Psychiatric Treatment at a forensic psychiatric hospital in South Africa: An ethnographic inquiry

by

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Submitted in fulfilment of the requirements for the degree of

Master of Social Science (Anthropology)

in the

Department of Anthropology, Archaeology and Development Studies
Faculty of Humanities
University of Pretoria

June 2023

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Declaration

I, Indira Pillay, hereby declare that the work in this dissertation titled "Psychiatric Treatment at a forensic psychiatric hospital in South Africa: An ethnographic inquiry" has not been submitted to any other University.

I also declare that the contents of this dissertation is original work completed by me for the purpose of a Master of Social Science Degree specialising in Anthropology.

Name	**Date**
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Acknowledgements

To complete this dissertation, there were many individuals who provided a great deal of advice and support. Firstly, I'd like to say a huge thank you to my supervisor, Dr Jimmy Pieterse. Without your support, constructive criticism, and encouragement, I would not have survived this process!

To the staff and my colleagues at the University of Pretoria's Department of Anthropology and Archaeology, thank you for welcoming me into the department, as well as your wise words and support throughout this degree. It will always be greatly appreciated. I am grateful for the new friends I made along the way.

To my parents, thank you for standing by me, pushing me to focus and encouraging me, especially when I was unsure of myself. You dealt with the late nights, early mornings and endless tea breaks amongst your busy schedule. To my brother, Sacha, thank you for all your encouragement and support. To Jithen, thank you for the continued support, especially when I was so uncertain of my progress and having faith in me when I struggled to have faith in myself. I love you!

Thanks also to Anne Kramers-Olen, who provided support at various points in this research.

To my participants, thank you for all the hours you have sacrificed speaking to me over video chat. Without our conversations this dissertation would not have been possible. Your knowledge and wisdom in the field of mental health care and your willingness to be honest and open about your feelings about mental health care in the forensic mental health facility is highly valued.

Abstract

The tragic deaths that resulted from the closure of the Life Esidimeni mental health facility in Gauteng, South Africa, questioned many facets of mental health care, patients' rights, and the agents of power in health care. It also revealed a division between government officials, high level decision-makers, and hospitals responsible for day-to-day care. This caused me to question how mental health care facilities function in South Africa, the power dynamics within and over these institutions, the extent to which patient support networks are recognised, clinicians' interactions with those patient support networks and within multidisciplinary teams, human rights issues, and the adequacy of funding of mental health care. I also became interested in how mental health care facilities coped with and adapted to COVID-19. With these questions in mind, I focused my research on a forensic psychiatric hospital in KwaZulu-Natal, South Africa, with clinicians in the multidisciplinary team as my participants. I set out to conduct the research using traditional ethnographic fieldwork methods, which characterises anthropological research. However, due to the restrictions imposed by the COVID-19 pandemic I modified my approach, because I would not be allowed entry into the hospital due to the lockdown. I, therefore, employed a virtual ethnography approach, conducting interviews using digital videoconferencing platforms, and developed a loose set of questions to guide my interviews. The broad themes that emerged threw light on the multidisciplinary team functioning, the agents of power within State mental healthcare and within the hospital, human rights issues affecting mental health care, funding concerns in mental health care, and the hospital's adaptation to the COVID-19 pandemic. Several sub-themes emerged within these thematic areas. Among the broad areas of concern were patients' rights to discharge and freedom, patients' right to participate in the country's elections, and problems related to the funding of mental health care in South Africa. From the perspective of critical medical anthropology, it seems evident that political and economic forces negatively influence patient care, and that change is needed. However, it also seems evident that clinicians coped well with the COVID-19 pandemic, despite financial and structural constraints.

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Chapter 1 – Introduction

1.1 Mental Healthcare in South Africa

The dawn of South African democracy in 1994 brought with it hopes for a brighter future; better living conditions; equality; opportunity; and improved access to health care, education, employment and municipal services. Of course, the country also faced enormous underlying challenges, not clearly visible amidst the great optimism. This included providing health services, including mental health care, to all who needed it. In the last two decades, however, attempts to destigmatize mental health care and provide adequate, sufficient and responsible treatment facilities across South Africa came under increasing focus from many mental health groups and professional associations including the South African Depression and Anxiety Group (SADAG), the Psychological Society of South Africa (PsySSA) and the South African Society of Psychiatrists (SASOP), among others (Matsea, 2017).

Almost 28 years after the fall of the apartheid regime, there is still great concern about our mental health services and access to care. In 2013, almost 75% of South Africans who had a mental disorder did not receive treatment, and only 15% of South Africans could afford private health care, which means that 85% of the population was dependent on government health services (Davids, 2013). The latter statistic may account for why such a high proportion of citizens needing mental health care are not receiving it. Government's inability or refusal to actively consider the needs and care of people with mental health problems must be considered within the realm of structural violence: the withholding of a service or the provision of an inferior service that results in individuals and communities not meeting their basic needs (Galtung 1969) and/or that creates and perpetuates health inequalities through political, social and economic processes that manifest in social exclusion, among other effects (The Center of Health Equity Research Chicago 2020). According to Farmer et al. (2004), structural violence is a term used to describe social activities and arrangements that may endanger individuals from a population. It also describes how the differences within society impact individuals' health and wellbeing as well as become a part of the "individual experience". In early October 2015, the closure of the Life Esidimeni mental health facility was initiated. As with many other government facilities, funding issues appeared to be a significant matter and this appears to have motivated the decision to close the facility and transfer patients to other places, with discharges taking place early in 2016. Mental healthcare practitioners and organisations across the country were outraged and many went to the lengths of warning the Department of Health about the serious fallout this decision would cause, with some organisations challenging the decision in court (Section 27, 2017). Organisations of mental health care practitioners and service groups such as the SADAG, SASOP, PsySSA and civil society had voiced their concerns to the Gauteng Department of Health, warning of the inherent dangers for patient care that their money saving attempts could have. These warnings were not heeded and the deinstitutionalisation plan went ahead.

From the Life Esidimeni facility, long term chronic mentally ill patients, needing ongoing treatment and care were moved to many nongovernmental organizations (NGOs), the majority of which were later found to have been appointed to accept the patients without the required inspections or regulatory processes carried out (Makgoba, 2017). Many of the NGO’s were not licensed or equipped to provide basic care for mentally ill patients. The Health Ombudsperson noted numerous irregularities in the way the plan to close the facility and transfer patients was executed, including concerns that some saw the process as a business opportunity (Makgoba, 2017). The net effect was that the lives of over 140 people with mental illness were lost. The injustice to this vulnerable group is symbolic of how mentally ill people are currently viewed/treated.

Gostin (2008) argued that, despite the various United Nations’ principles and declarations that are supposedly binding all of the country signatories, the protection of people with mental illnesses is shameful, with many affected individuals living in inhuman conditions, and under-resourced facilities, where it seems the mentally ill are conveniently pushed to the edges of society. He noted that “Despite countless promises for a better life by national commissions, governments and the international community, there has evolved a vicious cycle of neglect, abandonment, indignity, cruel and inhuman treatment, and punishment of persons with mental illness” (Gostin, 2008, p. 907). This strikes a chord with what happened in South Africa, and also reminiscent of the period that Michel Foucault wrote about, where societies enforced the removal of the “mad” from society for reasons of not fitting in with the social construction of mainstream society (Foucault, 2001). In South Africa, during the mid-1800s, individuals considered “mad” were moved to Robben Island, which at that point was created as a space to house individuals who did not conform to society.

The practice of marginalising of people with mental illness is, of course, a global phenomenon. In South Africa it began with the very colonisation of the country, and can be traced as far back as the mid-1600s, when Dutch settlers landed in the Cape of Good Hope. According to Gillis (2012), housing for those who were mentally ill and described as behaviourally disturbed, was located in a primitive building neighbouring the initial Jan van Riebeeck fort. Not long after those beginnings, several other 'housing' facilities were erected to keep mentally ill persons away from mainstream society. Minde (1974) describes, in graphic detail, some of the horrendous living facilities on Robben Island, which was used as a 'lunatic asylum' for the first time in 1846, and later as a prison. It is interesting to note that prior to it being used as a lunatic asylum it was used as a leper colony - a similar state of affairs where those who do not conform to society were pushed to the outskirts of society (Deacon, 1996). This physical separation of mentally ill people from the rest of society by the sea reflects a most drastic set of measures instituted to ensure that they do not mix with the rest of society, who are deemed "normal".

1.2 Selecting a field site

During the initial shutdown of the Life Esidimeni mental health facility, I came to wonder whether the situation was simply poorly handled by the Gauteng Department of Health or if it reflected a national way of thinking about mental health services, and especially patients in chronic mental health care (i.e. patients suffering mental illness for several years)? However, I soon learned of another mental health disaster, this time in my own province. The media was abuzz with news of patients not receiving food, and living in incredibly inhumane conditions at the Durban and Coastal Mental Health's Sherwood residential facility (Broughton, 2021). Corruption, poor management and related irregular activities were again, like in the Life Esidimeni tragedy, listed as reasons for the ill-treatment meted out to people with mental health problems.

I subsequently decided that an ethnography of a specific psychiatric facility could constitute a productive way of studying issues related to patient care. The primary aim of my investigation was to study how health professionals at this psychiatric hospital interact with patients, families, friends and other caregivers, how interactions are shaped by power relations, and how they influence admissions, care, treatment outcomes and coping during COVID-19. The idea was to provide a base for understanding the state of mental health care within this forensic psychiatric facility and to also understand how the situation may relate to the kinds of disastrous events like the Life Esidimeni Tragedy, and other instances of poorly managed mental health care.

There are a few standalone mental health facilities[1,2] in the KwaZulu-Natal province as well as general hospitals that provide mental health services as well. The facility I chose as my study site is a specialist forensic psychiatric hospital that deals with court ordered and criminally-related admission of people with mental illness or suspected mental illness. According to Leighton and Dogra (2009), there is not an agreed consensus of the definition of mental illness, however, the World Health Organisation (WHO) defines mental illness/mental disorder as "clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour" (World Health Organisation, 2022). These disturbances are associated with impairment in day-to-day functioning as well as distress. Although the medical definition is considered hegemonic/authoritative, there exist other, competing, definitions. This forensic psychiatric hospital also treats other patients without a forensic (i.e. criminal) history, but who have long-term, chronic mental illness. These are explained in more detail in section 1.6. below: *Types of patients at the forensic psychiatric hospital*.

A study of the forensic psychiatric hospital seemed potentially most productive, since it cares for both forensic mental health patients as well as patients under civil commitment in terms of the Mental Health Care Act of 2002 (Republic of South Africa, 2005), whereas the other mental health facilities deal only with the latter type of patient. I felt that this study site and interviews with its clinicians would, therefore, offer a much richer and diverse perspective on mental health care. For issues of confidentiality, and instruction from the study site, the hospital's name will not be disclosed in the study.

1.3 Historicising the hospital

Situated in the capital city of the KwaZulu-Natal province in South Africa, the forensic psychiatric hospital that I chose for this investigation, like so many others in South Africa and around the world, is situated on the outskirts of the city. The KwaZulu-Natal province is the country's second most populous province, with 11.5 million people, almost one-fifth of the country's population (Statistics South Africa, 2022). Formerly a military garrison in Pietermaritzburg, erected by the British in 1927, the facility was turned into the Colony of Natal's second mental health facility, nearly 40 years after the construction of the Natal Government Asylum and 60 years after the Colony of Natal passed legislation that allowed for

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[1] A great deal of information in this section was provided by Professor Anthony Pillay who is one of the longest serving clinicians at this hospital (from 1981 to date) and in South African mental health care, and is well qualified to provide historical data.
[2] Permission was granted by Professor Anthony Pillay, with respect to using his name in this research

the detention of individuals who were thought to be ‘mad’ (Parle, 2007). It is situated on a small hill, overlooking the Msunduzi River, where the world-famous Duzi Canoe Marathon begins. Not all the hospital buildings were constructed at the same time. As a result, varying architectural styles and features are evident. The initial structure of the hospital was built as a fort by the British in 1843 (KwaZulu-Natal Department of Health, 2014). It was used as a military base from 1843 to 1914 and subsequently adapted and used as a secure ward, fenced all around. During the first World War, the original structure and land were used as internment camps for German prisoners from around Africa (Dominy & Reusch, 1993). The fort was later handed over to the government to use as a mental health care facility, approximately 50 years after the initial structure was constructed. In 1928 the facility was used to house its first mentally ill patients (KwaZulu-Natal Department of Health, 2014). Just prior to South Africa’s democracy and before the racial integration of facilities, it was used for patients of colour, while white patients were housed in the city’s other mental health facility.

It is also important to understand the hospital’s involvement in South Africa’s apartheid history. Given the psychological stresses involved in the freedom struggle, it is not surprising to note that activists often became overwhelmed by the brute force and torture inflicted by the security police, with some ending up in psychiatric hospitals. Of course, many such cases are undocumented, in accordance with apartheid security force secret methods of operation. An example of the apartheid government’s security police use of a psychiatric hospital to detain anti-apartheid activists, was given by ANC stalwart and former democratic South Africa cabinet minister Ronnie Kasrils in his book *The Unlikely Secret Agent*. The book is an excellent read, in which he vividly described how, in the early 1960’s, his girlfriend Eleanor Griggs was arrested by the security police in their attempt to track him down on suspicion of sabotage and political activities (Kasrils, 2010). Following her arrest and interrogation in Durban, Eleanor Griggs convinced the police that she had a mental health problem and, with the aid of a sympathetic psychiatrist, a decision was made to transfer her to a secure ward at the forensic psychiatric hospital in Pietermaritzburg, which was used for White patients at the time. She subsequently managed to escape from the hospital with the aid of a sympathetic nurse and an academic from the nearby university, who arranged a car to pick her up a short walk from the hospital gate, after she walked out one afternoon pretending to be a staff member at the end of the day’s shift.

In this way the psychiatric hospital was used by the apartheid government, in a similar way as it was in countries such as the former Soviet Union to repress political activism, but much of that has been clandestine and is still covered in secrecy.

From the early twentieth century, the Natal Government Asylum and the forensic psychiatric hospital were run as racially segregated institutions. Patients were segregated into White, African, Indian and Coloured groups. The latter two were mostly grouped together, being of smaller numbers. From about 1980, when some new purpose-built facilities were constructed at what was the Natal Government Asylum, all white patients were moved to that hospital. All patients of colour were housed at what is now the forensic psychiatric hospital, which was quite dilapidated, although patients of African descent were kept in a separate section at the extreme rear of the property. Consistent with apartheid policy, the facilities and conditions for Black African patients were even more appalling than those for Indian and Coloured patients who were in wards closer to the hospital's main entrance (Professor Pillay, personal communication).

Aspects of segregation began to break down towards the last years of apartheid. In the hospitals, patients were no longer racially separated within living and social spaces. However, these changes were slow, and there was some reluctance from various quarters. According to Kohn et al. (2004), for several years after the fall of apartheid, racial inequality continued in the the field of mental health care.

1.4 The lay of the land

Around the dawn of democracy, buildings began to be adapted from their purpose-built fort requirements to facilities more usable for healthcare. Given the long history of inadequate facilities, there was a need for more appropriate buildings to be erected to house a large number of patients. The last set of construction to extend and renovate the hospital was done from about 1989, when an administration building, a forensic mental health observation complex, a pharmacy, and a child and adolescent facility with an office complex for clinicians, were constructed. Today, as this forensic psychiatric hospital stands, it is authorized to house 450 patients. Unfortunately, due to some of the older buildings being in disrepair, condemned or declared historical monuments, the hospital can currently accommodate 370 patients (KwaZulu-Natal Department of Health, 2014). The grounds of this facility are massive, extending over several acres of treed, parklike surroundings. At the present time, the grounds are not ideally maintained, and as a result has lost some of the natural charm of what could be a more beautiful, relaxing environment, conducive to rehabilitation.

Currently, this forensic hospital has an administration building, an office complex with a conference room and training facilities, a pharmacy, and an inpatient unit located about 150 metres from the hospital entrance, where there is also a bustling car wash project run by higher functioning patients and managed by the occupational therapy department. Further up the hill, along the property's main road (which is very long), one passes a disused bowling green and derelict tennis court. Thereafter, as the road curves leftwards, the imposing old water tower comes into view on the left, and remnants of strategically placed canons lie nearby. Further along are the rest of the inpatient units and wards that house the patients.

Still further into the vast landscape is the disused recreation hall across the road from a large institutional laundry. In line with the opulence of the time, and especially the needs of the prevailing agents of power, namely the powerful, privileged class at the fort, the facility also boasted a large Officers' Mess. This was where the military officers enjoyed their meals, and held their social and recreational activities. The building is a wood and iron structure, with interior wood panelling that even in its state of disrepair reveals its high level, period features, hinting at how beautiful it probably looked in its heyday.

A few hundred metres further and the very long main road culminates in another ward as well as other disused buildings (previously used as ward) and, on the right, a newer section built around 1990 known as the forensic mental observation unit, which is the highest security structure in the hospital. Ironically the rear boundary of this unit shares a common fence with what is known as the Pietermaritzburg "New" Prison. The hospital's environment also contains a swimming pool that is now unused, partly because of it not being properly maintained but also due to concerns about the safety of patients.

Apart from the buildings used as wards for patients, other recreation facilities are also found within the vast grounds. It is also important to remember that many of the original buildings were changed and adapted over time to suit the needs of the hospital as times changed. They were modified for use as secure wards for patients with severe mental illness or those considered dangerous or likely to abscond. Other buildings were converted for use as open wards for patients who are higher functioning and are allowed to walk around freely within the hospital and are not considered a danger to themselves or others, Special wards are allocated for women patients, of whom there are very few, to ensure their safety. There are consulting rooms for the multidisciplinary team members, workshops for repairs and maintenance of the hospital, storerooms, a kitchen to prepare meals for patients and a pharmacy. A few buildings were also turned into staff accommodation and there was also a library to house books needed by the multidisciplinary team members.

1.5 Clinicians staffing the forensic psychiatric hospital

In a specialized facility such as this forensic mental health facility, there are several different disciplines making up the mental health profession that is ultimately responsible for the diagnosis and treatment of patients. The hospital employs psychiatric nurses, psychiatrists, medical doctors, clinical psychologists, occupational therapists, social workers, and pharmacists. These mental health professions, when working together in managing patients, constitute a group called the Multidisciplinary team (MDT). The MDT is a well-known concept in mental health care around the world, given the move away from custodial care and towards holistic or biopsychosocial care (Engel, 1977). The MDT works together, bringing different areas of knowledge and expertise, with different inputs and sources of data gathered from the patient’s history, current presentation and collateral information obtained from interviews with family members and significant others. This method allows for a more holistic treatment plan and is in line with modern approaches in mental health care. According to Nic a Bháird et al. (2016), MDT meetings usually take place on a weekly basis, where each patient’s case would be presented and a discussion would be carried out on their progress and planned treatment, as well as the next steps in charting the patient’s path to recovery. It is important note that issues tackled during MDT meetings do not revolve solely around patient care and treatment, although that is the primary purpose. Other areas of discussion include finding more effective and efficient ways to work as a team, to ultimately improve patient care.

Of course, it would be a mistake to believe that patient care and treatment is reliant solely on the clinicians and their MDT. There is a host of support staff who enable the hospital system to function, and for the wheels to turn as they should. This includes administrative, finance, human resource, supply chain, building maintenance, laundry, catering, and ground staff.

The hospital is also a teaching site linked to provincial universities and medical school academic structures, and has an extensive history of teaching and training for the national context. In fact, very large numbers of clinical psychologists, psychiatrists, and other mental health professionals working in the United Kingdom, Australia, New Zealand and elsewhere were trained at this hospital. A research study examining the ‘brain drain’ from South Africa found that almost one-quarter of the intern clinical psychologists trained at this hospital over the two decades until the year 2000 left South Africa to practice their profession abroad (Pillay & Kramers, 2003). Until the early 1990's, there was a nursing college located on the property, which trained nurses in psychiatry, following their general nurse training. During the apartheid period, there were two nursing colleges on the property, one for white students and the other for nurses of colour.

The hospital is, therefore, always a hive of activity, not just with the business of treating patients, but also with students and interns being trained and given lectures in various aspects of mental health care, and especially teaching relevant to the specific discipline. There are at least two lecture rooms/ conference venues that are used for this purpose. The facility is also the site of much mental health research, given the fact that many of the clinicians are also academics jointly employed in university positions as well. A great deal of mental health and specifically forensic mental health research has been published from this institution, including ground-breaking work in children's criminal capacity, rape survivors with intellectual disability, among others, resulting also in collaborations with US and Canadian universities (Kramers-Olen, 2015: Pillay, 2012: Pillay, et al., 2023; Pillay & Willows, 2015).

1.6 Types of patients at the forensic psychiatric hospital

The forensic psychiatric hospital deals with the following three broad categories of in-patients (KwaZulu-Natal Department of Health, 2014). These are:

(i) *Long-term patients with chronic mental illness* who are usually admitted under the Mental Health Care Act of 2002 as involuntary care patients, and they usually do not have a criminal history (Republic of South Africa, 2005). They often do not have family willing to care for them outside of hospital, or families may be unable to care for them due to various reasons, including difficult behaviour on their part. These patients generally have chronic mental illness, meaning that they have more severe forms of illness which have persisted for many years, causing deterioration, and they are usually receiving ongoing treatment. It is important to remember that in some mental disorders, like schizophrenia, for example, psychiatric treatment helps to remove most of the severe symptoms, but residual symptoms may remain over the long term, resulting in patients being less functional than they were before the onset of their illness (American Psychiatric Association, 2022).

(ii) *State Patients* who have been sent to the hospital by the courts on a detention order, following alleged involvement in crimes. The courts have deemed these persons mentally unfit to stand trial and/or not criminally responsible for the alleged offence due to mental illness, but they have not gone through a full, exhaustive trial of all the evidence. In these cases, the court declares such individuals *State Patients*, in accordance with the Criminal Procedure Act of 1977 and the Mental Health Care Act of 2002, and orders their indefinite detention in a specialist forensic mental health facility (Republic of South Africa, 2005; 2008).

(iii) *Persons under forensic mental health observation* are sent to this specialist forensic psychiatric facility, under order from the courts. These individuals are not referred to as ‘patients’ because they are admitted specifically to be observed and not for treatment. They are in the initial stage of their court process and are sent to this specialist facility, under court-ordered evaluation for a period of up to 30 days, so that mental health specialist reports can be provided to the courts to determine if they are mentally fit to stand trial or could be deemed to have had criminal responsibility at the time of the alleged offence.

In addition, the hospital deals with several other categories of forensic ‘outpatients’ that are referred specifically to the clinical psychology department. These include (i) children accused of crimes for whom the law requires a forensic psychological examination, to determine if they can be held criminally responsible and prosecuted (Republic of South Africa, 2020), and (ii) survivors of rape who have mental illness or intellectual disability, and are referred by courts for psychological examinations to determine their competency to testify and their sexual consent capacity (Pillay, 2012). Again, these persons are referred specifically for assessment and reporting to the courts, and not for treatment, so they are, strictly speaking, not ‘patients’.

Apart from the forensic mental health work described above, the hospital’s clinical psychology department has an outpatient department for (non-forensic) children and adolescents with mental health problems needing treatment. Since these other categories of patients constitute outpatients, and make up a relatively smaller percentage of the hospital’s work, they will not be included in the focus of this study. At the time of this study, the hospital had around 350 inpatients, although the actual number varies considering that, at any point in time, there are patients out on leave of absence.

1.7 A Global Pandemic and a national emergency – COVID-19

Early in 2020, COVID-19 disrupted the lives of millions of people globally. A virus that primarily affects the respiratory system of an infected individual, COVID-19 leads to flu-like symptoms, as well as coughing, difficulty breathing, fever, headaches, fatigue, and in severe cases, pneumonia and other serious conditions (World Health Organization, 2022). It may also lead to death. It was for this reason, in consultation with my supervisor, that I opted to conduct this research using a research method that could adapt to the prevailing pandemic challenges. Rather than using a purely traditional ethnographic research method, where an anthropology researcher enters the physical location of their research field, spends a considerable amount of time in the field and then returns to analyse the data and write up the report, I opted to use a virtual approach to ethnography. I have detailed this approach in the Methodology section.

In order to protect the patients, clinicians and myself, I was aware prior to requesting clearance from the hospitals' research ethics committee and the KwaZulu-Natal Department of Health, that it would not be possible to enter the physical space of the hospital during the pandemic. An additional problem, of course, was that in the initial period of this research process, the government had placed the country in a state of strict lockdown, with regulations preventing various non-essential activities. Members of the public who were not considered essential workers were under not allowed to enter public spaces, and were confined to their homes (South African Government, 2020). As a result, the research approach had to be adapted and carefully reconsidered to accommodate the lockdown restrictions, while also trying to be true to a virtual ethnographic approach, which is discussed later. The research process has been tailored as a virtual ethnographic inquiry into psychiatric treatment at a forensic psychiatric facility.

During these unusual times, I saw an opportunity to research the hospital, looking at how mental health care treatment functioned in a previously "normal" state, how clinicians interacted with patients and their family members, to how it had to adjust to the new "normal". Conducting my fieldwork virtually provided the opportunity to protect my participants as well as myself during this pandemic and it provided a safe platform to ensure this research continued, despite not having physical access into the hospital.

1.8. Chapter Outline

In the introduction, I contextualise mental health care in South Africa, and refer to historic works. The psychiatric hospital and the different types of patients have been introduced. I have also contextualised COVID-19 and the impact it has had on the research process. In chapter 2, the literature review, I reviewed relevant literature with the aim of explaining important themes and pieces of literature that the reader should be aware of before delving into the findings presented in this research. In chapter 3, the methodology, I discuss the method used to conduct this research as well as the challenges faced, and how difficulties were navigated.

In the findings chapters, chapter 4 focuses on clinicians' (MDT members') roles within the treatment process, the ways in which clinicians interact with patients and their family members, and the role that power plays in these interactions. Chapter 5 – 'Power dynamics' focuses on the agents of power within mental health care, and the processes from admission to the discharge of patients within this hospital. This chapter looks at the hierarchy system within the hospital as well as the position of patients within the system. This chapter also looks at some of the structural violence issues within this forensic mental health facility and especially the role of the State in the power dynamic. In chapter 6, 'Funding and mental health care', focus is placed on mental health care funding, whether clinicians believe this sector of health care is funded adequately and whether the possible lack of funding may negatively influence patient care. In chapter 7, 'Adapting to the COVID-19 pandemic' we look at the impact COVID-19 had on the treatment process, how the MDT coped, the way it affected family visits, as well as the impact that the cigarette and alcohol ban had within this facility. Chapter 8, the 'Conclusion', summarises the main themes from this research, the contribution this research has made to the anthropological literature as well as the awareness this research can bring to how mental health care facilities in South Africa and around the world might be operating, and some of the challenges and issues that need to be prioritised by the provincial and national Department of Health.

Chapter 2 - Literature Review

2.1 Introduction

This chapter serves to contextualise mental health care and mental illness; the treatment of people with mental illness, especially at psychiatric hospitals globally and in South Africa; as well as the COVID-19 pandemic and the way it has impacted mental health care systems and research. This chapter will contextualise the study and present relevant arguments and critiques in the areas of mental health care and human rights, funding for mental health care, COVID-19 and its impact on mental health care, and power relations that will serve to contextualise important themes that came to the fore during the fieldwork. In order to begin thinking about mental illness and contextualising the study, it is necessary to first look at the history of mental illness and societal responses to affected individuals.

2.2 The historical context of "madness"

Current hegemonic, western understandings of 'madness' (or what we may call scientific/biomedical understandings) have a complex history and, crucially, biomedicine's understanding and dominance/prominence is partly attributable to power and politics. It is also important to remember that the biomedical model is not the only way of making sense of 'madness' and that other explanatory frameworks exist that sometimes work in tandem with biomedical explanations (plural medical frameworks), and sometimes stand in opposition to scientific/biomedical models.

It is important to understand that mental health care as we know it in the 21st century is not at all as it was in the times of early civilisation. This is because society's views and understanding of mental illness were quite different to what it is in the current age of scientific knowledge and health care. In many cultures, mental illness was considered, not in biological terms, but in spiritual or religious terms.

2.2.1 Religion and mental illness

Historically, mental illness was considered the ambit of various sectors of society. Hodgkins (2007) pointed out that "Medicine provides one language for describing and explaining mental disorder, but it does not have the field of madness to itself" (p. 40). This is an important consideration in trying to understand mental illness and the evolution of treatment. Unlike the present time, where advances in mental health research have brought us to the point where neurobiology and neurochemistry are viewed by mental health care professionals as the more significant components in the aetiology of mental disorders (Lebowitz & Ahn, 2014), mental illness was, and to this day may still be, viewed also from the religious perspective. Dating back to the 5th century, and the time of Hippocrates, mental illness was be viewed by many religious communities as an affliction from supernatural causes, evil forces, punishment from God, and even influences of the moon, among other explanations (Hodgkins, 2007).

Ideas around "mental health" or "madness" have developed along different trajectories in different contexts and places., as a result, we have to look at the intersection of religion and healthcare. This is important for many reasons, one of which is the historical relationship between religion and the state. Only with the separation of religion and the state, in the late 18th century in France, at the end of the French revolution, were people free to belong to a faith of their choice. However, how mentally ill people were responded to by the religious sector was very different to how it is now. In other words, mental illness and society's response is integrally linked to civilisation. According to Scull's (2015) view, mental illness was considered a disease of the soul, very much conceptualised in religious terms and supernatural causes, but has evolved substantially and has become a fundamental part of civilisation.

In Europe, specifically during the Renaissance (14th – 16th century), a new understanding of madness emerged that reflected changing attitudes towards the human mind and body. The Renaissance saw the emergence of a new culture of individuality and self-expression, and this was reflected in the ways in which society viewed mental illness. Instead of being seen as a form of demonic possession, madness was now seen as a medical problem that required treatment. According to Espí Forcén and Espí Forcén (2014) in the 13th century AD (Anno Domini) in Europe, mental illness was viewed by people subscribing to the Christian faith, as demonic possession by evil spirits or some form of spiritual or religious affliction that was being meted out to the individual by a higher power. They noted that exorcisms were the common approach to treating affected patients and that historical records from the fifth century BCE (Before Common Era/ Before Christ) pertaining to the Roman's and Ancient Greeks in Europe, showed symptoms of mood, psychotic, neurotic and personality disorders, as well as epilepsy, to be among the conditions that were treated in this way. Today, such symptoms would be understood within a research-based diagnostic systems nomenclature such as the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2022), leading to treatment on biomedical approaches rather than folklore, mythical ideology and cosmology. Historical records show from 2000 BCE, several radical and even unscientific treatments, many of which were promoted and prescribed by the medical experts of that time, used to treat people with mental illness, including teaching moral values, in the belief that mental illness was a morality issue. In addition, lobotomies (surgically disrupting brain circuits), bloodletting, trephination (boring holes into the skull), exorcism, insulin coma therapy (deliberately lowering blood sugar levels), isolation from society, and fever therapy (inducing fever to cure certain illnesses, including mental illness) for which Austrian psychiatrist Julius Wagner-Jauregg received the Nobel Prize for Medicine in 1927, gained prominence (Vann, 2014).

In the 18th century, psychiatrist, Philippe Pinel argued that people with mental illness were not inherently dangerous, but rather in need of compassionate care and treatment. He established humane treatment practices and is credited with changing the way society viewed people with mental illness (Weiner, 1992). Jean Marc Gaspard Itard, a physician, on the other hand, developed new techniques for educating and rehabilitating people with mental illness. His work with the "wild child" Victor is well known in the history of education, and his approach to individualized instruction has had a lasting influence on special education (Itard, 1962).

With the advent of the Enlightenment, new theories about the causes and nature of mental illness emerged. One influential approach was the "moral treatment" approach, which held that people with mental illness were not inherently different from other people but had suffered from negative life experiences that had led to their mental illness. This approach emphasized compassionate care and treatment as well as individualized therapy.

At the same time, the Romantic Movement stressed the importance of emotional expression and individualism, and this was reflected in the treatment of mental illness. In the treatment of mental illness, new forms of therapy such as art therapy, music therapy, and poetry therapy emerged.

These ideas about mental illness were exported to other places, but the degree to which they were adopted varied. In the United States, for example, mental illness was initially viewed as a social problem and was dealt with by incarcerating people with mental illness in prisons and asylums (Kleinman, 2009; 2012). Similarly, much of Europe saw approaches to dealing with the mentally ill that included isolation, punishment and a range of methods that were devoid of scientific or human rights foundations (Farreras, 2023). However, the moral treatment approach was eventually adopted, and asylums were designed to offer a more humane and compassionate care for those with mental illness. In other places, such as Russia and China, Western theories of mental illness were less readily accepted. In Russia, for example, the Soviet leaders rejected psychiatry as a bourgeois science, and people with mental illness were dealt with using harsh methods such as incarceration and forced labour. It has been shown that mental health care in Russia had a dramatic history and went through much transition (Krasnov & Gurovich, 2012). In China, traditional beliefs about the nature and causes of mental illness continued to shape mental health policy, and Western models of care were viewed with suspicion, and even today some level of stigma still exists (Yin, 2020). However, in some places, Western approaches to mental illness were adopted with great success. In Japan, for example, Western theories of mental illness were quickly adopted, and new forms of care and treatment emerged. Today, Japan has one of the most advanced mental health care systems in the world, and the country is known for its innovative approaches to treating mental illness (Setoya, 2012).

All of these approaches to the treatment of mental illness, borne out of religion, mythology, and concerns with morality, revealed a common thread of powerlessness that characterised the individual on the receiving end of the treatments. The mentally ill person was viewed by others, including health practitioners, as having no say in treatment decisions and being at their mercy. Those wielding the power had the complete authority to do whatever they deemed fit to change the behaviour and mental status of the patient (Foucault, 1998; 1976).

2.2.2 History of “Madness” and mental health care in South Africa

If we consider the situation in South Africa, the ways of dealing with “madness”, as Foucault describes it, came with the invasion of the country by European settlers. They brought with them their ideas and customs about how people with mental illness should be managed. It was during this period, that the Dutch East India Company made its first attempt to deal with “madness” in South Africa, among their own settlers and members of their army (Gillis, 2012). These were essentially modelled on methods employed in Europe.

It is important to recognize that the early mental health care systems in South Africa were intertwined with the country’s colonial and apartheid past (Sukeri, et al., 2014). While it stands to reason that there would have been attempts to deal with mental health problems during pre-colonial times, there are no accessible records in this respect. During the mid- 1600s, a temporary structure was constructed near the first fort erected by the initial settlers in the Cape, to house those who were deemed “behaviourally disturbed” (Gillis, 2012). This structure was used until the late 1600s when, due to increasing numbers, the facility could not accommodate all of the individuals deemed to be mentally disturbed. It is also important to note that this structure was designed to prevent these “disturbed” individuals from leaving. In other words, the approach to treating mental illness was confinement, which meant holding patients in these facilities almost always against their will. This was the beginnings, in South Africa, of what Foucault (2001), Scull (2015), and others, described in their critiques of the traditional, custodial approaches to mental health care. Of course, confinement as an intervention strategy in mental health care continues in many parts of the world in the present day. However, Kleinman (2012) noted that over the last 50 years, there has been a shift towards a more patient-centred approach to treatment.

Health practitioners have used the knowledge of past atrocities against people who were mentally ill, and their “treatment”, to reflect on the changes that needed to happen. These insights were, of course, supplemented to a substantial degree by the volumes of scientific information and research evidence that have been accumulated, to inform a type of evolution in the way that mental health was being conceptualised.

We are able to see this new way of thinking today. For example, in a panel discussion on South African mental health care at the 2016 Psychological Society of South Africa congress, a significant focus was placed on the decolonizing of the discipline of psychology and its role in mental health care, as well as respecting non-western knowledge systems which may not be biomedical. Panel members noted the extent to which psychology and mental health was rooted in western colonial influences and was being neglectful of the needs of South Africans, by imposing external ideas and ways of practice. In his interview on the ENCA news channel, the then President of the Psychological Society of South Africa, Professor Anthony Pillay, argued that our history has influenced the way mental health care has been practiced, and there was an urgent need for the discipline to adapt to better suit our nation and its multicultural society. He noted that, in the last 20 years, much work done has been done in this direction, but a great deal more is needed (Pillay, 2016). In other words, patients must be given what they need, based on developments and human rights principles, rather than what practitioners think they need, meaning a shift in the agency of power. However, as Foucault (2001) pointed out, change from a past characterised by ignorance and authoritarianism to a future typified by more progressive thinking is not easy.

