

**TOWARDS A DECOLONIAL MEDICAL TREATMENT TEAM APPROACH: THE
CASE OF MENTAL HEALTHCARE IN SOUTH AFRICA**

by

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I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

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ABSTRACT

Collaborative medical treatment teamwork through effective communication can enhance mental healthcare. Therefore, medical treatment teamwork is widely advocated as an approach for treating mentally ill patients, since diverse healthcare professionals, contribute expertise for patient care. Effective communication amongst members of the medical treatment team, is fundamental for effective medical treatment teamwork. Therefore, this research focused on exploring how the medical treatment team interacted in order to achieve effective patient care, from a South African perspective.

Approximately 80 per cent South Africans are influenced by socio-cultural factors when approaching and treating mental illness. Hence, a decolonial medical treatment team approach to mental healthcare, enables the medical treatment team to cater for important aspects such as cultural diversity within the medical treatment team, medical treatment team collaboration with traditional healers, and catering for the patient's cultural context in mental healthcare. This focus caters effectively for mental healthcare in a South African context. However, there is no single model or theory that caters for important aspects (such as the medical treatment teamwork context and socio-cultural aspects catering for diversity) that influence mental healthcare. Hence, the aim of this study was to propose a comprehensive conceptual framework that was synthesised from literature, which included various health communication theories, medical treatment teamwork theories, decolonial theories and cultural theories.

The conceptual framework was verified using four data collection methods namely, document analysis, observation, face-to-face semi-structured interviews, and focus group discussions. Data was analysed using specific steps from Braun and Clarke (2006) via a thematic analysis. The key findings from this study indicated that collaborative medical treatment teamwork which considers the socio-cultural context in mental healthcare, is beneficial in achieving effective mental healthcare. As a result, a comprehensive conceptual framework for a medical treatment team approach to mental healthcare was proposed as a contribution for this study.

Keywords: Mental health, decoloniality, health communication, multiple case study, qualitative, socio-cultural, medical treatment team, ubuntu, South Africa

ABSTRAK

Samewerkende mediesebehandelingspanwerk deur doeltreffende kommunikasie kan geestesgesondheidsorg verbeter. Mediesebehandelingspanwerk word dus wyd voorgestaan as 'n benadering vir die behandeling van pasiënte met geestesongesteldheid, aangesien diverse gesondheidsorgpersoneel kundigheid tot pasiëntsorg bydra. Effektiewe kommunikasie tussen lede van die mediesebehandelingspan is die grondslag vir spanwerk in effektiewe mediesebehandelingspanwerk. Hierdie navorsing het dus gefokus op die ondersoek na die wisselwerking tussen die mediesebehandelingspan om effektiewe pasiëntsorg te bereik, vanuit 'n Suid-Afrikaanse perspektief.

Ongeveer 80 persent van Suid-Afrikaners word deur sosiokulturele faktore beïnvloed wanneer hulle geestesongesteldheid benader en behandel. Gevolglik stel 'n dekoloniale mediesebehandelingspanbenadering tot geestesgesondheidsorg die mediesebehandelingspan in staat om voorsiening te maak vir belangrike aspekte soos kulturele diversiteit binne die mediesebehandelingspan, samewerking van die mediesebehandelingspan met tradisionele genesers, en voorsiening vir die pasiënt se kulturele konteks in geestesgesondheidsorg. Hierdie fokus maak doeltreffend voorsiening vir geestesgesondheidsorg in 'n Suid-Afrikaanse konteks. Daar is egter geen enkele model of teorie wat voorsiening maak vir belangrike aspekte (soos die mediesebehandelingspanwerkkonteks en sosiokulturele aspekte wat voorsiening maak vir diversiteit) wat geestesgesondheidsorg beïnvloed nie. Die doel van hierdie studie was dus om 'n omvattende konseptuele raamwerk voor te stel wat uit literatuur gesintetiseer is wat verskeie gesondheidskommunikasieteorieë, mediesebehandelingspanwerkteorieë, dekoloniale teorieë en kulturele teorieë ingesluit het.

Die konseptuele raamwerk is geverifieer deur gebruik te maak van vier data-insamelingsmetodes, naamlik dokumentontleding, waarneming, aangesig-tot-aangesig semi-gestruktureerde onderhoude en fokusgroepbesprekings. Data is tematies ontleed aan die hand van spesifieke stappe van Braun en Clarke (2006). Die sleutelbevindinge van die studie het aangedui dat samewerkende mediesebehandelingspanwerk wat die sosiokulturele konteks in geestesgesondheid in ag neem voordelig is in die bereiking van effektiewe geestesgesondheidsorg. Gevolglik is 'n omvattende konseptuele raamwerk

vir 'n mediesebehandelingspanbenadering tot geestesgesondheidsorg voorgestel as 'n bydrae vir hierdie studie.

Sleutelwoorde: Geestesgesondheid, dekolonialiteit, gesondheidskommunikasie, meervoudige gevallestudie, kwalitatiewe, sosiokulturele, mediesebehandelingspan, ubuntu, Suid-Afrika.

OKUCASHUNIWE

Ukusebenzisana kwethimba lokwelashwa ngokuxhumana okuphumelelayo kungathuthukisa ukunakekelwa kwezempilo yengqondo. Ngakho-ke, ukusebenzisana kwethimba lokwelashwa kukhuthazwa kabanzi njengendlela yokwelapha iziguli ezigula ngengqondo, njengoba ochwepheshe abahlukahlukene bezokunakekelwa kwempilo, benikela ngobuchwepheshe bokunakekelwa kwesiguli. Ukuxhumana okuphumelelayo phakathi kwamalungu ethimba lezokwelapha, kubalulekile ekusebenzeni kwethimba lokwelashwa okuphumelelayo. Ngakho-ke, lolu cwaningo lugxile ekuhloleni ukuthi ithimba lezokwelapha lisebenzisana kanjani ukuze kuzuzwe ukunakekelwa kwesiguli okusebenzayo, ngokombono waseNingizimu Afrika.

Cishe amaphesenti angama-80 abantu baseNingizimu Afrika bathonywa yizici zezehlalo namasiko lapho besondela futhi belapha ukugula ngengqondo. Ngakho-ke, indlela yethimba lezokwelapha elingasekho ekunakekelweni ngokwengqondo, yenza ithimba lezokwelapha likwazi ukubhekelela izici ezibalulekile njengokuhlukahluka kwamasiko eqenjini lezokwelapha, ithimba lezokwelapha ukusebenzisana nabelaphi bendabuko, kanye nokubhekelela amasiko esiguli ekunakekelweni kwengqondo. Lokhu kugxila kusiza ngempumelelo ekunakekelweni kwengqondo esimeni saseNingizimu Afrika. Kodwa-ke, asikho isifanekiso esisodwa noma umbono obhekelela izici ezibalulekile (njengomongo wethimba lokwelashwa kanye nezici zenhlalohle-zamasiko ezibhekelela ukuhlukahluka) ezinomthelela ekunakekelweni kwengqondo. Ngakho-ke, inhloso yalolu cwaningo kwakuwukuphakamisa uhlaka lomqondo olubanzi olwahlanganiswa ezincwadini, olwaluhlanganisa imibono yezokuxhumana yezempilo ehlukehukene, imibono yethimba lezokwelapha, imibono yokuqeda ubukoloni kanye nemibono yamasiko.

Uhlaka lomqondo lwaqinisekiswa kusetshenziswa izindlela ezine zokuqoqwa kwemininingwane okungukuthi, ukuhlaziya imibhalo, ukubuka, izingxoxo zobuso nobuso ezihlelwe kancane, kanye nezingxoxo zamaqembu agxilile. Imininingwane yahlaziywa kusetshenziswa izinyathelo ezithile ezivela ku-Braun and Clarke (2006) ngokuhlaziywa kwendikimba. Okutholiwe okubalulekile okuvela kulolu cwaningo kubonise ukuthi ukusebenzisana kwethimba lokwelashwa okucabangela umongo wenhlalohle-ngokwesiko ekunakekelweni kwezengqondo, kunenzuzo ekuzuzeni ukunakekelwa kwezempilo yengqondo okusebenzayo. Ngenxa yalokho, kwahlongozwa uhlaka olubanzi lomqondo wethimba lezokwelapha ekunakekelweni ngokwengqondo njengomnikelo walolu cwaningo.

Amagama asemqoka: Impilo yengqondo, ukuqeda ubukoloni, ukuxhumana kwezempilo, izifundo eziningi, okusezingeni eliphezulu, inhlalohle-ngokwesiko, ithimba lokwelashwa kwezempilo, ubuntu, iNingizimu Afrika

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CHAPTER 1: ORIENTATION AND RATIONALE FOR THE STUDY

1.1 INTRODUCTION

Mental health is an integral part of health and well-being (Viviers 2016; World Health Organisation 2021). According to the World Health Organization (WHO), mental health can be defined as a condition that affects a person's thinking, behaviour and emotions (WHO 2018). Mental health has been characterised as a burdensome problem affecting all segments of the population throughout the world (Nguse & Wassenaar 2021; WHO 2018). In 2020, coronavirus disease 2019 (COVID-19) emerged as a global pandemic, which increased mental health conditions as a result of the isolation imposed by the illness (Wang, Pan, Wan, Tan, Xu & Ho 2020). Therefore, COVID-19 brought unprecedented changes, leading to anxiety and depression (Kim, Nyengerai & Mendenhall 2020; Jungmann & Witthöft 2020). According to the WHO (2020), there are about one billion people living with mental illnesses globally. About 12 per cent of people living in sub-Saharan African suffer from common types of mental illnesses such as depression, anxiety, bipolar disorder, schizophrenia, dementia, and substance use (WHO 2018).

In South Africa, mental illness accounts for significant morbidity with an estimated lifetime prevalence of mental illness of 30.3 per cent (Jacobs & Coetzee 2018). Mental illnesses are severe enough to require professional intervention (WHO 2020). Over 17 million South Africans across all age groups, genders, and races are dealing with mental health problems, such as depression, anxiety disorder, bipolar disorder, schizophrenia, dementia, and substance use disorder (SUD) (Jacobs & Coetzee 2018; Willie 2017). The death of at least 118 mental health patients in the Life Esidimeni case depicted a dire need to treat mental health as a major healthcare problem in South Africa (Monteiro 2015). Thus, the high burden of mental illness necessitates using various strategies, such as medical treatment teamwork and alternative medicine (traditional healers), to facilitate effective care for mentally ill patients (DuBois-Maahs 2018; Saha et al. 2021; Willie 2017). This is because 80 per cent of South Africans consult with both the medical treatment team and traditional healers for mental healthcare (Nemutandani, Hendricks & Mulaudzi 2018; Jacobs & Coetzee). Therefore, the medical treatment team – which consists of healthcare professionals (HCPs) from diverse disciplines – needs to work collaboratively with traditional healers to provide mental healthcare in the South African context. Medical treatment teams are diverse teams that are thought to optimise patient care by capitalising on their larger pool of resources (namely different perspectives and

skills) to deliver high-quality mental healthcare (Allen 2020; Oflax, Ancel & Arslan 2019). Mental healthcare that emphasises medical treatment teamwork and coordination has been associated with greater implementation and continuous improvement in quality healthcare (Gautier 2015; Oflax et al. 2019). In other words, quality mental healthcare necessitates a greater focus on medical treatment teamwork. The members of the medical treatment team for the context of this study included nurses, medical officers, clinical psychologists, clinical managers who were also HCPs but held managerial positions at the hospital, occupational therapists, pharmacists, social workers, and psychiatrists from different disciplinary backgrounds who could synthesise different knowledge and skills and communicate with team members to deliver treatment to patients (Gautier 2015; WHO 2018).

This study is focused on exploring the interactions between these diverse members, of the medical treatment team, who ensure effective patient care. It is worth noting that even though the medical treatment team approach plays a fundamental role in mental healthcare, medical treatment teams in South Africa currently use a Western or biomedical approach to diagnosis and treat mentally ill patients (Tjale & de Villiers 2018). The biomedical approach to healthcare does not cater for socio-cultural factors that influence mental healthcare, in the South African context (Batisai 2016; Nmutandani et al. 2018; Tjale & de Villiers 2018).

An understanding of the socio-cultural factors that influence care-seeking for mental illnesses is crucial for effective planning and implementation of any intervention that is geared towards effective mental healthcare in South Africa (Nmutandani 2016). Socio-cultural factors that influence mental healthcare include the beliefs, values, and norms of the patient and their patient family (Jacobs & Coetzee 2018). The social aspect of the family needs to be incorporated into mental healthcare because family members can positively influence a patient's treatment by providing support and encouragement to the patient (Kuo et al. 2018; Raingruber 2013). In South Africa, some patients prefer consulting with traditional healers, mainly because of their cultural beliefs, revealing that cultural beliefs also influence mental healthcare in South Africa (Jacobs & Coetzee 2018; Nmutandani et al. 2018).

Thus, failing to address socio-cultural aspects that influence mental healthcare can impede effective patient care. Furthermore, the decolonisation of mental healthcare in South Africa becomes imperative, since decolonisation would enable the medical

treatment team to cater for socio-cultural factors, that influence mental healthcare in the South African context (Bene & Darkoh 2014; Grosfoguel 2013; Lake & Turner 2017).

Decolonisation for the purpose of this study is three-fold. First, it refers to catering for cultural diversity in the medical treatment team. Secondly, through the collaboration between the medical treatment team and trained traditional healers, it links to the use of alternative approaches of healing mentally ill patients. Lastly, it refers to the medical treatment team catering for the cultural aspects of the patient, during mental healthcare sessions.

In essence, members of the medical treatment team need to cater for the socio-cultural context of other team members, collaborate with traditional practitioners and the medical treatment team also needs to consider the socio-cultural needs of the patients in order to provide culturally congruent mental healthcare (Jacobs & Coetzee 2018). Thus, in a country as diverse as South Africa, it is imperative that the medical treatment team addresses the socio-cultural context of the team members and the individual patients as well as collaborate with traditional practitioners, to achieve a sustainable and culturally appropriate form of mental healthcare that indigenises, decriminalises, and destigmatises mental health (Nemutandani et al. 2018).

However, at present, there is no single model or theory that caters for important factors such as medical treatment teams and socio-cultural aspects that influence mental healthcare. The existing health communication models and theories do not provide a comprehensive approach to mental healthcare for the South African context. From this perspective, this research has aimed at conceptualising, proposing and presenting a comprehensive conceptual framework, that could assist in enhancing mental healthcare in South Africa. This framework was developed from the literature and then elements of the conceptual framework were empirically verified in the field, to determine if the proposed framework should be accepted, amended, or rejected. The proposed conceptual framework is the main contribution of this study.

This chapter provides a discussion on the context and background of the study. An explanation of the key concepts of the study, its purpose, the relationship of the topic to the discipline of communication. As well as the research problem and research objectives. Thereafter the operationalisation of concepts, including a brief methodology and chapter demarcation for this thesis are provided in this chapter.

1.2 CONTEXT AND BACKGROUND OF THE STUDY

According to the South African Depression and Anxiety Group (SADAG) (2021), one in three South Africans will have a mental illness at some point in their lives. The impact of mental health in South Africa is significant although mental health is often overlooked by the public agenda (Baxter, Whiteford, Vos & Norman 2011; Charlson, Baxter, Cheng, Shidaye & Whiteford 2016). Furthermore, research has indicated that mental illness is a major health problem in South Africa (Baxter et al. 2011; Charlson et al. 2016; Nguse & Wassenaar 2021; WHO 2018).

Against the backdrop of the rising burden of mental illness, management and treatment of mental illness becomes imperative. A decolonial medical treatment team approach to mental healthcare could assist with the treatment and care of mental health cases in South Africa (Bush 2016; Jacobs & Coetzee 2018; WHO 2019). Research suggests that effective communication amongst members of the medical treatment team leads to improved patient care and reduced medical errors (Bush 2016; Neese 2015; Sibiyi 2018; Vertino 2014). According to Sibiyi (2018), dysfunctional communication in the healthcare team accounts for 91 per cent of medical errors, and this results in inefficient patient care. Therefore, members of the medical treatment team need to work together and communicate effectively to ensure effective treatment for mentally ill patients. The members of the medical treatment team also need to communicate effectively with the patient's family to provide effective healthcare (Chichirez & Purarea 2018; Warnecke 2014). Given the background, it is important to explore the medical treatment team approach to mental healthcare in South Africa. This research study focused on exploring the communication aspects of mental healthcare using a medical treatment teamwork approach by examining communication between the HCP teams that treated mental health patients. Against this background, this study aimed to propose a comprehensive conceptual framework for mental healthcare in South Africa. The key concepts underlying this study are summarised below for the purposes of contextualising this study.

1.2.1 A medical treatment team approach for mental healthcare (HCP–HCP teamwork)

Medical treatment teamwork is widely advocated as an approach for improving treatment for mentally ill patients (Department of Health 2007; WHO 2018; Gautier 2015; WHO 2018). This is because HCPs from different disciplinary backgrounds work

collaboratively to deliver effective treatment to patients (WHO 2018). Such functional diverse teams are thought to optimise patient care by capitalising on their larger pool of resources, including different knowledge, perspectives and skills, to deliver high-quality healthcare (Wang, Wan, Lin, Zhou & Shang 2018). Therefore, the HCPs undertake different tasks and are expected to communicate effectively to provide effective services for the mentally ill patients (Lyubovnikova & West 2017; Vertino 2014). Therefore, the medical treatment team members (HCPs who treat patients with mental health issue) need to communicate with each other, as well as merge their observations and expertise to optimise effective patient care. Medical treatment team teamwork is essential for patient safety, as it minimises adverse events caused by miscommunication when caring for the patient (Bene & Darkoh 2014). Therefore, the focus of this study was to explore how the medical treatment teams at Fort England Psychiatric Hospital and Cecilia Makiwane Hospital interacted for patient care within the treatment team. The importance of medical treatment teams for patient care is discussed in detail in chapter 4.

1.2.2 The socio-cultural context of mental healthcare in South Africa

In the next sub-section, the socio-cultural context of mental healthcare as it relates to this study is discussed.

1.2.2.1 The social context of mental healthcare in South Africa

For the purposes of this study, the social context relates to the role of the patient's family in mental healthcare. Research has shown that family involvement in the mental health care of their family member results in significant benefits for both the patient and the healthcare system (Charles & Samarasinghe 2019; Dirik, Sandhu, Giacco, Barret, Bennison, Collinson & Priebe 2017; Olasoji, Maude & McCauley 2017; Raingruber 2013). According to Koren et al. (2017), family can make patients calmer and more cooperative during consultation. Brown et al. (2009) argues that there is a lower rate of mortality for patients who have family support compared to those who do not have family support. Thus, the critical role of the family in mental health care demands that they be recognised as partners in the care of their loved ones (Dirik et al. 2017; Olasoji et al. 2017). Thus, the notion of medical treatment teamwork in mental health care needs to be decolonised in order to empower and allow the patient's family to assist the medical treatment team to provide effective patient care in the South African context (Chichirez & Purarea 2018). The medical treatment team needs to interact with the patient's family in order to cater for the patient's socio-cultural needs and work as a team, when treating

the patient. Therefore, there is a need for a conceptual framework that incorporates decolonial knowledge, that is, information from the patient's family, in relation to the patient's culture from a healthcare perspective.

1.2.2.2 The cultural context of mental health care in South Africa

In the context of this study, the socio-cultural context includes factors that impact patient care such as, family and culture (Tjale & de Villiers 2018). For the purposes of this study, cultural consideration is two-fold (that is, for both the HCPs and for the patients). Cultural differences have the potential to hamper medical treatment teamwork, thus all members of the medical treatment team should be tolerant of each other's cultural differences, in order to work collaboratively in providing effective patient care. For the purposes of this study, the medical treatment team is required to provide comprehensive, quality mental healthcare services to the mentally ill patient. If the treatment recommended did not reflect their cultural beliefs, the patient may not have adhered to their treatment. Thus, there is a need to decolonise and indigenise mental healthcare in South Africa. In essence, the medical treatment team can cater for socio-cultural aspects if they tolerate diverse cultures (for both the patient and other team members) and if they involve the patient's family in their mental health care (a detailed discussion on the socio-cultural context is provided in chapter 3).

1.2.3 A decolonial approach for medical treatment teamwork for mental healthcare in South Africa

The impact of colonialism has extended beyond politics and the economic life of South African communities, since it contributed to the disoriented healthcare system (Nemutandani et al. 2018). Prior to the arrival of Europeans in South Africa, indigenous people treated illnesses according to their cultural belief systems (Tjale & de Villiers 2018). After colonisation, the West introduced a biomedical approach to healthcare in South Africa (Grosfoguel 2013; Tjale & de Villiers 2014). In the biomedical approach to healthcare, diagnoses and the treatment of illnesses are based on science and rationality (Nemutandani 2016). Even though the biomedical healthcare system serves an important purpose in healthcare and ensures access to the medical treatment team, scholars have argued that decolonising mental healthcare could support and assist mental healthcare in South Africa (Jacobs & Coetzee 2018; Nemutandani 2016; Tjale & de Villiers 2014). This is because members of the medical treatment team have diverse

cultural backgrounds and consideration for other team members' cultures could enhance medical treatment teamwork collaboration for patient care (Morley & Cashell 2017).

