Health Policy Framework and Strategic Plan 2013-2020 emphasizes (in point 7.5 on Advocacy) that there is a commitment from the Department of Health to (4) “give exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health in order to change discriminatory attitudes toward mental disability. This work will be framed within the provisions of the UN Convention of the Rights of Disabled Persons and the human rights based framework of South African law, as well as advocacy guidelines from the WHO” and further states (5) “Emphasis will be placed on ensuring representation of people with mental disability on the broader disability agenda, and developing capacity to place mental health user concerns on the political, development and public health agenda”. These goals were set to be achieved by 2015, and it is therefore critical that all persons with mental disabilities are empowered as a matter of urgency to ensure that they are able to fully participate within the ambit of these activities and successfully achieve these goals without any further delay.

Minister of Health, Aaron Motsoaledi, at the 2012 National Mental Health Summit in Ekurhuleni, Gauteng, where he stated that it was an offence against human rights to neglect the worst-off in society, and stressed that resources, infrastructure, social mobilization plans and employment targets had to take mental health into consideration. There was a need for an increased focus on mental health promotion, prevention programmes, public awareness and stigma and discrimination in South Africa.’

Department of Health; Republic of South Africa; NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013-2020

‘7.5 Advocacy

By 2015:
1. The Department of Health will engage with a range of stakeholders who lobby for political support for mental health on the public agenda. This will include discussion regarding the importance and place of mental health within the broader disability agenda, and within other development priorities and public concerns will be better articulated.
The Department of Health will also engage with consumer and family associations in policy development and implementation, as well as the planning and monitoring of services. Emphasis will be placed on ensuring representation of people with mental disability on the broader disability agenda, and developing capacity to place mental health user concerns on the political, development and public health agenda.’

World Health Organization, ADVOCACY FOR MENTAL HEALTH; Mental Health Policy and Service Guidance Package
‘The concept of mental health advocacy has been developed to promote the human rights of persons with mental disorders and to reduce stigma and discrimination. It consists of various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations. Advocacy in this field began when the families of people with mental disorders first made their voices heard. People with mental disorders then added their own contributions.

Gradually, these people and their families were joined and supported by a range of organizations, many mental health workers and their associations, and some governments. Recently, the concept of advocacy has been broadened to include the needs and rights of persons with mild mental disorders and the mental health needs and rights of the general population.

Advocacy is considered to be one of the eleven areas for action in any mental health policy because of the benefits that it produces for people with mental disorders and their families. The advocacy movement has substantially influenced mental health policy and legislation in some countries and is believed to be a major force behind the improvement of services in others. In several places it is also responsible for an increased awareness of the role of mental health in the quality of life of populations.’

‘The concept of advocacy contains the following principal elements.

1.1.1 Advocacy actions
> Awareness-raising
> Information
> Education
> Training
> Mutual help
> Counselling
> Mediating
> Defending
> Denouncing.

‘There is still no scientific evidence that advocacy can improve the level of people’s mental health. However, there are many encouraging projects and experiences in various countries, including the following:
- the placing of mental health on government agendas;
- improvements in the policies and practices of governments and institutions;
- changes in laws and government regulations;
- improvements in the promotion of mental health and the prevention of mental disorders;
- the protection and promotion of the rights and interests of persons with mental disorders and their families;
- improvements in mental health services, treatment and care.’

‘The emergence of mental health advocacy movements in several countries has helped to change society’s perceptions of persons with mental disorders. Consumers have begun to articulate their own visions of the services they need. They are increasingly able to make informed decisions about treatment and other matters in their daily lives. Consumer and family participation in advocacy organizations may also have several positive outcomes.’

SEAP Advocacy http://www.seap.org.uk/im-looking-for-help-or-support/what-is-advocacy.html
‘What is advocacy?’
‘Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to:
- Have their voice heard on issues that are important to them.
- Defend and safeguard their rights.'
• Have their views and wishes genuinely considered when decisions are being made about their lives.

Advocacy is a process of supporting and enabling people to:
• Express their views and concerns.
• Access information and services.
• Defend and promote their rights and responsibilities.
• Explore choices and options’

‘An advocate is someone who provides advocacy support when you need it. An advocate might help you access information you need or go with you to meetings or interviews, in a supportive role. You may want your advocate to write letters on your behalf, or speak for you in situations where you don’t feel able to speak for yourself.’

SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH (SAFMH);
http://www.safmh.org/index.php/who-we-are/what-we-do/advocacy#sthash.VI1r0CZW.dpuf

‘People with psychosocial and intellectual disabilities themselves are however yet to effectively communicate and raise awareness of their needs and to self-advocate on all public platforms for their rights to be implemented and their challenges to be addressed. The lack of a strong national self-advocacy movement results in continued social isolation and marginalisation of these individuals. In this way, human rights violations continue unmonitored and ignored, which result in unequal and limited access to resources and protection. These conditions impact directly on the material and lived reality of persons with psychosocial and intellectual disabilities.’

‘The Dept of Health’s National Mental Health Policy Framework and Strategic Action Plan for 2013-2020 emphasises (in point 7.5 on Advocacy) that there is a commitment from the Dept of Health to (4) “give exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health in order to change discriminatory attitudes toward mental disability. This work will be framed within the provisions of the UN Convention of the Rights of Disabled Persons and the human rights based framework of South African law, as well as advocacy guidelines from the WHO” and further states (5) “Emphasis will be placed on ensuring representation of people with mental disability on the broader disability agenda, and developing capacity to place mental health user concerns on the political, development and public health agenda”. The goals listed under point 7.5 are set to be achieved by 2015, and it is therefore critical that this be prioritised and that persons with psychosocial and intellectual disabilities are empowered and able to fully participate within the ambit of these activities and to successfully achieve these goals.

Thus far, advocacy groups have been established in some provinces, functioning at different levels. However, they very often still lack sufficient capacity to be strong, united and representative voices for persons with psychosocial and intellectual disabilities at a national level. This is where SAMHAM is of vital importance, as it has an extremely important role to play in the strengthening of existing advocacy groups, supporting the establishment of advocacy groups in parts of the country where such groups are still lacking, whilst at the same time also identifying individuals with leadership potential and developing them into leaders for the mental health movement around which ongoing advocacy and awareness activities can be built.’

Paul Cutler, Robert Hayward and Gabriela Tanasan; Supporting User Led Advocacy in Mental Health; eumap; 2006

‘The most effective advocacy is that which leads to public action to deliver change on a community level. Advocacy does not end with the assertion of any one right in a specific case. It is the way the community builds new services and relationships that ensures the sustainability of the rights achieved by individual instances of effective advocacy.’

‘It is important to see advocacy as part of a wider project of development and empowerment, in which service users and their families are at the centre. Advocacy enables them to have a voice, but it is also important to build other forms of civil society capacity, such as bottom-up policy development, organisational development and networking. Through this combination of local initiatives people will be able to run their own projects and deliver community level change.

It is also important that mental health advocacy is not seen as an isolated specialism and the lessons that it provides are taken into account in action on wider agendas such as social development, the disability movement and poverty reduction as well. Given the prevalence of mental health problems in populations, it is important to acknowledge that mental health will permeate all forms of community life and civil society activity.’
Anne Marie McLaughlin; Clinical Social Workers: Advocates for Social Justice

‘Advocacy activities provide an avenue for all social workers to connect their practice with the profession’s aim of social justice. In fact, it is this social justice connection to the advocacy role that may distinguish social work from other professions.’

