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THE MANAGEMENT OF A POLICY IMPLEMENTATION PROJECT: THE DISASTROUS GAUTENG MENTAL HEALTH MARATHON PROJECT

Jacobus S Wessels and Thevan Naidoo

INTRODUCTION

A South African mental health policy implementation project resulted in the deaths of at least 144 vulnerable human beings. This tragedy occurred despite the vision of the relevant policy of an improved mental healthcare project for all in South Africa. Known as the Gauteng Mental Health Marathon Project, it was implemented in Gauteng, one of South Africa's nine provinces.

Efforts by various individuals, institutions and organisations to make sense of these implausible occurrences followed this tragedy. Two of these formal sense-making endeavours are the widely reported investigation by the Health Ombud and the alternative dispute-resolution process under the guidance of retired Deputy Chief Justice Dikgang Moseneke. In addition to these formal and structured processes, a variety of scholarly articles have been published in an effort to make sense of the series of events.

Since this devastating project occurred in the public sphere, and more specifically in the sphere of public healthcare, the purpose of this contribution is to unpack it from a public administration perspective. In doing so, we have set out to establish exactly what happened by providing a chronological reconstruction of the main series of events. This is followed by a selection of the most appropriate theoretical lenses through which to identify those implausible events and comprehensively redraft this narrative so as to gain a better understanding of it.

This shocking series of events is known by different names, such as the Gauteng Mental Marathon Project (Moseneke 2018), the Gauteng Mental Health Marathon Project (Freeman 2018; Makgoba 2017b), the Life Esidimeni Project (Gauteng Province 2018), and the Life Esidimeni Tragedy (Ferlito &

Dhai 2018a; Jacobs, Agaba & Brady 2018; Robertson et al 2018; Robertson & Makgoba 2018). Since these events were known in the Gauteng Department of Health (GDoH) as the Gauteng Mental Health Marathon Project (GMMP), and neither the Health Ombud nor the arbitration process could establish the origin of this name (Makgoba 2017b: 1; Life Esidimeni Arbitration 2017b), we have decided to follow the same convention in this sense-making contribution.

METHODOLOGICAL AND THEORETICAL CONSIDERATIONS: SENSE-MAKING THROUGH DIFFERENT THEORETICAL LENSES

Sense-making is a well-established process, concept and method in the social sciences. For the purpose of this contribution, we have specifically relied on the seminal work of Weick (1993, 1995) in collaboration with colleagues (Weick, Sutcliffe & Obstfeld 2005) and the subsequent work of Public Administration scholars such as Vickers (2002, 2014), Parris and Vickers (2005) and Audette-Chapdelaine (2016). Similar to our case, the first contribution by Weick (1993) also relates to a disaster where people died. Where our contribution consists mainly of an analysis of the report by the Health Ombud (Makgoba 2017b), the transcriptions from the proceedings of the 43 days of the arbitration hearing (Life Esidimeni Arbitration 2017a), the arbitration award (Moseneke 2018) and various other documents, Weick's contribution consists of a re-analysis of an award-winning book on this disaster (Weick 1993). Weick focuses mainly on two questions: 'Why do organisations unravel?' and 'How can organisations be made more resilient?' (Weick 1993: 628). In a later contribution, he elaborates on this more abstractly by rephrasing these questions as 'What's going on here?' and 'What do I do next?' (Weick et al 2005: 412). With our study of a disastrous policy implementation project in mind, one may pose slightly different questions: 'Why do policy implementation projects become disastrous?' and 'How can policy implementation projects be vision-aligned?'

In order to answer these questions, it is necessary to understand the purpose, point of departure and strategy of sense-making. In this regard, Vickers, relying on the work of Weick (1995), underscores the extremely contested nature of sense-making, when the occurrence of a specific event is so implausible that it is 'getting hard to believe, and harder to explain' (Vickers 2007: 229). The implication of this is that existing theories may be found to be inadequate in explaining an unbelievable and implausible event. Through sense-making, these gaps in organisational theory (Weick et al 2005) can be closed through the 'ongoing retrospective development of plausible images that rationalise what people are doing' (Weick et al 2005: 409). By closing those gaps, as with theorising, we

understand sense-making as those interim struggles towards stronger theories (Weick 1995: 385) and plausible actions.

The literature shows that sense-making is not a once-off event, but a never-ending, retrospective human process (Weick 1993: 636, 647; Parris & Vickers 2005: 284–285; Weick et al 2005: 411–415) through which to obtain a sense of direction for the present and the future (Weick et al 2005: 419; Vickers 2007: 224, 234, 235). It is fuelled by a ‘desire or need to understand’ (Audette-Chapdelaine 2016: 2) why ‘the perceived state of things is not what we expect it to be’ (Audette-Chapdelaine 2016: 6). Not only did this desire to understand the devastating discrepancy between expectation and reality result in a formal investigation and report by the Health Ombud (Makgoba 2017b) and an alternative dispute-resolution process (Moseneke 2018); it also spawned an ongoing series of scholarly articles from various disciplinary perspectives.

In this scholarly process of sense-making, various theoretical lenses relating to the overlapping professional and authority spheres within which this tragedy evolved were used. This includes the lenses of health and human rights (Lund 2016; Jacobs et al 2018), the actuarial quantification of damages (Whittaker 2018), legal liability (Ferlito & Dhali 2018b; McQuoid-Mason 2018; Toxopeüs 2018), integrated health systems (Schneider et al 2016; Freeman 2018; Robertson et al 2018) and maladministration and quality assurance (Chambers et al 2017; Robertson & Makgoba 2018). While the phenomenon of this case study is evidently an intervention, that is, a policy implementation project, the logical choice of theoretical lenses for this study were from the sub-fields of public policy implementation and project management in the field of public administration.

The units of observation or material used for this study were almost exclusively primary and secondary textual material in the public domain. Consequently, it was not necessary to apply for research ethics clearance as this project constitutes no risk of harming any human participants (see Van Heerden, Visagie & Wessels 2016; Wessels & Visagie 2017). The textual material we consulted consisted, among other materials, of the following categories of document (all the material referred to is included in the list of references at the back of this book):

- regulatory documents, such as the Constitution of the Republic of South Africa of 1996, legislation, regulations and policy documents;
- annual reports of the Gauteng Department of Health (GDoH);
- the report of the Health Ombud into the circumstances surrounding the deaths of mentally ill patients;
- the arbitration ruling by retired Chief Justice Dikgang Moseneke;
- transcriptions of the arbitration proceedings;

- various court rulings related to this case;
- various newspaper reports related to this case; and
- various webpages related to this case.

While the purpose of the current study is to make sense of a devastating public policy implementation project – the GMMP – it may be necessary to select theoretical lenses that are appropriate to shedding light on the unanswered policy implementation and project management questions relating to this tragedy. These theoretical lenses are discussed in the section where we report on the sense-making process. The next section provides a chronology of the GMMP.

GAUTENG MENTAL HEALTH MARATHON PROJECT: A CHRONOLOGY

The GMMP sparked mass public indignation and cast a negative shadow on the country, both nationally and internationally. It was described as one of the worst human rights violations to have occurred in South Africa since the end of apartheid. This tragedy occurred against the backdrop of the constitutional responsibility of the South African state to protect the rights of this vulnerable group, while simultaneously making improved mental health services available to them (RSA 1996: ss 27 and 28). This responsibility is outlined in various regulatory documents, such as the National Health Act 61 of 2003 (RSA 2003), the Mental Health Care Act 17 of 2002 (RSA 2002) and its Regulations (DoH 2016), and the National Mental Health Policy Framework and Strategic Plan (NMHPFSP) 2013–2020 (DoH 2013). In addition to the country-specific regulatory framework, mental healthcare in South Africa is also situated within an international regulatory and value framework. This framework consists largely of the International Covenant on Civil and Political Rights (United Nations 1976; Camp 1999), the International Covenant on Economic, Social and Cultural Rights (United Nations 1967), the International Covenant on People with Disabilities (United Nations 2006), the African Charter on Human and Peoples' Rights (Organisation of African Unity [OAU] 1981) and the World Health Organization Mental Health Action Plan (WHO 2013). Whereas these documents collectively constitute the regulatory context for mental healthcare in South Africa, the immediate determining document is the NMHPFSP 2013–2020, as discussed in the next section.

DEINSTITUTIONALISATION: THE NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN 2013–2020

The legal framework for the admission and discharge of mental health patients in South Africa is provided by the Mental Health Act 17 of 2002 as amended (RSA 2002). While this Act predominantly has a protective purpose through its clarification and regulatory provisions (RSA 2002: s 3), it also provides for the state's promotive obligation regarding the provision of mental healthcare services (RSA 2002: Preamble, s 4). In order to give effect to the implementation of the Act, sections 66, 67 and 68 provide regulations which have the status of being part of the Act (RSA 2002: s 1).

While the various organs of state responsible for health services in South Africa have their own policies and procedures for giving effect to the provisions of the Act and Regulations, a wide 'variation between provinces in the availability of service resources for mental health' has been reported (DoH 2013: 15). In an attempt to identify best practices for continuously improving mental health services, extensive consultation processes with relevant stakeholders have been undertaken in the various provinces; these culminated in a national mental health summit in April 2012. Following the deliberations at this summit, a new national mental health policy framework and strategic plan, the NMHPFSP 2013–2020, was adopted in 2013 (DoH 2013: 3).