Furthermore, the majority of South Africans prefer a culturally aligned assessment and treatment of mental illness and thus consult with both the medical treatment team and traditional practitioners (Abbo 2011; Monteiro 2015; Sorketti et al. 2013; Tjale & de Villiers 2014). Therefore, the cultural context of interpreting, diagnosing, and treating mental illness and understanding the perceptions of mental illness should be considered by the medical treatment team in the South African context (Bene & Darkoh 2014; Monteiro 2015; O'Brien & Broom 2014). Thus, the medical treatment team should collaborate with trained traditional practitioners to provide mental healthcare that is tailored to the cultural reality of the communities in South Africa (Tjale & de Villiers 2014). Therefore, the decolonisation of mental healthcare in a South African context is imperative.

1.2.4 The importance of policy in mental healthcare

Mental health policies have been widely advocated as a key strategy to improve mental healthcare, in SA (Cooper 2015; Mulutsi 2017; Sibanyoni & Maritz 2016). Therefore, post-apartheid policies on mental healthcare encourages the medical treatment team to cater for the socio-cultural context of South Africans when providing mental healthcare (Davar 2014; Fernando 2012; Mills 2014; Sax 2014). This is because South Africans are influenced by their socio-cultural context. In essence, mental healthcare policies guide the functioning of any mental health institution (Mulutsi 2017). Thus, there is a need to consider both government and hospital policies as a guide to mental healthcare in South Africa, as explained in section 1.7 below and in chapter 7 further.

1.2.5 Theoretical approach adopted for this study

This study explored health communication models and theories from a teamwork, cultural, and decolonial perspective, as will be discussed below.

1.2.4.1 Teamwork theories

Health communication models and theories from a medical treatment team perspective were explored in order to contextualise the role of the medical treatment team in mental healthcare. The selected teamwork models and theories included: Tuckman's Teamwork Theory and Model (Tuckman 1965); the GRPI model (Rubin, Plovnick & Fry 1977); the

T7 Model of Team Effectiveness (Lombardo & Eichinger 1995); the Lencioni Model (Lencioni 2002); and the Theory of Collective Competence (Boreham 2004). These teamwork theories and models were selected to emphasise HCP–HCP teamwork in relation to mental healthcare since the medical treatment teamwork plays an important role in mental healthcare. A detailed discussion of these models and theories is also provided in chapter 4 to contextualise the need for the development of a conceptual framework that considers aspects of medical treatment teamwork in mental healthcare. Hence, providing a discussion on these models and theories also contextualises the conceptual contribution of this study.

1.2.4.2 Cultural theories

While teamwork factors contribute to mental healthcare, cultural factors must also be considered since culture plays an important role in mental healthcare in the South African context (Keikelame & Swartz 2019; Penson 2019). Thus, this study was also guided by cultural models and theories. It explored cultural health communication models and theories in order to acknowledge existing cultural models and theories in the field of health communication. The following cultural models were reviewed for the purposes of this study: the Theory of Cultural Care, Diversity and Universality (Leininger 1988), the PEN-3 model (Airhihenbuwa 1989); the Culturally Competent Model of Care (Campinha-Bacote 1995); and Cultural Safety Theory (Ramsden 2002). Criticisms of cultural models in relation to mental healthcare in South Africa will be explained in chapter 5 in order to contextualise the need for a comprehensive conceptual framework for mental healthcare in South Africa.

1.2.4.3 Decolonial theories

As noted above, the biomedical approach has its limitations in a country like South Africa where the majority of the population are influenced by their cultures (Nemutandani 2016; Tjale & de Villiers 2014). Western views of illness and mental illness cannot summarily be applied to a culture with a different view of life, a different value system, and a different perception of psychiatric illness (Batisai 2016; Bene & Darkoh 2014; Morrow & Malcoe 2017). This study argues that the decolonisation of mental healthcare could assist treatment outcomes for mentally ill patients. Therefore, this study explored decolonial theories for the purposes of this research.

The selected decolonial models and theories include: Decolonial Theory (Quijano 1990); postcolonial theory (Young 2003); Indigenous Standpoint Theory (IST) (Foley 2003); Grosfoguel's Model of Coloniality (Grosfoguel 2007); and Southern Theory (Connell 2007). It must be noted that these decolonial theories do not address mental healthcare *per se* but promote emancipation of oppressed and marginalised cultures, societies, and countries; they have thus been used in health communication research (Green 2019; Horril, McMillan, Schultz & Thompson 2018; Ramugondo, Lepere & Nebe 2017; Urena 2019). Criticisms of these theories will also be discussed in chapter 5 to contextualise the need for the development of a comprehensive conceptual framework that covers the broader perspectives relating to mental healthcare in the South African context.

1.3 CONTEXT OF THE RESEARCH SITES: CECILIA MAKIWANE HOSPITAL AND FORT ENGLAND HOSPITAL

For the purpose of this study, data were collected from two case study sites, namely Fort England Psychiatric Hospital (Site A) and Cecilia Makiwane Hospital (Site B). Both hospitals are public (state-owned) and are located in the Eastern Cape, a province of South Africa. Cecilia Makiwane Hospital is the only hospital in the BCMM that offers mental healthcare services to the entire BCMM and the Amathole district of the Eastern Cape (Sukeri, Alonso-Betancourt & Emsley 2015).

Fort England Psychiatric Hospital is located in Grahamstown in the Sarah Baartman District Municipality (TravelGround 2021). Fort England Hospital is the only forensic psychiatric hospital in the Eastern Cape. Both hospitals have medical treatment teams who treat mentally ill patients. Hence, these hospitals were selected for the purposes of this study. A detailed background of the selected sites is discussed in chapter 7. The next section explains the purpose of the study.

1.4 PURPOSE OF THE STUDY

The purpose of this study was to develop a conceptual framework for a medical treatment team approach to mental healthcare in the South African context. To achieve this, the study was executed in three different phases. In phase one, a detailed literature review was undertaken to propose a conceptual framework for mental healthcare in chapter 6. In phase two, elements of the proposed conceptual framework were verified at the selected case sites, namely Fort England Hospital and Cecilia Makiwane Hospital. In phase three, the proposed framework was re-worked based on the findings from the field

and the revised framework which is presented in the conclusion and recommendation chapter.

Thus, this study involved three different but complementary phases, which allowed the researcher to explore and describe the role of the medical treatment team approach in mental healthcare in South Africa. The aim of developing and verifying a conceptual framework for medical treatment team approach was to emphasise the important elements (these include, a medical treatment team, decolonial aspects, and the socio-cultural context and policy) that needed to be considered in mental healthcare, in the South African context. The following section provides an explanation of the relationship of the topic to the discipline of communication.

1.5 RELEVANCE OF THE TOPIC TO THE DISCIPLINE OF COMMUNICATION

The goal of health communication is to improve health outcomes by sharing health-related information (Schiavo 2007). Thus, this study is relevant to the field of health communication as it analyses interactions between members of the treatment team for patient care. The topic is also relevant to the field of health communication since it develops and proposes elements that should be considered in mental healthcare communication in the South African context. Furthermore, the results of this study provide deeper insights into the medical treatment team approach for mental healthcare within the communication discipline by providing valuable knowledge that can be adapted to strengthen medical treatment team interaction for patient care. In essence, this study is related to health communication as it provides insights into the communication phenomenon and medical treatment team interaction for mental healthcare.

In addition, this study argues that the socio-cultural context of the patient should be taken into consideration during diagnosis and treatment of mental illness. Therefore, this study describes the socio-cultural dimensions of health communication. The socio-cultural context of the patient can be achieved if the medical treatment team communicates effectively with the patient's family (Charles & Samarasinghe 2019). Hence the relationship of this study to the discipline of communication cannot be overemphasised. In the sections that follow, the research problem, research objectives, and research questions will be discussed.

1.6 FORMULATION OF THE RESEARCH PROBLEM, THE RESEARCH OBJECTIVES AND THE RESEARCH QUESTIONS

1.6.1 The research problem

Based on the preceding theoretical background, the following research problem statement was formulated:

The study aimed to explore and describe a decolonial approach for mental healthcare between the medical treatment team, for facilitating effective communication between team members, to adequately provide effective patient care, via a cross-sectional multiple case study approach.

The following research objectives and research questions stem from the above research problem statement.

1.6.2 Research objectives

The objectives of this study were both exploratory and descriptive and are presented below:

- 1 To explore the communication between the HCP medical treatment team members and its facilitation on effective patient care
- 2 To explore and describe possible medical treatment team communication challenges that affect collaborative teamwork
- 3 To explore if both government and hospital policies encourage or discourage the decolonisation of mental health care at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital
- 4 To explore if socio-cultural aspects are incorporated in mental healthcare by the medical treatment team at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital

1.6.3 Research questions

The research questions on which this study was based were formulated as follows:

- 1 How does communication between the HCP medical treatment team facilitate effective patient care?

- 2 What communication challenges affect medical treatment teamwork at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital?
- 3 How do both government and hospital policies at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital encourage or discourage the shift towards the decolonisation of mental healthcare?
- 4 Does the inclusion of socio-cultural aspects support mental healthcare at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital?

As noted above, this study aimed to explore elements, that is, the tenets of the proposed conceptual framework, that were derived from the literature in practice. Therefore, an overview of the research methodology that was used to verify the conceptual framework at the case sites, is discussed in the next section.

1.7 METHODOLOGY

Using a qualitative multiple case study approach, this research explored the decolonisation of mental health and the role of the medical treatment team approach to mental healthcare in South Africa. A qualitative multiple case study was used for this study since the benefits and analytic conclusions arising from multiple case studies are substantial (Brink 2018; Creswell 2012; Hancock & Algozzine 2011). Therefore, analysing the data from the two case study sites (Site A and Site B) was aimed to generate substantial information that would enable an understanding of a medical treatment team approach to mental healthcare.

The population for this study was made up of HCPs who formed part of the medical treatment team at each of the case study sites, namely nurses, medical officers, clinical psychologists, clinical managers, occupational therapists, social workers, pharmacists, and psychiatrists. The documents included both government and hospital mental healthcare policies that were developed post-apartheid. The government policy documents included two mental health policies, namely Mental Health Care Act (MHCA) 17 of 2002 and the National Mental Health Policy Framework for South Africa and Strategic Plan 2013–2020 (NMHPF). The hospital documents included 12 hospital policies that were relevant to this study that are explained in detail in chapter 7. The researcher used the same hospital policies for both hospitals, that is, hospital policies that were relevant to this study.

The HCPs and documents were purposively selected since purposive sampling enabled the researcher to select HCPs who had experience and a vast amount of knowledge, in relation to medical treatment teamwork for patient care (Bryman & Bell 2014; Cleary et al. 2014; Creswell 2014). With regard to the policy documents, purposive sampling allowed the researcher to select post-apartheid government policies that were related to mental healthcare.

Yin (2018) recommends that three or more sources of evidence should be used in case study research. Therefore, data were collected at two hospitals (Fort England Psychiatric Hospital and Cecilia Makiwane Hospital) via four data collection methods, namely documentation, observation, face-to-face, semi-structured interviews and focus group discussions (FGDs). The data were analysed using thematic analysis, as per the steps from Braun and Clarke (2006) and the results from the four data collection sources were presented thematically.

1.8 OPERATIONALISATION OF CONCEPTS

The following concepts are operationalised as they were applied for the purposes of this study.

1.8.1 Mental health

Mental health is a general term describing a range of disorders that affect thinking, behaviour, and mood (Monteiro 2015). In this study, mental health refers collectively to all diagnosable mental problems that become “clinical”, that is, where healthcare professional intervention and treatment is required. A detailed discussion on the types of mental illnesses is provided in chapter 2.

1.8.2 Medical treatment team

A team refers to a group of people actively cooperating to achieve a common goal (Wang et al. 2018). In the context of this study, a team refers to the medical treatment team of all the HCPs who worked collaboratively at each case study site. The medical treatment team at the sites, consisted of nurses, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists. Teamwork is widely advocated as an approach for improving treatment for mentally ill patients (Department of Health 2017; WHO 2018) because HCPs from different disciplinary backgrounds can synthesise their different knowledge and skills to deliver effective

treatment to patients (WHO 2018). Hence, this study advocates for a medical treatment team approach to mental healthcare. For the context of this research, at the case study sites the medical treatment team is referred to as a multidisciplinary team (MDT).

1.8.3 Decolonisation of mental healthcare

Decolonisation is the unlearning, deconstructing, and dismantling of the systems of colonialism (Nemutandani 2016). In this study, decolonisation is three-fold: catering for cultural diversity within the medical treatment team; collaboration between the medical treatment team and trained traditional healers; and the medical treatment team catering for the socio-cultural aspects of the patient during patient treatment and care in the South African context. For the purposes of this study, decoloniality emerges within the context of South African communities, since decolonisation considers South African cultures that were negated by the unfair elevation or dominance of Western culture (Connell 2014; Morrow & Malcoe 2017). Thus, the inclusion or necessity for a decolonial framework in South Africa, is an element in the proposed conceptual framework, that addresses diverse cultural aspects that support mental healthcare.

1.8.4 Health communication

Health communication is the art and technique of informing, influencing, and motivating individuals as well as institutional and public audiences about health issues (Mahmud et al. 2013). For the purposes of this study, health communication is defined as effective interaction or communication between members of the medical treatment team who treat mentally ill patients for various mental illnesses. In the context of this study, health communication also extends to communication between the medical treatment team and the patient's family members and the medical treatment team and trained traditional health practitioners. The effectiveness of medical treatment teams depends on effective communication between team members (Gautier 2015; Neuhaus, Lutnæs & Bergström 2020; Rosen, DiazGranados, Dietz, Benishek, Thompson, Pronovost & Weaver 2018). Therefore, effective communication should be considered an attribute and guiding principle of medical treatment teamwork (Amiri et al. 2018; Buljac-Samardzic, Doekhie & van Wijngaarden 2020; Rosen et al. 2018; Wang et al. 2018). This is because teamwork becomes ineffective when members of the medical treatment team are unable to provide information to each other actively, accurately, and quickly (Buljac-Samardzic et al. 2020).

Research suggests that effective communication between members of the medical treatment team leads to improved patient care and reduced medical errors (Bush 2016; Neese 2015; Sibiya 2018; Vertino 2014). Effective communication between members of the medical treatment team is, therefore, fundamental to effective teamwork (Gautier 2015; Rosen et al. 2018). Therefore, this research focused on exploring the communication aspects of mental healthcare from a medical treatment team approach, that is, communication between the HCP teams who treated mental health patients at the selected sites.

The medical treatment team also need to effectively communicate with the patient's family (especially in a situation where the patient is cognitively impaired) in order to provide effective patient care (Charles & Samarasinghe 2019). Furthermore, the medical treatment team also needs to communicate effectively with trained traditional practitioners, since the majority of South Africans consult with both the medical treatment team and traditional practitioners for patient care. Thus, in the context of this study, effective health communication needs to occur between the medical treatment team, and the patient's family and trained traditional healthcare practitioners.

1.8.5 Socio-cultural context

In the context of this study, socio-cultural context includes social factors such as family and culture that impact patient care (Tjale & de Villiers 2018). For the purposes of this study, socio-cultural consideration is two-fold: for the HCPs and for the patients. Cultural differences have the potential to hamper medical treatment teamwork thus all members of the medical treatment team should be tolerant of each other's cultural differences, for the team to work collaboratively and provide effective patient care. For the purposes of this study, to cater for social factors in mental healthcare, the medical treatment team were required to provide culturally congruent mental healthcare by involving the patient's family in their care.

1.8.6 Ubuntu

Ubuntu is an African concept which stands for "I am because we are" (Ngondo & Klyueva 2022). In essence, there is no "I" without "we" (Chigangaidze 2021). Hence, ubuntu encompasses a spirit of oneness, solidarity, and harmony. For the purposes of this study, members of the medical treatment team were expected to be in solidarity and work collaboratively, as a team in order to achieve individualised patient care (Molala &

Downing 2020). Therefore, the decolonial approach to mental healthcare fitted well with the African philosophy of ubuntu, which focuses on a collective approach to mental healthcare. A discussion of ubuntu as it relates to medical treatment teamwork is elaborated on in chapter 5.

1.8.7 Culture

Culture is defined as a system of interrelated values that are active enough to influence and condition perception judgement, communication, and behaviour in a given society (Mazrui 1986). People are influenced by their cultural beliefs; hence, the majority of South Africans use both traditional and Western medicine for mental health treatment (Batisai 2016; Tjale & de Villiers 2014). This study argues that cultural factors should be considered for effective patient care in the South African context in order to cater for both the cultures of the members of the medical treatment team and the patient's cultural context. Hence, a conceptual framework that caters for the culture of both the medical treatment team members and the patient is required since the majority of South Africans are influenced by their cultural beliefs.

1.8.8 Multicultural context

South Africa is a multiculturally diverse society; hence, patients have different cultural backgrounds (Adams & Rother 2017). This study argues that the medical treatment team should treat each patient as unique individuals, with different cultural backgrounds. Since this will enable the medical treatment team to cater for the patient's cultural needs (Gopalkrishnan 2018). Members of the medical treatment team also need to be tolerant of the cultures of other team members in order to work collaboratively for effective patient care.

1.8.9 Elements

Elements in the context of this study refers to the aspects of the proposed conceptual framework. These include: mental health policies; medical treatment teamwork; the socio-cultural context which is two-fold (catering for medical treatment team diversity, and patient cultural diversity); and decolonial factors which are three-fold (catering for cultural diversity in the medical treatment team, collaboration between the medical treatment team and trained traditional healers, and the medical treatment team catering for the cultural aspects of the patient during mental healthcare).

1.9 CHAPTER DEMARCATION

Chapter 1: Orientation and rationale for the study

The current chapter, the introduction, presents the background and explains the key concepts of the study. The research problem and the research objectives are discussed. The core of this chapter is the problem necessitating this research, namely the high prevalence of mental illnesses in South Africa. The goal of the study is, therefore, to propose a conceptual framework for a medical treatment team approach to mental healthcare.

Chapter 2: An overview of the South African healthcare system: Mental health perspectives

The literature review chapters are chapters 2, 3, 4, and 5. Chapter 2 provides an explanation of the South African healthcare system in order to contextualise the study. Chapter 2 also provides an overview of mental illnesses and the prevalence of mental illness worldwide, in sub-Saharan Africa, and in South Africa to emphasise the need for a conceptual framework that caters for factors that influence mental healthcare in the South African context. Factors which contribute to a high prevalence of mental illness in South Africa are also discussed in this chapter.

Chapter 3: An overview of mental healthcare in South Africa

Chapter 3 provides a discussion of South African mental healthcare policies from the colonial to decolonial periods and the decolonisation of mental healthcare. To contextualise the study, the chapter provides an overview of the healthcare system during the apartheid era and moving on to the democratic era. The chapter also provides an overview of mental healthcare policies pre- and post-apartheid to explore if the government and hospital policies support the decolonisation of mental healthcare in South Africa. Furthermore, the need for decolonisation of mental healthcare is discussed in detail in this chapter.

Chapter 4: Health communication models and theories from a teamwork perspective

In this chapter, health communication models and theories from a medical treatment team perspective are discussed to contextualise the role of the medical treatment team in mental healthcare. These models are also reviewed and critiqued in this chapter and illustrate their limitations in order to explain the need for a conceptual framework that

considers aspects such as socio-cultural factors that influence mental healthcare in the South African context.

Chapter 5: Contextualising health communication in relation to cultural and decolonial models

Chapter 5 explores cultural and decolonial theories in order to contextualise this study. The exploration of these theories is carried out against the background of earlier discussions regarding the need to decolonise mental healthcare in South Africa. Criticisms of the cultural and decolonial theories in relation to mental healthcare in South Africa are also provided in order to contextualise the need for a comprehensive conceptual framework for mental healthcare in South Africa.

Chapter 6: The proposed conceptual framework

Chapter 6 presents the proposed health communication conceptual framework for mental healthcare in South Africa that was synthesised from literature and theory in chapters 2, 3, 4, and 5. The framework is designed in such a manner as to indicate and highlight the socio-cultural, teamwork, decolonial and policy factors that influence mental healthcare. This comprehensive conceptual framework is meant to serve as an appropriate conceptual framework for mental healthcare in South Africa.

Chapter 7: Methodology.

The chapter presents the research methodology. A qualitative, multiple case study research design is discussed. The population, sampling, data collection, data analysis, reliability and validity, and ethical considerations for this study are also discussed.

Chapter 8: Findings and analysis

Chapter 8 reports and interprets the findings obtained from document analysis, hospital observations, face-to-face, semi-structured interviews and FGDs to determine whether the proposed elements of the conceptual framework were accepted, amended, and/or rejected. The findings were reported according to the elements of the proposed conceptual framework. These elements include (1) teamwork, (2) decolonial factors, (3) socio-cultural factors, and (4) the role of the government in terms of policy. Hence, the findings of this study are comprehensively covered in one chapter to facilitate understanding of all the themes which emerged from all the elements of the proposed conceptual framework.

Chapter 9: Conclusions and recommendations

This is the last chapter. It concludes the study by answering the research questions and presenting the revised conceptual framework. Limitations and recommendations are proposed based on the findings of the study.

