Mental health care in Mamelodi: Disadvantaged geographical positioning in a South African township

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OPSOMMING

Geestesgesondheidsorg in Mamelodi: Benadeelde Geografiese Posisionering in 'n Suid-Afrikaanse Township

Hierdie artikel fokus op die huidige geestelike gesondheidsorglandskap in Suid-Afrika binne die konteks van die Suid-Afrikaanse Grondwet, sowel as die Wet op Geestesgesondheidsorg en die Millennium Ontwikkelingsdoelwitte vir Afrika. Teen hierdie agtergrond bespreek dit die werk wat gedoen word by die Itsoseng Gemeenskapskliniek in Mamelodi, 'n sielkunde dienspunt. Alternatiewe benaderings tot werk gedoen met kwesbare kinders word in die besonder aangebied en oor gereflekteer in terme van om moontlikhede uit te wys om die tekort aan hulpbronne aan te spreek vir voldoende en effektiewe geestesgesondheidsorg in die huidige Suid-Afrikaanse gesondheidsorg konteks. Die kliniek neem 'n sistemiese benadering tot dienslewering aan wat dikwels versorgers sowel as kinders in behandelingsplanne insluit. Met verloop van tyd het die kliniekpersoneel bevind dat verskeie groepwerkmetodes, wat nie-verbale behandelings betrek, effektief is. Die doeltreffendheid van hierdie behandelingsmetodes word tans ondersoek deur 'n deurlopende waglysstudie uit kommer oor die baie kinders wat op die waglys sit vir tot 8 maande.

1 Introduction

This article focuses on the mental health care landscape in South Africa at present within the context of the South African constitution as well as the Mental Health Care Act and the Millennium Development Goals for Africa. Against this backdrop it discusses the work done at the Itsoseng Community Clinic in Mamelodi, a psychology service outlet. In particular alternative approaches to work done with vulnerable children are presented and reflected on in terms of indicating possibilities to address the shortage of resources for adequate and effective mental health care in the current South African health care context. The clinic takes a systemic approach to service delivery often including caretakers as well as children in treatment plans. Over time, the clinic staff has found that various group work modes, involving non-verbal treatments, are effective. The effectiveness of these treatment modes are currently being explored through an ongoing wait-list study out of concern for the many children sitting on the waiting list for up to eight months.

2 Contextualising the Current Mental Health Landscape in South Africa

With its almost universal neglect globally, mental health care can be regarded as the poor step-sister of general health care, but especially so in Africa[1] where the consequences have a far reaching impact. Yet until recently, it remained a topic seldom debated in public or political fora. Anthea Gordon[2] refers to it as an "… invisible problem in Africa". She discusses several factors challenging progress in mental health care in Africa and these include poverty, a lack of recognition for western treatment concepts engaged in by psychiatrists and clinical psychologists, and the overshadowing by what misguidedly appear to be independently more pressing health care issues such as HIV/AIDS and infant mortality.[3]

Arguments have been presented that mental health care has a significant impact on both the prevalence of HIV/AIDS and infant mortality. Miriam Davis explains the interrelationship between HIV/AIDS and mental illness as a reciprocal and complex interaction involving factors such as persons with untreated mental illness are more likely to engage in risky sexual behaviour and also to adhere poorly to anti-retroviral treatment.[4] She states that some 50% of persons with HIV/AIDS also carry a mental illness diagnosis. This has grave implications for the contracting and transmission of HIV as well as significance for the effective treatment of mental illness.[5]

The link between maternal mental health and infant health is well documented,[6] leaving infants who are born to mothers with mental health issues, at risk in terms of adequate care and optimal development.

In their review of mental health services in South Africa in 2012, Lund, Petersen, Kleintjes, and Bhana state that "mental disorders rank third in their contribution to the burden of disease in this country, and approximately 1 in 6 South Africans are likely to experience a common mental disorder (depression, anxiety or substance use disorder) during

1 Olatawura *Mental healthcare for children: The needs of African countries World Psychiatry* (2005) 159.

2 Gordon "Mental health remains an invisible problem in Africa" (2011) available at http://thinkafricapress.com/health/mental-health-remains-invisible-problem-africa (accessed on 2014-05-06).