The main purpose of the NMHPFSP 2013–2020 has been formulated as a vision for improved mental health 'for all in South Africa by 2020' (DoH 2013: 19). Therefore, it is not only a policy framework but a strategic plan to realise this vision. Despite the clarity and simplicity of this vision statement, the complexity of realising this vision and objectives is evident from the regulatory context referred to in the previous section. The NMHPFSP 2013–2020 has tasked healthcare professionals and professional public administrators with actioning the 12 identified areas (DoH 2013: 22–29). While the implementation of these 12 areas of action was, by their nature, interrelated, it is especially the first area – the organisation of services – that is of importance to this study.

These settings and levels provide for a diversity of instances of mental healthcare, healthcare professionals and mental health facilities such as 'community-based settings, general hospitals and specialised psychiatric hospitals' (DoH 2013: 22). The 'heavy reliance on psychiatric hospitals' was not only identified as labouring 'under the legacy of colonial mental health systems' (DoH 2013: 9) but in need of further downscaling through deinstitutionalised services. The reported risk involved in deinstitutionalisation (Lund et al 2011: 31) is highlighted with reference to the fact that deinstitutionalisation

has progressed at a rapid rate in South Africa, without the necessary development of community-based services. This has led to a high number of homeless mentally ill people living with mental illness in prisons and revolving door patterns of care (Department of Health 2013: 16).

The NMHPFSP 2013–2020 consequently provides for the scaling up of ‘decentralised integrated primary mental health services, which include community-based care, PHC clinic care, and district hospital level care’ (DoH 2013: 19). This up-scaling of community mental health services (consisting of community residential care, day-care services and outpatient services) was supposed to occur ‘before further downscaling of psychiatric hospitals can proceed’ – of which all were supposed to happen by 2020 (DoH 2013: 23). The specific provisions in the policy framework are remarkably similar to the mental healthcare reforms announced by the governor of Illinois in the United States, 20 years earlier, on 4 May 1992 (Lynn 1996: 297). These reforms also constitute the deinstitutionalisation of mental care users to decentralised local area networks (LANs) at community level (Lynn 1996: 305–307).

The envisaged upscaled community health services were intended to be provided by eligible and funded non-governmental organisations (NGOs) and voluntary and consumer organisations. The eligibility of these organisations was determined through a licensing and regulating process, a responsibility of the provincial Departments of Health (DoH 2013, 2016: Regulation 43). Therefore, the implementation of the abovementioned provisions of the NMHPFSP 2013–2020 requires the provincial Departments of Health to ensure that the community mental health service-providers meet the regulatory eligibility and funding requirements before the start of the process of deinstitutionalisation. The eligibility requirements have been set by national community-based care norms, for which the Ministerial Technical Advisory Committee on Mental Health is responsible (DoH 2013, 2016: Regulations 5 and 43). The adoption of the NMHPFSP 2013–2020 therefore signified an attempt to align further the mental healthcare policies of the nine provinces in South Africa with the objectives of the Mental Health Care Act of 2002, and also with international trends and guidance provided by the WHO (WHO 2007; DoH 2013). This observation is confirmed by a resolution adopted at the 66th World Health Assembly in May 2013 to the effect that member countries should ‘provide comprehensive, integrated and responsive mental health and social care services in community-based settings’ (WHO 2013: 6). The qualification of this resolution is noteworthy, namely, appropriateness to country-specific situations (WHO 2013). In the South African context, the implementation

of the NMHPFSP 2013–2020 should have occurred within a framework of extensive checks and balances as provided by the Mental Health Care Act of 2002 and its regulations. These checks and balances, in addition to a consideration of and learning from international and local experiences of deinstitutionalisation processes, could have guided this process away from the inherent risks attached to the implementation of this policy framework and strategic plan.

In order to mitigate these risks, the NMHPFSP 2013–2020 has identified specific timelines for meeting certain milestones on the path to realising the vision of improved mental health by 2020. These milestones for the different years from 2013 to 2020 were (DoH 2013: 23–29):

- 2013: Intersectional collaboration in planning and service development, the targeting of certain vulnerable groups for special mental health needs and developing a national mental health research agenda by 2013.
- 2014: Principled and integrated financing of mental health, the promotion and protection of the human rights of people with mental illness and the aligning of quality improvement initiatives for mental health.
- 2015: The integration of mental healthcare into general healthcare, advocacy of mental health on the public agenda, basic mental health training for staff working in general health settings, and the availability and monitoring of psychotropic medicines at all levels.
- 2020: The up-scaling of community health services.

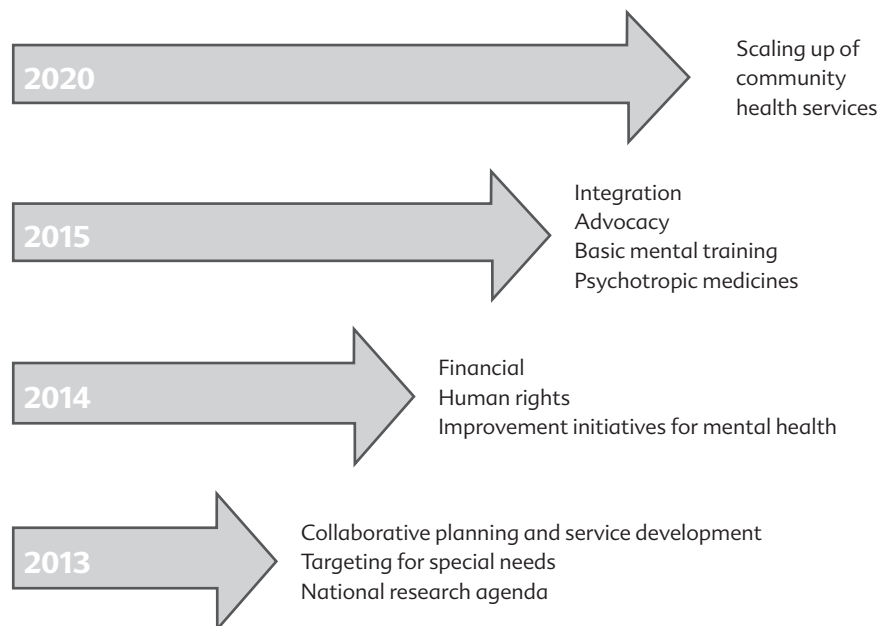


Figure 1: Deinstitutionalisation timelines of the NMHPFSP 2013–2020

The 2020 due date for the objective of up-scaling community health services is perhaps an indication of the envisaged time necessary for achieving this objective. Meanwhile, a considerable percentage of healthcare services have continued to be rendered by psychiatric hospitals, provided through contractual agreements with private-sector service-providers, such as the Life Healthcare Group.

LIFE HEALTHCARE ESIDIMENI CONTRACT WITH THE GAUTENG DEPARTMENT OF HEALTH

Life Esidimeni (meaning ‘place of dignity’) is a subsidiary of the private-sector Life Healthcare Group, which has delivered healthcare and related services to the public sector for more than 50 years (Life Healthcare 2019). Their seven centre-based service categories are aligned with various government and transnational policies, mandates and action plans, such as the National Development Plan and the National Mental Health Policy Framework and Strategic Plan (NMHPFSP) 2013–2020 (DoH 2013). These services focus on chronic mental healthcare, frail care, children’s mental health and frail care, intermediate care and substance-abuse recovery (Life Healthcare 2019).

Life Esidimeni’s initial contract, dating back to 1979, was with the National Department of Health (NDoH), while the previous four provinces (Transvaal, Natal, Orange Free State and Cape) individually took over the contract in 1987 (Life Esidimeni Arbitration 2017b). Since 1994, Life Esidimeni has provided mental healthcare services to various newly constituted provinces, such as the Eastern Cape, KwaZulu-Natal, Limpopo and Gauteng (Makgoba 2017a: Annexure 4a). According to a report submitted to the Health Ombud (referred to here as ‘the Ombud’) during their investigation, Gauteng ‘remained the province with by far the highest number of clients contracted to Life Care’ while the other provinces had terminated their contracts with Life Esidimeni over time (Makgoba 2017a: Annexure 4a).

Although a contract existed between Life Healthcare Esidimeni and the GDoH for the provision of services to those mental healthcare users requiring specialised chronic psychiatric treatment, we could not establish the specific duration, conditions and terms of reference of this contract and service-level agreement. Transcripts of the arbitration hearing revealed that the legal counsel for SECTION27 (a public-interest law advocacy group for ‘substantive equality and social justice in South Africa’ acting on behalf of 55 deceased former mental healthcare patients) was also unable to obtain copies of such documents at the start of the hearings on 9 October 2017 (Life Esidimeni Arbitration 2017a: 26). However, information provided by Life Healthcare Esidimeni on their public

website, as well as the testimonies during the arbitration hearings, indicate that these services, provided in three Life Esidimeni psychiatric facilities (Waverley Care Centre, Randfontein Recovery Centre and Baneng Care Centre), included long-term, intensive and professional services to people living with mental illness who are unable to care for themselves and subsequently require 24-hour attention (Life Esidimeni Arbitration 2017b: 94; Life Esidimeni 2019).