1.10 SUMMARY

This chapter has introduced mental health as a global health problem. This chapter discussed the purpose and context of this research. The background of the research problem, the research questions, and the research objectives were also discussed. Literature in relation to health communication and mental health was also explained. The chapter has also provided a summary of the methodology. Lastly, the demarcation of the study was explained. The next chapter provides the context for the research by explaining the prevalence of mental illness worldwide, in sub-Saharan Africa, and in South Africa. The next chapter provides a discussion on the South African healthcare system.

CHAPTER 2: AN OVERVIEW OF THE SOUTH AFRICAN HEALTHCARE SYSTEM: MENTAL HEALTH PERSPECTIVES

2.1 INTRODUCTION

This chapter provides an epidemiological overview of mental illness by discussing the different types of mental illnesses that exist globally. A discussion on the diagnosis and treatment of mental illnesses are also provided. The chapter also provides an explanation of the prevalence of mental illness from a global to Africa, sub-Saharan Africa, South Africa, and specifically the Eastern Cape province of South Africa where the research was conducted. Over 17 million South Africans are dealing with mental health issues (Jacobs & Coetzee 2018; Willie 2017).

The chapter also provides information on the South African two-tier healthcare system, which is made up of both public and private sectors. This study argues that medical treatment teamwork is imperative for effective mental healthcare. Hence the inclusion of a discussion on the South African healthcare system enabled the contextualisation of a medical treatment team approach to mental healthcare, within the healthcare system.

Furthermore, background information is provided on the South African healthcare system by explaining the impact of apartheid on the current healthcare system. This chapter concludes by providing a brief discussion on the National Health Insurance (NHI), a health financing system that is designed to provide accessible and affordable healthcare to all South Africans (Conmy 2018).

2.2 MENTAL ILLNESS: AN OVERVIEW

According to Augustus, Bold, and Williams (2019), mental illness is a state where a person's mental health is disrupted to such an extent that they cannot cope with daily activities. Viviers (2016) adds that mental illness affects a person's behaviour and emotions and is severe enough to require professional intervention. It is clear from the definitions above, that in order to establish the existence of a mental health condition the diagnosis must be made by a qualified healthcare practitioner. Therefore, members of the medical treatment team play a critical role in the diagnosis and treatment of mentally ill patients (Legg 2018; Burns & Roos 2016; WHO 2018). In the context of this study, mental illness refers to all diagnosable mental health problems requiring professional intervention and treatment. Thus, the term mental illness will be used throughout this

study when referring to collective mental health problems such as depression, anxiety, schizophrenia, bipolar disorder, and dementia.

One in four people suffer from some form of mental illness (MacGill 2017, Jenkins 2011, Viviers 2016; WHO 2018; Worden 2018). Common mental illnesses such as depression, anxiety, schizophrenia, bipolar disorder, dementia, and SUD are prevalent in communities around the world (Augustus et al. 2019). Over 17 million South Africans suffer from mental illnesses (Jacobs & Coetzee 2018; Willie 2017). Therefore, South Africa's response to the burden of mental illnesses must include various strategies that can facilitate effective mental health care. A medical treatment team approach can help in effective mental healthcare since HCPs from different disciplinary background can synthesise different skills to deliver effective mental healthcare (Gautier 2015; Wang et al. 2018; WHO 2018). As discussed in chapters 1 and 3, the decolonisation of mental healthcare in South African is also important since decolonisation will allow the medical treatment team to cater for socio-cultural aspects that influence mental healthcare in the South African environment (Lake & Turner 2017). The next section will provide a discussion on different types of mental illnesses.

2.3 DIFFERENT TYPES OF MENTAL ILLNESS

2.3.1 Depression

Depression presents a feeling of extreme sadness, low self-worth, loss of interest in activities, irritability, somatic complaints, preoccupation with death and fatigue, or lack of energy which persists beyond a few weeks (Augustus et al. 2019; WHO 2017; Worden 2018). It is a serious mental illness that prevents afflicted persons from leading a normal life (Ferrari & Villa 2017; MacGill 2017; Malhi & Mann 2018). People with depression may sometimes feel that life is not worth living. Depression can sometimes cause insomnia (inability to sleep). Tightness of chest, shortness of breath, and fatigue are some of the physical symptoms of depression (Ferrari & Villa 2017). Over 4.4 per cent of the world's population suffer from depression (Viviers 2016; WHO 2018). One in six South Africans suffer from depression (South African Federation for Mental Health 2018). It is, therefore, imperative to implement strategies that can curb the prevalence of depression and other mental illnesses in South Africa. The South African Depression and Anxiety Group (2018) indicate that the perception and interpretation of depression are dependent on cultural context. Over 80 per cent of South Africans seek help from traditional healers because they provide culturally appropriate treatment (Morrow & Malcoe 2017;

Nemutandani 2016; Sigida 2016; Zingela et al. 2019). The fact that many South Africans consult with traditional healers reinforces the idea of the decolonisation of mental healthcare in South Africa. Depression can be associated with anxiety (Charles & Samarasinghe 2019; Ferrari & Villa 2017).

2.3.2 Anxiety

According to Augustus et al. (2019), anxiety is a word often used to report a feeling of unease, worry, and fear. People feel anxious now and then. For example, one may feel anxious when going for a test. However, when anxiety becomes persistent, intense, and frequent, it becomes a source of distraction and suffering (Bandelow 2017; Rauch 2017; WHO 2017)). This kind of anxiety can interfere with daily activities (Worden 2018). Symptoms of anxiety disorder include constant fear and worry, muscle tension, difficulty in concentrating, being easily fatigued, irritability, and sleep problems (such as being unable to fall asleep) (Locke, Faaf & Shultz 2015; Rauch 2017).

2.3.2.1 Panic disorder

Panic disorder refers to the feeling of terror that strikes constantly without warning (Uys & Middleton 2014). This feeling is so intense and typically peaks within about 30 minutes. Some of the physical symptoms experienced during panic attacks are chest pain and palpitations (Bandelow 2017).

2.3.2.2 Social anxiety disorder (SAD)

This type of anxiety is also called social phobia (Ramsden 2013). According to Worden (2018), people with SAD constantly worry and fear in almost every social situation. Rauch (2017) adds that people with SAD are very self-conscious and are terrified of others judging them. The anxiety can be so intense that a person with SAD might avoid any interpersonal contact (Burns & Roos 2016; Charles & Samarasinghe 2019).

2.3.2.3 Specific phobias

These occur when someone experiences intense fear for a specific object or situation. Examples include swimming or flying (Ramsden 2013). If this condition is left undiagnosed and untreated, the condition can continue for decades, resulting in functional impairment (Ramsden 2013; WHO 2017).

2.3.2.4 Generalised anxiety disorder (GAD)

GAD is one of the most common anxiety disorders (Fuller-Thomson & Hollister 2016; Ramsden 2013; Rauch 2017). According to Burns and Roos (2016), GAD involves a constant feeling of worry regarding ordinary day-to-day situations. A person with GAD worries with little or no reason. They always anticipate some sort of disappointment or disaster (Uys & Middleton 2014).

2.3.3 Schizophrenia

According to Fuller-Thomson and Hollister (2016), schizophrenia is a brain disorder that leads to irrationality. This mental illness can lead to insanity and suicide (Burns & Roos 2016; Fuller-Thomson & Hollister 2016; Ramsden 2013). The signs and symptoms include delusions, lack of motivation, hallucinations, social withdrawal, extreme disorder thinking, disorganised speech, inappropriate emotions, and bizarre perceptions (Burns & Roos 2016; Ramsden 2013; Uys & Middleton 2014; WHO 2018). Currently, no other mental illness has symptoms that are as apparent as the symptoms of schizophrenia (Augustus et al. 2019; Ramsden 2013). Over 23 million people worldwide suffer from schizophrenia (WHO 2018).

2.3.4 Bipolar disorder

Bipolar disorder is a mental illness that is characterised by elevated or irritable mood (mania) (Ramsden 2013). At least one episode of mania must occur in order for a diagnosis of bipolar disorder to be given (Burns & Roos 2016; Ramsden 2013). According to the WHO (2018), over 46 million people live with this illness. Symptoms of bipolar disorder include intensity and oscillation (ups and downs), impulsivity, recurrent suicidal behaviour, poor judgement, extreme feeling of emptiness, decreased need for sleep, talkativeness, and increased activity (Burns & Roos 2016; Ramsden 2013; WHO 2018).

2.3.5 Dementia

Dementia is a mental illness that leads to gradual loss of mental abilities or cognitive skills such as reasoning and remembering (Charles & Samarasinghe 2019; Uys & Middleton 2014). Memory loss is a common symptom of dementia (WHO 2018). Other symptoms include hallucinations, difficulty in controlling emotions, personality change, becoming lost in familiar places, and losing track of time (Swarfer 2014). The diagnosis

of dementia is made when there is great memory loss (Ramsden 2013). In the advanced stage of dementia, the person may even forget their occupation, children, and sometimes even their name (Swarfer 2014; Villemagne, Doré & Burnham 2019; WHO 2018). According to the WHO (2018), dementia results from a variety of diseases and injuries such as Alzheimer's disease or stroke. About 50 million people worldwide live with this mental illness and this is projected to double every 20 years (WHO 2018).

2.3.6 Substance use disorder (SUD)

According to Legg (2018), SUD (drug abuse) occurs when a person recurrently uses drugs and alcohol to the extent that it causes significant impairment. This mental illness affects a person's brain and consequently leads to an inability to lead a normal life (Legg 2018). Symptoms of SUD include a feeling of wanting to use drugs or alcohol on a regular basis; doing abnormal or illegal activities to obtain drugs or alcohol; failing in the attempt to stop using drugs or consuming alcohol; paranoid thinking; and an exaggerated craving for food at usual times (Legg 2018; Richert, Anderberg & Dahlberg 2020; WHO 2018). Globally, over 164 million people suffer from drug and alcohol disorders (Ritchie & Roser 2018; WHO 2018).

It is evident from the above discussion that mental illness can disrupt a person's life or even cause suicide. Therefore, effective strategies must be implemented to reduce mental illnesses. This study advocates that medical treatment teams should consider the socio-cultural context of the patient, as a strategy to curb mental illness in South Africa. The section below provides an explanation of the diagnosis and treatment of mental illnesses.

2.4 DIAGNOSIS AND TREATMENT OF MENTAL ILLNESS

2.4.1 Diagnosis of mental illnesses

An individual needs to meet the minimum diagnostic criteria in order to be given a diagnosis for any mental illness (Legg 2018). Largely, the individual needs to have been experiencing symptoms for at least six months and it should be recognised that these symptoms significantly impact on the individual's functioning (Burns & Roos 2016; Legg 2018). To determine a diagnosis and check for symptoms for mental illness, a person may undergo a physical examination where the doctor tries to determine physical problems that might have caused the symptoms or uses a laboratory test. These might

include a screening for alcohol and drugs, or a psychological evaluation where the HCP communicates with the person about their symptoms, feelings, and behavioural patterns (Burns & Roos 2016; Legg 2018). After the diagnosis, it is likely that the HCP will identify the mental illness, the individual is suffering from (James, Brooks, Susanti, Waddingham, Irmansyah, Keliat, Utomo, Rose, Colucci & Lovell 2020). It is essential for the HCP to ascertain the type of mental illness so as to develop and implement an evidence-based treatment plan for the patient (Burns & Roos 2016; Legg 2018). At this stage, working as a multidisciplinary team can be particularly helpful as one HCP can assess the patient and align the patient to another HCP as required (Wang et al. 2018; Weller, Boyd & Cumin 2014). Gautier (2015) adds that medical treatment teamwork can facilitate patient-centred care, allowing the collaborative development of an individualised treatment plan. Therefore, there is a need for a conceptual framework which caters for important aspects, such as cultural diversity in the medical treatment team, as well as collaboration between the medical treatment team and trained traditional healers, and the cultural inclusion of the patient during mental healthcare.

2.4.2 Treatment for different types of mental illness

As noted above, different types of mental illness exist, and treatment will depend on the type of mental illness that a person is suffering from (Sandoiu 2019). However, a medical treatment teamwork approach to mental healthcare is always recommended to ensure all the patient's physical, medical, social, and psychological needs are met (Barlow & Durand 2012; Lake & Turner 2017). This is especially important in the case of severe mental illnesses such as dementia, bipolar disorder, and schizophrenia. The medical treatment team, which includes medical officers, nurses, psychiatrists, pharmacists, social workers, clinical managers, clinical psychologists, occupational therapists, and psychiatrists, can substantially work together and assist with patient mental healthcare (Gautier 2015; Lyubovnikova & West 2017; Salas, Zajac & Marlow 2018; Wang et al. 2018).

According to Sandoiu (2019), psychiatric medication does not cure mental illnesses, however, they can help to significantly reduce symptoms. The most common types of psychiatric medications include antidepressants, mood-stabilising medication, antipsychotic medications, brain-stimulation treatments, and hospital and residential treatment programmes (Lake & Turner 2017; Legg 2018; Sandoiu 2019). Antidepressants are used to treat depression and anxiety disorders (Burns & Roos

2016). This medication helps to reduce symptoms such as insomnia, fatigue, and sadness. Ideally, medication for anxiety disorders should be used in the short term otherwise it can cause dependency (Ellis & Alexander 2016; Sandoiu 2019). Benzodiazepines are commonly used to treat anxiety disorders (Augustus et al. 2019; Burns & Roos 2016; Sandoiu 2019).

According to Worden (2018), a form of mental health treatment includes lifestyle treatments and remedies. Lifestyle changes include sticking to a good treatment plan, avoiding alcohol and drug use, getting sufficient sleep, and eating healthily. This regime can enhance mental well-being and consequently reduce the relapse risk for many mentally ill patients (Lake & Turner 2017; Legg 2018; Rauch 2017). MacGill (2017) explains that hospital and residential treatment programmes are used for severe mental conditions that need close psychiatric care. Options include intensive outpatient care, inpatient care, partial or day hospitalisation, or residential treatment which provides temporary accommodation to the patient (Fuller-Thomson & Hollister 2016; Rauch 2017).

However, researchers suggest that mental health treatment should be holistic and should, therefore, involve physiological, sociological, psychological, and cultural dimensions (Kuo 2018; Tjale 2018; Zingela et al. 2019). This is because 80 per cent of South Africans are influenced by their cultures, and consulting traditional healers, in conjunction with their HCPs for mental health treatment (Mabunda et al. 2022; Zingela et al. 2019). Therefore, the medical treatment team should work collaboratively with traditional practitioners to enhance mental health treatment. Thus, there is a need for a conceptual framework that caters for collaboration between the medical treatment team and traditional practitioners in the South African context. The next section provides a discussion on the prevalence of mental illness worldwide.

2.5 PREVALENCE OF MENTAL ILLNESS WORLDWIDE

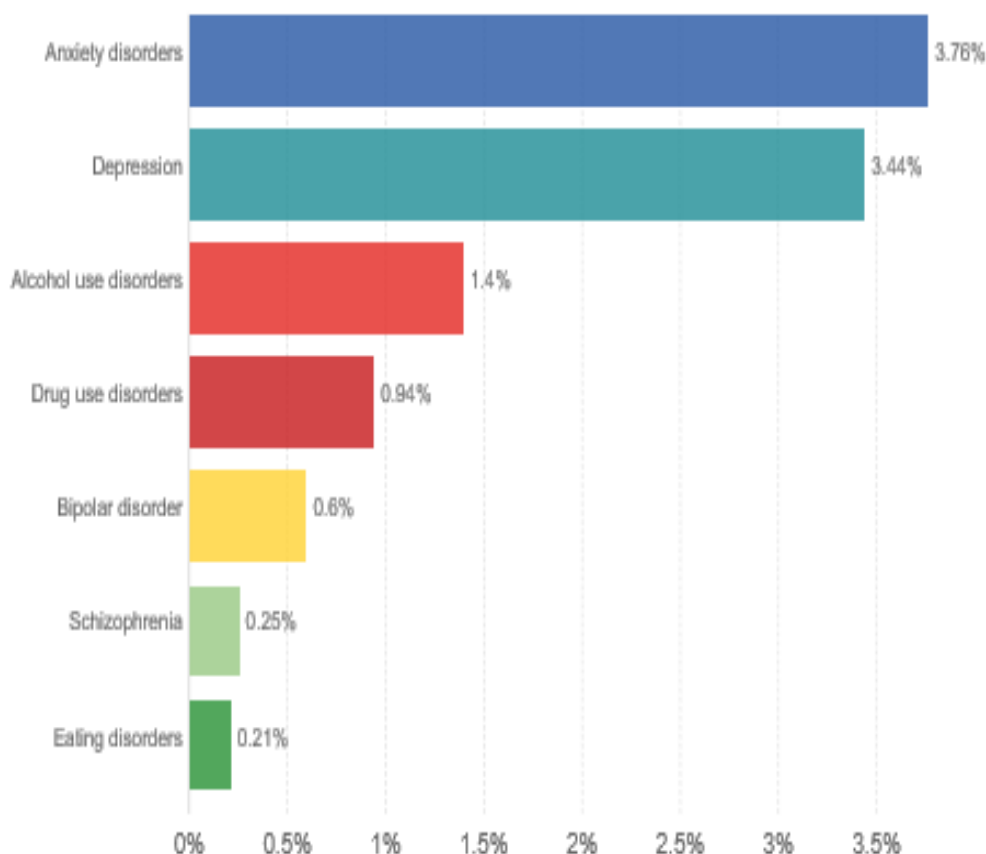
Mental health has increasingly become recognised as a key priority in international public health arenas (Jenkins 2011; Mulutsi 2017; Viviers 2016). Worldwide, about 970 million people suffer from mental illness, placing mental illness as a leading cause of disability worldwide (Jacobs & Coetzee 2018; WHO 2018). At least one in four people suffers from some type of mental illness (Chisholm, Sheehan, Rasmussen, Smit, Cuijpers & Saxena 2016; Viviers; WHO 2018). Therefore, the need exists for research to acknowledge mental health issues. Mental illness affects children, adolescents, and adults thus there

is a need to focus on effective strategies to reduce mental illnesses in South Africa (Jacobs & Coetzee 2018; Patel, Chisholm, Parikh, Charlson, Degenhardt, Dua & DCP MNS Author Group 2016; Vigo, Thornicroft & Atun 2016).

With the global coronavirus emergency in 2020, the prevalence of mental illnesses increased substantially (Nguse & Wassenaar 2021; WHO 2020). Therefore, the World Federation for Mental Health (2020) appealed to all countries to ensure that effective strategies were used to manage the mental illnesses. According to the WHO (2018), mental healthcare cannot be considered solely from a Western perspective since South Africans are influenced by their socio-cultural context (Nemutandani 2016) Thus, there is a need for a conceptual framework which considers the socio-cultural factors that influence mental healthcare. Figure 2.1 depicts the prevalence of mental disorders and SUD worldwide.

Prevalence by mental and substance use disorder, World, 2017

Share of the total population with a given mental health or substance use disorder. Figures attempt to provide a true estimate (going beyond reported diagnosis) of disorder prevalence based on medical, epidemiological data, surveys and meta-regression modelling.



Source: IHME, Global Burden of Disease

CC BY

Figure 2.1: Prevalence, ordered by mental disorders and SUD, worldwide in 2017

(Source: WHO 2017)

Figure 2.1 depicts the prevalence of many mental disorders and SUD worldwide in 2017. Therefore, various strategies such as medical treatment teamwork should be used to support mental healthcare. Figure 2.1 shows that the global prevalence of anxiety disorder was 3.76 per cent while the global prevalence of depression was 3.44 per cent. Alcohol use disorder is next with 1.4 per cent. Drug use disorder follows with 0.94 per cent and bipolar disorder is 0.6 per cent. Schizophrenia is 0.25 per cent and eating disorder is 0.21 per cent. It must be noted that although schizophrenia has a very low prevalence globally, it has been found to be associated with considerable disability worldwide (Burns & Roos 2016; Fuller-Thomson & Hollister 2016; Mulutsi 2017;

Ramsden 2013; Uys & Middleton 2014; WHO 2018). As depicted in Figure 2.1, there are many mental illnesses that affect people globally. Therefore, the burden of mental illness necessitates using various strategies to facilitate effective care for mentally ill patients. This study suggests that the medical treatment team should collaborate with trained traditional healers and also cater for socio-cultural diversity in the team and during patient care, to enhance mental healthcare in South Africa.

2.6 PREVALENCE OF MENTAL ILLNESS IN AFRICA, SUB-SAHARAN AFRICA, SOUTH AFRICA, AND THE EASTERN CAPE

Mental illnesses affect all segments of the African population (Sankoh, Sevalie & Weston 2018). According to the WHO (2018), one out of four people in Africa will experience a mental illness. This implies that the loss of productivity and risk for physical disease continue to increase due to mental illness. Effective measures must, therefore, be put in place to reduce mental illness. One such measure is a decolonial medical treatment teamwork approach to mental healthcare. This is because preferred treatment options for mental illnesses vary considerably from one cultural context to another (Kuo et al. 2018; Nemitandani et al. 2016; Tjale & de Villiers 2018). In Africa, the majority of the population consult with traditional healers therefore, the decolonisation of mental healthcare becomes imperative (Batisai 2016; Morrow & Malcoe 2017; Tjale & de Villiers 2018).