3 *Idem*; Lund *et al* "Mental health services in South Africa: Taking stock" (2012) African Journal of Psychiatry 402; Miranda & Patel "Achieving the Millennium, Development Goals: Does mental health play a role?" (2005) available at http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0020291 (accessed on 2014-05-06).

4 Davis National Research Council. *Public Financing and Delivery of HIV/AIDS Care: Securing the Legacy of Ryan White* (2005) 250-256.

5 *Ibid*.

6 Field *et al* "Maternal mental health care: refining the components in a South African setting". In *Essentials of global mental health*, 173-186. Cambridge University Press.

the current year [2012]".[7] This review was a response to a paper presented at the first National Mental Health Summit convened by the Department of Health, Republic of South Africa from 12-13 April 2012. Other authors[8] confirm the high statistics of mental health cases in Africa generally, in a context lacking resources for treatment of such numbers of individuals needing treatment.

While globally the recognition of interrelationships between mental and physical health exists, efforts at addressing mental health issues forge ahead, albeit not with great strides. Lund *et al*[9] refer to a 2008 study conducted by Williams *et al*[10] in which it is estimated that up to 75% of people who live with mental disorders in South Africa do not receive adequate health care. Patel, a psychiatrist active in global mental health issues and based in New Delhi, suggests that in developing countries 90% of persons with mental illness do not receive the care they need.[11] There may be multiple reasons for this gap in this aspect of general health care and no doubt the stigma associated with mental health[12] continues to contribute to the cyclical effect of untreated mental health issues in communities with few resources of any kind. Working and writing in South Africa, Lund *et al* call for the "… development of evidence-based and culturally appropriate mental health services that can feasibly be delivered within available resource constraints …".[13] Miranda and Patel suggest that local communities may indeed have such resources necessary to treat mental health.[14] This call is certainly not new and for decades psychology professionals have been questioning the appropriateness of mental health models developed in the socio-economic environment of the middle class west and frequently transported undiluted to the developing world and other non-western or socio-economically disadvantaged contexts.[15]

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7 Lund *et al* 402.

8 Gordon available at http://thinkafricapress.com/health/mental-health-remains-invisible-problem-africa (accessed on 2014-05-06).

9 Lund *et al* 402.

10 William *et al Prevalence, Service Use and Demographic Correlates of 12-Month Psychiatric Disorders in South Africa: The South African Stress and Health Study. Psychological Medicine* (2008) 211-220.

11 Patel "Mental health for all by involving all" (2012) available at http://www.ted.com/talks/vikram_patel_mental_health_for_all_by_involving_all (accessed on 2014-05-06).

12 Miranda & Patel (2005). "Achieving the Millennium, Development Goals: Does mental health play a role?" available at http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0020291 (accessed 2014-06-07).

13 Lund *et al* 402.

14 Miranda & Patel (2005). "Achieving the Millennium, Development Goals: Does mental health play a role?" available at http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0020291 (accessed 2014-06-07).

15 Eskell-Blokland *Voice to the silent: An ecology of local knowledge in psychology* (doctoral thesis 2005 UP); Ruane "Obstacles to the Utilisation of Psychological Resources in a South African Township Community" (2010) *South African Journal of Psychology* 214-225.

3 Challenges in the Socio-historic Context of South Africa

The Western Cape Minister of Health, Theuns Botha, has referred to what he calls "the vicious cycle between poverty and mental ill health" in South Africa. He was speaking at the Mental Health Summit at Lentegeur Hospital in the Western Cape in 2012. This article will view a single site of mental health services in a South African township in Gauteng Province, Mamelodi, a marginalised section of the Tshwane greater metropolitan area.