While the NMHPFSP 2013–2020 provides for a specific policy intention and a strategic plan for the deinstitutionalisation of psychiatric services, the subsequent decision regarding the discontinuation of the contractual relationship with private healthcare service-providers, such as Life Healthcare Esidimeni, has fallen directly within the scope of the various provincial Departments of Health, such as the GDoH.

DECISION TO TERMINATE THE CONTRACT WITH LIFE HEALTHCARE ESIDIMENI

While the NMHPFSP 2013–2020 came into effect in 2013, the implementation of the strategic plan to deinstitutionalise the mental healthcare services in Gauteng surfaced for the first time in the public domain on 21 October 2015; the Gauteng Member of the Executive Council (MEC) for Health announced that the GDoH ‘had given notice to terminate its contract with Life Healthcare Esidimeni Hospital’ (Gauteng Health 2015). However, this decision was already communicated for the first time internally (within the sphere of the GDoH) on 4 March 2015. This occurred at a meeting between the Mental Health Directorate of the GDoH, a representative of Life Esidimeni, and ‘managers and psychiatrists from psychiatric hospitals, psychiatric units in the central hospitals as well as community psychiatric services’ (Makgoba 2017a: Annexure 8a). At that specific meeting it was allegedly announced that

a decision had been taken to immediately reduce beds at Life Esidimeni Hospitals in Gauteng by about 11,5% by 31 March 2015, 20% by April 2015, and by a further 10% annually going forward, in order to curtail costs.

This summary of the announcement forms part of the memorandum by clinical heads of the Gauteng specialised psychiatric hospitals, heads of psychiatric departments or units of Gauteng central hospitals and academic departments to Dr Manamela, Director: Mental Health, dated 28 April 2015 (Makgoba 2017a: Annexure 8a). The reason provided at this meeting was therefore a financial one;

namely, to reduce costs for the department. This reason had also been stated in the GDoH Annual Report 2015/2016 (Gauteng Province 2016). Regarding the time implications of this decision, it is noteworthy that this decision was communicated to the stakeholders only 27 days before the first deadline of 31 March 2015 had to be met. No trace could be found in any of the documents in the public domain of any earlier formal consultation with stakeholders related to this decision.

Some of the embedded risks of such a short time frame had been identified by senior mental healthcare practitioners in a memorandum to the Director: Mental Health in the GDoH dated 28 April 2015 (Makgoba 2017a: Annexure 8a). This group of concerned experts included the clinical heads of Gauteng specialised psychiatric hospitals and the heads of psychiatric departments and units of general and academic hospitals. They were seriously concerned about the manner in which the policy framework was implemented, specifically regarding the decision to reduce the number of beds immediately at Life Esidimeni Hospitals. They drew the director's attention to international and South African experiences and reported studies of the deinstitutionalisation of psychiatric patients, leading them to conclude as follows (Makgoba 2017a: Annexure 8a):

We wish to reiterate our support for the deinstitutionalisation of mental health care users, as envisioned in our National Mental Health Policy Framework and Strategic Plan. We are however gravely concerned that the decision to reduce beds at Life Esidimeni does not follow the processes outlined in the same Plan.

We note that this decision will have a devastating impact on the health and social wellbeing of mental health care users, the health care system and members of the community. We also note that this decision will likely escalate health care costs in our province.

While the internal memorandum – addressed to Dr Makgabo Manamela (Director of Mental Health) and signed by Dr Madigoe (Clinical Head, Tara Hospital) on behalf of seven other professional officials on 28 April 2015 – referred to the announcement of the abovementioned decision (Makgoba 2017a), no indication was given as to who made this decision. The fact that this memorandum was addressed to Dr Manamela indicates that she, at least, made the announcement. The decision was evidently not her own, as the report by the Ombud referred to a 'high-level decision' by three key players, namely, Ms Qedani Dorothy Mahlangu (the MEC), Dr Tiego Ephraim Selebano (the Head of the GDoH) and Dr Makgabo Manamela (Director of Mental Health). The

arbitration process revealed that the formal termination notice to Life Healthcare Esidimeni in September 2015 was authorised and signed by the head of the GDoH, who claimed that he had done so on the instruction of and in fear of his political principal, the MEC (Moseneke 2018).

In addition to this internal memorandum, an official response was also compiled by the South African Society of Psychiatrists (SASOP) during June 2015 (Makgoba 2017a:Annexure 8b). This memorandum, addressed to the MEC for Health (Ms Quedani Mahlangu), was signed by the national convenor of SASOP Public Sector Psychiatrists, the chairperson of the SASOP Southern Gauteng Subgroup, the president-elect of SASOP and the president of SASOP. These professionals collectively raised their concern that ‘the reduction of beds at Life Esidimeni will have unintended, costly, negative consequences’ (Makgoba 2017a:Annexure 8b). They furthermore stressed that as the community healthcare services are ‘still severely underdeveloped and unable to support the current demand’, they believed that ‘the reduction of beds and planned closure of Life Esidimeni is premature, and acts in contradiction to the Policy’ (Makgoba 2017a: Annexure 8b).

No evidence could be found of any responses to both the memorandum and the letter. It is also not clear whether the GDoH met the targets set for reducing the number of beds at Life Esidimeni Hospitals as announced on 4 March 2015. However, the contract was terminated through a formal six-month notice authorised and signed by the Head of the GDoH, Dr Tiego Selebano, on 29 September 2015 (Moseneke 2018: 18). A public announcement was subsequently made by the Gauteng MEC of Health on 21 October 2015 to the effect that the GDoH had given notice to terminate its contract with Life Healthcare Esidimeni with effect from 31 March 2016 (Gauteng Health 2015). The implication of this notice was that all mental healthcare users would be removed from the Life Healthcare Esidimeni facilities by 31 March 2016.

An analysis of the content of the announcement reveals the following argument as motivation for the decision to terminate the contract:

- Premise 1: As the GDoH ‘cannot afford’ the continuation of the contract with Life Healthcare Esidimeni to the annual value of ZAR323 717 000 for providing ‘inpatient care, treatment and rehabilitation for people with chronic psychiatric disorders, and severe intellectual disability’ (Gauteng Health 2015; Life Esidimeni Arbitration 2017b: 94).
- Premise 2: As the Auditor-General allegedly had concerns about ‘unmanageable contracts’ (Makgoba 2017b) and ‘renewing one contract with one provider all the time for many years’ (Life Esidimeni Arbitration 2017b).

Premise 3: The GDoH has decided to use stipulations of the Mental Health Care Act of 2002, implying that mental healthcare users be treated in the least restrictive environment.

Conclusion: 'To reduce psychiatric patients at facilities by discharging all those who are responding well to treatment and integrate them back to communities and afford them treatment at their respective homes' (Gauteng Health 2015).

The non-affordability of the continuation of the contract, and not improved mental healthcare for those patients (see the vision of the DoH 2013: 19), was shown to be the primary reason provided in the public announcement by the MEC for terminating the contract. In the arbitration award, Deputy Justice Dikgang Moseneke contemplated the possible reason for the decision as follows:

Ms Mahlangu, Dr Selebano and Dr Manamela gave three reasons for the termination of the contract with Life Esidimeni: the policy requirement to de-institutionalise mental health care users; the Auditor-General's concern regarding the duration of the contract with Life Esidimeni; and budgetary constraints.

Unsurprisingly, the reasons are neither cogent nor rational ... This is so because towards the end of the hearing, the testimony of the Minister, Premier, member of the Executive Council for Health and member of the Executive Council for Finance convincingly demonstrated that all three reasons put up by the leaders of the Department were false, disingenuous and advanced in order to conceal the true reasons for ending the contract and moving the patients (Moseneke 2018: 19).

And yet the claimants and indeed the nation knows not the true reason why the triggering decision was taken by powerful Government Officials against defenceless mental health care users and their families (Moseneke 2018: 75).

Following the announcement by the MEC, professional bodies in the mental health sector, expert individuals and civil society interest groups advised and cautioned against the decision being implemented by the department. As a public-interest law advocacy group for equality and social justice, SECTION27 was alerted to the impending calamity (SECTION27 2018), while engagements with the South African Depression and Anxiety Group (SADAG) occurred (Stevenson 2019). They became a crucial public interest support group, alerting

the director-general of the NDoH at an early stage of the drastic effects of the transfer without a proper plan for deinstitutionalisation being in place.

In November 2015, SECTION27, SADAG, SASOP and the South African Federation of Mental Health (SAFMH) raised their well-substantiated concerns with the GDoH (SECTION27 2017) during a meeting chaired by the Head of Department (HoD) of the GDoH on 23 November 2015 (Life Esidimeni Arbitration 2017d). A follow-up meeting was held on 7 December 2015, followed by a letter to the department asking for the appointment of a curator (Life Esidimeni Arbitration 2017d). The department replied in a letter dated 15 December 2015 that they would continue to discharge patients (Life Esidimeni Arbitration 2017d). As their concerns were not adequately responded to, SECTION27 started a litigation process on 17 December 2015 to prevent the GDoH from 'placing these patients in other facilities until such time that we bring a curatorship application' (as quoted in the High Court Gauteng Local Division 2016: 52), followed by a settlement agreement with the department on 22 December 2015 (Life Esidimeni Arbitration 2017d: 51; SECTION27 2017; High Court Gauteng Local Division 2016). The settlement agreement seemingly resulted from the intervention of the Director-General (DG) of the NDoH, and specifically her assurance to SECTION27 that an implementation plan existed (Makgoba 2017b). This assurance was on the strength of an SMS response from the HoD of the GDoH on the readiness of the plan (Makgoba 2017b: 12).