In sub-Saharan Africa, about 12 per cent of the population suffer from mental illness (Ssewamala, Bahar, McKay, Hoagwood, Huang & Pringle 2018). Some countries in sub-Saharan Africa have prevalence rates ranging from 12 to 33 per cent (Apkan, Ojinnaka & Ekanem 2010; WHO 2018). South Africa is located in sub-Saharan Africa and also has a high prevalence of mental illness (WHO 2018). Over 17 million South Africans across all age groups, genders, and race suffer from mental illnesses (Jacobs & Coetzee 2018; WHO 2018; Willie 2017). Therefore, effective strategies that consider socio-cultural aspects in mental healthcare must be used in hospitals to provide effective mental healthcare.

The focus of this study was on a decolonial medical treatment team approach to mental healthcare in South Africa. Thus, it is important to discuss the factors that contribute to the prevalence of mental illnesses in South Africa since these factors are associated with the burden and high prevalence of mental illnesses in South Africa (Schneider, Docrat, Onah, Tomlinson, Baron, Honikman & Lund 2016). This discussion is provided to further

contextualise the study by providing a discussion on factors that contribute to a high prevalence of mental illness, in South Africa.

2.6.1 Factors contributing to the prevalence of mental illness in South Africa

According to Sankoh et al. (2018), the lack of sufficient HCPs, structural barriers, poverty, stigma, and socio-cultural factors are some of the factors that are associated with the prevalence of mental illness in South Africa. These factors are explained below.

2.6.1.1 Lack of sufficient healthcare professionals

Researchers have documented the lack of sufficient HCPs in providing healthcare for mentally ill patients (Booyesen, Mahe-Poyo & Grant 2021; Mulaudzi, Mashua, Akinsola & Murwira 2020; Benjamin, Vickerman-Delport & Roman 2021). According to the Department of Health (2017), HCPs who work in mental health facilities in South Africa make up 9.3 per cent per 100,000 of the population. Most of the HCPs work in the private sector which only serves 17 per cent of the South African population (WHO 2017). Jacobs and Coetzee (2018) indicate that about 75 per cent of the South African population do not receive mental health services because health facilities are under-resourced. Therefore, the lack of sufficient HCPs is a barrier to the fight against mental illnesses in South Africa (South African Human Rights Commission 2017). This is because the shortage of HCPs results in a treatment gap (Ebrahim 2019). It is important to note that there are more traditional practitioners in South Africa than HCPs (Nemutandani 2016; Tyilo 2019; Zingela et al. 2019). Thus, any intervention that is geared towards improving mental healthcare must consider all aspects of the existing healthcare system. This study argues that mental illnesses constitute a public health problem. Thus, interventions implemented to reduce mental illnesses should address the treatment gap.

To improve mental healthcare, mentally ill patients need to have access to mental healthcare and the patients need to choose which type of care they wish to access, that is, HCPs or traditional healers (Eaton et al. 2011; Patel, Minas, Cohen & Prince 2013). This study suggests that the treatment gap can be addressed by decolonising mental healthcare. This study therefore advocates for cooperation between the medical treatment team and traditional healers to improve mental healthcare in South Africa. Cooperation between HCPs and traditional healers will not only increase access to

mental healthcare, but will also ensure that patients receive mental healthcare that is culturally appropriate. Since the cultural beliefs of the patient will be addressed.

2.6.1.2 Structural barriers

The design of some of the hospitals in South Africa is not appropriate for mental health services (Viviers 2017). Some are condemned buildings, some are old prison facilities, and some are old leprosy hospitals, hence healthcare infrastructural challenges are a prevailing problem in South Africa (Viviers 2016; Van Rensburg 2012). Mental healthcare thus requires substantial attention and investment, as failing to address structural issues can impede mental healthcare (Summergrad 2016). Effective healthcare can only be achieved when all levels of the healthcare system work together. In this regard, the South African government can play a pivotal role by improving structural barriers to healthcare. All sectors (such as the professional regulatory bodies and the medical treatment team) must work together to improve health outcomes. This justifies the inclusion of both government policy and HCP teamwork in the conceptual framework developed in chapter 6.

It is noteworthy that the structural barriers are a legacy of apartheid (Schneider et al. 2016; Van Rensburg). Factors such as poor living conditions, social and cultural stigma, and the treatment gap are associated with mental illness in South Africa (Schneider et al. 2016). Therefore, the post-apartheid era continues to predispose many South Africans to mental illnesses since the majority of South Africans lack access to adequate healthcare, as a result of these structural barriers (Sibiya & Gwele 2013; Uys & Middleton 2014).

2.6.1.3 Poverty

Jacobs and Coetzee (2018) indicate that other segments of the African population, including South Africa, are vulnerable to mental illnesses due to poverty. Many South Africans are struggling to earn a livelihood in a highly competitive labour market (Acha-Anyi & Acha-Anyi 2021; Elliot 2016; Jacobs & Coetzee 2018; Mulutsi 2017). Many will experience psychological issues as they struggle to realise their ambitions by gaining employment and some will become depressed and have anxiety, as a result of this (Breedvelt 2016). The Rural Mental Health Campaign (2015) indicates that 40 to 45 per cent of South Africans live in rural areas and that few HCPs provide mental healthcare

in these areas. Many patients living in rural areas do not have the financial resources to seek healthcare facilities in urban areas.

Thus, traditional health practitioners are the first point of call for people living in rural areas (Nemutandani 2016; Van Rensburg 2012; Zingela et al. 2019). Therefore, there is a need to decolonise mental healthcare. The COVID-19 pandemic has exacerbated the need to decolonise mental healthcare, since many more South Africans are suffering from mental illnesses, as a result of the lockdown and jobs losses (Khambule 2020; Kim et al. 2020; Statistics South Africa 2020). This study suggests that the medical treatment team should collaborate with traditional healers to provide effective treatment for mentally ill patients. This is important as South Africa faces a 55 per cent poverty rate (Statistics South Africa, 2020). Therefore, the decolonisation of mental healthcare becomes imperative. Decolonising mental healthcare will help to improve the well-being of mentally ill patients living in poverty and thus positively contribute to mental illness in South Africa (Breedvelt 2016; Elliot 2016).

2.6.1.4 Stigma

According to the WHO (2018), mental illness is associated with stigma. The term stigma connotes a deep mark of shame for the patient (Tadesse 2016). Experiencing stigma due to a mental illness may lead to low self-esteem and reduce the patient's willingness to seek medical mental health care (Ross & Devereil 2010; Tadesse 2016). People with mental illness often face widespread stigma and violence (Morrow & Malcoe 2017). According to Tadesse (2016), most people do not take the initiative to seek mental health treatment due to fear of being stigmatised. A study conducted by Dharitri et al. (2015) indicated that people in rural, semi-urban and urban communities had a stigmatising attitude towards mentally ill patients. The study further revealed that disclosure of mental illness was a contentious issue due to a fear of being ridiculed, discrimination, and job losses. Hence, people did not disclose the presence of mental illness. The findings from this study are similar to those reported by Tadesse (2016), Murthy (2005), and Thara and Srinivasan (2000) on stigmatisation of tuberculosis in countries such as India. Jacobs and Coetzee (2018) state that the proportion of people who do not get treatment for mental illnesses is about 75 per cent in South Africa due to a fear of stigmatisation. Therefore, stigmatisation contributes to the prevalence of mental illness.

Considering the wide impact of stigma on mental illness, stigma related to mental illness must be addressed at all possible levels. This study suggests that the decolonisation of mental healthcare can help reduce stigma. Since the individualistic nature of the diagnosis that is a feature of the biomedical approaches often perpetuates stigma (Ramugondo et al. 2017; Truter 2007). Contrarily, diagnosis by traditional healers is not individualistic and is, instead, collective. This is because consultation as a form of diagnosis often involves communication with ancestors and is dependent on the patient agreeing with the messages being transmitted through the traditional healer as the medium (Ramugondo et al. 2017; Truter 2007). For example, “Si ya vuma!” is an Nguni refrain that means “We agree!” and is used in most if not all African healing traditions in South Africa (Andrade & Ross 2005). Thus, the collective nature of the refrain, suggests that the mentally ill patient is never seen as an individual who comes for consultation alone (Truter 2007). It is imperative to note that the traditional healer finds the cause of mental illness in spirits or ancestors (Washington 2010). This is because some South African communities believe that people become mentally ill when they break cultural rules such as, not adhering to the demands of the ancestors (Kopytoff 2010; McKay 2010). The ancestors therefore connect with people through traditional healers and the ancestors notify the traditional healers what can be done to bring harmony (Kopytoff 2010; McKay 2010).

Thus, the medical treatment team needs to collaborate with trained traditional healers in order to provide culturally congruent mental healthcare. However, it is worth noting that the different roles played by members of the medical treatment team can also assist mentally ill patients, to confront the perceptions and value judgements they have of themselves (Dharitri et al. 2015). This can also help in the fight against stigma. Therefore, a decolonial medical treatment teamwork approach to mental healthcare becomes necessary to support mental healthcare in South Africa.

2.6.1.5 Socio-cultural factors

Studies have also revealed that socio-cultural factors contribute to the prevalence of mental illnesses (Cheung 2015; Klopper, Stellenberg & Van der Merwe 2014; Nemutandani 2018; Tadesse 2016). As mentioned above, majority of Africans seek the services of traditional healers (Mahomoodally 2013; Jacob & Coetzee 2018). Mental illness encompasses more than the physiological disease process embraced by biomedicine but rather being ill is interpreted as being determined by social, cultural, and

psychological dimensions (Bene & Darkoh 2014; O'Brien & Broom 2014). Therefore, the co-existence of Western and traditional medicine provides different options of consultation for South Africans. To some South Africans, the traditional understanding and interpretation of mental illness is important (Monterio 2015; Nmutandani 2016). For example, a traditional healer may be consulted to impose meaning and significance on mental illness and a healthcare practitioner may be consulted for the treatment of symptoms. Therefore, people in South Africa consult with both the medical treatment team and traditional healers for their mental healthcare concerns (Nmutandani 2016; Tadesse 2016; Zingela et al. 2019). Hence, there is a need for a conceptual framework that considers collaboration between the medical treatment team and traditional healers, for mental healthcare in the South African context.

Raingruber (2013:28) has also suggested that “significant others” such as family members can influence a patient’s treatment by providing support and encouragement to the patient. Therefore, an understanding of socio-cultural factors is critical in finding solutions to mental healthcare in South Africa. If socio-cultural factors are considered to be contributing factors in mental healthcare, they have the potential to develop new and effective strategies in the fight against mental illness, in the South African context (Jacobs & Coetzee 2018).

The next section provides a discussion on the prevalence of mental illness in the Eastern Cape province of South Africa. This discussion will be provided since the case studies selected for this study were both in this province.

2.6.2 Prevalence of mental illness in the Eastern Cape

South Africans in the Eastern Cape also suffer from mental health problems (Acha-Anyi & Acha-Anyi 2021). Some of the factors that contribute to the prevalence of mental illness in the Eastern Cape are poverty, stigma and discrimination, inadequate infrastructure, and insufficient HCPs (Ellis 2018) (See section 2.6.1 for the discussion on these factors). As discussed above, poverty is closely associated with mental illnesses and the Eastern Cape is one of the poorest provinces in South Africa (Ellis 2018; Sukeri 2015).

Inadequate infrastructure is another factor that contributes to the prevalence of mental illnesses in the Eastern Cape. According to the South African Human Rights Commission (2017), a deficiency of 1,600 psychiatry beds exists in the Eastern Cape. There are also insufficient HCPs. The shortage of HCPs is so dire that there is only one forensic

psychiatric at Fort England Psychiatric Hospital. This hospital is home to some of the most dangerous patients of the state (Adrienne 2021).

2.7 OVERVIEW OF THE TWO-TIER SOUTH AFRICAN HEALTHCARE SYSTEM

Colonialism and the legacy of apartheid have greatly influenced South Africa's healthcare system (Mulutsi 2017). Since the focus of this current study is on the medical treatment teamwork approach to mental healthcare, it is imperative to provide a discussion on the South African healthcare system. Thus, the aim of this section is to briefly discuss the South African healthcare system post-1994. Currently, South Africa has a two-tiered healthcare system, namely the public and private sectors (Conmy 2018; Mack 2011; Mulutsi 2017; Van Rensburg 2012). The next section provides a discussion of the two-tier healthcare system in South Africa in order to contextualise this study.

2.7.1 Public healthcare system

Conmy (2018) indicates that the apartheid legacy shaped the country's healthcare system. During apartheid, there were 14 health departments in the country which provided services that were grossly discriminatory, on the basis of race (McCrea 2010). According to Petersen et al. (2009), the focus of mental health services was on institutional care and psychopharmacological (the scientific study of the effects of drugs on the mind) treatment of patients with psychiatric disorders.

Healthcare was deemed a privilege rather than a right (Van Rensburg 2012; Viviers 2016). According to Eagle (2014), historical factors such as racial discrimination, poverty, and social, economic, and political alienation are linked to mental illness in South Africa. Therefore, it is unsurprising that mental illnesses have become additional markers of the long-standing poor health of the black majority.

In 1994, the African National Congress (ANC) won the first democratic election in South Africa and thus ended the apartheid era (Van Rensburg 2012). Under the ANC government, every person has the right to achieve optimal healthcare and be treated with dignity and respect (Van Rensburg 2012). Ned, Cloete, and Mji (2017) indicate that the public healthcare system is funded by government and offers free health services to all South Africans. Free healthcare policies under the ANC government brought greater access to healthcare, for people who had been economically disadvantaged (Viviers

2016). In fact, free primary healthcare is one of the most effective strategies of the post-1994 health system transformation (Van Rensburg 2012).

However, despite the progress that has been made since the dawn of democracy in South Africa, the public healthcare system still faces a lot of challenges (Rensburg 2012; Viviers 2016). South has limited public mental healthcare facilities (Ned, Cloete & Mji 2017). Most hospitals do not have dedicated wards for mental health patient, hence limited mental healthcare services are provided in public healthcare system (Jacob & Coetzee). Some of the reasons for the ineffectiveness of South Africa's public healthcare system include: inadequate implementation of the policies such as the Public Health Care Act; healthcare workers not being sufficiently equipped; poverty; lack of contextual intersectoral action for social care determinants and indicators; inadequate HCPs; and insufficient clinics and hospitals (Jacobs & Coetzee 2018; Ned, Cloete & Mji 2017; Ramlall 2012; The Rural Mental Health Campaign 2015).

Section 27 of the South African Constitution guarantees all South Africans access to healthcare (Vergunst 2016). Although the constitution and other policies guarantee South Africans free access to public healthcare, considerable inequalities still remain due to the discrepancies in resource allocation (Ned, Cloete & Mji 2017; Sukeri et al. 2015). As noted in section 2.6.1.3 above, many South Africans are from lower socio-economic backgrounds and therefore lack basic needs (Ned et al. 2017; The Rural Mental Health Campaign 2015; Sukeri et al. 2014). South Africa faces serious public health challenges, including burden of illnesses and diseases such as mental illness, tuberculosis, HIV/AIDS, and COVID-19 (Harrison 2009; Malakoana, Heunis, Chikobvu, Kigozi & Kruger 2020; Mathee 2009; Wenham, Smith & Morgan 2010). According to Weeramanthri and Bailie (2015), the health status of South Africans can be improved by providing communities with the basic needs of sanitation, employment, drinking water, food, transport, infrastructure, and other social health determinants. Ned et al. (2017) concur, indicating that health systems' activities and their outcomes are effective and efficient when people's basic health needs are met.

Thus, health-related behaviours such as adhering to treatment need to be complemented with a healthy environment, stable economy, and peaceful living, in order to produce effective results (Ned et al. 2017; Sukeri et al. 2015). It is not solely up to the individual to maintain their health; it is also the right of people to have access to facilities which would serve as protective factors against adverse health outcomes. As noted above, the

research suggests that about 80 per cent of South Africans rely on public healthcare (Ned et al. 2017; Schneider et al. 2016). The South African population increased to 58.8 million in 2019 (Statistics South Africa 2019). Thus, demand for public healthcare should also increase. This is because the majority of South Africans rely on the public healthcare and traditional healers for mental healthcare (Jacobs & Coetzee 2018). The following section provides a discussion of private healthcare in South Africa.

2.7.2 Private healthcare system

The private healthcare system is made up of private medical aids schemes (Conmy 2018). These medical aids schemes were created during the apartheid era for white miners, who did not want to receive their healthcare with the black population (Lund & Flisher, 2006). Black people were only allowed into these medical aids schemes from 1970 (Van Rensburg 2012). Conmy (2018) indicates that the private sector offers world-class facilities for those who can afford to pay for healthcare visits, pharmaceuticals, and additional resources. The majority of South Africans cannot afford private healthcare (Coovadia, Jewkes, Barron, Sanders & McIntyre 2009).

Under the ANC government, public healthcare is available for free to all citizens. However, the low-quality care, long waiting periods, and inaccessibility of public healthcare is a huge problem for many South Africans (Ned et al. 2017; The Rural Mental Health Campaign 2015). In an attempt to improve healthcare services, the NHI scheme is scheduled to begin in 2026 (Britnell 2015). The COVID-19 pandemic has, without doubt, exposed the inequalities in the South African healthcare system. The NHI will address the inequalities presented by the current private and public systems by creating a single, unified healthcare system which will be available to all South Africans (Conmy 2018; Republic of South Africa Health Department 2018). This will be done by making healthcare more accessible and affordable to all South Africans (Young 2016). The South African government claims that the NHI will present and implement new plans that will change the face of the South African healthcare system (Britnell 2015; Conmy 2018). Mkize (2020) has also indicated that COVID-19 assisted in the implementation of the NHI, since a test trial was done during the pandemic. Parliament's Portfolio Committee is currently working on the next steps needed to introduce the NHI bill (Mkize 2020).

2.8 SUMMARY

In this chapter, different types of mental illnesses were discussed followed by a discussion on the aetiology of mental illness. A discussion was also formulated on the diagnosis and treatment for mental illness. The statistics available in the literature on the prevalence of mental illness worldwide, in Africa, sub-Saharan Africa, South Africa, and the Eastern Cape province of South Africa were also provided. Some of the causes of mental illness in South Africa were discussed. The chapter also provided a discussion of the two-tier healthcare system and the NHI. The next chapter will present the literature relating to mental healthcare during the colonial period and the decolonisation of mental healthcare in South Africa.

CHAPTER 3: OVERVIEW OF MENTAL HEALTHCARE POLICIES IN SOUTH AFRICA

3.1 INTRODUCTION

The previous chapter presented the epidemiology on mental illnesses and the South African healthcare system in order to provide context on the need for a medical treatment teamwork approach to mental healthcare in South Africa. In this chapter, the discussion is focused on the dominant aspects guiding the study, namely healthcare in South Africa during the colonial period, as well as mental healthcare policies, and the move towards the decolonisation of mental healthcare in South Africa. Since the majority of South Africans are influenced by their socio-cultural context. The chapter aims to explain how healthcare policies have moved from inequality (apartheid era) to equality (democratic era) in working towards the decolonisation of mental healthcare. These aspects will be discussed to further contextualise the study.

In chapter 2, it was established that socio-cultural factors should be considered in mental healthcare, thus, in its entirety, this chapter is aimed at reviewing the literature that relates to the socio-cultural aspects that contribute to mental healthcare. While the chapter is focused on explaining the need for the decolonisation of mental healthcare in South Africa, it is also dedicated to discussing healthcare in South Africa during the colonial period, and mental healthcare policies during post-apartheid South Africa. In doing so, the chapter positions the study within the context of existing literature.

3.2 OVERVIEW OF HEALTHCARE IN SOUTH AFRICA DURING THE COLONIAL PERIOD

Colonialism in South Africa began in 1652 when the first permanent European settlement was established at the Cape of Good Hope (Coovadia et al. 2009; Van Rensburg 2002). The Dutch East India Company had political control over the settled area of the Cape until the British occupation in 1806. It was an era of British rule that was characterised by intense contact and confrontation between Black and White, the Great Trek, and the discovery of diamonds and gold (Van Rensburg 2012). This era is generally characterised by widespread influence in all areas of South African society, including healthcare (Coovadia et al. 2009). The British influenced healthcare by providing legislation and professionalism that governed healthcare. The main healthcare policies, plans, and programmes in South Africa during the colonial period are summarised in the next paragraphs.

One of the healthcare policies in South Africa during the colonial period was Public Healthcare Act 4. This Act was promulgated in 1883 (Van Rensburg 2004). It made notification of communicable diseases and inoculation against smallpox compulsory. In 1891, the Medical and Pharmacy Act 34 was introduced (Van Rensburg 2012). This Act stipulated that professionals who did not belong to the Colonial Medical Council or Pharmacy Board were not allowed to practice without a licence from the colonial secretary. Coovadia et al. (2009) indicate that 1897 saw the emergence of the Public Amendment Act. This Act stipulated that local authorities could appoint medical officers of health. Also noteworthy is the Public Health Act 36 of 1919. This act stated that the responsibility for curative, preventive, and promotive healthcare in hospitals was to be given to the local authorities (Van Rensburg 2004). This Act prevailed for many decades as the basis for the organisation of public healthcare.