Marginalisation of township life continues even after twenty years of democratic government. In Mamelodi, one of the largest townships in South Africa, few resources for mental health care are available. The population of Tshwane[16] stands at approximately 2,921,488, with about 25% under the age of fourteen. This figure includes the population of Mamelodi which is estimated at close to one million. Mamelodi is one of five major townships surrounding or within Pretoria and lying within the City of Tshwane boundaries. In townships access to health services in general is poor. For twenty years the Itsoseng Community Clinic has provided and continues to provide the only comprehensive psychology based mental health care service in Mamelodi. Sporadic psychiatric services can be located at one or two municipal sites in Mamelodi but there are almost no other psychological services and certainly no other psychological assessment centres in the township.

In line with section 27 of the Constitution of South Africa whereby every citizen is acknowledged the right to health care, the Mental Health Care Act was enacted in 2002 and promulgated in December 2004. The World Health Organisation – Assessment Instrument for Mental Health Systems (WHO-AIMS) report of 2007, reminds us that the Mental Health Care Act makes provision for:

> "(1) access to mental health care including access to the least restrictive care;
> (2) rights of mental health service consumers, family members, and other care givers;
> (3) competency, capacity, and guardianship issues for people with mental illness;
> (4) voluntary and involuntary treatment;
> (5) accreditation of professionals and facilities;
> (6) law enforcement and other judicial system issues for people with mental illness;
> (7) mechanisms to oversee involuntary admission and treatment practices; and
> (8) mechanisms to implement the provisions of mental health legislation".

16 Statistics South Africa available at http://beta2.statssa.gov.za/?page_id = 1021&id = city-of-tshwane-municipality (accessed on 2014-05-06).

However, in 2014 there remains no national mental health plan, and only Kwa-Zulu Natal has a separate mental health plan at provincial level. This makes it impossible to estimate expenditure on mental health care as national and provincial budgets are integrated into general health care. What is likely is that a minor fraction of general health care budgets goes into mental health care in all provinces. This seems to be typical of the picture seen in developing countries where it is stated that less than 2 % of national budgets are allocated to mental health care.[17]

Yet we should bear in mind that health care features significantly in the Millennium Development Goals (MDG)[18] which is described in the 2013 report as the "… most successful global anti-poverty push in history". However, although health sits squarely in the centre of the MDGs, no separate mention of mental health is made. Miranda and Patel (2005)[19] remind us that even, or especially, in Africa and other developing countries, mental health is closely associated with social determinants such as poverty and gender. Despite this mental health continues to be overlooked in policies and budgets and the result is as Vikram Patel states:

> "[I]n developing countries mental disorders are amongst the most important causes of sickness, disability, and, in certain age groups, premature mortality … Mental health–related conditions … contribute to a significant proportion of disability-adjusted life years (DALYs) and years lived with disability (YLDs) … [and are] closely associated with social determinants, notably poverty and gender disadvantage, and with poor physical health, including having HIV/AIDS and poor maternal and child health".[20]

4 The Township Socio-economic Context

Township culture typically blends traditional indigenous customs and rituals with modern western urban ways. Township areas were established in the latter half of the1940s to house the black population. Many of the original residents were relocated from traditional areas of living to provide workers to service the then white city. Inevitably there resulted a measure of disconnectedness from traditional ways of life. Nevertheless, over the 50 years since this process was initiated, a rich, distinctive township culture has emerged. The main language spoken in the Tshwane municipality is Sotho; local languages also spoken are Pedi, Afrikaans, Tswana, Tsonga, Zulu and English. Paradoxically, as suggested above, the majority of city populations live in these contexts: many

17 Gordon available at http://thinkafricapress.com/health/mental-health-remains-invisible-problem-africa (accessed on 2014-05-06).
18 The Millennium Goals Report (2013) available at http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013-english.pdf
19 Miranda & Patel (2005) available at http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0020291 (accessed 2014-06-07).
20 Patel available at http://www.ted.com/talks/vikram_patel_mental_health-for_all_by_involving_all (accessed on 2014-05-06).

people living in the city centres by day and returning to townships on the outskirts by night.

Further movement of people have swelled the population of Mamelodi as they relocate to seek work and opportunity from rural areas and from across SA borders using the major roads from Botswana, Zimbabwe and Mozambique leading directly to Pretoria. Many of these immigrants remain "illegal citizens" and thus live under the radar of public health care services. The resulting picture is one of complex and diverse social networks.