‘Advocacy is a well-established strategy for achieving social justice (Gehart & Lucas, 2007; Hoefer, 2006; Kiselica & Robinson, 2001; Miley, O’Melia & Dubois, 2007). Moreover, advocacy is considered a professional obligation (Hepworth, Rooney & Larson, 2002). National and international professional social work bodies entrench professional social work practice, advocacy and social justice through their codes of ethics (British Association of Social Workers, 2002; International Federation of Social Workers, 2004; National Association of Social Workers, 2008). The Canadian Association of Social Workers (2005) explicates the link between advocacy and social justice:

Social workers advocate for fair and equitable access to public services and benefits. Social workers advocate for equal treatment and protection under the law and challenge injustices, especially injustices that affect the vulnerable and disadvantaged. (CASW, 2005)”

‘Social justice as well as advocacy are both considered professional and ethical obligations, yet few studies have explored with practitioners how these may be linked in practice. Clinical social workers and those in direct practice carry the same professional and ethical obligations to work for social justice but may feel limited in their opportunities. This study explores how participants expressed social justice in their work.’

Interesting view from the US... Obviously the right balance is required going forward in South Africa...

DJ Jaffe; Mental Illness Advocate vs Mental Health Advocate; Stephen Seager M.D. BrainTalk; Psychology Today; Dec 01, 2014

‘I think we need less mental health spending and more mental illness spending. It is the most seriously ill not the worried-well, who disproportionately become homeless, commit crime, become violent, get arrested incarcerated or hospitalized. 360,000 are behind bars and 200,000 homeless because we are now focused on improving mental health, rather than treating serious mental illness.

‘My number one message is that we have to stop ignoring the most seriously ill. Send them to the front of the line for services rather than jails, shelters, prisons, and morgues.’

‘Now before beginning, I admit the boundary between mental health and mental illness is debatable, but the extremities are clear. 100% of the population can have their mental health improved. 20% have some sort of illness that can be found in DSM, mainly minor illnesses like anxiety. And most of the illnesses in DSM are minor. But only 4.2% have a serious mental illness like schizophrenia, treatment resistant bipolar, major severe depression or another illness that prevents them from functioning.’

That distinction between mental health and mental illness is the main debate going on today around the country and is certainly at the core of the two bills Congress is now considering and was at the core of some bills being considered in New York like the SAFE Gun Control Legislation. NAMI/NYS is one of the few groups doing both. They have always done a stellar job at trying to improve the mental health of the 20% and they also advocate for the 4%.

Mental “health” advocates claim everyone is well enough to volunteer for treatment. That is simply not true. As Congressman Murphy—who is also a psychologist, mentioned last night, some have anosognosia: They are so sick, they don’t know they are sick because the brain is impaired so insight is lacking. When you see someone walking down the street screaming they are the Messiah it is not because they think they are the Messiah. They know it. Their illness tells them it is so.

‘Current laws prevent people from getting treatment until after they become danger to self or others. That’s ludicrous. Laws should prevent violence not require it. Think seatbelts.’

‘To improve care for people with serious mental illness money is not missing, leadership is.’
Activism
Mandisa Mbali; The Treatment Action Campaign and the History Of Rights-Based, Patient-Driven Hiv/Aids Activism in South Africa; University of KwaZulu-Natal Centre for Civil Society; Research Report No. 29

‘Conservative gay AIDS activists affiliated to Gay Activists of South Africa (GASA) tried and failed to gain access to the apartheid government’s AIDS committees during the 1980s. In the early 1990s, anti-apartheid gay AIDS activists used transition-era negotiating spaces such as the National Aids Convention of South Africa (NACOSA) to further their aims. However, the post-apartheid era brought much greater scope for AIDS activism as it brought with it a free press and the Constitutional Court, which were used to maximum potential by TAC activists, especially in advocating HIV treatment access for all.’

‘In the post-apartheid era, the AIDS policy-making process has been characterised by a well-documented conflict between AIDS activists aligned with the Treatment Action Campaign (TAC) and the government over official denialism and inadequate access to HIV treatment. Contemporary AIDS activists aligned to the TAC have framed their struggle for HIV treatment access in terms of the human rights of people living with HIV/AIDS. They insist that access to such life-saving combination antiretroviral drug treatment for all HIV positive people is a human right, in as much as it fulfils their rights to life and the socio-economic right to access to health care. As a result of the TAC’s campaign, in September 2003 the South African Cabinet instructed the health ministry to develop a comprehensive HIV treatment and prevention plan. The government has since begun to roll-out HIV treatment at public health care facilities across South Africa. TAC is now seen by many commentators as perhaps the most successful example of civil society pushing for South African – and indeed international – government policy to reflect socio-economic and health rights in the post-apartheid era.

‘It should also be noted that South African AIDS activists used rights-based discourses to attain different goals in different periods. Whereas during the early 1990s the focus was on confidentiality, by the late 1990s openness was used to push for access to treatment. This suggests that activist uses of rights-based discourse are contested and changing. Despite these historical legacies of AIDS activism of the late 1980s and early 1990s, TAC’s formation in 1998 was based much more upon distinctly post-apartheid democratic cultures and institutions. Similarly, TAC’s success in pushing for wider access to HIV treatment using the language of socio-economic rights poses wider theoretical questions about the potential power and meaning of discourses of human rights, when used by new social movements to fight for socio-economic justice in post-apartheid South Africa.’

‘What is new and specifically post-apartheid about TAC are its demands for access to new drug therapies which did not exist until after 1996 and its use of South Africa’s new democratic constitution to forward its aims. Furthermore, it is far more militant than any earlier forms of rights-based, patient-driven activism and it has had far greater success in encouraging mass-openness. As legally, philosophically and politically contingent as rights-based discourses may be, TAC has powerfully deployed this rhetoric to push for policies that have literally saved lives.’

‘It is unclear whether TAC’s success in invoking rights-based discourses in new democratic spaces will be replicated by other new social movements pushing for the realisation of socio-economic rights. For instance, will they be able to marshal the kind of funds and legal support TAC has used in its court challenges if they wish to pursue similar action?’

Post-Apartheid Change

Lloyd Vogelman; Psychology, Mental Health Care and the Future; Is appropriate transformation in a future South Africa possible? Social Science and Medicine, Vol. 31, No. 4, pp. 501-505, 1990.

‘Criticisms of South Africa’s mental health system are numerous. The American Psychiatric Association, for instance, reported that mental health care in South Africa is inequitable along racial lines, is inadequate, often absent, sometimes hazardous to the client’s health and helps to reinforce the ideology of apartheid. While many aspects of the socio-political and health-care framework in South Africa have changed since 1979, many of the APA’s criticism’s still remain valid.’

‘The difficulties with transforming mental health care are numerous. Buch and De Beer (17) state that:
At transformation there will be two options: to be totally true to the characteristics of a national health service or to go for a compromise as an interim step. The compromises include: the maintenance of some private health care; ... setting equity as only a medium- or long-term goal; compromising with professionals; and treading softly ... with ... health-manager practice.

Whether compromises should be made and, if so, what form will they take, are questions that require urgent attention. Whatever the answers to these questions, transforming mental health care in South Africa will not be an event. It will be a long and arduous process. Psychologists should therefore attempt to create a vision of the future in the present. This requires working towards removing apartheid, finding spaces that permit the appropriate social application of psychology and the acquisition of relevant psychological skills. It is crucial for psychologists and mental health practitioners committed to this task to continually remember that the present never remains the same and the future must never be relegated to the forgotten.’

‘Political transformation, less economic privilege, changed social relationships, and major shifts in the type of mental health work, will not be easily accepted by mental health professionals. As suggested, a primary complicating factor is that new mental health policy and practice is likely to conflict with past training and professional registration in America and Europe. This is because there may be a shift towards briefer term work, the inclusion of traditional healers, and greater emphasis on the educative aspects of mental health work. The difficulty that mental health professionals are likely to have in adapting to numerous changes may result in South Africa finding itself in a similar situation to Nicaragua, where many mental health professionals emigrated because of their opposition to the new social, economic and community mental health programme of the Sandanista government.’