2.2.3 Power in mental health during early times

To truly understand power within the mental health context, it is useful to examine the definition of power. According to Foucault, power and knowledge are inseparable. Therefore, an interesting place to begin this literature review is by looking at the work of Michel Foucault, given his ideas about power and knowledge, and how these manifest within society. One of the key terms he used in this context was ’biopower’, by which he referred to the power wielded over the bodies of citizens, as a way of control (Foucault, 1998; 1976). He also referred to sovereign power and disciplinary power in his triad of describing power within society. The concept of biopower features strongly in the way people with mental illness were dealt with, controlled and marginalised in society. Foucault was one of the leading philosopher-historians on the topic of “madness” which was the acceptable term during the twentieth century, when he wrote on the topic. Among his very influential works are The *Birth of the Clinic: An Archaeology of Medical Perception* and *Madness and Civilization: A History of Insanity in an Age of Reason.*

In *Madness and Civilization*, Foucault gave us great insight into the history of “*madness*” as it was referred to in Europe from the Middle ages to end of the 18th century. Foucault situates the rise of madness from the end of the Middle Ages (late 15th century), when leprosy was on the decline. This was due to the previous ‘leprosaria’ being used as a space of confinement for the “mad”, along with the poor and sick individuals within society. According to Foucault, “madness” was socially constructed and a product of the knowledge/power amalgam (Foucault, 2001).However, he noted that power comes from everywhere and was not necessarily located in a structure or agency (Foucault, 1998). During that period, madness was not conceptualised as a natural or biological phenomenon, but rather part of a ‘man-made’ idealism that forcibly incarcerated the “mad” because they were considered different, and did not fit into the social structure, as envisaged by those in power. That was the prevailing knowledge, and Foucault (1980; 1998) used the phrase ‘power/knowledge’ to suggest that power is developed through an uncritical acceptance of knowledge. Therefore, according to Foucault (2001), the powerful in society did not want the ‘mad’ to be part of their environment, because they were seen as different, in much the same way as people of colour were excluded from mainstream society in South Africa and elsewhere because they were viewed as different. It is important to note that individuals who were labelled ‘mad’ were confined to the rules and social constructions imposed by the powerful, and they were forcibly removed and separated from the rest of society. Andrew Scull (2015) referred to this as the “The Great Confinement” and, like Foucault (2001), he viewed it as progressing down the path towards inhumane treatment of people with mental illness.

Although Foucault's writings and analyses of mental health care were done much later, his work concerns the people of the 19th century, when madness became viewed as a moral and mental disease (Foucault, 2001). This resulted in the removal of the mentally ill from mainstream society. However, it is important to recognise, in Foucault's (1998) writing, that the power was conceptualised as often anonymous and diffuse, and was effected more as a reign of truth or knowledge. In Foucault's work "Discipline and Punish" he argued that power was wielded through disciplinary methods and institutions in society, such as schools, prisons, the military, etc. Of course, the psychiatric hospital has been a perfect example of such an institution of discipline and control. This is where confinement as a treatment plan for mental illness came into being. This meant that individuals whose thinking was disturbed or were labelled as "mad", were removed from society and placed into asylums, usually on the outskirts of the city or further away. It is in this context that we must understand the tendency, even in later years, after "The Great Confinement", to construct mental health facilities in distant locations, far removed from general society.

In his much later exploration of mental health care, Goffman (1961) noted that patients were kept in isolated facilities or asylums, as they were called, as if they were prisoners and separated from society, with hardly any contact with the world outside. The restrictions on the freedom of patients, that Goffman (1961) describes, is consistent with Foucault's earlier analysis of the way power and control were used to subjugate people with mental illness. Even though the control measures were implemented by the authorities of the day, they were cast as being based on the prevailing knowledge, rather than on the will of agents or structures wielding power, in line with Foucault's idea of the power being anonymous. In a similar way, the Algerian psychiatrist, Frantz Fanon viewed the institutionalised approach to mental health care as a control mechanism and a way of wielding disciplinary power in order to regulate people (Fanon, 1963).

2.2.3.1 Power and mental health care since the 20th century

Considering the way in which people with mental illness were stigmatised and isolated from society, we can understand Kleinman's (2009) concern about the extent to which the formal mental health systems have (i) made mentally ill people reluctant to enter hospitals for institutional care (ii) caused affected individuals to move away from society, and usually in a downward socioeconomic direction, often towards homelessness. This became known as the Drift Hypothesis in mental illness, especially with respect to the illness of schizophrenia

(Lapouse, et al., 1956). According to Kleinman (2009), of the very large number of homeless people in the United States, between one-third and half of them suffer from a mental illness.

Even though psychiatric facilities were usually constructed and funded by the state and some improvement in terms of human rights had occurred in the late 20th century, the influential and powerful voices, like those in government, continued to infiltrate government planning, location of facilities, and the laws governing mental health care, like the earlier legislation in South Africa. McCrea (2010) noted that South Africa's outdated Mental Health Act of 1973 was not based on individual rights, but on patient control and treatment, with the legislation effectively produced as a panic response to the assassination of apartheid architect and Prime Minister Hendrik Verwoerd. Loughran (2016) noted how the apartheid government went to great lengths to make the assassination of Verwoerd appear as the behaviour of a deranged individual, even though Dimitri Tsafendas made it clear in his statement to the police that he stabbed Verwoerd because of his disgust at the leader's racist policies. Through this malicious social construction, the government of the day was at pains to show that a sane person would not be against Verwoerd or his apartheid policies, and that such opposition could only be borne out of mental illness. In other words, the authorities constructed mental illness in a manner that would support their political ideology. In a more recent publication, Dousemetzis (2018) noted that Tsafendas had even confessed to Greek Orthodox priests that his action in killing Verwoerd was politically motivated (Dousemetzis, 2018). Despite this, Tsafendas spent the rest of his life (about 33 years) in prison and then in a psychiatric hospital, where he died. This is an example of how mental illness has been used by those in power to achieve their own ends. In this regard, the Algerian psychiatrist Frantz Fanon (1963) pointed out that 'madness' is one of the ways in which individuals can lose their freedom (Robcis, 2021), and this was certainly the case for Tsafendas on whom 'madness' was conveniently thrust for political aims.

Shifting our focus to another one of the colonies, we can see Biehl's (2013) account of the marginalisation and social exclusion at the Vita facility in Brazil, where he found that people with mental illness were not given the help they needed, and were left to die. He noted an even broader context to the power base in mental health care. Biehl (2013) found that the network of patients' families, government and structural inequality contributing to the problem. He pointed out that the network that played into his participants' social exclusion from society and ultimate demise included family, friends, and the government, and he highlighted the lack of appropriate care for those who required mental health treatment. He expressed concern about the insufficient constructive involvement by families in the care of mentally ill members, referring to the ways in which psychiatric diagnoses were used for the ‘disposal’ of family members considered ‘unsound’ or unproductive (Biehl, 2004). He went on to note that the approach to health care became mechanical, lacking the empathy and level of social interaction that is needed in health care, with financial issues and politics playing a significant part in determining the approach to treating people with mental illness (Biehl, 2013). In analysing the situation in Brazil, Biehl (2013) argued that the decentralising of state funding affected mental health care and led to an increase in the use of pharmaceutical treatments. Moreover, he noted that these politically driven shifts impacted people with mental illness. Consistent with Biehl’s commentary on the role of pharmaceutics in the management of people with mental illness, Scull (2015) notes that that the antidepressant and antipsychotic drugs are the most profitable on earth. Again, we see that the power is widespread and diffuse, rather than located in a single agent.

Arthur Kleinman, understood to be one of the founders of medical anthropology, argues that although the State is viewed as the main power over the citizenry, there will come a time when our ideology of the State will diminish. We will begin to see States across the world unable to protect, care and provide essential and basic services, including people with mental illness who are among the most vulnerable population (Kleinman, 2012). For us living in South Africa, and more so those who have seen the transition to democracy, with all of the promises for a better life, Kleinman’s words start to ring true. Considering the improvements in living conditions and basic services that the country’s majority had hoped for, there is much disappointment, anger and even violent protests (Khambule, et al., 2022). Kleinman points out that historical forces such as colonialism, conflict and prejudice (like apartheid in South Africa), played a significant role in how patients with mental illness were identified and treated (Kleinman, 2012).

2.2.4 The clinical gaze

In the *Birth of the Clinic*, Foucault (1973) looked closely at the public health care systems in the 20th century, the experiences of patients and the language within the clinic. A recurring theme, the “clinical gaze” is described, reflecting how doctors have come to view a patient, almost as if a human body is just an object to be prodded and checked for faults, and then using their power to observe and categorize patients in a way that reflects their own biases and societal norms. According to Foucault, the clinical gaze reflects the unequal power relationship between the doctor and the patient. Doctors have the power to label and diagnose patients based on their perceived mental and physical attributes, and it is this power dynamic that shapes the way in which medical knowledge is produced and utilized. Misselbrook (2013) described this phenomenon as

> "…how doctors modify the patient's story, fitting it into a biomedical paradigm, filtering out non-biomedical material. A 'gaze' is an act of selecting what we consider to be the relevant elements of the total data stream available to our senses. Doctors tend to select out the biomedical bits of the patients' problems and ignore the rest because it suits us best that way (p. 312).

This view, reflects the attitude of paternalism, which is the actions of those in positions of power that limits individual's or a group's autonomy, and is intended to be self-serving, by simplifying the patient's diagnosis and portraying it purely in a purely biomedical perspective. This perspective is applied to neatly fit the patient into a specific diagnostic criterion based on the biomedical model. According to Murjic et al. (2015), paternalism has been a hallmark of medical care, based on the idea that the doctor knows best and makes decisions that they consider to be in the patient's best interest, even when the patient is able to make decisions. Arthur Kleinman, the renowned psychiatrist and medical anthropologist, is one of those who believed that not enough credence is given to what patients have to say. He argued that eliciting patients' understanding and explanations of their ill health, can empower the doctor with knowledge about what patients feel, what the illness means personally and socially, as well as patients' expectations of care and treatment (Kleinman, 1980).

The 'clinical gaze' runs contrary to Kleinman's recommendation. There appears to be little to no empathy or kindness towards the patient because the gaze is focused on the disease, or the diseased organ, rather than the person. This gaze, to an extent, dehumanizes the patient (Foucault, 1973). A Foucauldian investigation of the clinician's "gaze" would ultimately ask the question as to whether mental health, as a healing discipline, has moved beyond viewing a patient as merely an illness. Considering Foucault's early criticism of the type of care that was meted out to patients and the way he saw health care systems functioning, it is important at this time in history, for us to look carefully at this question.

As I mentioned earlier, the "clinical gaze" plays an important role in the way illness and disease are constructed socially and historically, and the individuals holding power, according to Foucault (1973), were the State, doctors and, to some extent, families of patients. These ideas of Foucault have been effectively incorporated into modern day research and thinking about mental health care. In her research in Papua New Guinea, Alice Street (2014), noted the excessively complicated issues and challenges of biomedicine within a public hospital that she studied. Street (2014) speaks directly to Foucault's' work on the "clinical gaze". She described in detail the way patients yearned to be seen as human beings. They wished to be seen as more than just their illness and disease and, above all, they wanted to be treated in a more empathic manner. During the country's colonial period (from the late 18th century), mental illness was viewed as a form of divine punishment or demonic possession, and treatment often involved exorcisms and other religious practices. With social and political changes later in the 19th century, approaches to mental healthcare began to change, reflecting new understandings of mental illness and the role of medicine in society.

The South American nation of Brazil is another country that deserves attention in terms of its mental health care history, especially considering its similarities with South Africa, namely, the history of colonisation, the imposition of European ideas of mental illness on local populations, and parallels in the various developmental and economic indices. In the early 20th century, Brazil underwent a period of rapid industrialization, urbanization, and modernization, which led to significant changes in the provision of mental health care. The Brazilian government established a national system of mental healthcare, which included the construction of new psychiatric hospitals and the training of mental health professionals. However, this period also saw the rise of eugenic ideologies, which held that people with mental illness and other disabilities were biologically inferior and needed to be controlled or eliminated through sterilization, institutionalization, or other forms of intervention. These ideas had a significant impact on mental healthcare policy in Brazil, leading to the construction of large psychiatric hospitals and the use of harsh and often inhumane treatments. In the 1960s, a movement for mental healthcare reform emerged in Brazil, emphasizing the need for community-based care and the deinstitutionalization of mental health patients. This movement, known as the "anti-asylum" movement, was inspired by similar movements in Europe and the United States and aimed to shift the focus of mental healthcare from institutional care to community-based care.

Today, mental healthcare in Brazil is provided through a network of public and private services, including community mental health centres, psychiatric hospitals, and private clinics. However, access to mental healthcare remains a significant challenge, particularly for marginalized communities such as Indigenous populations and low-income communities (Street, 2014). When we, as social scientists, think about this type of request from patients, we have to ask "Is that too much to ask?" Clearly, it is not – but the medical model has continued this practice, with only a few exceptions, and exceptional practitioners who view their role in a more progressive way.

The concept of the 'clinical gaze' can be critiqued in terms of its usefulness in understanding the dynamics of power within the South African health care system. Looking at the above examples, it is evident that the way in which health care professionals conduct their work and relate to their patients influences the power relationship in a significant way. As Murjic et al. (2015) noted, the idea that the doctor knows best dominates the relationship, affording minimal patient input. With South Africa's history of power imbalances, the spill-over into health care is inevitable, and the extent to which patients can be equal partners with their providers is limited.

2.3 Social Issues in Africa

2.3.1 Mental health care in Africa

Western biomedical care was spread throughout the colonised world by erecting hospitals and clinics, especially in poorer communities for colonisers to protect their slave labour force (van der Geest & Finkler, 2004). However, Feierman and Janzen (1992) pointed out that oftentimes biomedicine was imposed violently in Africa in which the colonial government intended to replace local healing practices. In a form of structural violence, colonial psychiatry used the racist laws of the time and gave "scientific justifications for diagnosis that treated white and black patients as biologically different groups" (Sukeri, et al., 2014). Similarly, Livingston (2007) discussed the issues that arose in Tanzania when biomedicine was imposed. There was no identifiable relationship between indigenous Tswana healing and biomedicine, but as translation began, doctors began to identify TB as the local sickness and began to use the local name. However, even more disturbing reports have been provided by Lowes and Montero (2021), in their analysis of colonial medicine in Central Africa. They noted that local villagers were at times forcibly physically examined at gunpoint "and injected with medications with severe, sometimes fatal, side effects" (p. 1284). These authors argued that it is this type of treatment that fuelled the deep-seated distrust of western medicine. However, this type of harshness in the name of health care was also applied to people with mental illness, as the American Psychiatric Association found during their inspection visit to apartheid psychiatric facilities. In commenting on the Smith Mitchell facilities contracted by the apartheid government, they noted that "All patients interviewed in Smith Mitchell facilities were asked if they had been beaten or assaulted by staff or had witnessed assaults on other patients by staff. A majority of black patients responded in the affirmative." (American Psychiatric Association, 1979, p. 1503).

The system of apartheid in South Africa, on the other hand, was geared towards separate residential areas, schooling, health care facilities, and basically separate living in as many areas as the government could practically organise, as a way of ensuring that white and black communities do not mix while entrenching the idea of white dominance. Therefore, mental health facilities were also separate, and those reserved for black patients were in poor condition and usually in a dilapidated state that was not fit for human habitation (Pillay & Kramers-Olen, 2014). During apartheid, mental health care facilities were infamous for reports and concerns about the inferior treatment, human rights abuses, discrimination, and considerably higher than expected death rates among black patients (American Psychiatric Association, 1979; Dommisse, 1985). An investigation revealed that "Most of the black facilities are converted mine compounds, previously used as dormitories for black workers" (American Psychiatric Association, 1977, p. 1502). The racist policies of apartheid were evident in mental health care very early in the country's history, and was noted at the time when Robben Island was used to house people with leprosy and those with mental illness (Sukeri, et al., 2014). Sukeri, et al. (2014) goes on to state that, whether the inmates housed had a mental illness or leprosy, white and black inmates, were separated while being incarcerated.

In some cases, clinicians were believed to be proxies for the apartheid state, using their supposedly healing relationships and its inherent power differences and authority to carry out orders of abuse and racist practice for the state (Jones, 2012). This could be viewed as a natural progression of the way in which doctors work, considering "Foucault's charge that doctors are 'doctor-oriented', not patient-oriented, and thus medicine creates an abusive power structure" (Misselbrook, 2013, p. 312). This is in line with the story recounted by anti-apartheid activist and democratic South Africa's first Minister of Intelligence Services, Ronnie Kasrils' description of his girlfriend's detention at Fort Napier Hospital, orchestrated by the apartheid government and facilitated by clinicians (Kasrils, 2010). During apartheid, the line between mentally ill people being helped and oppressed became quite a blurry one. The political abuse of psychiatry and mental health facilities is a historic problem and has been noted in several countries, including Communist bloc[3] countries when governments felt the need to control citizens through illegal means (van Voren, 2010).

Apartheid policies were harsh on any attempt at developing services, including the health system, that could benefit or improve the lives of oppressed groups. For example, rather than train large numbers of black doctors because of the expense and perceived threat to the white medical fraternity, the apartheid government created a workforce of black health assistants (Noble, 1999). However, the progressive work of husband and wife medical team, Emily and Sidney Kark, challenged the idea of inferior levels of care for rural and black communities. Sidney Kark viewed illness and disease as a product of the geographic and social environments, and believed that a health care team was required to treat the individual by collating various sources of information, including home, family, work, social and geographic factors (Caesar, 2015). The Karks enthusiastically began a project in the Drakensberg region to help poor local people access biomedical health care (Kark & Kark, 1999). However, their innovative, development model for 400 community health centres across the country was shut down by the apartheid government and they were forced to leave the country.

One of the challenges that is still faced today is the issue of language within psychiatric hospitals in South Africa. Towards the end of apartheid, many psychiatric hospitals saw the hospital wards becoming more integrated and black patients were being moved (in some cases) from dilapidated, inadequate care facilities to formerly “white-only” institutions that had better facilities (Swartz, 1996). Although South Africa started to see a change in its psychiatric care facilities, these movements left challenges for clinicians that had still not received attention. Hospitals began to face difficulties of shortages of interpreters since many clinicians did not speak the language of their patients (Swartz, 1996). This led to psychiatric nurses being deployed from their duties to assist in interpreting for clinicians which, of course, is an inappropriate use of a highly skilled professional resource. A further problem is that translation can result in the over-simplification of responses from patients which benefits neither the clinician nor the patient. The translation process has the potential to result in clinicians misunderstanding the patient’s illness concerns and/or the family’s account of the patient’s behaviour and illness manifestation. This also speaks to Kleinman’s Explanatory Model of illness and his concern that often patients’ expressions of how they feel are not fully heard by

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[3] Bloc countries are a group of countries that follow the same political ideas and principles and work together in terms of certain issues. Communist bloc countries included states which, under the cold war era, were under the influence of the Soviet Union, for example; Bulgaria, Poland, Cuba, etc.

the clinician (Kleinman, 1988). Incorrect diagnoses can be one of the serious consequences. This is unfair to patients and raises a serious human rights concern, because in South Africa, every human being should have the right to access services in the language of their choice. In fact, that is recognised in the Constitution of democratic South Africa, which makes it clear that the government must ensure that all 11 languages must receive equal recognition and be regarded with parity (Republic of South Africa, 1996). In this respect, Elkington and Talbot (2016) noted that more than two decades after the collapse of apartheid, the imposition of language and culture remains very evident, as it was previously, with the power dynamic limiting access to certain services and perpetuating disempowerment in black communities.

2.3.2 Funding of mental health care

Among the many issues of concern regarding mental health care is that government funding for service provision has always been rather low, more so for poorer communities (Ahmed & Pillay, 2004). This is a problem all over the world. Mental health care is not given the priority that it deserves, considering the high prevalence of mental ill-health (Dixon, et al., 2006). The situation in South Africa is also dire, and must be attended to urgently, because even with the planned National Health Insurance (NHI) there are still concerns about the extent to which the government will be able to sufficiently care for citizens with mental health problems. In this context, Docrat et al. (2019) have argued that the NHI financial policy and package must be expanded to enable the provision of mental health care at the different service delivery levels. They point out that unless decisive steps are taken, mental health care will likely continue to have a lower priority in South Africa.

The World Health Organisation (2003) has expressed concern over the insufficient spending on mental health care globally, and has made several recommendations, among them the need to tie funding allocation to national policy and planning priorities. It is clear that inadequate planning and policy directives have resulted in serious consequences for people with mental health problems, and also put unnecessary pressure on clinicians, forcing them into ethical dilemmas. According to Rhodes (1991), mental health care workers in Midway City, California, were urged to discharge patients as quickly as possible but still provide adequate treatment in that time. This was due to the decentralization of funds from the psychiatric unit, and resulted in inadequate care. This financial pressure places the clinicians in a difficult position, knowing that patients have to be discharged even though they may not be well enough. It is also unfair to patients who need ongoing treatment, but are not getting it at the level that they require, and the families who the patients are discharged to have the added burden of caring for the individuals who may still be unwell and need more specialised care than they can give in the home environment.

In South Africa, the health financing system has been under significant pressure with poor service delivery and a resultant call for universal health coverage through a national health insurance (Ataguba & McIntyre, 2018). There have been numerous consequences of poor health financing, both in the physical and mental health arenas. The Life Esidimeni tragedy in South Africa reflects one such consequence, and mental health experts constantly warn of the dangers of underfunding services. Events such as the Life Esidimeni tragedy also make patients and families concerned that mental health is not taken as seriously as physical health and diseases.

The overall consequence of underfunding mental health care is that thousands of people who need care do not receive it, which results in their health deteriorating further and placing an even greater cost burden on the state because they will subsequently require more intensive and extended forms of treatment. Dixon et al. (2006) have argued that while social health insurance may offer protection for poor and rural populations, mental health care services that are publicly funded are difficult to access by the poor and rural communities. With South Africa in the midst of planning its NHI programme, we have to be concerned about whether that will solve our mental health service access problems, because the combined public and private mental health service sectors are not meeting current demands and that will be the sum of resources available when the NHI is fully implemented.

South Africans have fought and strived for democracy, however there is still a need for increased mental health funding on a human rights platform. Mahomed (2020) noted that the stark neglect in mental health policy and services is not only unacceptable, but must be viewed with a human rights lens, and that improved funding of mental health services must be aligned with the principles of the United Nations Convention on the Rights of Persons with Disabilities, to which South Africa is a signatory. Of course, the situation of underfunding mental health care is even more troublesome because many people with mental health problems are quite ill and unable to express their dissatisfaction with the inadequate services.

2.3.3 Social support and the ‘therapy managers’

In her discussion of mental health and the evolving systems of care and social support in South Africa, Hayley MacGregor (2018) argued that the value of kinship must be emphasised because it has the ability to positively influence societal responses to mental illness. This goes hand-in-hand with Feierman and Janzen (1992) observations on the importance of "therapy managers" and the role they play in patients' care and recovery, such as choosing health care providers, making critical decisions, and providing meals for patients. Of course, many people, especially mental health professionals, will question the use of the term "therapy managers", considering the likelihood of it being confused with therapy providers, case managers, and similar clinical roles within the multidisciplinary team contexts. Moreover, Feierman and Janzen (1992) used the term to describe non-clinicians who are part of the patient's social network of family and friends who take an interest in providing support and assisting the patient with key decision making that may be needed. Nevertheless, it is fair to say that most clinicians would agree that modern mental health care places greater value on the patient's social network in the individuals' recovery and rehabilitation, than previous systems. Research shows unequivocally that social support correlates positively with improved mental health, meaning that the more patients receive support from their social network and families, the more likely they are to show improved mental health and reduction in symptoms (Harandi, et al., 2017).

However, if we look at historical developments in mental health care, we find quite a different picture. The manner in which people with mental illness were treated in the 19th century, was contrary to the current ideas on the value of social support, and the evidence of its benefit to people with mental illness, especially those who are receiving ongoing treatment in a hospital. According to Julie Parle (2007), Fort Napier Hospital and Town Hill Hospital, in Pietermaritzburg, were both initially built as asylums for mentally ill patients for the Natal province, as it was known then. Considering Durban is the province's largest and most populous city, it is both interesting and critically important to note that those who were regarded as mentally ill were taken to Pietermaritzburg, quite far away from KZN's main city. A mental health specialist who began working at the hospitals in 1981, noted that at the time, and to the current date, only a minority of the hospitals' patients were from the immediate Pietermaritzburg area, with the vast majority from Durban and other places further away (Pillay, personal communication). The 80-kilometre distance represented a great travel challenge in earlier times, and even now for many families who are of lower socioeconomic status. This usually meant that families were not able to visit the sick person, let alone be there on a regular basis as "therapy managers". This, of course, interferes with the treatment of mentally ill people, considering the need for collateral information and familial involvement in patient care, as we now know to be vitally important in holistic mental health care. This is also referred to as the biopsychosocial model, which is globally recognised as a preferred approach in mental health care (Engel, 1977).

The colonial government in South Africa, in the mid to late 1600s, used the same method of "treatment" that Western countries were using, namely isolating patients in a place of confinement far removed from their social network and support (Parle, 2007). However, it may be ironic to call this 'treatment' when there was, in fact, not much treatment given to the mentally ill / "mad". Largely, the 'treatment' involved separating individuals diagnosed with "insanity" from the rest of society. This isolation from family and friends was obviously destructive to the patients' well-being and it can easily be seen that it would do little good to their mental health functioning. After all, humans are social beings and, as such, have an innate need to relate to others, more so those connected to them by family ties or friendship bonds (Petersen, et al., 2019). This would apply even more during a time of illness, when greater support is needed. The practice of deliberately separating the mentally ill person from those networks and dislocating those social bonds adds to the person's psychological disturbances. This type of mental health care is referred to as 'custodial care', and has been effectively discredited as an intervention for mental illness because of its destructive effects on the critical inter-relatedness and support that individuals need from their social networks (Wold Health Organization , 2003). Custodial care is largely a form of detention (like imprisonment) and rooted in the early ideas of punishing people presenting with mental illness because it was believed that they brought this on themselves through their actions. The approach is aimed more at keeping society 'safe' from the mentally ill person, than at improving the individual's mental health and well-being. It works against the supportive role that families can play as "therapy managers", as identified by Feierman and Janzen (1992).

In her work on the psychosocial rehabilitation approaches to patients with chronic mental illness, Kramers-Olen (2014) repeatedly noted the role of families and other significant individuals in the patient's social circle, in facilitating their recovery. She pointed to the evidence on enhanced recovery, symptom reduction, shorter hospitalisation, reduced relapse rates, and improved compliance with treatment, when families are jointly involved in the patient's treatment. However, there are situations, especially in poorer communities, where it is difficult to engage families into the therapeutic process. This could be for practical reasons of socioeconomics or reluctance related to the historical distrust that communities have developed, from the colonial era, and the way in which western health care systems were thrust upon them (Lowes & Montero, 2021).

The concept of 'therapy managers' is one that fits in well with the power relationships in health care and can contribute substantially in understanding how this operates within the South African mental health context. Given that 'therapy managers' help patients make crucial decisions, we need to explore the extent to which the mental health system under study allows this form of input. This can make a meaningful contribution in developing and enhancing the country's mental health service.

2.3.4 Mental illness and human rights

Mental illness and human rights appear to have been in diametrically opposite corners from the dawn of time. This is despite what one might see as a common-sense notion that people with mental illness are sick and vulnerable, therefore needing special care and a context of social justice. However, human rights violations against people with mental illness is neither new, nor geo-specific in nature. It has, in fact, been a global phenomenon (Gostin, 2000).

Foucault (2001) noted that people with mental illness were regarded as less than human, and as a result they were denied the basic rights that were afforded to ordinary citizens. Countries throughout the world have treated people with mental illness "horribly throughout history and into the present" (Gostin & Gable, 2004, p. 121). In recent years, and with an increasingly strong human rights culture globally, there has also been a growing focus on the multiple human rights issues involved in mental health care. Activists for equality and mental health justice note that since the 18th century, the rights of those deemed "mad" within society were taken away without concern about their rights as citizens and human beings. In the early understanding of "madness", Foucault (2001) noted that those displaying signs of "difference" were separated against their will. This idea of marginalising specific groups was not too different to the way Hendrik Verwoerd's government in South Africa separated people who appeared different. This highlights the intolerance of societies in the face of groups that appear different or what is referred to as an 'outgroup'. In the context of mental illness, it shows the marginalisation of people displaying symptoms, ways of thinking and behaving that are perceived to go against the grain or norms accepted in a society (Benbow, 2009).

Unfortunately, this scenario is an ongoing one and signs of significant improvement are not as apparent as mental health activists would like to see. A relatively recent review of the global context revealed that people with mental illness experience a host of human rights violations, whether they are in living in mental health facilities or in mainstream society. These include discrimination in terms of employment opportunities, marriage, reproductive rights, education, nutrition and various forms of abuse and neglect (Mfoafo-M'Carthy & Huls, 2014). Many of these human rights abuses apply in South Africa as well, where the stigma of mental health problems still prevails to an alarming degree. For example, women and children with mental health problems are targeted for rape crimes in the belief that they will not be able to testify in court, and these individuals face enormous challenges within the criminal justice system which places additional hurdles for them to overcome, before they can be allowed to testify against perpetrators (Pillay, 2012). Similarly, in many other facets of life, people with mental illness tend to be regarded as children, even by the law, and their autonomy and individual rights are stripped away (Smith, 2017). Despite numerous advances in human rights for people across the world, there are still many challenges remaining, either because of an unwillingness to afford rights to certain groups or because of ignorance by the relevant authorities. However, offering an important legal perspective, Gostin and Gable (2004) emphasise that

> "human rights do not rely on government beneficence. Governments do not possess the power to grant or deny human rights and freedoms. Persons possess rights simply because of their humanity. Thus, persons with mental disabilities need not prove that they deserve certain rights …" (p. 22).

This is an important consideration and tells us that the instances of structural violence (Galtung, 1969) and epistemic injustice (Fricker, 2007) that currently deny rights to people with mental illness in South Africa, and elsewhere, need to be challenged, and that governments must be made to realise that their policies and practices are unjust. Gostin and Gable (2004) add that while many governments have effected significant mental health law reforms, other countries continue to use outdated laws that are not consistent with international principles or current standards of human rights.

Perhaps one of the more significant issues of concern has been that of unjustified confinement or detention in mental health facilities, and the ease with which such detentions could be effected, making abuse of the system very likely. Like many other countries South Africa was one of those where it was fairly easy to have someone suspected of being mentally ill certified as such, and detained under the previous mental health legislation enacted by the apartheid government. Fortunately, the Mental Health Care Act of 2002 has significantly reduced the opportunity for abuse through a 72-hour assessment period by two mental health care practitioners and authorisation by the head of the relevant health establishment, before an order of detention can be instituted (Republic of South Africa, 2005). In forensic cases and those declared *State Patients*, the process is handled by the courts with magistrates and judges making final decisions. Although the mental health legislation of democratic South Africa is progressive, the various amendments to date confirm the need for ongoing attention to identify areas that are flawed or of concern.

Among the various concerns regarding human rights infringements in the lives of people with mental illness is the denial of their right to vote in many countries. A detailed study by Bhugra et al (2016), found that of the 193 countries' laws that they examined, 69 (36%) deny voting rights to persons with a mental health problem, with only 21 (11%) placing no restriction on the right to vote by people with mental illness. Sadly, South Africa falls into the 36% mentioned in the Bhugra et al (2016) study, because its Electoral Act 73 of 1998 denies the vote to people with mental illness (Republic of South Africa, 1998). Despite its various amendments since its enactment, the law still applies a firmly discriminatory approach to adults living with mental illness. Although the Constitution of South Africa makes it clear that every adult South African has the right to vote, which is guaranteed as a basic right, the Electoral Act which was enacted two years later, says otherwise in respect of people with mental illness (Republic of South Africa, 1996; Republic of South Africa, 1998). The Electoral Act of 1998 denies the right to vote to any citizen

> "(c) who has been declared by the High Court to be of unsound mind or mentally disordered; (d) is detained under the Mental Health Care Act 2002 (Act 17 of 2002)" (Section 8).

It is quite clear, then, that the Electoral Act goes against the Constitution. This is an odd situation because the Constitution is supposed to be the supreme law of the land, and should supersede every other law. However, in their commentary on the rights of people with mental illness and governments' development of laws, Gostin and Gable (2004) point out that "persons with mental disabilities need not prove that they deserve certain rights or that they can be trusted to exercise them in socially and culturally acceptable ways." (p.22). Clearly many governments, like ours in South Africa, are breaching international principles and human rights that should be protecting people with mental illness.

Given South Africa's history of human rights violations, especially its treatment of marginalised groups, it is critical that we try to understand how people with mental illness are treated in terms of respect for their human rights. Considering the broader way in which an individual's dignity and self-esteem are affected by environmental responses to them, it is important to ensure that the rights of people with mental illness are not stripped away or removed simply because of their health status (Smith, 2017).

2.3.5 Culture and mental illness

Although anthropologists differ on exactly what 'culture' means, for human beings our cultural affiliations are an important definition of who we are and how we relate to the world. Medical anthropologist Patricia Hudelson views culture as a glue that enables members of a specific group to work together effectively and communicate with a common understanding (Hudelson, 2004), Her conceptualisation of culture is that it is not static, but evolving and it is dynamic within the reality that is socially constructed and mutually understood by members of the group. Interestingly, concepts such as culture have been conveniently used in countries like South Africa as a proxy for race, with the argument that because of the different traditions, belief systems and worldview of social groups it is necessary to provide specific spaces for them to live and commune. The apartheid government used this rationale, based partly on Hendrik's Verwoerd's ideas as a social psychologist, where he tried to argue that 'separate development' (the English translation of 'apartheid') was necessary. In his paper titled "Separate Development as a Failed Project of Social Engineering", Moodie (2017) argued that

> "While 'separate development' presented an apparently moral (if anthropologically questionable) 'separate cultures' argument for 'national development', it was always fundamentally undercut by racist assumptions of apartheid." (p. 153).

With the fall of apartheid, its foundational argument that equated culture with race is being dismissed (in some cases very gradually), but the value of an individual's cultural belief must be respected and recognised, including in contexts that pertain to health beliefs and worldview.

Hassim and Wagner (2013) argued that culture influences psychopathology and plays a key role in the way that health care and healing processes are constructed, meaning that clinicians need to take cognisance of cultural issues and recognise their influential role in mental health. They also noted that culture influences the way people behave when they are ill, as well as their interaction patterns during their mental illness. Considering the critical need to incorporate cultural issues into mental health care practices, Mental Health First Aid USA (2019) provided a useful guide on four ways in which culture impacts mental health. They noted these as follows:

(1) Cultural stigma – cultural groups have different ways of conceptualising mental health problems, and in many cultures, there is a stigma, a consideration of weakness and that it is something to hide.

(2) Understanding and interpretation of symptoms – culture can influence how people describe their symptoms and illness.

(3) Community and family support can be determined by cultural factors, because the extent of support received can vary by culture.

(4) Available resources to assist individuals can be limited, because people often prefer to speak to someone they feel will understand not only their symptoms, but also their worldview and belief systems.

The last point is a very significant one, and can be difficult to negotiate, like the language issue noted earlier, and its importance in psychological care. This is especially difficult in countries like South Africa that have had a history of favouring the training of psychologists of European descent. The legacy of that system will be with us for decades, because the majority of the country’s people are of African cultural backgrounds, whereas only the minority of psychologists are from this cultural group (Pillay & Nyandeni, 2021). One has to, therefore, question the efficacy with which the country’s mental health system can treat the nation’s mentally ill people.

An example of the first point on the above list by Mental Health First Aid USA (2019) can be found in Kleinman’s (2012) argument that, in the 21st century with so many improvements in the worlds’ health systems, the stigma around mental illness still prevails in various cultural contexts. The result is that these societies marginalise affected individuals on the basis of the culturally rooted stigma. He reported on the situation in China where patients with a mental illness may be considered as socially and morally dead and regarded as “non-persons”. He related this to one of his earlier important questions for medical anthropology and mental health for the next 50 years – what can medical anthropology do to redefine the stigma of mental illness, if “ground zero” for mental illness is the terrible way that people with severe mental disorders, like psychosis, are treated by society and excluded because of the cultural stigma (Kleinman, 2009)? In a similar way, Abi (2019) noted that in parts of Africa, mental illness is a taboo subject, with the entire family being viewed as cursed if a member falls mentally ill. Interestingly, among the explanations for the increase in mental health problems is the loss of the close-knit family ties and the protection that it offered. In South Africa for example, Nwoye (2015) notes that symptoms presented in an individual may be associated with a mental illness, but may in fact be culturally related, such the calling to become a traditional healer may present symptoms clinicians might identify as psychosis (van der Zeijst et al., 2020).

In using the ethno-medical approach to medical anthropology, Brown, et al. (2010), argue that a complex relationship exists between issues of health and illness, cultural beliefs, social environmental factors and healing practices. This, more specifically, refers to the way that individuals from different cultures and belief systems make sense of and understand health and disease, and how they choose which treatment they want to use. It influences their health-seeking behaviour and is also affected by the extent to which treatments are accessible and/or meet the cultural needs of these individuals. This approach fits together with Kleinman's explanatory model and his distinction of disease, illness and sickness. This distinction bears on the medical model and Kleinman's (1988) critique, noting that doctors see the *disease* or the pathological process in the body, whereas *illness* refers to the affected person's subjective experience of ill-health, and *sickness* refers to the individual's health problem as defined by others (Kleinman, et al., 1978; Kleinman, 1988; Yew & Noor, 2014). Kleinman seeks to understand how people explain and understand health and sickness, noting that each person has a different way of explaining their ill-health, why they are sick and what caused it. These narratives must be considered in the planning of treatment (Kleinman, 1988). The present study may contribute to the way treatment is approached, to consider changes in the way patients are viewed, and their ability to provide their own explanation of their illness, which may be considered during treatment.

In South Africa, with the rich multicultural context that constitutes our nation, it is critical that mental health practitioners take note of the cultural and social experiences of patients in developing their treatment plans. Given the long history of tradition and custom that African people have, as well as the three centuries of colonial rule that tried to negate those belief systems, it is important that, with the country's improved mental health laws, there must be recognition of local understandings of mental health practice. As an example, religious practices and spiritual callings from ancestors were never taken seriously by colonists, who were generally dismissive of such cultural beliefs (van der Zeijst et al., 2020).