Howitz (2009) indicates that the National Urban Act was established in 1923 and it focused on dealing with urban slums. In 1923, the Group Areas Act was established. This Act stipulated that white doctors could not provide healthcare in black areas and black patients could not access healthcare in white areas (Coovadia et al. 2009). Van Rensburg (2012) indicates that the last official policy or programme during the apartheid era was the Gluckman Commission. This commission was promulgated between 1942 and 1944. The objective of the commission was to establish community centres as forerunners of community-based primary healthcare (Coovadia et al. 2009). However, this was not implemented because the National Party took to power in 1948 and established a system of apartheid, that was characterised by racial, political, and economic injustice to the black population. The following section provides a discussion on mental healthcare in South Africa during the colonial and apartheid periods. This discussion is provided to further contextualise the need for a medical treatment team approach to mental healthcare and the decolonisation of mental healthcare.

3.3 MENTAL HEALTHCARE IN SOUTH AFRICA DURING THE COLONIAL AND APARTHEID PERIODS

During the colonial period, mentally ill patients in South Africa were confined in institutions to avoid the patients from procreating and passing on undesirable characteristics (Horwitz 2009; Van Rensburg 2012). By 1910, there were eight mental institutions that could accommodate 1,932 black, coloured, and Indian patients and 1,692

white patients. White patients received better healthcare compared to black, coloured, and Indian patients (Coovadia et al. 2009; Horwitz 2009; Van Rensburg 2004).

The Nationalist Party assumed power in 1948 and proceeded to institutionalise racial segregation in a country already deeply immersed in colonial segregation. The apartheid period was characterised by repression and human rights abuse (Coovadia et al. 2009; Sibiya & Gwele 2013; Van Rensburg 2012). During the apartheid era, black people were denied professional healthcare services and black patients who were mentally ill were stigmatised and confined to permanent institutions (Horwitz 2009; Sibiya & Gwele 2013). The healthcare policies, plans, and programmes during apartheid are discussed in the following paragraphs.

The Public Health Amendment Act was introduced in 1952 (Horwitz 2009). This was a more centralised health policy. Van Rensburg (2004) indicates that the Mental Health Act 18 was established in 1973. This Act focused on controlling and treating mentally ill patients to ensure “protection” of the well-being and safety of South African society (Republic of South Africa 1973). Furthermore, van Rensburg (2004) notes that the Health Act was introduced in 1977. With this Act, the roles of national, provincial, and local authorities within healthcare were redefined. The Brown Commission was introduced between 1980 and 1986 (Horwitz 2009). The aim of this commission was to rationalise health services, promote effective services, and advocate the privatisation of health services, which the state was having challenges with, related to affordability.

In 1986, the National Health Plan was established (Van Rensburg 2012). The objective of this plan was to bring structural unity to the organisation of health services in South Africa. Also, noteworthy is the National Policy for Health Act 116 of 1990 (Coovadia et al. 2009). The Act encouraged the private sector to provide health services (Horwitz 2009).

The ANC came to power in South Africa in 1994. The main developments in healthcare in the post-1994 policies, plans, and programmes in South Africa included the National Health Plan for South Africa. This plan was established in 1994 (Van Rensburg 2012). It called for the creation of a single, comprehensive, equitable, and integrated national health service (Coovadia et al. 2009). The Free Healthcare Policy was also established in 1994 (Van Rensburg 2012). The objective of this policy was to remove all user fees for all health services for children under the age of six years and pregnant and

breastfeeding women (Howitz 2009). Furthermore, the White Paper on transforming public service delivery (Batho Pele White Paper) was promulgated in 1997 (Department of Health 1997). The White Paper set out eight transformation priorities to transform service delivery in the public domain, including the public sector.

Howitz (2009) notes that the Patient's Right Charter was established in 1999. The charter services ensured the realisation of the right of health access of patients, as guaranteed in the Constitution. The charter also specified the obligations of both patients and health workers in this regard (Republic of South Africa 2013). The Mental Healthcare Act (MHCA) was established in 2002 (Van Rensburg 2012). The Policy on Quality in Health Care for South Africa was promulgated in 2007 (Republic of South Africa 2013). This policy addressed issues such as access to healthcare, patients' participation in healthcare, and the underlying causes of disability, injury, and illness (Department of Health 2007; Howitz 2009).

Also important is the Green Paper on NHI in South Africa. The Green Paper was proposed in 2011 (Republic of South Africa 2013). It prepares the ground for the institution of the NHI with a view to effecting universal coverage, overhauling the financing system, and unifying the two-tier national health system (Coovadia et al. 2009). Furthermore, the Ekurhuleni Declaration on Mental Health was established in 2012 (Department of Health 2013). The declaration aimed to increase the efficiency of mental health interventions (Van Rensburg 2012). Also noteworthy is the National Mental Health Policy Framework and Strategic Plan 2013–2020 (NMHPF) (Department of Health 2013). This plan focuses on improving mental health services in South Africa by 2020 (Mulutsi 2017; Uys & Middleton 2014).

3.4 MENTAL HEALTHCARE POLICY IN POST-APARTHEID SOUTH AFRICA

Mental healthcare policies have been widely advocated as a key strategy to improve mental healthcare in South Africa (Cooper 2015; Mulutsi 2017). However, researchers have noted that health policies should be relevant to the cultural context of societies (Davar 2014; Fernando 2012; Mills 2014; Sax 2014). This is because perceptions of physical and psychological well-being differ substantially within communities or societies (Batisai 2016; Bene & Darkoh 2014; Nemitandani 2016; Tjale & de Villiers 2014). For example, post-apartheid, mental healthcare policies in South Africa promote the collaboration between the medical treatment team and traditional practitioners, mainly because most South Africans consult the services of both HCPs and traditional healers,

for mental health treatment (Cooper 2015; Morrow & Malcoe 2017; Prince 2009). Post-apartheid policies such as the MHCA 17 of 2002 also cater for cultural diversity within the medical treatment team and these policies also stipulate that the medical treatment team should cater for the cultural aspects of the patient, during their mental healthcare sessions. However, these policies are not fully implemented, hence the need for a conceptual framework which considers all the above-mentioned aspects in mental healthcare in the South African context. The conceptual framework is necessary because the biomedical approach to healthcare does not fully cater for the needs of mental health patients in South Africa (Batisai 2016; Monterio 2015). A detailed discussion on the biomedical approach is elaborated on in section 3.4.1).

As discussed in chapters 1 and 2, South Africa has a high prevalence of mental illness; thus, it is important to review mental health policies to determine if these policies promote medical treatment teamwork, collaboration between HCPs and traditional healers, and the decolonisation of the medical treatment teamwork approach to mental healthcare.

After the end of apartheid, South Africa developed a number of mental health policies such as the MHCA of 2002, which promotes a decolonial approach to medical treatment teamwork (Szabo & Kaliski 2017; Van Rensburg 2012). Augustus et al. (2019) note that a mental health policy must identify mental health issues, create plans to prevent mental health problems, as well as set services to improve mental healthcare, and create rules to safeguard mentally ill patients and the wider public. Therefore, any mental health policy should include concrete strategies and actions that will be implemented to tackle mental health problems. Many South Africans are suffering from mental illnesses (Acha-Anyi & Acha-Anyi 2021; Meyer, Matlala & Chigome 2019). It is thus essential, to have an understanding of the mental health policies in South Africa, since mental health policies play a fundamental role in the promotion of mental healthcare (Mulutsi 2017; Van Rensburg 2012).

It is worth noting that a detailed analysis of all mental health policies in South Africa is beyond the scope of this study, since policies prior to apartheid were discriminatory and not fully inclusive. In essence, policies under the apartheid government may not reflect the developments in mental health policies after the ANC came to power in 1994. Van Rensburg (2012) maintains that developments following democracy in 1994 aimed to dismantle or redress the injustices in mental healthcare inherited from the apartheid government. This development is in line with Article 25 of the Universal Declaration of

Human Rights, which states that all human beings have the right to access basic necessities such as food and medical care (Universal Declaration of Human Rights 1948). This justifies the need to focus on the policies guiding mental healthcare under the current ANC government. Post-apartheid policies will be reviewed next, to provide an understanding of current mental healthcare policies in South Africa.

3.4.1 Mental Health Care Act 17 of 2002

Before democracy in South Africa in 1994, mental health care was provided in terms of the Mental Health Care Act (MHCA) 18 of 1973 (Mulutsi 2017; Szabo & Kaliski 2017; Van Rensburg 2012). The MHCA of 1973 was not sensitive to human rights (Uys & Middleton 2014). This is because the main focus of this Act was to control and treat psychiatric patients to ensure welfare of society (Van Rensburg 2012). Following the democratic transition, South Africa introduced the MHCA 17 of 2002 (Republic of South Africa 2002, Van Rensburg 2012). The goals and provisions of the MHCA for the purposes of this study are discussed in the next section.

3.4.1.1 Provide for the care, treatment, and rehabilitation of persons who are mentally ill

The MHCA 17 of 2002 provides for the regulation of mental health care in a manner that makes the best possible mental healthcare, treatment, and rehabilitation of services available to the population equitably, efficiently, and in the manner that is in the best interests of mentally ill patients (Van Rensburg 2002). The Act also coordinates access to mental healthcare and rehabilitation services to various categories of mental healthcare users (Van Rensburg 2012).

3.4.1.2 Mental healthcare professionals: the medical treatment team

The Act permits HCPs with experience in psychiatry (for example, nurses, social workers, and psychologists) to work together collaboratively in assessment of the mental state of a mentally ill patient (Republic of South Africa 2002). The Act further permits that “users” (a mental healthcare user) should receive professional attention from psychiatrists, medical officers, nurses, occupational therapists, and social workers to provide mental healthcare (Landman & Landman 2014; Republic of South Africa 2002; Szabo & Kaliski 2017). Therefore, a medical treatment team approach to mental healthcare is core in the treatment of mentally ill patients (Augustus et al. 2019; Bene & Darkoh 2014; Gautier 2015; WHO 2018).

3.4.1.3 The role of “significant other” in healthcare and treatment

The Act also permits a parent, a spouse, a sister, or a brother to give consent to the medical treatment of a mentally ill patient (Republic of South Africa 2002). Therefore, “significant others” such as the patient’s family members play a fundamental role in the patient’s healthcare and treatment (Rainingruber 2013: 28). Thus, mental health treatment requires a comprehensive approach that includes the active participation of the patient’s family. Since family members can positively influence a patient’s treatment, by providing support and encouragement to them (Javed & Herrman 2017; Olasoji et al. 2017). There is, therefore, a need to develop a comprehensive conceptual framework, that acknowledges the role of significant others and their contribution to mental healthcare in South Africa.

Even though the MHCA 17 of 2002, has been hailed as the most progressive piece of mental legislation on mental health issues in South Africa, it has been less successful in integrating mental healthcare into primary health services (Ramlall 2012). Lack of adequate infrastructure, insufficient HCPs, and poor support from government are some of the reasons that undermine the successful implementation of this Act. Ramlall (2012) suggests that greater implementation of resources is needed to ensure a comprehensive implementation of the MHCA 17 of 2002.

However, the MHCA17 of 2002, made an important advance, as it emphasised the human rights of mentally ill patients, including access to healthcare (Mulutsi 2017; Uys & Middleton 2014; Van Rensburg 2012). After a major consultative process in 2012, a further important mental health policy was established in 2013 (Uys & Middleton 2014). The National Council adopted the National Mental Health Policy Framework and Strategic Plan 2013–2020 (NMHPF) as explained below.

3.4.2 National Mental Health Policy Framework and Strategic Plan 2013–2020

The adoption of the NMHPF stands out as the defining moment in the fight to improve the mental healthcare in South Africa (Department of Health 2013; Van Rensburg 2012). One of the objectives of the NMHPF is to promote the mental healthcare of South Africans through collaboration between the Department of Health and other sectors (Van Rensburg 2012). The Society of Psychiatrists of South Africa (2015) suggests that this objective is in line with promoting expert mental health teams. Medical treatment teamwork is imperative in mental healthcare (see chapter 4 for a detailed discussion on

a treatment teamwork approach to mental healthcare). Thus, the NMHPF policy embraces a teamwork approach to mental healthcare as per the context of this study.

However, effective teamwork can only be achieved when all levels of the healthcare system work together (El-Jardali & Fadlallah 2017; Porter & Lee 2013; Health Systems Trust. 2019). The Society of Psychiatrists of South Africa (2015) also noted that there is need for cooperation and effective communication at all levels of healthcare (Mulutsi 2017). This is because effective communication is necessary in mental healthcare (Amiri, Khademian & Nikandish, 2018; Buljac-Samardzic et al. 2020).

One of the objectives of the NMHPF is to empower local communities and carers. While also including the patient's family members and trained traditional practitioners, to participate in promoting mental healthcare in South African communities (Republic of South Africa 2013). The NMHPF also states that maximum support should be provided to families, to assist and cope with mental healthcare (Republic of South Africa 2013). Therefore, the NMHPF acknowledges the important role of significant others, this referring to the social context/social inclusion in mental healthcare in South Africa.

In principle, the NMHPF has been lauded as a significant step forward in mental healthcare in South Africa (Mulutsi 2017; Ramlall 2012; Van Rensburg 2012). However, its implementation has been challenged due to poor communication and resource limitations (Department of Health 2013; Mulutsi 2017; Petersen et al. 2016). The failure to implement policy on mental health was brought to light by the Life Esidimeni tragedy in 2017, in South Africa (Docrat & Lund 2019; Meyer et al. 2019). In this incident, about 144 mentally ill patients died after being transferred from the Life Esidimeni Hospital to unlicensed facilities (Docrat & Lund 2019; Jacobs & Coetzee 2018). Thus, despite the policy interventions aimed at the attainment of quality mental healthcare in South Africa, the achievement of the goal remains elusive (Burns 2011; Lund et al. 2011; South African College of Applied Psychology 2020).

Even though the NMHPF policy stipulates that varying cultural expressions and interpretations of mental illness should be respected, mental healthcare in South Africa still carries characteristics of the colonial and apartheid regimes (Ahuja, Mirzoev, Lund, Oforri-Atta, Skeen & Kufuor 2016; Breuer, De Silva, Shidhaye, Petersen, Nakku, Jordans & Lund 2016). The medical treatment team adheres to a biomedical approach of practice, even though policy claims that cultural considerations should be considered in mental

healthcare. Thus, while there is a growing interest in evidence-based policymaking, there is, perhaps, less attention paid to the question of the socio-cultural aspects, that can help in the full implementation of a mental health policy in South Africa. Many South Africans are influenced by their socio-cultural beliefs as mentioned in earlier chapters (Nemutandani 2016; Nemutandani et al. 2016; Tjale & de Villiers 2014). The following section provides a discussion on the decolonisation of mental healthcare in South Africa, which could play an immense role in supporting diverse patient care in the country (Jacobs & Coetzee 2018).

3.5 THE DECOLONISATION OF MENTAL HEALTHCARE IN SOUTH AFRICA

Prior to colonialism, South Africa's source of healthcare was ethnomedicine as offered within the context of clans, tribes, and later kingdoms (Cooper 2015; Ibrahim & Morrow 2015; Keikelame & Swartz 2019; Nemutandani, Hendricks & Mulaudzi 2018). This is because of the belief that ill health and diseases are caused by ancestral spirits, sorcerers, witches, or the violation of taboos (Ibrahim & Morrow 2015; Morrow & Malcoe 2017; Prince 2009; Robb 2012). After colonialism, healthcare was profoundly exposed to European culture and power and Europeans condemned the traditional healing system. The European colonial administration outlawed African medical practices (Van Rensburg 2012). Traditional healers were curtailed and criminalised (Coovadia et al. 2009). Traditional African healers were condemned as evil, malevolent, satanic, and ungodly (Prince 2009). Therefore, the Europeans institutionalised the biomedical (Western) approach to healthcare. The apartheid regime retained the Western biomedical approach to healthcare (Coovadia et al. 2009). Thus, a major cause of the pre-eminence of the biomedical approach in South Africa was its connection with the colonialist and, later, the apartheid regime (Prince 2009; Robb 2012; Van Rensburg 2012).

Although traditional medicine was relegated to an inferior and covert position over more than three centuries, it survived (Abbo 2011; Coovadia et al. 2009; Jacobs & Coetzee 2018; Nemutandani 2016; Van Rensburg 2012). However, the biomedical approach to healthcare never replaced traditional African healing (Nemutandani 2016; Van Rensburg 2012) as shown by the fact that 80 per cent of South Africans still consult with both HCPs and traditional healers (Batisai 2016; Bene & Darkoh 2014; Nemutandani 2016; Van Rensburg 2012). Therefore, South Africans make use of both the biomedical and the traditional approach for mental healthcare in SA. This study advocates for a medical

treatment teamwork approach (biomedicine) and the decolonisation of mental healthcare, since using both approaches will ensure that patients are provided with culturally congruent care (Kelly 2015; Penson 2019; Zingela et al. 2019). Thus, decolonisation of mental healthcare will allow the mental healthcare team to cater for the socio-cultural needs of the patient. Therefore, it is imperative to discuss the biomedical approach to healthcare, in order to contextualise the study.

3.5.1 Biomedical healthcare

The biomedical approach refers to the scientific mode of thinking in medicine (Batisai 2018). According to Ross and Deverell (2010:13), the basic assumptions of the biomedical approach include: the nature and causes of diseases and illnesses can be traced to specific aetiologies; individuals are not considered to be responsible for becoming ill; diseases and illnesses do not have psychological causes; and treatment is based on medical knowledge and skills. Therefore, the biomedical approach is based on modern scientific medicine (Batisai 2018). With this approach, illness is caused by specific identifiable factors that can be detected through diagnosis and manipulative treatment (Deverell 2010; Tjale & de Villiers 2014). However, the biomedical approach has its limitations in a country like South Africa, because the majority of the population still consults with traditional healers (Nemutandani 2016; Tjale & de Villiers 2014). Thus, South Africans should be treated within the framework of their own cultural beliefs (Batisai 2016; Bene & Darkoh 2014; Morrow & Malcoe 2017). It is, therefore, important to cater for the cultural context of mental healthcare in South Africa.

3.5.2 The cultural context of mental healthcare in South Africa

Mental illness is one of the health challenges in South Africa, as mentioned previously (Jacobs & Coetzee 2018; Mabunda et al. 2022; Monterio 2015). Hence, mental healthcare in South Africa should consist of HCPs who can contribute expertise knowledge for patient care. These HCPs come from different cultural backgrounds; hence, team members need to consider the cultural aspect of other team members in order to work collaboratively to provide effective patient care (Morley & Cashell 2017). The medical treatment team also needs to cater for the patient's culture when providing mental healthcare. However, the medical treatment team adheres to the biomedical approach to healthcare in South Africa (Ibrahim & Morrow 2015; Morrow & Malcoe 2017; Robb 2012). Jacobs and Coetzee (2018) argue that, in spite of the availability of biomedicine and other approaches to mental healthcare such as lifestyle modifications,

mind-body approaches, and Chinese medicine, the majority of mentally ill patients in South Africa continue to seek mental healthcare from traditional health practitioners. This is because the biomedical approach does not consider cultural factors that influence healthcare and well-being (Batisai 2016; Bene & Darkoh 2014; Jacobs & Coetzee 2018; Nmutandani 2016; Tjale & de Villiers 2014).

Sigida (2016) points out that if the treatment recommended for a mentally ill patient does not reflect their cultural beliefs, they may not adhere to it. It is, therefore, important that the medical treatment team provides treatment of mental healthcare that is culturally appropriate for the patient. Cultural factors need to be incorporated so that healthcare aligns with the realities of South Africans (Jacobs & Coetzee 2018). Thus, the need exists to decolonise and indigenise mental healthcare in South Africa and the medical treatment team needs to consider the cultural context of the patient, during mental healthcare consultations, in the South African context (Kaved & Herrman 2017; Olosoji et al. 2017).

Some South Africans believe that mental illness is caused by conflict between an individual and the ancestors or a witch, spirit, or sorcerer (Botha & Moletsane 2012; Ross & Deverell, 2010). Owing to these beliefs about the causes of mental illnesses, some South Africans consult with traditional healers for mental healthcare. Hence, there is a need for a conceptual framework which caters for collaboration between the medical treatment team and traditional healers.

African traditional medicine is the oldest and, perhaps, the most assorted of all therapeutic systems (Morrow & Malcoe 2017; Nmutandani 2016). Traditional healers diagnose and treat patients using plants, animals, and mineral substances (Morrow & Malcoe 2017). Furthermore, traditional health practitioners use methods based on socio-cultural background (Bereda 2002; Nmutandani 2016). This implies that traditional healers deal with the complete person and provide treatment for physical, psychological, spiritual, and social symptoms (Morrow & Malcoe 2017; Prince 2009). They do not separate the physical from the supernatural, because these dimensions are viewed as intertwined (Nmutandani 2016).

Traditional healers treat patients with herbs like *Rauwolfia Vomitoria*, which has tranquilising effects similar to those of psychotropic medications used by HCPs (Prince 2009). Traditional healers also use therapies, psychotherapies (in different forms), and even psychosurgery (Morrow & Malcoe 2017). Since most South Africans consult with

both HCPs and traditional healers, traditional healing is part of South African culture (Jacobs & Coetzee 2018; Lovell 2009; Monterio 2015; Nmutandani 2016). Therefore, the decolonisation of mental healthcare is essential since decolonisation will cater for a three-fold needs as per the context of this study namely: catering for cultural diversity within the medical treatment team; using alternative approaches of healing mentally ill patients through collaboration between the medical treatment team and trained traditional healers; and the medical treatment team catering for the cultural aspects of the patient during mental healthcare in the South African context.