‘(), questions persist about the “relevance” of psychology for the lives of the majority of South Africans. Claims of professional “irrelevance” are substantiated by referring variously to the skewed racial demographics of the country’s registered psychologists and counselors (Pillay & Slyothula, 2008), the dearth of qualified professionals that speak indigenous African languages (Ahmed & Pillay, 2004), biased selection criteria for admission into professional training programs (Stevens, 2001), and the uneven racial composition of selection panels (Mayekiso, Strydom, Jithoo, & Katz, 2004).

In respect to academic psychology, concerned intellectuals have been arguing since the late 1970s that psychological theories remain beholden to American and European (especially Germanic) explanations of human functioning (Holdstock, 1981a; Turton, 1986) and that the paradigmatic inclinations of psychology are in keeping with “the worldview of the colonizer” (Ahmed & Pillay, 2004). Others criticize what they imagine as the implied alternative, namely, the reification of culture and relegation of class, with all its evocations of apartheid-style characterizations of cultural difference (Nell, 1990; Seedat & Nell, 1990; Swartz, 1991; Turton, 1986).

For those sympathetic to an Afrocentric psychology, however, it remains a largely marginal endeavor, leading one commentator to remark that psychologists in South Africa are in fact without a psychology (Ratele, 2004). And on the research front, suggestions have been made of continuing indifference to socio-political priorities—as in, for example, an analysis of articles appearing in the South African Journal of Psychology between 1999 and 2003, according to which a mere 2% of articles dealt with the issue of HIV/AIDS, while a further 2% handled that of “race” (Macleod, 2004). Whether in theory, practice, or research, the slow-moving transformation of psychology in South Africa remains a focus of concern.’

‘In the case of psychology, this much is clear from Stevens’s (2001, p. 51) description of a “double bind” that overtakes Black South African trainees in professional psychology, forcing an impossible choice between the foreign values of the discipline and the familiar ones of their communities of origin. For Callaghan (2005, p. 143), South African student psychologists “dis-identify with activist subject positions because of the explicit and implicit censure of such identities in the discourse of professionalisation that is characteristic of psychological practice.” This assumes, of course, that candidates with strong political views have not already been “selected out” of training programs (Callaghan, 2005, p. 143), since the “authority to speak” demands the foregoing of all other subject positions (p. 145).’
Social Services
Department of Social Development/Department of Women, Children and People with Disabilities/UNICEF; Violence Against Children in South Africa

‘The Department of Social Development has a record of more than 85,000 non-profit organisations (NPOs) across the nine provinces, of which almost 34,000 provide social services. Included in this number is a substantial number of early childhood development centres. Also included are organisations that do not focus on services for children. However, all provinces rely heavily on the services of NPOs to deliver children’s services. In 2012/13, provinces allocated an average of 48.9% of their social welfare programme budgets for NPO transfers, slightly down from the 51.4% for 2011/12 adjusted estimates. Despite the slight decrease, this percentage remains an indicator, in monetary terms, of the heavy reliance on NPOs. If NPOs were fully funded for their work and NPO-employed staff earned the same salaries as government staff doing similar work, the percentage would need to be even higher. The subsidies provided by the provincial departments to NPOs do not cover the full cost or scope of the services.

In not covering the full costs and scope of the services, government expects NPOs to find funds elsewhere. However, internationally, the fact that South Africa is viewed as a middle income economy has resulted in decreased funding opportunities. The decrease in available funds has been aggravated by the global financial crisis. The result is ongoing retrenchments and closures of NPOs. The consequence is a decrease in services available for vulnerable populations, including children.’

‘The multiplicity of actors means that the various government agencies as well as non-government actors, including parents and other family members, need to work together. Small-scale experiments have demonstrated the value of local community-based responses, within involvement by community members, in ensuring child protection. However, these efforts can only succeed if they are backed up by the availability of formal services. This will ensure, among others, that there are agencies to which community members can refer children or turn to help when the problems are beyond what they can deal with alone. Without these services, there can be no continuum of care.’

SAFMH


‘Mental health societies of the SAFMH are community service organizations operating in the field of psychiatric disability, intellectual disability, and/or the promotion of mental well-being. They are registered as separate non-profit organizations with their own management boards and staff. They are not financially accountable to the SAFMH, but are accountable in so far as the standard of service delivery is concerned. Although other non-government organizations (NGOs) provide services at a local or provincial level, the SAFMH is the only NGO that provides a coordinated national mental health service, is the largest national mental health service provider in the NGO sector and receives government subsidies for its services.’

‘1. SOUTH AFRICAN FEDERATION FOR MENTAL HEALTH

The SA Federation for Mental Health is a registered national, not for profit, non-governmental organisation (000-238 NPO), constituted by 17 mental health societies and 107 member organisations, all actively involved in the field of intellectual and psychosocial disability and mental wellbeing. The organisation was established in 1920 with the aim to coordinate, monitor and promote services for persons with intellectual and psychosocial disability, as well as promoting good mental health and wellbeing amongst the South African public.

2. OUR MISSION

We actively work with the community to achieve the highest possible level of mental health for all by:

- Enabling people to participate in identifying community mental health needs and responding appropriately
- Developing equal, caring services for people having difficulty coping with everyday life, and those with intellectual and/or psychosocial disability
- Creating public awareness of mental health issues
• Striving for the recognition and protection of the rights of individuals with intellectual and / or psychosocial disability
• We aspire to contribute to a just and fair society.

3. OUR KEY FOCUS AREAS

3.1 Capacity building

Our role as a national organisation is to capacitate our constituencies with skills, thereby ensuring the services they deliver are of a high standard. We also focus on building the capacity of service users and other partner organisations through training initiatives (including care giver training).

3.2 Human rights

We monitor services rendered to persons with intellectual and / or psychosocial disability and try and ensure the full social integration of persons with intellectual and / or psychosocial disability into society, along with supporting the upholding of their constitutional rights, as enshrined in the Mental Health Care Act and UN Convention on the Rights of Persons with Disabilities.

3.3 Awareness

We aim to raise awareness about services rendered by the SA Federation for Mental Health and advocating for the rights of persons with intellectual and psychosocial disability. The overall purpose of creating awareness about mental wellbeing is to dispel myths and stigma attached to these disabilities, and ultimately to eradicate discrimination against persons with psychosocial and / or intellectual disability. The promotion of mental wellbeing is equally important and focuses on preventative measures through the promotion of healthy lifestyles and other relevant issues. As part of this, the Federation supports World Mental Health Day on the 10th of October every year. Currently, 3 annual mental health awareness programmes are run each year:

- Intellectual Disability Awareness during March
- Psychosocial Disability Awareness during July
- Mental wellbeing and health promotion and awareness during October

Additional to this, we also run a large-scale public education campaign every year in support of the national Mental Health Policy Framework and Strategic Action Plan 2013-2020.

3.4 Research and information management

We conduct ongoing small-scale research into mental health-related issues. This is to enable the National Office to effectively function as an information hub and resource center through the development of mental health-related information sources, aimed at informing all our areas of focus.

3.5 Advocacy and social integration

As described above, advocacy is a key part of our focus, and cuts across most of our other focus areas. It is a vital part of our work and an important outcome of most of the work we engage in. One of our main objectives related to advocacy is the integration of persons with intellectual and / or psychosocial disability into society. Due to myths, stigmatisation, poverty and lack of support systems, society in general (including the labour market) is sometimes hesitant accepting persons with intellectual or psychosocial disability.

3.6 Corporate wellness

We provide corporate wellness sessions as a key income generating initiative of the National Office. These sessions can be customised to suit the needs of the organisation, or can be in the form of a standard mental health awareness session.

