

Profile of Community Mental Health Service Needs in the Moretele District (North-West Province) in South Africa

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Abstract

Background: The emergence of democracy in South Africa led to a need to transform all public structures, including the health care system. The aim has been to transform these structures in order to bring them in line with the new culture of human rights. Transformation of the whole health care system is motivated by a number of key objectives, which include achieving equity in resource allocation and health service delivery, developing primary health care infrastructure and decentralising services to promote community participation.

Aims of the Study: In the context of de-institutionalising mental health services in South Africa, this study aimed to investigate community mental health service needs of mental health service users and that of their families in the Moretele District, North-West Province, South Africa.

Methods: The study was conducted in three clinics situated in three different communities in the Moretele district. Data collection consisted of: 147 clinical record reviews, 105 interviews with patients followed by a joint interview with a family member, 83 interviews with caregivers and eight interviews with community key informants (traditional healers, a civic leader, a councillor, a retired teacher, and a physician).

Results: The majority of service users were males (54%). The mean age was 41 years and 63% had completed primary schooling. Patients were recorded as having only one of two primary diagnoses, namely "schizophrenia" (57%) or "epilepsy" (41%). However, a review of prescribed drugs and caregiver interviews showed that there was a presence of mood disorders among service users. The local hospital was service users' primary entry point into the mental health care system, followed by traditional healers (30%). Interviews with service users, service providers and caregivers reveal limited knowledge of patient illness. Nevertheless, service users who had epilepsy were more likely to provide details of their illness than those with mental illness. Above half of service users had basic social skills such as bathing, eating, washing and using public transportation independently. Feelings of loneliness and isolation were common among service users in the community; seventy nine percent (79%), for example spent their days entirely in their homes. Only 7% reported contact with friends. Experiences of community

discrimination and exploitation of people with mental illness were reported in key informant interviews and by service users themselves.

Discussion: The main community mental health service needs identified in this study were: (i) Improved quality of mental health services at clinics. (ii) Better co-ordination of services (clinic, hospital, social work and traditional healers) and removal of barriers to health service utilisation. (iii) Alleviation of the social isolation of mental health service users by building on existing community structures and individuals willing to engage in partnerships with service providers. The authors identify a need to train primary health care providers in mental health in order to promote the adequate diagnosis and detection of common psychiatric illnesses. They also point out the need for social support interventions to enable people with mental illness to deal with loneliness and isolation and a need for psycho-educational programmes to make patients and caregivers better informed about mental illness.

Received 30 October 2001; accepted 12 April 2002

Introduction

The emergence of democracy in South Africa led to a need to transform all public structures, including the health care system. The aim has been to transform these structures in order to bring them in line with the new culture of human rights. Transformation of the whole health care system is motivated by a number of key objectives, which include achieving equity in resource allocation and health service delivery, developing primary health care infrastructure and decentralising services to promote community participation.¹ As part of the broader process of change, a review of mental health services was conducted in 1995. Motivating factors for this review included the longstanding allegations of inhumane care and violation of patients' rights in chronic psychiatric institutions. Consequently, a national mental health committee was established in 1995, with the specific objective of investigating these allegations in South Africa's mental institutions.² The findings of this committee confirmed the initial allegations and as one of its major recommendations was to overhaul the mental health care system.² Shortly afterwards, de-institutionalisation of mental health care services was made a priority on the national policy agenda.² A key focus of this proposed South African policy is decentralisation and provision of community mental health care to persons with mental illness. While the current policy

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Source of Funding: Health Systems Trust (Grant N° 231/98)

Table 1. Data Collection Tools, Indicators, Sample size and Response Rate

Tools	Indicators	Sample	Response Rate N (%)
Record Review	Age, Gender, Diagnoses, Medication, and Histories of Clinic Attendance	150	147 (98)
Service Users/ Patient Interview Schedule	Experience of Illness and Treatment, Community and Family Life, Employment, and Accommodation, Social Support, Substance Abuse, Employment, and Psychosocial Wellbeing, Visions of Community Mental Health Services.	147	105 (71)
Joint Family Member/ Service User Interview Schedule	Service User Clinic Attendance, Household Demographic and Economic Profile, Caregiver Time, and Service User Symptomatology	147	105 (71)
Caregiver Interview Schedule	Assessing Service Needs for Accommodation, Social Support, Substance Abuse, Employment, and Psychosocial Wellbeing.	147	83 (56)
Community Key Informant Interview Guide	Perceptions of Community Mental Health, Service Needs	8	8 (100)

emphasis is to move towards community care, this is occurring against a background of limited access to mental health services, including hospital and outpatients services.^{3,4}

