

HEALTH PLANNERS AND SELECTED SERVICE PROVIDER PERSPECTIVES ON THE CHALLENGES OF IMPLEMENTING LEGISLATION ON COMMUNITY-BASED MENTAL HEALTH SERVICES

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ABSTRACT

The purpose of this study was to explore and describe health planners and selected service provider perspectives on the challenges of implementing legislation on community-based mental health services (CBMS). A qualitative design was followed. The total number of participants was 15. Data were collected through individual face-to-face interviews and analysed inductively. The findings indicated that there were different views on the implementation of legislation on CBMS among the participants. The majority of participants agreed that there were challenges in the implementation of legislation. These challenges included poor political will and implementation, low prioritisation of mental health and CBMS, prevailing stigma and mental health issues, shortage of resources (human and funds) for mental health and the lack of intersectoral collaboration. Recommendations include a need to educate and inform the stakeholders about the legislation and policies to facilitate implementation. Mental health and CBMS need to be prioritised. For programmes to be implemented and provided, the position in the priority list plays an important role. Greater trust and enhanced



cooperation between stakeholders are needed. Lastly, adequate resources are required for the implementation of CBMS.

Keywords: community-based, mental health services, legislation, health planners

INTRODUCTION

The World Health Organization (WHO) reported that mental and behavioural disorders affect more than 25% of people in the population and account for a substantial amount of the burden of disease in every country of the world (WHO, 2011:13). Neuropsychiatric disorders accounted for 13% of the global burden of disease and unipolar depression was the largest contributor to the burden of disease in middle and high income countries. The co-morbidity of mental disorders with other chronic conditions, for example HIV and AIDS, increases the burden of disease yet research evidence found that most countries did not prioritise mental health programmes (Makan et al., 2015:1). Nationally, the *South African Stress and Health* survey found that the lifetime prevalence of mental disorders in the population was 30.3% (Herman, Stein, Seedat, Heeringa, Moomal & Williams, 2009:340), which was higher than the global prevalence of mental disorders by the WHO.

Moving towards a comprehensive, integrated and responsive mental health service in community based settings is a major task. Health policy makers have faced the challenge of increased mental disorders by developing policies. Health planners and service providers have, however, not coped with the need to change the scourge of mental illness in individuals, families and society at large. While health systems at international and national levels are undergoing change in health promotion and prevention, not much has been done to change mental health service provision (Burns, 2011:104). The need for the provision of community-based mental health services (CBMS) is high as mental disorders contribute a large proportion of the burden of disease (Odenwald et al, 2012:8). Changes in the health system are instrumental in allowing mental health care users to be accommodated in community care (Barbato, Agnetti, D'Avanzo & Frova, 2007:779)

DEVELOPING COMMUNITY-BASED MENTAL HEALTH SERVICES

The legislation and policies that address the transformation of health service delivery in South Africa include the *White Paper for the Transformation of Health Services in South Africa*, which endorses a Primary Health Care (PHC) system and prescribes that a comprehensive and community-based mental health and related service should be planned and coordinated at national, provincial, district and community levels (South Africa, 1997:136). South Africa passed the *Mental Health Care Act No. 17*

of 2002 in 2005 (Amended in 2014) to, among other things, provide for the care, treatment and rehabilitation of persons who are mentally ill and to set out different procedures to be followed in the admission of such persons. The Act promotes the provision of CBMS (South Africa, 2014). Health planners and service providers at provincial, district and community levels are responsible for the provision of CBMS as stipulated in the *National Health Act No. 61 2003* (South Africa, 2003).

The Department of Health in South Africa developed norms for community-based mental services, to guide health planners (Lund & Flisher, 2006:588) on planning for CBMS. Although the norms further clarified the framework for CBMS and human resources that were required for the provision of CBMS, there seemed inadequate implementation at provincial and district levels (Bird, Omar, Doku, Lund, Nsereko & Mwanza, 2011:360).

There are three components in a framework for community mental health services in South Africa. The components of the framework are Type A services that comprise outpatient and emergency services, clinics and satellites, community health centres and mobile facilities. Type B services in the framework are residential care services constituted by group homes, boarding houses and half-way houses. Type C services are day care services constituted by sheltered employment, home based care, supported independent living, support groups and social recreational clubs. This study focused on Type B services as challenges were noted in the development and provision of this component of services. Many strides were achieved in the provision of Type A services at all the levels of the care system. Type C services are inter-sectoral and are provided by other government departments including the Department of Social Development and the Department of Labour.