In terms of this settlement agreement, the department would act in the best interests of the patients. There would be adequate consultation on the process and nobody would be moved until there was agreement on the process and facilities (SECTION27 2017). At the arbitration hearings, it was discovered that no such plan was provided by the GDoH, nor were any of the other obligations agreed to by the department ever met.

Evidence obtained by the Ombud revealed that, despite the settlement agreement of December 2015, the GDoH proceeded with the implementation of their decision to transfer mental healthcare users from Life Healthcare Esidimeni facilities according to a plan not shared with the 'many stakeholders', such as Life Esidimeni and the NDoH (Makgoba 2017b: 55). While a 'draft plan' was signed by the Director of Mental Health, Dr Manamela, on 22 September 2015 (Life Esidimeni Arbitration 2017d: 34), the investigation by the Ombud revealed that this plan was 'actually a cost accounting plan' (Makgoba 2017b: 15). As confirmed by the Ombud, there was indeed 'a policy decision by the GDoH to de-institutionalise mentally ill patients from hospital settings into community care' (Makgoba 2017b: 21), and this decision had to be implemented.

IMPLEMENTATION OF THE DECISION TO TERMINATE THE CONTRACT

The purpose of this section is to describe and reflect on the formal project to implement the decision announced by the MEC on 21 October 2015. This process unfolded with the appointment of the project manager, the constituting of the project team, the non-existence of a project plan, the first progress reports and a request for the extension of the completion date, implementation challenges and the aftermath of the project.

Appointment of the project manager

This process started two weeks after a public announcement by the MEC, when Mr Levy Mosenogi was approached by the MEC on 5 November 2015 to act as project manager to implement this decision (Life Esidimeni Arbitration 2017d, 2017b). This was evident during the arbitration hearings as it was recorded at an internal meeting of the GDoH that ‘Mr Mosenogi is appointed by MEC as project manager for the Life Esidimeni project’ (Life Esidimeni Arbitration 2017d: 113). Mr Mosenogi, a Master’s graduate who had also completed courses in project management, was an experienced public manager: a former Director of Policy and Planning in the North West provincial government and a former Chief Director: District Management. At the time when he was approached, he was the Chief Director: Policy, Strategic Planning and Monitoring (Gauteng Province 2016; Life Esidimeni Arbitration 2017d), but Mr Mosenogi testified at the arbitration hearing that his position was Chief Director Planning, Policy and Research (Life Esidimeni Arbitration 2017b). In addition, he successfully managed the Selby Park transfer project (Makgoba 2017b) after the contract between the GDoH and Selby Park Hospital was not renewed during the 2015/16 financial year (Gauteng Province 2016; Life Esidimeni Arbitration 2017b). He was evidently an appropriate choice as project manager.

While his appointment as project manager by the accounting officer, the HoD of the GDoH, was officially finalised only on 10 December 2015 (Life Esidimeni Arbitration 2017b), the project was shown to have been in operation since (at least) 1 April 2015. Reportedly, 160 patients were transferred during the period 1 April 2015 to 31 March 2016, while about 1 371 chronic mentally ill patients were transferred between 1 April 2016 and 30 June 2016 to either hospitals or NGOs (Makgoba 2017b). It therefore seems that Mr Mosenogi took over the management of an already running project, although it is not clear from whom – most probably from the Director: Mental Health, Dr Manamela, who managed the project as part of her line function.

Composition of the project team

After Mr Mosenogi was approached to take up this task, he sought clarity about his role from the HoD of the GDoH (Dr Selebano) and, considering the complexity and magnitude of the task, he simultaneously suggested the names of experts as possible members of such a project team (Life Esidimeni Arbitration 2017d: 35, 80). He subsequently received his formal letter of appointment on 9 December 2015 and ‘signed it off’ on 10 December 2015, along with most of the team members he had recommended (Life Esidimeni Arbitration 2017d: 34–35). In the words of Mr Mosenogi, the project team comprised

several senior managers together with relevant CEOs, especially of the psychiatric hospitals, Weskoppies, Sterkfontein, Cullinan and Tara. But also with the support staff, senior managers and the support staff, HR, infrastructure and finances (Life Esidimeni Arbitration 2017b: 82).

According to Mr Mosenogi, this project team contained several task teams, such as human resources ‘to look at the staff of Life Esidimeni, especially those who were taking care of our patients there’, finance, as they needed ‘a lot of ... funds to carry out our task’, infrastructure, as they ‘needed to renovate some areas in our facilities to show that we are able to accommodate additional patients’, and for mental health, which was already working ‘[b]ecause the project, when I took it over, was already running’ (Life Esidimeni Arbitration 2017b: 84). The latter task team, which included the clinicians, continued ‘to deal with the patient issues, because that one was already established under the Directorate of Mental Health unit in terms of ... their normal task’ which included ‘dealing with the admission, the discharge, the assessment of patients within Life Esidimeni’ as well as ‘taking care of the NGOs’ (Life Esidimeni Arbitration 2017b: 85).

From the above, one can deduce that the composition of the project team was broadly representative of all the key stakeholders in the department. The individual membership and the composition of task teams within the project team clearly provided the main functions required by the project. While the other task teams had to be temporarily convened for the purpose of this project, the core task team – the one responsible for mental health aspects – in essence consisted of a permanent part of the GDoH, the Directorate: Mental Health.

Non-existence of a project plan

After officially being appointed, the project manager set out to acquaint himself with the objectives, scope and strategic links of the project. Therefore, in his own words, ‘what was already there in terms of the project, what was called the project plan’; and he discovered that the project plan consisted of only a ‘cost analysis or cost effectiveness study [that] was done by our health economics’ with ‘no other document except the mental health policy’ (Life Esidimeni Arbitration 2017d: 81). His assessment corresponds to that of the Ombud referred to above. This also explains why the DG of the NDoH testified during the arbitration hearings that she ‘never got the plan, not in writing and not in any form’ (Life Esidimeni Arbitration 2017d: 154).

According to one of the evidence leaders during the arbitration hearings, the key purpose of this project team was ‘to facilitate smooth termination of contract between GDoH and Life Esidimeni for care to chronic mental health users by 31 March 2015’ (Life Esidimeni Arbitration 2017d: 62). The project manager interpreted his brief as to

ensure that the patients who are chronic patients who are in Life Esidimeni are catered for. Those who need to be at our facilities, they are taken back to our facilities. Those who are liable for discharge are discharged. And those who need to go to NGOs are taken to NGOs, non-governmental organisations ... that was the main task. But also, to ensure that the facilities are ready for that (Life Esidimeni Arbitration 2017b: 90).

While clarity existed on the final completion date of the project, namely, 31 March 2016, he discovered that ‘there was no due diligence done’ before the commencement of the project (Life Esidimeni Arbitration 2017d). Consequently, no prior identification of possible challenges, the project parameters, the length or duration and the cost of the project was considered by the newly appointed project team (Life Esidimeni Arbitration 2017d: 81).

A reconstruction of the events from various sources has shown that, immediately after its official appointment, the newly established project team was confronted with a request by SECTION27 and SADAG on 9 December 2015 for the appointment of a curator for the affected patients (Life Esidimeni Arbitration 2017d: 51); a formal written response by the department on 15 December 2015 informing the concerned bodies that the department would continue to discharge patients (Life Esidimeni Arbitration 2017d: 50); and meetings between the HoD of the GDoH and the DG of the NDoH with SECTION27 on their

specific concerns about patients' transfer to Takalani (Makgoba 2017b: 15). The Takalani NGO was a registered organisation that specialised in working with children with intellectual disabilities.

First progress reports and a request for extension

The project manager submitted his first progress report on 26 January 2016 to his principal and thereafter fortnightly until the completion of the project on 30 June 2016 (Life Esidimeni Arbitration 2017d: 4–5). While a copy of the first progress report could not be found, Mr Mosenogi testified during the arbitration hearings that the report provided a reflection on how he understood the purpose of the project and what would be necessary to implement the project (Life Esidimeni Arbitration 2017b: 113). His second report to the MEC of Health, dated 12 February 2016, consisted of two parts: an email and a memorandum, allegedly from the Mental Health Directorate (Makgoba 2017a: Annexure 5). The list of attachments to the email indicates that a PowerPoint presentation to the MEC was also included.

Mr Mosenogi's email to the MEC (Makgoba 2017a: Annexure 5) was copied to Dr Selebano (HoD of the GDoH), Dr Lebethe (Deputy DG Clinical Services) and Ms Kyanyisa (Director in the Office of the HoD). It is worth noting that the email was not copied to the Director of Mental Health, Dr Manamela. Considering that the HoD of the GDoH was the most senior public official in the department, as well as the accounting officer for this department, it was uncommon for the project manager not to report to him, but to report directly to the political head of the department, namely, the MEC. But it was revealed during the arbitration hearings that due to Dr Selebano's fear of the MEC, he asked Mr Mosenogi 'to write a letter to Ms Mahlangu pleading for an extension of the contract because he could not' (Moseneke 2018: 82).