As emphasised in previous chapters, decolonisation of mental healthcare in South Africa will allow cooperation between the medical treatment team and traditional healers, thereby providing more access to treatment for mentally ill patients. As noted in chapter 2, there are insufficient mental health professionals in the South African healthcare system (Docrat & Lund 2019; Meyer et al. 2019; South African Human Rights Commission 2017; Viviers 2017). The levels of staffing in public mental health facilities, particularly in rural areas are poorly equipped to provide mental healthcare services (Gray & Vawda 2016; Jacobs & Coetzee 2018; Viviers 2016).

South Africa has a traditional medical policy (Nmutandani 2016). However, this policy has not been practically implemented (Moola 2015; Mulutsi 2017; Nmutandani 2016). Thus, the Traditional Healthcare Practitioner Council promulgated in 2013, calls for the integration of traditional medicine into the national healthcare system (Nmutandani 2016). This council comprising 20 members has representatives from all provinces in South Africa. It is estimated that South Africa has about 200 000 traditional healers (Tyilo 2019). A majority of mentally ill patients in South African seek mental health treatment from traditional healers, and given that there are insufficient HCPs, there may be value for the medical treatment team to work collaboratively with trained traditional healers for mental healthcare (Batisai 2016; Zingela et al. 2019). A case in point where traditional healers played a fundamental role in healthcare was during the COVID-19 pandemic. The National Corona Command Council made recommendations to the government after consulting with stakeholders such as traditional healers (Mkize 2020). The government also had to work collaboratively with traditional healers in order to encourage people to take the COVID-19 vaccine.

Traditional healers are widely dispersed throughout South Africa. They are knowledgeable about the cultural beliefs, and mentally ill patients consult with them.

Thus, the strengthening of the traditional system seems to be realistic, economically affordable, and sustainable in the long run (Batisai 2016; Bene & Darkoh 2014; Nmutandani 2016). If mental healthcare is decolonised, this could support treatment, care and access for all South Africans, especially those in rural communities (Bene & Darkoh 2014; O'Brien & Broom 2014).

Thus, based on the sheer number of traditional healers, it is essential to consider using traditional healers within the mental health services. In essence, the large number of traditional healers, the inaccessibility of mental healthcare services due to lack of resources calls for the decolonisation of mental healthcare in South Africa. There should also be referral pathways between the medical treatment team and traditional healers where possible (Appiah-Poku et al. 2004; Kamsu-Foguem, Diallo & Foguem 2013; Sordsdahl et al. 2009). It is evident from the above discussion that the medical treatment team needs to collaborate and engage with traditional healers in order to provide healthcare that meets the needs of South African citizens.

However, the practice of traditional healing needs to be regulated effectively, to ensure that mentally ill patients are treated by trained and registered traditional healthcare practitioners (Sordsdahl et al. 2009; Zingela et al. 2019). Well-trained traditional healers have the potential to play an important role in mental health treatment in South Africa (Freeman, Lee & Vivian 1994; Nmutandani et al. 2018; Mbanga, Niehaus & Mzamo 2002; Peltzer et al. 2006; Tjale & de Villiers 2014). Researchers have noted that the decolonisation of mental healthcare will help provide patient-centred care, which is fundamental in mental healthcare (Gishen & Lokugamage 2018; Lokugamage & Pathberiya 2020; Richardson & Williams 2007). Therefore, the next section provides a discussion on patient-centred care in the context of this study.

3.6 A PATIENT-CENTRED TREATMENT TEAM APPROACH TO MENTAL HEALTHCARE IN SOUTH AFRICA

In the context of this study, patient-centred care is an approach that prioritises effective patient care. The high burden of mental illness and a global demand for quality patient care, necessitates the medical treatment team to focus on a patient-centred medical treatment approach (Babiker, Hussein, Nemri, Frayh, Juryyan, Faki, Assiri, Saadi, Shaikh & Zamil 2014; Jacobs & Coetzee 2018). This can only be achieved by placing the patient at the centre of mental healthcare. Therefore, medical treatment teams must interact and have the common goal of working collaboratively towards

delivering effective health services to patients (WHO 2018). In essence, patient-centred care is now recognised as a crucial component of effective mental healthcare (Muth et al. 2014; Santana, Manalili, Jolley, Zelinsky, Quan & Lu 2018). WHO (2018) concurs by arguing that the primary objective of medical treatment teamwork is to serve the patient by providing effective healthcare. According to the WHO (2018), medical treatment teams are responsible for assessing the medical needs of patients and coordinating specialised mental healthcare services, to provide patient-centred care. Thus, the medical treatment team should work collaboratively to prioritise patient care (Babiker et al. 2014).

Coffey, Hannigan, Barlow, Cartwright, Cohen, Faulkner, Jones & Simpson (2019) argue that patient-centred care, is healthcare that is responsive to the needs of the patient. For example, every patient is unique, hence the medical treatment team needs to provide individual healthcare plans for different patients (Babiker et al. 2014; Coffey et al. 2019). Patient-centred care includes dimensions such as, respect for the patient, cultural consideration, emotional support, information and communication, an individualised care plan, and involvement of family members in care of the patient. Researchers argue that patient-centred care is imperative since it improves the patients experience and leads to effective mental healthcare (Babiker et al. 2014; Bháird et al. 2016; Oflax et al. 2019). Findings from a study conducted by Oflax, Ancel, and Arslan (2019) also suggest that effective medical treatment teamwork can be achieved if the medical treatment team prioritises the patient.

Coffey et al. (2019) add that when members of the medical treatment team and the patient's family work collaboratively or in partnership, the overall health care experiences are improved. Therefore, the medical treatment team should acknowledge the patient's family, when providing patient-centred care. Failure to do so, is likely to result in an insufficient understanding of the patient's culture, thus the patient may not adhere to treatment. It is also important that the medical treatment team communicate effectively with each other and with the patient's family and merge the knowledge gained, to ensure effective patient-centred care is achieved, as per the context of this study.

Social factors such as family also influence healthcare as mentioned previous in chapter 1 (Augustus et al. 2019; Lake & Turner 2017; Olasoji et al. 2017). Social factor is a term often used to describe the influence that an individual or individuals can have on one another. While culture is referred to as a shared set of beliefs, customs, norms, and

values between social groups (Augustus et al. 2019; Lake & Turner 2017). Therefore, culture and social factors or social influence are closely linked. Both culture and social factors can have a profound influence on an individual's decision to adhere to mental health treatment (Charles & Samarasinghe 2019; Penson 2019). Therefore, mental healthcare has to be responsive to the cultural and social needs of South Africans, as explained throughout this chapter. The following section provides a discussion on the social context of mental healthcare in South Africa. This discussion is provided in order to contextualise this study.

3.7 THE SOCIAL CONTEXT OF MENTAL HEALTHCARE IN SOUTH AFRICA

As discussed in section 3.4, post-apartheid South African mental health policy acknowledges the importance of the social context in mental healthcare. Therefore, the social aspect of the family also needs to be incorporated into mental healthcare in order to achieve effective patient care (Kue et al. 2018). This is because mental well-being is also determined by social factors (Lake & Turner 2017). According to Raingruber (2013), the patient's family members can positively influence a patient's treatment by providing support and encouragement to the patient. Therefore, the treatment and care of mentally ill patients require a comprehensive approach, that includes active participation of the patient's family (Barret, Benninson, Collinson & Piebe 2017; Dirik et al. 2017; Raingruber 2013). Support from the family also helps in the physical and psychological well-being of the patients with mental illnesses (Kuo et al. 2018; Raingruber 2013). Therefore, socio-cultural aspects that contribute to illness and health are important (Tjale & de Villiers 2018).

Research has shown that family involvement in mental healthcare results in significant benefits for both the individual and the healthcare system (Charles & Samarasinghe 2019; Dirik et al. 2017; Olasoji et al. 2017; Rangruber 2013). For instance, results from research conducted by Koren et al. (2017) revealed that family can make patients calmer and more cooperative during consultations. Furthermore, the findings from a study carried out by Brown et al. (2009) yielded results which suggested that there was a positive health benefit amongst patients who had family support, as compared to patients who did not have this type of support. Results from Brown et al. (2009), also suggested that patients who had family support had lower mortality, compared to those who did not have any family support. These findings highlight the need for including the patient's family in mental healthcare sessions. Therefore, the role played by families in mental

healthcare cannot be overlooked. This critical inclusion of family in mental healthcare demands that they be recognised as partners, in the care of their loved ones (Dirik et al. 2017; Olasoji et al. 2017). Therefore, the decolonisation of mental healthcare is crucial since decolonisation considers the role of the family in mental healthcare.

According to WHO (2017), mental healthcare comprises three interlinked service delivery channels namely, self-care which includes healthcare delivery in collaboration with families and HCP); informal health care by community structures which includes, traditional healers, faith healers, villagers, elders, and family members) and primary and specialist healthcare, this caters for all the HCPs who deal with mental health patients. Figure 3.1 displays the mental healthcare delivery channels. These delivery channels, which were developed by WHO, are referred to as a service organisation pyramid for optimal mix of mental health services (WHO 2017).

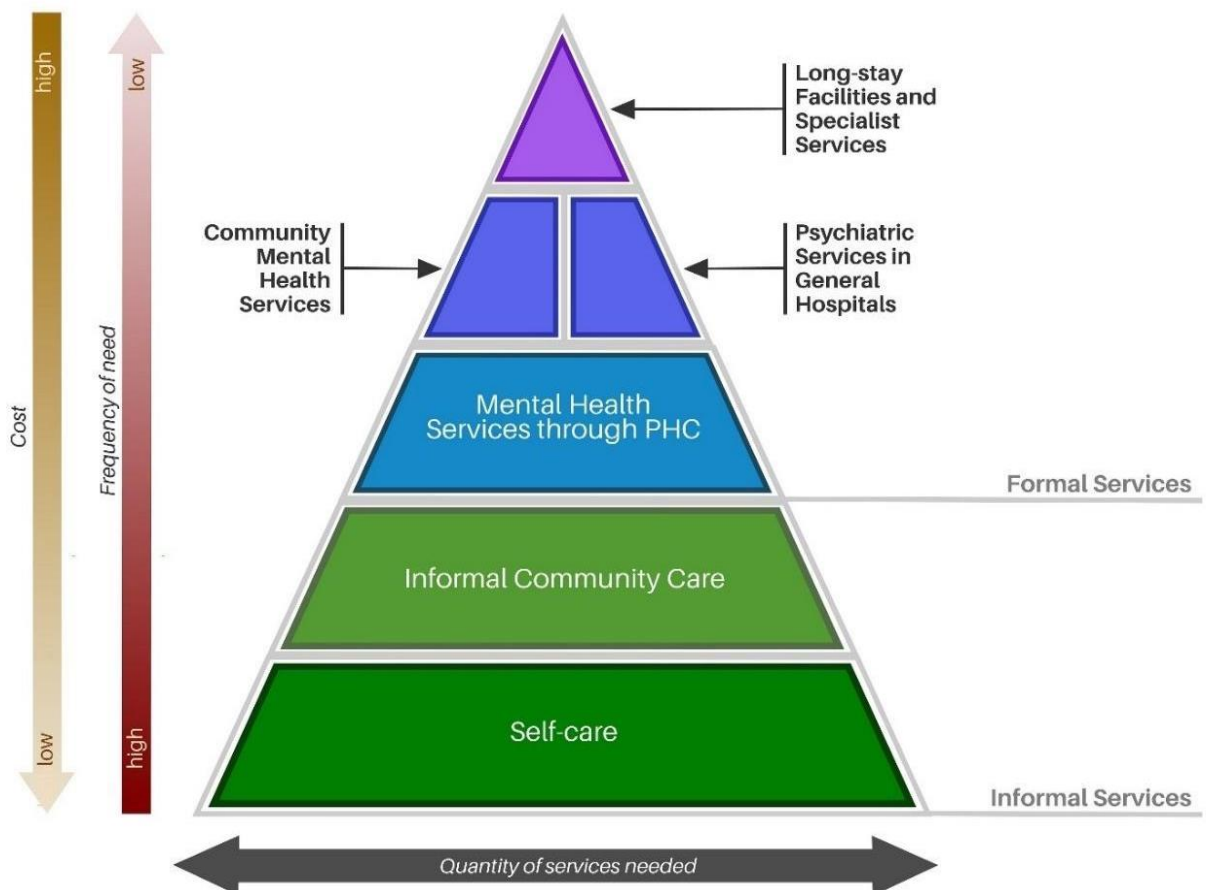


Figure 3.1: WHO optimal mix of services for mental health

(Source: WHO 2017)

Figure 3.1 depicts self-care as fundamental in care delivery in collaboration with families, friends, community leaders such as traditional healers, and healthcare practitioners. Informal care involves community structures such as village elders or community elders, traditional healers, and user organisations (Dube & Uys 2016; Morrow & Malcoe 2017). Thus, WHO (2017) acknowledges the collaboration between the medical treatment team, family members, and traditional healers as per the context of this study. A need therefore exists to acknowledge a decolonial medical treatment teamwork approach as well as socio-cultural aspects in mental healthcare, as per the conceptual contribution of this study. Therefore, the medical treatment team should collaborate with traditional healers and family members in order to care for mentally ill patients, in South Africa (Sordsdahl et al. 2009; Zingela et al. 2019).

WHO's Mental Health Action Plan 2013–2020 also called for greater collaboration with families and other “informal” mental healthcare providers, such as religious leaders and traditional healers in mental healthcare (WHO 2013). Therefore, WHO (2017) recommends integrated healthcare, that is, catering for patient's holistic healthcare needs, as an efficient way of caring for mentally ill patients. The medical treatment team, traditional healers, and family must collaborate, in order to achieve effective patient care. Thus, a significant factor in addressing mental illness requires consideration of the role that socio-cultural factors play in mental healthcare (Javed & Herrman 2017).

South Africa needs to address mental healthcare, taking into account the socio-cultural factors to achieve a sustainable and culturally appropriate form of mental healthcare that indigenises, decriminalises, and de-stigmatises mental health (Batisai 2016; Jacobs & Coetzee 2018; Monterio 2015). In line with WHO's (2017) recommendation that traditional healers, family, and the medical treatment team must collaborate to achieve effective patient care, thus this study proposed a conceptual framework, that caters for all these aspects for effective mental healthcare, in the South African context.

3.8 SUMMARY

The purpose of this chapter was to review the literature on mental healthcare in South Africa, during the colonial and apartheid periods. Current mental health policies in South Africa were reviewed over these timeframes. The decolonisation of mental healthcare in South Africa, the cultural context of mental healthcare in South Africa, and the social context of mental healthcare in South Africa were also discussed. Therefore, the chapter

provided a detailed discussion of mental healthcare during the colonial, apartheid, and post-apartheid periods.

To contextualise the concept of decolonisation in relation to the study, this chapter provided a discussion on the decolonisation of mental healthcare and how this is relevant in the quest for effective mental healthcare in South Africa. The chapter further provided a discussion on the cultural and social contexts of mental healthcare in South Africa. It concluded with the proposition that the use of both a Western (biomedical) and a traditional (use of traditional healers) approach to mental healthcare will enhance effective patient care. The next chapter provides a discussion of selected teamwork models and theories for the purposes of this study. The next chapter also highlights the limitations of these models and theories and the need for a comprehensive conceptual framework that covers critical aspects in mental healthcare in the South African context.

CHAPTER 4: LITERATURE REVIEW PART 1: HEALTH COMMUNICATION MODELS AND THEORIES FROM A TEAMWORK PERSPECTIVE

4.1 INTRODUCTION

In this chapter, health communication models and theories from a medical treatment team perspective will be discussed. This is done in order to contextualise the role of the medical treatment team, in mental healthcare. For the purposes of this study, the medical treatment team refers to the HCPs who diagnose, treat and take care of the mentally ill patients. These HCPs for the purpose of this study include, nurses, medical officers, clinical psychologists, clinical managers, occupational therapists, pharmacists, social workers, and psychiatrists. Teamwork theories are discussed in this chapter, because the healthcare team plays a critical role in mental healthcare. Diverse medical teamwork allows HCPs from different disciplinary backgrounds to combine their skills to provide care for mentally ill patients (Bene & Darkoh 2014; Gautier 2015; Wang et al. 2018).

As the chapter focuses on theories and models, it is important to clarify the difference between a model and a theory. A model involves a deliberate simplification of a phenomenon while a theory represents a set of statements that are developed via a process of continued abstraction (Nilsen 2015). Heath and Bryant (2000) argue that a good theory must be heuristic, which suggests that it should be used to guide something valuable such as mental healthcare. For the purposes of this study, different models and theories that have been applied to health communication were selected to contextualise the contribution of this study.

This chapter provides a discussion on selected teamwork models and theories in healthcare namely, Tuckman's teamwork theory and model (Tuckman 1965), the goals, roles, processes, and interpersonal relationships (GRPI) model (Rubin et al. 1977), the T7 Model of Team Effectiveness (Lombardo & Eichinger 1995), the Lencioni Model (Lencioni 2002); and the Theory of Collective Competence (Boreham 2004). These teamwork theories and models are explained in order to emphasise HCP–HCP teamwork in relation to mental healthcare since medical treatment teamwork plays an important role in mental healthcare. The chapter also provides criticisms of all these models and theories to contextualise the need for the development of a conceptual framework, that considers teamwork aspects such as, tolerance for cultural diversity in teamwork and socio-cultural consideration, for medical treatment teamwork for mental

healthcare. Therefore, providing a discussion on these models and theories also contextualises the contribution of this study.

In providing patient care, the medical treatment team is required to adhere to some principles of teamwork. Thus, this chapter also provides a discussion on the principles of effective mental healthcare treatment teamwork, such as, shared goals, hierarchical leadership, clear roles, effective communication, empowerment, and ubuntu.

4.2 A MEDICAL TREATMENT TEAM APPROACH TO MENTAL HEALTHCARE

Mental illness can be acute, relapsing, or chronic (Gautier 2015; O'Leary, Sehgal, Terrell & Williams 2012; Vertino 2014; Wang et al. 2018; Weller et al. 2014). Providing mental healthcare is a task that requires HCPs from different disciplinary backgrounds to combine their unique expertise and knowledge to provide effective care to mentally ill patients (Gautier 2015). Therefore, medical treatment teamwork is imperative for effective mental healthcare. Medical treatment teamwork involves collaborative teamwork between two or more HCPs who work interdependently to make shared decisions regarding patient care and deliver mental healthcare in an integrated (rather than sequential) way (Bene & Darkoh 2014; Wang et al. 2018). Such functional, diverse teams are thought to optimise patient care by capitalising on different knowledge, perspectives, and skills to deliver effective mental healthcare to individual patients (Gautier 2015; Wang et al. 2018). The HCPs undertake different tasks and are expected to communicate effectively, to provide effective services for mentally ill patients (Lyubovnikova & West 2017; Vertino 2014).

The medical treatment team need to communicate effectively with one another when treating patients. Research has indicated that effective communication can enable responsiveness and increase patient care (Lee, Allen & Daly 2012; Maxfield, Lyndon, Kennedy, Keeffe & Zlatnik 2013). Healthcare that emphasises teamwork and coordination has been associated with greater implementation and continuous improvement in quality healthcare (Gautier 2015; Wang et al. 2018). Quality patient care necessitates a greater focus on medical treatment teamwork. Thus, the current study advocates for a medical treatment team approach to mental healthcare.

Research suggests that a medical treatment team approach to healthcare results in positive patient outcomes (Kholed, Hassan, Ma'on & Hamid 2017; Rosen et al. 2018). Scholars have argued that these positive results accrue because medical treatment

teams make better quality decisions, and produce integrated plans when based on combined expertise (Grumbach & Bodenheimer 2004; Rosen et al. 2018; Wagner 2000). Effective teamwork is now globally recognised as an essential tool for providing effective mental healthcare (WHO 2018). Therefore, medical treatment teamwork and effective communication amongst HCPs are fundamentals for effective mental healthcare (Vertino 2014; Wang et al. 2018). The benefits of a medical treatment team approach to mental health, in the context of this study, is summarised in Table 4.1.

Table 4.1: Benefits of a medical treatment team approach to mental healthcare

Areas of benefits	Benefits of medical treatment team	Application to mental healthcare
Organisational	<ul style="list-style-type: none"> • More effective (service user-centred goal setting) • Improved coordination and continuity of care 	<p>For the purposes of this study the organisation refers to the healthcare system (see chapter 2 for a discussion on the healthcare systems). Thus, medical treatment teamwork will enable the provision of collaborative patient care in a hospital setting (case study sites: Cecilia Makiwane Hospital and Fort England Hospital).</p> <p>The organisational policies also guide the medical treatment team at both sites since medical treatment team must adhere to both the government and hospital policies for patient care.</p>
Team level (the treatment team)	Knowledge, skill and experience to inform improved decision-making	In the context of this study, the diverse knowledge and experience of members of the medical treatment team (nurses, medical officers, clinical psychologist, occupational therapists, pharmacist, clinical manager, social workers and psychiatrists) can result in holistic mental healthcare and improved coordination and continuity of care for the individual patient.