De-institutionalisation has been defined as a process which aims "to reduce the inpatient population of the institutions for the mentally impaired and the development of more appropriate, less restrictive community based and therapeutically oriented resources".⁵

Countries such as the United Kingdom and the United States have had a mixed experience with de-institutionalisation.⁶⁻⁸ On the one hand, their experience has demonstrated that de-institutionalisation is achievable where there are appropriate policies and community support structures to facilitate the reintegration of people with mental illness into meaningful community living. On the other hand, when hospital resources have not followed discharged patients into communities, most patients have found themselves on their own in the community, with no where to turn for support. In this situation, an increasing number of the mentally ill have become homeless or imprisoned.⁶

To better inform emerging debates and policy processes regarding de-institutionalisation in South Africa, the discharge potential and community services needs of psychiatric in-patients at seven of the country's 27 hospitals were assessed.⁸⁻¹⁰ These studies caution against rapid and widespread de-institutionalisation and emphasise the resources and services needed. They document the challenges of a successful move away from institutional care, for example, the lack of community-based services to support the mentally ill, and explain the need for a gradual development of such services.⁸⁻¹⁰ This is supported by the international literature which associates unsuccessful de-institutionalisation programmes with under developed community care services.^{6,7,11}

Effective de-institutionalisation requires more than access

to health facility-based services. The development of community based *social support* is also critical to the successful community living of people with mental illness. A number of components of social support have been identified, namely, emotional sustenance, building self-esteem, giving advice, and tangible support.¹² These social support functions have also been catalogued as instrumental (material aspects such as adequate shelter, food, ability to be mobile etc.); informational (knowledge of the illness and how best to manage it, rights, available resources, including welfare grants etc.); and emotional.¹³ Social support is derived principally from having meaningful relationships with other people.¹⁴

In de-institutionalising mental health services and developing district primary health care systems, there is a need for community participation in the planning of health services. There is a paucity of studies which look at the perspectives of mental health service users.¹⁵ This paper presents the findings of a study which aimed to assess community mental health service needs in a health district in the rural areas of South Africa, based on interviews with mental health clinic service users, their families, and community leaders. The specific objectives of the study were to:

- (i) establish the profile of outpatient mental health service users living in the Moretele District, North-West Province;
- (ii) investigate the broad service needs of current service users as perceived by themselves, their families, providers and community leaders;
- (iii) use these data to make recommendations regarding mental health community service requirements.

Methods

The study was descriptive in nature, combining both

quantitative and qualitative research approaches.

A list of all primary mental health clinics was obtained from the Moretele district mental health coordinator and used to select three clinics for the study. The clinics that were selected had the highest number of registered mental health service users at the time of the study. They were situated in three different areas of Moretele District, namely Temba, Mathibestad and Stinkwater. Temba is an urban township with a population of 70 000, about 60 km from the Pretoria metropolitan area. The township is managed by local government authorities together with the local civic association. Mathibestad is a typical rural village with a population of about 40 000. The village is co-managed by a tribal authority, local government, and a civic association. Stinkwater is a semi-rural community, and similar to Mathibestad, is governed by co-existing management structures. There are no mental health services in the district, except for the clinic-based services which users access for follow-up psychiatric treatment.

From each of the selected clinics, we systematically chose approximately fifty clinical records of mental health service users (N=150). We then followed up these service users at their homes, where most of the data were collected by means of interviews. The interviews were conducted independently by three fieldworkers, who were specifically recruited and trained for the purpose. All mental service users were given a choice as to whether they wished to be interviewed. Their permission was also obtained to interview their caregivers or immediate family members. Eight key informants were interviewed from the Moretele District and they included traditional healers, a civic leader, a municipal counselor, a retired teacher, and a medical officer.

The data collection tools used in this study and the indicators they measured are outlined in **Table 1**. They consisted of record reviews, a patient interview schedule, a joint patient/family member interview schedule, caregiver interview schedule and a key informant interview guide.

The data collection process for this study took two months to complete from July 1999 to September 1999.

The Statistical Package for Social Sciences (SPSS) was used to process the quantitative data by means of descriptive statistics. Qualitative data were analysed by summarising common and divergent themes.

Limitations

Because the study was clinic-based, some bias may exist as the circumstances and perceptions of people with mental illness and their caregivers, who use other than the clinics studied are not represented. Nevertheless, we believe the study highlights general trends that are useful to mental health workers in other parts of the country.