Extending on the explanatory models of illness, Vikram Patel (1995) noted that psychiatric instruments need to be refined to better understand mental health concerns in culturally specific contexts. This also speaks to the way in which mental health problems are conceptualised. In a recent study, Kometsi et al. (2020) found that African residents in a non-urban area of South

Africa described schizophrenia with terms such as being bewitched and *ukuthwasa*. In this context, Mkhize and Kometsi (2008) argued that the training of mental health practitioners would be incomplete if it did not include exposure to and collaboration with indigenous healers, such that the two systems of health care can work side-by-side. They noted the need to incorporate indigenous healers such as *izangoma* (diviners) and *izinyanga* (herbalists) into the mental health care system, since “traditional healers are likely to use illness explanatory models that are more consistent with the patient’s view of the origins of mental health problems” (p.110). This is very interesting, considering that western (or modern) health care began delving into the practice and theory behind the explanatory model in the last few decades with Kleinman’s work (Kleinman, et al., 1978), whereas indigenous healing systems have used the practice for centuries. It also flies in the face of the medical hegemony that prevails with modern, scientifically-based health care continually attempting to assert its position as leader in all aspects of health care. What has been termed “evidence-based” health care has come to dominate health care systems and services (Hanemaayer, 2016).

It is also important to note that many individuals and families first consult indigenous healers when illness occurs (Campbell-Hall, et al., 2010). Unlike westerners, many traditional communities seek the assistance of traditional healing practitioners before consulting western trained health professionals, because they are well recognised within the community as experts who can provide the required assistance and curative care that is needed. It has been noted that women consult traditional health practitioners considerably more than men, and psychosocial problems are among the more frequent conditions for which consultations are sought (Peltzer & Mngqundaniso, 2008). It is, therefore, important that any mental health system, or attempt to enhance community mental health, not try to impose western ideology and methods, but rather look to work alongside the traditional healing services. With the advent of western health care and its increasing influence within traditional communities globally, we find that communities that relied solely on traditional healing services are now also embracing western health care as well. In her research in Botswana, Livingstone (2007) found that communities were shifting the way they expressed their healing preference and conceptualising the systems in a different manner. Rather than viewing one system as dominant, patients developed a recognition for both systems and were able to navigate them, and learn to use them in a manner that gave them most benefit. Earlier research in the Limpopo province of South Africa also demonstrated that the majority of patients preferred a form of collaborative health care where they could receive consultation from both traditional and western trained practitioners

(Muelelwa, et al., 1997). However, Maluleka (2020) noted that while collaboration between traditional health practitioners and western doctors is being encouraged, the collaboration on the ground appears to be one-sided where traditional healers refer patients to hospitals when needed, but find that Western doctors hardly ever refer patients to traditional healers when they have patients whose illnesses they do not understand or who require traditional remedies.

Culture is a vital concept in analysing health care, because individuals and communities must be treated in ways that are consonant with their worldview. Clashes in this respect do nothing to help people recover from their ailments, and serve only to perpetuate past approaches in South Africa, where the voices and views of marginalised groups were ignored. Exploring the influence of culture and patient preferences in their treatment at the hospital under study is, therefore, important in understanding how the system works and what (if anything) needs to change.

2.4 Coronavirus, health care and mental health

The conceptualisation of this research project coincided, quite unintentionally, with the onset of the COVID-19 pandemic that took the world by storm early in 2020. For South Africans, March 2020 represented ground-zero, when the first case was diagnosed. Interestingly, the country's first identified COVID-19 patient was a resident of Pietermaritzburg, a few kilometres from my home.

The pandemic brought one of the biggest catastrophes in modern history and is matched only by the Spanish flu of 1918 which killed more than 50 million people and infected over 500 million globally (Centers for Disease Control and Prevention, 2019), and to a lesser extent, the HIV/AIDS epidemic, which continues to affect the lives of thousands of people every day. Like it did worldwide, the virus caused much illness, suffering and death in South Africa, with over 3.7 million infections and more than 100 000 deaths across the country as at 1 May 2022 (Department of Health, 2022). This has put huge pressure on our already overburdened health care facilities and related resources.

In addition to the consequences for health care, the pandemic and the resultant lockdown disrupted lives in a very big way, especially in terms of job losses, poverty, education and massive uncertainty that communities faced. The lockdown received mixed response from citizens, because although it was aimed at reducing the viral spread, it was also felt to be unnecessarily harsh, draconian, and fraught with epistemic injustices in the name of public health. For example, Pillay & Kramers-Olen (2021) commented on the deployment of the army with menacing firearms, blockading poor, historically Black residential areas considerably more than others, leaving many wondering who was being considered the ‘enemy’. They argued further that within 10 weeks of the lockdown, there were over 600 complaints against the police, 11 deaths, and numerous instances of brutal police violence, mainly against Black men, and usually in the context of trivial offences relating to alcohol or tobacco possession, for which sales were restricted.

The extent of poverty caused by the thousands of job losses hit hard, and more severely in poor communities. A national study revealed that 47% of households ran out of money for food within a month of the lockdown, compared to the pre-lockdown figure of 21% (Wills, et al., 2020). Poverty, as always, is accompanied by higher levels of psychosocial and mental health problems. The COVID-19 pandemic inevitably affected mental health across the nation, as well. The pandemic affected mental health in two ways, namely people responding to this unprecedented global threat with mental health symptoms and individuals who have had existing mental health problems that have worsened during the pandemic for various reasons.

A national South African survey indicated that although the rates of depressed mood ranged between 24-29% across the different waves, the proportion of people reporting depressive symptoms in any wave was 52% (Hunt, et al., 2021). That study also found that people who reported hunger in the home over the past week were more likely to report having depressive symptoms, which ties in with the established link between poverty and mental health. An online study of over 11 000 young people between 18-35 years, found depressive symptoms reported by 72% of the participants (Mudiriza & De Lannoy, 2020). Hunger has been cited as the main driver in the increased depression noted during COVID-19 (Hunt, et al., 2021). Considering the seriousness of COVID-19 infections in some cases, and the high death rates, many people became overly worried and anxious about catching the virus, developing what mental health specialists refer to as a ‘crisis preoccupation’. Research has shown that high proportions of people became preoccupied with fear of contracting the virus, which impairs their mental health and reduces their daily functioning ability, resulting in secondary health issues (Kroencke, et al., 2020).

There is also serious concern for mentally ill persons who have been on treatment before the pandemic, and especially those with more severe mental illness. The latter is a vulnerable group, very much like the patients at the psychiatric hospital that I planned to study in this research. Mental health specialists have expressed concern about patients who are being treated as outpatients and not able to access clinics to receive their medication due to the lockdown and fear of travelling out of home (Javan, 2020). In addition, there has been more serious concerns about the shortage of medications due to the global lockdowns, affecting some of the most commonly used antidepressant and antipsychotic medications (South African Federation for Mental Health, 2020). This obviously necessitates changes to be made in prescribed medications, which has the possibility of patients relapsing or having various adverse responses that they did not have previously. Yet another area of concern has been the ability of patients with severe illness or intellectual disability to cope with public health prevention strategies like masking, physical distancing & sanitising. Clearly the COVID-19 pandemic has, and is continuing to have, multiple consequences for the mental health of individuals and communities, as well as for the mental health care services that were already under enormous pressure before the pandemic.

Of course, given the huge pressure on health care facilities, the mental strain on health workers has been a significant concern. Mental health research on health workers during the pandemic has found that, while good organisational support was experienced, they did report feelings of psychological distress and anxiety related to personal and occupational stressors (Cook et al., 2021). A review of research into health workers' responses and coping during COVID-19 and other outbreaks found that post-traumatic stress, anxiety, depression, as well as other mental health problems have been noted. Burnout was also reported, especially in sub-Saharan Africa with high workloads, adverse working conditions and shortages of staff being contributory factors (Robertson, et al., 2020). These findings are of relevance to the present study, considering that one of the areas of enquiry relates to the impact of COVID-19 on mental health care.

Exploring the impact of the COVID-19 pandemic on treatment at the study hospital was also a part of this research. Since this research was conducted during 2021, the adjustment to living and working during a pandemic was still an ongoing process. Many healthcare workers were still braving the risks and their own safety in ensuring that they continue working and providing the services required for the wellbeing of so many people during this period. (Spoorthy, et al., 2020). How this infection and all of the associated challenges affect the mentally ill, and the extent to which it impedes their treatment and recovery are critical areas about which I have conversed with my participants. In a recent article in the journal *Medical Anthropology*, Manderson and Levine (2020) noted the effect of a pandemic like COVID-19 on health services. While they note that people change their behaviours quickly in response to institutional mandates, they express concern about the extent to which our country is able to deal with the various prevention measures needed to respond to the pandemic, given the numerous social and economic constraints. It is also important to recognise that while certain behaviour changes are needed to curb the spread of the infection, we have to be concerned about the ability of mentally ill persons to make the necessary changes. Being a marginalised group in society, people with mental illness have many adversities with which they have to cope. Anthropologist Jean Segata (2020) pointed out that the COVID-19 virus attacks all people, but it also “hides deep unequal social structures”. For these reasons, it is important that my research looks at how the pandemic has affected the treatment of people with mental illness at the study hospital.

2.5 Summary

The chapter explored the literature relevant to the study, beginning with some of the historical perspectives relating to ‘madness’ and its care in society, as well as the ways in which religion, power and the clinicians’ approach to their patients impact mental health care. In addition, social and contextual issue such as culture, human rights, funding, and the immediate support systems available to patients were discussed. The unexpected COVID-19 pandemic and its impact on mental health care were also explored.

Chapter 3 - Methodology

3.1 Introduction

The hospital that I chose to conduct my fieldwork is one of six Forensic Psychiatric Hospitals in South Africa and the only one situated in the KwaZulu-Natal province. It has approximately 350 patients. The reason for choosing this hospital is that it has a combination of chronic mentally ill patients who have no forensic history, State Patients, and persons sent to the hospital for observation. The latter group is sometimes referred to as 'patients', but they are not admitted for treatment, and therefore they are not strictly-speaking 'patients'. This hospital is situated on the outskirts of the capital city in KwaZulu-Natal (KZN). I also selected this hospital because it is a major psychiatric hospital in KZN and has a very interesting colonial, military and apartheid history. As someone who grew up in the same city, I also became quite familiar with the facility.

The "thick description" which characterises anthropology has proved beneficial to health research (Kumreich, et al., 2001). The qualitative methodology is suited to this research aim, and allows for rich description and interpretation of individuals' feelings and experiences within sociocultural, political and economic contexts. This makes it an ideal method of field- and community-based research.

The qualitative, ethnographic research method was employed in this anthropological study. It was chosen as it offers more of a collaborative process between my participants and myself during the fieldwork process. I used the following field techniques: informal interviews and participant observation which are well known and established techniques in the field of ethnographic research (Allen, 2017).

For this study, my initial plan was to use a qualitative research approach, and more specifically a traditional ethnographic research method that involved field visits and conversations in the hospital where members of the MDT work and where patients stay and receive treatment. However, with this study being undertaken during the COVID-19 pandemic, like every other facet of life, my approach had to change. After the initial 21-day lockdown, announced by the President, was extended, I had to rethink some of the methodological processes for conducting this research. It became quite clear that I was not going to be allowed onto the field-site, which was a hospital environment, firstly because the COVID-19 regulations disallowed that, and secondly, because it would be unsafe for my participants and myself, exposing all of us to increased risk of COVID-19 infection. My entry to the field-site could mean that I transmit the virus to the site that could affect the staff and their patients, and that would be unethical.

COVID-19 has forced social scientists to reconsider and to creatively adapt their research strategies. I, too, had to think ‘outside the box’, as it were, and consider a different approach that could still achieve my original research aims. Virtual ethnography represented a solution to the problem at hand (Miller, 2020) as it promised to allow me to reflexively adapt to changing contexts and participants’ circumstances.

Virtual ethnography, which has been around from the early 2000s, became more popular during the onset of the COVID-19 pandemic Virtual ethnography, according to Hine (2008), is “of, in and through” the internet and virtual platforms. This type of ethnography occurs sporadically in agreement with participants. It also takes place where the researcher immerses themselves into online communities and cyberspaces. This is unlike traditional ethnography wherein a researcher conducts fieldwork in a physical location. Strengths of virtual ethnography include field sites being accessible easily via an online platform, it can be a cost-effective way to conduct research, it can be conducted in a shorter time-frame, it is a safer form of data collection given the concern of the COVID-19 pandemic, as well as having the ability to navigate time-zones and geography (Clarke, 2000). Among the many strengths of virtual ethnography, there are also weaknesses. One key weakness is the limited participant observation. An example of this is social cues, body language, and observing the participants in their environment is either limited or non-existent (Hine, 2000). This may, in fact, hinder the thick description a researcher would hope for during the ethnographic process. Another weakness is that conversations via the online platforms may not be an accurate depiction of what is reality, but merely what the participant would like you to know.

Virtual ethnography (or digital anthropology) is an emerging field heralding many research possibilities, and the present research certainly will add to the development and refinement of this innovative research methodology (Kaur-Gill & Dutta, 2017). At this stage, there is understandably uncertainty about validity and what is considered true digital anthropology (Boellstorff, 2013). During this pandemic and its stranglehold on traditional research techniques, authentic fieldwork comes into question. Malinowski’s (1922) critique of ‘arm chair’ anthropologists, and other leaders in the field, such as Franz Boas and Clifford Geertz, have suggested researchers should be in the field, rather than conducting research using secondary data. To a large extent, I would agree with those viewpoints. However, there are some notable differences between the research eras of those ethnographers and us in 2022, and I will mention just two of them. Firstly, we are working in a time of a great pandemic, somewhat like the Spanish flu of 1918-1920, but with more severe restrictions within a context of improved scientific knowledge of viral transmission and a vibrant international travel industry that fuelled global transmission (Pillay & Kramers-Olen, 2021). Secondly, it is widely documented that research ethics practices were considerably less stringent, and in some cases not even considered, when we look at the time-line a few centuries (Resnik, 2021). Similarly, there are many other reasons why research, and especially ethnographic research, has be considered in an adapted light in the current times, because researchers do not have the kinds of latitude enjoyed by ethnographers of old.

In order to conduct virtual ethnographic fieldwork with my participants and ensure I was able to gain as much information as possible during our prearranged Zoom meetings, I made a point of carefully observing my participants during conversations with them, and noting down their contextual responses. This enabled me to pick up subtle signs that related to the way they reacted to certain questions. I was able to note the emotions they felt if a certain topic made them feel uncomfortable or seemed too sensitive to talk about.

As part of the ethnographic approach to data collection, I preferred the use of informal interviews and conversations with participants. This technique allows for a more relaxed atmosphere, and for the participants to be more spontaneous in their responses. In this way, the research process does not feel too structured, and the participants do not feel like they are being tested or interrogated in any way. Cohen and Crabtree (2006) noted that informal interviewing is helpful in that it serves to build rapport with participants, and it also helps gain their trust, which is vital in ethnographic research. The use of an informal interviewing style also facilitates easier and better understanding of the questions or issue that the researcher is exploring. According to Hastrup (2004) we have to take care not to be inquisitors because that will prevent us from getting a deeper understanding of our participants' thoughts and beliefs. An inquisitorial style could put participants on their guard and be defensive about what they say, constantly worrying about the possible consequences of what they disclose. Informal interviewing, however, would make the process more conversational, friendly, and trusting, thus reducing the anxiety that could creep into research interviews.

In addition to the informal interviews with my participants, and to further understand the hospital's history, and consistent with COVID-19 safety precautions, I have also undertaken an archival search (e.g. books, newspapers, magazines and other print and digital publications) from the last three decades to complement the interview information. This is important to critically understand the hospital's social and political context and its policies, especially given the varied and colourful history of the facility. This information is incorporated into my findings to provide a richer and fuller picture.

3.2 Participants

In this research, I conducted numerous interviews with 10 participants working within the Multidisciplinary Team (MDT) at the selected Forensic Psychiatric Hospital. In terms of my initial plan, I had hoped to speak to two participants from each discipline i.e. psychiatrists; psychologists; nurses; social workers and occupational therapists, and refer to their discipline-specific accounts. This changed slightly as I was instructed during the gate-keeping phase of hospital's ethics clearance, that since the number of staff members in certain disciplines is very small, compared to others, it may be easy to identify participants in the written report. In granting gate-keeper permission, the hospital authorities insisted that I refrain from mentioning the hospital name or the disciplines to which my participants belong when narrating their responses within my dissertation. This was not an unreasonable instruction, and I complied with the guidelines, and arranged interviews with MDT members who were willing to be interviewed.

After the ethics reviews and gatekeeper permission formalities were accomplished, I initiated contact with a few clinicians who were willing to speak to me. After those initial contacts and interviews, I employed the snowballing method of sampling to gain introduction to other participants. According to Sedgwick (2013), snowball sampling is a method used when participants are not readily available and may be hard to access due to various reasons, but the accessed participants assist in recommending others. In this case, the population that I chose to sample was clinicians working in the specialized forensic psychiatric hospital. With the COVID-19 pandemic and the added pressure placed on clinical staff, it was a challenge to find clinicians who had time readily available to engage with me and converse around the areas of research that I wanted input. Nevertheless, my initial key informants were very helpful in locating colleagues who were willing to participate in interviews. As a result, I was able to meet my target of 10 participants.

My aim in this project was to focus on clinicians and their relationships with patients, rather than focusing solely on patients. This was a way of 'studying up', which is a concept advanced by Laura Nader (1974). She argued that anthropologists should use their ethnographic skills to study the elite and powerful members of a community, and not just those at the lower end of the social hierarchy. This includes people who occupy positions of power, like clinicians, scientists and those in government. This way we are able to get an understanding from another perspective, as opposed to only studying people at grassroots level. In the health care sector, a ‘studying up’ approach enable us to critically examine the power issues, how power is wielded and this can help us determine ways of dealing with the situation. In this respect, van der Wiel (2019) noted that ‘studying up’ has the benefit of allowing a greater breadth of knowledge development, and enables us to find solutions to social, health and related challenges. Nader’s (1974) argument that ‘studying up’ makes the gaps in institutional practices more visible is a strong one, from which we can learn a great deal, and which will ultimately benefit society.

3.3 Facilitating questions and interview guide

In ethnographic research, the interview process does not adopt a systematic set of fixed questions to which the participant is expected to provide an answer, before moving on to the next question on the researcher’s list. Instead, ethnography, according to Tim Ingold, is the process of giving an account of the way in which individuals live and go about their daily activities, which is usually done by a researcher spending extended periods of time taking part in and living with their subjects in order to give an honest account of their reality (Ingold, 2017). The approach seeks to engage the research participant in a conversation that facilitates an understanding of the participant’s world and experiences. According to Reeves, et al. (2013), such interviews involve engaging the research participant in a manner that encourages conversing about a specific area of discussion that is relevant to the researcher’s questions or topic of exploration. With this consideration in mind, I was mindful of two important issues to guide my interviewing process, firstly to avoid being rigid in my list or sequence of questions, and secondly, to ensure that I enabled the interview to flow smoothly, with minimal interruption, and more like a conversation than an interview. Nevertheless, it was important for me to have an idea of the types of questions and areas of enquiry that I was planning to cover in my interviews. Therefore, I drafted a list of questions, presented below, which served mainly to remind me of my planned areas of enquiry and to guide my interviews. I was very careful not to view this as a rigid list of questions to be put to participants in a clerical fashion, and not to come across too formal in the way I raised questions. Instead, I wove them into our conversations. For example, sometimes I raised a later question on my list much earlier because the participant had been speaking about a specific issue and that question followed on naturally.

The following questions were used to guide my interview and were subject to change as needed:

(1) What interactions do you have with patients' "therapy managers" (significant others in the patients' social network)?
(2) How has COVID-19 affected your interactions with patients' "therapy managers"?
(3) Is your definition of adequate care the same as that of the rest of the Multidisciplinary Team (MDT), "therapy managers", and patients, or are there differences of opinion on this issue?
(4) Does the MDT discuss patients' treatment? What is that process like?
(5) Does language play a role in patients' treatment? If so, how?
(6) Are there certain things you don't agree with in the mental health care policies?
(7) Does government fund mental health care sufficiently? Please explain.
(8) How has the COVID-19 pandemic affected the treatment of your patients?
(9) Do patients understand the pandemic, COVID-19 transmission, and how to prevent infection?
(10) Have the demands for mental health care changed for patients and significant others in the patient's support circle If so, how?
(11) Do you still have MDT meetings during this time of COVID-19? If so, are they handled differently?
(12) What are your main concerns about COVID-19 in relation to your patients?
(13) How has COVID-19 affected State Patients, their leave and discharge processes?
(14) In your experience, have patients been given the opportunity to cast their vote in democratic elections?
(15) Are there other human rights issues that affect the patients in the facility?

Although a list of questions is unnecessary in ethnographic field research, as a novice researcher this has helped me to ensure that I cover important aspects such as mental health care funding, how the COVID-19 pandemic affected the treatment process, and the interactions MDT members have with patients and 'therapy managers' (Boellstorff, et al., 2012). On reflection, I realise that without a list of guiding questions, it is possible that, due to the anxiety, I could have omitted one or two. So, the list certainly helped me remember all that I needed to cover.

3.4 Research procedure - background

As mentioned earlier, COVID-19 coincided with the commencement of this research and, therefore, I had to develop a change of plan and execute the research process in a different way. However, I was careful to adapt my research procedure in a way that was in line with the pandemic lockdown regulations, but also stayed true to my research aims and areas of enquiry. This called for a relatively novel approach. This was consistent with most people and many workers finding the need to develop different ways of living and working, at the start of the pandemic. It was clear that the traditional approach to ethnographic research, and specifically traditional participant observation, was not going to be possible. This is where my reading of the literature led me to the virtual ethnographic research approach with which I tried to make myself more familiar and apply to my research project and its stated aims. With the guidance of my supervisor, it soon became clear that I could use this approach successfully in my project.

According to Daniel Miller (2020), one can achieve significant results using virtual ethnography. This resonates with Christine Hine's (2008) argument that the field is not a physical place, but rather an experience. It follows that one does not have to be in a physical place to conduct ethnographic research. Unlike traditional ethnography where researchers immerse themselves in their field site over a long term, virtual ethnography occurs sporadically in agreement with participants (Hine, 2008). Hine (2015) further discusses "netnography", a research method focusing on embedded technologies and groups/forums to conduct online ethnography. 'Netnography' uses the well-known ethnographic tools of thick description and participant observation with online interviews that can be successfully applied through deep immersion in an online community. This includes communication with members, and observations of online interactions, expressions, emotions and behaviours.

Driscoll and Gregg (2010), however, believe that the "fabric of community" is vital to research. This is relevant to my research, and I was quite fortunate in this respect because, through my earlier volunteering work, I have personal knowledge of my proposed field site, such as the layout of the wards, offices and grounds and the general functioning of the hospital. This knowledge helped me, to some extent, to overcome not being able to observe interactions within open spaces because I already knew the wards, for example, including those with higher security and those allowing patients free movement. It is worth noting that, even without the COVID-19 protocols and restrictions, I may not have been allowed to enter some wards for ethical and legal/confidentiality reasons, since I am not a registered health worker. Of course, the additional COVID-19 challenges closed off certain interpretive avenues that I might have had. I have persevered to the best of my ability under the current circumstances, and I am confident that the information that I have gathered has been valuable, while using the virtual ethnography approach described by Miller (2020), Hines (2008; 2015) and others. Being unable to visit my field site, I relied solely on videoconferencing applications such as Skype or Zoom to interview participants. Being in the current digital age with internet applications and mobile data advantages, assisted me in overcoming the challenges thrown my way by the COVID-19 pandemic. However, electricity outages and weak internet connection did pose some limitations. Nevertheless, my knowledge of the hospital, its wards and context contributed greatly towards providing the 'material world' context, which is important in ethnographic research. However, not being able to do participant observation, in the classical sense, has limited my research to some extent.

To ensure that I collected rich data, the interview questions shown earlier were adjusted as necessary, during the conversations with participants. Also, since the participants were generally very committed to their work and excited about sharing their experiences and views with me, it sometimes happened that we moved the conversation to different questions that did not coincide with the order reflected above, and that sometimes we came back to a particular area of discussion because the participant felt the need to add further details or additional points that they remembered. I felt this approach worked well because I got the distinct impression that the participants felt at ease with my interviewing style and that sufficient rapport had been developed to make them feel comfortable enough to be spontaneous in their interactions. Participants were also requested to provide in-depth descriptions of work contexts that were not ethically sensitive. This data enabled a clearer image and richer information of my field site. Although it would have been helpful to get some pictures of the field site, the gatekeeper permission made it clear that the facility should not be identified.

One-on-one digital conversations can enable participants to speak privately about subjects they may be uncomfortable discussing with other MDT members present, and my approach reinforced the fact that the dialogue context was, in a way, more private and they could feel safer. In addition, in order to maintain anonymity and protect my participants' identities, I have not identified any participant and I have not linked any response or narrative to a specific discipline. Only participant numbers are used (e.g. Participants 1, etc.). According to Miller (2020), this openness may take time, but he suggested that individuals may find it easier to speak over digital media as many individuals may feel safer behind an internet screen, avoiding colleagues listening in on responses as well as avoiding colleagues identifying them. Crises generate new opportunities; therefore, innovative research strategies will emerge from this pandemic, and this represents an exciting time for anthropology and other social science research developments.

Online ethnography involves participating in participants' daily lives, which Miller (2020) noted as including the researcher being helpful to participants. Therefore, I decided to, again, volunteer my services to the hospital when the pandemic subsides. My volunteer participation will address two issues, firstly, it will form a reciprocal exchange with participants which counters the ethical considerations around payment, since no money changes hands through my volunteer activities. Secondly, I will volunteer my services, in very much the same way as other students do, for work experience, but also as a service to the community and those in vulnerable positions.

3.5 Research procedure – the interviews

With respect to conducting the participant interviews, I first obtained research ethics clearance from my university (University of Pretoria) and thereafter obtained permission from the KwaZulu-Natal Department of Health, as well as gate-keeper permission from the hospital that I planned to use as my field research site. As mentioned earlier, I had initiated contact with a few clinicians at the hospital, and so after getting ethical clearance to commence the research, I discussed the research briefly with them, after which I sent them a copy of my approved participant information leaflet, as well as the proof of the ethics clearance and gate-keeper permission. Once participants agreed to be interviewed, I arranged dates and times for the interviews, based on my participants' availability. At this time, I arranged for the informed consent form to be completed and collected by one of the hospital staff whom I knew and who agreed to assist me with this logistical issue, since I was not allowed to attend the hospital to collect the signed form. I set up Zoom or Skype interviews, depending on the specific preference of the participant.

At the start of each interview, I thanked the participant for making the time to assist me in the project and spent a few minutes establishing rapport to make them feel comfortable. I was fairly anxious during the first few interviews, so the rapport building helped both participant and researcher feel at ease. I also requested permission to digitally record the interview to enable accurate interpretation within the qualitative paradigm. Fortunately, all participants agreed.

Once rapport had been established, I began by exploring the participant's entry into the field of mental health and their specific discipline (e.g. psychiatry, psychology, nursing, etc.) within mental health. I then moved onto the areas of enquiry listed above, in my list of guiding questions, but keeping very flexible and allowing the participant to dictate the pace, sequence and depth of exploration. However, if a certain participant did not delve sufficiently into an area that I wished to know about, I carefully asked a facilitating question or two to enable a bit more depth-exploration. According to Le Marcis & Grard (2015), interviewing participants in a formal context may gather different responses to observing them in their working environment. As a result, reflexivity on my part was important. In most cases, I did multiple interviews with each participant, in order to ensure that the broad areas that were intended for exploration had been covered. Also, multiple interviews were conducted until data saturation, which is the point at which no new information is obtained, was achieved. According to Braun and Clarke (2021), this is an important research consideration in the collection and interpretation of qualitative data (Braun & Clarke, 2021).

The participants with whom I had initial contact (key participants) were helpful in introducing me to other clinicians in the hospital (i.e. snowball sampling), some of whom agreed, while a couple were willing but not available to meet due to their commitments. As stipulated in the hospital’s gatekeeper permission letter, I cannot detail the names or the disciplines that each participant is from and, therefore, I have accordingly used pseudonyms in referring to participant responses and narratives.

3.6 Ethical Considerations

Ethics approval to conduct this study was provided by the Research Ethics Committee at the University of Pretoria. The reference number for the approval of this research is 15107923 (HUM008/0121). Once this was done, ethics approval and gatekeeper permission were obtained from the KwaZulu-Natal Department of Health (NHRD Ref: KZ_202106_008) as well at the forensic psychiatric hospital. The relevant approval letters are included in the Appendix.

Before being given gatekeeper permission, the hospital stipulated that the name of the facility must be removed from my report and dissertation, and that the facility should be simply referred to as a forensic psychiatric hospital to protect the identity and privacy of the hospital. They also informed me that the participants should not be identified by name or other identifiers such as profession. The reason that was provided related to the fact some of the professional departments are very small and therefore individuals could be easily identified by stating, for example, a male clinical psychologist said…..

To conduct ethical ethnographic research with human participants, informed consent is required. A consent form and information leaflet that included details about the nature of the research were drawn up and given to the potential research participants after the participants were verbally informed about the nature and purpose of the study. This form (see Appendix) explained all aspects of the research, the reason for the research study, that participation is voluntary, and that participants had the right to refuse to participate and to discontinue the interview at any time, without negative consequences. Participants were also informed that, should the research cause emotional distress, I will arrange for them to receive mental health care. This is necessary as these individuals may be affected by their involvement in my research, e.g. through answering certain questions that may provoke underlying emotional issues. It is noteworthy, that my first responsibility is to my research participants and to ensuring their well-being, safety, anonymity, respect and dignity (Orb, et al., 2000). For this purpose, I had arranged with clinical psychologists whom I knew in the Pietermaritzburg area to be available to assist participants who may show adverse reactions following the interviews.

In writing this report, participant’s names had to be changed to protect their identities. I have therefore used pseudonyms (numbers) to safeguard my participants’ identities. Anonymity in ethnographic research is a longstanding practice to protect participants (McGranahan, 2021). As required by the gatekeeper permission, I will provide a copy of my report to the hospital once it has been accepted and passed by the university. I also intend to give my research participants feedback from my findings at that stage, including what I have learnt from them and how they have assisted me in completing this Master’s degree.

It is important for me to note that the information that my participants shared are a true reflection and that it has not been manipulated to suit any preconceived research outcome. I am pleased to note that none of the participants reported adverse events, such as unwanted emotional responses, harmful reactions, etc., and there were no requests for psychological or other assistance following the interviews. Also, no participant opted to discontinue participation once they had begun interviews. All of the data collected during this research will be stored on a password protected computer to which I alone have access, for five years, as is required by university’s research ethics guidelines. I also informed my participants that the digital data will be erased from my electronic devices once I have transcribed the interviews for the analytic procedure, but that those copies will be securely locked in a secure environment in accordance with the university’s ethics procedures. In navigating the ethical issues in health research, I accept that I may not be privy to certain patient information. I have also conducted the research in a manner that abides by the ethical research guidelines of the American Anthropological Association (1998) and Anthropology Southern Africa (2005). The ethical research guidelines of the American Anthropological Association (AAA) and Anthropology Southern Africa (ASA) provide procedures to ensure that ethical considerations are central in anthropological research. Both organizations emphasize respect for the welfare, dignity, and rights of research participants, requiring informed consent and confidentiality. The AAA and ASA also stress the importance of collaborating with research partners and communities to ensure appropriate representation, and promoting responsible, culturally sensitive engagement with research participants. The guidelines require anthropologists to work towards avoiding harm, discrimination, and exploitation, while promoting social justice and sustainability. Together, these guidelines aim to promote ethical research practices that respect the rights and wellbeing of research participants and their communities.

3.7 Data analysis

Since ethnographic research is a form of qualitative research where the researcher observes, converses with, and/or participates in the lives and work of the participants in their own environment, large amounts of data are usually gathered. Given the restrictions put into place due to the COVID-19 pandemic, I was unable to enter the hospital environment, but rather relied on conversations via online platforms. The resulting data has to be analysed in an acceptable, scholarly manner, in order that meaning can be made from the data, and that could render it useful in understanding the field site and even for informing change and policy development if relevant. In this regard, there are several approaches to analysing data obtained from ethnographic and qualitative research. According to Braun and Clarke (2006) thematic analysis is an established method of analysing qualitative research data which seeks to identify, analyse and report patterns that emerge within the obtained data. Since my research was expected to produce a large amount of qualitative information from participant responses, the thematic analysis approach appeared to be well suited.

Ethnographic data lends itself to the interpretive approach of *Thematic Analysis* which, according to Braun and Clarke (2006), can be used quite effectively by researchers with little research experience, and has the advantage of being able to summarise the main features of large amounts of data. They also note that this method of data analysis can also generate insights that were not anticipated in the research, and can be useful for analytical processes that are geared towards informing the development of policy.

Under the circumstances we find ourselves in during a worldwide pandemic, the type of optimal interaction with participants and maximum observation within field-sites that is usually expected in ethnographic research was not possible. Nevertheless, participants were very responsive to the interviews and I found them enthusiastic to speak to me about their work and experiences within the mental health system. As a result, the participants provided extensive amounts of data which far exceeded my expectations. The accounts and narratives given by the participants were recorded using a digital recording device and analysed, looking at the emerging themes, in a way to give meaning to the research and the participants' accounts and experiences.

Unlike quantitative research that produces numbers and statistics as findings, which have to be calculated and analysed using statistical tests, qualitative research results in verbal accounts, views, stories and rich descriptions provided by the participants, some of which are shared by the various participants being studied. Guest et al. (2013) noted that earlier anthropologists such as Boas and Malinowski focused on issues of shared belief systems and practices, and such a perspective is relevant in the present study. This is because, although the research participants are all mental health professionals, they are from different disciplines, and it is important to understand how similar or different their views and experiences of mental health care may be. To this end, as the researcher, I had to carefully read and re-read the narrative accounts captured in the verbatim transcripts many times, before attempting to analyse the information, in order to understand participants' experiences and perspectives.

Chapter 4 – The Multidisciplinary Team (MDT) and 'Therapy Managers'

This chapter presents and discusses the interview data that was obtained from my conversations and interactions with the participants, in relation to the multidisciplinary team (MDT) and 'Therapy Managers'.

4.1 Summary of findings and emergent sub-themes

For meaningful exploration and discussion, this chapter is sectioned off into the themes that emerged from the conversations with my research participants. Under some of the thematic areas, sub-themes are discussed. As mentioned in the Ethical considerations section earlier, the stipulation by the hospital prevented me from identifying participants by descriptors such as profession, and other variables. Therefore, even though it is not ideal, the informants are described as Participant 1, 2, 3, etc.

4.2 What is a multidisciplinary team?

The team responsible for providing specific services is referred to as a Multidisciplinary Team (MDT). According to Taberna et al. (2020), the primary function of an MDT in a clinical environment is to harness the talents of a group of professionals from the relevant specialties in order to consider and develop an optimal plan of care for a patient, incorporating both the diagnostic and treatment aspects. In modern health care, this is now regarded as best practice, and is standard around the world.

Within the forensic psychiatric hospital of study, the MDT consisted of clinical psychologists, psychiatrists, occupational therapists, social workers and psychiatric nurses. Each discipline has junior or trainee staff who may also be regarded as first-line clinicians for that department, e.g. psychiatrists have medical officers; clinical psychologists have intern clinical psychologists; registered psychiatric nurses have enrolled nurses and nursing assistants; Occupational therapists and social workers have aides or assistants. As I mentioned earlier, during my application for gatekeeper permission, the ethics committee at this hospital had requested that I refrain from identifying which discipline my participants are from, as they may be easily identifiable since some disciplines are quite small. The implication this has for my study is that the prevention of identifying disciplines restricts certain information being used as it will be easy to identify the participant based on number of years served at the facility as well as discipline, as there is a much smaller number of staff working at the hospital for over 20 years.

4.2.1 Biomedicine – the psychiatrist and medical officer

During my interactions with my participants, discussions around the roles of their discipline within the psychiatric facility became a topic of conversation. In a conversation with Participant 8, she stated that although the nurses are the first-line contact with patients, the medical officers are involved in the admission of patients into this psychiatric facility.

"*When patients are brought into the hospital, uhm… the medical officer is usually the first professional he/she comes into contact with. The patient undergoes a medical examination upon entry to the admission ward and spends up to 72 hours before being moved to other wards in the hospital"*.

Participant 10 expanded on this aspect of the clinical work, stating that the role of a medical officer was to

"Firstly, do a full health assessment… then he does a mental state examination … then he orders any other tests like a CAT scans, EEG, bloods. In his mental health examination, besides the physical health examination, he asks a whole lot of questions to determine whether the patient is psychotic or not and then he will prescribe the medication accordingly. After 3 or 4 days the medical officer will…by then the medication would have started to work and then the medical officer will do another mental state examination where he asks the patient a whole lot of questions and then he will also ask the nurses for their input. Then if he is still not satisfied he will ask that the patient be presented at the next ward round"*.