However, few resources exist even today in the townships, with major resources being set in and around the inner city of Pretoria, requiring Mamelodi residents to travel long and costly distances to access them. Satellite branches of these resources offering supportive services are sometimes set in the township itself, frequently sporadically. For example, the Mamelodi Day Hospital provides services for routine procedures in short stays but any treatment requiring specialist services will have to be conducted in the major provincial hospitals in the city centre of Pretoria, or elsewhere, accompanied by a formal referral. Such services referred to include neurological, occupational therapy, speech and audiology, remedial educational, assessments and treatments, as well as clinical psychological and psychiatric care beyond the filling of repeat prescriptions. Few clinical psychological services are available in any public general hospital in South Africa and they are limited in public psychiatric hospitals.

In this context of inadequate resources, residents have formed their own ways of handling problems including health care problems and especially mental health care, relying much on indigenous traditional and church based helping methods.[21] A challenge that various clinical and other psychologists have acknowledged as a result of their work in South Africa in typical township contexts, is for the practitioner to integrate different perspectives into a useful framework.

The criticism of the form, role and relevance of modern mainstream clinical and other psychology in non-western countries has been a long on-going dialogue among such psychologists worldwide.[22] However, academic, clinical, and other therapeutic psychologies remain rigid to the underpinning principles of their roots and thus, Eurocentric.

21 *Ibid*; Eskell-Blokland 108.

22 Eskell-Blokland 27; Gordon available at http://thinkafricapress.com/health/mental-health-remains-invisible-problem-africa (accessed on 2014-05-06); Lund *et al* 402; Ruane 214-225.

5 Challenges Faced Delivering a Psychological Service in the Context

Some initiatives in the Itsoseng Clinic have been embarked on in attempts to meet the clientele appropriately and relevantly.[23]

5.1 Disease in the Clinic

Presenting problems seen in the Itsoseng Community Clinic frequently differ from those found in more western acculturated societies. In the township there is little awareness of what therapeutic psychology is, and certainly life challenges are seldom thought of in psychological terms by the local population. Presenting problems are more likely to take the form of psychosomatic symptoms; proclaimed spirit afflictions; or vague feelings of dis-ease, with many of these symptoms being accompanied by stigma.[24] Social problems of such magnitude often accompany psychological problems that the situation often appears to the practitioner as hopeless, and can ultimately overwhelm the practitioner. Within this relatively psychologically unsophisticated population, children are often referred for psychological services by the school. The school is one of the few formal systems where behavioural problems can be picked up. Teachers who refer these children tend to see failure to learn, change in school performance, and/or conduct challenges as "learning problems" and refer children in large numbers with this label. It takes experienced and alert practitioners to probe beyond the label. Children in any society do not typically express problems in any way other than through school performance signs.[25] Despite the fact that children in South Africa are rendered more vulnerable to mental illness by their exposure to a variety of factors such as HIV infection, substance use, and increased violence, there exist few mental health services for African children in Africa.[26] Prof Melvyn Freeman, the 2013 recipient of the Rhodes University Department of Psychology's social change award, spoke on mental health services in South Africa mentioning that there are "virtually no services for children".[27]

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23 Blokland "Marching to the Beat of a different drum: Ethical issues in intercultural professional practice." Unpublished paper presented at International Congress of Psychology, Cape Town, South Africa, June 23-27, 2012; Ruane 214-225; Visser "Expressive arts interventions in a socio-economically challenged environment in South Africa". Unpublished paper presented at University of Haifa, Arch of Arts in Health conference, Haifa, Israel, 17-19 March, 2013.

24 Lund *et al* 402.

25 Pastor *et al* Identifying emotional and behavioral problems in children aged 4–17 Years: United States, 2001–2007 (2012) *National Health Statistics Reports*.

26 Flisher *et al* "Child and adolescent mental health in South Africa" (2012) *Journal of Child and Adolescent Mental Health* 149-161.