The email by Mr Mosenogi briefly reports on the number of clients at Life Esidimeni, hospital beds that would be ready by the end of March, a breakdown of available beds for adults and children by the end of March at NGOs, the processing of applications for clients' identification documents, clinical profiling, staff uncertainty at Life Esidimeni and the renovation and maintenance of own facilities. Noteworthy is his request that 'the department seriously consider an extension of the contract [with Life Healthcare Esidimeni] to about 6 months minimum to a year' to assist them 'to do better work with regard to beefing up our own facilities to cater for such vulnerable patients; and also ensure that the NGOs are trained and also adjust to handling a variety of specialised patients, and also well prepared for such venture'. In addition, he conveyed the request from Life Healthcare Esidimeni for clarity on the project plans as they 'need to issue notices to staff before the end of February 2016' (Makgoba 2017a: Annexure 5).

The memorandum attached to this email provides feedback of meetings with relatives of patients at two of the facilities and his realisation that the way the project 'is going to unfold may have unintended consequences resulting in the disruption of mental health services broadly in the province' (Makgoba 2017a: Annexure 5). He specifically warns that the policy decision will cause 'the relapse of the most vulnerable patients', 'huge shifts in ... [the] overall way of life' of the relatives of patients, job losses for those healthcare workers 'with specific care skills although not professionally qualified', and the disruption of academic programmes at the Life Esidimeni facilities (Makgoba 2017a: Annexure 5).

The project manager concluded the memorandum with a recommended alternative implementation approach, which has been 'discussed and shared amongst ourselves as senior managers, ie HoD, DDG and the LE project managers' (Makgoba 2017a: Annexure 5). This proposal boils down to extending the process by 'at least a financial year', the possible procurement of some centres of Life Healthcare Esidimeni, and a subsequent 'smooth deliberate process' of the one centre not procured (Makgoba 2017a: Annexure 5).

From the above it is evident that two months after his appointment as project manager, Mr Mosenogi realised that the 31 March 2016 completion date for this project was unrealistic, considering what had to be undertaken as part of the project (Makgoba 2017b). Hence his request to the MEC for an extension of the project completion date in order to plan and prepare properly for this evidently complex project, and to mitigate the identified risks of harming these vulnerable patients. This request is indeed an example of the identification of early warning signs in a typically complex project, as discussed by Williams, Klakegg, Walker, Andersen and Magnussen (2012). These early warnings were evidently not taken seriously and the proposed alternatives were also not accepted by the project sponsor, namely, the MEC (Makgoba 2017b). No evidence exists of any serious consideration of, or response to, these concerns or alternative approaches by the MEC. In fact, ample evidence exists of the opposite, namely the disregarding of these concerns, as confirmed by the subsequent Ombud report and the arbitration hearings (Makgoba 2017b; Moseneke 2018).

Implementation challenges

Several implementation challenges have emerged, of which the limited time frame, the non-existent project plan and the disputable eligibility of NGOs as health facilities are the most prominent.

Following the request for an extension of the due date by six months to a year, the GDoH announced in a press statement on 18 February 2016 that the MEC had agreed to an extension of three months. The due date of the project

to remove all mental care users from the Life Esidimeni facilities and to transfer them to eligible NGOs was accordingly moved from 31 March 2016 to 30 June 2016 (Life Esidimeni Arbitration 2017b: 103; SECTION27 2017; Algorithm Consultants & Actuaries 2018: 2). Meanwhile, the experience of various parties acting on behalf of mental healthcare users and their families was that insufficient information provided by the department severely constrained any consultations with the GDoH during the first three months of 2016 (SECTION27 2017). The lack of sufficient information can be attributed to the lack of a coherent project management plan to facilitate the availability and integration of the different categories of project-related information.

In addition to the time-frame challenge and related to the apparent non-existence of an integrated project management plan challenges related to the eligibility of the new community facilities to take care of vulnerable healthcare users increased. During March 2016, the various organisations acting on behalf of the family members of the healthcare users (eg the South African Federation for Mental Health (SAFed), SADAG and SASOP) became aware of the intention of the GDoH to proceed with the relocation of 54 healthcare users with various diagnoses (eg severe intellectual disability, hyper-sexuality and psychosis) to Takalani Home (SECTION27 2017; Algorithm Consultants & Actuaries 2018). Takalani Home was not regarded as an eligible facility for these healthcare users between the ages of 24 and 101 as it catered exclusively for children.

Subsequently, the SADAG, SAFed, SASOP, and the Association of Concerned Families of Residents of Life Esidimeni (ACFRLE) made an urgent application to the Gauteng South Division of the High Court against the MEC for Health, GDoH, Life Esidimeni and Takalani Home to prohibit the discharge and placement of users at Life Esidimeni to alternative facilities 'until such time as the first to third respondents [the MEC and the GDoH] have engaged meaningfully with the applicants and other stakeholders and developed a reasonable plan for the discharge of users from Life Esidimeni' (Valley 2016: 2). The applicants argued that the discharges were

in breach of the settlement agreement concluded on 22 December 2015, in that they are planning to discharge users from the Life Esidimeni mental health facilities without having engaged in a meaningful consultative process with the applicants (Valley 2016: 2).

The GDoH argued that that settlement ended on 31 January 2016 and that they were subsequently 'within their rights to discharge the patients' (Child 2016: 1–2). The application was dismissed by the court on the ground that the patients were

discharged by a clinician (Valley 2016; Mooney Ford 2017; Ferlito & Dhai 2018b). It is significant that the court specifically stated that the finding ‘must not be construed, as sanctioning the housing of the 54 users at Takalani’ (Valley 2016: 5).

Following this ruling by the court, the MEC declared in a media statement:

we will continue to work with all stakeholders to make sure that no patient will be neglected or thrown on the streets as result of this contract termination (Gauteng Health 2016).

The court application highlighted the concerns of the various parties with the project management process, specifically regarding the perceived inadequacy of the assessment of healthcare users and the eligibility and readiness of the NGO facilities to which they were being transferred. This decision prompted the GDoH to continue with the rapid transfer of patients to the earmarked NGOs without consulting stakeholder groups during the period March to June 2016 (SECTION27 2017). However, it became evident that the ‘earmarked NGOs’ referred to above may have been non-existent at the time of the urgent court application. In fact, the Ombud established that

people were called to a meeting to one of the Life Esidimeni halls and told that ... we are going to transfer patients from Life Esidimeni and this is an opportunity to provide empowerment to people who can either modify their homes [sic] in order to accommodate patients (Life Esidimeni Arbitration 2017b: 21).

While the urgent application of 15 March 2016 related to mental healthcare users’ transfer to a specific NGO, namely, Takalani Home, it highlighted a crucial aspect of the vague project plan, namely, the selection and licensing of NGOs as eligible mental healthcare facilities. The licensing of NGOs became a key area of scrutiny by the investigation of the Ombud (Makgoba 2017b) as the arbitration hearings and award (Moseneke 2018).

Even though NGOs were supposed to play a key role in providing community-based mental healthcare, they were evidently either non-existent or not ready to take up this role. The Ombud reported that

the NGOs were invited to attend a meeting held by GDoH and were informed about the opportunity of housing mentally ill patients. Some of the NGOs were residential homes and families moved out and relocated to accommodate conversion of their

homes into centres of care because they saw a business opportunity in the transfer project (Makgoba 2017b: 21).

Therefore, NGOs were recruited at short notice to make themselves available as mental healthcare facilities.

The project team has nevertheless been shown to be aware of section 8.7 of the NMHPFSP 2013–2020 (DoH 2013), which determines that, for NGOs to provide community-based mental health services, provincial Departments of Health should license and regulate them in terms of regulation 43 (DoH 2016, Regulation 43) of the Mental Health Care Act of 2002 (RSA 2002). While no evidence could be found of favouritism (eg the accommodation of large numbers of patients for large amounts of money) in the granting of licences (Life Esidimeni Arbitration 2017b), the Ombud revealed instances of the inadequate preparation of NGOs prior to the placement of mental healthcare users, the back-dating of licences and a lack of professional experience at NGOs for dealing with mental healthcare users (Makgoba 2017b).

Furthermore, it has been revealed that all the licences granted to 27 NGOs to which mental healthcare users were moved were irregular as they were signed by the Director of Mental Health and not by the HoD of the GDoH, who has been legally authorised to do so (RSA 2002; DoH 2016; Moseneke 2018). It has also been established that the authority given by the Act to the Head of the NDoH ‘with the concurrence’ (RSA 2002: 5) of the GDoH has not been legally delegated by the Head of the GDoH to the Director of Mental Health, Dr Manamela and that this resulted in all the licences she signed being invalid (Life Esidimeni Arbitration 2017c: 161–162).