It is important to note that, as illustrated above, our key areas of focus are extremely integrated and cross-cutting. It is therefore important not to view each as a stand-alone programme, but more as a key component of the overall focus of SAFMH.'
'The World Health Organisation defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

The South African Federation for Mental Health focuses on promoting mental health for all South Africans, as well as promoting and protecting the rights of individuals with psychosocial and intellectual disabilities. Psychosocial disability is a term used to describe the experience of people with impairments and participation restrictions related to mental health conditions. Psychosocial disability relates to the effect that a mental illness has on someone’s ability to participate fully in life. Individuals with a psychosocial disability are prevented from taking part in opportunities such as education, training, and achieving their goals and ambitions. Not everyone with a mental illness will necessarily have a level of impairment that will result in a psychosocial disability.

Intellectual disability is characterised by significant limitations in both intellectual functioning and abilities, and adaptive function and behaviour, which covers many everyday social and practical skills. The disability originates during the developmental period, so during early childhood or adolescence. Limitations in intellectual abilities refer to intellectual functions that include problem solving, practical understanding, reasoning, learning from example or instructions, and abstract thinking. This can include verbal communication, working memory and perceptual reasoning. Intellectual disabilities are classified according to severity into four categories; mild, moderate, severe or profound. Each level of severity comes with its own degree of intellectual, physical and adaptive functioning, and will require a specific level of support or care. There can be multiple causes for intellectual disability; it may be caused by a genetic syndrome, such as Down syndrome, or it may be caused by an illness such as meningitis or by brain trauma.

SAFMH implemented its Mental Health Watch reporting system for human rights violations to ensure that persons with psychosocial and intellectual disabilities have the most accessible methods at their disposal to report any such violations and assist individuals in accessing equal justice and where required, linking them up with SAFMH legal partners.

SADAG

“The illiterate of the 21st century will not be those who cannot read and write, but those who cannot learn, unlearn, and relearn.” Dr Colinda Linde SADAG

SADAG’s activities are carried out through:

- A network of over 200 Support Groups throughout South Africa (including outreach groups in remote rural areas), where the community members lack access to resources and have no funds for treatment.
- A professional counselling staff, headquartered in Sandton, Gauteng, who operate the counselling lines from 8am to 8pm, seven days a week.
- Educational materials, including free multilingual brochures on mental health issues, including depression, bipolar, PTSD, OCD, anxiety, trauma, sleeping disorders, schizophrenia, teen suicide and substance abuse.
• A monthly newsletter is sent out to over 20 000 callers and we have DVD’s and books available.
• A referral service to mental health professionals, and free medical treatment where available.
• A comprehensive and informative website that can be accessed at www.sadag.org
• SADAG offers workshops and training programmes countrywide, in various languages. These include Commercial and large Corporates, Traditional Healers, Home-Based Care Workers, Hospitals and Clinics, Correctional Facilities, Schools, Universities, Churches, and Youth Groups. Topics include Depression, Panic, Bipolar, Dealing with Stress, PTSD, Suicide Prevention and Mental Health Stigma.
• SADAG has worked in schools in all 9 provinces, with learners, parents and educators. Our programme “Suicide Shouldn’t be a Secret” is aimed at reducing SA’s high rate of teen suicide. 9.5 % of all teen deaths are due to suicide. SADAG teaches youths that Depression is treatable and Suicide is preventable.
• SADAG also does extensive EAPs, corporate training, and employee wellness days.
• Powerful media campaigns designed to destigmatise mental illness and promote mental health are at the forefront of SADAG’s patient advocacy work. In order to achieve this, SADAG runs TV and radio adverts, sends out weekly press releases to print, radio and electronic media, as well as running specific campaigns to raise awareness of Bipolar Disorder, Teen Suicide, Men and Depression and Panic Disorder. SADAG has produced over a dozen radio adverts, in various languages, and 8 TV adverts. Most months, SADAG’s media exposure amounts to over R5 million.
• SADAG is recognised for its work in rural communities in the identification of depression in HIV and Aids patients, and the training of Home-based Care Workers in how to recognise the symptoms, as well as where to access treatment for their patients. Many have started support groups in their community.’

Psychology & PsySSA

“It is believed, furthermore, that a “relevant” South African psychology should immerse itself in the substantive issues facing the nation—such as “race” and racism, HIV/AIDS, and poverty” (Ahmed & Pillay, 2004; Macleod, 2004).


Lloyd Vogelman; Psychology, Mental Health Care and the Future; Is appropriate transformation in a future South Africa possible? Social Science and Medicine, Vol. 31, No. 4, pp. 501-505, 1990.

‘The expense of training clinical psychologists is a growing concern and is likely to intensify in the future. For a primary mental health care approach to be successful, other individuals will have to receive some clinical training. This may include medical practitioners, who are often the first to make contact with individuals suffering psychological difficulties; prominent and credible community members, such as religious ministers, who are often visited and consulted by community residents; and ordinary community members. These and other groupings of individuals could be trained to detect pathology, monitor high-risk groups, counsel, help in aftercare treatment, for example administering medication, and provide family support.

The broadening of clinical skills to other groups may pose an economic and social threat to clinical psychologists, since clinical skills would no longer be their exclusive domain. It is also probable that the training of non-professionals will make the issues of registration and who is permitted to conduct certain treatment procedures highly contentious.’

‘A democratic national health service demands that it be sensitive to the needs of the people. The professional ethos sometimes breeds a sense of superiority which inhibits the psychologist from learning about mental health from the ordinary folk of a community. Most importantly, the establishing of community mental health projects requires joint participation, constant consultation and informed consent before implementing new policies. The latter practice is contrary to the prevailing work ethic in everyday private professional life which largely comprises individual decision-making. While joint participation may be more democratic it is a lengthier process and this in itself can be exasperating for professionals, who often place great emphasis on efficiency and their centrality in decision-making processes.’
‘Despite the heavy practice orientation, there is serious attempt to ground psychology in the sciences. In the next few years, we are going to be inundated with conferences like we have already been. South Africa is a firm member of the International Union, but it is amazing how many other countries, both western and from the global south, have looked to South Africa to unpack issues that have just been stalematized in a sense.

We have access to a veritable human laboratory of behaviors that we have not come to understand. And we have to take advantage of that in its multicultural richness, in its violence and daily stress ridden conditions but also in its propensity for resilience. So a lot of people will, I think, start taking lessons from South Africa if we continue to play those leadership roles. Already, we have sizeable bodies of thought in psychology that are ground-breaking. We need to extend those to other areas, for example, development in education, in policy, in new interventions through our understanding of fellow South Africans.

We should also make psychology more in tune with the realities we face. I am not saying find a different psychology, but the psychology we end up with should have an element of proudly South African . . . South Africa, warts and all . . . so that we are not presenting only the negatives. It is easier to do research on the negatives. There are positives too. For example, we are the only country I know of where the salaries of psychologists are on par with doctors and dentists in the public sector. There are so many other firsts that we’ve got despite the terrible history of apartheid.’


‘Concerning the call for “relevance” in South African psychology, three cautionary notes emerge. First, a cursory knowledge of the workings of today’s academy suggests that “relevance” has become a red herring of sorts: It has long been recognized that the natural subversiveness of intellectuals has been overtaken by “technical, applied social service functions” (Sampson, 1970, p. 2), the inevitable consequence of living in an increasingly administered society where students function as little more than human inputs for the machineries of graduate schools and industry. Second, the ongoing demand for cultural “relevance” undermines, to some extent, the prospect of a nonracial society and perpetuates the same false consciousness propagated by “positive” apartheid theory. And third, to imagine the very existence of a “relevant” psychology, one must presume that Spivak’s subaltern can speak after all—and if that is possible, whether it makes any difference in the end: “For me, the question “Who should speak?” is less crucial than “Who will listen?” “I will speak for myself as a Third World person” is an important position for political mobilization today. But the real demand is that, when I speak from that position, I should be listened to seriously; not with that kind of benevolent imperialism . . . (Spivak, 1990, pp. 59–60)”

Garth Stevens, Leswin Laubscher; Facing the Apartheid Archive; PINS, 2010, 40, 1-7

‘Trapped by an ideology of tolerance (Žižek, 2008) and a national desire and discourse to look forward rather than to the past, the vicissitudes and contours of everyday personal accounts of apartheid are rapidly fading into a forgotten past. How we as psychologists and social scientists of all persuasions come to utilise these accounts to augment our understanding of the vexing question of xenophobia; the emotive debates about affirmative action, employment equity and institutional transformation; the forms of ethnic and identity politics that rear their heads each time we have an election; the racialisation of social ills such as crime and HIV/AIDS; the old, new and more subtle manifestations of racism; and of course, continuing forms of racialised subjectivities that characterise everyday South African society; are all some of the questions that we have been grappling with.’