*Gender representation transcribed exactly in participants' words throughout this dissertation

Considering the medical officer's discipline, the approach to treatment is purely biomedical. This reveals the dominance of the biomedical approach as the first-line care when patients are admitted. While one might want to view this as medical hegemony, it is important to understand also that this safeguards the patient, because a patient could be admitted with unreported (even serious) physical illness that requires treatment. Although one obviously thinks about the 'clinical gaze', that Foucault (1973) described, there is no evidence here that the patient's view is not considered. Misselbrook (2013), however, does note the tendency for the biomedical practitioner to look at the patient and assess how he/she fits into the biomedical paradigm (i.e. "whether the patient is psychotic" Participant 10). As Participant 10 noted, if the medicines have not worked after a few days, the patient will be presented at the next ‘ward round’ which is the MDT meeting. While this indicates the authority structure in the team (i.e. the doctor as the conductor of the orchestra), it is also a positive sign. It shows that the doctor is not restricting the diagnostic and treatment processes to biomedicine, but is wanting to get the input of the other team members as well. In other words, the team is being involved in the decision-making process – a definite move forward from mental health care of the past. This is in line with the work of Haines, et al. (2018) who note that MDT meetings are very valuable, although they argue that there is a power component, determined to a large extent by the team’s characteristics, and that a completely collaborative, democratic team approach may not always be a reality. This is true in any organisation. The personalities involved will obviously be influential. During conversations with my participants, it became clear that the medical officer, in many cases assumes the leadership role of the MDT during the ward rounds/MDT meetings.

As indicated above, the medical officer works under the psychiatrist, who comes into contact with the patient during the ward rounds (i.e. the MDT meetings). Here, the psychiatrist, who is a medical doctor who has specialized in the field of psychiatry, works together with the MDT to review patient diagnoses, treatment (especially medication) and management. However, in the case of persons who are sent by the courts for the period of mental observation (discussed in section 1.6 (iii)), the psychiatrist has direct contact with the individual, because it is more often the psychiatrist who reports to the court and will be called to court to testify on the patient’s mental state (clinical psychologists are involved to a lesser extent in these cases). Regarding the psychiatrist’s role, Participant 3 stated,

“*For example, those who are coming in for observation are assigned immediately to...to the psychiatrists and the psychiatrist would, in the consultation with the multidisciplinary team, decide who and what is required. So, for example in a particular case the psychiatrist may decide that well there is a need to get a detailed social work background because more information is needed about the individual’s early life, their family background, the social context in which the person lives, etc. So, in such a case, the psychiatrist will then… would refer to the social worker to be involved in the case. Using another example, the psychiatrist may be concerned about the person’s level of intelligence. Whether this person has a cognitive level, an intelligence level to understand uhm whether, what is going on… whether he is able to understand questions, for example, when he has to go to court. The psychiatrist may want a cognitive test to be done if there might be concern of whether this person’s thinking ability, in* *terms of his understanding of right and wrong. What was the person's cognitive abilities like? So there also, the psychiatrist may want a clinical psychologist to be involved.*

This excerpt points clearly to the psychiatrist being in charge of the processes and functioning of the overall clinical system. Haines et al. (2018) note that in MDTs the legal frameworks entrust greater control in certain disciplines that are designated with legal responsibility. In their study, Stacey et al. (2016) found that, for psychiatrists that responsibility meant making the decisions rather than shared involvement in decision-making. In the context of this forensic hospital, and the South African legal system, the Criminal Procedure Act of 1977 states that the person is sent specifically to the psychiatrist for observation and reporting, and only in certain instances to a clinical psychologist (Republic of South Africa, 2008). Therefore, it is the psychiatrist's decision regarding from whom specific tests or opinions should be requested, which will be incorporated into the final report to the court.

4.2.2 Occupational therapy

In terms of occupational therapy, Participant 10 explained,

"*For example, the OT will determine their abilities in terms of their day-to-day functioning, to see what is it they can do, and what is it they can't do. Occupational therapists may also be called in terms of helping patients get more training and more experience in terms of using their skills, both their cognitive skills and their manual skills… helping to prepare them for the work life etc.*"

From this excerpt and what came through from the interviews is that occupational therapy was involved in the patient care in certain specific instances, rather than in every case, unlike the case for medical officers and psychiatrists. This is an interesting issue in several ways. First, it brings to light the idea that the occupational therapist functions as a specialist who is only drawn into the frame when the patient has a specific concern, or when there is an assumption that the patient might one day be able to function in a work environment, or to prepare the patient for the work setting. Second, the role of the occupational therapist is often misunderstood, with research revealing that they are not always included in broader decision-making (Simpson et al., 2005). As this participant indicated, the occupational therapists perform significant functions in terms of enhancing patients' day-to-day functioning and preparing them for work situations. This is important considering that the hospital concerned has many chronic patients with conditions like schizophrenia and other severe mental disorders, which lead to deterioration in daily life skills and occupational abilities. Participant 1 gave the following opinion on this issue,

"However, there are a couple of smaller disciplines, in terms of staff numbers, who make very valuable contributions to patient care, but they do get over-shadowed by the larger, more dominant disciplines like medicine, which is a pity."

This participant obviously believes that the occupational therapists play a significant role in patient care, but notes the power dynamic of the MDT. The narrative clearly notes that there are some disciplines that are more dominant, and it is quite evident that the medical discipline is one of those. As Simpson et al. (2005) point out the role of occupational therapist and their visibility could be improved in various ways. From a medical anthropological perspective, one cannot help thinking of the dominance of the biomedical model that is likely responsible for the situation, given its long tradition in hospitals and health care. As a result, biomedicine appears to have stamped its authority and the other, smaller mental health disciplines, may be backgrounded, for example; Occupational Therapy, Social Work and Psychology. While it may be argued that the MDT can serve to subvert biomedical hegemony because it incorporates the input of various disciplines, the dominance of biomedicine can be difficult to over-ride (Weber, 2016).

4.2.3 Clinical Psychology

The department of clinical psychology at this forensic psychiatric facility, plays an important role in the diagnosis, treatment and recovery of patients and court referred cases. The duties of clinical psychologists include conducting psychological assessments for clinical and court purposes, and psychotherapy. Participant 6 stated,

"*If a cognitive test needs to be done when there is concern about an individuals' thinking ability, in terms off his understanding of right and wrong, then a referral is made by the psychiatrist to the clinical psychologists. Also, the clinical psychologist will do personality and neuropsychological testing where needed. The … focus is not just on treatment but the focus is on evaluation of the person, and that's where the clinical psychologists come in.*"

Participant 1 gave some detail about the intervention work done by the clinical psychology department, saying

"For example, if we look just at the facility that we work in, where a big portion of our work is with long term state patients, where the focus is on rehabilitation, what we call Psychosocial

Rehabilitation. This is aimed at preparing patients for reintegration into society, especially considering that with their illness and behaviour, families and community tends to alienate and marginalise them."

As we can gather from Participants 6 and 1, the clinical psychologists are involved in diagnostic work, conducting clinical interviews and psychological testing, as well as psychological treatment work, including helping patients work through their emotional problems, as well as prepare for discharge and life outside the hospital. Similarly, Foucault (2001) and Scull (2015) referred to "The Great Confinement", which was the period between 1650 and 1900 in Europe where the psychiatric asylum was developed as a confinement house rather than a space for treatment for re-entry into society, but the MDT approach at this psychiatric hospital is obviously quite different. It is evident that the hospital MDT is keen to get patients discharged and back to their communities, which is evident in their psychosocial rehabilitation programme – a treatment approach that involves life skills development, not relying on biomedicine. This is a most encouraging aspect in modern day mental health care.

An inclusion of spiritual treatment has also been proposed which can be seen by the BioPsychoSocialSpiritual model, which combines psychological, physiological, social and spiritual aspects of an individual in their diagnosis and treatment (Beng, 2004).

4.2.4 Nursing

In terms of the nursing discipline, we must remember that nurses spend more time interacting with and caring for patients than any other discipline. So, in the workings of this psychiatric facility nursing is a very important discipline for the care and treatment of psychiatric patients. According to Participant 3,

"*Nurses play a bigger role in a patients' treatment than any other team member. As the nurses spend the most time with patients', they are able to monitor their progress and report back during MDT meetings and ward rounds.*"

Participant 2 noted that,

"We have high numbers of patients, and we have professional nurses and enrolled nursing assistants, which is like just caregivers, you know, who do just the basic work for our patients."

Participant 10 added that,

"The nurses see the patients a lot more than the other staff. So, they are able to assess whether the patient is improving or deteriorating on the medication. The nurses are also able to observe any abnormal behaviour."

What is very apparent from these excerpts from three different participants is that the role of the nursing discipline is key to the patient care system. Participants seem to be uniform in their view of nurses as critical to the day-to-day functioning of patients while in hospital, and in monitoring their progress and keeping the MDT informed. These participant responses are very much in line with research findings confirming that nurses make up the major workforce in the MDT, placing them in a critical position providing care amidst the substantive challenges that arise when managing mentally ill patients (Joubert & Bhagwan, 2018). The implication of this is that other members of the MDT may overlook and take opinions and feedback from nursing staff as unimportant or irrelevant due to the traditional "hierarchy" system within the MDT.

4.2.5 Social Work

The final discipline, that I would like to discuss, working within the MDT at this forensic psychiatric facility are the social workers. From the participant responses it emerged that this discipline works with patients' directly, both in gaining the important background details, family history data that the MDT needs to better understand the patients and their mental health problems. They also provide interventions in individual, group and family settings, depending on the circumstances. Clinicians in the social work discipline also have significant amounts of contact with patients' family members and "therapy managers" as Feierman and Janzen (1992) referred to the key individuals in the patient's social support network. According to participant 4, social workers are generally required, during MDT meetings, to

"provide a detailed social work background because more information is needed about early life of the individuals… early life, their family background, the social context in which the person lives, etc. So, in such a case, the MDT would request for a social worker to be included in the specific case."

Participant 3 gave a very similar perspective on the role and input needed from the social work department at this hospital, stating that,

"in a particular case the psychiatrist may decide that, well, there is a need to get a detailed social work background because more information is needed about the individual's early life,

their family background, the social context in which the person lives, etc. So, in such a case, the psychiatrist will then… would refer to the social worker to be involved in the case."

Evidently, the social workers form a significant link between the mental health team and the patient's family and significant others. It is easy to understand the value of obtaining information about the patient's life history, especially their early life, given how mental health is so closely tied in with earlier life experiences (Hughes, et al, 2016). In this respect one sees that the MDT relies on the input of the social workers, because without some of that key background information, critical processes like formulating the correct diagnosis can be negatively affected. Of course, the referral dynamics again come through, and almost reflect a form of structural hierarchy noted earlier where the social worker does not make an independent decision to consult with a patient, instead it is on referral from the psychiatrist or medical team member who decides on that. This is consistent with the analysis given by Haines, et al. (2018), of how MDT's function and the power dynamic within them. Nevertheless, the team seems to work amicably and productively in the interest of patient care, which is the general impression I gained from all of the participants.

Summary of the MDT functioning

These responses of the MDT members strike an interesting chord for me as a researcher who is not a mental health care practitioner, and as an outsider looking in, through the virtual ethnographic approach (Miller 2020; Hines 2008; 2015). The descriptions from the participants regarding the discipline-specific roles and the way the MDT works, relates very much to Max Weber's theory of bureaucracy and authority (Jain, 2004). Weber argues that organisational tasks should be divided among the employees, and the division should be based on competencies and the specialist capabilities that the employees have (Harappa, 2021). Of course, Weber's theory has been subject to criticism that includes its rigidity of rules and regulations, the hierarchical system that lends itself to dominance issues, as well as the fact that this theory was developed specifically in the context of Western societies a century ago (Blau, 1963).

The ways in which these disciplines are able to work together as a team, work in collaboration with patients and "therapy managers" and other key roles players within the hospital are vital to the overall patient care. According to CordisBright (2018), multidisciplinary teams are tasked with coordinating skills and knowledge provided by each team member to be able to provide the best quality of care for patients. Although each discipline may not be equally involved in every patients' treatment, specific disciplines will be required to provide their input on cases as and when needed. This allows for a variety of opinions and theoretical views on diagnosis, so that a richer picture of the patient's mental health emerges. This allows for treatment approaches to be formulated in a more holistic way, instead of the historical biomedical approach dominating. The psychosocial rehabilitation approach described by Participant 1 is evidence of this, given that the intervention is non-medical and aimed at improving independent functioning and community living (Kramers-Olen, 2014). According to Participant 1, and similarly with Participants 3, 9 and 10 – those participants who have worked in this facility for more than 30 years – treatment approaches and the hospital's thinking about mental health care has changed drastically. For example, Participant 3 noted that,

"we have a lot of family contact that we have like open days, as days where we invite families and families are educated, each discipline will have a chance to speak to families like the doctor, educating the families on the treatment plans and such."

Previously, treatment plans and options were to a large extent, purely biomedical. This meant that the discipline of psychiatry and biomedicine was completely in charge of directing what treatments were used. While biomedicine does, to a large extent, still dominate mental health care, there has been movement toward inclusivity of different disciplines within healthcare, consulting traditional health care, as well as the inclusion of family members in this process. Psychotherapy and related rehabilitation programmes are now much more in use. Since this is more of a collaborative process, the inclusion of patients and, family members or "therapy managers", is important in the effective treatment of patients (Swientozielskyj, 2015). This represents a more progressive era in mental health care, unlike the time of the 'Great Confinement' when the power of biomedicine was greater (Foucault, 2001; Scull, 2015). Similarly, from the perspective of critical medical anthropology, one would view this positively since the power issues seem to have shifted over time, and are now more in the patient's favour. However, one would also want to know about the specifics of the power relationship between the MDT (as a whole) and patients and their families. Additionally, there would be questions about the ways in which understandings of mental health/illness at the community level articulate with those of the MDT.

Although there appears to have been a move away from the traditional system of mental health care, and a reduction in the levels of medical hegemony and biomedical dominance, that was evident in the previous century (Parle, 2007), it is important that we consider the current state of care with a critical eye. For example, how do the decisions get made about exactly when patients are considered well enough for independent functioning and discharge, and who gets to have the final say. The impression gained is that, even though patient and family views and opinions are considered, the final decisions rest with the MDT, and largely the biomedical discipline.

4.3 Interactions with “therapy managers”

As I have outlined earlier in this research dissertation, “therapy managers”, family members and caretakers, play a vital role in the treatment of patients. According to Feierman and Janzen (1992) “therapy managers” play a major role in patients’ treatment, deciding on health care providers, participating in decision-making, visiting patients and, in many cases, ensuring a smooth transition back into society when treatment is complete. During my interviews with participants, a big area of conversation surrounded interactions with patient’s families and support network (“therapy managers”) and the ways in which members from the different disciplines engaged with family members and significant others with decision-making capabilities.

Social workers, nurses and clinical psychologists within this forensic psychiatric facility have the largest amount of contact with patients’ family or “therapy managers”. Other MDT members also interact with patients’ families, but to a lesser extent. From several conversations with participants, it seems clear that the extent to which interactions take place vary from patient to patient, due to each patient’s specific needs. In many unfortunate cases, families do not want to have contact with the patient for reasons such as stigma, previous altercations, and/or for reasons relating to the crime (for those who were declared State Patients). In this regard, Participant 2 had had this to say:

“*Families are allowed to come at least once a week, and all our patients are informed. We contact families, but the sad part is some families change the phone numbers, and we are unable to contact them. And look now with COVID we can't even go out into the community because of the disease, you know. Yeah, so a lot of families actually shy away from the patient's leave of absence or even visiting them. They like are not forgiving them for the crimes they have committed, because remember, our patients here, have committed murder, some robbery, so families are not always too forgiving.*”

Similarly, Participant 10 reported that

"Some patients' families come to visit when we ask them to come, and they bring food or other things for the patient. But there are also many families that don't come to visit. It's as if they don't want to have anything to do with the patient. That is really sad, especially when some patients see other families coming to visit they feel quite bad. Our social workers also try to do home visits, and some respond well, but others do not seem to care."

Stories like these two cases are not uncommon. Participants mentioned that patients tend to question them as to why their families have not come to visit. According to Participant 4, their discipline's contact with "therapy managers" can go on "forever". The participant noted that this included family, friends, the surrounding community of patients during their leave of absence, and the local clinic in the patient's community to which he/she is referred during periods of leave or on discharge. The participant further indicated that 'home visits' were conducted at certain times, especially prior to discharge or leave planning. This is quite an intensive exercise, considering that some of the visits are to places that are quite remote and rural, as Participant 6 noted. However, it is clear that there is a genuine interest shown by the team members in trying to get the patients discharged or sent on leave to a home environment that will be able to care for him/her adequately. These home visits are also needed to inform accurate reports to the courts when applications are made for leave or discharge, because courts want to know about the home support systems. Therefore, it is clear that MDT members are involved in these home visits in order to make accurate assessments. It also goes on to speak to the invested interest that the MDT have in the maintenance of patients' well-being in the community.

4.3 Families' cultural beliefs regarding mental illness

According to Sue and Sue (1999), psychotherapy and counselling are rooted in a Western paradigm, and there is still a great need for a more culturally appropriate and sensitive worldview to which patients of non-western cultures can relate and in which they can find meaning. This is important since the field of mental health care is not applied specifically to one community or cultural system. The inclusion of traditional views relevant to patients' communities and cultural backgrounds is crucial, especially in a multicultural society like South Africa which experienced a history of structural racism and epistemic injustice (Fricker, 2007) that saw various cultural systems marginalised and disrespected. For example, Participant 4 stated that if a family member wanted a patient to see an indigenous (traditional) healer for an opinion or spiritual blessings then they (the 'therapy managers') are encouraged to apply for leave of absence for the patient, so that he/she can be sent home for a short period to consult an indigenous healer. There was no objection from the MDT.

Participant 9 stated that as clinicians they are respectful of patients' and family's cultural views and belief systems, noting,

"*For instance, if someone will then blame it on witchcraft or blame it on the ancestors, and things like that, when they could do things differently. However, my approach has been always to try and accommodate the family if they think performing a ritual will ease the symptoms. I do, upfront, declare my limitation in that regard, and tell them how I see it as a clinician, how I see their problem as a clinician, however, if they think that rituals could assist I don't prevent them from do that, or discourage them in any way.*"

According to Participant 1, this was not always the case, especially during the apartheid era, because when clinicians were confronted with patients' and families' alternate explanations for illness, they were quite negative.

"The hospital management and clinicians previously, during MDT meetings would not want to hear of alternate explanations of illness. During that time, things were situated in a biomedical treatment plan. Mental health practitioners now though, are a lot more accommodating to patients."

Participant 8 also reflected a similar experience:

"Because like, there were family that come to us and to the hospital and say, my family member passed away, ... such and such were the rituals they have to do. We have to come and do the prayer in the ward. So anyway, and then we do accommodate them. We don't reject whatever traditional thing they wanted to do for the patient."

According to Jenkins (2007), globalization had a significant effect on the discipline of mental health and created an emergent need for awareness of cultural factors and worldviews in relation to mental health care. It is, therefore, vital that mental health care clinicians develop a more inclusive approach to health care, as noted by my participants. Moreover, the South African Department of Health supports the approach of incorporating traditional healing practices into the formal health care system (Mokgobi, 2013).

However, the MDT has the task of navigating the issue of 'therapy managers' wanting to play an active role in the patient's treatment, which they want to encourage, and situations where family members pose alternate explanations of the illness and desire a complementary indigenous healing approach. This must be understood in the context of Kleinman's Explanatory Model where he argues that how the patient feels is as important as how the doctor conceptualizes the disease, if not more important (Kleinman, 1988). According to Participant 7,

"We've never had a case where they wanted to bring a traditional healer to the hospital, we do have cases where the traditional healer requests a patient to come and visit them, and tell us that actually, the patient needs to undergo some traditional ceremony or ritual for them to get better. In fact, we don't necessarily disregard that, because that's the system as well. But again, we try and psycho-educate them, in terms of saying, we would try not to mix pharmacological treatments with whatever medicine."

The request to perform a traditional ceremony or ritual is not at all an unusual one (Srivastava & Panday, 2017). In fact it speaks to the research showing that certain cultural presentations of the calling to become an indigenous healer, known as *ukuthwasa* (in IsiZulu) may appear as mental health symptoms to westerners, but the individual and the family are required to perform a ritual to the ancestors (van der Zeijst, et al., 2020). Similarly, it has been found that cultural presentations may show similar signs as mental illness, but culturally contextualised as a result of supernatural causes, evil forces or a response from God (Hodgkins, 2007). An example of this include evil forces such as witchcraft which may present with symptoms identified in the DSM-V- TR as Schizophrenia (Kanyiswa & Leickness, 2006). It is critical that such presentations are not confused with mental disorders, because they would clash with cultural belief systems and can affect the individual later in the spiritual part of their life. Currently MDT members rely on individuals within the team who are familiar with the cultural belief systems and who are able to discern whether the presentations are mental disorders or supernatural in nature. It is for this reason that Mkhize and Kometsi (2008) argued for mental health practitioners to be trained to recognise these presentations and be able to work alongside indigenous healers, rather than in competition. Currently, plans are underway for the development of a professional body for traditional healers, that could eventually result in health care professionals referring patients to traditional healer. However, this process is yet to be fully developed and operationalised.

Participant 2 stated,

"Occasionally a patient doesn't want to use the medication and the family wants to use cultural aspects and, you know, sometimes involve witchcraft" (participant defines this as the consultation of traditional healers, to ward off evil and negativity that may have been cast onto the patient).

I have to concede that I was a little surprised to hear the participant mention that in one case the family members were trying to convince patients not take the western medication. The shock and horror radiating from my participants' voice when relaying this story was ever so distinct. She described how she was appalled by the unwillingness of her patient and their family to take the western medication. However, it is important to stress that among all of the participant responses I received, this was the only such response. Nevertheless, we must view this in the context of the arrogant manner in which biomedicine was imposed on the continent of Africa, and hence the lack of trust that many communities are likely to have on western medicine (Feierman and Janzen, 1992). The health care system must have a space for such patient and family concerns. It has long been argued that the contextual and life circumstances of the patient should be considered in any treatment effort that is planned, because the patient must be a central part of the process. In terms of the Explanatory model of health and illness, Kleinman (1988) argued that each patient has a way of explaining their illness, emanating from their cultural system, and this must be considered in developing treatment approaches that the patient will find acceptable.

It is important to remember that the patient comes from a cultural background, and will be returning to the context. Therefore, his/her treatment must take that into consideration. As Hudelson (2004) noted, culture is like a glue that keeps the community together, and that is important, because when patients return to their community and take their rightful place, they must still feel comfortable and a genuine part of the group. Any attempt to impose western medicine in isolation of the patient's cultural belief system will take us back to the position when biomedicine was violently imposed in Africa (Feierman and Janzen, 1992).

As we progress through the 21st century with modern medicine and the scientific approach bringing great discoveries and treatments, it is vital that we also do not leave patients behind. In her work, Alice Street (2004) raised concerns in this regard, of the structural inequalities that can compromise interactions with patients' families, which is an example of the power relations dynamic that can influence interactions with 'therapy managers'. Situations of epistemic violence, as described by Gayatri Spivak (1988) where attempts are made to 'silence' certain groups whose views are not consonant with the dominant view are destructive and not conducive to helping subaltern populations. As Livingstone (2007) found, in her work in Botswana, there is no need for one system to be dominant, because biomedicine and traditional healing can coexist quite compatibly, with patients using both systems as and when they felt the need. Earlier South African research also noted a preference among patients, especially in rural contexts, to have a collaborative form of health care and where they can access both (Muelelwa, et al., 1997). It is, therefore, gratifying to find that, in the main, clinicians are accepting and understanding of patient and family ("therapy managers") views and belief systems, and are willing to consider them in the overall treatment process. This speaks to the biopsychosocial model of health that George Engel (1977) introduced to the world close to five decades ago. However, Sulmasy (2002) added that a holistic approach to health care is needed in order to address the totality of the patient and his/her problems and in order to do this, it is necessary to include a fourth dimension i.e. the spiritual dimension to the BioPsychoSocial model – as a result leading to the BioPsychoSocialSpiritual model being developed. While this model has been put into place, tension still exists within institutions where the adoption of this model and the inclusion of different belief systems exist. Within this facility, however, there is a lag in its total inclusion within the therapeutic programme, as we are likely to find in mental heath facilities elsewhere, given the biomedical legacy.

4.4 The language gap in the mental health care facility

Drennan & Swartz (2002) pointed out that in the South African health care system, a "language gap" has long existed between patients and clinicians. Of course, we have to also understand language in its rightful socio-political context, because language was used a tool by the apartheid government, and earlier colonialism, within their oppressive structures. We can think here of the world renowned 'Soweto uprising' that gave the anti-apartheid struggle movement much impetus, and it was largely stimulated by young school pupils' opposition to being forced to learn the language of Afrikaans. Elkington and Talbot (2016) noted that we need to understand language within its power dynamic context and also that it served to limit access to certain services. Clearly in democratic South Africa, that has to be addressed.

The language issue in health care is obviously a serious concern, especially if patients are not able to accurately describe their illness and history to the clinicians, and also if clinicians are not able to adequately understand the patients' complaints or convey important diagnostic and treatment information to the patient and the family. In an earlier work, Drennan, et al. (1991) noted the way a language gap or barrier showed up the inequalities of the system, for example, when a Western-based diagnostic tool like an English-language depression inventory is used with people whose first language is an African language. Among the various problems with such practice, the problem of incorrect diagnoses is a likely result.

Considering that this psychiatric facility is situated in the centre of the "Kingdom of the Zulu", it was an interesting path to follow to unpack the ways in which clinicians viewed this issue and navigated possible differences in understanding and communicating with patients and their families. According to Participant 1,

"*Language is definitely a problem. Especially a bigger problem is with patients who are isiZulu speaking. That's the main language in KZN. And remember that a lot of our clinicians are English speaking. Obviously, we do have a large number of staff in the hospital, especially nursing staff, who are able to understand and converse in isiZulu. But among the other staff, medical staff, psychologists there's, there's a lot of people who are ... whose first language is English, so it is difficult. And we have no choice but to use translators.*

It is interesting to note here that translators are not officially employed by this psychiatric hospital (or in other Department of Health facilities) due to, among other reasons, insufficient funding. I will discuss the funding issue later. In terms of using a translator, in this hospital, the clinicians who are not proficient in IsiZulu, which is the main African language in KZN, tend to rely on nursing staff members to assist. Of course, the nurses are not trained in translating, and they have their own clinical work to do. Nevertheless, the participants indicated that nurses do help with translation, when they are able to fit that into their schedule. We have to also remember that using a translator in transmitting confidential health information between patient and clinician does carry some ethical issues of concern. However, as participants pointed out, because they are aware of this concern, they prefer to ask assistance from nursing staff who are also part of the MDT and registered health professionals, as opposed to some other individual who is neither. This was noted by Participant 3, who stated

"*It's not an ideal approach. Because for one thing, there's the confidentiality problem that tends to be interfered with, because you got a third party now in the room. That's the one thing but of course, that's also why we will try to enlist the help of a translator who is another health professional, instead of, for example, using a translator, who is not a health professional. Because remember, health professionals are bound by ethics, confidentiality, all of those professional regulations. So that's the one issue. The other issue is, of course, that the there's no guarantee that the person is translating exactly what the patient is intending to convey. You* *know, because the person who's assisting with translating, is not trained as a translator. So that is another issue. Yet another issue, too, we often wonder about to what extent is the patient feeling a bit inhibited about having to now tell more than one person their story*."

These are important issues raised by the participant and speak to the value that the system is giving to hearing exactly what the patient is conveying and exactly what he/she is feeling, within the current constraints. Again, we think here of Kleinman's Explanatory model which emphasises the value of hearing the patient, in his/her own voice, describe his/her illness (Kleinman, 1988). This issue of clinicians not conversant in the patient's language of choice is, of course, one that has to be addressed. However, the answer, as participants noted, lies in government training more clinicians with the appropriate language skills. Sadly, almost three decades into our democracy the government has failed to do that to any sufficient degree (Pillay & Nyandeni, 2021). The language gap or barrier in health care must be considered in the context of structural violence, because, there are systemic issues for which the past and present governments are responsible, that are obstructing patients from receiving the best quality of health care that they deserve. A further issue is that, as noted, when nurses are available, they assist with translation, but what happens when they are not available? This is an even more serious problem, and speaks to Galtung's (1969) concern.

In addition, we must remember that the use of translators brings with it other issues such as a power imbalance, as well as a real 'barrier' in the literal and figurative senses. Participant 6 stated

"*There was always a power imbalance in the helping relationship with the patient, whether you've got a translator in the room, or whether it's simply the patient and the clinician, because that's how healthcare evolved. Now you're involving another individual into this process and may result in more distrust between patient and clinician*."

Having a third person in the conversation between the patient and the clinician, literally imposes a barrier between the two parties. We know from communication dynamics and psychological theory that such a barrier hampers the free flow of communication, feelings and thoughts. Furthermore, since the translator is usually another health professional, the patient can feel that he/she is being ganged up on, when he/she is alone on the one side and there are two health professionals questioning him/her on the other side.

4.5 Summary of Chapter 4 findings

The responses from the MDT participants have indicated that the disciplines involved in the clinical teams have very specific duties and contributions to the mental health care of the patients. This suggests a holistic approach to patient care, and even though biomedicine appears to be dominant, it is clear that there are additional inputs from disciplines like occupational therapy, psychology and social work, that were not incorporated in earlier times, as noted in Julie Parle’s (2007) description. While the MDT functions in a fairly democratic manner, with clinicians being able to give the input they wish to provide, there is evidence that biomedicine leads the MDT, with the medical officer being the first-line contact with the patient on admission and the psychiatrist making the decisions on which patients to refer to specific disciplines.

Regarding contact with patients’ families or “therapy managers”, it appears that social work is one of the disciplines having key interaction with patients’ families or “therapy managers”, although other disciplines are also involved. The programme of home visits to families to plan leave or discharge is a progressive initiative that is unlike traditional mental health care and suggests concerted effort to keep or re-establish the patient-family bonds, and to facilitate discharge. It also reveals the clinicians stepping out of their comfort zone (the hospital) and venturing to the community. An unfortunate finding has been that, although families are encouraged to visit patients in hospital, many do not visit, for various reasons, including not wanting to maintain contact in some cases. This is a phenomenon that works against the MDT’s attempts at family re-integration and discharge. However, we have to understand this in the broader context of the patients’ admission, their mental illness and the circumstances that led to their detention and/or involvement with the law. We think here of Scull’s (2015) description of the ‘Great Confinement’ and how the confining agents broaden to include the family, to the extent that the contact with the person with mental illness is broken. Biehl’s (2013) work in Brazil also highlighted the situation of families being part of the network, with government, that led to an isolating of the patient. The effect that this has on the patient is obviously significant, and the power of the people and structures around the patient are overwhelming and imprisoning. The institutionalisation serves to regulate and control the person and keep them outside of mainstream society (Fanon, 1963).

Regarding the role of cultural factors in mental illness, many families hold traditional beliefs, with some wanting the MDT to take this into account into the treatment process. Although it appeared that the MDT is generally open to their input and willing to accommodate alternative explanations and requests from families to include spiritual healing, the extent of this accommodation has to be viewed critically. The finding that the MDT attempts to educate families against mixing western and cultural treatment approaches may reflect an attempt to be politically correct, in the midst of biomedicine's reluctance to collaborate in mental health care. We have to wonder whether this is an attempt to quieten the voices of cultural input into health care because it is not consonant with the dominant view, as described by Gayatri Spivak (1988). This must be seen in the context of research showing that over 70% South African consult traditional healers (Zuma, et al., 2016). The fact that many clinicians do not speak the language of their patients is a significant concern, with the use of translation and, moreover, the absence of trained translators being additional problem areas constituting a structural inequality that continues to be a marginalising factor for this vulnerable group. This is consistent with the concerns raised by Alice Street (2004) regarding the way in which such inequalities compromise interactions with patients and their families.

Chapter 5 – Power Dynamics

Anthropology and critical medical anthropology as a sub-discipline offer an excellent way to examine the power structures within health care and how they impact patients and broader society. Using the tools of ethnography, the ability to dissect structures within a public healthcare system offers one the ability to understand how power may affect the provision of adequate healthcare. Ethnography also helps us understand the organisation of health care and how it can be improved (Savage, 2000).

In doing this research, focus was placed on examining the ‘clinical gaze’ (Foucault, 1973) and the ways in which power dynamics between MDT members, and the dynamics between MDT members, patients and their families have a ripple effect on the patient’s treatment and the care provided by clinicians. Although Foucault (1973) did not write about MDT’s and MDT members, I have tried to apply his work to these groups. In conducting this research, the aim of focusing specifically on clinicians and their relationships with patients, as opposed to focusing solely on patients, was a way of ‘studying up’. The concept of ‘studying up’ is an interesting one that was given to us by Laura Nader (1974) who suggested that anthropologists should use their ethnographic skills to also study the powerful and elite members of a community. Here she included all of those in power, like governments, scientists, clinicians, and even corporate entities, rather than only studying the people at grassroots level.

Within this research process, ‘studying up’ enables us to shine a spotlight on those individuals who have the ability to shape and mould the ways in which we understand mental healthcare. The advantage of this approach that looks at the clinicians and healthcare workers, as opposed to patients, is that it lends itself to a critical reflection of the system, the way that power is wielded and can point to ways of addressing issues of concern. After all, there is probably not enough research literature focusing on the powerful members in the community. Nader (1974) believed that it is crucial to do research among the rich and powerful individuals who are, in many cases, the decision-makers and possibly even responsible for some of the ills of society. C. Wright Mills (1956), the American Sociologist, believed that information is key to social transformation and, therefore, gaining crucial information and knowledge from and about the elite and powerful in society may aid in problem-solving and advancing society. Similarly, van der Wiel (2019) highlighted the lack of research done with clinicians in South Africa. She argues that research in this area is valuable as it will help guide the treatment of patients, because the more knowledge is available to clinicians, the more efficient the treatment can be. Similar to Mills (1956) and Nader (1974), van der Wiel (2019) argues that ‘studying up’ allows for the contribution to knowledge production and to understanding the connection it has with suffering in society. Nader (1974), goes on to state that the purpose of ‘studying up’ allows for institutional gaps to be made visible, and that is so important for us in South Africa with our histories of colonialism, apartheid and the present rampant corruption that is affecting government services.

5.1. Power wielded by the State over *State Patients*

The forensic hospital that I am studying, like other forensic hospitals in the country, have a large number of State Patients (described in detail earlier). The process by which people are declared State Patients and detained in a facility like this forensic hospital reveals an inordinate power vested in the courts (i.e. the State).

Participant 1 described the type of patients at the hospital, revealing the power and authority at one of the highest levels in the land, namely the courts:

"*Then the other group of patients we have as in-patients in the hospital are those who have previously gotten into trouble with the law, where they have been accused of crimes before and they have been found not fit to stand trial because of their current mental illness. Because of their mental illness it would be unfair for the courts to put them on trial because they are unable to defend themselves or advise their lawyers how to defend themselves so because they're unfit to stand trial they could be declared state patients. Now state patients refer to that group. The other reason why they could be made state patients is if at the time of their offence they were mentally ill…… The courts then order them to be detained in the mental health facility like this hospital and the facility then has to keep them in hospital for an extended period of time until they get well enough for the courts then to subsequently say well you're ready now to go home.*"

Participant 6 also raised a concern regarding the process by which a person is declared a State Patient and the way the law operates in this respect:

"And so, in a court of law, they haven't been found guilty of a particular offence for which they have been charged. I have raised this issue with colleagues in the National Prosecuting Authority, who assure me that there's always a very strong prima facie case against any state patient that is admitted. But the reality is that for many of these accused persons, they don't get an opportunity to go to court and to present the cases and although there is an allowance for a request for a retrial in the legislation, this practically doesn't seem to happen."

Participant 6 provided additional information on aspects of the discharge process for State Patients, reflecting the courts' role in those applications:

"The other difficulty that we face with state patients is around an application for conditional discharge. So, the Act allows for us as a treating team to apply, once the mental health care user is sort of stable and is managing quite well on leaves of absence into the community. The

legislation allows us to apply for a conditional discharge through the court, so of course the court still adjudicates the discharge of the state patient…. We cannot discharge a state patient"

These excerpts reflect the process that, the general public may not be aware of in terms of criminal justice system and what happens to people charged with crimes who are mentally ill. Clearly, as participant 1 noted, the court makes the final decision as to whether the person can be tried for the crime or whether to detain him/her in a forensic hospital for treatment of the illness. As Participant 6 noted, the discharge process is not a simple one. It requires applications to be made with considerable documentation and clinical reports. The participant also made it clear that the MDT and hospital does not have the authority to discharge the State Patient. This phenomenon is in line with Weber's theory of bureaucratic authority (Harappa, 2021). Authority is vested right at the top, and while it is expected that courts will function with fairness, there is always concern in cases of State Patients. Firstly, a person is usually declared a State Patient without a full trial like any ordinary case, as Participant 6 stated above. In this regard, Louw (2006) pointed out, it is quite possible that a person who is innocent of the crime could be regarded as having been involved in the crime, made a State patient, and spend years or decades detained in a forensic psychiatric hospital. This is because, without a complete, exhaustive trial of the evidence, the burden of proof is a less stringent one, and this is clearly unfair to the person with mental illness, who may have just happened to be in the wrong place at the wrong time, and due to his illness and the Criminal Procedure Act 51 of 1977, he/she is not given an opportunity to argue his/her case (Republic of South Africa, 2008). This can be considered an epistemic injustice, as described by Miranda Fricker (2007) because individuals are being prevented from giving their version of events simply because they are mentally ill. However, the injustice is even more serious than Fricker described, because in these cases the individuals are incarcerated, sometimes for decades as a result of that prejudice. It speaks to the power of the State as the chief incarcerator and the unfair manner of application to people with mental illness, because the general public is not treated in this way. Even though Foucault (1998; 2001) described power as diffuse, coming from everywhere and not necessarily located in a structure or agency, it is in the legislation, the courts, the clinical decision-making regarding wellness, and the lack of family support (in many cases), that the power resides, with the patient being quite powerless in this myriad of control.