		Team members have different cultural backgrounds, hence, cultural tolerance amongst members of the treatment team may also result in improved patient care as per the context of this study.
Service user for healthcare	Improved access to healthcare for the patient	The service user in the context of this study is the mentally ill patient. The patient has access to members of the medical treatment team. The mentally ill patient will be provided with effective treatment (from the knowledge and skills from medical team from different disciplinary backgrounds).
Medical treatment team member	Increased social affiliations for the treatment team member and mutual support and greater role clarity	In the context of this study, a team member is either the nurse, medical officer, clinical psychologist, occupational therapist, psychotherapist, pharmacist, clinical manager, social worker or the psychiatrist. The role of each member of the medical treatment team, is defined in relation to treatment of the mentally ill patient. Having shared roles will reduce stress and enhance job satisfaction for the team member.

(Source: Mental Health Commission of Ireland 2019)

As noted in Table 4.1 above, a medical treatment team approach to mental healthcare offers great benefits such as, improved coordination, continuity of care, and delivery of high-quality mental healthcare (Gautier 2015; Rosen et al. 2018). However, these benefits can only be achieved if the medical treatment team adheres to basic principles of a medical treatment team approach such as, shared goals, mutual trust, and cultural respect between treatment team members. Not adhering to these principles can result in immediate risks for mental health patients (Bene & Darkoh 2014; Gautier 2015; WHO 2014). For example, poor communication between members of the medical treatment team has emerged as a common reason for medical errors (Gautier 2015; WHO 2018).

In addition, not adhering to decolonial aspects such as, catering for cultural diversity in the medical treatment team, collaboration between the medical treatment team as well as trained traditional healers, and catering for the cultural aspects of the patient during mental healthcare diagnosis and treatment sessions. This can impede effective medical treatment teamwork in the South African context, since both members of the medical treatment team and the patients are influenced by their cultural values (Jacobs & Coetzee 2018; Morley & Cashell 2017). Hence there is a need for a conceptual framework which caters for aspects such as, effective communication and cultural tolerance in medical treatment teamwork. The following section provides a discussion on the principles of treatment teams.

4.3 PRINCIPLES OF EFFECTIVE TREATMENT TEAMS

The principles of effective healthcare teams include, shared goals, hierarchical leadership, mutual trust, clear roles, effective communication, empowerment, and ubuntu. (Benishek, Gregory, Hodges, Newell, Hughes, Marlow & Salas 2016; Buljac-Samardzic et al. 2020; Fleury, Grenier, Bamvita & Farand 2017). These aspects are discussed below.

4.3.1 Shared goals

According to Marlow, Hughes, Sonesh, Gregory, Lacerenza, Benishek and Salas (2017), the foundation of successful medical treatment teamwork, is the entire team's active adoption of a clear set of shared goals for the HCPs (as per the context of this study, this includes nurses, medical officers, clinical psychologists, occupational therapists, social workers, and psychiatrists). The medical treatment team must organise their mission, goals, and performance to enhance patient care (Oflax et al. 2019; Rosen et al. 2018). Mitchell, Wynia, Golden, McNellis, Okun, Webb, Rohbach & Kohorn (2012) add that healthcare must evaluate progress toward the shared goals on a regular basis. In the context of this study, the overall goal must be to provide quality healthcare to individual patients. In order to achieve effective patient care, members of the medical treatment team should communicate with each other about expectations and goals. Frequent communication will help the medical treatment team to work collaboratively to accomplish the goal of patient-centred care.

4.3.2 Hierarchical leadership

Hierarchical leadership enables team effectiveness. By coordinating interactions between members of the medical treatment team and defining the roles of each member of the team (Armstrong 2013; Oflax et al. 2019; Xu et al. 2021). Hierarchical leadership in a team structure may facilitate conflict resolution by creating order and improving coordination (Xu et al. 2021). Fleury et al. (2017) contend that one of the keys to a successful team is having good leadership. Swart (2017) adds that it takes guidance from the team leader to develop an effective medical treatment team that can provide effective care to mental health patients. A leader's primary goal is to lead the team to achieve goals (effective patient-centred care) (Burke 2014). Thus, team leadership influences various elements in a team including coordination, cooperation, information sharing, problem-solving, commitment, and overall performance (Burke 2014). Therefore, good leadership is imperative when enabling medical treatment teams to provide effective mental healthcare (Jeevanie 2012). For the purposes of this study, the clinical managers supervised the overall function and management of the medical treatment team and ensured that all members of the treatment team implemented policies related to the medical treatment teamwork and socio-cultural aspects of the medical treatment. The medical officers led the HCPs by ensuring that the medical treatment team members implemented the treatment plan for the mentally ill patients (WHO 2018).

Fleury et al. (2017) add that in order to communicate and coordinate teamwork activities effectively, the leader of the medical treatment team should be part of the team. For example, the clinical manager who is also an HCP, is part of the medical treatment team at the case study sites. Burke (2014) suggests that the team leader should be approachable and encourage members of the medical treatment team to work collaboratively for patient care. As evident in the above discussion, leadership is a prerequisite for effective mental healthcare teams. Thus, leadership was included as one of the constructs in the conceptual framework developed in chapter 6.

4.3.3 Clear role

Mitchell et al. (2012) argue that the medical treatment team should have clear expectations for each team member's functions and responsibilities. The medical treatment team should also establish which member is most appropriate for each role, including the leadership position (Mitchell et al. 2012; Rosen et al. 2018). Despite the potential benefits of defining clear roles, treatment teams have been criticised for not

involving the patient's family in healthcare planning (Bradley & Green 2018; Eliacin, Salyers, Kukla & Mathias 2015). As noted in chapter 3, the patient's family can also play a role in healthcare. Therefore, the medical treatment team should also consider the role that family members can play, in enhancing patient healthcare (Eliacin et al. 2015; Hungerford & Richardson 2013). Ideal mental healthcare should involve a medical treatment team which invites the patient's family to participate in mental healthcare (Bradley & Green 2018). Thus, the decolonisation of mental healthcare becomes imperative.

As discussed in chapters 2 and 3, there is limited availability of HCPs to deliver healthcare services in SA and this continues to be a barrier to appropriate care for many mentally ill patients (Docrat & Lund 2019; Meyer et al. 2019). Therefore, the medical treatment team should involve and educate the family on how to carry out their caring role (Kuo et al. 2018). Thus, this study acknowledges the clear role of the medical treatment team, but also proposes that the role of the family should be considered in overall patient healthcare.

4.3.4 Mutual respect

Rosen et al. (2018) suggest that team members should respect the role of each other. Kholed et al. (2017) argue that collaboration occurs when individuals have mutual respect for one another. This can be done through understanding and respect for the other professions within healthcare (Kholed et al. 2017; Rosen et al. 2018). Mutual trust is fundamental in teamwork, however, mutual trust among team members is not sufficient to enhance mental healthcare (Bradley & Green 2018; Dirik et al. 2017). Some patients do not trust HCPs but trust their family members, since they are living with them (Bradley & Green 2018). This reinforces the need for the medical treatment team to include the family in mental healthcare.

4.3.5 Effective communication

The effectiveness of medical treatment teams depends on effective communication between team members (Gautier 2015; Jacobs & Mkhize 2021; Neuhaus et al. 2020; Rosen et al. 2018). Medical treatment teamwork becomes ineffective when team members are unable to communicate effectively with each other (Buljac-Samardzic et al. 2020). Medical errors and other adverse events may also occur due to ineffective communication in medical treatment teamwork (Bene & Darkoh 2014; Gautier 2015).

Communication is, therefore, essential in the continuity of care among the treatment team. Rosen et al. (2018) suggest that the team leader, in consultation with other team members, should set clear expectations as to the manner in which healthcare information needs to be shared.

Mitchell et al. (2012) add that the treatment team must prioritise and continuously refine its communication skills in order to enhance effective communication amongst team members. However, effective communication amongst members of the medical treatment team can be hindered due to cultural barriers such as, race, language, values, and lack of interprofessional respect (Rosen et al. 2018). Team effectiveness maybe affected by the different cultural contexts of the team members (Cagiltay, Bichelmeyer & Akilli 2015). Therefore, each HCP must acquire knowledge about the cultural values of the other team members (Johnson, MacDonald & Oliver 2017). Thus, this study argues for a decolonial medical treatment teamwork approach, which caters for cultural diversity within the medical treatment team, as well as collaboration between the medical treatment team and trained traditional healers, and for the medical treatment team to cater for the cultural aspects of the patient during mental healthcare. This is because the majority of South Africans are influenced by their cultural norms and most patients consult with both the medical treatment team and traditional healers for their mental healthcare (Jacobs & Coetzee 2018).

Acquiring knowledge and understanding other team member's cultures, as well as collaboration between HCPs and traditional healers, and cultural tolerance during mental healthcare, will help the HCPs to achieve the cultural competencies needed in healthcare teamwork (Johnson et al. 2017). Effective communication also offers the potential for effective performance and the promotion of multicultural understanding among team members (Cagiltay et al. 2015; Rosen et al. 2018). Thus, cultural differences amongst members of the medical treatment team can be minimised through effective communication.

It is worth noting that it may be challenging to provide effective healthcare without effective communication between the patient's family and the medical treatment team (Chichirez & Purarea 2018; Warnecke 2014). Since effective communication enables the medical treatment team to provide patient-centred care, in terms of their informational, emotional, and decisional needs (Warnecke 2014). Therefore, the medical treatment team needs to communicate effectively with the patient's family members, in order to

provide effective care. Hence, the need for a decolonial medical treatment teamwork approach to mental healthcare in South Africa.

4.3.6 Empowerment

Empowerment in the healthcare setting is defined as the ability to effectively motivate and mobilise team members to accomplish goals, that lead to quality healthcare (Barry, Longacre, Carney & Patterson 2019). A medical treatment team approach requires that team members draw on individual expertise and work collaboratively, to provide effective patient healthcare (Wåhlin, Ek & Idvall 2010). Delany, Richards, Stewart and Kosta (2017) argue that opportunities for knowledge-sharing and collaboration lead to team empowerment. Barry et al. (2019) add that the medical treatment team is empowered, when the team adheres to principles such shared goals, leadership, and effective communication (see section 4.4).

Craig, Eaton, Belitzky, Kates, Dimitropoulos, and Tobin (2020) argue that empowerment is positively related to team effectiveness. Hector and Manz (2016) add that effective healthcare is provided to patients when team members are empowered. Empowering team members has benefits such job satisfaction, staff retention, and ultimately patient-centred care (Barry et al. 2019; Delany et al. 2017). Therefore, team empowerment is a key principle for effective treatment teams (Hector & Manz 2016; Radhakrishnan & Anuchithra 2016).

However, an empowered team alone cannot meet all the needs of a patient (Craig et al. 2020). The patient's family also needs to be empowered to enable them take care of the patient (Craig et al. 2020). Literature in chapter 3 suggested that family plays a fundamental role in healthcare (Charles & Samarasinghe 2019; Dirik et al. 2017; Javed & Herrman 2017), therefore, the patient's families also need to be empowered. The findings of a study carried out by Wheeler, Mackay, Moody, D'Souza, and Gilbert (2020) on engaging the family in healthcare system planning revealed that involving the patient's family in healthcare contributed to a positive healthcare experience for the patient. A study conducted by Craig et al. (2020) on empowering medical treatment teams also suggested that empowerment should not only be limited to treatment teams, but should be extended to the patient's family. Therefore, the medical treatment team and the patient's family need empowerment for patient care (Barry et al. 2019; Delany et al. 2017; Wheeler et al. 2020).

4.3.7 Ubuntu: collaborative treatment teamwork

According to Downing and Hastings-Tolsma (2016), ubuntu is an Nguni word which translates as “human kindness”. Molala and Downing (2020) add that ubuntu emphasises humanness, cohesion, connectedness and mutual respect, which are all characteristics that a medical treatment team approach should apply when working together. Thus, ubuntu promotes cohesion, cooperation, interdependency and reciprocal value amongst HCPs (Nzimakwe 2014). Taylor (2014) suggests that ubuntu cultivates a team spirit towards healthcare. Hence, every member of the medical treatment team must view teamwork from a perspective of interdependence and interpersonal connections, as stipulated by the ubuntu philosophy. A decolonial approach to mental healthcare fits well with the African philosophy of ubuntu, which focuses on a collective approach to mental healthcare. Therefore, a need exists to propose a conceptual framework that caters for a collective approach to mental healthcare, in South Africa.

The ubuntu philosophy encourages respect for culture in mental healthcare (Madaka 2019; Molefe 2011). In essence, ubuntu is one of the principles of teamwork, in which the members of the medical treatment team are encouraged to cater for cultural diversity, as well as encourage collaboration between members of the treatment team and trained traditional healers, and cater for cultural needs of the mentally ill patients. Hence this study argues that a decolonial medical treatment teamwork could support mental healthcare in South Africa. The ubuntu philosophy also promotes collaboration between the medical treatment team and the patient’s community (such as family members). Since community members, such as the patient’s family, play a huge role in mental healthcare (Metz 2007). Therefore, ubuntu encourages caring, cultural tolerance, and interconnectedness (Molala & Downing 2020) and the values of ubuntu contribute to effective healthcare (Molala & Downing 2020; Taylor 2014). Therefore, all members of the medical treatment team should practice the values of ubuntu since these values can positively influence medical treatment teamwork and mental healthcare.

It is worth noting that the humanistic ideal of ubuntu encourages the empowerment of communities to participate in healthcare. Marcus (2014) indicates that the medical treatment team should educate the patient’s family about illness management, medications, and post-discharge management. Green-Thompson, McInerney and Woollard (2017) suggest that the empowering communities (referring to the patient’s family in this research context) should contribute to the patient’s healthcare. Thus,

ensuring shared responsibility between the patient's family and the medical treatment team, which will lead to enhanced healthcare. Therefore, the ubuntu philosophy is fundamental in supporting a positive interaction between the treatment team and the patient's family (Molefe 2011; Green-Thompson et al. 2017) (a detailed discussion on ubuntu is provided in chapter 5).

In the light of the discussion that team-based health principles contribute to effective mental healthcare, it is imperative that the medical treatment team in South Africa consider and adhere to these principles. The next section provides a discussion on the teamwork models and theories, to acknowledge existing teamwork models and theories. The teamwork theories and models emphasise HCP–HCP teamwork, for the purposes of this study.

4.4 TEAMWORK MODELS AND THEORIES

Various teamwork models and theories have been proposed in the context of this research. These include: Tuckman's Teamwork Theory and Model (Tuckman 1965), the GRPI model (Rubin et al. 1977), the T7 Model of Team Effectiveness (Lombardo & Eichinger 1995), the Lencioni Model (Lencioni 2002) and the Theory of Collective Competence: challenging the neo-liberal individualisation of performance at work (Boreham 2004).

The choice of the above-mentioned theories and models is based on the need to have a general overview of the main areas of focus of existing teamwork theories and models. These main areas of focus include team development, team competence, and team effectiveness. These five team-based healthcare models and theories were selected because they have been used in health communication research to explore teamwork in a medical setting (hospital context) and are, therefore, appropriate for the purposes of this study (Epstein, Peisachovich, Silva, Lee & Solomon 2017; Liberati, Tarrant, Willars, Draycott, Winter, Chew & Dixon-Woods 2019; Anderson, Pollard, Conroy & Claque-Baker 2013).

Anderson et al. (2013) used Tuckman's Teamwork Model to explore a new clinical team for frail older people. In addition, Have (2014) employed the GRPI model to assess the quality of interdisciplinary rounds in the intensive care unit. Interdisciplinary rounds are meetings in which HCPs from different disciplines collaborate to develop an integrated healthcare plan for individual patients. Thus, these teamwork models and theories are

appropriate for the purpose of this study, as they have been used in previous studies that have dealt with healthcare teamwork. In the next section, a discussion of the selected teamwork models and theories are discussed as they relate to mental healthcare, for the purposes of this study. These models and theories are also discussed as they emerged in chronological sequence of development.

4.4.1 Tuckman's Teamwork Model and Theory

This model was developed by Tuckman in 1965. Tuckman (1965) argues that teams grow through clearly defined stages, namely forming, storming, norming, and performing (Tuckman 1965). These stages will be explained below.

4.4.1.1 Forming

Forming is the first or orientation stage (Krietner & Kinicki 2014; Tuckman 1965). In the context of this research, the medical treatment team, which consist of nurses, medical officers, clinical psychologists, clinical managers, occupational therapists, pharmacists, social workers, and psychiatrists is formed at this stage to treat mentally ill patients (Buckley 2008; Phalane 2011).

4.4.1.2 Storming

The storming stage is characterised by “turf” conflicts regarding who does what, and what power certain members have over others (Phalane 2011; Tuckman 1965). This conflict may result in some loss of performance or focus on the task (Buckey 2008). In this stage, conflicts get resolved when there is effective communication between members of the team (Krietner & Kinicki 2014). This reinforces the need for effective communication in healthcare teams. Krietner and Kinicki (2014) indicate that good leadership, and mutual respect among team members can also mitigate conflicts at this stage. Cultural tolerance amongst members of the treatment team could also mitigate some of the conflict that may arise due to cultural differences (Cagiltay et al. 2015). This reinforces the need to develop a framework that caters for cultural diversity among members of the treatment team.

4.4.1.3 Norming

At this stage, the team members develop processes and establish ground rules for the team (Krietner & Kinicki 2014). A feeling of team spirit is also experienced because

members have established their roles (Krietner & Kinicki 2014; Tuckman 1965). It is during this stage that the medical treatment team (nurses, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists) need to come together in informal meetings and clarify the role and responsibilities of each HCP (Begg & David 2009). In the context of this study, during the norming stage, the clinical managers assign roles to all members of the medical treatment team and the team works collaboratively, as per the mental healthcare policies, the MHCA OF 2002 and the NMHPF, to provide patient care.

4.4.1.4 Performing

At this stage, all members of the medical treatment team contribute to getting their work done without hampering others. Thus, members of the medical treatment team need to be tolerant of other team members' cultures and work collaboratively, in the spirit of ubuntu to provide patient care. Furthermore, the patient's family should be involved when assisting with patient adherence and care, in terms of mental healthcare. As noted in chapter 3, the medical treatment team should involve the patient's family, in order to provide effective patient care. Since the patient is influenced by their family. Thus, the medical treatment team should collaborate with the patient's family at the performing stage. A graphical representation of Tuckman's model is presented in Figure 4.1 below.

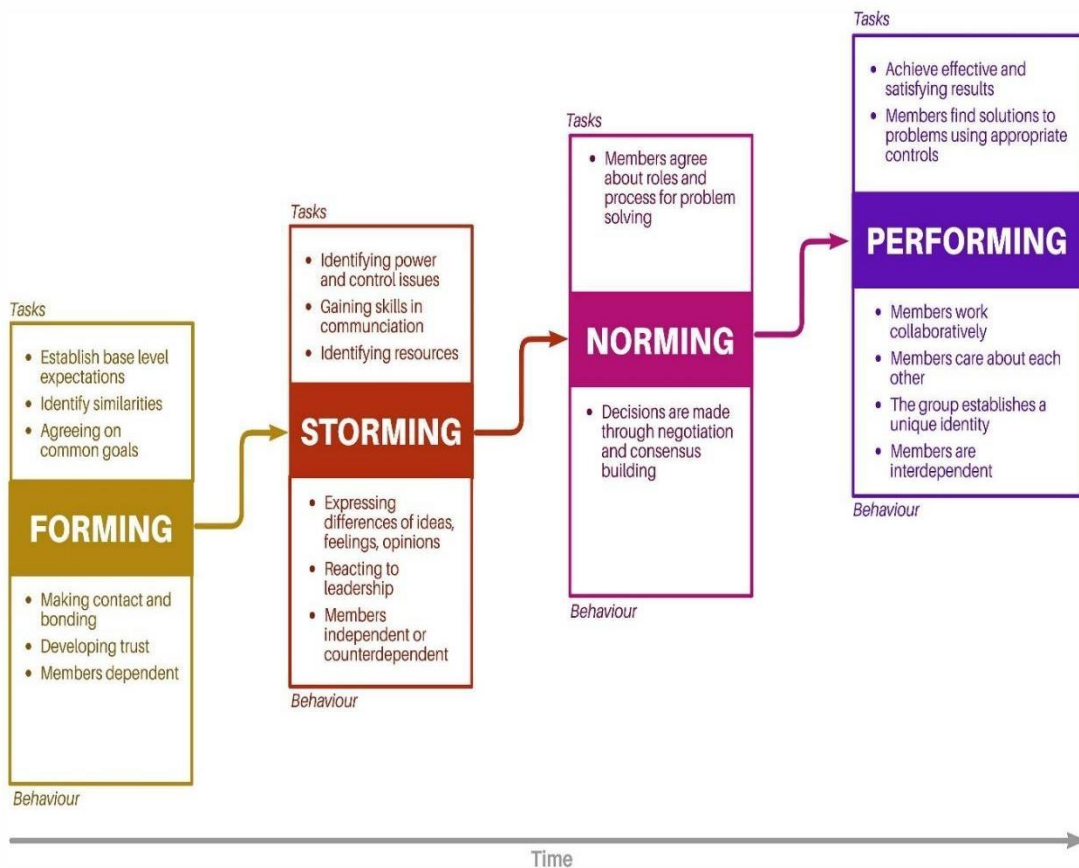


Figure 4.1: Tuckman's Teamwork Model

(Source: Tuckman 1965)

In the next section, criticism of Tuckman's Teamwork Model in relation to the current study is explained.