RESEARCH PROBLEM

Progressive policies and legislation that impact on mental health services exist in most countries, but little progress has been made in the implementation of these policies. The development of CBMS throughout the world has been fraught with a number of opportunities and challenges. In North America a number of innovations in the field from mental health services research, consumer initiatives and programmes provided hope. However, a lack of political will and low funding often hampered accelerated progress levels (Drake & Latimer, 2012:51). Eaton et al. (2011:1592) found that, while most countries in Africa have developed mental health policies, there were major challenges with the implementation. According to Odenwald et al. (2012:31), poor implementation of policies is experienced especially in low and middle income countries. Lund et al. (2008:432) found that despite legislative reforms, there was inadequate CBMS in South Africa.

The root problem seems poor compliance to legislation that prescribes provision of CBMS. The distal problems appear to be poor translation of legislation on the

provision of CBMS, inappropriate use of allocated resources by health planners and service providers, as well as the lack of strategies to provide CBMS (WHO, 2013:4). These problems have manifested in heavy reliance on institutional care, overcrowding and high average length of stay for users in psychiatric hospitals in South Africa (Lund et al., 2008:444).

This problem has also been confirmed by media reports on the poor conditions of psychiatric hospitals as reported in *The Star* newspaper (Mentally ill patients 2010:9). The human rights of users were being violated due to, among other factors, the lack of CBMS. Health planners may be reluctant to improve the provision of mental health services as mental health is mostly not regarded as a priority health programme. Health planners and providers may be persuaded to do so through legislation (WHO, 2005:31). Most of these challenges are, however, in the translation of the policies and the implementation of effective strategies.

OBJECTIVES OF THE STUDY

The objective of this study was to explore and describe health planners and selected service provider perspectives on the challenges of implementing legislation on community-based mental health services (CBMS).

RESEARCH METHODOLOGY

Research design

A generic qualitative, explorative, descriptive design was utilised in order to describe and understand the perspectives of health planners and service providers at provincial, district and community levels in providing CBMS (Plano-Clark & Creswell, 2010:55). The aim was not to measure and observe variables, but to build a complex and holistic picture by means of the analysis of words and the reporting of the specific views of stakeholders (Corbin & Strauss, 2008: 25).

Research site

The research was conducted in South Africa within the Department of Health and selected service providers, namely, non-profit organisations (NGOs) providing mental health services.

Study population, sample and sampling technique

The population included top management stakeholders involved at provincial, district and community levels in providing CBMS and included representative heads of health departments, district managers and non-governmental organisations.

Participants were purposefully selected (Creswell, 2014:189) to ensure that specific elements were included in the sample. Such an approach employed a considerable degree of selectivity. Participants needed to have at least six months experience of implementing CBMS.

The total number of participants was 15. Of the 15 participants, five participants represented heads of health departments at provincial level. Two of the participants were female and three male. All five participants were South African, of which four were African and one was white. The age range of the representative heads of health departments was 44 to 62 years.

Four district managers participated in the interviews, three females and one male. All four district managers were South African. Three district managers were African and one was coloured. Three district managers were professional nurses with experience in clinical nursing and management and one was a registered medical practitioner with training in health management. The age range of the district managers was 40 to 55 years.

Six managers of non-governmental organisations (NGOs) providing mental health services participated in the interviews. Four of the managers of NGOs were white while two were African. Five of the managers of NGOs were female and one was male. The age range of the participants was 38 to 59 years.

Data collection and analysis

Data were collected by the researcher and an independent qualitative research expert with experience in mental health through individual face-to-face semi-structured interviews (Creswell, 2014:190). The questions were open ended in order to elicit the views and opinions of participants. The central question was: 'Tell me about implementing CBMS'. Facilitative communication techniques were used to probe, reflect and summarise responses. Data were recorded and later transcribed by the researcher. Data were collected until saturation occurred, meaning that no new information was revealed.

Data were analysed using thematic coding as described by Tesch (Creswell, 2014:196). Transcripts were read several times in their entirety to establish a sense of the whole before breaking it into parts. Memos (short phrases or ideas) were written in the margins. Initial codes and categories were formed and later refined. Multiple forms of evidence to support each theme were sought. These were aggregated to form one major theme. The data were co-coded using an external expert in qualitative data analysis.