Secondly, it is very difficult to get a State Patient discharged, as Participant 6 mentioned. This is because the court is very strict in the extent of assurances they require from the clinicians regarding the person's future behaviour and whether he/she will engage in offending behaviour again. This type of prediction of future offending is virtually impossible to make with certainty, according to the MDT members that I have interviewed. The scientific research shows clearly that assessing future dangerousness and predicting violence is a much more complex issue than commonly assumed, and the general success rate is poor among practitioners who assess dangerousness as part of their work (Ward-Lasher, et al., 2017). As a result, many of the applications for discharge from this hospital are refused. We see, here, how structural impediments in the form of the criminal justice system and its inflexible approach, fails to consider the nuances of mental illness. In addition, the discrimination against people with mental illness and their bid for freedom is evident, because so called ‘normal’ individuals serving prison sentences for a crime are usually released after their prison terms, without any assurances or guarantees from anyone that they will not engage in criminal behaviour again. Clearly, this reflects double standards. This approach is similar to Goffman’s (1961) description during the mid-1960’s and early 1970’s when patients were kept like prisoners in ‘asylums’, as they were called, so that they are separated from society. He noted that the restrictions on patients’ freedom was consistent with Foucault’s analysis of how power and control were wielded keep people with mental illness in submission.

In a somewhat similar situation, and closer to my research in KwaZulu-Natal, Julie Parle (2007) noted that in the period prior to 1918, colonial mental health care placed the power in the hands of the courts and lawmakers, rather than clinicians. She went on to add that decisions regarding the mental capacity of the *Amandiki*, a woman possessed by a spirit, were not made by clinicians, as one might expect, but rather by the courts. However, Robert Barrett (1996) noted the power lying with clinicians when he analysed the way in which schizophrenia was constructed in Australia. The diagnosis and treatment process by the clinicians were deemed to involve a lot of alterations in the social construction of how the patient and the illness were viewed. This began with the patient being changed to a “case”, then reconstructing the patient using biomedical perspectives and treatment approaches by members of the clinical team. This fits perfectly into the idea of the “clinical gaze” that Foucault identified (Foucault, 1973). In my research context, the situation of State Patients is affected more by the power wielded by the courts, and by extension, the government, than by the clinicians.

The power issues at play in the context of mentally ill persons accused of crimes and then declared State Patients is very significant and multi-layered. We are reminded here, of the concerns raised by Foucault about the way institutional power was wielded on the bodies of citizens, as a way of control (Cisney & Morar, 2015). This issue of State Patients is a troubling issue within the South African criminal justice system and its treatment of people with mental illness. It requires serious attention in terms of the human rights concerns, and it is surprising that our human rights bodies have not seen fit to take up this issue. The very term *State Patient* that was decided on years ago, is so indicative of the power dynamic. If we deconstruct the label, it is quite evident that the patient is considered to be under the direct authority and power of the State, meaning that he/she has little or no autonomy, even as an adult citizen.

5.2 Power dynamics within the MDT at the forensic psychiatric hospital

Like many other sectors of work, healthcare, and in this case mental healthcare, operates with hierarchy structures and the power dynamics that go with them. While one may be under the impression that the move into the 21st century has brought about a sense of equality within structural organizations, questions around whether this is really the case have begun to surface. Becker, Boonzaier and Owen (2005) make the point that power relations are a highly complex issue and more so in a country like South Africa, with its history, and even in research contexts, for example, the relationships we have with our participants are anything but equal. Therefore, working in a team with members from various disciplines, a range of power dynamics are likely.

I have come to understand from my participants, that there is a hierarchy system and inherent power dynamics within the MDT, and within the context of the hospital. Many participants with whom I have spoken, since the beginning of my fieldwork journey, mentioned that although there is, in theory, a leader of the MDT (in most cases participants cited either the psychiatrist or medical officer), there are no real power differentials between MDT members.

Participant 3, who had a long history working in the facility was able to comment on the changes over time:

"*It was very medical centric and the doctor made the decisions. Now, there has been a shift. I've noticed a shift because I can give you a time period in which it has shifted to a much more equal balance.*"

Participant 8 also responded in a similar way, reporting a shift in the way the MDT works now, compared to previous times:

"*Yes, yes, it's changed now. Everybody contributes equally and discussions take place. And it's not like about this is my view and so we do that. Yeah, everybody's entitled to say what they want to then they come to have to a proper plan of how to handle the patient together.*"

Participant 9 also noted that the situation in this specific psychiatric hospital was quite different to that evident in other hospitals where the power issue was more problematic:

"*We were one of the lucky few, where the opinion of the members of the MDT members a solicited and you feel that they are genuinely taken into consideration. However, as I've been in settings previously where psychiatry, coming from the medical aspect, tends to be viewed as perhaps even the leader of the MDT and with their views being taken as superior*."

These responses give an indication that the MDT participants have noticed a positive shift in the way that the MDT functioning has evolved over the years, with a more democratic style evident in recent times. Whether this is a general trend globally or a local development consonant with South Africa's shift to a democratic style of governance is unclear. However, it is important to reflect on the work of Haines et al. (2018) noting that multidisciplinary collaboration works in an ideal manner only when the various participants have the same goal in mind and understand the issue at hand in the same way. Perhaps a difficulty that will always arise relates to the fact that the disciplines are from different backgrounds with different ways of conceptualising mental health issues, and the inevitable result of some viewing their approach as superior.

It is interesting to note, however, that a few participants added another perspective, while acknowledging the fundamental improvements in mental health care and that a multidisciplinary approach to care is now more accepted and standard practice. For example, Participant 10 articulated the decision-making process as largely centred around the biomedical discipline:

"*Because the psychiatrists who's the person in charge and then you get the ward doctor …*".

In a similar way, Participant 4 sketched out the typical scenario when a patient is admitted and the decision-making process regarding the involvement of specific team members:

"The team comprises of a doctor as a chairperson, and then there are the nurses, social workers, psychologists and occupational therapist as members of the team. So, what happens is when the patient is admitted, like the team sits, and then like referrals are made by the chairperson who is the doctor"

Participant 1 gave much the same response regarding the newly admitted patient and who gets to consult with the patient:

"*So, for example in a particular case the psychiatrist may decide that, well there is a need to get a detailed social work background because more information is needed about the individual's early life, their family background, the social context in which the person lives, etc. So, in such a case, the psychiatrist will then… would refer to the social worker to be involved in the case. On, another, the psychiatrist may be concerned about the person's level of intelligence…. So there, the psychiatrist may want a clinical psychologist to be involved.*"

From these participants' excerpts it is evident that the psychiatrist is viewed as head of the team or the leader of the MDT. In many ways this is the same situation that is seen elsewhere in the world, and probably due to the power of the biomedical model. Interestingly, the Royal Australian and New Zealand College of Psychiatrists (2002), in their reference to the team approach in mental health care, notes that "Clinical authority is vested in the psychiatrist by virtue of training and experience…" (The Royal Australian and New Zealand College of Psychiatrists, 2002). It is likely that other disciplines in the MDT may take issue with this reasoning, but biomedicine's dominance within health care is a longstanding phenomenon. The Royal Society of Psychiatrists of the United Kingdom (2010), adopts a more moderate position, however, noting that "A consultant psychiatrist cannot see every patient (the money and the time are simply not there) or be personally responsible for every patient seen by a member of the team that they lead." (p. 13). In their study of a forensic psychiatric facility, Haines et al. (2018) found that each of the MDT's had a psychiatrist as the manager of the team. Of course, every team needs to have leader, but perhaps the issue is more that of how democratically and effectively he/she leads the team.

The fact that the psychiatrist decides which discipline should be involved with a specific patient has been somewhat strange to observe, especially for someone who is not a mental health practitioner. It almost conjures the image of a conductor in an orchestra, indicating to the players when he/she wants each instrument to play their part. However, it reveals the paternalism that has characterised the medical model and psychiatry, in particular (Barker & Stevens, 2000; Murjic et al., 2015). It would be assumed that the individual clinicians would be better placed to decide what (and when) their speciality could contribute to enhance the diagnostic or therapeutic process.

However, in addition to the hierarchical issues and referral decision-making noted above, Participant 7 felt more strongly, stating:

"I do feel the power dynamics during MDT meetings. If you do not speak with authority during the MDT meetings, many times you and your opinion may be overlooked. To be honest I feel frustrated when my opinion is overlooked. I work hard at my job and I feel that a certain discipline, in many cases tends to try and control the MDT meetings, despite the fact that each member's opinion and knowledge should be considered."

Participant 5 gave a similar account reflecting strong feelings:

"*We would have the specialist joining us. They will just address the medical doctor, and don't care about what the other MDT members have to offer. Regarding the patient, so basically you just go in there and listen to what they have to say. And if you don't force your opinion or what you think should happen with the patients in your voice.*"

These are quite powerful statements and reflects the MDT members' feelings about being in the middle of the power politics of the meeting and relationships within the MDT. The sentiments from these two participants also convey the structural inequality and power differentials faced by the clinicians within the therapeutic system. However, the fact that other participants did not report feeling this strongly could be due to various reasons, including their reluctance to disclose or it could reflect on their training which prepared them to expect this or to position themselves in this way within the team.

According to Haines et al. (2018), decisions made in MDT meetings are strongly influenced by the personal and professional attitudes and beliefs systems of the MDT members and invariably by the power relationships that exist, and which relate to the members' knowledge level and perceived accountability within the system. The situation arising when team members feel their input is side-lined or not given the respect they deserve can be a troubling one for team members who feel that their input should contribute to the decision-making. However, Stacey et al. (2016) noted that, for psychiatrists, the idea of responsibility means personally making the decisions, rather than working collaboratively towards jointly made decisions. In her study, Brosnan (2012) described a similar power dynamic in psychiatrists' relationships with patients regarding the prescription and choice of medications, arguing that greater collaborative discussion and giving the patient a say, can address the power imbalance.

As Participant 7 emphasised, the clinicians work hard at their job, and to have one of the disciplines control the entire proceedings leads to feeling 'frustrated'. This is clearly an issue of power, and one needs to understand this within the context of the team members' professional positions, as determined by their employment. The biomedical specialists are more highly paid than the other MDT clinicians which, among other differences, immediately brings in a power differential. We can relate this dynamic to the *power-elite theory* which is often described in power politics, but can contribute to understanding the MDT situation, as well. Described by C Wright Mills (1956), the theory is based on the idea of a ruling class that calls the shots, so to speak. By virtue of biomedicine's long tradition, greater recognition by the health authorities, and its ultimately higher salaries, they become the ruling class, and others find themselves having to "listen to what they have to say" or have their opinion overlooked.

In considering the way forward for mental health care, and given the multiple challenges that face mental health care, it is very important that clinicians find a way to address these power dynamics. This is because the power issues have the potential to undermine the good work of the team and reduce the overall efficacy of the MDT's intervention efforts with their patients.

5.3 Power dynamics between the forensic psychiatric hospital management and the MDT

As "madness" was constructed and dictated by the structures in society that held power, the control over citizens in terms of their bodies and their lives was a significant concern (Foucault, 1976). In the present study, the role of the hospital management on clinical decision-making and patient care would be an important consideration. Generally, the participants I had spoken to stated that the hospital management does not get involved in the treatment of patients or in clinical decisions about specific patients, which makes sense. In a conversation quite early into this research process, in response to my inquiry about whether there have been cases in which the hospital management deemed it necessary to overrule clinicians' diagnoses or treatment of a patient, Participant 1 stated:

"*Since the fall of the apartheid government, the hospital management had moved away from getting involved in the treatment of patients. When I first started working in this facility, over 30 years ago, from time to time there were cases where hospital management had stepped in and made decisions regarding patients' treatment.*

Of course, that scenario could be understood within the apartheid context and the paranoia of that government regarding any possible opposition and dissenting views that may threaten its political position. It is also known that state institutions, like hospitals, colluded with government policies to maintain its racist policies. It is encouraging to note the positive shift in patient care and clinical decision-making, with clinicians being left to get on with their work and make decisions independent of the hospital's management structure. This includes decisions to discharge non-forensic patients, or to apply to courts to discharge State Patients. In this respect, this is a positive move away from Foucault's (2001) description of earlier times when institutional managements worked (under State authority) to institute social control over mentally ill people.

Participant 6 made in clear that the hospital's management does not over-ride the decisions of the MDT:

"*I think that there is a lot of power in the clinical team and where the clinical team stand together in pursuit of a particular agenda, particularly in terms of patient care….No, the clinical team will assert themselves and, and, yeah, the decision won't be overridden by management.*"

Participant 3 also gave a similar response:

"*Management is not familiar with the details of each individual clinical case of the MDT, so they won't override the team's decisions. The MDT has more control now, than some years ago. Where needed, the head of the health establishment will just be given the information about the team's decision and then we're pretty much in agreement.*"

From the participants' responses, it is clear that the clinicians do not feel their decisions are over-ridden by the hospital management. Applying Max Weber's theory of bureaucracy to this context we see one of the characteristics he proposed for organisations to work optimally, namely the division of labour and specialisation, based on competencies (Weber, 1947). In the case of the forensic psychiatric hospital that I am studying, it is evident that the hospital's management and the clinical team have their specialised areas of work that they are trained to perform, and they stick to it. Weber (1974) advocated that each worker be given the authority necessary to execute their job in an efficient manner. From the general feedback given by my participants, it appears that their work does not receive interference from the hospital management. This is definitely a good sign, and allows for the MDT to function with the level of autonomy that it needs to make sound clinical decisions.

5.4 Mental health care and human rights

It is important to remember that issues of human rights cut across all sectors of society and, in the present study, across different aspects of mental health care. Despite the advancements in human rights across the world, there are still many challenges, especially for marginalised groups. According to Gostin & Gable (2004), governments should ensure that their human rights duties toward citizens include respect, protection and fulfilment. Each of these should work against confinement for an unjustifiable reason, discrimination and prejudice, while working to promote every citizen's human rights. Anthropologists have critiqued human rights fundamentalism as early as the mid 1940's. According to Messer (1993), the American Anthropological Association (AAA) had rejected the concept of "universal human rights", stating that human rights is culturally relative and one cannot instate a blanket understanding of what is entailed within human rights. According to the American Anthropological Association (1947), anthropologists have long critiqued human rights injustices with little assistance, acknowledgement and support, all while risking relationships developed with their participants during the fieldwork process.

During the many conversations I had with my participants, concerns were raised around various matters that highlighted human rights abuses against mentally ill patients who are in institutional treatment. Three human rights and structural violence issues were identified: patients' rights to intimacy during their stay in the hospital, patients' rights to vote in the country's elections, and patients' rights to discharge from their detention in the forensic psychiatric hospital. These are discussed below.

5.5 Patients' rights to intimacy in the hospital

According to the South African Human Rights Commission (2018), one of the basic human rights of every citizen is the right to dignity. Similarly, the Mental Health Care Act of 2002, which is the foundational legislation governing mental health care in democratic South Africa, makes it clear that the patients' dignity and privacy must be respected (Republic of South Africa, 2005). Considering that the patients in a long-term forensic psychiatric hospital like the one that I am studying are all adults, their intimacy needs does become an issue of concern. It is important to note that section 14 of the Mental Health Care Act of 2002 states that the health establishment may only limit intimate adult relationships if the patient's consent capacity is impaired. In other words, patients have the right to engage in intimate relationships, should they choose to and be mentally capable of consenting. However, the legislation gives no further clarification on the provisions that the State and hospitals must make to ensure related dignity, such as private rooms. According to Kramers-Olen (2016), authorities often give little or no attention to the intimacy needs of people with mental health problems, almost viewing such needs as inappropriate. This could well be one of the reasons that, apart from the single mention in the Act allowing intimacy in mental health facilities, no further consideration is given.

In my conversation with Participant 6, the issue of patients in this psychiatric facility not having a specific place to have consensual sexual relations in a dignified manner was discussed. According to Participant 6,

"*Patients do not have a place to take part in consensual sexual relations unlike you or me. So, you generally find patients engaging in these activities behind buildings and in the grass fields. And frankly to be honest this is unacceptable. The problem is wards do not have individual bedrooms. So at least 4 patients tend to share a room. So, there is a lack of privacy and this speaks directly to lack of mental health care funding. The issue I have, is why do patients' not have the right to engage in these acts in a dignified manner? At this hospital, condoms are provided in bathrooms for patients, it just does not make sense".*

The anger in this participant's voice was very evident, and this was merely the start of the mental healthcare and human rights concerns regarding patients that this participant reflected on, and felt very strongly about. Similarly, on the same topic of discussion, Participant 10 mentioned,

"*Patients' generally tend to sneak into other communal rooms to engage in sexual activities in the middle of the night when other patients are asleep. In other cases, male patients would come to the female only wards and they would walk together behind the buildings or go into the bushes*".

Participant 1 expressed a similar concern:

"*The issue is two-fold, because on the one hand patients are allowed to engage in consensual sexual relationships, that is if they have the capacity to consent, otherwise it is an issue of rape. But the bigger issue is that the hospital does not provide the facilities for patients to engage in sexual relationships in a private manner. This is an unfair situation that goes against their human rights. Patients are taught sexual literacy, how to protect themselves from sexually transmitted infections, etc., but they are not afforded the space to conduct their relationships in a dignified manner.*"

It is rather striking, firstly that the State affords adult mentally ill patients the right to engage in sexual relationships, but does not provide the appropriate spaces for patients to be intimate in a dignified manner. This appears to fly in the face of the Constitutional and Human Rights legislation in the country. Secondly, this lack of a rather basic provision, forces patients to enage in intimate relations in inappropriate contexts, like in the bushes or behind a building.

Interestingly, this phenomenon is not unique to South Africa, and in a study in the United Kingdom, Warner et al. (2004) found that a large proportion of the patients they interviewed had reported having consensual sex in inappropriate spaces like the toilet, stairwell or the garden. The need to provide private rooms is a key recommendation.

If we consider that many of the State Patients in the forensic psychiatric hospital being studied were charged with rape, and that the psychosocial rehabilitation treatment is aimed at improving their sexual literacy and understanding of appropriate sexual behaviour, then this approach that denies them appropriate intimacy space, is contradictory. In this context Kramers-Olen (2016) argued for greater education and policy development to guide sexuality matters in long-term care facilities, such as the forensic psychiatric hospital under study. She noted that patient needs in this respect, must be taken more seriously, especially since it is a part of their human rights, and our mental health facilities need to ensure that they act in a manner that promotes patient rights in all respects.

In addition to the inappropriateness and apparent contradictory nature of the mental health legislation in relation to the human rights principles of ensuring dignity of persons, the current situation, as noted during the interviews with my participants, needs to also be viewed critically in terms of Johan Galtung's work on structural violence (Galtung, 1969). There is a clear argument here that the policy and structural inefficiencies of the State is preventing patients from meeting a basic adult need. As is well known in situations of structural violence, such social forces serve to perpetuate inequality in well-being and health (Center of Health Equity Research Chicago. 2020). For those patients who have the mental capacity to consent to sexual activity, the State needs to take note of these issues and act to ensure their dignity of persons is maintained, by providing the appropriate physical spaces. According to medical anthropologist, Paul Farmer, structural violence is described as social activities and arrangements that may endanger individuals from a population. It also describes how the differences within society impact individuals' health and wellbeing as well as become a part of the "individual experience (Farmer, 2004).

5.6 Patients' rights to vote in the country's elections

There are some rights that we take for granted as members of the general public, without even stopping to question or think about them. One of them is the right to vote, especially since 1994 when the dawn of democracy brought voting rights to every adult in South Africa. Or did it really give *every* adult the right to vote?

In this respect, Participant 6, who was visibly angry about the issue, stated:

"*Yeah, patients in psychiatric hospitals don't have this this right to vote, which is a clear violation of their rights, and it's also a violation of the Constitution of South Africa which, you know, details the rights of people in our country to vote. So, you know, it's difficult to argue that that they shouldn't have the rights to vote, particularly when people convicted of all kinds of crimes have that right to vote. …There's no doubt in my mind that there are many, many patients in the hospital who would have the capacity to vote. The electoral system is an unjust one that has to be fixed to suit a democracy"*

Participant 4 noted that patients have not voted because they are not allowed to vote according to the law:

"*As far as I know, they have never come here to take patients votes. The Election officials have not contacted us to allow our patients to vote. In all the time that I have worked in mental health, nobody has come to talk to our patients about voting or informing us about what the procedure is for our patients to vote. As far as I know, the law says our patients are not allowed to vote. I feel that is unfair*"

Participant 1 was clearly quite annoyed about this issue, citing the laws as unjust to people with mental illness. He said:

"*Well that is something that I feel quite strongly about. You see the South African laws are problematic and, in my opinion, they are quite discriminatory. The Electoral Act says that a person who is of "unsound mind", whatever that means, or committed under the Mental Health Care Act is not allowed to vote. This is despite the fact that prisoners are allowed to vote. It is appalling that we have such legislation in democratic South Africa. It is terribly prejudicial and derogatory to people with mental illness.*"

The responses of the three participants show that the issue of mentally ill people not having the right to vote is a significant one that affects their patients and, as clinicians, they view it as an unfair and discriminatory system. Of course, it was very interesting for me to hear the anger in the voices of Participants 6 and 1, both of whom appear to have been very aware of the legislation issue in this respect and, therefore, viewed the electoral system as one that is not working in the way that it should, and needs drastic reform.

There are several reasons why it is important to have a democratic order where people with mental illness have the right to vote. First, we have to understand that it is the right of every adult to be able to participate in the democratic processes of their country, to be able to choose the representative they want, and to be able to vote for a government that they believe will be best for their nation. However, a diagnosis of a mental disorder prevents this right. In this context, Biehl and Locke (2010) noted that anthropological fieldwork has the ability to highlight the constraints of psychiatric approaches and models, especially in relation to human agency, structural violence and biopolitics.

This situation of denying people with mental illness the right to vote, reminds us of James Scott's (1998) arguments about state planning, attempts to shape the citizenry and the disasters and failures that result. He noted that state authoritarianism, in its attempts to create a strict ordering of society and nature, uses its full might and power to effect its plans of control, while civil society is often unable to provide resistance. Of course, this sounds very much like the social engineering that was apartheid, and based on Verwoerd's ideas of control and power. In his work "Discipline and Punish", Foucault (1977) also addressed the issue of control, noting how this power and control were wielded through certain institutions such as schools, hospitals, prisons, laws, etc.. Therefore, we think also of the institutionalised processes and instruments like the South African Electoral legislation which is the ultimate authority on this matter. In the present study we find that it is the biomedical diagnoses of mental disorder that determine who should be denied the vote. We can draw analogies here with the medical anthropology work of Vinh-Kim Nguyen (2010), who described the HIV/AIDS situation in West Africa during the late 1990's when the biomedical triage process denied some people the limited life-saving treatments they desperately needed. Of course, Nguyen went further to reveal how people, desperate to access the limited medical treatments for HIV/AIDS, traded their stories about their health status as a way gaining access to treatment. This level of desperation by people with health issues is concerning.

In denying mentally ill people the right to vote, the state is selectively identifying who can have a say in the country's 'democracy' – but then is that really democracy? It has, therefore, been argued that health professionals and others need to adopt an advocacy approach to champion the rights of people with mental illness, so that they can take their rightful place in society, and especially in the democratic processes of their country (Satyanand, 2016). It is vital that activists and advocates for mental health work towards eradicating the structural violence perpetrated against people with mental illness.

Second, we must consider, especially the case of people with mental illness and the psychosocial rehabilitation programmes that form part of their treatment. Among the treatment goals, reintegration into the community is considered a significant outcome variable, given that, ultimately, the patient is being treated and prepared for discharge back into the community to take up a life like all other members in society (Kramers-Olen, 2014). In this context, learning about the electoral system and the voting process (if that knowledge and experience was absent) is a vital component of the patient's rehabilitation. It is one of the many skills and tasks of daily living that he/she has to learn to deal with when they are discharged. So, it makes sense, from this perspective as well, to ensure that people hospitalised with mental illness are allowed to vote in their country's elections.

Third, there are also valuable self-development opportunities that arise when people with mental illness are involved in important civil responsibilities, like voting in national or regional elections. According to Bhugra, et al. (2016),

> "An ability to participate in the democratic process allows individuals to feel included, improve their self-esteem and make them feel valued. This is likely to make them more active citizens and active participants in the democratic process." (p. 399).

This description of the psychological benefit that comes to individuals by participating in critical civic responsibilities can be seen quite clearly in the experiences of South Africans in 1994. For those who were adults and voted for the first time, and even for the younger groups who have heard the narratives or seen the footage of the pictures of the long, snaking queues, it was a joyous occasion that filled people with great pride. Although the background to that event was apartheid that deprived people of their basic right, it is much the same form of discriminatory, prejudicial laws that currently marginalise people with mental illness. Previously people were denied the vote due to the colour of their skin, and now we see people denied the vote due to their mental state.

Government must be brought to see the wrongfulness of their actions in legislating against the voting rights of mentally ill people. Especially in a country like South Africa, where unjust laws prevailed for decades, causing much harm, it is necessary that pressure is put on the State to stop its discrimination and marginalisation policies. For true and complete democracy to be achieved, concerted efforts are needed to get the State to realise that people with mental illness are citizens like all others, and to remove the structural barriers they impose on the advancement of certain vulnerable groups.

It is also vital that we view the denial of the vote to people with mental illness from a critical viewpoint. The infringement of this human right constitutes yet further acts of both structural violence and epistemic injustice against people with mental illness (Fricker, 2007; Galtung, 1969). By withholding the right to vote, the State is preventing this group of people from meeting a basic need, namely to fulfil their role as a member of society and be a recognised member. In a similar way, we must recognise that, by imposing their Electoral laws, the State is effectively silencing this group of people, by taking away their voting voice, much like Gayatri Spivak described (1988). The State is thereby saying that their voices and opinions do not count. Moreover, in this way, the State is reinforcing the archaic voices and attitudes of stigma against people with mental illness. We think here of Erving Goffman’s (1063) definition of stigma as an extremely disparaging attribute. However, we must take this further to note that such an attribute is highlighted in a negative and destructive manner that denies people their rightful place in society. Of course, in this way the stigma adds to the structural violence and epistemic injustice suffered by people with mental illness.

5.7 Patients’ right to freedom and discharge from forensic hospital detention

The issue of the discharge of State Patients has been covered in the earlier section dealing with power, but will be discussed here as well, given the significance of this matter within the justice and human rights contexts, and especially the structural violence that is at play within the criminal justice system that affects the discharge process. There are a few issues of concern in this respect, namely (1) the declaration as State Patient by the courts, with little input by the accused person, and without a full trial, (2) The difficulty experienced by State Patients in getting discharged from the forensic psychiatric hospital.

Regarding the individuals’ declaration as State Patient by the courts, one of the concerns is that the patient has had little say in the initial court proceedings. If the court has determined that the person is mentally unfit to stand trial or was mentally ill at the time of the alleged offence (and unable to appreciate the wrongfulness of their actions or act accordingly) they cannot be held criminally responsible, then the court orders that the person be detained in a forensic psychiatric hospital as a State Patient (Republic of South Africa, 2008). In this respect, Participant 3 pointed out that sometimes the court makes decisions regarding detention as a State Patient that the clinicians do not think should have been done, depending on their evaluation of the person's mental state:

"*But, as you know, we go to court and we give evidence and input. And we then tell the court, we feel that this person, let's use an example that the person doesn't need mental health treatment. But for whatever reason, the court decides to send the individual to the hospital as a State Patient.*"

Participant 9 noted the clinicians' powerlessness in the situation:

"*That's the sad part. Yeah. Because if the court decides that this person should be made a State Patient, then the clinicians tend to be powerless, even when the clinicians feel that now this person, with treatment could be sent back to the courts.*"

Regarding the extended length of time in hospital detention, Participant 6 said:

"*And so in a court of law, they haven't been found guilty of a particular offence for which they have been charged….And the other real sort of human rights issue pertains to the length of time that many State Patients land up spending in a hospital context. So in reality, State Patients accused of particular crimes, on average might end up spending even longer in a forensic hospital than they would if they were actually sentenced to prison.*"

Clearly the participants are expressing their concerns about the process that unfolds in courts with the person being declared a State Patient, sometimes even if the clinicians giving their reports (expert testimony) indicate that the person is not mentally ill or does not warrant treatment. In this respect, Louw (2006) pointed to a case where the court stated that "it was not bound even by a unanimous decision of the psychiatrists, but that it had to make its own findings after considering all the evidence" (p. 45). The courts clearly have the ultimate authority regarding the decision as to whether the accused person should be considered mentally unfit to stand trial or mentally not criminally responsible, and made a State Patient. Since this decision is usually made before (or at the beginning of) the trial, it means that the accused person who is declared a State Patient has not had the opportunity to give their version of events because the trial is not completed. This has been the concern expressed by Louw (2006) who argued that, as a result, an innocent person could erroneously be deemed to have committed the offence. Moreover, there is a greater likelihood that a person declared a State Patient will spend a considerably longer period in detention in a psychiatric hospital, than if they were found guilty and sentenced to prison. This is because imprisonment is usually for a defined term, whereas the State Patient detention is an undefined term. The chain of events in the court process is obviously a travesty of justice, and also an example of the epistemic injustice which refers to a wrong inflicted on someone due to prejudice, which is unjustified. It is also a situation of being judged unfairly or presumed not to possess knowledge that could contribute meaningfully to the trial (Ficker, 2007). Miranda Fricker (2007) describes this as epistemic injustice because the law is such that court decides to detain the person as a State Patient without affording him/her a chance to voice their side of events.

It is important to understand that the law allows for the State Patient to go back to face a new trial at a later date when their illness has been successfully treated. However, Participant 6 raised concern in this regard:

"*Some people are admitted as State Patients, they are actually stabilized quickly and our mental status examination shows improvement to the point that they're well enough to be able to stand trial. And so the question is, should they not be then given the opportunity to go back to court to tell their version of events*"

Participant 1 also raised concern in this respect pointing out that patients are not usually sent back for trial following their treatment and recovery.

"*The courts then order them to be detained in the mental health facility like this hospital and the facility then has to keep them in hospital for an extended period of time until they get well enough for the courts then to subsequently say well you're ready now to go home. Those patients can't be discharged home by the hospital because they are there actually under court order. Also, even though the patient can be treated and then sent back for trial, according to the law, this largely never happens.*"

The concerns raised by Participants 6 and 1 over State Patients not having the opportunity to go back to court for the trial to be restarted is a serious issue. Similarly, Participant 4 stated that since working at the hospital (almost 10 years), the participant has never come across a patient having the opportunity to have a retrial, despite feeling that it would be a fair process to follow. Equally, in another conversation, Participant 2, who has many years of experience with patients at the hospital, said that it becomes very difficult for the clinicians because they listen to patients, who are quite knowledgeable about the legal system, express their complaints about not being allowed the opportunity for a retrial.

This means that for the second time (i.e. after recovery) the State Patients are denied the opportunity to clear their name, after not having had this opportunity at the start of the legal proceedings when they were declared State Patients. These seem to be human rights violations, because all people are supposed to have the opportunity to clear their names if accused of a crime. From an anthropological perspective, we need to look at this issue in terms of the epistemic injustice to which State Patients are being subjected (Fricker, 2007). Effectively, they are being silenced by the legal system, by not being granted an opportunity to have their voices heard regarding the alleged crime, their involvement or lack of involvement therein. Similarly, the work of Gayatri Spivak (1988) recognises the concept of epistemic violence wherein individuals, due to their status, are prevented from speaking for themselves. Regardless of the accusations that were levelled against them, State Patients deserve the right to be heard, and ultimately seek justice for themselves and the other parties in the case. Galtung's (1969) work on structural violence is also applicable to these individuals since the laws and instruments of the State are preventing them from meeting their basic need – i.e. freedom and the right to tell their side of the story.

South African law is is clearly out of step, because it lacks the kind of legislation that is present in other countries, such as the United States, where a system of *competency restoration* is enshrined in the law (Gowensmith, 2019). Such a system mandates that individuals found mentally unfit to stand trial should be treated and subsequently allowed to return to court to participate in the trial when they are competent to do so. This allows them the opportunity to defend themselves, while also offering the victim (or victim's family) the opportunity for closure. Regarding the substantial difficulties in attempting to discharge State Patients, Participant 6 said:

"*You know, there'll be an application for a discharge or a reclassification based on the patient's progress in terms of psychosocial rehabilitation programs. And demonstrable successful periods of leave of absence, where the treating team is quite confident that the patient is actually a lot better. But ultimately, the decision to discharge lies with the court, so that decision doesn't lie with the multidisciplinary team, in the case of a State Patient.*"

Participant 3 indicated that the discharge process is completely in the hands of the court:

"*Whenever we send an application for discharge or conditional discharge, then the judge views all the information and then the application is approved or it is declined. It becomes a legal* *process, which is really out of our control. We can only tell them all the information that they need.*"

Participant 8 said that the clinical team cannot discharge the patient:

"*But according to the Act, they cannot be discharged by the MDT. So that's why they try to write all the reports. And they make the application to the DPP's office. Yeah, so because they came via the courts, we cannot discharge.*"

Participant 10 also raised the difficulty in getting patients discharged:

"*I've got about eight patients that are State Patients and the rest are long term patients with schizophrenia and other illnesses. The problem is that the State Patients we just cannot get discharged, because when we apply, the courts are not willing to discharge them. It's like the court wants us to guarantee they will behave well after discharge.*"

The four participants' narratives, above, reflect their concern about how difficult it is to get State Patients discharged. Listening to these participants, I began to realise how powerless they feel in the situation. The care and commitment that these clinicians have for their work comes through, and I could sense the compassion they feel for their patients, especially the injustice that their patients suffer due to the structural injustices that they have to endure, purely because they have a mental illness. Here we can see Foucault's ideas of power, noting the three types of power that he referred to (sovereign, disciplinary and biopower), and it is apparent that the notion of sovereign power reveals itself within the context that State Patients are detained (1998; 1976). It is the law of the country and government declaration that serves to curtail the rights of this group of people. Here we see that the government appears to be treating the accused person (bearing in mind they are not convicted) who is also a mentally ill person in a confused manner – they are locking up the mentally ill person because of the criminal accusation, and hospitalising the accused person because they are ill. The power over the ill person (biopower) and the power over the accused person (disciplinary power) appear to be conflated, but the bottom-line issue is that the State Patient is marginalised, stigmatised and treated in a way that is not equal to the rest of society.

In listening to the participants, I could see that the 'clinical gaze' that Foucault (1973) wrote about was absent in this mental health facility. Even though I set about this research on the look-out for the 'clinical gaze', examples like this from my participant narratives made me realise that it was not prevalent in this hospital. If anything, I got the impression of a 'legal gaze' or 'judicial gaze' because it was the law that was looking at the State Patient as a disease entity, rather than a human being, with feelings.

Participants noted the great disappointment they experience as an MDT when they put in a great deal of effort to motivate a discharge application to the courts, only to receive a negative response. The attitude they held towards their patients was a vastly more caring one than might have been expected in the context of Foucault's (1973) 'clinical gaze' description. There was clear concern about their patients' need to reunite and reconcile with their families, in other words a more humanistic attitude, rather than a medical model, disease-oriented, way of viewing patients.

The response from Participant 10, that it seems as if the court wants a guarantee of future good behaviour was echoed by the other participants. This is a quite a serious issue and appears to be largely responsible for the extended detention of the State Patients. The issue sounds as if judges presiding over the State Patient discharge decisions are afraid to make a mistake in discharging someone who subsequently commits a violent act, and keep them incarcerated longer than if they were imprisoned. In this respect, Participant 1 made an interesting revelation:

"*I've had patients spending decades (over 20 years) here for crimes that they would have been released from prison in about 7 or 8 years, if they were found guilty and sent to prison. Sometimes patients even tell us that, because many are aware of the discrepancy between imprisonment and State Patient detention. They see the unfairness and discrimination in the system*"

That cautiousness (or over-cautiousness) of the judges is understandable, but then we have to question whether it is justifiable or ethical to lock someone away for the rest of their lives because (i) they are mentally ill and (ii) society is afraid that they *might* commit a violent act in the future? That reasoning sounds absurd, not to mention discriminatory and even archaic. There is also a lack of sound evidence showing that people with mental illness are more violent than so-called 'normal' individuals. In fact, it has been shown that people with mental illness are more often victims of violence than perpetrators of violence (Stuart, 2003). We must remember here, that prisoners are released from prison when their sentences are over (or even paroled much earlier), without anyone guaranteeing their future behaviour, and some go back to the community and commit crimes again. Here again, we see the issue of power coming through the mental health care system. As Fanon (1963) pointed out, madness is one of the ways in which individuals can lose their freedom (Robcis, 2021). That was a similar consequence for Dimitri Tsafendas, even though madness was conveniently thrust upon him for political aims (Dousemetzis, 2018). Nevertheless, we see society and governments using the instrument of incarceration to discriminate against people with mental illness and create a type of apartheid, to view them as inferior and separate them from others in society. This is how mental illness is viewed and socially constructed and it is disappointing, especially in South Africa which has a history of discrimination and marginalisation based on socially constructed classifications. I cannot help thinking that our government should know better.