The main concern was not with the legal technicality regarding the authority of the Director of Mental Health, but with the integrity of the process to ensure that the NGOs had the capacity to render appropriate specialised care. This would have been indicated by years of experience and insight into the needs of mental healthcare users, adequately qualified staff, reasonable staff–patient ratios, access to medical care and financial sustainability (Makgoba 2017b). Evidence was provided during the arbitration hearing that licences were finalised and signed by the Director of Health, despite explicit warnings by the relevant Deputy Director that these NGOs did not comply with the licensing requirements (Moseneke 2018). The implication of the licensing process was the transfer of mental healthcare users from the Life Healthcare Esidimeni facilities to the NGOs that were not eligible or qualified for the tasks for which they were licensed. This resulted in the withdrawal of quality healthcare, which was substituted with sub-standard care (Makgoba 2017b: 39).

Furthermore, the flawed licensing process resulted in severe financial and staffing challenges for these NGOs – another indication of the absence of an integrated project management plan. Newly licensed NGOs received financial support from the GDoH only three to four months after the arrival of these mental healthcare users (Makgoba 2017b: 21, 37, 47). Subsequently, it was revealed that the staff members who had to receive patients from the Life Esidimeni facilities were reportedly unskilled, non-professional and untrained to assess the medical conditions of patients and their medical records (Makgoba 2017b: 22).

In addition to the non-eligibility of the 27 NGOs to which healthcare users were transferred, the physical transfer process was another major challenge. Five types of transfer have been distinguished:

- within different Life Healthcare Esidimeni facilities;
- from Life Healthcare Esidimeni facilities to NGOs;
- from Life Healthcare Esidimeni facilities to psychiatric hospitals;
- from NGOs to psychiatric hospitals; and
- between different NGOs (Makgoba 2017b: 20, 30, 31).

The Ombud observed that the multiple transfers of mental healthcare users added to their anxiety and stress. In addition, these organisations were sporadically located in different geographical areas, resulting in a breakdown of communication with the families of patients who were moved to them. This in itself was contrary to the objective of the policy framework of integrating patients closer to the communities they came from (DoH 2013: 21).

While it has been reported that a total of 1 450 healthcare users were transferred during the period from October 2015 to June 2016, of which 817 were transferred in May 2016 and a further 512 in June 2016 (Makgoba 2017b), the statistics indicate that no fewer than 10,4% of those transferred to NGOs died. The Ombud's analysis of the casualties revealed that about 80% of patients died in five NGOs, namely, Precious Angels, Cullinan Care and Rehabilitation Centre/Siyabadinga/Anchor, Mosego/Takalani, Tshepong and Hephzibah (Makgoba 2017a: 8). Only 2,4% of those users transferred to hospitals died (Makgoba 2017b; Moseneke 2018). While the first person died about one month before the project was completed on 25 May 2016, five more people passed away by the last day of this project: 30 June 2016 (Makgoba 2017b). However, after the official closure of the project, mental healthcare users continued to die. The report of the Ombud referred to more than 94 deaths (Makgoba 2017b: 41), while Deputy Justice Moseneke referred to the death of at least 144 mental healthcare users in his award on 19 March 2018 (Moseneke 2018: 2). This figure is likely to grow, as further investigations reveal more information.

AFTERMATH: INVESTIGATION BY AND FINDINGS OF HEALTH OMBUD AND ARBITRATION HEARING

The main aftermath of the project was the growing numbers of deaths of healthcare users who were discharged from Life Healthcare Esidimeni facilities and transferred to NGOs. This resulted in the National Minister of Health requesting the Ombud to investigate ‘the circumstances surround in the deaths of mentally ill patients in the Gauteng Province’ during October 2016 (Makgoba 2017b: 3). His investigation was informed by the work of an expert panel, inspectors of the Office of Health Standards and Compliance (OHSC) and evidence provided by individuals, families and relatives of the deceased (Makgoba 2017b). The subsequent report was released on 1 February 2017 (see reference to the date in Toxopeüs 2018). The Ombud concluded that the decisions and actions by the decision-makers and implementers were either negligent or reckless and in contravention of the Constitution of 1996, the National Health Act of 2003 and the Mental Health Care Act of 2002 (Makgoba 2017b: 49–52).

With reference to the project management process, the Ombud found that the project plan was not approved by the relevant authority, while aspects related to the planning, monitoring and time frames were non-existent (Makgoba 2017b: 52). He subsequently recommended that similar projects in future be undertaken within a clear policy framework and guidelines, under the supervision of the relevant oversight mechanisms and with the permission obtained from the National Minister of Health (Makgoba 2017b: 54–55). Based on the evidently low levels of trust, ‘anger, frustration, loss of confidence’ in the GDoH among stakeholders, the Ombud also recommended that the National Minister of Health and the Premier of Gauteng must lead and facilitate an ‘Alternative Dispute Resolution process’ (Makgoba 2017b: 55) that would result in the various parties’ agreeing to an arbitration process before former Deputy Chief Justice Dikgang Moseneke (Toxopeüs 2018).

The proceedings in the arbitration process started on 9 October 2017 and ended on 9 February 2018 (Moseneke 2018). No fewer than 43 days were allocated to the hearings, while an additional two days were set aside for the legal arguments. The 60 witnesses included senior government officials, officials at the middle-management level, political office-bearers, the managing director of Life Esidimeni, managers and owners of NGOs, expert witnesses and family members of deceased and surviving mental healthcare users (Moseneke 2018). Furthermore, an abundance of documentary evidence was also admitted to the record of the hearing. The purpose of the arbitration proceedings was to determine the

nature and extent of the equitable redress, including compensation due to mental health care users and their families who were negatively affected by the Marathon Project that led to the closure of Life Esidimeni mental health care facilities after 1 October 2015 (Moseneke 2018: 4).

During the proceedings, the state

conceded that the deaths of the concerned mental health care users were not natural deaths but caused by the unlawful and negligent omission or commissions of its employees – starting with Ms Mahlangu Dr Selebano and Dr Manamela – and of the personnel of non-governmental organisations who were agents of the State and who bore the same duty of care and the same statutory and constitutional obligations as the State towards the mental health care users and their families (Moseneke 2018).

On 19 March 2018 Justice Moseneke made a binding award for funeral expenses, general damages for shock and psychological trauma and, as appropriate, relief and compensation for unlawful actions that caused the deaths of 144 mental healthcare users. An award was also offered for ‘the pain, suffering and torture of 1 418 mental health care users who survived and their families’ (Moseneke 2018: 43). After actuarial evidence was led on 30 November 2017, the arbitrator’s award amounted to a total of ZAR159 460 000 (Whittaker 2018: 4).

Not only did the decision to terminate the contract with Life Healthcare Esidimeni and transfer the majority of the mental healthcare users in these facilities to NGOs who were not eligible to act as mental healthcare facilities directly result in the deaths of at least 144 healthcare users; it also led to a considerable amount of public money being wasted or lost. The question is therefore: How can one make sense of this series of events constituting the GMMP?

RETROSPECTIVE SENSE-MAKING OF A DISASTROUS POLICY IMPLEMENTATION PROJECT

The purpose of this section is to report on a sense-making process driven by a relatively simple question posed by Weick et al (2005: 412), namely: ‘What is going on here?’ It does so by repeatedly asking this question with reference to the NMHPFSP 2013–2020 as a strategic framework for the deinstitutionalisation of mental healthcare users, the contract between the GDoH and Life Healthcare

Esidimeni, the decision to terminate the contract, the implementation of the decision and the aftermath. While the chronology of this contribution may result in various unanswered factual and conceptual questions, the following two questions are the most pressing for the purposes of the current contribution:

- How can one make sense of the respective roles of the MEC, the HoD of the GDoH and the Director of Mental Health in the GMMP as an instance of policy implementation failure?
- How can one make sense of the GMMP as an instance of a disastrous policy implementation project?

The first question relates to the vast collection of theories on policy implementation, policy failure and implementation failure, while the second question relates to those theories which try to shed some light on the project management dimension of a policy implementation project.

How can one make sense of the respective roles in the GMMP as an instance of policy implementation failure?

A review of the different role-players' behaviour in implementing the decision to terminate the contract with the private service-provider shows that the most influential role-players were the MEC of Health (the responsible political office-bearer), the HoD of the GDoH (the accounting officer and most senior public servant), the Director of Health (the direct line manager of the directorate responsible for mental healthcare in the GDoH) and the project manager (a Chief Director in the GDoH). While each of them has a distinct role to play in the GDoH, the following discrepancies in their respective roles in the GMMP were identified for sense-making:

- The MEC, and not the HoD, approached Mr Mosenogi to serve as project manager.
- While the GMMP was labelled a project, a formal project plan was not used.
- While the project was initiated within the scope of the NMHPFSP 2013–2020, the project was not aligned to the vision, requirements and timelines of this policy document.
- The HoD did not agree with the termination of the contract, but nevertheless signed the termination notice.
- The project manager's progress report was addressed and submitted to the MEC and not to the HoD, who was the accounting officer of the GDoH.
- The MEC did not grant the requests of the project manager for an extension of the project timeframe to a year, or to pursue suggested alternative options.
- The GDoH continued to house mental healthcare users in facilities that did

not meet the eligibility requirements, irrespective of the court ruling that its finding ‘must not be construed, as sanctioning the housing of the 54 users at Takalani’ (Valley 2016: 5).