27 Freeman "Mental Health in South Africa–A Luta continua" available http://www.ru.ac.za/psychology/speechespresentations/name,83630,en.html (accessed 2014-04-04).

At the Itsoseng Community Clinic in Mamelodi, some 400 plus sessions are held each month with the greatest category of clients being children as can be seen in tables 1 and 2 below, referred to as *school referrals*. Children are also present in several of the other categories of the table.

Table 1: Typical presenting problems in any one month (2012)

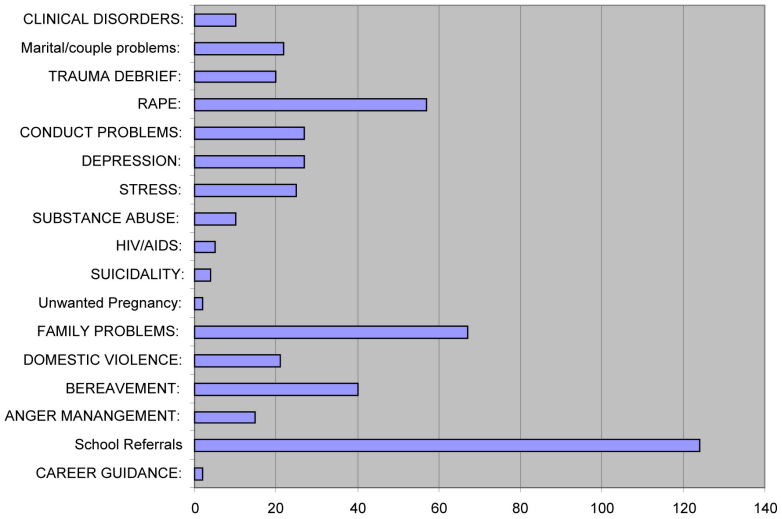

Table 2: Top four presenting problems (2013)

TOP PRESENTING PROBLEMS - 2013:				
	SCHOOL REFERRALS	FAMILY PROBLEMS	SEXUAL ASSAULT	CONDUCT PROBLEMS
JAN	17	7	1	2
FEB	71	30	25	18
MRCH	80	50	39	18
APRIL	124	67	57	27
MAY	115	64	50	25
JUNE	111	90	39	29
JULY	113	51	45	24
AUG	99	39	32	25
SEPT	61	26	43	10
OCT	78	39	39	18
NOV	104	30	25	13
TOTALS:	973	493	395	209

Table 2 above shows how pervasively children are affected by social problems and problems presenting at the clinic for mental health care. The categories "school referrals" and "conduct problems" refer specifically to children. However, children are also invariably affected by "family problems" and in the "sexual assault" category some of the victims seen at the clinic are as young as six months old, many are children, young boys, and pre-adolescent girls.

5.2 Practical Daily Challenges for Mental Health Care Service Providers

The challenges facing mental health care service providers in community settings threaten to interfere with effective treatment[28] unless these are integrated meaningfully into therapeutic programmes. A common response from service providers is to retreat to the comfort of in- patient treatment at psychiatric hospitals, leaving poorly resourced communities with little hope of services in their places of residence. The challenges can include any or many, if not all, of the following discussed.

Language barriers can present challenges to even local African language speakers as clients may originate from anywhere in South Africa or even from neighbouring countries as refugees. This then can also present cultural barriers in addition to those already being experienced.[29] Students who provide the services are often not familiar with the cultural ways confronting these barriers and can feel blocked from engaging with the clients especially as their training has most likely been largely western focussed and seldom addressing cultural issues in any depth.[30]

Stories of poverty and social disadvantage can distract service providers from thinking psychologically as a desire to rescue kicks in and clouds therapeutic judgement.[31] Because Itsoseng Community Clinic is the only comprehensive clinical psychology service point in this large geographical and heavily populated area, demand for services exceeds supply. The service providers in the clinic consist of masters students in professional training programmes in clinical and counselling psychology working under supervision, intern registered counsellors, psycho metrists, and volunteers having varying skills and experience. Clinical students deal with the clinical disorders and more serious pathologies while the counselling students handle the problems falling into the categories of adjustment disorders, career counselling and they also run self-help and preventative groups.