From the conversations with my participants, it was evident that the numerous unsuccessful discharge attempts, despite their detailed reports and great efforts, was due to the judges reviewing the clinicians' reports not being sufficiently satisfied that the State Patient will desist from further offending behaviour or violence upon discharge or conditional discharge. However, the ability of mental health clinicians to predict dangerousness in future behaviour is not very good. The scientific research shows that it is not possible to make such predictions with accuracy (Ward-Lasher, et al., 2017). Of course, this is a reality, and the MDT and individual clinicians cannot be faulted for this, because it is clear that they are doing the best they can in their treatment interventions from the time the person has entered the hospital, through the treatment process, and years later applying for his/her discharge, when improved. It is, therefore, easy to understand the frustration that the clinicians experience, given the challenges they work under. It is important that legislative and policy changes at higher levels begin looking at this intersection of mental illness and criminality, bearing in mind that State Patients have not been found guilty. Currently people with mental illness accused of crimes are being treated worse than convicted prisoners who generally have a definite release date. Evidently, it is the mental illness tag that hangs around the neck of these individuals that results in the more extreme treatment. It is vital that we begin looking at people with mental illness in a different way. As Benbow (2009) noted, we have to focus on the barriers, devaluation and discrimination that society thrusts on people with mental illness, and remove those societal abuses. .

5.8 Summary of Chapter 5 findings

Issues of power are very prevalent within mental health care today, as they have been centuries ago. However, the intricacies of how the power is wielded has changed over time. Two main areas of interest regarding power and agents of power emanated from this research. The one is the power relations within the MDT, where the balance of power is clearly in favour of the biomedical disciplines, namely the psychiatrist and medical officer. The extent to which biomedicine controls the team functioning and dynamics has been raised as concerns by the members. This is, in many ways, a reflection of the traditional role of medicine and its dominance (Barker and Stevens, 2000). An even more troubling power dynamic that emerged from my conversations related to the way the courts (who are, in fact, a proxy for the State) control the detention and movement of the State Patients, from the point of making the determination of their status as State Patients, ordering the detention in a forensic psychiatric hospital, controlling whether they can go out on leave to visit family, and keeping them confined for lengthy periods. This is reminiscent of the *Great Confinement* that Foucault described as a European phenomenon, but which spread globally with colonisation (Foucault, 2001; Porter, 1990), and which Scull (2015) also critiqued. While the level of control is obviously viewed by the courts in the context of the crime, the fact that the individual is mentally ill is a worrying factor. The legal procedure that prevents the accused person from giving their version of events and offering a defence, simply because of their mental illness reeks of an epistemic injustice (Fricker, 2007). Moreover, considering that it is probably near impossible to predict with accuracy whether the State Patient, or anyone, will commit a violent offence in the future (Ward-Lasher, et al., 2017), the decision to keep the person continuously detained in the forensic hospital seems problematic and is an issue of social control that deserves the attention of human rights groups.

Another stark finding from this study has been that, even though the journey through civilisation has moved steadily along over the centuries, the State and society still feel the need to exert control over people with mental illness to a degree that must be considered oppressive. Furthermore, the tendency to treat affected individuals as though they are less than human is a serious human rights violation. For example, hospitalised mentally ill patients have the legal right to engage in intimate relations if they are able to consent, but the hospital does not provide private spaces for patients choosing to exercise that right. This can be viewed as an instance of structural violence in terms of Galtung's (1969) argument regarding barriers to human needs.

Among the human rights challenges facing those individuals declared State Patients is that they have little or no input in the life-changing decision by the court. It is really sad to think about that experience for the person, knowing that his/her life course is being determined by some other individual assigned great power by the State (i.e the Judge). Here, we are again reminded of Foucault's description of the Great Confinement in which people with mental illness are not granted a voice over their own lives or in broader society (Foucault, 2001). We can think also of the concept of ‘biopower’ that the State wields. These are shown up clearly in South Africa’s Electoral law which denies people with mental illness the right to vote in public elections. This is done while allowing every other adult, including prisoners, the right to vote. By the State withholding their right to vote, it is committing acts of both structural violence and epistemic injustice against people with mental illness, constituting a serious human rights violation (Fricker, 2007; Galtung, 1969).

The difficulty in achieving a discharge from the forensic psychiatric hospital is a major problem for the State Patient and violates his/her rights to freedom as a citizen. It is quite surprising that, to date, the South African Human Rights Commission has not taken up this issue (or the election issue). The very fact of an indeterminate period of detention is contrary to local and international principles and laws, making this a serious area of concern. Again, the comparison with prisoners is a useful one here, because with the exception of a small number of extremely dangerous prisoners, they are generally given defined periods of incarceration. Why people with mental illness, and more so those who have not been found guilty in a full trial, are incarcerated indefinitely in the 21st century is incomprehensible.

Chapter 6 – Funding and mental health care

In South Africa, like most countries in the low- and middle-income category, funding for public mental health services is a significant problem. It is almost as if in some countries, mental health is regarded as a non-essential, and therefore its priority rating is much lower than other national expenses (World Health Organization 2021). With South Africa having gained the dubious reputation of being the world’s most unequal country (World Bank, 2022), it is not surprising that we will have both high rates of mental health problems as well as poor access to mental health resources due to the inadequately funded services. According to Lund (2012)

“The social conditions of poverty increase the risk of mental illness and, conversely, people living with mental illness are more likely to drift into, or remain in, poverty as a result of their disability and the associated stigma” (p. 213). The literature on the link between poverty and mental health problems is quite compelling, and the fact that South Africa has millions of citizens living in poverty, it is important that the government takes note and works towards appropriately funding mental health care services.

Considering the current poor state of health services in South Africa, as well as the country’s struggles with “State Capture”, corruption and mismanagement of government funds, there is much concern on several fronts regarding the future health and wellbeing of our citizens. As mentioned earlier in this report, the Life Esidimeni tragedy that took the lives of so many people with chronic mental illness, was largely driven by a financial decision in which the contract with the private service provider was cancelled, because the State felt it could save money. However annual reports state that the department of health spent twice the amount of money in irregular expenditure than they claimed they would save during that financial period, by shutting down the mental health facility (Gonzalez and Msomi 2018).

Over recent years, the State’s plan to address the health service inequities in our country has been to introduce a National Health Insurance (NHI) that promises to provide universal health coverage. While government views this as the answer to our health services problems, some groups have viewed it as overly ambitious, while others have viewed it as yet another opportunity for corrupt officials, given the country’s history of corruption in virtually every facet of government, including health (Corruption Watch, 2020). With respect to mental health care services, the Psychological Society of South Africa (PsySSA) supported the broad principle of universal health coverage, but raised concerns regarding the need for improved human resources for mental health care, rigorous accountability mechanisms, and including mental health expertise on the NHI advisory structures (Kleintjes, et al. 2021). Clearly, in the literature and the professional society sphere, there is much concern about the funding of mental health care.

In my conversations with participants, there was a general consensus that mental health services are an under-funded sector. Participant 3 stated:

“*There is a significant lack of funding. All healthcare in general but specifically mental health care is significantly underfunded…. I still think that the funding is one of the deficits but there's also deficits in terms of infrastructure in the facility.*

Participant 1 was quite adamant on this matter:

"*No, definitely not. I think if you talk to any mental health professional, you'll find the same answer. We, from our experience working in the mental health system, it's clear that the government, in our country and in many other countries, does not spend as much on mental health care, as they should, especially if you consider that mental health problems, cut across all other problems as well. And I think if one takes a narrow view of mental health, then one starts to think that only a small proportion of people have mental health problems. That is totally incorrect. The proportion of people who have mental health problems are at least 20% or higher. In fact, it's generally regarded that about at least one out of four or five people has a mental health problem.*"

Participant 1 added:

"*There isn't sufficient money available for all of the areas of need for mental health care. So, for example, you'll find staffing is not enough. We're understaffed. You'll find that facilities are not sufficiently adequate, they either not enough or not big enough to house all of our patients, the quality, the infrastructure is not good, the maintenance is not good…… So, the various things that we need, occupational therapy, for example, we need a whole lot of equipment, etc....We also find that when one of our clinicians resign, the post is frozen by the Department of Health and we are then short of clinicians to attend to patients. So, this is not a problem created by the hospital, or something that the hospital can fix, it is a problem at the level of the government*"

Participant 6 was vociferous in condemning the inadequate funding of mental health care in the country:

"*So, no, I think that mental health is not sufficiently funded. There isn't enough investment in mental health from the national level. I think what we tend to do in mental health is create beautiful policies. There was a strategic framework setting the 2013 to 2020 strategic framework for mental health – beautiful legislations, beautiful policy, because this policy was superb and beautifully crafted. We get academics to write, you know, what we need to be writing about, but we don't enact it…But we don't have the resources and facilities to enact that legislation. And so, at the end of the day, mental health costs money just like every other illness. Our staff to patient ratio is a problem because we have a high number of patients for very few staff. And we need to invest in mental health. Much more money is needed for mental health care!*"

Here we note the clinicians' concern about the specific hospital under study, and their comments about the infrastructure deficits that are due to under-funding must be taken seriously. Being a health care facility, especially for people with mental illness, the infrastructure should be of appropriate quality to lend itself to care and rehabilitation. As noted in Chapter 1, sections of the hospital are in a state of disrepair, and very evidently in need of funding. Similarly, participants complained about the staffing shortages, which impact their ability to provide the necessary mental health services. In particular, the staff to patient ratio in this specific hospital is a concern, considering that standards are set in this respect and these benchmarks should be met in order to ensure optimal service (Sorsdahl, 2023).

The participants' concerns about underfunding is very real and, based on the evidence provided by a University of Cape Town Faculty of Health Sciences (2019) analysis, which showed that South Africa spends only about 5% of its health budget on mental health care, and has a treatment gap of over 90%, meaning that nine out of 10 people with mental health problems do not receive treatment. It is also worrying to hear the clinicians say that they have to continue providing mental health services when one of the staff members leaves the service, because that vacant post may not be filled. As social scientists, and as South African citizens, we have to ask the obvious question: What happens to the money that was used to pay the salary before the clinician left the service, because it should be available to pay a replacement? We are reminded here, of the Life Esidimeni tragedy, in which so many lives were lost due to higher level financial ineptitude by the government in their inappropriate and ill-conceived attempts to save money (Makgoba, 2017).

It is almost as if mental health is not taken seriously, and therefore it could be viewed as an area where spending can be restricted. Again, this shows the tendency to view people with mental illness as lesser beings, and relates to Foucault's (1977) concept of biopower and the way people with mental illness were controlled, albeit it in a diffuse, somewhat anonymous way. This speaks also to Goffman's (1961) account of how mentally ill people were almost imprisoned in asylums, and to Fanon's (1963) view of institutionalisation as a control mechanism and a way of wielding disciplinary power in order to regulate people (Fanon, 1963). This reminds us of the more modern-day Explanatory Model of illness that Kleinman (1988) developed in medical anthropology, in which he argued that too often patients' own experiences of their illness are not considered. It is the ideas and convenience of those around the patient that take priority.

If we draw a comparison to the 1880s, Parle (2007) mentions a similarly unacceptable ratio of psychiatric staff to patients, resulting in inadequate care. She noted that during this period many staff members had been requesting additional assistance in managing patients. So, what has changed? Currently, my participants indicated that when staff members resign they have to continue providing the service with fewer staff.

Similarly, we are aware through the media about the national maintenance budgets that should be earmarked for necessary building maintenance, especially our health and educational facilities, which are obviously not being channelled into the much-needed projects. A recent University of Pretoria construction economics research into South Africa's maintenance policies and regulations relating to public infrastructure has highlighted serious flaws, even revealing under-spending of repair budgets in many municipalities (Wall, 2021). So, the issue is evidently not just a shortage of funds, but rather an inefficient usage of available funds, which speaks to the incompetence in government. It is, therefore, not surprising that there is a growing uprising and protest action by civil society across South Africa against incompetent governance (Essoungou, 2015).

With my research participants pointing out that the funding problems relating to staffing decisions, maintenance of facilities, etc. are the result of directives from higher levels of government, it is evidently not the hospital at fault here, because it has to work with what it is given. The clinicians are doing the best they can with what they have available. In this context, Witeska-Młynarczyk (2015), in her paper on critical medical anthropology, noted the discipline's broader concern with the multiple determinants of health and illness, and it is clear that State ineptitude in adequately staffing and funding mental health services falls squarely into this area of concern. National bureaucracies are ultimately responsible for the way that health programmes are run at lower levels, and society needs to hold government accountable. In this regard, and also from the perspective of critical medical anthropology and global health, Gamlin, et al. (2021) emphasise the need to speak truth to power. They note that the discipline of critical medical anthropology "considers the political economy of health and social inequality in people's lives" (p. 2), and it is imperative that social science critiques the state of our health facilities and services. This is absolutely vital in the case of mental health facilities, where patients may not be as able to fight for social justice on their own. Social scientists and other activists have to pressure the State to recognise their wrong doing. Witeska-Młynarczyk (2015) adds that governments need to take decisive steps to care for their citizens, arguing at the same time for a *Militant Anthropology*, as proposed by Nancy Scheper-Hughes (1995).

6.1 Summary of Chapter 6 findings

The findings emanating from this aspect of the interviews have been rather concerning when listening to participants' reports of the underfunding of the mental health services generally, as well as the difficulties encountered locally with shortages of basic therapeutic equipment. Similarly, the staffing shortages due to funding shortfalls is a serious issue which obviously affects the level of service delivery that can be managed by the clinicians, who are themselves highly critical of the infrastructural deficits and the way they impact patient care. The findings leave little doubt about how highly the State prioritises people with mental illness, and is somewhat reminiscent of the period that Foucault (2001) described when this group was marginalised and viewed as lesser beings. Critical medical anthropology's responsibility in highlighting these concerns comes to the fore, given the advocacy that is desperately needed.

Chapter 7 – Adapting to the COVID-19 pandemic

COVID-19 is one of the first pandemics the world has encountered in the past 100 years, considering that the *Spanish flu* ended in 1920. So, for most of us on the planet this is our first experience of such a biological catastrophe. The pandemic turned our lives upside down, disrupting our daily lives, education, health care, food production, business, work, and basically every facet of life. When President Ramaphosa declared a State of Disaster in March 2022, and placed our country in lockdown, most of us spent the following 21 days expecting that our lives would be back to 'normal' thereafter, but that was wishful thinking. Lockdowns were extended, in South Africa and across the world. Countries were trying to contain the spread of the virus, and health care was a serious concern. With many uncertainties, including job losses, food, housing, health and education, the rise in mental health concerns came to the fore. The social isolation resulting from the lockdown and public health measures became a major problem.

According to the South African Depression and Anxiety Group (2021), the organisation was receiving around 600 calls each day before the pandemic, but that doubled during the initial stage of the lockdown, and by September 2021 they were receiving more than 2 200 calls each day. They went on to state that problems faced by callers have the underlying theme of depression, suicidal ideation, anxiety and feelings of isolation. In addition, individuals with pre-existing mental health problems constituted a significant group warranting concern. Therefore, a significant question arose: How did a group of individuals with mental illness, residing in a mental health care facility for extended periods cope with the onset of the COVID-19 pandemic, especially considering the strain on health care facilities during this period? During my conversations with participants, I raised this issue.

Regarding the general COVID-19 effect on population mental health, Participant 1 stated:

"*COVID-19 is affecting mental health in a number of ways. One is where the actual pandemic and its restrictions and lockdowns etc. are creating additional mental health and psychological reactions in people, because this is a very unusual situation. So essentially, we're dealing with people responding to an abnormal situation in their lives. The other is, people who have had mental health problems even before COVID are finding that the pandemic and all its restrictions are exacerbating the conditions, in other words, making it worse in some ways. They're not able to access the mental health care, sometimes, or they're afraid to go to hospitals or clinics, etc.*"

This is a serious issue as there have been warnings about the mental health fallout for which governments need to prepare. It has been pointed out that countries have spent much of their energies and resources in the initial period preparing to manage the infection and resulting illness within their health care systems, without giving sufficient attention to the mental health consequences that the pandemic and its associated lockdown would bring (Van Hoof, 2020). However, as Participant 1 indicated, people with existing mental health problems are likely to have their illness worsen, given their difficulty adjusting to the pandemic life, as well as difficulties in getting their treatments during the lockdown. As Jean Segata (2020) noted, the COVID-19 pandemic affects everyone, it also hides the deep inequality in society, especially as it affects marginalised groups. People with mental illness, in long-term facilities, constitute one such group, for whom life is not as simple or straightforward, given the power structures under which they live their daily lives. They are a powerless group, now facing a pandemic, in addition to the other challenges noted earlier in this report.

7.1 The initial period of COVID-19 in the hospital

Discussing the initial period of the pandemic, a very interesting fact came to light, regarding the route of the virus into this forensic psychiatric hospital. Participant 3 stated

"*As long as they (patients) were in the hospital, they weren't exposed. The initial cases were staff bringing it into the hospital. But we managed to contain that. The second part was educating the patients about the use of masks and the use of social distancing. And sanitising too. They did really well with that. And the staff did very well with the education of the patients in terms of telling them about COVID or telling them about a viral infection.*"

Participant 2 gave a similar account of the virus' path into the hospital:

"*And right now, right now, we have COVID in the hospital and it's brought in by staff because they are the ones moving in and out, and two of our wards are affected.*"

The same point was made by Participant 1:

"*So, when the infection has come into the hospital or into the ward in more cases than not, it's come in via members of staff, because they are the ones who are going in and out, and that's what we know about the viral transmission.*"

This is a most interesting finding because if we think of hospitals, we think of sick people going there to get well under the agency of the clinicians. However, in this facility the situation was somewhat different, because it is a long-term facility where the patient population is fairly static. As a result, the staff constituted the only human traffic into and out of the facility on a daily basis. Hence, they were largely responsible (unintentionally) for bringing the virus into the facility. Of course, staff have their own lives and could pick up the virus anywhere in society, so it is not a matter of blaming them for the transmission. There is an irony, however, inherent in the fact that patients got infected with COVID-19 in a place where they are secluded, ostensibly for the sake of their health/wellbeing or, as Goffman (1961) might have argued, to impose an identity on them through confining them to a total institution. However, in the situation under study, the patients were further subjected to the risk of getting the virus from those caring for them, and of course, they were powerless to escape such a risk, because they could not go anywhere. It is almost a double dose of jeopardy.

7.2 The hospital's response to the outbreak

Regarding the hospital's response at the start of the COVID-19 pandemic, Participant 1 stated:

"*It has affected the patient care, like it's affected everybody else's lives. So, we take special care, in terms of patients' social distancing. We take special care, in terms of the patient's contact with each other in the wards. We take special care, in terms of families, for example, so during the COVID pandemic the family visits have been stopped, especially when, the transmission rates have been high. And so, in that respect we were guided by the national policy. Also, patients have been taught about COVID transmission methods, and how to prevent or reduce transmission so they've been taught about physical distancing, that we talked about using masks, they've been taught about sanitizing…Our experiences have been that patients have generally shown a reasonable understanding of COVID, because it's been explained to them quite simply, and they've understood it.*"

Participant 2 mentioned the actions they had to take when the pandemic started:

"*We had to do a lot of education, and education is ongoing. It's really just that we tell them about washing of hands, sanitising, and social distancing. We've put posters all over. We make sure that we've got enough soap, enough tissue paper at all entry points and all points where they hang around. We just tried very hard to keep to the rules of COVID. We have enough isolation, we really keep far apart and we wear masks, and we sanitise, everything is sanitised, the room, the tables, the chairs. Yeah, COVID has really affected us. We also educate them on COVID, what it is, how it started, and how it got here to South Africa… Like every hour we are just educating them on this COVID and to be honest, some of them are really good and more knowledgeable that we thought they would be. As a result our number of cases has not been as high as it could have been"*

Regarding personal protective equipment and supplies, Participant 2 responded:

"*We really are fortunate to have sufficient resources like face masks and sanitisers.*"

All of the participants noted that patients responded well to the initial education campaigns and information-sharing that had been instituted as part of the hospital's public health strategies to contain and reduce the viral spread. I must confess to being a little surprised by this, perhaps assuming that because the patients are mentally ill, and some have intellectual disabilities, they may not understand the situation or cope with the prevention strategies. This kind of stereotyping which I am embarrassed to admit to, and which much of the public do, became evident and challenged my thinking. Through constant education by the nurses and the MDT members, patients have learned to keep physical distancing, wash their hands, and wear masks.

Even though the American Psychiatric Association (2022), notes that persons with intellectual disabilities have difficulties coping with cognitive tasks, they indicate that affected individuals are capable of learning, to varying degrees. In this regard, it was gratifying to hear these clinicians say that generally most of their patients had some basic level of understanding of the pandemic and the responses needed from them. However, according to Stein (2022), hospitalised psychiatric patients are at higher risk for COVID-19 infection due to their closer proximity to each other in their dormitory-style wards. Again, we see the powerlessness of mentally ill people who are forcibly hospitalised, because had they been in the community they may not have had to live in dormitories with so many other people, thus increasing their infection risk, especially if one person in the ward becomes infected. They (i.e. the State Patients) are in this situation of increased risk due to decisions made by the courts. It was also sad listening to Participant 2 referring to the fact that some patients lost family members due to COVID-19:

"*Some of the patients even lost family members due to COVID. And worse, they cannot go to the funeral, so it leaves these patients feeling depressed. But we always have to reassure them, you know, as an MDT, we have meetings with them, as we always keep them updated on the COVID situation.*"

One cannot help thinking of the emotional pain suffered by the patients, as well as people not committed in hospitals, on losing family members and not being able to attend the funeral. This was at the height of the infection rates, when limited numbers were allowed to attend funerals, but the issue for the hospital was that leave of absence was curtailed due to the likelihood of bringing back the virus. Here also, the patients' circumstances of confinement against their will has resulted in this unfortunate situation. It is important to understand that, because the patients are mentally ill, it does not mean that they do not suffer the grief that others feel. Burrell & Selman (2020) raised concerns about the restrictions on funerals and attendance during the pandemic, and noted that cultural and religious groups that usually perform rituals after the deaths of family members have been affected by the COVID-19 regulations against these. Increases in mental health responses as a result of the way that the grief processes and rituals were curtailed, must be expected.

7.3 Admissions, leave of absence and family visits

Participants also spoke about the admission process during the height of the COVID-19 period, as well as the issue of leave and family visits. Participant 3 said:

"*And then the issue, remember I told you at the beginning we had many people from prison, awaiting trial individuals, and we have to screen all of those individual before we bring them into the ward. We have to wait for them to be tested first before we start seeing them*."

Participant 2 clarified the process for those who had already been on leave, but were returning, because their prescribed leave period expired or because they relapsed, became ill and could not be managed at home:

"*Yeah, because when they come back from leave. We have to test for COVID.*"

Regarding family visits and leave of absence, Participant 3 said:

"*Then there was the issues pertaining to going out on home visits and the issues of family coming to visit that we had to put that on hold for a while because of the lockdown and to avoid infection. We couldn't really send individuals home or bring family to the hospital. So, we've managed by, like telephonic ways allowing the patient to speak to their families*"

All of the participants made it clear that the hospital functioning was subject to the special directives received from the Department of Health regarding procedures to follow and changes that had to be made during the height of the COVID-19 pandemic, when infection rates were very high. This included having to test all new or returning patients, given the possibility that they could be carrying the virus and thus infect the rest of the hospital. An additional regulation entailed the curtailment of family visits to the hospital (which are usually encouraged) as well as patients' leave of absence. This is in line with the view of Stein (2022), who argued for limiting visitors for hospitalised psychiatric patients. As mentioned by Participant 3, attempts were made to arrange telephone calls so patients could speak to family members. With measures such as this, it was again clear to me that the clinicians really felt for their patients and tried to do whatever they could to make them feel connected, for those who had existing contacts with families, bearing in mind that some have no family contact.

What became clear, in listening to the participants, was that COVID-19 halted the interactions of patients with their families and significant others. This is a serious issue, considering the value of family support and kinship in influencing societal responses to mental illness, as argued by Hayley MacGregor (2018), and the importance of family and friends as "therapy managers" in promoting patients' care and recovery, as argued by Feierman and Janzen (1992). It has also been noted that the widely accepted psychosocial rehabilitation approach to patients with chronic mental illness is dependent on the support of families and other significant individuals in the patient's social circle, to facilitate their recovery (Kramers-Olen, 2014). Research has confirmed that social support correlates positively with improved mental health (Harandi, et al., 2017) and, therefore, the onset of the COVID-19 pandemic with the strict lockdown, impacted negatively on the well-being of patients in long-term institutional care.

7.4 The COVID-19 vaccines for the hospital's patients

During my interviews, I asked the clinicians about how the governments' COVID-19 vaccine programme had been managed within the hospital.

Participant 3 mentioned that:

"*staff have been receiving vaccinations from March 2021 and patients had been getting vaccinated from the beginning of July*."

Regarding vaccines for patients, Participant 6 responded as follows:

"*So, patients have been educated and given the opportunity to take the vaccine, and they have also consented. So, we, as far as I'm aware, we have administered the vaccine to patients who have agreed to take the vaccine so obviously there's been quite a lot of teaching in the wards around COVID. And of course, the patients are watching the news, you know. And within the system the nurses teach them a lot, the doctors and the rest of the team also educate them about COVID…. There have been a few patients here and there who have declined and they haven't been forced to take the vaccine if they have declined.*"

Regarding vaccinations, Participant 3 stated:

"*But in general, I must say the patients have been very compliant and also not against vaccination. I've actually spoken to some that seem very knowledgeable pertaining to issues of COVID and haven't been against vaccinations, where we have a challenge is sometimes some of the individual don't have ID's. The answer to your question is that there hasn't been a lot of opposition. I think we underestimate how knowledgeable patients are*"

It has been encouraging to hear the participants' reports that both staff and patients had been receiving COVID-19 vaccines. It was heartening to note that the mentally ill patients were not forgotten, and that even early in the vaccine programme, they were considered a vulnerable group prioritised for vaccination. Mazereel et al. (2021) noted that people with mental illness, especially severe forms, are at increased risk of contracting, and even dying from COVID-19 and, therefore, vaccine prioritisation is indicated. It was also a positive sign that patients were largely agreeable to having the vaccine, showing that the education programme implemented by the clinicians had good results. In addition, it highlights the fact that there was generally some level of understanding in the patients regarding the virus and the necessary prevention strategies.

It is also very heartening to note the clinician's responses, regarding the way they handled the COVID-19 issue. They did not focus on the patient simply as a 'schizophrenia' or a 'bipolar disorder', in other words, the 'clinical gaze'. In the clinician narratives, it was clear that they were really concerned about the patients as human beings, and the feelings they experienced. They felt for the patients, and were not simply viewing them as disease entities. For example, when the lockdown prevented patients' leave of absence or family visits, the clinicians expressed their sadness about this, and tried to make other plans to keep patients in contact with their social networks. These social networks are what Feierman and Janzen (1992) referred the 'therapy managers', and the clinicians tried not to break the link that the patients had with their social network, and rather looked to maintain it even in difficult circumstances.

7.5 Changes to the therapeutic programme due to COVID-19

I also enquired from my participants about the MDT functioning during the pandemic, in particular whether the meetings continued, and whether the treatment programme had changed in any way, as a result.

Regarding the MDT meetings during COVID-19, Participant 1 stated:

"*Obviously COVID has interfered with that. But we still do have meetings we do it in a way that ensures that there's good social distance that start with masks and taking all the precautions. So, we take all of the precautions, but it is important for us to have the MDT meetings because if we don't, then we're missing out on the important decision making that needs to take place regarding our patient care.*"

In response to the question of how the treatment programmes have been affected by COVID-19, Participant 1 said:

"*We have tried not to let it disrupt treatment in our facility too much. And the reason for that is because our facility has a fairly stable patient population. These are people who've been* *there for a long time, years in fact. So, we've just continued the treatment, but taking adequate precautions, etc. In some instances, therapy programmes have been modified, for example, group therapy programmes now take into consideration social distancing, etc.*"

The absolute need for the therapeutic programme to continue is without doubt, especially considering that the hospital houses patients with severe mental disorders and if there are significant changes to their treatment that could risk them relapsing. In this regard it was good to see that several steps had been taken by the hospital and especially the clinicians to work in a safer manner that reduced the risk of infection to the patients and staff, while continuing the treatment programme. Noting the higher risks faced by patients with severe mental disorders, such as psychosis, Stein (2022) pointed to the need for their continued treatment, citing the risk of poor health outcomes overall, should they become infected with COVID-19. It is unfortunate that this group of individuals, who are marginalised to the edge of society because of their mental illness, are also at greater COVID-19 morbidity and mortality risk, than the general population. This speaks to the structural inequalities in society and mental health that are so entrenched and woven into the fabric of society. As a result people with mental illness (and other marginalised people) are more vulnerable to physical health problems, disease and social adversities than others in society. Medical anthropologist Arthur Kleinman (2009) noted that the conditions under which people with mental illness live, more so in poor countries, increases their vulnrerability to wider social and health problems. If we consider that the patients in the hospital have to live alongside dozens of others, their risk of COVID-19 infection is drastically increased, merely because they are mentally ill and are forced to live in those circumstances. This is the structural violence that Paul Farmer (2004) referred to in his exploration of how those belonging to a certain social order suffer ongoing and cumulative adversities that accentuate adverse outcomes such as "death, injury, illness, subjugation, stigmatization, and even psychological terror" (p. 308).

7.6 The cigarette sales ban during the COVID-19 lockdown

During the initial lockdown phases in South Africa, cigarette and alcohol sales were prohibited by law, as part of the State of Disaster regulations (Smart & Broadbent, 2020). This affected the availability of cigarettes and tobacco to the hospital's patients. It is well known that smoking is common in patients with serious mental illnesses (Stein, 2022). Given their circumstances living in a chronic mental health facility for years, it is understandable that patients develop such habits, which become a way of coping with their situation. We must remember, in the context of the history of smoking behaviour, that smoking, tobacco and nicotine use and addiction represent a centuries-old tradition, as Hughes (2002) points out. Even though he describes it as a global pandemic, he notes how its use relates to issues of identity and developmental and life changes in individuals. Similarly, in his book "Asylums", Goffman (1961) highlighted the history of institutions like prisons and psychiatric hospitals where inmates received tobacco as a weekly ration. In other words, the system created a state of nicotine addiction in these individuals, feeding and reinforcing the addiction over time.

Therefore, during the lockdown, the non-availability of tobacco products meant that patients were suddenly without their nicotine fix, which is a serious issue for people addicted to the substance, which we tend to forget is actually an addictive drug. It is important to consider here that the American Psychiatric Association, in their *Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision* (DSM-5-TR), lists tobacco withdrawal as a mental disorder, with the following symptoms: irritability, frustration, or anger; anxiety; difficulty concentrating; increased appetite; restlessness; depressed mood, and insomnia (American Psychiatric Association, 2022). We have to then consider that for the hospital's patients, most of whom have been severely addicted over the years, they have to endure the withdrawal effects and cope with these psychological symptoms in addition to their existing illness. That seems quite unfair.

A few of the participants that I had conversed with, mentioned that protests broke out in the hospital, among patients who were demanding cigarettes and tobacco, wanting the use of these substances to be reinstated. Participant 3 stated:

"*…although I was not around at the precise time of the protest, stories were conveyed to me from other clinicians about the meetings held between the protesting patients and the hospital management. Patients were quite unhappy about the situation*"

Participant 2 also raised an issue regarding patients smoking behaviour:

"*It's just like a daily ongoing education, but our big challenge is smoking. Our patients like to smoke, and therefore they share cigarettes. So, that is a major problem.*"

Participant 1 expressed quite a strong view on the tobacco ban, saying:

"*Of course, another effect of the lockdown has been the ban on cigarettes. Remember our patients are here for many years and smoking is a common pastime for psychiatric patients. So, they have become dependent on nicotine. Let's remember that tobacco has been a legal product that government has allowed stores to sell and for people to become dependent on it.*

Just stopping sales now and expecting compliance may be wishful thinking. As a result, our patients have expressed their unhappiness about this, one of the symptoms of nicotine withdrawal is irritability, so we are lucky that we have not had any serious outbursts as a result."

The responses from the participants on this issue raised a number of concerns in my mind, relating to tobacco use, as well as about the lives of mentally ill patients in long-term hospitalisation. First, I have to confess finding it both interesting, but also strangely admirable, that the patients embarked on a protest over what they believed to be an infringement of their right to be able to access tobacco. Even though smoking is a known health risk, the fact that the patients were dependent on it does raise a serious concern about the sudden sales ban. In a highly critical paper on the government's response during COVID-19, Pillay and Kramers-Olen (2021) argued that:

> "… it is naive to believe that all or most smokers would stop smoking because government stopped their supply. If smoking cessation was that simple, the world would have witnessed a greater proportion quitting decades ago. That smoking is harmful and should never be encouraged is not in question. However, the tobacco ban ignores the nicotine addiction problem which government created and reinforced over many years by allowing citizens to legally become dependent on the drug. To suddenly cut off supply of the drug raises human rights issues. Similarly, the sudden tobacco ban in chronic mental health facilities, where patients have *lived* for decades, sometimes with no family contact and little or no social pleasures, is a matter requiring serious deliberation, and perhaps an issue for ethicists." (p. 297).

It is difficult to argue against the view put forward by these authors regarding the ethics of suddenly cutting off the supply of tobacco to mentally ill people, or others for that matter. As Pillay and Kramers-Olen (2021) noted, if quitting smoking was that simple to achieve, the world would not be sitting with such a massive nicotine addiction problem. The imposition of this ban by the State as the primary agent of power, against those addicted to tobacco, reflects (i) the double standards of first allowing the addiction through legalising the product and then denying those who became addicted, and (ii) the type of 'othering' and marginalisation of this group, as described by Gayatri Spivak (1988). Governments all over the world have historically fought a losing battle trying to get their citizens to stop smoking, and one cannot help wondering whether this type of ban was not an opportunistic move to punish that group. After all, there has been considerable debate about whether banning tobacco sales during the pandemic could actually have any beneficial effect for the nation or its health care pressures. In fact, research by the University of Cape Town revealed that 90% of smokers were still able to buy cigarettes on the illicit market (van Walbeek, et al., 2020), thus negating the effect of the ban, while benefiting the illicit traders. Of course, the patients in the forensic psychiatric hospital are not able to access the illicit market as easily as the general public can, showing yet again how this group is marginalised and discriminated against.

In this context of mental illness, and especially people with chronic mental health problems in institutions, it is important to historicise the use, availability and regulation of tobacco which is a feature of institutionalised communities worldwide. The use of tobacco and the smoking of cigarettes must be seen against the historical discovery of the psychoactive nature of certain plants centuries ago. However, as Waetjen, Hodes and Parle (2019) have argued, the use of the substance became entangled with issues of colonialism, power, inequality, and economics. Corruption also featured over time, and certainly manifested during the COVID-19 pandemic, where the government's tobacco ban fertilised the illicit trade – could the government not have predicted that would happen? Of course, the very nature of the substance as an addictive one, resulted in tobacco and cigarettes developing dependencies in people, with the vulnerable and marginalised groups more affected than mainstream society, due to their challenges in obtaining the drug (tobacco / nicotine). In her work, "Where there's smoke there's fire" Sharon Cook (2006) noted that, over time, the smoking of cigarettes came to develop special meaning and symbolic significance for those who have been disenfranchised from conventional society. This is quite evident in the institutionalised population of people with mental illness. While its use may be initiated due to the novelty, it becomes a pastime for those in institutions, and quickly thereafter assumes the role of an addiction, at which point the corporate establishments responsible for their commercial production begin their lifelong profiteering.

7.7 Summary of Chapter 7 findings

The main impression that came through from my conversations with participants was that the hospital coped quite well with the COVID-19 pandemic, given the various challenges it faces at a broader level, and that we face as a country. For example, having listened to all of the participants complain severely about the underfunding of mental health care nationally, I was expecting to hear similar complaints about the availability of personal protective equipment that is so vital in preventing viral transmission. That was not the case and, in fact, it was made clear to me that there was sufficient supply. This was a positive finding, considering that the health of the vulnerable group of mentally ill patients and the staff depended on it. It was also significant, given the multi-million-rand corruption allegations within the Department of Health, in relation to the procurement of personal protective equipment during the pandemic (Payne, 2022).

Similarly, the reports indicated that from the start of the pandemic, patients were educated about the virus and prevention strategies, and being a static population, unlike a general hospital that has daily admissions and discharges, clear steps were taken to try to limit the patient infections as much as possible. Here we are dealing with the issue of knowledge and the power of knowledge, which Miranda Fricker (2007) argued can be used in an unjust manner (i.e. epistemic injustice). However, in her subsequent work she raised the concept of epistemic justice, which is more applicable here. According to Geuskens (2018) “epistemic justice is best understood as the proper alignment between truthfulness and trust” (p.79). The scientific knowledge of the COVID-19 virus is a good example of where trust and truthfulness need to be aligned, for reasons of honesty, moral responsibility and population health. The clinicians had the responsibility of openly sharing their knowledge of the viral transmission, in simplified terms, so that patients developed an understanding of the virus, its mode of transmission, and the recognised prevention approaches. This was what the hospital’s clinicians did, and the result, as noted by the participants, was a minimising of the infection, especially considering how much worse it could have been in terms of morbidity and mortality, given the patients’ close living arrangements.