Results

Response Rate

All the data collection methods achieved a high response rate, except for the caregiver interview (**Table 1**).

Table 2. Characteristics of service users

Characteristic	N	(%)
Gender (n=147)		
Male	80	(54)
Female	66	(45)
Not indicated	1	(1)
Age group (n=147)		
0-15	3	(2)
16-20	3	(2)
21-29	22	(15)
30-49	73	(50)
50-59	22	(15)
60 and above	16	(11)
Not indicated	8	(5)
<i>Mean age: 41 years</i>		
Primary diagnosis (n=147)		
Schizophrenia	84	(57)
Epilepsy	61	(41)
Not indicated	2	(2)
Education (n=105)		
None	9	(9)
Lower primary	40	(38)
Higher primary	26	(25)
Secondary level	23	(22)
Work status (n=105)		
Previously employed	50	(48)
Currently employed	4	(4)
Never employed	51	(48)
Housing (n=105)		
Shack (serviced site)	18	(17)
4 roomed house	27	(26)
big house (>= 5 rooms)	44	(42)

There were more male than female service users and they ranged in age from eight to 81 years, with a mean age of 41 years (**Table 2**). Service users had been given either "schizophrenia" (57%) or "epilepsy" (41%) as their primary diagnosis. There were clear gender differences by primary diagnosis: 62% of the respondents who had been given schizophrenia as a primary diagnosis were male versus 38% female. However, these differences were not statistically significant ($\chi^2 = 2.026$, $df = 2$, $p = .363$). There were statistically significant differences in the primary diagnosis of respondents by level of education ($p = .928$) and current work status ($p = .947$). Just over one third of the respondents (38%) and 52% of the caregivers had a primary level of education. Only four service users were working for an income at the time of data collection (two females and two males). Just under half of service users had previously worked (55% male versus 45% female), ($\chi^2 = 1.242$, $df = 2$, $p = 0.537$). The differences between current work status and level of education were not statistically significant ($\chi^2 = 1.909$, $df = 6$, $p = .928$).

Sixty percent (60%) of the caregivers in this study were women and just above half (54%) were biological parents or

Table 3. Acute symptomatology over past month, according to caregivers (n=83)

Symptomatology Questions	Yes N (%)	No N (%)	Don't Know	Total
Has the patient experienced hallucinations and or delusions?	29 (35)	50 (60)	4 (5)	83 (100)
Has the patient experienced seizures/fits?	27 (33)	54 (65)	2 (2)	83 (100)
Has the patient felt sad/ depressed?	42 (50)	38 (46)	3 (4)	83 (100)
Does the patient have a problem with alcohol and drugs	20 (24)	61 (74)	2 (2)	83 (100)

grandparents of the respondents. Service users had lived in their current residential areas for a mean of 24 years. The mean number of people per household was 5.6, ranging from one to fifteen. The majority of households had more than one person above the age of 16 years. Only 18% of the households had children three years of age or younger. There was at least one person employed in 4% of the households. Social grants were a main source of the income, with 67% of households having one to three persons in receipt of an old age state pension and 52% with one person on a state disability grant. Fifteen percent of the households had a family member who had had to stop working to take up the responsibility of caring for the service user with a mental illness. All the households had a clean water supply. A radio, television and refrigerator were owned by more than 60% of the households.

Diagnosis and Knowledge of Illness

There was considerable evidence of limited understanding and knowledge of mental illness from the record review, interviews with service users and caregivers. Only two primary psychiatric diagnosis were recorded by service providers: schizophrenia and epilepsy. The profile of medication prescribed and the caregiver and service user interviews, however, suggested a definite presence of mood disorders amongst service users. One service user described how previous suicidal behaviour was the reason for initial contact with mental health service: "I tried to hang myself then my son cut that rope off and took me to the hospital". Half (50%) of service users were reported by caregivers to have had periods of sadness in the month prior to data collection (Table 3). Thirty five percent were said to have had hallucinations and delusions. This experience was not statistically different by gender ($\chi^2 = 3.370$, $df = 3$, $p = .338$). Sixteen percent (16%) of service users with a diagnosis of schizophrenia and sixteen percent (16%) with a diagnosis of epilepsy had had seizures or fits in the month prior to this study ($\chi^2 = .946$, $df = 2$, $p = .623$), and just below a quarter (24%) were reportedly misusing alcohol or drugs. Of the twenty-one service users who had a problem of alcohol and drug abuse, 67% were male and 33% were female, ($\chi^2 = 1.940$, $df = 1$, $p = .164$).