Desmond Pointer and Martin Terre Blanche; Critical Psychology in South Africa: Looking back and looking forwards; http://www.criticalmethods.org/collab/critpsy.htm

‘The development of psychology in South Africa follows a path that closely parallels the discipline’s international history. Dominated from the outset by especially American intellectual and methodological trends, early South African psychologists enthusiastically imported and adapted various psychological tools and technologies, most notably intelligence tests, for use in education and industry (Louw & Foster, 1991). Always favouring applied over basic research, intelligence testing became the trump card in pre-Second World War psychology’s bid to contribute rationally and scientifically to South Africa’s social problems - which were, at the time, dominated by issues of "mental hygiene", "race relations" and the so-called "poor white problem", framed by the challenges of an
industrialising economy split along class and race lines (Lipton, 1985; Terreblanche, 2003). Foster (1993) provides a good summary of the conditions that precipitated the importation to and adaptation of psychology in South Africa:

Psychology as a separate discipline was only established in the 1920s. The impetus for its development came from the rise of mental testing and concern about the "menace" presented by the "discovery" - from about 1913 - of a category of people known as mental defectives. It was a time of intense class-ordering in the new South African union and the great political worry at the time concerned a potential class alignment between the emerging black and white proletariat in the cities. Thus problems of class-ordering, labour, "race"-thinking (informed by social Darwinism), mental deficiency and crime were all intertwined. (p. 68)

Psychology’s response to these problems fell far short of being progressive. In both its active advocacy for apartheid policies based on the "results" of mental testing and (increasingly after the Second World War) its apparent scientific neutrality with regards to matters of discrimination and social inequality - in industry for example - psychology carved out its professional niche, and invested its intellectual capital in the service of an explicitly racist-capitalist system.

'The major achievement of the psychology mainstream in South Africa was probably the tendency, despite psychology’s expanding influence in various spheres of government, education, social research and intervention, to keep politics out of psychology altogether - or at least, to hidepolitics. This was done, first and foremost, by playing the politics of scientific neutrality and neutral professionalism. Durrheim and Mokeki (1997) for example, in a content analysis of the South African Journal of Psychology, indicate that while 32% of papers published in this journal from 1970 to 1995 addressed race in some way, most of these, especially during the apartheid era, attempted to do so in a value-free and scientific way. This is their explanation:

Although psychologists ignored issues of race, it is unlikely that very many thought of themselves or consciously acted as racists or the servants of apartheid. Rather, the ideological structure of South African psychology promoted certain themes which supplied warrants for ignoring race. Specifically by adopting the medical model and by understanding their practice as value-free science, psychologists could ‘legitimately’ ignore issues of race. (p. 211)'

'The second strategy whereby politics was positioned outside the ambit of psychological research and practice was the re-packing of politics as "culture". This entailed, in short, that the structural demands for inequality upon which the political and economic dominance of the white minority rested, were treated as objective facts about the social environment; "differences" that could be studied objectively and managed rationally by psychology. Industrial psychology, for example, researched culture, worldviews, and the so-called "African personality", often accompanied with the appropriate liberal sentiments about the integrity and equality of other forms of life, in order to address (lack of) productivity as a function of the "cultural" divide between the worldviews and value systems of (black) workers and (white) management (Nzimande, 1984; Fulager & Paizis, 1986). "Culture" here, fraught with exotic, essentialist references to "the African", successfully masked the more relevant social and political dimensions of black labour under apartheid and of the actual experiences of black workers.'

‘During the apartheid years the boundaries between mainstream and critical psychology were already somewhat permeable, and in the post-apartheid era it has become even more difficult to trace a clear line between the two. This is partly due to the relatively small size of South African psychology, with groups and individuals who in other countries may have been pushed to the margins of the discipline, here not infrequently finding themselves in more central positions. Nevertheless, it is possible to discern in parallel with, but separate from, the expansion in professionalism noted in the previous section, a new flowering of critical thinking and action in psychology - especially among academic psychologists.’

‘However, despite the political importance of this work, it still operates within the coordinates of traditional social psychology, re-working existing categories such as social identity and attitudes and implicitly appealing to traditional liberal democratic politics. There is, for example, little theoretical discussion of racism above the level of individual rhetorical performance, which means that its relationship - past and continued - to liberal-capitalist ideology is not interrogated. There also still hangs about this work a whiff of methodolatry; as if at some level these social psychologists still wish to resort to method in order to render their position transparently universal and their "findings" of a uniform exchange value in the global marketplace of psychological ideas.’
PsySSA


‘Mission: Actively representing and promoting the interests of members and developing psychology nationally and internationally as a means of enhancing human well-being.

Vision: To advance South African Psychology as a science and profession of global stature and promote psychological praxis as relevant, proactive and responsive to social needs and well-being.’

‘As the representative body of psychology professionals in the country, PsySSA operates as a trade union for the discipline. The Society lobbies for members and advocates for psychology as a vital science and an essential and relevant field of practice.’

### Table of Objectives

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Prof Juan Nel, President of PsySSA;  [PsyTalk 2015](http://www.psyssa.com/); Issue 2

‘As psychology professionals we are hopefully able to rise above the current dire situation. Are we not meant to be equipped to become active agents of change? Also, as the saying goes” “When the going gets tough, the...”

In this regard you may find inspiration in knowing that the Psychological Society of South Africa (PsySSA) is.. in a better shape than ever. Also, I don’t think I am exaggerating when saying that this, indeed, makes us one of the largest – if not the largest – voluntary professional societies in South Africa. This, of course, may also imply that we have a greater contribution to make in ‘leading South Africa’ towards a better dispensation.’


‘But having survived the transition, PsySSA has got stuck. The idea of transformation that prevails in the organisation is the sort critical black psychologists and counsellors must reject. The sort of transformation we have settled for in PsySSA is the same kind as that pursued by government and other organisations. This is a form of transformation that effectively depletes black spaces, institutions and cultures. It is transformation undertaken at the expense of rebuilding convivial life and psychologies. In view of the fact that it often defeats what it primarily seeks to achieve, transformation, as it is commonly understood in the psychology body and indeed larger society, is not necessarily the best solution to a history of discrimination. Whereas the goal of transformation is to develop people so as to widen the pool from which to choose talent and enrich the organisation, more often transformation is wrongly assumed to mean representation. It’s as if we started out being sold, got free of it, then sold ourselves to the highest bidder.’

‘PsySSA and other bodies that have sought to integrate in post-apartheid South Africa are haunted by unintegrated and indeed disintegrating black communities. Like other integrated organisations, schools, companies and sport teams overly focused on integration by numbers, PsySSA is contributing to depleting the moral capital accumulated in the struggle against and triumph over apartheid. We need to replenish our imagination. We have to reimagine the desirable society we wanted, before it is too late. That desirable society includes making viable all communities and selves, but especially those black neighbourhoods and selves which were deliberately made unliveable.’
'There are several failures and shortcomings of organised psychology. We have not done enough to help prevent and reduce the burden of trauma and counter the effects of the pervasive violence that challenges the development of poor black children, men and women. There is a lot to do to try to understand the psychosocial effects of the magnitude and depths of unemployment and poverty in our country.'