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28 Lund *et al* 404.

29 Geffen (2013) *The discursive practices of clinical psychologists in private practice in the Cape Metropole* Unpublished masters dissertation, UCT 3-6.

30 Ruane (2010) "Obstacles to the utilisation of psychological resources in a South African township community" *South African Journal of Psychology* 214-225.

31 Eskell-Blokland 78-79.

Waiting lists lengthen to months while crises often present in the interim, needing to be dealt with urgently, further interrupting and delaying services to those on the waiting list. Many of the children can sit on waiting lists for up to 8 months. The clinical diagnoses can vary greatly and among the more common diagnoses made we find trauma; depression, autism spectrum disorders, conduct disorder, neurological problems, developmental lags, substance abuse, and grief. Many present as co-morbidities.

In an attempt to ease the waiting, the clinic was able to draw on the skills of the team of dedicated and enthusiastic volunteers to develop non-therapeutic group activities to which children were invited to attend weekly. Some children manage to get to the clinic to engage in these activities which vary from year to year but generally include some form of expressive art such as music, art, dance, drama, and sport.

The groups have been led by a skilled or trained volunteer who was assisted by a second volunteer-in-training. Group leaders may or may not be students at different levels of training, or they may be community members interested in the clinic activities. The groups started out being open with fairly large numbers of children – up to 20 in each. Through a process of experimentation, observation, and reflection, the group size was whittled down to about 12 maximum and children were selected and invited to attend more structured closed programmes lasting 8 weeks each.

In the groups, instances of remarkable changes were being observed. In a specific instance a child coming from extreme circumstances of neglect and abuse, who had not spoken for years, started communicating spontaneously. Cases of encopresis and enuresis ceased without further intervention. Caretakers would accompany the children and report stories of changed behaviours. This was occurring through no specific therapeutic intervention as the groups were designed to be fun, creative, and containing, but not specifically therapeutic. Qualified therapists waited in the wings for referrals from the groups or to discuss concerns the volunteers might have with particular individual children.

6 Exploring Creative Arts Therapies

This process sparked an interest in exploring expressive arts therapies as a viable mode for treating not only the children, but sometimes also the adults in the clinic. The exploration resulted in two of the staff members registering for a master programme at Haifa University in Israel in expressive arts therapy. There is no such training programme in South Africa at present although a registration category does exist with the Health Professions Council of South Africa, interestingly enough falling under the category of *Occupational Therapy, Medical Orthotics/Prosthetics and Arts Therapy*. The two staff members have now returned to South Africa and have continued to make useful contributions to the treatment

models used in the clinic especially with children. Among the several beneficial factors to using this type of treatment mode is that it offers an alternative to the labour intensive and often slow pace of one-on-one therapies when appropriate. The use of expressive arts therapies through group modes has enabled the clinic staff to reach more children and adults in a shorter space of time and also to address issues of language and culture. The exact mechanisms of healing and effective treatment may be more challenging to identify as is the case in all psychotherapies, it being a largely intangible and invisible process. However, studies in terms of evidence based practice (EBP) have begun in this area both in the Itsoseng Clinic and elsewhere where art therapies are used. The ability to identify EBP outcomes, with EBP origins standing in medicine,[32] is in itself challenging for psychotherapy models but research has been reported as different models find different and appropriate ways to provide evidence of efficacy from within their differing paradigms.[33]

6.1 A Creative Arts Approach to Treatment with Children

There have been advances in the acceptance of art therapies as viable modalities of therapeutic treatments and a corresponding body of literature supports theoretical conceptions of the dynamics of the therapeutic effects. Research into the theoretical conceptualisation of art therapy benefits, as well as professional issues surrounding these practices, in therapeutic psychology and psychiatric practice have been more widely reported on in recent studies.[34]

The use of expressive art therapies have been suggested to be particularly useful in cross cultural settings of practice where practitioners typically face numerous challenges in their effective client engagement. Besides the advantage in possible group treatment modes, art therapies may become effective through the use of and reference to culturally appropriate symbols and mythologies.[35] Success through these processes has been reported on when working across cultures, and with

32 Lilienfeld (2014) "Evidence-based practice: The misunderstandings continue" available http://www.psychologytoday.com/blog/the-skeptical-psychologist/201401/evidence-based-practice-the-misunderstandings-continue (accessed 2014-04-04).