ETHICAL CONSIDERATIONS

The research was approved by the Higher Degrees Committee of the Department of Health Studies of the University of South Africa (No. HSHDC/119/2012).

Approval to access the study sites was obtained from the Director-General of the National Department of Health as well as heads of health facilities/services in the provinces. The research plan was reviewed by the Ethics Committee in each of the nine provinces as the research sites were approached for approval to access the provincial sites and the study participants signed informed consent forms. Interviews were conducted in private at venues preferred by the participants. Participants were allocated unique identifiers, which were entered into the database. Unique identifiers were linked to the study participant numbers. Data in electronic files were kept in a separate password-protected file and hard copy transcripts were shredded once data processing was completed. The participants of this study remained anonymous by ensuring that their responses were not in any way linked to particular individuals. The participants were informed of their liberty to withdraw from the study at any time without any detrimental consequence and of the benefits that they may gain from this study in the letter of invitation to participate.

Burns and Grove (2011:691) describe coercion as a situation where individuals are threatened with harm or excessive reward for compliance in a study. The official position of the researcher being employed at a national level could deter the participants from sharing their experiences for fear of exposure or being labelled. To prevent this, the researcher outlined her position in the letter of invitation and at each interview the participants were requested to de-role their official positions to those of participants. A co-interviewer was included to conduct the interviews with the heads of health departments and to debrief the researcher. Some of the participants, specifically heads of health departments, were reluctant to participate in the study and share their experiences due to, among other things, power issues, political positions and tight schedules.

Strategies to ensure trustworthiness

Strategies employed to ensure the quality of data included the following measures of trustworthiness (Krefting, 1990:216): credibility (triangulation); applicability (rich descriptions and purposeful sampling); dependability (code, recode procedures); confirmability (triangulation); and authenticity (fairness, awareness, understanding, action and empowerment) (Onwuegbuzie, Leach & Collins, 2008).

DISCUSSION OF RESULTS

There were different views regarding the implementation of legislation on CBMS among the participants. The majority of participants agreed that there were challenges in the implementation of legislation, but one participant was not in agreement.

The legislation isn't a problem; it's the implementation of services at that level. (P8)

We have good legislation in South Africa; we have a services problem with implementation and financing. (P14)

Table 1 represents the major theme, that is, the challenges in implementing legislation on CBMS. The following categories emerged under the theme, namely, poor political will and implementation, prioritisation of mental health and CBMS, stigma and mental health issues, shortage of resources for mental health and a lack of intersectoral collaboration.

Table 1: Themes and categories

Theme	Category
Challenges in the implementation of legislation on CBMS	Poor political will and implementation
	Prioritisation of mental health and CBMS
	Stigma and mental health issues
	Shortage of resources (human and funds) for mental health
	Lack of intersectoral collaboration

Poor political will and implementation

Eaton et al. (2011:1592) define political will as the understanding of decision-makers and political leaders of mental health issues as well as planning, prioritisation of actions and allocation of resources to address the needs. Legislation is the vehicle for the implementation and provision of CBMS. The general experience of the participants was unanimous that political attention to mental health and CBMS was poor and there existed a gap between the declared health promotion policy and practice.

A head of health representative stated:

For legislation to happen we need a political will. If the political will is not there, then even in terms of driving that legislation it will not be on the agenda...it takes political will, if they want it to happen. (P5)

Another commented:

The policies are there but they are just ignored. (P15)

NGO managers contended that:

Uhm there is a big difference because the policies are made but when it comes to implementation, it's a totally different story. (P15)

I think we are getting there as the department is more involved in mental care as previously there was nothing happening but now with the mental health care act (P11).

The study confirms the findings by (Hanlon, Wondimagegn & Alem, 2010:185) that while most countries in Africa had policies that supported decentralisation of mental health services and development of community-based mental health care, the policies were not implemented. The authors state that only 56.5% of African countries had implemented community-based mental health care.

According to (Zalmanovitch & Cohen, 2015:31), the lack of political will is not so much due to politicians' or stakeholders' lack of courage or good sense, but rather that the involvement in the execution does not offer them immediate results.