A review of the scholarly literature revealed an abundance of possible theoretical lenses to be applied for making sense of the discrepancies listed above and other instances of policy implementation failure. The most applicable theories to the present study are those of policy regime (Nowlin 2011; May 2015), policy commitment (Staw & Ross 1978; Staw 1981; Barton, Duchon & Dunegan 1989; Brockner 1992; Simonson & Staw 1992), policy failure (Howlett, Ramesh & Wu 2015; McConnell 2015), implementation failure (Howlett et al 2015; Dunlop 2016), public service failures (Van de Walle 2016) and the political–administrative interface (Audette–Chapdelaine 2016). While this project has been implemented within the framework of the NMHPFSP, and as the roles of the relevant political office-bearer and the accounting officer have been shown to be key in this tragedy, we will apply, for the purposes of this sense-making process, three interrelated lenses, namely, the policy regime lens, the policy commitment lens, and the political–administrative interface lens.

Making sense through the policy regime lens

Through a network of political and institutional forces related to a specific policy problem, the policy regime lens makes sense of the role of the various political and administrative governing arrangements (May 2015) in the playing out of a policy implementation project. This contribution also reports on the regulatory framework as part of the macro policy regime of the project under investigation. This regime consists of the national and provincial government role-players and the diversity of professional stakeholders in mental healthcare. This macro policy regime contributed to the development of the NMHPFSP 2013–2020 during 2012. The policy regime of the project under investigation consists of what May refers to as ‘the constellation of political and institutional forces’ (2015: 295) that approach the problem of mental healthcare in South Africa. This policy regime also determines the political and administrative governing arrangements for giving effect to the constitutional, legislative and regulatory requirements for mental healthcare in South Africa.

In the context of this study, the policy regime consists of a dense network of political, administrative and professional role-players legally authorised by equally dense regulatory frameworks. In addition to these role-players, the policy regime also includes those regulatory arrangements referred to above, of which the policy and strategic direction are determined by the vision of the NMHPFSP

2013–2020: ‘Improved mental health for all in South Africa by 2020’ (DoH 2013: 19). The implication of this strategic direction is that any project constituted to implement any aspect of this policy framework needs to be aligned to this vision as a determining strategic success factor of the project (Abednego & Ogunlana 2006).

The contract between the GDoH and Life Healthcare Esidimeni leads to the sense-making question: ‘What’s going on here?’ (Weick et al 2005: 412). We, as researchers, tried to understand the reasons for the contract between the two parties. This contractual agreement for specialised psychiatric care has been shown to be an instance of a public–private partnership inherited by the GDoH (and the departments in other provinces) from the pre-1994 provincial healthcare structures. It is noteworthy that the national policy regime closely linked this ‘heavy reliance on psychiatric hospitals’ to ‘the legacy of colonial mental health systems’ (DoH 2013: 9). The GDoH has apparently not followed the example of departments in other provinces to terminate these contracts and, by implication, to depart from this colonial legacy. Consequently, Gauteng became the province with the highest number of mental healthcare users being cared for through this partnership with its colonial label. The political implication of this comparison may have contributed to the urgency with which the decision to terminate the contract was driven by the Gauteng-specific policy regime.

The decision to terminate the contract with Life Healthcare Esidimeni was announced for the first time internally on 4 March 2015 by the Director of Mental Health and not by the HoD of the GDoH or by the MEC. To what extent was this instance of reality in line with what could have been expected? (See the sense-making question posed by Audette–Chapdelaine 2016: 6.) In answering this question, we have chosen the policy regime perspective developed by May (2015) as the most appropriate theoretical lens for obtaining clarity. This lens draws the attention to the ‘interplay of the ideas, institutional arrangements, and interests that undergird a given regime’ (May 2015: 278) for resolving policy problems and converting them into actions. This perspective specifically emphasises ‘the constellation of political and institutional forces ... to address a given problem’ (May 2015: 295–296). From this perspective, one could reasonably expect that this decision by the GDoH was the result of the collective work all key stakeholders, as was the case with the development of the NMHPFSP 2013–2020 in 2012. However, this announcement indicates an attenuation of the meaning and scope of the concept of ‘policy regime’ in this specific context. It is evident that key role-players in the translation of policy into integrative actions across multiple subsystems were excluded; therefore, this policy implementation process was deprived of legitimate, coherent and durable policy implementation and feedback regimes (Nowlin 2011: 54; May 2015: 281, 295–296).

Furthermore, the affordability and contractual reasons provided for the termination of the contract (see the reconstruction of the argument earlier in this contribution) have also been shown to be dislocated from both the policy regime as the national policy intent of ‘improved mental health for all in South Africa’ (DoH 2013: 19). In a study of public service failure, Van de Walle refers to public service failure by design in areas where the ‘demand for services is high but resources scarce’ (2016: 836). However, evidence by the MEC for Finance during the arbitration proceedings revealed that a lack of finance was not a contributing factor to this decision (Moseneke 2018: 19). From the above it seems that the only plausible explanation for this decision is provided by the policy regime lens. The all-inclusive national healthcare policy regime has been attenuated by the GDoH to the exclusion of the national policy intent and the wide variety of legitimate healthcare stakeholders.

Situational theory of policy commitment

Related to the policy regime lens are the situational theories of political and policy commitment (Staw 1981; Barton et al 1989; Brockner 1992; Simonson & Staw 1992; May 2015). These theories have several variations:

- a preference for a commitment to the general rule compared to the particular incidence (Staw & Ross 1978: 62);
- a tendency ‘to escalate commitment above and beyond what would be warranted by the “objective” facts of the situation’ (Staw 1981: 584); and
- a tendency that the escalation of commitment is inversely related to the way the decision-maker perceived the risk attached to proceeding with a commitment (Barton et al 1989).

The interpretation obtained from this subsection is that the policy decision that justified a commitment is the general rule as set by the NMHPFSP 2013–2020 and not the particular brief for the project. The NMHPFSP 2013–2020 not only provided the strategic objective of better mental healthcare for all, but also the broad timeline within which the project was supposed to be implemented (DoH 2013; see also Figure 1). Therefore, the situational theory of policy commitment implies that the decision to terminate the contract with the private service-provider and subsequently to transfer mental healthcare users from those facilities to NGOs should have been aligned to the NMHPFSP 2013–2020. This alignment evidently did not happen. Although the objective facts of this specific situation indicated that the practice of the GMMP was not adequately aligned to the NMHPFSOP 2013–2020, the attenuated policy regime of the GDoH did not demonstrate a commitment to the national policy framework, but a

commitment to its own non-aligned policy decision. Considering the theory explaining a tendency ‘to escalate commitment above and beyond what would be warranted by the “objective” facts of the situation’ (Staw 1981: 584), it makes sense why the MEC did not grant the project manager’s request to extend the project time frame to a year or to pursue suggested alternative options.

Furthermore, it seems that the ruling of the court on 15 March 2016 was interpreted by the GDoH as an indication of a reduced risk attached to their commitment to their decision to transfer mental healthcare users to NGOs. With the abovementioned third variation of the situational theory of policy commitment in mind (Barton et al 1989), the escalated commitment of the GDoH to proceed with the implementation of their decision makes sense.

Political–administrative interface

Our investigation revealed a peculiarity regarding the respective roles of the MEC (political office-bearer) and the HoD (accounting officer), in this case with the MEC being actively involved in the operational aspect of the project. Not only did she approach Mr Mosenogi to serve as project manager, but she also received progress reports directly from the project manager. She was also directly approached to approve the extension of the project and to consider alternative operational options. On the other hand, according to his own testimony, the HoD signed the termination notice against his will. He was also afraid to approach the MEC with the alternative options suggested by the healthcare professionals.

In order to make sense of this peculiarity, we have applied the complementary lens of political–administrative interface, according to which public managers are supposed to ‘[strengthen] democracy, whereas elected officials help support the professionalism of the civil service’ (Audette–Chapdelaine 2016: 5). This model relies on a communal relationship between politicians and senior public managers. However, in our case the relationship between the political office-bearer and the HoD does not demonstrate such an equal complementary relationship. In fact, ample evidence shows the MEC’s overstepping in the sphere of public administration while the HoD abdicated his legal authority as accounting officer.

How can one make sense of the GMMP as an instance of a disastrous policy implementation project?

One of the defining characteristics of the GMMP is the fact that it is known as a project with a project manager, a project team and a due date. Another defining characteristic is that it is known for its disastrous failure. The purpose of this section is to make sense of GMMP as an instance of a disastrous policy implementation project. In doing so, we also attempt to make sense of this major

discrepancy: that although the project was managed by a well-qualified and experienced project manager, it turned out to be a catastrophic failure.

This attempt at sense-making can be approached through the relevant project management theories to shed some light on the necessary conditions for project success or failure. While a rich collection of literature exists in the field of project management, we have identified different theoretical approaches, such as the identification of success factors (Abednego & Ogunlana 2006: 625), the criteria for measuring project performance (Chapman & Andersson 2017: 336) and the distinct stages of a project management approach (Alotaibi & Mafimisebi 2016). Abednego and Ogunlana (2006: 625) identify two success factors for a project: the success of the project's management and the success of the product of the project. The latter implies meeting the strategic objective or mission of the policy and, by implication, the project (Abednego & Ogunlana 2006: 625). In addition to these two success factors, Chapman and Andersson (2017: 336) provide five criteria for measuring the performance of a project:

- whether the strategic objective of the policy has been met (similar to the second success factor mentioned above);
- the nature of the internal project characteristics and external contingencies;
- the resources and capabilities available for the project;
- the key project success factors; and
- the expectations regarding the ultimate value delivered by the project.