Almost all of the caregivers interviewed (N = 82) said they knew why the service users were attending the clinic, referring broadly to mental illness and epilepsy. However, when asked to explain further, most displayed little knowledge of

the illness; 42% of caregivers said that they could not explain further and 30% explained the illness in terms of the patient's "doing funny things", "not being normal", "mind is no longer working", "losing his mind" or "being mad". Understanding and knowledge of the illness was clearly higher amongst service users with epilepsy than those with mental illness. Mentally ill service users employed terms such as "head disease", "treatment for tablets" and "nerve problem" to explain their illness. Some service users viewed themselves as not normal, with statements such as "I am sad about my illness because I am not normal".

Medication

A total of 262 courses of psychotropic drugs had been given at service users' latest consultation. The mean number of psychiatric drugs per respondent was 1.85. Service users were most frequently given anti-psychotic drugs (47%), followed by anti-convulsants (34%).

A quarter of service users (25%) were reported by their caregivers as unable to take medication without their supervision. This was not significantly related to gender ($\chi^2 = .000$, $df = 1$, $p = 1.000$) and primary diagnosis ($\chi^2 = 2.976$, $df=1$, $p = .226$). Only 14% had relapsed due to not taking medication regularly, and 6% were said to have refused to take medications. Just above half of caregivers (52%) said they were aware of side-effects of the medication that the service users take.

Mental Health Services Used

Caregivers reported service users to have used most commonly the local general hospital (n=35) as their first entry point into the mental health care system. The second most frequent entry point to the mental health system was the traditional healer (n=25), followed by the primary health care clinic (n=3), the mental hospital (n=3), and the police (n=2). Data from the record review reveal that 32% of service users had attended the clinic for two to four years and more than one third (37%) had attended for eight years and more.

The policy at the clinics where we conducted the study is that service users should attend the clinic once a month for psychiatric treatment follow-up. Service users who have made eight and more visit in a year are regarded as regular attenders. Contrasting results on service user clinic attendance were revealed from the record review and the service user interviews. While a significant proportion of service users

(91%) said they attended the clinic at least once a month, half (51%) of service users were recorded as having made six or less visit in the past year. More than a quarter of service users (27%) needed to be accompanied to attend the clinic. A logistic regression was done to identify factors associated with the attendance of the clinic. Service users who had been ill for more than three years were 2.4 times more likely to be regular clinic attendees than those with a lesser period of illness ($p = .043$). Another predictor of clinic attendance was educational level; service users with a primary school education were 1.4 times more likely to be regular clinic attendees than those with other levels of education ($p = .036$). Access to social welfare services such as a social worker was marginally significant in predicting clinic attendance (odd ratio = 2.3, $p = .055$).

More than three quarters of the caregivers (77%) said the clinic was helpful to the service users, and their perceptions were mainly based on the positive improvement in the service user's health or social functioning. As some caregivers explained, "*The patient has not experienced any attack*", "*Attacks are now less*", "*He is now able to do things for himself, like making his bed*".

In terms of their history regarding the use of other mental health services, three quarters of the service users (75%) said they had a history of admission to hospital for treatment of mental illness. More than half of these users (54%) had had two or more hospital admissions in their lifetime. Less than half of the service users (45%) had had one or more consultations with a social worker or traditional healer.

Social Functioning

Social functioning refers to the everyday skills a person needs to be able to interact with the social environment and to achieve successful community living. The social functioning skills of service users in this study were assessed. The findings highlight that, by and large, service users had the ability to engage in most everyday activities. For example the majority were assessed by caregivers as able to bathe independently (71%), eat without supervision (88%), wash independently (70%), do domestic chores (54%), and use money properly (51%). Very few service users (12%) were judged by caregivers as violent or disruptive and as posing a danger to others when left alone, and only five service users were reported to be violent and disruptive in the community.

Service User Psychosocial Wellbeing and the Experience of Stigma

Caregivers reported 52% of service users to have lasting relationships and 13% of service users to have been lonely or isolated in the month prior to data collection. A sizeable proportion of service users (40%) had difficulty talking to other people about their problems. Reports of loneliness and isolation were clearly more evident from the interviews with service users than caregivers. Most service users wished to have someone with whom to talk. As some users indicated "*I don't have friends here*", "*I get bored because it is only me, my*

father, and my child and I cannot share important things to them". Whilst some service users expressed a wish for more social engagement, they perceived their illness as a barrier to achieving this. "*I would like to go out but I am afraid I will fall*", "*I like to go out but I cannot because of my illness*".