Another NGO manager commented that:

... it is not just implementation of the legislation, but also mind change. (P12)

According to Eaton et al. (2011:1592), there are variations in the provision of mental and community-based mental health services between low and middle income countries. The differences emanate from a number of factors, including available human and financial resources as well as the translation of legislation and policies on mental health. In low income countries, emphasis is placed on identification and management of mental disorders at primary health care, while middle income countries concentrate on the development of acute mental health care, out-patient mental health services, community mental health teams and community residential mental services.

Prioritisation of mental health and CBMS

Prioritisation refers to the process of making decisions and placing specific issues on an agenda according to importance as well as allocating resources among competing priorities. The process of prioritisation affects the policy development process, the content of the policy, as well as the development and implementation of plans. From the interviews, it emerged that there was low priority given to mental health and community-based mental health services in South Africa. A comparative approach with other health programmes, for example HIV and AIDS, was raised to stress the point.

A manager of an NGO stated:

I would be happy if mental health can be given the recognition that is given to HIV and TB and mental disability has also challenges. I haven't seen the implementation strategy working; maybe it's working for HIV as everyone has been so afraid of HIV and AIDS and TB. (P14)

The only challenge is that most of our mentally ill patients are not in a critical position so in most areas priority is given to other departments, but we still have a budget. (P6)

And

... it tends to be side-lined or not brought up even though there is a non-contentious attitude to non-communicable diseases which was now at the bottom of the agenda, but now the minister has brought it up. (P2)

If the Department of Health can put mental health as a priority and look at managing the illnesses. (P15)

A head of health concurred:

... but when one looks at national and provincial health meetings other health care topics get more attention than mental health care. It's still not as sexy as HIV Mental health care compared with other components such as HIV is very under-funded. It is slowly getting recognition as probably the major health care challenge with incredibly high proportion of the population suffering from mental illness at any one time. (P8)

Bird, Omar, Doku, Lund, Nsereko and Mwanza (2011:361) found that Ghana, South Africa, Uganda and Zambia had not put mental health among health priorities. These authors argue that the low prioritisation of the mental health programme affects the policy development process. Burns (2011:99) agreed that the low priority of mental health in the South Africa is identified through inequities in resource allocation between the physically ill and the mentally ill.

The *Sunday Times* newspaper (Tromp, Dolley, Iaganparsad & Govender, 2014:4) reported on the low priority of mental health in South Africa and further stated that mental health was not defined as a priority, and the programme was left at the bottom of the list in financing health services. Lund et al. (2013:43) concur that mental health has low priority on public health agendas. Due to the neglect and lack of priority of mental health, there is a gap in the provision of a comprehensive community-based approach to address the needs of mental health care users.

Stigma and mental health issues

According to Uys (in Uys and Middleton 2013:199), stigma is a mark branded on an individual in a negative manner, and this mark leads to prejudiced attitudes and discriminating behaviour. Stigma is a complex construct that includes public, self and structural components (Corrigan, Druss & Perlick, 2014:37). The participants explicitly raised stigma as a contributory factor and a challenge in the establishment of CBMS. It emerged that both mental health care users and the mental health programmes are stigmatised within communities.

... we really struggle to establish services in the community so these people are normally stigmatised; they are seen as violent and people are scared of them so they are put back in institutions.

And

... and also of course the stigma around the service, the fears from health professionals leading to the service that is distant and far from the client. (P4)

... this kind of service but because of stigma again you find that it so and so who is supposed to see these patients you know. (P5)

Stigma against mental health care users is common in South Africa. According to DeSilva, Samele, Saxena, Patel and Darzi (2014:1597), the stigma attached to mental health problems in some instances leads to unscrupulous human rights violations and also delays action for service delivery. Stigma needs to be addressed as a marker in its own right.

Shortage of resources (human and funds) for mental health

The shortage of resources for mental health, specifically human and financial resources, was cited as an impediment for the implementation and provision of CBMS by participants.

Most health professionals are not keen on working in mental health care provision. A problem with OSD and recruitment of the private sector is also a problem. (P9)

A head of health added:

... even the 4 year course professional nurses coming out they do not seem to have the interest of pursuing mental health as something I want to do. (P5)

... the challenge is that we have limited people who can manage, due to a lack of skills. (P6)

DeSilva et al (2014:1600) suggest that the inadequate number of health professionals trained in mental health contributes to the weak improvement of mental health services.

Among other factors that impede the development of CBMS, the participants cited funding as a major issue.