33 David & Montgomery (2011) "The scientific status of psychotherapies: A new evaluative framework for evidence-based psychosocial interventions" *Clinical Psychology: Science and Practice* 89-99.

34 Camic (2008) "Playing in the mud: health psychology, the arts and creative approaches to health care" *J Health Psychol* 287–298; Chapman, Morabito, Ladakakos, Schreier & Knudson (2001) "The effectiveness of art therapy interventions in reducing post traumatic stress disorder (PTSD) symptoms in pediatric trauma patients" *Art Therapy* 100-104; McNiff & Barlow (2009) "Cross-Cultural Psychotherapy and Art" *Art Therapy,* 100-106; National Coalition of Creative Arts Therapies Associations http://www.nccata.org/#!research/cihc.

35 McNiff & Barlow (2009) "Cross-Cultural Psychotherapy and Art" *Art Therapy* 100-106.

various age groups and disorders.[36] Indications of how art therapy brings about efficacy in treatment are beginning to emerge in recent studies.[37] Both randomised control trials as well as single-case studies are yielding results that can contribute to evidence-based models of art therapy.[38] Some studies have focussed specifically on the effectiveness of art therapies with children.[39]

Despite the evidence for the effectiveness of psychotherapy with children, the reality is that individual therapy services are not readily available for many socio-economically disadvantaged children who need help.[40]

Research at the Itsoseng Community Clinic is in the process of studying whether putting these children in experiential activities can provide therapeutic benefits or whether it is just a "fill-in the gap" for delayed therapy. There is also a need for more research into experiential activities to determine what these can offer to complement child psychotherapy for children who have to be on the waiting list until formal therapy interventions can be provided. Finally, to our knowledge, relatively few empirically designed studies with control samples have been conducted on university-run clinics with a primary focus on children's mental health in South Africa.

36 Camic (2008) "Playing in the mud: health psychology, the arts and creative approaches to health care" J Health *Psychol* 287–298; Chapman, Morabito, Ladakakos, Schreier & Knudson (2001) "The effectiveness of art therapy interventions in reducing post traumatic stress disorder (PTSD) symptoms in pediatric trauma patients" *Art Therapy* 100-104.

37 Gilroy (2006) "Art therapy, research and evidence-based practice" London:Sage 120-150; Slayton *et al* (2010) "Outcome studies on the efficacy of art therapy" *Journal of the American Art Therapy Association* 108-11.

38 Stuckey & Nobel (2010) "The connection between art, healing and public health: A review of current literature" *American Journal of Public Health* 254-263.

39 Lassetter (2006) "The effectiveness of complementary therapies on the pain experience of hospitalized children" *J Holist Nurs* 196–207; Moss (2009) *Art Therapy for Young Children: A Review of the Research and Literature* ERIC Document Reproduction Service No. ED367437.

40 Cartwright-Hatton, McNicol & Doubleday (2006) "Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children" *Clinical Psychology Review* 817-833; Lucock *et al* (2008) "Controlled clinical trial of a self-help for anxiety intervention for patients waiting for psychological therapy" *Behavioural and Cognitive Psychotherapy* 36, 541–551; Silverman *et al* (2008) "Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events" *J Clin Child Adolesc Psychol* 156-83; Weersing *et al* (2006) "Effectiveness of cognitive-behavioral therapy for adolescent depression: A benchmark investigation" *Behavioral Therapies* 36-48; Weisz & Kazdin (eds) (2010) *Evidence-Based Psychotherapies for Children and Adolescents* 204-206.