‘How can we forget the racism that characterised psychology up until 1994? We have to celebrate having overcome racist discrimination and attained a non-racial society to represent the interests of psychologists and psychology students. Yet PsySSA has failed to think further and undertake the work of leading psychologists to imagine what a truly integrated country, transformed organisations and free psyches might look and behave like. Given the levels of trauma in the country, there is no denying South Africa is desperately in need of psychological expertise and services. However, it is time PsySSA revisits its dreams of the transformation of psychology and society.’

Suntosh Pillay; Is Psychology Serving Humanity? February 18, 2015; Mail & Guardian; http://www.thoughtleader.co.za/psyssa/2015/02/18/is-psychology-serving-humanity/

‘An active citizenship is the one pragmatic solution, if indeed the price of democracy is eternal vigilance. There are some promising examples in education, leadership development, the media, and youth development. Rather than waiting for “service delivery”, these organisations are imagining and actualising the society that has been promised to them. They refuse to volunteer to become victims of the system.’

‘But does this active citizenry contain a sustained and audible voice from social scientists in general, and psychologists in particular, beyond the insular and closed spaces of academia, or the rent-an-expert approach that values quick sound bites?

Dr Zuma, for example, questioned the role of our profession’s public intellectuals.

“Is there a memorandum of understanding between PsySSA and society?” he asked, “and are psychologists contributing to public discourse?”

‘Unlike apartheid, when 18 000 books were banned and the state repressed progressive media and critical voices, there is no deliberate muzzling of progressive analyses today (of which there is plenty from a range of writers). But there does appear to be a general reticence from professional communities to voice their socio-political opinions in the media, or to offer critical psychological analyses of social problems in public forums. Thought Leader, for example, has only a handful of psychologists who write their own column; and even globally, there is a dwindling of the elusive “public intellectual”.’

‘The first problem may be a skewed system that only rewards outputs in academic journals and conferences. The transition from writing polished academic pieces to the messy, hotter zone of interactive public debate is avoided at best, or disparaged at worst. The second problem is an overreliance by journalists and the media to use psychologists only as mental health experts. While mental health and emotional distress is an important part of what some psychologists are trained in, all psychologists at the very least have a master's degree with research experience; most academics have a PhD; and most training happens from a social sciences and humanities background, offering psychologists an arsenal of theoretical tools to use in their analyses.’

‘This opening article on this newly launched PsySSA column is therefore both an invitation to the intelligentsia in general, and psychology scholars in particular, to amplify their voices in the public domain and help deepen the quality of public debate in South Africa. Though I was still too young to witness it at the time, the history of PsySSA’s formation 20 years ago emerged from a fractured and racially divided professional community that has been critiqued for their complicity with the apartheid system — either through active collaboration, or head-in-the-sand denialism (bar some dissidents).’

‘Closed — dare I say, elitist — spaces like conferences and academic publishing can and should co-exist with dialogical, open spaces that are socially responsive, or we risk repeating this complicity with a currently problematic government and society. If we can’t transform the complex theories of Sigmund Freud, Frantz Fanon or Michel Foucault into easily digestible arguments for a discerning public audience, what’s the point of our convoluted, closed conversations?’
**Psychiatry & SASOP**


‘Time has come for Psychiatry to engage in a social contract with the people of South Africa, as well as with people in countries across the world in line with the theme of the 2016 Congress, which is “Psychiatry: Integrative Care for the Community’.”

SASOP

The South African Society of Psychiatrists (SASOP)’s comments on the NATIONAL DEPARTMENT OF HEALTH’S GREEN PAPER ON NATIONAL HEALTH INSURANCE; Published on 12 August 2011

‘The South African Society of Psychiatrists (SASOP) is the only organization representing the interested of the discipline of psychiatry as the peer specialist representative organization in South Africa. These interests are championed by the State Employed Special Interest Group (SESIG) representing the concerns of state employed and academic psychiatrists and the Psychiatrists in Private Practice Special Interest Group (P3 SIG) through the commercial company Psychiatry Management Group (PsychMG), which is a founding member of SAPPF. Attention is drawn to the SAPPF comments pertaining to private practice specialists. SASOP currently represents two thirds of all its potential members in South Africa as paid-up members.’


‘The SASOP was established in 1952 and is currently an association incorporated under Section 21 of the Companies Act, 1973. The SASOP is the only professional body in South Africa that represents the interests and protects the rights of the majority of psychiatrists in South Africa. Its members currently consist of about 520 psychiatrists and psychiatric residents in seven geographical regions across South Africa (Eastern Cape, Free State, Kwazulu-Natal, Limpopo, Northern Gauteng, Southern Gauteng and Western Cape).

The SASOP Board of Directors is assisted by its executive structures consisting of members from two Vocational Groups (SASOP Private Sector Group and the SASOP Public Sector Group), as well as SASOP Divisions, Task Teams, Subgroups and Special Interest Groups (SIGs). Current SIGs include: Biological Psychiatry; Psychotherapy; Forensic Psychiatry; Child and Adolescent Psychiatry; Social Psychiatry; Old Age Psychiatry; Philosophy of Psychiatry; HIV and Neuropsychiatry; Young Psychiatrists; Spirituality and Psychiatry; and Substance Use and Addiction Disorders. More information about SASOP can be obtained from its website: www.sasop.co.za.

The mission of the SASOP is to promote, maintain and protect the honour and interests of members, the discipline of Psychiatry as a medical speciality and to serve the community.

The objectives of the Society include:

- To promote and protect the rights and interest of the members of the Society
- To monitor, evaluate and advise on policies related to the delivery of clinical services and the protection of patients’ rights
- To promote research appropriate to Psychiatry in South Africa
- To promote appropriate training and evaluation of standards of undergraduate and postgraduate students in Psychiatry
- To promote continuing education in Psychiatry
- To maintain standards in Psychiatry by peer review
- To promote and uphold the principles of human rights, dignity and ethics in the practice of Psychiatry
- To oppose unfair discrimination in the field of Psychiatry
- To promote the de-stigmatization of Psychiatry and increase the awareness of mental illness.
- To promote the academic status of Psychiatry as one of major clinical disciplines in all schools of clinical medicine in the different South African universities, in collaboration with the different appointed heads of academic departments
To act as a lobby group to further the interest of the discipline of Psychiatry in both the public and private sector

A B R Janse van Rensburg, MB ChB, DCH, FC Psych (SA), MMed, PhD; Contributions from the South African Society of Psychiatrists (SASOP) to the National Mental Health Action Plan; S Afr J Psych 2013;19(4):205-212. DOI:10.7196/SAP.501

‘While there is no health without mental health, there is also no complete mental health without psychiatry.’ – SASOP

In terms of the specialty status of psychiatry (PS10), SASOP’s main business remains to promote, maintain and protect the honour and interest of its members and of the discipline of psychiatry as a medical specialty. The board will continue to pursue the following outcomes:

- Restoring the academic status of psychiatry as one of the five major clinical disciplines in all South Africa schools of clinical medicine.
- Creation of appropriate management structures for psychiatrists on all levels to ensure that psychiatrists themselves supervise and manage psychiatric services.
- Extension of the training of medical interns in psychiatry to at least two months within the different departments of psychiatry and not as a sub-programme of family medicine.
- Creation of appropriate structures and posts on the appropriate levels for psychiatric sub-specialists, including child and adolescent, geriatric, addiction, consultation-liaison, neuropsychiatry and forensic psychiatry.

The South African Society of Psychiatrists (SASOP)’s comments on the NATIONAL DEPARTMENT OF HEALTH’S GREEN PAPER ON NATIONAL HEALTH INSURANCE; Published on 12 August 2011

‘Primary Health Care (PHC) services will be re-engineered to focus mainly on community outreach services and to ensure a comprehensive primary care package of services, extending beyond services traditionally provided in health facilities such as clinics, community health centres and district hospitals. SASOP strongly argues for the strengthening of psychiatric services at community level and for its inclusion into the primary care package of services.