Analysis of the service user's daily schedule reinforced the findings from their interviews as to experience of loneliness and isolation. Eighty-seven daily schedules were completed and analysed. Just over three-quarters of the service users (79%) spent time entirely within the boundaries of their own homes. Only 28% spent any time with other people. To overcome loneliness and isolation, service users wished for a common place where they could meet other people with the same illness and achieve self-improvement. "*I would like people with mental illness to be given a chance to do something to improve their lives and that of their families*". Key informants shared similar views about the need for a central place whereby people with mental illness could engage in various activities such as vegetable gardening, knitting, sports, brick-making, sewing and craft work.

Service users' accounts of community living revealed a considerable experience of stigma and abuse from the family and community, often resulting in feelings of sadness. Common expressions made by the service users included: "*My brother took my money*" "*People say I am stupid and laugh*", "*They throw stones at me when I walk in the streets*", "*I get sad when people discriminate against people with the same illness as I have*". "*I feel sad for people who don't care for people with mental illness*". The key informants also told tales of community stigma and abuse towards persons with mental illness and epilepsy: "*Other community members attack a mentally ill patient with stones and hurt him although they know that he is ill*"; "*Some do gardening in hot sun and don't get paid, the pay is the bottle of beer*".

Evidence of self-stigma was identified in interviews with service users and caregivers. Self-stigma is a situation whereby people with mental illness absorb and assimilate societal conceptions and stereotypes about themselves.¹⁶ The following consequences of self-stigma were identified: reduced self-esteem, diminished self-efficacy, and reluctance to engage in broader social activities.¹⁶ The concept of self-stigma has also been identified among family members of people with chronic mental illness. We asked caregivers to identify talents that service users possessed and to indicate whether these talents could be used to earn a living. For this study, a talent was defined as a skill or an attribute that a person possesses and that he or she could potentially use to earn a living. Most service users in this study could not view themselves in a paid working situation. The illness was seen as a barrier to work, but they did wish for economic independence. "*I can not work because of my illness*". Caregivers reported 36% of service users as having no talent. Thirteen percent (13%) of service users were said to be skilled in handwork including, knitting, sewing and brick-making.

Caregiver and Family Psychosocial Wellbeing

Many (55%) caregivers reported that there was no one to help

Table 4. Caregiver and family psycho-social wellbeing (n=83)

	Yes		No		Could not indicate
	N	(%)	N	(%)	N (%)
Caregiver:					
Does caring for the patient cause you stress?	27	(32)	53	(64)	3 (4)
Does this stress cause problems between you and other family members?	7	(8)	71	(85)	5 (6)
At times does this stress causes you to lose sleep?	18	(22)	59	(71)	5 (6)
Has this stress led to other family members being neglected?	2	(2)	74	(89)	7 (8)
Family:					
Does caring for the patient cause stress in the family?	13	(16)	65	(78)	5 (6)
Does this stress at times cause problems between members of the family?	4	(5)	67	(81)	12 (14)
Does the patient cause other family members to lose sleep?	11	(13)	54	(65)	18 (22)
At times does this stress lead to violence in the family?	7	(8)	62	(75)	14 (17)
Has the stress led to some form of family breakdown?	2	(2)	67	(81)	14 (17)
Have members of the family needed psychological help due to the patient's illness?	1	(1)	69	(83)	13 (16)

them to care for the patient if they needed time away, and a few (11%) said their caring roles stopped them from maintaining close social relationships. Participation in community organisations was high among caregivers; more than two-thirds (67%) said they were churchgoers and 18% were members of women's social groups. About a third of the caregivers (32%) reported stress from their caring roles and nearly a quarter had lost sleep due to the stress. The experience of stress was reported in 16% of the service users' families and in a few families (13%) this stress led to a loss of sleep amongst members (**Table 4**).

Table 5 provides a summary of mental health service needs identified by the study.

Conclusions

The findings of this study indicate little to no understanding or knowledge of the service users' illness on the part of service providers, service users and caregivers. While the review of prescribed drugs, service users and the caregiver interviews showed the presence of mood disorders, service providers were able to identify only two diagnoses among service users, namely schizophrenia and epilepsy. This suggests a low detection of depression at the clinic level. This situation is compounded by a lack of mental health personnel in the Moretele District. Service users and their caregivers display only a general understanding of the illness and often use negative terms to describe the illness. The general lack of knowledge and awareness is not surprising, given the limited knowledge among primary care providers themselves. These limitations pose major obstacles to the empowerment of mental health service users and their ability to participate meaningfully in their care.