Stopping family visits and patients’ leave of absence in the early phase of the pandemic, which were Department of Health directives, had been instituted. This can be understood in terms of the biopower and sovereign power that Foucault (1998) referred to, but has to also be viewed within the context of the knowledge-base at the time and the health authority’s intention to limit infection, morbidity and mortality. Of course, with hindsight, there are different views on how the situation could have been handled. The actual mental health treatment programme had not changed significantly, as clinicians felt that patients needed to continue with their treatment. Here again, it is positive to note that the clinicians had not neglected their patients’ mental wellness within the drama that was COVID-19. We must remember that the early days of the pandemic created anxiety for everyone, including health workers, who also had their own health and that of their families to consider. So, the early weeks and months of COVID-19 was a real-life drama.

Another positive finding was that staff and patients had received vaccines, and that patients had generally not been opposed to receiving the vaccines, after they had been appropriately educated about it. We see again the epistemic justice at play, because the information that was available at the time, was given to patients by the clinicians, and they were able to decide (Geuskens, 2018). It is often incorrectly assumed that people who are mentally ill cannot make decisions – that applies only to some individuals. An extensive systematic review confirms that most patients, even with severe mental illness are capable of rational decision-making regarding their health (Calcedo-Barba, et al., 2020). It is clear that the absolutist power dynamic that pervaded traditional mental health care is not the dominant picture anymore, especially considering the rights-based Mental Health Care Act of 2002, which has been a significant shift from the archaic system (Republic of South Africa. 2005).

A significant issue, however, was the national ban on the sale of cigarettes and tobacco, to which many patients are addicted, following years of use. The understandable unhappiness about this caused patients to protest this situation to express their discontent. To me as a researcher, this presented at least two notable conclusions. Firstly, it highlighted this specific COVID-19 regulation, which has been criticised for its absurdity, punitiveness and feeding the illicit tobacco trade (Pillay & Kramers-Olen, 2021). Secondly, it showed me a side to mentally ill patients that the general public may not necessarily see. It revealed their resilience, courage and tenacity in the face of structural violence, very much as Galtung (1969) described the situation of laws and regulations preventing people from meeting their basic needs, and smoking was a basic need because the government had allowed them to become dependent on nicotine. I have to confess to secretly smiling when I heard about the protests, and thought to myself "Good for you!" It reminded me of the stories of our struggle heroes standing up against the unjust laws of apartheid.

Overall, it was clear that the hospital and the clinicians worked hard at keeping patients as safe and healthy as possible. Very importantly, in relation to my research aims, I did not get the impression of the 'clinical gaze' predominating, which was a feature that Foucault (1973) identified in the earlier days of mental health care. This is not to say that such attitudes have been completely eliminated from medical practice, but it is rather pleasing to note that it did not feature in this hospital. Of course, we must also remember the methodological constraints of the present study which was not able to observe clinical care exactly as it occurred. Nevertheless, I found that the participants related to me in an honest manner, and I did not get the impression that they held back or were reluctant to disclose functional aspects of their work and the systemic issues in the hospital. To me, this finding makes it is apparent that mental health care has come a long way from the time that Foucault wrote about, and that the current practice of care is better informed by the modern literature and rights-based mental health legislation.

Chapter 8 – Conclusion

Looking back at this journey, it is clear that anthropology has much to offer mental health care, especially in providing critical social analysis, identifying areas of concern, and those needing improvement. Questions that need to be asked from the critical medical anthropology standpoint are (i) what current policies and practices in mental health care are shaped by the political and economic structures and (ii) what social inequalities are evident in our mental health care services that put poor and other marginalised groups at a disadvantage.

When I started this journey, the focus of my research was a forensic psychiatric hospital in Pietermaritzburg, KwaZulu-Natal. My specific aims were to look into the relationships that MDT members had with people in the patient's social network ("therapy managers"), the agents of power in the mental health care system, the way in which patient rights were managed, issues of funding in mental health, and (later) the ways in which COVID-19 affected the treatment process. Initially, when this study was planned, the project and the aims did not look too much like a tall order. It seemed fairly manageable, and even though I had anxieties as a novice researcher, I felt that I would be able to achieve these aims without too much difficulty. Of course, that was before COVID-19 hit the world and our shores, and changed most aspects of our lives.

8.1 The challenge of ethnographic research during a pandemic

I originally planned to spend about six months in the field, interviewing participants and doing fieldwork in the true ethnographic form. I realised very soon that, with the onset of the COVID-19 pandemic, that was not going to be possible and I would be unable to meet with my participants in a physical space. It was clear that I would need to devise an alternate plan of action to conduct my fieldwork without placing my participants or myself at risk. Furthermore, I became aware that I would be unable to gain access to the psychiatric hospital due to hospitals across the country limiting access only to essential visits. Since all of my proposed participants were mental health care professionals, I was becoming aware that the amount of time I would be able to spend conversing with them would have to be reduced, especially considering that the COVID-19 situation had brought new challenges to their daily work and, therefore, they were busier than ever. The COVID-19 challenges, therefore, led me to look at the alternative approach of virtual ethnography as described by Daniel Miller (2020) or 'netnography' as articulated by Christine Hine (2015). In this respect, I am grateful to my participants for their willingness to use the virtual platform despite a few challenges, and for sharing their knowledge and views, as well as the reality of how treatment and interactions between clinicians, patients and families are shaped.

I believe that if I was able to spend a more significant amount of time with my participants, while situated in the field, the information and the knowledge I would have gained could have been richer and the descriptions much thicker as Clifford Geertz (1973) recommended. Of course, I attempted to compensate for this by spending time scouring secondary data that could complement the picture that was to emerge from my findings, in order to compensate for the lack of traditional ethnographic fieldwork. The other significant challenge I experienced during the fieldwork was preventing it becoming a formal interview. The challenge of meeting and conversing with participants over a technological platform, did not allow for relationships to be formed in the comfortable manner that is usually achieved in the field. This new digital or virtual form of fieldwork challenged me to engage more with responsive conversational skills and also pushed the narrative of me trying not to let a computer screen prevent me from revealing my care, interest and deep desire to know about the views and experiences of my research participants. As I did not have endless amounts of time with each of my participants, the challenge was to prioritize what topics of conversation I wanted to cover, while also allowing for diversion to follow other interesting avenues that arose in our interactions, or that participants felt they really wanted me to know about.

Unfortunately, the COVID-19 pandemic uncovered technological challenges that were bound to happen living in a country like South Africa with unstable electricity and internet connectivity problems, among others. As a result, thinking on my feet and quick changes were necessary. An example of this was during a few interviews, when the internet connection used by either my participant or me became unstable or the electricity went off. I then turned to using my cellular phone to contact my participant to continue our conversation. Spending a longer time with participants, a greater number of contact times and in different spaces, for example on hospital premises, could have made them feel more at ease and elicited more information. Murchison (2010) discusses the important issue of balancing participation and observation to ensure that we get a good understanding of our participants and their life experiences. Through the use of 'netnography' however, this task was a slight hindrance to the quality of information I was hoping to gain. In this context, Gupta and Ferguson (1997) argue that a conscious shift in geographic or social location can be a valuable methodology, and they define 'location' as something one works at strategically. Nevertheless, I am pleased that with a number of the participants I was able to have more interviews, going up to four interviews in some cases. I also quickly learned how to develop the relationship with the participants in a warm, friendly manner that resulted in all of them feeling quite comfortable chatting to me, as if they knew me for a long time.

During my fieldwork, as the focus was on mental health care, I opted to interview 10 mental health care professionals working within the multidisciplinary team. This team included psychiatrists, clinical psychologists, occupational therapists, nurses and social workers. Through approximately 27.5 hours of interviews, themes emerged that shed light on important aspects of mental health care, the MDT functioning and interactions with patients' 'therapy managers', power relations, funding, coping with the coronavirus pandemic, as well as human rights issues relating to mentally ill institutionalized patients.

8.2 The findings

In the first of the discussion chapters I related my findings regarding the MDT and 'therapy managers' or significant people in the patient's social network who provide them with support and advice. The quite distinct job functions of the MDT members were evidenced when they related their work contexts and contributions to patient care. Although the team functioning was largely described as a democratic process, it was quite clear that biomedicine ruled, which may be related to historical factors and the role that biomedicine played in health care over the centuries. Of course, as Becker, Boonzaier and Owen (2005) noted, power relations are a highly complex issue, and more so in a country like South Africa. Regarding relationships with patients' family members and significant others, or what Feierman and Janzen (1992) referred to as 'therapy managers', it emerged that social workers had the primary task of liaison with them, although other MDT members also interacted with them as the need arose. Sadly, while families are encouraged to visit patients, some families are unwilling to have contact with the patients, which in many cases relates to the alleged offence resulting in the person being declared a State Patient. It was also clear that the MDT was not opposed to families and/or patients intent on including cultural rituals and belief systems into their treatment. Participants noted that the MDT accommodates alternative explanations, including spiritual healing. I got the impression that the MDT were open to working alongside cultural healing systems and do not view themselves in competition. However, the fact that many of the clinicians do not speak African languages, which are often the patients' first language, is a significant problem, resulting in the use of translators that add to the structural inequality and marginalisation, and is certainly an issue that needs addressing.

The second thematic area relates to agents of power within the mental health system. Here, very interesting and informative narratives came through, broadly looking at the power dynamics as they occur nationally, within the broader system that controls mental health care and especially State Patients, as well as the more localised power dynamics within the specific forensic psychiatric hospital. The difficulties experienced by the clinicians in getting State Patients discharged is a significant issue, given that the court (which constitutes the State as the primary agent of power) is the only authority that can discharge the individual and set him/her free. This speaks to the *Great Confinement*, that Foucault (2001) referred to in his work *Madness and Civilization*, and which Scull (2015) also described in the context of how people with mental illness were locked away against their will, and had no say in the matter. Frantz Fanon (1963), was also very critical of the way that the State wielded control over individuals with mental illness. The case of the State Patient is one that needs ongoing attention, given that they have not received a full trial and their guilt has not been proven, yet they are detained against their will, simply because they were accused and are also mentally ill – showing the immense power that the State wields over this marginalised group. The power dynamics within the forensic psychiatric hospital shows quite clearly that the biomedical model rules, with the psychiatrist in charge. This reflects the historical and globally defined paternalism that characterises health care, with the medical model quite dominant (Barker & Stevens, 2000; Murjic et al., 2015). A very positive finding has been that, since the demise of apartheid, the hospital management does not interfere with patient management and clinical care decisions, and the participants appeared to appreciate their clinical independence.

The third theme emerging from the interviews is that of mental health care and human rights. Again, the issues that emerged were significant, but pertained to the broader power dynamic with the State being the primary agent. Here patients' rights to intimacy, their right to vote in the country's elections, and their right to freedom from detention were the key themes emerging. The first mentioned infringement is at odds with the country's mental health legislation that states that hospitalised patients have the right to intimacy (Republic of South Africa, 2005). However, the State does not, in its hospital planning and infrastructure, allow physical spaces for consenting patients to engage in intimate relations, resulting in patients using the bushes and other inappropriate places that impact negatively on human dignity. Considering that the issue relates to consenting adults and the infringement of a basic right, including human dignity, it evokes concern about the structural violence suffered by affected patients (Galtung, 1969). The right of mentally ill patients to vote in the country's elections emerged as another serious violation of their human and constitutional rights, given that the Electoral Act of 1998 denies them this basic right as adult citizens (Republic of South Africa, 1998). The application of this law reeks of both structural violence and epistemic injustice to a group that is already marginalised due to having a mental illness (Fricker, 2007; Galtung, 1969). Moreover, not being allowed a voice in their country's elections, reflects the State's efforts in silencing and excluding from society, groups that are regarded as low in political or social ranking, as Gayatri Spivak (1988) raised concern about. Regarding the continued detention, the difficulty achieving a release, and the fact that State Patients have not had the benefit of a full trial, but are locked away indefinitely, we have to heed the concerns expressed by Miranda Fricker (2007) in her discussion of epistemic injustice. This is because these individuals are effectively being denied a voice (in not being allowed to testify in their defence), and it is possible that some of them may not have committed the offence, but because of the accusation and their mental illness they are declared State Patients and given an indefinite detention, which is an issue highlighted by legal expert Ronald Louw (2006). The unjustness of this situation is difficult to believe in democratic South Africa, and it is one that demands urgent attention.

The underfunding of mental health care was another theme that emerged from my conversations with participants. Listening to these clinicians share their complaints about the lack of money to fill posts that have been vacated, even though those were funded positions, left me wondering, perhaps naively, what has happened to the money that was used to pay the previous employee? Clearly that money has gone somewhere – but it is not clear exactly where, because my participants, who are devoted to patient care, were very frustrated by the situation. As a nation, we have to wonder about the movement of funds within the upper levels of the governing structures in our country, and the *Zondo Commission* reports have brought some of this to light (Commission of Inquiry into Allegations of State Capture, 2022). If we accept that mental health, like all other aspects of health care, must be considered basic necessities, and if the availability of high-quality mental health care is being compromised, then this must be considered an injustice to people with mental health problems. The issue also reflects how the State views people with mental illness, and in some ways, it is possible that the State does not value them enough to ensure that adequate funds are directed to this marginalised group for the care they desperately need. Perhaps the State needs reminding of the number of deaths caused by its money saving attempt in the Life Esidimeni tragedy, which tarnished South Africa’s mental health care reputation, just a few years ago.

The final theme that came to the fore was the hospital’s adaptation to the COVID-19 pandemic. It was clear that, given the hospital’s funding challenges, the facility responded very well to the pandemic which was a new challenge for everyone. Even with their limited budgets, they provided all of the required personal protective equipment to ensure that patients and staff could be as safe as possible. The clinicians took all of the necessary public health steps, including educating patients, to prevent and minimise viral transmission. During my interviews with participants, it was evident that nursing staff, more than any other discipline, had stepped in quite quickly to educate patients on the new threat. This, they achieved within the constraints of their facility catering for around 350 patients in mostly very old buildings that were not purpose-built for mental health care. The clinicians’ dedication and care for their patients’ well-being was evident. Among the steps was the curtailment of leave of absence for patients and family visits to the facility. Other than those changes, the MDT kept the therapeutic programme going, believing that it was vitally important to ensure that the patients were as mentally well as possible, while keeping them as safe as possible from the COVID-19 virus. The vaccine programme was also initiated with patients generally keen on being vaccinated. However, a difficulty arose when some patients did not have an Identity Document and were thus not able to receive the vaccine. That is obviously a bureaucratic matter that should be addressed. A significant issue, however, was the effect of the State's ban on cigarettes and tobacco products during the early period of the pandemic. Patients were not able to access tobacco, unlike the public's ease of access through the illicit market, and this caused an uprising, where patients engaged in social activism and protested, to express their dissatisfaction. In the context of the COVID-19 issue, and more generally, I certainly did not get the impression of the 'clinical gaze' (Foucault, 1973) as a *modus operandi* in this hospital. Considering that I used a virtual, rather than field, ethnographic approach, it is possible to argue that I did not see the true manner of approach used by the clinicians in dealing with their patients. That is true, but I would find such an argument difficult to accept in its entirety, because through the in-depth descriptions that I was able to elicit, and the way that the clinicians spoke about their patients it was clear to me how much they cared about their patients, and how they viewed their patients as human beings rather than as disease entities. The numerous narratives and the subtexts made it clear to me that my conclusion is justified. The multiple critical comments that I have raised in this report regarding mental health care and the approach to State Patients are issues for which the State is responsible, as the highest level of government.

8.3 Limitations of the study

Among the limitations of the study are obviously the practical constraints imposed by the COVID-19 pandemic and the lockdown regulations. As a result, I was not able to use a traditional ethnographic approach to fieldwork, and was not able to interview and hold conversations with my participants in their work context at the hospital. The COVID-19 period placed the clinicians under greater pressure than usual, which meant that I was not able to spend as much time with them as I would have liked. Nevertheless, I have always believed that we must work with what we have. In this respect, I know that I was able to get the gist of what my participants were conveying, and the concerns they had, and it was clear to me that they went out of their way to assist with information sharing, which is a fundamental aspect of ethnographic research.

8.4 Recommendations for future research

For future research on this topic, it will be ideal to conduct interviews in the hospital context and spend more time with the clinicians in their work environment. I also believe that future research should try to gain a complementary perspective of the situation by interviewing patients with mental health problems, and especially State Patients to learn how they feel about their predicament and the changes they would like to see.

8.5 Some personal reflections

Looking at this fieldwork journey, I noted that, considering my inexperience as an ethnographic researcher and the spanner that COVID-19 had thrown into the works, there have been unexpected challenges, but this is a reality and as researchers we have to find a way to work around them or with them. We have to be reflexive and resilient. We cannot allow such challenges to stop us from conducting research which could benefit humanity. I realised that I am one of many researchers, globally, embarking on a research project in a very different manner to what was developed as traditional ethnographic fieldwork, and I believe that the way in which I approached the research was appropriate, given the circumstances. As researchers, the COVID-19 pandemic has made us realise that future global catastrophes may force even further changes on how we conduct research. Research methodologies will be an ever-changing phenomenon over the coming decades. In this respect, I am truly very grateful to my participants for allowing me to ‘pick their brains’, to have some fairly difficult conversations with them, and for being so honest in their responses and reflection. Although mental health care, and forensic mental health in particular, may not be ideal right now, there is clearly much good work being done. Mental health care has progressed substantially from the past, and research such as the present study will no doubt be able to contribute to developing the field in the right direction.

References

Abi, S. 2019. *Psychiatric problems: Metaphysical explanations*. https://www.dandc.eu/en/article/west-africa-traditional-or-religious-practices-are-often-preferred-method-treating-mental#:~:text=The%20subject%20of%20mental%20health,in%20the%20past%2050%20years

Ahmed, R. & Pillay, A.L. (2004). Reviewing Clinical Psychology Training in the Post-Apartheid Period: Have We Made Any Progress? *South African Journal of Psychology*, 34(4), 630-656. doi:10.1177/008124630403400408

Allen, M. 2017. *The SAGE Encyclopedia of Communication Research Methods*. Thousand Oaks, CA: SAGE Publications, Inc.

American Anthropological Association. 1947. Statement on human rights submitted to the Commission on Human Rights, United Nations. *American Anthropologist*, 49, 539-543.

American Psychiatric Association. 1979. Report of the Committee to visit South Africa. *American Journal of Psychiatry*, 136, 11, 1498-1506.

American Psychiatric Association. 2022. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision*. Washington, DC: American Psychiatric Association.

Ataguba, J. E., & McIntyre, D. 2018. The incidence of health financing in South Africa: findings from a recent data set. *Health economics, policy, and law*, 13(1), 68–91. https://doi.org/10.1017/S1744133117000196

Barker, P. & Stevens, C. 2000. *Construction of Power and Authority in Psychiatry*. London: Elsevier.

Becker, H., Boonzaier, E. & Owen, J. 2005. Fieldwork in shared spaces: positionality, power and ethics of citizen anthropologists in southern Africa. *Anthropology Southern Africa*, 28, 123-132, https://doi.org/10.1080/23323256.2005.11499922

Benatar, S., 2013. The challenges of health disparities in South Africa. *South African Medical Journal*, 103(3), 154-155.

Benbow S. 2009. Societal abuse in the lives of individuals with mental illness. *The Canadian Nurse*, 105(6), 30–32.

Beng, K. S. 2004. The last hours and days of life: a biopsychosocial-spiritual model of care. *Asia Pacific Family Medicine*, 4, 1–3.

Bhugra, D., Pathare, S., Gosavi, C., Ventriglio, A., Torales, J., Castaldelli-Maia, J., Tolentino, E. J., Jr, & Ng, R. 2016. Mental illness and the right to vote: a review of legislation across the world. *International Review of Psychiatry*, 28(4), 395–399. https://doi.org/10.1080/09540261.2016.1211096

Bickford, J. 2006. Democracy in the multidisciplinary team: face or fiction?." *Psychiatric Services*, 24(10), 700-a–701.

Biehl, J. 2004. Life of the Mind: The Interface of Psychopharmaceuticals, Domestic Economies, and Social Abandonment. *American Ethnologist*, 31(4), 475–496. http://www.jstor.org/stable/4098864

Biehl, J., 2013. *Vita: Life in a Zone of Social Abandonment*. Berkeley, CA: University of California Press.

Biehl, J., & Locke, P. 2010. Deleuze and the Anthropology of Becoming. *Current Anthropology*, 51(3), 317–351. https://doi.org/10.1086/651466

Blau, P.M., 1963. Critical remarks on Weber's theory of authority. *American Political Science Review*, 57(2), pp.305-316.

Boellstorff, T., 2013. Digital Anthropology. *Oxford Bibliographies*. https://escholarship.org/content/qt94j4h0p4/qt94j4h0p4.pdf

Boellstorff, T. D., Nardi, B., Pearce, C. & Taylor, T. L. 2012. *Ethnography and Virtual Worlds A Handbook of Method.* New Jersey: Princeton University Press.

Braun, V. & Clarke, V. 2021. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales, *Qualitative Research in Sport, Exercise and Health*, 13(2), 201-216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V. and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2). 77-101.

Brosnan, L. 2012. Power and participation: An examination of the dynamics of mental health service-user involvement in Ireland. *Studies in Social Justice*, 6 (1), 45-66.

Broughton, T. 2021. *Residents starve and lie in urine-soaked beds as service providers walk out of Durban mental health facility*. https://www.timeslive.co.za/news/south-africa/2021-05-14-residents-starve-and-lie-in-urine-soaked-beds-as-service-providers-walk-out-of-durban-mental-health-facility/

Burrell, A., & Selman, L. E. 2020. How do Funeral Practices Impact Bereaved Relatives' Mental Health, Grief and Bereavement? A Mixed Methods Review with Implications for COVID-19. *OMEGA - Journal of Death and Dying*. https://doi.org/10.1177/0030222820941296

Caesar, M.S. 2015. *A 'new experiment in local government' - The Local Health Commission: A Study of Public Health and Local Governance in Black Urban Areas in Natal, South Africa, 1930 – 1959*. Doctoral thesis. Queen's University, Canada. https://qspace.library.queensu.ca/bitstream/handle/1974/13100/Caesar_Mary_S_201505_PhD.pdf?sequence=1

Calcedo-Barba, A., Fructuoso, A., Martinez-Raga, J. et al. 2020. A meta-review of literature reviews assessing the capacity of patients with severe mental disorders to make decisions about their healthcare. *BMC Psychiatry*, 20, 339. https://doi.org/10.1186/s12888-020-02756-0

Campbell, D. 2011. Anthropology's Contribution to Public Health Policy Development. *McGill journal of medicine : MJM : an international forum for the advancement of medical sciences by students*, pp. 13(1), 76-83.

Campbell-Hall V, Petersen I, Bhana A, et al. 2010. Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Transcultural Psychiatry*, 47(4), 610–28.

Center of Health Equity Research Chicago. 2020. *What is structural violence?* http://www.cherchicago.org/about/structuralviolence/

Centers for Disease Control and Prevention. 2019. *1918 pandemic (H1N1 virus)*. https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

Cisney, V.W. & Morar, N. 2015. *Biopower: Foucault and Beyond*. University of Chicago Press. https://cupola.gettysburg.edu/cgi/viewcontent.cgi?article=1090&context=books

Clarke, P. 2000. *The Internet as a medium for qualitative research*. Paper presented at the 2nd Annual Conference on World-Wide Web Applications. http://generalupdate.rau.ac.za/infosci/conf/Wednesday/Clarke.htm

Cockerham, W. C. 2015. Max Weber: Bureaucracy, Formal Rationality and the Modern Hospital. In: *The Palgrave Handbook of Social Theory in Health, Illness and Medicine*. London: Palgrave Macmillan, pp. 124-138.

Cohen, D., & Crabtree, B. 2006. *Qualitative Research Guidelines Project*. http://www.qualres.org/HomeInfo-3631.html

Commission of Inquiry into Allegations of State Capture. 2022. *The Judicial Commission of Inquiry into Allegations of State Capture, Corruption and Fraud in the Public Sector*. https://www.statecapture.org.za/

Cook, S.A. 2006. “Where There’s Smoke, There’s Fire”: Tobacco Use and the Construction of the Canadian Citizen, 1890–1930. *The Social History of Alcohol and Drugs*, 21(1), 69-95.

CordisBright, 2018. *What are the key factors for successful multidisciplinary team working?* https://www.cordisbright.co.uk/admin/resources/05-hsc-evidence-reviews-multidisciplinary-team-working.pdf

Corruption Watch. 2020. *From crisis to action: annual report*. https://www.corruptionwatch.org.za/wp-content/uploads/2021/04/Corruption-Watch-AR-2020-DBL-PG-20210324.pdf

Cook, Lindsay J., Hassem, Tasneem, Laher, Sumaya, Variava, Tarique, & Schutte, Enid. (2021). Mental health experiences of healthcare professionals during COVID-19. *SA Journal of Industrial Psychology*, 47(1), 1-10. https://dx.doi.org/10.4102/sajip.v47i0.1865

Curry, L. A., Nembhard, I. M. & Bradley, E. H. 2009. Qualitative and mixed methods provide unique contributions to outcomes research. *Circulation*, 119(10), 1442–1452.

Dixon, A., McDaid, D., Knapp, M., & Curran, C. 2006. Financing mental health services in low- and middle-income countries. *Health policy and planning*, 21(3), 171–182. https://doi.org/10.1093/heapol/czl004

Davids, N. 2013. Depression, anxiety, trauma…can you afford it? https://www.sadag.org/images/pdf/high_cost_of_mental_health.pdf

Deacon, H.J., 1996. Madness, race and moral treatment: Robben Island Lunatic Asylum, Cape Colony, 1846-1890. *History of Psychiatry*, 7(26), 287-297. https://doi.org/10.1177/0957154X9600702606

Department of Health. 2022. COVID-19. https://sacoronavirus.co.za/

Docrat, S., Lund, C. & Chisholm, D. 2019. Sustainable financing options for mental health care in South Africa: findings from a situation analysis and key informant interviews. *International Journal of Mental Health Systems*, 13, 4. https://doi.org/10.1186/s13033-019-0260-4

Docrat, S. et al., 2019. Mental health system costs, resources and constraints in South Africa: a national survey. *Health Policy and Planning*, 34(9), 706-719.

Dominy, G. & Reusch, D. 1993. Handicrafts, philanthropy and self-help: the Fort Napier Kamp-Industrie during World War I. *Natal Museum Journal of Humanities*, 5, 207-224. https://journals.co.za/doi/pdf/10.10520/AJA16815564_371

Dommisse, J. 1985. Apartheid as a public mental health issue. *International Journal of Health Services*, 15(3), 501–510. http://www.jstor.org/stable/45140200

Dousemetzis, H. 2018. *The Man Who Killed Apartheid: The Life of Dimitri Tsafendas*. Johannesburg: Jacana Media.

Durojaye, E. & Agaba, D. K. 2018. Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa. *Health and Human Rights Journal*, 20(2), 161-168.

Elkington, E. J., & Talbot, K. M. (2016). The role of interpreters in mental health care. *South African Journal of Psychology*, 46(3), 364–375. https://doi.org/10.1177/0081246315619833

Engel G. L. 1977. The need for a new medical model: a challenge for biomedicine. *Science*, 196(4286), 129–136. https://doi.org/10.1126/science.847460

Espí Forcén, C., & Espí Forcén, F. 2014. Demonic possessions and mental illness: discussion of selected cases in late medieval hagiographical literature. *Early science and medicine*, 19(3), 258–279. https://doi.org/10.1163/15733823-00193p03

Essoungou, A-M. (2015). *The rise of civil society groups in Africa*. https://www.un.org/africarenewal/magazine/december-2013/rise-civil-society-groups-africa

Everatt, D. 2021. *South Africans are revolting against inept local government. Why it matters*. https://www.wits.ac.za/news/latest-news/opinion/2021/2021-03/south-africans-are-revolting-against-inept-local-government-why-it-matters.html

Fanon, F. (1963). *The Wretched of the Earth*. New York: Grove Press.

Farreras, I. G. (2023). History of mental illness. In R. Biswas-Diener & E. Diener (Eds), *Noba textbook series: Psychology*. Champaign, IL: DEF publishers. Retrieved from http://noba.to/65w3s7ex

Farmer, P., 2004. An anthropology of structural violence. *Current Anthropology*, 45(3), 305-325.

Foucault, M., 1973. *The Birth of the Clinic: Archaeology of Medical Perception*. London: Routledge Publisher.

Foucault, M. 1977. *Discipline and Punish : the Birth of the Prison*. New York: Pantheon Books.

Foucault, M. 1980. Body/power. In C. Gordon (Ed.) *Power/knowledge: Selected interviews and other writings 1972–1977*. London: Harvester.

Foucault, M. 1998; 1976. *The History of Sexuality Vol. 1: The Will to Knowledge*. London: Penguin.

Foucault, M. 2001. *Madness and Civilization A History of Insanity in an Age of Reason*. New York: Routledge.

Fricker, M. 2007. *Epistemic Injustice: Power and the Ethics of knowing*. Oxford University Press

Fricker, M. 2013. Epistemic justice as a condition iof political freedom. *Synthese*, 190, 1317-1332.

Galtung, J. 1969. Violence, Peace, and Peace Research. *Journal of Peace Research*, 6(3), 167 191. https://doi.org/10.1177/002234336900600301

Gamlin J, Segata J, Berrio L, et al. 2021. Centring a critical medical anthropology of COVID-19 in global health discourse. *BMJ Global Health*, 6, e006132. http://dx.doi.org/10.1136/bmjgh-2021-006132

Geertz, C. 1973. *The interpretation of cultures*. New York: Basic Books.

Geuskens, M. 2018. *Epistemic Justice: A Principled Approach to Knowledge Generation and Distribution*. Doctoral Thesis, Tilburg University. https://pure.uvt.nl/ws/portalfiles/portal/28669897/Geuskens_Epistemic_11_12_2018.pdf

Gillis, L. 2012. The historical development of psychiatry in South Africa since 1652. *South African Journal of Psychiatry*, 18(3), 5, 78-82. https://doi.org/10.4102/sajpsychiatry.v18i3.355

Goffman E. 1961. *Asylums; essays on the social situation of mental patients and other inmates*. Garden City: Anchor Books.

Goffman, E. 1963. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon & Schuster.

Gonzalez, L.L and Msomi, N. 2018. *No money for #LifeEsidimeni, but millions for consultants*. Available from: https://mg.co.za/article/2018-01-31-gauteng-spent-millions-on-consultants-as-it-closed-life-esidimeni-to-save-money/ [accessed 20 April 2023].

Gostin L.O. 2000. Human rights of persons with mental disabilities. *International Journal of Law and Psychiatry*, 23, 125–159.

Gostin, L.O. 2008. ‘Old’ and ‘new’ institutions for personswith mental illness: Treatment, punishmentor preventive confinement? *Public Health*, 122(9), 906-913.

Gostin, L.O. & Gable, L. 2004. The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health. *Georgetown Law Faculty Publications and Other Works*. 98. https://scholarship.law.georgetown.edu/facpub/98

Gowensmith, W.N. 2019. Resolution or resignation: The role of forensic mental health professionals amidst the competency services crisis. *Psychology, Public Policy, and Law*, 25(1), 1–14. https://doi.org/10.1037/law0000190

Guest, G., Namey, E. and Mitchell, M. 2013. Qualitative Research: Defining and Designing. In: *Collecting Qualitative Data: A Field Manual for Applied Research*, London: SAGE Publications, Ltd pp. 1-40. https://dx.doi.org/10.4135/9781506374680.n1

Haines, A., Perkins, E., Evans, E. A., & McCabe, R. 2018. Multidisciplinary team functioning and decision making within forensic mental health. *Mental health review (Brighton, England)*, 23(3), 185–196. https://doi.org/10.1108/MHRJ-01-2018-0001

Hanemaayer, A. (2016). Evidence-based medicine: A genealogy of the dominant science of medical education. *Journal of Medical Humanities*, 37(4), 449–473. https://doi.org/10.1007/s10912-016-9398-0

Harandi, T. F., Taghinasab, M. M., & Nayeri, T. D. 2017. The correlation of social support with mental health: A meta-analysis. *Electronic physician*, 9(9), 5212–5222. https://doi.org/10.19082/5212

Harappa 2021. *Max Weber's theory of bureaucratic management*. https://harappa.education/harappa-diaries/max-weber-theory-of-bureaucracy-2/

Hassim, J. & Wagner, C. 2013. Considering the cultural context in psychopathology formulations. *South African Journal of Psychiatry*, 19(1), 4-10. https://doi.org/10.4102/sajpsychiatry.v19i1.400

Hine, C., 2008. The Sage Handbook of Online Research Methods. In: N. Fielding, R. M. Lee & G. Blank, (Eds). *Virtual Ethnography: Modes, Varieties, Affordances* (pp 257-270). Los Angeles: SAGE Publishers.

Hodgkin, K. 2007. Without Sense and Understanding: Concepts of Madness in Early Modern Thought. In: *Madness in Seventeenth-Century Autobiography*. *Early Modern History: Society and Culture*. Palgrave Macmillan, London. https://doi.org/10.1057/9780230626423_3

Hudelson, P.M. 2004. Culture and quality: an anthropological perspective. *International Journal for Quality in Health Care*, 16(5), 345–346. https://doi.org/10.1093/intqhc/mzh076

Hughes, J. 2002. *Learning to smoke*. Univerrsity of Chicago Press.

Hughes, K., Lowey, H., Quigg, Z. et al. 2016. Relationships between adverse childhood experiences and adult mental well-being: results from an English national household survey. *BMC Public Health*, 16, 222. https://doi.org/10.1186/s12889-016-2906-3

Hunt, X., Breet, E., Stein, D.J. & Tomlinson, M. 2021. *The COVID-19 Pandemic, Hunger, and Depressed Mood Among South Africans*. https://cramsurvey.org/wp-content/uploads/2021/07/6.-Hunt-X.-Breet-E.-Stein-D.-_-Tomlinson-M.-2021-The-COVID-19-Pandemic-Hunger-and-Depressed-Mood-Among-South-Africans.pdf

Ingold, T., 2017. Anthropology contra ethnography. *HAU: Journal of Ethnographic Theory*, 7(1), 21-26.

Itard, J. M. G. 1962. *The Wild Boy of Aveyron*. United Kingdom: Appleton-Century-Crofts

Jain, A. 2004. Using the lens of Max Weber's theory of bureaucracy. *Proceedings of the 37th Annual Hawaii International Conference on System Sciences, 2004*, Big Island, HI, USA, pp. 127-136, doi: 10.1109/HICSS.2004.1265321.

Javan, M. 2020. *Covid-19: How life has changed for providers of mental health services*. https://www.news24.com/health24/Medical/Infectious-diseases/Coronavirus/covid-19-how-life-has-changed-for-providers-of-mental-health-services-20200626

Jenkins R. 2003. Supporting governments to adopt mental health policies. *World Psychiatry*, 2(1), 14–19. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525068/

Jones, T. F. 2012. *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa*. New York: Routledge.

Joubert, P.D. & Bhagwan, R. 2018. An empirical study of the challenging roles of psychiatric nurses at in-patient psychiatric facilities and its implications for nursing education. *International Journal of Africa Nursing Sciences*, 9, 49-56. https://doi.org/10.1016/j.ijans.2018.08.001

Kanyiswa, G. M & Leickness, C. S. 2006. Perspectives and Practices of Xhosa-speaking African Traditional Healers when Managing Psychosis, International Journal of Disability, Development and Education, 53:4, 417-431, https://doi.org/10.1080/10349120601008563

Kark, E. & Kark, S. 1999. *Promoting Community Health: From Pholela to Jerusalem*. Johannesburg: Wits University Press.

Kasrils, R. 2010. *The Unlikely Secret Agent*. New York: Monthly Review Press.

Kaur-Gill, S. and Dutta, M.J. 2017. Digital Ethnography. In *The International Encyclopedia of Communication Research Methods* (eds J. Matthes, C.S. Davis and R.F. Potter). https://doi.org/10.1002/9781118901731.iecrm0271

Khambule, I., Nomdo, A. & Siswana, B. 2022. *The social costs of violent and destructive service-delivery protests in South Africa*. http://www.hsrc.ac.za/en/review/hsrc-review-dec-2018/service-delivery-protests

Kleinman A. 1980. *Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley: University of California Press.

Kleinman, A. 1988. *The illness narratives*. New York: Basic Books.

Kleinman, A. 2009. *Global mental health: a failure of humanity*. *Lancet*, 374(9690), 603-604. https://doi.org/10.1016/S0140-6736(09)61510-5

Kleinman, A. 2012. Chapter 5 Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years. In: M. C. I. Emily A. Wentzell, ed. *Medical Anthropology at the Intersections: Histories, Activisms and Futures* (pp. 178- 196). Durham: Duke University Press,.

Kleinman A., Eisenberg L., Good B. 1978. Culture, illness, and care: clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine*, 88, 251–88.