The re-engineered PHC will focus on health promotion and preventative care, whilst also ensuring quality curative and rehabilitative services. SASOP supports the principle that all members of the population will be entitled to a defined comprehensive package of health services at all levels of care in keeping with the spirit and letter of the Mental Health Care Act.

‘SASOP would strongly argue that psychiatric services should be included in the benefit package of district hospitals. District hospitals are often the entry point for mental health care users in need of emergency involuntary care, treatment and rehabilitation services. It is often also the health establishments in which the 72 hours observation is conducted before a mental health care user is referred to secondary or tertiary care. Provision of psychiatric services at district level hospitals will not only be in keeping with the provisions of the Mental Health Care Act and its regulations but will also prevent fragmentation of service delivery and enhance seamless referral and continuity of care.’

SASOP; South African Society of Psychiatrists (SASOP); http://www.sasop.co.za/B_Profiles.asp

‘Being a member of SASOP means that

- You and what you do are respected (based on work done, by SASOP, to ensure that psychiatry is recognized for the role it plays in securing patient rights, delivery of service to State patients and those who choose to see private psychiatrists; that as a discipline psychiatry deserves its own place in the training curriculum at universities; that psychiatry, and hence psychiatrists, is an integral part of any program seeking to secure good health for the citizens of this country (no health without mental health); that there is a body that can be consulted for peer review)
- You and your rights as a Psychiatrist are protected (ongoing work with funding industry (private), SAMA and the National DOH)
- You are fairly compensated for what you do (based on work done in the past and ongoing work done in the background for private psychiatrist and in the State with respect to input given in the OSD matter)
- You are considered relevant (enough for psychiatrists to now be consulted first before decisions are made with respect to matters of compensation (private practice), policy and planning (State practice))
You are seen to be honourable, ethical and a “safe bet” (by virtue of the work done by SASOP to do peer review, offer opinion on accepted practise, and in the same way that tradesmen are seen to be a “safe bet” if they belong to a national governing body able to exert influence on the way they provide their services)

All of the above mean that what you do, how you do it and how you are considered (by the public) remain sustainable and enduring.'

SASOP; Position Statement: The ethical and professional boundaries of clinical cooperation between psychiatrists and psychologists; http://www.sasop.co.za/C_DC_PState_024.asp

Position Statement

The ethical and professional boundaries of clinical cooperation between psychiatrists and psychologists.

The definition of the science of psychiatry according to the American Psychiatric Association’s Glossary is: “The medical science that deals with the origin, diagnosis, prevention, and treatment of mental disorders.” The psychiatrist is often called on within this context to collaborate in the treatment of mentally disordered patients, with psychologists of various registrations with the Board of Psychology.

The Department of Health recently promulgated the following act:” HEALTH PROFESSIONS ACT, 1974 (ACT NO. 56 OF 1974) REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF PSYCHOLOGY.” (2) This act clearly defines the scope of practice of the variously registered types of psychologists, and as such therefore defines the boundaries of cooperation of psychiatrists with psychologists.

The ETHICAL RULES FOR PSYCHOLOGISTS of the Board of Psychology contains the following general ethical rules that are pertinent to this discussion:

3. Competency limits (1) A psychologist shall limit his or her practice to areas within the boundaries of his or her competency based on his or her formal education, training, supervised experience and/or appropriate professional experience. (2) A psychologist shall ensure that his or her work is based on established scientific and professional knowledge of the discipline of psychology.

5. Adding new competencies (1) When a psychologist is developing competency in a psychological service or technique that is either new to him or her or new to the profession, he or she shall engage in ongoing consultation with other psychologists or relevant professions and shall seek and obtain appropriate education and training in the new area. (2) A psychologist shall inform a client of the innovative nature of and the known risks associated with such new psychological services or techniques, so that the client may have freedom of choice concerning such services or the application of such techniques.

20. Cooperation with other professionals Where indicated and professionally appropriate, a psychologist shall - (a) cooperate with such professionals as approved by the board in order to serve his or her clients effectively and appropriately; and (b) arrange for appropriate consultations and referrals based on the best interests of his or her clients, subject to such consent and other relevant considerations as may be appropriate, including the applicable legal and contractual obligations.

A detailed examination of the act (1) describing the scope of practice of psychologists, guides psychiatrists as follows on the clinical cooperation (or not) with the various categories of psychologists:

(1) Cooperation with counselors: the scope of practice stipulates that counselors work essentially with normal “individuals aiming at enhancing personal functioning”. Their interventions therefore fall outside of working with mentally ill patients.

Psychiatrists should therefore not cooperate with counselors in the treatment of mentally ill patients. Counselors may however be “identifying clients requiring more sophisticated or advanced psychological assessment and referring such clients to appropriate professionals”. A psychiatrist may therefore accept a referral from a counselor.

(2) Cooperation with psychometrists: a psychiatrist may refer a patient to a psychometrist for psychometric testing. A psychiatrist may accept patients referred by a psychometrist. A psychiatrist may however not cooperate with a psychometrist in the treatment of a mentally ill patient.

(3) Cooperation with clinical psychologists: a psychiatrist may freely cooperate with a clinical psychologist in the treatment of mentally ill patients.

The scope of practice of the clinical psychologist in relation to psychopathology and mental illness is: “assessing, diagnosing, and intervening in clients dealing with life challenges, particularly those with developmental and forms of psychological distress and/or psychopathology; identifying psychopathology in psychiatric disorders, and
psychological conditions; identifying, and diagnosing psychiatric disorders and psychological conditions; applying evidenced-based psychological interventions to people with psychological, and psychiatric conditions; referring clients to appropriate professionals for further assessment or intervention.”

(4) **Cooperation with counselling psychologists:** a psychiatrist may cooperate with a counselling psychologist in the “Assessing, diagnosing, and intervening in clients dealing with life challenges, and developmental problems to optimise psychological wellbeing; assessing cognitive, personality, emotional and neuropsychological functions in relation to life challenges and developmental problems; assessing developmental processes (e.g. career choice), and adjustment;” It is therefore clear that mental illness and serious psychopathology fall outside of the scope of practice of a counselling psychologist. A psychiatrist may therefore, for instance, request career counselling for a patient from a counselling psychologist.

A psychiatrist may accept a referral from a counselling psychologist as their scope of practice includes: “Identifying psychopathology, and its impact on developmental processes, and adjustment; identifying, and diagnosing disorders of adjustments; applying psychological interventions to clients with developmental challenges, and adjustment problems; performing therapeutic counselling interventions; referring clients to appropriate professionals for further assessment or intervention.”

(5) **Cooperation with educational psychologists:** the scope of practice of an educational psychologist includes: “Assessing, diagnosing, and intervening in order to optimise human functioning in the learning and development; assessing cognitive, personality, emotional, and neuropsychological functions of people in relation to the learning and development in which they have been trained.” The focus is thus on human functioning in relation to learning and development.

A psychiatrist, especially child psychiatrists, may cooperate with an educational psychologist when a patient’s case involves aspects of “human functioning in relation to learning and development”.

The scope of practice of educational psychologists further includes “identifying, and diagnosing psychopathology in relation to the learning and development; identifying and diagnosing barriers to learning and development; applying psychological interventions to enhance, promote and facilitate optimal learning and development; performing therapeutic interventions in relation to learning and development; referring clients to appropriate professionals for further assessment or intervention”. The emphasis remains therefore on learning and development.

This obviously excludes mental illness and psychopathology. It would therefore be inappropriate to cooperate with an educational psychologist in the treatment of patients’ mental disorders. It is appropriate to receive a referral from an educational psychologist.

(6) **Research psychologist:** A psychiatrist may not treat patients with the cooperation of a research psychologist.