... people are not positive to give funds to people with special needs because they do not really contribute back into the country and businesses, so people ask themselves how they will contribute back so they think it is better to fund someone who will benefit. (P11)

Lund, Kleintjies, Kukuma, Flisher & MHaPP (2010:400) attest to this in the following statement:

Like many other low and middle income countries, mental health services in South Africa have been chronically under-resourced.

Most government funding is directed towards in-patient care in psychiatric hospitals rather than CBMS. This process is noted as limiting the development of equitable and cost-effective CBMS (Burns, 2011:99). According to Bird et al (2011:361), lack of funding, competing health and development priorities, advocacy and stigma contribute to the poor response for support to a health programme.

Lack of intersectoral collaboration

Intersectoral collaboration refers to a sustainable, effective and efficient relationship between parts of the health sector with parts of other sectors that have been formed to take action on issues in order to achieve positive health outcomes (WHO, 1997). In order to address mental health issues in South Africa and to effectively implement mental health policy and legislation, sectors other than health need to be involved. Participants shared similar views on the need for an intersectoral approach in the provision of CBMS. However, there were differing opinions among the participants regarding the government department that was to lead the implementation and provision of CBMS. Sectors responsible for the different inputs, for example provision of housing, and were cited to provide these services.

I think it's two departments. If I can put it that way, Health and Social Development both have to work together and that is the difficult[y], none of them wants to take responsibility. (P10)

And

Social Development, Health, maybe you will have to talk to Education. You may have to talk to Housing, Human Settlement for this facility. You may have to talk to, I am a little bit weary of the Department of Labour because the moment these people are able then they are not disable[d] anymore. (P12)

The Department of Labour can come on board and they can provide training. (P11)

One of the participants added:

“The Department of Education is really struggling as the children have to sit in horrible conditions and some children with disabilities get sick quickly and need to be transported with a van but provide buses for schools so they should do the same with our children”. (P11)

Another participant stated:

You know what we do when we work in an area we try to involve the stakeholders, like the Department of Agriculture (P15).

One participant cited the relevant departments that have roles to play in CBMS:

We need to get forums for the stimulation centres in the provinces which only focus on the centres with the Departments of Health, Education, Labour, NGOs and Social Development on board. (P11)

There seems to be little change since the Mental Health and Poverty Project (Lund et al., 2008) examined and recommended the need for intersectoral collaboration. There is a dire need for a concerted and coordinated intersectoral collaborative approach.

CONCLUSIONS

Until mental health is acknowledged as a basic human right and prioritised as such, meaningful implementation of legislation is unlikely. Political will is required to bridge the gap between legislation and action. The understanding of legislation and policies on CBMS by the stakeholders contributes to the implementation and provision of CBMS. There is therefore a need to educate and inform the stakeholders about the legislation and policies to facilitate implementation. Capacity building requires leadership, resources and sustained commitments. For programmes to be implemented and provided, the position in the priority list plays an important role. Mental health should also be integrated into disease-specific programmes such as HIV/AIDS and maternal, sexual and reproductive health programmes (WHO, 2013:22). Greater trust and enhanced cooperation between stakeholders are needed. An anti-discrimination perspective must be promoted in mental health.

The World Health Organization (WHO, 2013:20) suggests that, among other goals for the development of CBMS, funds that are available for long-stay facilities should be redirected to community care. Resources earmarked for in-patient care should be redirected to training of staff and support for mental health care users who are placed in community care. In instances where there are no resources, new funds for the development of CBMS should be identified. Furthermore, the WHO proposes that funding allocated for psychiatric hospitals should be shifted to community-based mental health care. In cases where additional funding is required, donor funds should be sourced.

Burns (2011:99) suggests that the involvement of users within communities as advocates is effective in reducing discrimination and stigma as well as for achieving human rights for the users. Users' participation in advocacy requires empowerment through collaboration with mental health practitioners and researchers. The task to make a difference is not an easy one. It requires passion, commitment and a will to change.

LIMITATIONS

None of the participants held the position of heads of health departments; attempts to obtain cooperation from heads of health departments were unsuccessful. The study did not include the perspectives of patients or caregivers of such community-based patients.

ACKNOWLEDGEMENT

Ms. Nomvula Sibanyoni sadly passed away in 2015. Her efforts in promoting Mental Health Nursing are acknowledged and appreciated. We wish to thank the Director-General of Health and the provincial government departments for permission to conduct the research.

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