Mental health service user households are highly dependent

on social grants for economic survival. There is high rate of unemployment in this group. Only four service users were employed at the time of the study.

An analysis of pathways to care shows that service users by-pass the primary health clinics and a considerable number of them use traditional healers and the local hospital as their first entry points into the mental health system.

The experience of loneliness and isolation is high among mental health clinic users. However, this was more evident from interviews with the service users than from those with the caregivers. It is possible that social integration of service users in this study was hindered by self-stigma. For instance, most service users viewed their illness as a barrier to social interaction or participation.

Although there were some service users who reported experiencing abuse from the community and family members, others were satisfied with community living. Reasons associated with satisfaction with community living included being treated with respect and dignity, being understood, and support from families.

Service users in this study were competent at everyday skills. Most were judged as able to bathe, eat, wash and use public transport independently, do domestic chores, and use money responsibly.

Violence and family disruption caused by the mental illness did not appear to be a significant problem in this study.

Caregivers experienced psychosocial burdens in caring for service users, but this was not very common within the sample. Half did not have someone who could assist them with care of the patient if they needed time away, and one-third experienced stress due to caring for the patient, although disruptions at the level of the household as a whole did not appear to be common. Most of the caregivers were members of social groups.

Table 5. Mental health service needs identified by the study

Category of need	Specific problem
Socio-economic	<ul style="list-style-type: none"> - Unfair distribution of resources within households - Little control over disability grants in some households - Sub-group with no household income or access to welfare benefits
Quality of health care	<ul style="list-style-type: none"> - No differentiation of mental illnesses (all patients are “schizophrenic”) - Low awareness of mood disorders - Poor symptom control (hallucinations, seizures etc.) - Lack of supervision and support of clinics
Coordination and utilisation of health services	<ul style="list-style-type: none"> - Sub-group (1/5th) with frequent hospital admission - Little access to social welfare staff - Loss to follow-up - People attend care on their own (73%) - Need for coordination between clinics, hospitals, traditional healers and welfare personnel (pathways) - Negative attitudes towards traditional healers - Little communication between health care staff and communities
Knowledge and awareness	<ul style="list-style-type: none"> - Lack of knowledge of diagnosis, treatment and side-effects by users and their caregivers - Lack of awareness of rights - Internalised perception of not being normal
Basic social functioning	<ul style="list-style-type: none"> - Sub-group that requires assistance in bathing, feeding and washing - Nearly half are unable to use public transport (limits mobility and attendance at clinic) - Small sub-group at risk to themselves and others
Social networks and community integration	<ul style="list-style-type: none"> - Isolated and little contact with outside world - Considerable inactive and sleeping time - Boredom - Abuse and exploitation by the community, and in some households - Internalised stigma and poor self-worth
Caregiver burden	<ul style="list-style-type: none"> - Experience of stress in a sub-group

Recommendations for Community Mental Health Service

Based on the findings of this study and discussions of the findings dissemination workshop, the following recommendations were made with respect to the community mental health service needs in the Moretele District:

- Improve the quality of mental health services. This could be achieved through training and support for primary health care providers, to allow for the adequate detection of common psychiatric disorders at the primary level and to enable follow-up. Diagnostic, treatment and follow-up guidelines are essential for appropriate care. Psycho-educational programmes are necessary to increase service users and caregivers’ knowledge of the illness, as well as to encourage adequate clinic attendance, and medication compliance.
- Develop social support programmes for service users and caregivers so that users can overcome loneliness

and isolation, and provide care givers with some social relief. Developing peer support groups and community drop-in centres are crucial steps in this direction.

- Establish partnerships between the Moretele District mental health services and some mental health stakeholders in the district, such as traditional healers. This is important for facilitating patient referrals.
- Develop mental health promotion programmes that focus on fostering and protecting the rights of mental health service users in their families and community. Programmes should also seek to improve public understanding of mental illness in an effort to reduce stigma. There is a need to explore various self-advocacy strategies aimed at achieving self-empowerment among service users. These could ultimately allow service users to gain control over their lives, and could incorporate information on what to do and where to go when problems emerge.

Acknowledgements

We are grateful to all service users, their families, community key informants and to all the fieldworkers, who participated in the research.

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