(7) **Industrial psychologists:** the focus of industrial psychologists is on “the workplace” and “individual, group, and organisational behaviour”. The scope of practice refers to “performing psychometric, and other assessments in order to determine the potential and/or suitability for training, development and employment and to determine individual, group and organisational effectiveness; referring clients to appropriate professionals for assessment or intervention; designing, developing, standardising, and implementing assessment tools, and procedures related to the work environment”.

A psychiatrist should therefore only cooperate with an industrial psychologist in the management of mentally ill patients as it relates to the patient’s work functioning. Any other cooperation in the treatment of the mental disorders would be inappropriate.

(8) **Cooperation with neuropsychologists:** the scope of practice of neuropsychologists describes: “assessing, diagnosing, and intervening in the psychological disorders of people experiencing neuropathology or compromised functioning of the central nervous system; diagnosing, and evaluating psychological disorders caused by neurological conditions and differentiating them from other psychological and non-neurological disorders; treating, and rehabilitating the psychological disorders of people suffering from central nervous system dysfunction; referring clients to appropriate professionals for further assessment on intervention.”

It is therefore appropriate for a psychiatrist to freely cooperate with a neuropsychologist in the treatment of “neuropathology or compromised functioning of the central nervous system”.

(9) **Cooperation with forensic psychologists:** It is appropriate for a psychiatrist working in a forensic setting to cooperate with forensic psychologists as their scope of practice is described as: “conducting psychological assessments, diagnoses, and interventions, referring clients to appropriate professionals for further assessment or intervention; providing therapeutic interventions.”

**Hospital admissions by psychologists:**
SASOP does not support admission of mentally ill patients into hospitals by psychologists. SASOP believes that a hospital admission should always be under the care of a medically trained person for the following reasons:

- Patients requiring hospital admission needs medical care for not only mental illness, but also other medical conditions;
- Medication treatment routinely forms part of hospitalization and can only be prescribed by a medically trained person;
- Interactions with other medical specialists, should the need arise, can only be performed by a medically trained person.

Position statement compiled by Dr. P.F. Colin for the SOUTH AFRICAN SOCIETY OF PSYCHIATRISTS.’

A B R Janse van Rensburg, MB ChB, DCH, FC Psych (SA), MMed, PhD; Contributions from the South African Society of Psychiatrists (SASOP) to the National Mental Health Action Plan; S Afr J Psych 2013;19(4):205-212. DOI:10.7196/SAPJ.501

‘During the 2nd SASOP/SESIG strategic weekend meeting, the eight objectives of the final draft of the national MHAP were considered in the light of the relevant SASOP position statements (PSs).’

‘The following paragraphs summarise these deliberations, as well as the comments (italicised) submitted by the SASOP Board of Directors to the Deputy Minister’s task team in December 2012. All comments must be understood to include child, adolescent and geriatric psychiatric services.’

Objective 1: District-based mental health services and primary healthcare re-engineering

‘In view of the reality that there are currently not enough psychiatrists, appropriate task shifting can be supported, with psychiatrists involved in training, supervision and specialist support services.’

‘As a point of departure, SASOP would like to see the establishment of fully constituted MHRBs in all areas, with the information technology capacity to effectively monitor and track the admission and discharge of users from facilities and services. The MHRBs should engage in a good, co-operative and ethical working relationship with mental health practitioners.’

Objective 2: Institutional capacity

‘It is important to ensure adequate structures and channels for psychiatrists to be incorporated at all the levels of decision-making: facility, district, provincial and national.’

Objective 3: Surveillance, research and innovation

‘Structures and channels should be established for psychiatrists, individually or through SASOP, to participate in all monitoring and evaluation processes (facility, provincial and national).’

‘The inclusion of psychiatrists in the process of strategic and operational planning of mental health services at all levels should also include the proposed district clinical specialist support structures for the implementation of the NHI in the provisional 10 identified districts, as well as in later phases of implementation.’

‘It is strongly recommended that appropriate partnerships should be developed with non-governmental agencies (NGOs and private-sector bodies) with expertise in adequate information systems and surveillance.’

‘The role of health, mental health and in particular psychiatry as part of a comprehensive approach to substance abuse and addiction needs to be emphasised. Psychiatrists are well-positioned to involve other health practitioners and medical specialists who often need to be consulted in the management of these patients (from detoxification to rehabilitation), as well as treating patients with ‘dual-diagnosis’ with the appropriate services/facilities.’

‘With regard to culture, religion and psychiatry, care must be taken not to elevate the status of one religious/healing group above others, as there are many groups which all have concepts on health, healing, culture and spirituality. More discussion and debate is required, as the role of faith traditions and belief systems in health and mental health
can’t be disregarded, while in relation to and in comparison with a scientific perspective, it can’t be considered on an equal basis.’

Objective 4: Infrastructure and capacity of health facilities

‘It is SASOP’s position that psychiatrists should be part of the development of task teams on all levels (e.g. task teams on the review of the status of existing health facilities).’

‘Each level of health service (primary, secondary and tertiary) must have infrastructure suited for the particular level required: primary and community care clinics, district hospitals, regional hospitals, tertiary hospitals, central hospitals, and psychiatric/specialised hospitals. Existing national norms and standards must be reviewed to adequately reflect the situation on different service levels and for identified service packages, including community residential facilities.’

‘Safe medical facilities in general hospitals should include low-, medium- or high-security areas to accommodate restless medically ill (delirious) patients.’

‘Requirements for the licensing of private sector hospitals need to provide guidelines for psychiatric beds for voluntary and non-voluntary (assisted and involuntary) users.’

‘Forensic services must be reviewed, preferably through an interdepartmental committee comprising the departments of health, justice and social development. Psychiatrists must form part of such a structure.’

Objective 5: Mental health technology, equipment and medicines

‘Over the past 10 years, SASOP has been developing treatment guidelines and algorithms for a range of psychiatric disorders, including attention deficit hyperactivity disorder, major depressive disorder, bipolar mood disorder, schizophrenia, dementia and the various anxiety disorders. These draft SASOP Treatment Guidelines were proposed during the second SASOP/ SESIG strategic workshop, at a consensus meeting attended by over 100 representatives of both public and private sector psychiatrists in the different SASOP regional sub-groups, and approved as current best practice by the delegates and session chairs. It was agreed that the SASOP Treatment Guidelines document would be finalised and published during the subsequent six months, and these guidelines duly appeared in the previous issue of the SAJP.’

Objective 6: Intersectoral collaboration (Table 6)

‘Examples of cases in psychiatry where intersectoral collaboration is central include: community-based residential and psycho-social rehabilitation facilities and services; forensic psychiatry; substance abuse and addiction; child and adolescent psychiatry, and geriatric psychiatry.’

Objective 7: Human resources for mental health (Table 7)

- ‘It must be emphasised that mental healthcare services cannot be realised without psychiatric services, and the implied adequate post structures and appropriate levels of seniority for general practitioners, general psychiatrists and sub-specialists (e.g. child and adolescent and forensic psychiatrists).
- Existing national human resources (HR) norms and standards must be reviewed to adequately reflect the situation at different service levels.
- Funding packages should provide adequately for appropriate multidisciplinary services and HR packages, as per provincial strategic plans.
- When planning and funding mental health services, cognisance must be taken of joint-appointee psychiatric specialists’ responsibility for 70:30 ratio of service: training (teaching and research) activities. Due consideration should be given to providing for training as per financial package provision.
- It is imperative that medical interns rotate through psychiatric units (in general hospitals) and not only/primarily through mental health/family medicine services.’
Objective 8: Advocacy, mental health promotion and prevention of mental illness (Table 8)

- Suicide risk assessment must be made a core competency of all medical practitioners, specifically identifying people at risk and the correct management thereof. [34-36]
- Systems must be strengthened for the detection and management of child and adolescent mental disorders in schools and the referral to mental health and psychiatric services where appropriate, aligned with the pertaining school health policy.