7 Extending Health Care Accessibility

Margaret Chan, Director-General of the World Health Organization, refers to alternative methods in health care practice in order to extend health care to greater numbers of people, many of whom would not normally have access to formal treatments. She mentions "task shifting" as a possible effective method of achieving this in specific circumstances, and several researchers in this field, such as Vikram Patel, have explored such ideas in their work in under resourced contexts and also in the mental health arena.[41] "Task-shifting" is defined as a strategy in resource-poor areas to maximise health care benefits for patients whereby community or lay health workers under professional supervision provide "front-line" care.[42] In the preface to the WHO document outlining global recommendations and outlines (2008), Chan suggests that "[t]he task shifting approach represents a return to the core principles of health services that are accessible, equitable and of good quality. These recommendations and guidelines on task shifting provide a framework that is informed by all we now know about the ways in which access to health services can be extended to all people in a way that is effective and sustainable."

With the debates around new proposed National Health Insurance process in South Africa (NHI), the government places a heavy emphasis on primary health care in order to underpin this process. Van Zyl[43] reports on the inception of NHI as fundamentally a financial arrangement, and quotes Professor Morgan Chetty, chairman of the Independent Physicians' Association Foundation of South Africa and the KwaZulu-Natal Managed Care Coalition Limited referring to the success of primary healthcare management as the "fulcrum" of health care delivery under the NHI involving public-private partnerships.

The exploration of alternative approaches to mental health care at Itsoseng Clinic makes use of *gogos* (grannies) and retired teachers. Unemployed youth wanting to make a difference and pick up some skills in the process, students frustrated by the inability to further their studies, students looking for experience, and family members of patients and clients, can contribute in varying ways to providing services complementing the professional activities of the clinic. Such volunteers are trained in different skills such as translation, administrative work, informal group facilitation, front desk assistance to new and revisiting clients.

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41 Miranda & Patel (2012) available at http://www.ted.com/talks/vikram_patel_mental_health_for_all_by_involving_all (access on 2014-05-06); see also Miranda & Patel available at http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.0020291.

42 Buttorff *et al* (2012) "Economic evaluation of a task-shifting intervention for common mental disorders in India" 813-818.

43 Van Zyl (2013) "NHI: The nuts 'n bolts" *The Bulletin HPCSA* 9-13 available at http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/publications/bulletin/2013/bulletin_magazine_2013.pdf.

Of particular interest at this point in time is the focus on service to children. Many of the children come from situations of poverty such that appointments are often not kept if the bus fare is not available. Some children walk several kilometres to visit the clinic to meet with their therapist or group. Stories of hunger preventing children from completing assessments have led to some therapists bringing sandwiches for children to eat prior to testing. An important objective of the waiting list study mentioned above, is to gather empirical data that can inform the development and delivery of effective mental health services for children in a university-run clinic. Preliminary considerations of some factors which influence the benefit of engaging children in expressive art therapies include:[44]

- Universal language of art in myths and symbols;
- Non-verbal expression;
- Catharsis in expression;
- Immediate impact;
- Element of fun, creativity in a non-threatening activity;
- Clients return for follow up;
- Can be done in groups;
- Draws from clients' cultural perspective.

8 Conclusion

The findings from the study could have implications for enhancing the clinic's programmes in formulating policies and developing new levels of service. The use of expressive arts especially with children, can move towards a task shifting process whereby clients and patients are able to access service alternatives to one-on-one expensive and time consuming processes in a geographic location where such services are not readily available or accessible.

The profession of psychology can be challenged to shift its framework from a one-on-one individual activity developed in a western last millennium period, to something more appropriate for the tremendous need in contexts such as the South African one. The psychology developed for an elitist population may still have notions and theories of some relevance but the practice may be very different. The courage to develop a practice for mental health care for our local populations may provide a shift toward a solution for the ever swelling tide of general health problems. In responding to local needs and in becoming more sensitive to socio-cultural issues, psychological practices, both therapeutically and diagnostically may provide a meaningful change to local communities while contributing to general health care.

44 Visser "Expressive arts interventions in a socio-economically challenged environment in South Africa". Unpublished paper presented at University of Haifa, Arch of Arts in Health conference, Haifa, Israel, 17-19 March, 2013.