In addition to these lenses, the distinct stages of the project management approach suggested by Alotaibi and Mafimisebi (2016: 96) may also serve as valuable lenses for making sense of the devastating outcome of the project under investigation. These stages are as follows: project definition and initiation, project planning, project launch, project execution, and project closure. Table 1 provides a comparison of the lenses provided by the three empirical referents. While the three contributions had different foci and sense-making indicators, they share at least one sense-making indicator: the strategic intent of the project (product success, strategic objective, ultimate value, deliverables, definition and initiation – see the highlighted cells in Table 1).

Table 1: Theoretical lenses for making sense of policy implementation projects

Empirical referents	Foci	Sense-making indicators				
Abednego and Ogunlana (2006)	Success factors	Project management success	Meeting time, cost and quality objectives	Quality of project management process	Satisfying stakeholders' needs	Strategic objective: product success
Chapman and Anderson (2017)	Project performance	Strategic objective	Internal characteristics and external contingencies	Resources and capabilities	Key success factors	Ultimate value/deliverables
Alotaibi and Mafi-misebi (2016)	Stages of the project management	Definition and initiation	Planning	Launch	Execution	Closing

The chronology of the GMMP has shown that the overarching strategic intent of this project was captured in the vision of NMHPFSP 2013–2020 as improved mental health for all in South Africa by 2020 (DoH 2013: 19). However, the key purpose of the project team was something more operational, that is, to ensure the smooth transfer of psychiatric patients in the different Life Healthcare Esidimeni facilities to NGOs or to other psychiatric hospitals who were ready to receive these patients by 31 March 2016 (Life Esidimeni Arbitration 2017d: 62). The operational project management process, however, focused almost exclusively on ensuring that all the patients accommodated by the Life Healthcare Esidimeni facilities were removed from these facilities by the extended target date of 30 June 2016. No evidence could be found of an intention to ensure that those facilities to which they were transferred constituted the envisaged improved mental healthcare for them. While this study has not conducted a detailed project management analysis and assessment of this project, ample evidence exists of the fact that the brief received by the project team was not embedded in the vision of the NMHPFSP 2013–2020.

FUTURE-ORIENTED SENSE-MAKING: ALIGNING POLICY IMPLEMENTATION PROJECTS TO POLICY VISIONS

Whereas the never-ending process of sense-making predominantly has a retrospective focus (Weick 1993: 636, 647; Parris & Vickers 2005: 284–285; Weick et al 2005: 411–415), the purpose of this process is to obtain insight into the present and the future (Weick et al 2005: 419; Vickers 2007: 224, 234, 235) fuelled by a 'desire or need to understand' (Audette-Chapdelaine 2016: 2) why 'the perceived state of things is not what we expect it to be' (Audette-Chapdelaine 2016: 6).

By drawing on the past experiences from this disastrous policy implementation project as discussed above, this future-oriented sense-making intends to plot this narrative ‘by anticipating future events and actions’ (Cunliffe & Coupland 2012: 67). By doing this, we share the view of Maclaen, Harvey and Chia that ‘looking to the future is also about living in the real world’ (2012: 30). However, for us, living in the real world means also imagining (Klein, Moon & Hoffman 2006: 89) how things could have played out should different choices have been made. Therefore, to anticipate a similar policy implementation project for the future (Cunliffe & Coupland 2012), we start by imagining a different GMMP by bringing the meaning obtained from the previous sections into existence (Weick et al 2005: 410).

Our futuristic story starts in 2020. Instead of 144 deceased mental healthcare users, there are 1 418 traumatised surviving mental healthcare users and about 44 missing mental healthcare users (Moseneke 2018: 2). The mental healthcare users in Gauteng will experience an improved state of care (DoH 2013: 19) in comparison with the state of being in 2012. Most of them will receive mental healthcare in eligible community-based residential facilities provided by NGOs or community-based organisations (CBOs), day-care services or outpatient services (DoH 2013: 23). Others, according to their specific needs and diagnostic profile, will receive mental healthcare through a strengthened district mental health system, general hospitals or specialised psychiatric hospitals (DoH 2013: 23–24). The strengthening of the mental health system was financed through an amount of ZAR 159 460 000 (DoH 2013: 25; Whittaker 2018: 4), especially budgeted for by the GDoH for scaling up these services ‘to match recommended national norms’ (DoH 2013: 23).

This state of being has been the result of the mobilisation of the all-inclusive national healthcare policy regime by the GDoH in collaboration with the wide variety of legitimate healthcare stakeholders in order to realise the national policy intent of improved mental healthcare for all. A decisive factor in realising this improved state of mental healthcare was the exceptional demonstration of policy commitment by all the role-players in the GDoH to the NMHPFSP 2013–2020. This commitment has been escalated (see the theoretical explanation by Barton et al 1989) due to the relevant decision-makers’ perception of the low risk attached to the systematic and well-planned implementation of this policy (DoH 2013: 22–29).

The systematic and well-planned implementation of this policy in Gauteng over a period of seven years was facilitated by an equal and complementary relationship between the responsible political office-bearer, the MEC for Health, the accounting officer and the HoD of the GDoH. Their respective roles in

this implementation process have been informed by, among other guidelines, the NMHPFSP 2013–2020 (DoH 2013: 29–32) and other national legislation.

The operational project necessary for the transfer of the mental healthcare users was earmarked for launching during 2019, after the formal project plan has received the necessary regulatory due diligence and approval, and after all the regulatory and policy prerequisites had been met (Life Esidimeni Arbitration 2017d: 81–82).

With all the required preparation completed, this project will focus predominantly on ensuring that all the patients accommodated by the Life Healthcare Esidimeni facilities are transferred in the most respectful way to improved mental healthcare facilities and within the agreed time frame. The entire project management plan and its execution will be embedded in the vision of the NMHPFSP 2013–2020.

Through this process of sense-giving by replacing the present storyline with an envisaged future one, we have tried to bring a different event into existence (Weick et al 2005). While this contribution has predominantly focused on the event as a disaster, the process of sense-making turns the retrospective focus towards the desired future as a ‘natural focus for analysis’ (Brown, Colville & Pye 2015: 268). Looking to the future can indeed be ‘about living in the real world’ (Maclean et al 2012: 30).

CONCLUSION

This contribution set out to make sense of the widely reported, disastrous GMMP that caused the deaths of about 144 vulnerable individuals. In doing so, we add to various other sense-making processes; formal, informal, legal and academic. We have selected the sense-making approach for the simplicity with which it guides the sense-maker with naïve questions through the messy field of discrepancies. As this specific case has been intensively and widely scrutinised in the public domain, we have relied almost exclusively on publicly available material. By doing so, we acknowledge that there are numerous other perspectives and stories that we have not sourced and analysed. Furthermore, we also acknowledge that our selection and use of a range of theoretical lenses is by far neither exhaustive nor adequate. However, we hope that our contribution will serve as a starting point for Public Administration scholars and practitioners to continue with their own sense-making endeavours.

Our study provides a chronological narrative of the so-called GMMP. The name of this project allegedly originated in the GDoH. The inclusion of the word ‘marathon’ in the title of the project has been shown to be more than a

bit ironic. Our narrative reveals that the project, officially started in December 2015, has a three-year background starting in 2012 with the development of a national mental health policy framework and strategic plan for the period 2013 until 2020. This framework and strategic plan document was remarkably detailed, comprehensive and internationally aligned. It is this document that provides the backdrop for the deinstitutionalisation of mental healthcare users in Gauteng. We have also revealed that while the GDoH's contract with the privately owned Life Healthcare Esidimeni stretched back almost indefinitely in history, the decision to terminate the contract had a definite aura of urgency about it.

This urgency to terminate the contract with Life Healthcare Esidimeni defined the entire GMMP. The subsequent project to implement the decision to terminate the contract started even before it was officially constituted, which resulted in a project without a project plan. Despite of the appointment of a well-qualified and experienced project manager, supported by a project team of experts in the fields included in the project, the project failed dismally.

In our retrospective effort to make sense of what actually happened, we have applied several theoretical lenses. As a result, we have found that the all-inclusive national healthcare policy regime has been attenuated by the GDoH to the exclusion of the national policy intent and the wide variety of legitimate healthcare stakeholders. We have argued that the behaviour of the GDoH in this saga can be attributed mainly to the situational theory of policy commitment. Furthermore, we found that the relationship between the political office-bearer and the HoD in this case was neither equal nor complementary at all: the MEC overreached himself in the sphere of public administration, whereas the HoD did not execute his legal authority as accounting officer sufficiently.

Finally, we have found that the operational project management process focused almost exclusively on removing the mental healthcare users from the Life Healthcare Esidimeni facilities before 30 June 2016 without any evidence having been obtained that those facilities to which they were transferred would constitute or provide the envisaged improved mental healthcare they required.

With this contribution we have shown that through retrospective sense-making it is possible creatively to rectify and replace the errors of the past with an envisaged future storyline.

Chapter 2

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Chapter 3

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