Kleintjes, S., den Hollander, D.H., Pillay, S.R., & Kramers-Olen, A. 2021. Strengthening the National Health Insurance Bill for mental health needs: response from the Psychological Society of South Africa. *South African Journal of Psychology*, 51(1), 134–146. https://doi.org/10.1177/0081246320954317

Kohn, R., Saxena, S., Levav, I. and Saraceno, B., 2004. The treatment gap in mental health care. Bulletin of the World health Organization, 82(11), 858-866. https://doi.org/10.1590/S0042-96862004001100011

Kometsi, M.J., Mkhize, N.J. & Pillay, A.L. 2020. Mental health literacy: conceptions of mental illness among African residents of Sisonke District in KwaZulu-Natal, South Africa. *South African Journal of Psychology*, 50(3), 347-358.https://doi.org/10.1177/0081246319891635

Kramers-Olen, A.L. 2014. Psychosocial rehabilitation and chronic mental illness: international trends and South African issues. *South African Journal of Psychology*, 44(4), 498-513. https://doi.org/10.1177/0081246314553339

Kramers-Olen, A. L. 2015. Neuroscience, moral development, criminal capacity, and the Child Justice Act: Justice or injustice? *South African Journal of Psychology*, 45(4), 466–479 https://doi.org/10 1177/0081246315603633

Kramers-Olen, A. 2016. Sexuality, intellectual disability, and human rights legislation. *South African Journal of Psychology*, 46(4), 504–516. https://doi.org/10.1177/0081246316678154

Krasnov, V. N., & Gurovich, I. 2012. History and current condition of Russian psychiatry. *International Review of Psychiatry*, 24(4), 328–333. https://doi.org/10.3109/09540261.2012.694857

Kroencke, L., Geukes, K., Utesch, T., Kuper, N., & Back, M. D. 2020. Neuroticism and emotional risk during the COVID-19 pandemic. Journal of research in personality, 89, 104038. https://doi.org/10.1016/j.jrp.2020.104038

Krumeich, A., Weijts, W., Reddy, P. & Meijer-Weitz, A. 2001. The benefits of anthropological approaches for health promotion research and practice, *Health Education Research*, 16(2), 121–130, https://doi.org/10.1093/her/16.2.121

KwaZulu-Natal Department of Health. 2022. *Referral System : Levels of Health Care*. http://www.kznhealth.gov.za/Referral-system.htm

KwaZulu-Natal Department of Health. 2014. *Fort Napier Hospital*. http://www.kznhealth.gov.za/fortnapierhospital.htm

KwaZulu-Natal Department of Health. 2014. *History of Fort Napier Hospital*. http://www.kznhealth.gov.za/fortnapier/history.htm

Lapouse, R., Monk, M.A. & Terris, M. 1956. The Drift Hypothesis and Socioeconomic Differentials in Schizophrenia. *Mental Diseases*, 46(8), 978-986. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1623959/

Lebowitz, M.S. & Ahn, W. 2014. Effects of biological explanations for mental disorders on clinicians' empathy. *PNAS*, 111(50), 17786–17790. https://doi.org/10.1073/pnas.1414058111

Leslie, M., Fadaak, R., Davies, J., et al. 2020. Integrating the social sciences into the COVID-19 response in Alberta, Canada. *BMJ Global Health*, 5, e002672.

Livingston, J., 2007. Productive Misunderstandings and the Dynamism of Plural Medicine in Mid-Century Bechuanaland. *Journal of Southern African Studies*, 33(4), pp. 801-810.

Loughran, G. 2016. *Apartheid hero was tortured and detained in mental hospital*. https://nation.africa/kenya/news/africa/apartheid-hero-was-tortured-and-detained-in-mental-hospital-1237900

Lowes, S. & Montero, E. 2021. The Legacy of Colonial Medicine in Central Africa. *American Economic Review*, 111 (4), 1284-1314. DOI: 10.1257/aer.20180284

Lund, C. 2012. Poverty and mental health: a review of practice and policies. *Neuropsychiatry*, 2(3), 213-219.

Mahlati, Z. 2021. *Life Esidimeni Inquest* https://www.iol.co.za/news/politics/live-feed-life-esidimeni-inquest-september-13-2021-4ae1b0f0-ca89-4c71-8e57-191194db742e

Mahomed F. 2020. Addressing the Problem of Severe Underinvestment in Mental Health and Well-Being from a Human Rights Perspective. *Health and Human Rights*, 22(1), 35–49. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348439/

Makgoba, M. W. 2017. *The report into the 'circumstances surrounding the deaths of mentally ill patients: Gauteng province'*. http://www.ohsc.org.za/images/documents/FINALREPORT.pdf

Maluleka, R. 2020. The status of traditional healing in the Limpopo province of South Africa. *HTS Theological Studies*, 76(4), a6103. https://doi.org/10.4102/hts.v76i4.6103

Manz, S. & Panayi, P. 2020. *Enemies in the Empire: Civilian Internment in the British Empire during the First World War*. Oxford: Oxford University Press.

Marais, B. & Subramaney, U. 2015. Forensic state patients at Sterkfontein Hospital: A 3-year follow-up study. *South African Journal of Psychiatry*, 21(3), 86-92. https://dx.doi.org/10.7196/SAJP.8255

Matsea, T.C. 2017. Strategies to destigmatize mental illness in South Africa: Social work perspective. Social work in health care, 56(5), pp.367-380. https://doi.org/10.1080/00981389.2017.1284704

Mazereel, V., Van Assche, K., Detraux, J., & De Hert, M. 2021. COVID-19 vaccination for people with severe mental illness: why, what, and how? *Lancet. Psychiatry*, 8(5), 444–450. https://doi.org/10.1016/S2215-0366(20)30564-2

McCrea, N. 2010. An Analysis of South Africa's Mental Health Legislation. *National Law Review*, 294, https://www.natlawreview.com/article/analysis-south-africa-s-mental-health-legislation

McGranahan, C. 2021. "The Truths of Anonymity: Ethnographic Credibility and the Problem with Pseudonyms." https://americanethnologist.org/features/collections/rethinking-pseudonyms-in-ethnography/the-truths-of-anonymity-ethnographic-credibility-and-the-problem-with-pseudonyms

Messer, E., 1993. Anthropology and human rights. *Annual Review of Anthropology*, 22(1), 221-249.

Mental Health First Aid USA. 2019. *Four Ways Culture Impacts Mental Health*. https://www.mentalhealthfirstaid.org/2019/07/four-ways-culture-impacts-mental-health/

Mfoafo-M'Carthy, M. and Huls, S. 2014. Human Rights Violations and Mental Illness: Implications for Engagement and Adherence'. *SAGE Open*. 4(1), 1-18. https://doi.org/10.1177/2158244014526209

Mills, C. W. 1956. *The power elite*. New York, NY: Oxford University Press.

Minde, M. (1974). History of mental health services in South Africa. *South African Medical Journal*, 48, 1629-1632.

Misselbrook, D. 2013. Foucault. *The British Journal of General Practic*e, 63(611), 312. https://doi.org/10.3399/bjgp13X668249

Mkhize, N. & Kometsi, M.J. 2008. Community access to mental health services: lessons and recommendations. *South African Health Review*, 1, 103-113. https://hdl.handle.net/10520/EJC35509

Mokgobi M.G. 2013. Towards integration of traditional healing and western healing: Is this a remote possibility? *African journal for physical health education, recreation, and dance*, 2013(Supplement 1), 47–57.

Moodie, T.D. 2017. Separate Development as a Failed Project of Social Engineering: The Flawed Logic of Hendrik Verwoerd. *South African Historical Journal*, 69(2), 153-161. https://doi.org/10.1080/02582473.2017.1293720

Muelelwa, E., Sodi, T. & Maake, M.J. 1997. Attitudes of patients in a rural hospital towards traditional healers. *Paper presented at the 3rd Annual Congress of the Psychological Society of South Africa, Durban, South Africa*, 10–12 September 1997.

Mudiriza, G., & De Lannoy, A. 2020. Youth emotional well-being during the COVID-19-related lockdown in South Africa: UCT. (SALDRU Working Paper No. 268). https://www.opensaldru.uct.ac.za/bitstream/handle/11090/991/2020_268_Saldruwp.pdf?sequence=1

Murgic, L., Hébert, P. C., Sovic, S., & Pavlekovic, G. 2015. Paternalism and autonomy: views of patients and providers in a transitional (post-communist) country. *BMC Medical Ethics*, 16(1), 65. https://doi.org/10.1186/s12910-015-0059-z

Nader, L. 1974. Up the Anthropologist — Perspectives Gained From Studying Up. In D. Hymes (Ed.) *Reinventing Anthropology* (pp.284-311). New York: Vintage Books.

Nguyen, V-K. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham: Duke University Press.

Nic a Bháird, C.N., Xanthopoulou, P., Black, G., Michie, S., Pashayan, N. and Raine, R. 2016. Multidisciplinary team meetings in community mental health: a systematic review of their functions. *Mental Health Review Journal*, 21(2), pp.119-140. https://doi.org/10.1108/MHRJ-03-2015-0010

Nwoye A. 2015. African psychology and the Africentric paradigm to clinical diagnosis and treatment. *South African Journal of Psychology*, 45(3), 305-317. https://doi.org/10.1177/0081246315570960

Orb, A., Eisenhauer, L. & Wynaden, D. 2000. Ethics in Qualitative Research. *Journal of Nursing Scholarship*, 33(1), pp. 93-96.

Parker, C., Scott, S., & Geddes, A. 2019. Snowball Sampling. In P. Atkinson, S. Delamont, A. Cernat, J.W. Sakshaug, & R.A. Williams (Eds.), *SAGE Research Methods Foundations*. https://dx.doi.org/10.4135/9781526421036831710

Parle, J. 2007. *States of Mind Searching for Mental Health in Natal and Zululand*. Pietermaritzburg: University of KwaZulu-Natal Press.

Patel, V. 1995. Explanatory models of mental illness in sub-Saharan Africa. *Social Science & Medicine*, 40(9), 1291-1298. https://doi.org/10.1016/0277-9536(94)00231-H

Payne, S. 2022. Special Investigating Unit uncovers multimillion-rand Covid-related corruption in Northern Cape. *Daily Maverick*. https://www.dailymaverick.co.za/article/2022-12-06-special-investigating-unit-uncovers-multimillion-rand-covid-related-corruption-in-northern-cape/

Peltzer, K., & Mngqundaniso, N. 2008. Patients consulting traditional health practioners in the context of HIV/AIDS in urban areas in KwaZulu-Natal, South Africa. *African Journal of Traditional, Complementary, and Alternative Medicines*, 5(4), 370–379.

Petersen, E., Fiske, A.P. & Schubert, T.W. 2019. The Role of Social Relational Emotions for Human-Nature Connectedness. *Frontiers in Psychology*, 10. https://doi.org/10.3389/fpsyg.2019.02759

Pillay, A.L 2012. The rape survivor with an intellectually disability vs. the Court. *South African Journal of Psychology*, 42, 312-322. https://doi.org/10.1177/008124631204200303

Pillay, A.L. 2017. Is deinstitutionalisation a cheap alternative to chronic mental health care? *South African Journal of Psychology*, 47, 141-147. https://doi.org/10.1177/0081246317709959

Pillay, A. 2016. *Presidential Address*. *Annual Psychological Society of South Africa Congress*, *Johannesburg*, 20 September 2016.

Pillay, A.L, Gowensmith, W.N., Roesch, R., Hopkins, A. 2023. A brief comparison of forensic psychology in South Africa, the United States, and Canada. *South African Journal of Psychology*. 53(2):172-184. https://doi.org/10.1177/00812463221128166

Pillay, A.L. & Kramers, A.L. 2003. South African Clinical Psychology, Employment (In)Equity and the "Brain Drain". *South African Journal of Psychology*, 33(1), 52-60.

Pillay, A.L. & Kramers, A.L. 2021. COVID-19, psychosocial issues, politics, and public mental health care. *South African Journal of Psychology*, 51(2) 293–303. https://doi.org/10.1177/00812463211015750

Pillay, A.L. & Kramers-Olen, A.L. 2014. The changing face of clinical psychology intern training: a 30-year analysis of a programme in KwaZulu-Natal, South Africa. *South African Journal of Psychology*, 44, 364-374. https://doi.org/10.1177/0081246314535683

Pillay, A.L. & Nyandeni, L.N. 2021. Is post-apartheid South Africa training more black African clinical psychologists and addressing the historical imbalance? *South African Journal of Psychology*, 51(1), 147-157. https://doi.org/10.1177/0081246320977985

Pillay, A.L. & Willows, C. 2015. Assessing the criminal capacity of children: A challenge to the capacity of mental health professionals. *Journal of Child and Adolescent Mental Health*, 27(2), 91–101. https://doi.org/10.2989/17280583.2015.1040412

Porter, R. 1990. Foucault's great confinement. *History of the Human Sciences*, 3(1), 47–54. https://doi.org/10.1177/095269519000300107

Reeves, S., Peller, J., Goldman, J. & Kitto, S. 2013. Ethnography in qualitative educational research: AMEE Guide No. 80, *Medical Teacher*, 35(8). e1365-e1379, DOI: 10.3109/0142159X.2013.804977

Republic of South Africa. 2020. *Disaster Management Act: Regulations to address, prevent and combat the spread of Coronavirus COVID-19*. https://www.gov.za/documents/disaster-management-act-regulations-address-prevent-and-combat-spread-coronavirus-covid-19

Republic of South Africa 2020. *Child Justice Amendment Act No. 28 of 2019*. Pretoria: Government Gazette.

Republic of South Africa. 2008. *Criminal Procedure Act 51 of 1977*. Pretoria, South Africa: Juta Law.

Republic of South Africa. 2005. *Mental Health Care Act 17 of 2002*. Pretoria: Juta and Company.

Republic of South Africa. 1998. *Electoral Act 73 of 1998*. Pretoria: Juta and Company.

Republic of South Africa. 1996. *Constitution of the Republic of South Africa, Act no. 108 of 1996*. Pretoria: Author.

Resnik, D.B. 2021. *Research Ethics Timeline*. National Institute of Environmental Health Sciences. https://www.niehs.nih.gov/research/resources/bioethics/timeline/index.cfm

Robcis, C. 2021. Frantz Fanon, the Pathologies of Freedom, and the Decolonization of Institutional Psychotherapy. C. Robcis (Ed). *Disalienation: Politics, Philosophy, and Radical Psychiatry in Postwar France* (Pp. 48-73). Chicago: University of Chicago Press. https://doi.org/10.7208/9780226777887-005

Robertson, L. J. et al. 2022. Mental health of healthcare workers during the COVID-19 outbreak: A rapid scoping review to inform provincial guidelines in South Africa. *South African Medical Journal*, 110(10), 1010-1019. http://www.samj.org.za/index.php/samj/article/view/13101/9538

Royal Australian and New Zealand College of Psychiatrists. 2002. *Psychiatrists as team members*. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/psychiatrists-as-team-members

Royal Society of Psychiatrists of the United Kingdom. 2010. *Role of the consultant*

Psychiatrist. https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/startwell/startwell-clinical-leadership-op74.pdf?sfvrsn=8b6e1f_12

Satyanand, A. 2016. Mental illness and the right to vote. *International Review of Psychiatry*, 28(4), 400-401. https://doi.org/10.1080/09540261.2016.1211094

Savage J. 2000. Ethnography and health care. *BMJ*, 321(7273), 1400–1402. https://doi.org/10.1136/bmj.321.7273.1400

Scheper-Hughes, N. 1995. The Primacy of the Ethical: Proposition for a Militant Anthropology. *Current Anthropology*, 36(3), 409–440.

Scott, J.C. 1998. *Seeing Like a State*. New Haven, CT: Yale University Press.

Scull, A. 2015. *Madness in Civilization: A Cultural History of Insanity*. Princeton University Press.

Section 27. 2017. *The Life Esidimeni Case*. http://section27.org.za/wp-content/uploads/2017/02/Life-Esidimeni-Fact-Sheet-1.pdf

Serpa, Sandro & Ferreira, Carlos. 2019. The Concept of Bureaucracy by Max Weber. *International Journal of Social Science Studies*, 7(2), 12-18. http://redfame.com/journal/index.php/ijsss/article/view/3979

Setoya, Y. 2012. Overview of the Japanese Mental Health System. *International Journal of Mental Health*, 41(2), 3–18. http://www.jstor.org/stable/42003803

Smart, B.T.H & Broadbent, A. 2020. *South Africa's COVID-19 lockdown: cigarettes and outdoor exercise could ease the tension*. https://theconversation.com/south-africas-covid-19-lockdown-cigarettes-and-outdoor-exercise-could-ease-the-tension-134931

Smith, I. 2017. *Mental age theory hurts people with intellectual disabilities*. http://nosmag.org/mental-age-theory-hurts-people-with-intellectual-disabilities/?fbclid=IwAR3rIowvza--uPeczRKzMiw0CAKCtfQEc92vS6RyacqUD6zBAJ80rUB8Lk

Simpson, A., Bowers, L., Alexander, J., Ridley, C., & Warren, J. 2005. Occupational Therapy and Multidisciplinary Working on Acute Psychiatric Wards: The Tompkins Acute Ward Study. *British Journal of Occupational Therapy*, 68(12), 545–552. https://doi.org/10.1177/030802260506801203

Sorsdahl, K., Petersen, I., Myers, B., Zingela, Z., Lund, C. & van der Westhuizen, C. (2023). A reflection of the current status of the mental healthcare system in South Africa, Social *Science and Medicine - Mental Health*, 4, 100247. https://doi.org/10.1016/j.ssmmh.2023.100247

South African Depression and Anxiety Group. 2021. *World Suicide Prevention Day – SADAG Is Creating Hope Through Action*. https://www.sadag.org/index.php?option=com_content&view=article&id=3195:world-suicide-prevention-day-september-2021&catid=149&Itemid=132

South African Federation for Mental Health. 2020. *Stop stockouts: antidepressant and antipsychotic shortages*. https://www.safmh.org/stop-stockouts-antidepressent-and-antipsychotic-shortages/

South African Government. 2020. Disaster Management Act: Regulations to address, prevent and combat the spread of Coronavirus COVID-19: Amendment. Retrieved March 14, 2022, from https://www.gov.za/documents/disaster-management-act-regulations-address-prevent-and-combat-spread-coronavirus-covid-19

South African History Online. 2021. *Robben Island, Cape Town*. https://www.sahistory.org.za/place/robben-island-cape-town

South Africa Online 2022. *Pietermaritzburg*. https://southafrica.co.za/pietermaritzburg.html#:~:text=Founded%20in%201838%2C%20Pietermaritzburg%20is,maintain%20its%20English%20country%20atmosphere.&text=Aerial%20view%20of%20Pietermaritzburg.

Spivak, G. C. 1988. Can the subaltern speak? In C. Nelson & L. Grossberg (Eds.). *Marxism and the interpretation of culture* (pp. 21–78). University of Illinois Press.

Spoorthy, M. S., Pratapa, S. K. & Mahant, S. 2020. Mental health problems faced by healthcare workers due to the COVID-19 pandemic–A review. *Asian Journal of Psychiatry*, 51, 102119. https://doi.org/10.1016/j.ajp.2020.102119

Srivastava, P & Panday, R. 2017. Psychoeducation an Effective Tool as Treatment Modality in Mental Health. *The International Journal of Indian Psychology*. 4. 123-130. https://doi.org/10.25215/0401.153.

Stacey, G., Felton, A., Morgan, A., Stickley, T., Willis, M., Diamond, B., Houghton, P., Johnson, B. & Dumenya, J. 2016. A critical narrative analysis of shared decision-making in acute inpatient mental health care. *Journal of Interprofessional Care*, 30(1), 35-41.

Statistics South Africa. 2022. *60,6 million people in South Africa*. https://www.statssa.gov.za/?p=15601

Stein, M.B. 2022. *COVID-19: Psychiatric illness*. https://www.uptodate.com/contents/covid-19-psychiatric-illness

Stuart, H. 2003. Violence and mental illness: an overview. *World Psychiatry*, 2(2), 121–124.

Sue, D. W. & Sue, D. 1999. *Counseling the culturally different: Theory and practice*. New Jersey: John Wiley & Sons Inc.

Sukeri, K, Betancourt, O A, & Emsley, R. 2014. Lessons from the past: Historical perspectives of mental health in the Eastern Cape. *South African Journal of Psychiatry* , 20(2), 34-39. https://dx.doi.org/10.7196/SAJP.568

Swartz, L. 1996. Culture and Mental Health in the Rainbow Nation: Transcultural Psychiatry in a Changing Society. *Transcultural Psychiatric Research Review*, 33, 119-136.

Swientozielskyj, S., 2015. *MDT Development - Working toward an effective multidisciplinary/multiagency team*, London: NHS England. https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf

Taberna, M., Gil Moncayo, F., Jané-Salas, E., Antonio, M., Arribas, L., Vilajosana, E., Peralvez Torres, E., & Mesía, R. 2020. The Multidisciplinary Team (MDT) Approach and Quality of Care. *Frontiers in oncology*, 10, 85. https://doi.org/10.3389/fonc.2020.00085

van der Zeijst, M., Veling, W., Makhathini, E.M., et al. 2020. Ancestral calling, traditional health practitioner training and mental illness: An ethnographic study from rural KwaZulu-Natal, South Africa. *Transcultural Psychiatry*. 58(4), 471-485. https://doi.org/10.1177/1363461520909615

Vann, M.R. 2014. *The 10 Worst Mental Health Treatments in History*. https://www.everydayhealth.com/pictures/worst-mental-health-treatments-history/

Van Hoof, E. 2020. *Lockdown is the world's biggest psychological experiment – And we will pay the price*. https://www.weforum.org/agenda/2020/04/this-is-the-psychological-side-of-the-covid-19-pandemicthat-were-ignoring/

van Voren R. 2010. Political abuse of psychiatry--an historical overview. *Schizophrenia bulletin*, 36(1), 33–35. https://doi.org/10.1093/schbul/sbp119

Waetjen, T., Hodes, R. & Parle, J. 2019. Convenors' Preface to Special Issue: 'Drug Regimes in Southern Africa'. *South African Historical Journal*, 71(4), 533-535. https://doi.org/10.1080/02582473.2019.1681073

Waetjen, T., Hodes, R. & Parle, J. 2019. Convenors' Preface to Special Issue: 'Drug Regimes in Southern Africa'. *South African Historical Journal*, 71(4), 533-535. https://doi.org/10.1080/02582473.2019.1681073

Wall, K. 2021. *Maintenance and repair spending realities: what can be done?* Paper presented virtually at the 39th International Southern African Transport Conference on 05 -07 July 2021. https://repository.up.ac.za/handle/2263/82379?show=full

Ward-Lasher, A., Sheridan, D. J., Glass, N. E., & Messing, J. T. 2017. Prediction of interpersonal violence: An introduction. In J. C. Campbell & J. T. Messing (Eds.). *Assessing dangerousness: Domestic violence offenders and child abusers* (pp. 1–32). Springer Publishing Company. https://doi.org/10.1891/9780826133274.0001

Warner, J., Pitts, N., Crawford, M. J., Serfaty, M., Prabhakaran, P., & Amin, R. 2004. Sexual activity among patients in psychiatric hospital wards. *Journal of the Royal Society of Medicine*, 97(10), 477–479. https://doi.org/10.1258/jrsm.97.10.477

Weber, D. (2016). Medical Hegemony. *International Journal of Complementary and Alternative Medicine*, 3(2), 00065. DOI: 10.15406/ijcam.2016.03.00065

Weber, M. 1947. *The theory of social and economic organization* (trans. T. Parsons). New York, NY: Oxford University Press.

Wills, G., Patel, L., van der Berg, S., & Mpeta, B. 2020. *Household resource flows and food poverty during South Africa's lockdown: Short-term policy implications for three channels of social protection*. https://cramsurvey.org/wp-content/uploads/2020/07/Wills-household-resource-flows-and-food-povertyduring-South-Africa's-lockdown-2.pdf

Witeska-Młynarczyk, A. 2015. Critical Medical Anthropology – a voice for just and equitable healthcare. *Annals of Agricultural and Environmental Medicine*, 22(2), 385-389.

World Bank. 2022. *New World Bank Report Assesses Sources of Inequality in Five Countries in Southern Africa*. https://www.worldbank.org/en/news/press-release/2022/03/09/new-world-bank-report-assesses-sources-of-inequality-in-five-countries-in-southern-africa

World Health Organization. 2003. *Mental health financing*. Geneva, World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/333119/9241545933-eng.pdf

World Health Organization. 2003. *Custodial psychiatric hospitals in conflict situations*. https://www.who.int/mediacentre/background/2003/back4/en/

World Health Organization. 2021. *WHO report highlights global shortfall in investment in mental health* [online]. Available from: https://www.who.int/news/item/08-10-2021-who-report-highlights-global-shortfall-in-investment-in-mental-health [accessed 20 April 2023]

World Health Organization. 2022. Coronavirus disease (COVID-19). https://www.who.int/health-topics/coronavirus#tab=tab_3

Yew, V.W.C. & Noor, N.A.M. 2014. Anthropological inquiry of disease, illness and sickness. *Journal of Social Sciences & Humanities*, 9(2), 116-124. https://core.ac.uk/download/pdf/33344837.pdf

Yin, H., Wardenaar, K.J., Xu, G. et al. 2020. Mental health stigma and mental health knowledge in Chinese population: a cross-sectional study. *BMC Psychiatry*, 20, 323. https://doi.org/10.1186/s12888-020-02705-x

Zuma, T., Wight, D., Rochat, T. et al. 2016. The role of traditional health practitioners in Rural KwaZulu-Natal, South Africa: generic or mode specific? *BMC Complementary and Alternative Medicine*, 16, 304. https://doi.org/10.1186/s12906-016-1293-8

Appendix

(1) Information leaflet for potential participants

(2) Informed consent form for participants

(3) Research Ethics Approval – University of Pretoria

(4) KwaZulu-Natal Department of Health Research Approval

(5) Hospital ‘Gate-Keeper’ Approval

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Psychiatric Treatment at a Forensic Psychiatric Hospital in KwaZulu-Natal: An ethnographic inquiry

Conducted by Indira Pillay

INFORMATION LEAFLET

Dear Participant,

I am a Master's student in the Department of Anthropology and Archaeology at the University of Pretoria. I am conducting research to understand how healthcare professionals at a Forensic

Psychiatric Hospital interact with patients, family, friends and other caregivers, how the interactions are shaped by power relations, and how they influence admissions, care, treatment outcomes and coping during COVID-19. I hope to learn the impact of these interactions on patient care and gain information that can inform mental healthcare development. The ultimate benefit, of course, would be the enhancing of mental healthcare development.

Participation in this study is entirely voluntary. You have the right to refuse or discontinue participation at any time. Should you choose to participate after reading this information sheet, an informed consent form will be sent to you and a date and time will be discussed for a virtual conversation to take place. This should be a time when you do not have any prior engagements or responsibilities. Pseudonyms will be used to safeguard your identity. The researcher will be available to answer questions you may have. After the completion of the fieldwork process, the researcher will analyze all of the data that has been gathered from all participants in order to understand the interactions of healthcare professionals with patients, families and friends. The final dissertation with the results will be made available to you as well as to the relevant departments to assist in the development of mental healthcare treatment.

If you feel the need for professional help or support during the research process please free to speak to the researcher following the session, and assistance will gladly be arranged.

CONTACT PERSONS

Researcher

In the case of any difficulty or problem associated with this research please contact: Indira Pillay - Master’s student in the Department of Anthropology & Archaeology - University of Pretoria – 0824010149

Supervisor

In the case of any difficulty experienced in the research process that cannot be resolved with the researcher please contact: Dr. Jimmy Pieterse - Department of Anthropology and Archaeology – University of Pretoria - (012) 420-5223

Psychiatric Treatment at a Forensic Psychiatric Hospital in KwaZulu-Natal: An ethnographic inquiry

Researcher: Indira Pillay

Supervisor: Dr Jimmy Pieterse

INFORMED CONSENT – DECLARATION

I…………………………………………..…………………………………(full names of participant) hereby confirm that I have been informed about the abovementioned research and understand the purpose of the research project and I consent to participating in the research project.

I understand that consent is voluntary, and that I am at liberty to withdraw from the research at any time, should I so desire, and any information gathered will not be used in the research.

☐ I agree to the use of an audio recorder during the duration of my participation in the research (Tick if you agree).

SIGNATURE OF PARTICIPANT: DATE:

……………………………………….. …………………………..

Thank you for your time and participation.

Researcher:

Indira Pillay
Student No.: 15107923
Masters Student: Department of Anthropology and Archaeology

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23 June 2021

Dear Miss I Pillay

Project Title: Psychiatric Treatment at [redacted] Hospital, Pietermaritzburg: An ethnographic inquiry
Researcher: Miss I Pillay
Supervisor(s): Dr J Pieterse
Department: Anthropology and Archaeology
Reference number: 15107923 (HUM008/0121)
Degree: Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 23 June 2021. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely,

Prof Innocent Pikirayi
Deputy Dean: Postgraduate Studies and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

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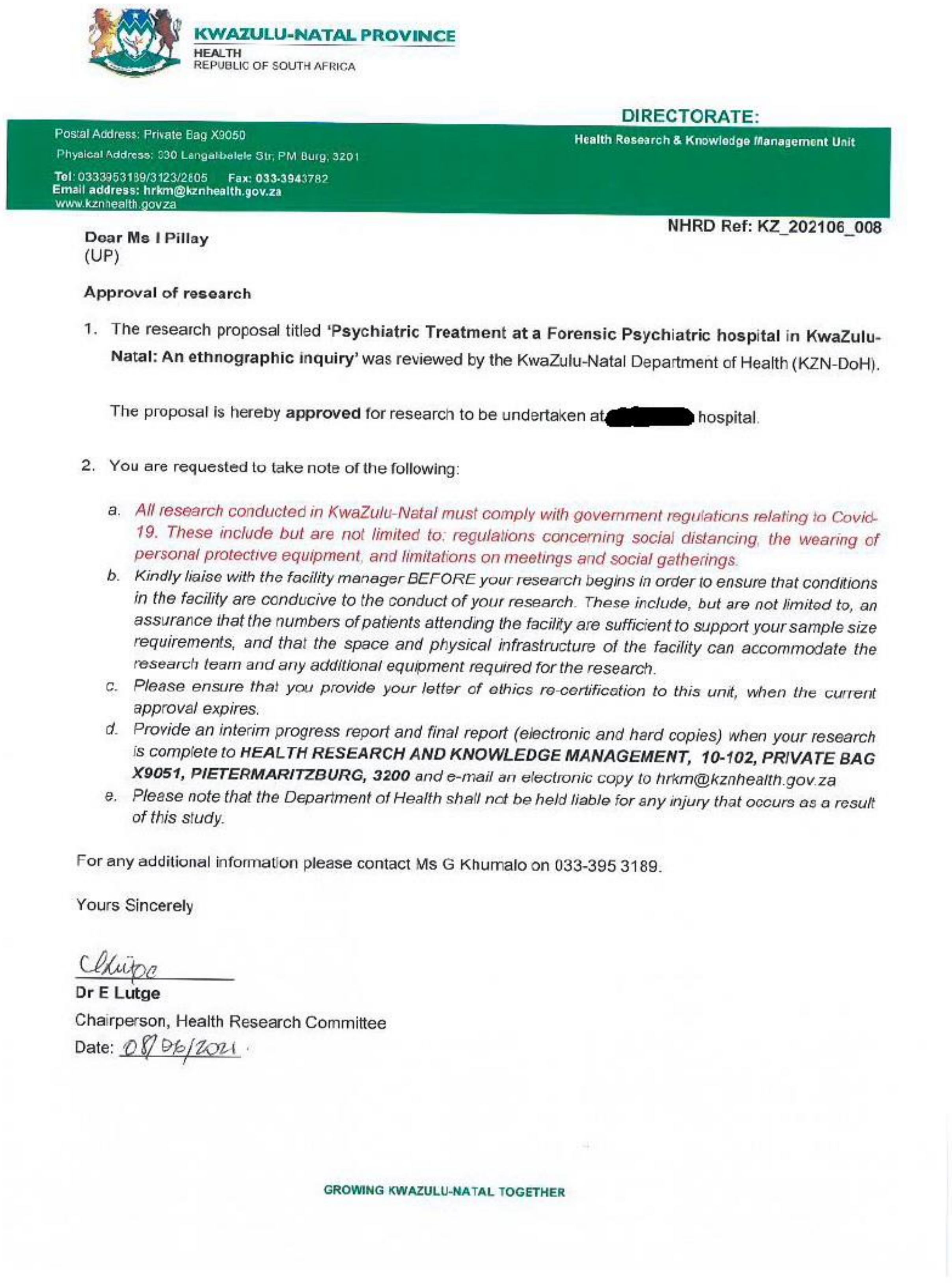

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:
Health Research & Knowledge Management Unit

Postal Address: Private Bag X9050
Physical Address: 330 Langalibalele Str, PM Burg, 3201
Tel: 0333953189/3123/2805 **Fax: 033-3943782**
Email address: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

NHRD Ref: KZ_202106_008

Dear Ms I Pillay
(UP)

Approval of research

1. The research proposal titled **'Psychiatric Treatment at a Forensic Psychiatric hospital in KwaZulu-Natal: An ethnographic inquiry'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at [redacted] hospital.

2. You are requested to take note of the following:

   a. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
   b. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to* ***HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200*** *and e-mail an electronic copy to hrkm@kznhealth.gov.za*
   e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 08/06/2021

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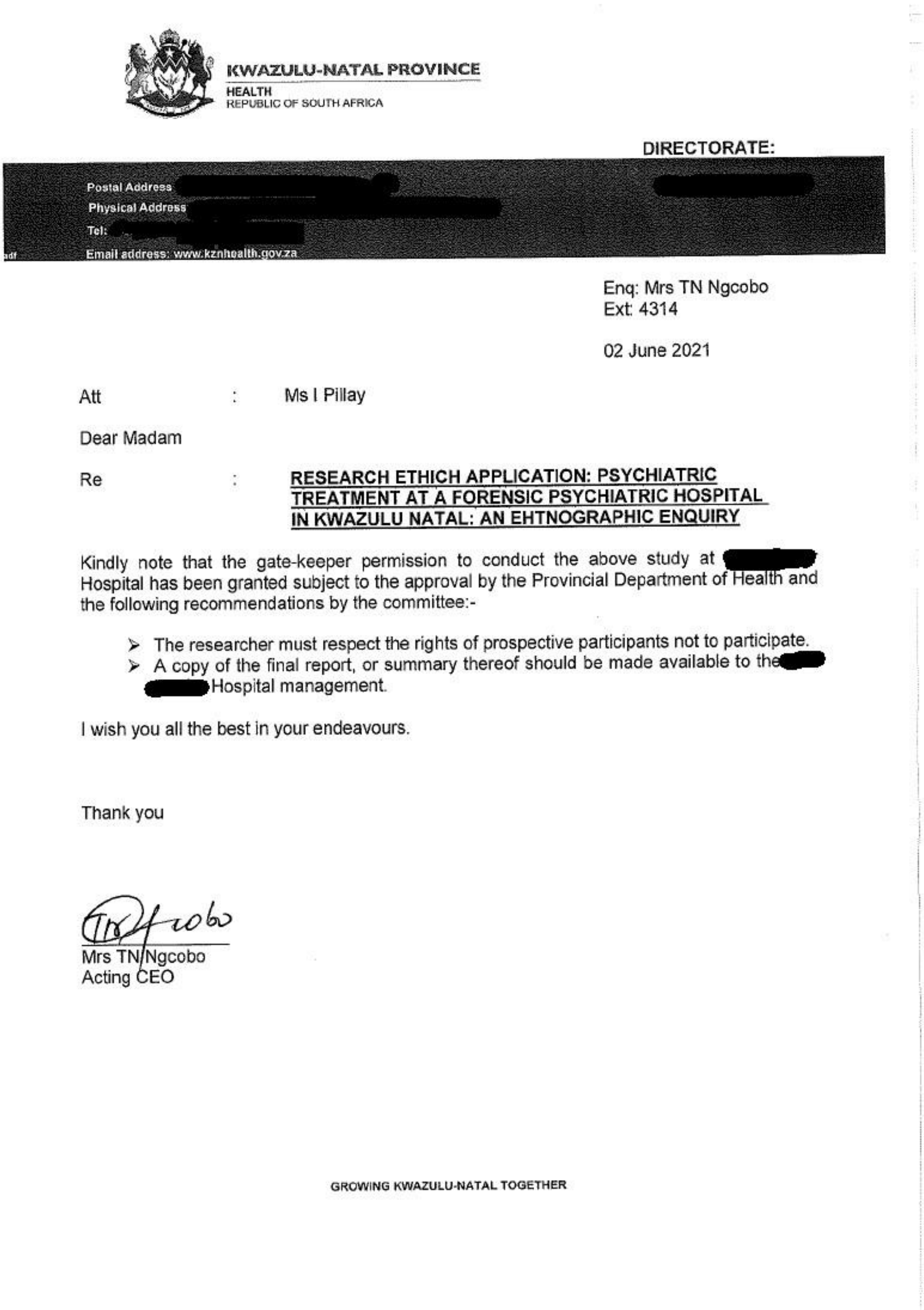

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:

Postal Address [redacted]
Physical Address [redacted]
Tel: [redacted]
Email address: www.kznhealth.gov.za
[redacted]

Enq: Mrs TN Ngcobo
Ext: 4314

02 June 2021

Att : Ms I Pillay

Dear Madam

Re : **RESEARCH ETHICH APPLICATION: PSYCHIATRIC TREATMENT AT A FORENSIC PSYCHIATRIC HOSPITAL IN KWAZULU NATAL: AN EHTNOGRAPHIC ENQUIRY**

Kindly note that the gate-keeper permission to conduct the above study at [redacted] Hospital has been granted subject to the approval by the Provincial Department of Health and the following recommendations by the committee:-

- The researcher must respect the rights of prospective participants not to participate.
- A copy of the final report, or summary thereof should be made available to the [redacted] [redacted] Hospital management.

I wish you all the best in your endeavours.

Thank you

Mrs TN Ngcobo
Acting CEO

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