4.4.1.5 Criticisms of Tuckman's Teamwork Model

Harris (2003) argues that the forming and storming stages developed by Tuckman are very confusing, as they barely improve team performance. Therefore, the Tuckman Model (1965) is limited, since a mental patient needs a fully functional medical treatment team, that aims to provide effective mental healthcare. Harris (2003) adds that the norming stage occurs when the team members are beginning to realise common goals, objectives, roles, and procedures, as well as show improvement in team performance. The performing stage is when the team begins to enter high achievement (Harris 2003). However, focusing solely on the team life cycle will not result in effective teams (Gordon 2002; Harris 2003; Krietner & Kinicki 2014; Phalane 2011). Therefore, a need exists to

develop a framework that caters for all the components that will result in effective treatment teams.

It is important to note that Tuckman's Model is intertwined with Lencioni's model (2002). During the forming stage of Tuckman's Model, teams may experience invulnerability and suffer from an absence of trust (Lencioni's 2002). During the storming stage, a fear of conflict may exist, and this can hamper relationships since team members may not bring real issues to the surface. This may lead to ineffective communication between the treatment team members. As noted in section 4.2, ineffective communication or a communication error might have negative consequences for the patient, hence effective communication is paramount to team effectiveness. Therefore, there is a need for a conceptual framework that clearly advocates the need for effective communication in medical treatment teamwork. In the following section, the goals, roles, processes, and interpersonal relationships of the GRPI model (Rubin et al. 1977) will be discussed.

4.4.2 GRPI Model

GRPI stands for *goals, roles, processes and interpersonal relationships*. This model was developed by Rubin et al. in 1977. The model suggests that there are four components of an effective team, namely goals, roles, processes, and interpersonal relationships (Mattia 2019; Rubin et al. 1977). It assumes that a medical treatment team should always begin with a level goal. In the context of this study, the goals for the medical treatment team are to work as a team to provide effective patient care. As discussed in chapter 3, the goal of the medical treatment team should also be directed towards the socio-cultural needs of the mentally ill patient.

Rubin et al. (1977) indicates that after the goals are defined, the roles and responsibilities of the nurse, medical officer, clinical psychologist, occupational therapist, pharmacist social worker, and psychiatrist will become clear. For the purpose of this study, roles and responsibilities should be patient-centred to ensure effective treatment. The medical treatment team is comprised of HCPs from different disciplinary backgrounds; therefore, working together requires effective communication between the HCPs. Effective communication will help the HCPs undertake their different roles and provide effective healthcare to the patient (Lyubovnikova & West 2017; Vertino 2014).

As the individuals work together (nurse, medical officer, clinical psychologist, occupational therapist, clinical manager, pharmacist, clinical manager, social worker,

and psychiatrists), they will see that their respective goals and responsibilities are often not sufficiently clear. Therefore, working together as a medical treatment team requires them to spend a substantial amount of time negotiating and communicating the roles of each team member. This reinforces the need for effective communication in medical teamwork. Rubin et al. (1977) also indicates that addressing the processes and procedures associated with task-related performance difficulties enables the team to redefine their responsibilities in terms of processes. This redefinition enables the medical treatment team to adjust and re-adjust team processes as required (Dyer, Dyer & Dyer 2013; Rubin et al. 1977). A graphical representation of the GRPI model is presented in Figure 4.2.

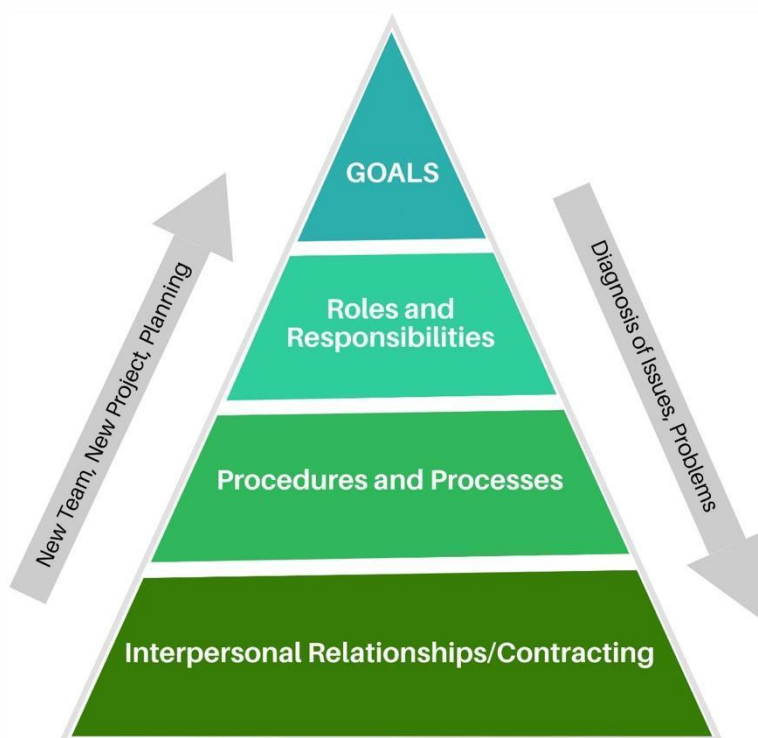


Figure 4.2: GRPI Model

(Source: Rubin et al. 1977)

In the next section, criticism of GRPI Model in relation to this study will be addressed.

4.4.2.1 Criticism of the GRPI Model

Although the GRPI Model highlights the different aspects of team cooperation by identifying the goals, clarifying roles and responsibilities, processes, and interpersonal relationships of the team members, the model has been critiqued for being static (Zernik 1972). Its purpose refers to a specific point in time rather than being useful to all phases of a team's development (Zernik 1972). Mental healthcare requires a medical treatment team that is fully functional, at every point in time, to provide patient-centred care. The model has also been critiqued for looking at teams as rational, structured entities (Zernik 1972). Teams need to be dynamic, especially when it comes to healthcare. Any medical treatment health team that is static will find it difficult to cope and function effectively in a society such as South Africa, where people are influenced by their socio-cultural beliefs. As discussed in chapter 3, the HCPs also need be dynamic and collaborate with the patient's family in order to achieve the goal of effective patient care. Thus, this teamwork model is lacking in that it does not consider other external factors, such as, the patient's socio-cultural factors, that can hinder the team from achieving its goal.

Therefore, a need to develop a comprehensive conceptual framework that caters for the socio-cultural factors that influence mental healthcare. For the purposes of this study, socio-cultural consideration is considered to be two-fold, that is, for the HCPs and for the patients. All the members of the medical treatment team should be tolerant of each other's cultural differences, that is, within the team, in order to work collaboratively and provide effective individualised care for the patient. Furthermore, the medical treatment team should provide culturally appropriate mental healthcare to all patients. The medical treatment team is required to involve the patient's family in their care, in order to cater for social factors in mental healthcare. Thus, the decolonisation of mental healthcare becomes important. Since decolonisation may help to improve teamwork and produce effective patient care. In the following section, the T7 Model (Lombardo & Eichinger 1995) is discussed in relation to this study.

4.4.3 T7 Model of team effectiveness

The T7 Model differs from the other teamwork models discussed in this study because it introduces external predictors (determinants) of team effectiveness. Lombardo and Eichinger (1995) developed the model in 1995. The model identifies seven factors, all starting with the letter "T", that affect team effectiveness in relation to mental healthcare. The model identifies five internal factors, namely *thrust*, *trust*, *talent*, *teaming skills*, and

task (Hansen 2017; Lombardo & Eichinger 1995; Mattia 2019). The two external factors are *team-leader fit* (the extent to which team members needs are satisfied by the team leader) and *team support* from the organisation (the extent to which organisational leaders assist members) (Lombardo & Eichinger 1995; Mattia 2019). Lombardo and Eichinger (1995) suggest that all seven factors must be present for the medical treatment teamwork to be effective. If any of the factors are lacking, the team might not be effective (Hansen 2017; Mattia 2019). Therefore, the T7 Model (Lombardo & Eichinger 1995) assumes that medical treatment teams become effective when team members learn to work collaboratively and accept goals that are patient-centred.

The medical treatment team members must trust and respect one another, communicate often and openly, and have expertise (talent). The team must have a leader who fits the needs of the team. The team leader and hospital or organisation must support the team to provide effective patient care. In the context of this study, the medical treatment team should work collaboratively, by accepting and respecting the role of each team member, as well as communicating effectively, and the team leader, who is part of the team, must be a HCP. The hospital, through its mental health policies, should promote a decolonial medical treatment team for patient care. Figure 4.3 is a graphical representation of the T7 Model.

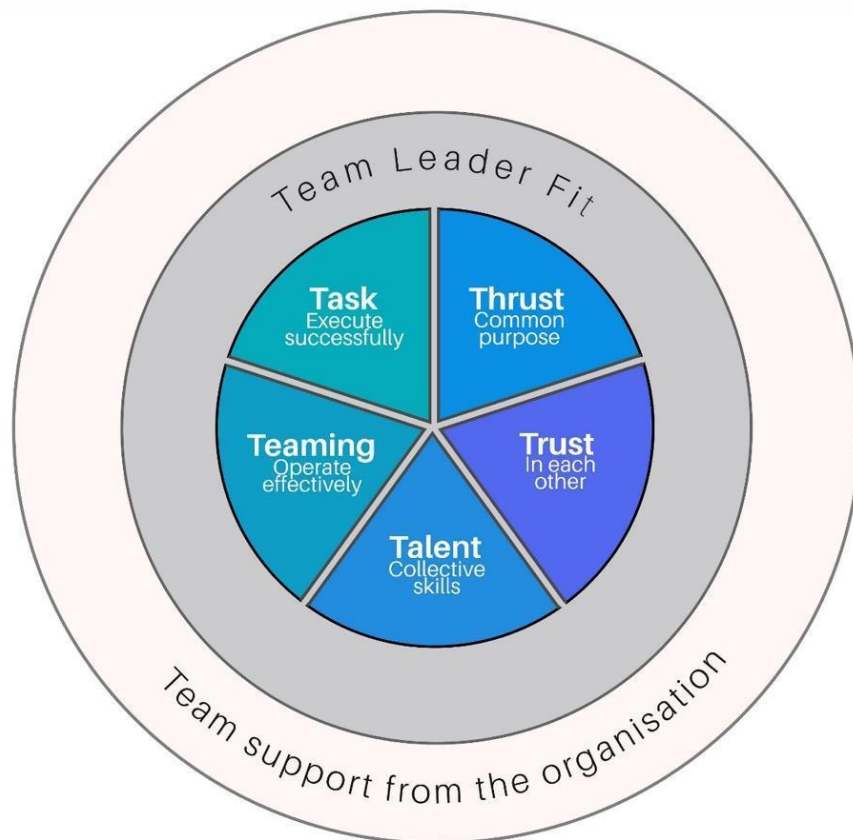


Figure 4.3: T7 Model of Team Effectiveness

(Source: Lombardo and Eichinger 1995:4)

In the next section, criticism of the T7 Model in relation to this study will be examined.

4.4.3.1 Criticisms of the T7 Model

The T7 Model has been critiqued for not including the key role of the leader in the team environment (Burke, Stagl, Klein, Goodwin, Salas & Halpin 2006; Swart 2017). Leadership support is a pre-requisite for a team to be a high performance team (Swart 2017). The effectiveness of the thrust, trust, talent, teaming, and task skills is dependent partly on the leadership of the clinical manager, in the context of this study (Swart 2017). Team leadership influences various elements of the medical treatment team including cooperation, information sharing, empowerment, commitment, and overall performance (Burke 2014; Swart 2017). For the purpose of this study, the clinical manager needs to ensure that the members of the medical treatment team cooperate, share information, empower each other, and implement both government and hospital policies during the care of a mentally ill patient. In light of the above discussion, it is clear that leadership is

an important concept that plays a key role in successful medical treatment teamwork management. Therefore, based on the literature reviewed (see section 4.2), a need to develop a comprehensive conceptual framework that will consider leadership as a prerequisite for effective medical treatment teamwork. In the next section, a discussion of the Lencioni Model will be provided.

4.4.4 Lencioni Model

This model is closely related to the GRPI Model (Rubin et al. in 1977) discussed in section 4.4.2 above, since it assumes that internal factors, such as trust, determine medical treatment team effectiveness. This model was developed by Lencioni in 2002. Lencioni (2002) suggests that all medical treatment teams have the potential to be dysfunctional and that teamwork can only be achieved if the team members overcome five obstacles, namely

- Dysfunction 1 - absence of trust,
- Dysfunction 2 - fear of conflict,
- Dysfunction 3 - lack of commitment,
- Dysfunction 4 - avoidance of accountability, and
- Dysfunction 5 - inattention to results.

These five conditions will be discussed in the following paragraphs.

4.4.4.1 Trust

This construct is linked to the T7 Model Lombardo and Eichinger (1995) discussed in section 4.4.3 above which emphasises that trust is a pre-requisite for team effectiveness. According to Lencioni (2002), the medical treatment team members must be vulnerable with each other. They must be able to acknowledge their personal shortcomings, feel free to make mistakes without judgement, and be able to request help from team members with strengths opposite to their own (Lencioni 2002). Lencioni's (2002) argument fits well with the African philosophy of ubuntu, which states that effective medical treatment teamwork can be achieved if members of the treatment team are caring, vulnerable, interdependent, generous, and support each other to provide patient care (Bush 2013; Ngondo & Klyueva 2022). Therefore, members of the medical treatment team are expected to be in solidarity and work collaboratively for patient care (Molala & Downing 2020).

According to Lencioni (2002), without trust the medical treatment team will not be able to solve problems (Bush 2013; Lencioni 2002). Researchers suggest that effective communication, as discussed above in section 4.3.5 should occur amongst team members in order to help built trust among team members (Buljac-Samardzic et al. 2020; Rosen et al. 2018). This reinforces the need for effective communication in medical treatment teams.

4.4.4.2 Conflict

Conflict is related to Tuckman's (1965) construct of storming, which states that all teams go through a stage of conflict. Lencioni (2002) states that medical treatment teams go through conflict and that this conflict may result in some loss of performance. Often, individuals in a team need to feel heard before committing to a decision, whether it is based on their idea or not (Lencioni 2002). Thus, communication becomes crucial in medical treatment teamwork.

4.4.4.3 Commitment

To achieve clarity, all members of a medical team must be aware that the decisions made are from their perspective and thus avoid hesitations about supporting the decisions (Bush 2013; Lencioni 2002). According to Lencioni (2002) all members of the medical treatment team must be able to fully support decisions and understand their respective member roles, for a team to be productive.

4.4.4.4 Accountability

When medical treatment team members are committed to a clear plan of action, they will be more willing to hold one another accountable for patient care (Bush 2013). The team could be unsuccessful when team members are not willing to approach their peers about their performance or behaviours (Lencioni 2002, 2005). This could be due to fear of conflict. Lencioni (2002) argues that ignoring these negative behaviours leads to resentment and deterioration of relationships, based on their failure to live up to expectations (Bush 2013; Lencioni 2002).

4.4.4.5 Results

According to Lencioni's (2002) trust is a fundamental aspect for ensuring treatment team effectiveness. the (as per the context of this research) must trust each other. These

HCPs (nurses, clinical managers, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists) must engage in a constructive conflict of ideas. So that all HCPs can commit to group decisions. HCPs must also hold their peers accountable, and collective results must be the team's overarching goal (Bush 2013; Lencioni 2002, 2005). However, as noted in chapters 3 and 5, the medical treatment team cannot work alone to provide patient care. The team needs to include the patient's family in order to achieve effective patient-centred care. Therefore, the medical treatment team needs to collaborate with the patient's family to achieve results. Thus, a decolonial medical treatment teamwork approach for mental healthcare is needed in SA. A graphical representation of Lencioni's model (Lencioni 2002) is presented in Figure 4.4.



Figure 4.4: Lencioni Model

(Source: Adapted from Lencioni 2005:11)

In the next section, criticism of the Lencioni Model in relation to this study will be examined.

4.4.4.6 Criticism of the Lencioni Model

Like Tuckman's (1965) model, the first two stages of Lencioni's Model (2002) do not contribute to team performance. This is because the first two stages barely improve team performance (Harris 2003). Therefore, this model is limited, since mental healthcare needs a fully functional team that aims to provide effective mental healthcare. In addition, the researchers maybe unaware of the challenges when the model is applied to settings in which Lencioni (2002) has less experience or in which Lencioni (2002) has not considered how other facilitators (besides himself) would apply the model.

Another critique of Lencioni's Model (2002) is associated with the credibility of the five dysfunctions. These five dysfunctions relate to the numerous claims made by Lencioni (2002). For example, Lencioni (2002) assumes that trust is the foundation of team effectiveness; however, there are other external factors that may have a far more significant effect on performance beyond the quality of interpersonal relationships, within a medical treatment team. These external factors can include the social aspect of the patient's family. As discussed in chapter 3, the family should be included in the mental healthcare as the family can influence the patient's adherence to treatment. Thus, the medical treatment team needs to collaborate with the patient's family for patient care. Lencioni's Model (2002) does not incorporate this social aspect. Therefore, a comprehensive conceptual framework that includes medical treatment teamwork and family as determinants of effective mental healthcare is required since Lencioni (2002) does not pay sufficient attention to the external factors that impact on a team's effectiveness. Furthermore, cultural factors are external factors that can affect teamwork. Hence, this study argues that a decolonial medical treatment team approach that caters for: cultural diversity amongst team members; team members collaborating with traditional healers for patient care; and team members being tolerant of and catering for the patient's cultural beliefs during mental healthcare. In the following section, the Theory of Collective Competence will be discussed.

4.4.5 Theory of Collective Competence: challenging the neo-liberal individualisation of performance at work

According to Boreham (2004), competence is considered a feature of an individual. In the case of this research, it refers to an HCP. Therefore, an HCP has the necessary knowledge, skills, and attitude to perform a task, that is, to provide mental healthcare to patients at the required standard. Boreham (2004) adds that individual competence is

necessary but not sufficient for effective healthcare. Thus, the Theory of Collective Competence to complement the concept of individual competence. The Theory of Collective Competence assumes that competence is jointly accomplished through the interdependent and emergent relationships amongst members of the medical treatment team. Therefore, collective competence is offered as both a contrast and a complement to individual competence (Lingard 2012). The theory suggests that mental healthcare cannot be addressed by any single HCP. Therefore, the Theory of Collective Competence suggests that mental healthcare requires professionals from multidisciplinary backgrounds to combine their unique skills and knowledge and work collaboratively, in order to provide effective healthcare. The Theory of Collective Competence upholds the notion that mental healthcare should be based on effective teamwork (Lingard 2012; Macke & Crespi 2016; Reilly 2018; Wang et al. 2018).

According to Reilly (2018) the medical treatment team must have set goals to attain patient care and strive to work in the same direction, in order to collectively achieve these goals. The theory suggests three normative principles to which a medical treatment team must conform to (Boreham 2004; Lingard 2012). These principles are discussed below.

4.4.5.1 Making collective sense of events in the workplace

According to Lingard (2012) to understand the situation, HCPs should position themselves within the more ordered structure of collective experience. Lingard (2012) adds that HCPs should have an exchange of feelings about the situation and focus on defining the boundaries of the occupational roles of those involved. The challenging situation provides material for narratives or stories which are exchanged within the team (Lingard 2012; Reilly 2018). The collective re-interpretation of these stories is the primary way in which the team makes sense of what is occurring in the given context (Lingard 2012; Liberati et al. 2019; McLean 2015). For example, the medical treatment team involved (nurses, medical officers, clinical psychologists, occupational therapists, psychotherapists, counsellors, social workers, clinical managers, and psychiatrists) will come together to discuss the patient's problem and exchange their feelings and understanding of the patient's problem.

4.4.5.2 Developing and using a collective knowledge base

According to Boreham (2004), the medical treatment team must possess knowledge resources in order for the medical treatment team to be effective (Lingard 2012; Macke

& Crespi 2016). Many organisations including hospitals, develop specialist sub-languages tailored to the specific events in their domains (Boreham 2004; Liberati et al. 2019; Von Krogh & Roos 1995). Even if members of the medical treatment team do not possess a specialist language, it is common to find a rich “organisational memory” to which the organisation’s members have access (Boreham 2004; Lingard 2012; Reilly 2018). Therefore, concepts of the work process formed in this way are maintained as concepts over time, and organisational members continue to refer to these in their conversations (Boreham 2004; Lingard 2016; Macke & Crespi 2016). Thus, collective knowledge is an organisation’s identity, which suggests that the uniqueness of an organisation depends on its capacity to develop a “knowledge structure”, which can be maintained (Boreham 2004). The organisation’s collective knowledge is maintained and renewed in such a way that this information will still be available even if a member of the treatment team terminates his or her work at the organisation (Bleakley 2014; Boreham 2004; Lingard 2012; Reilly 2018).

4.4.5.3 Developing a sense of interdependency

According to Lingard (2012), there must be a sense of interdependency between medical treatment team members. Therefore, the medical treatment team needs a powerful sense of interdependency, without which the members may act without regard for the collective purpose. Therefore, a medical treatment team must be constituted of diverse, knowledgeable individuals with different expertise (such as the clinical psychologist, psychiatrist, medical officer, social worker, nurse, pharmacist, occupational therapist, and psychiatrist) who are interdependent. These members must work interdependently to achieve collective competence for delivering effective medical care. The next section provides a discussion of criticisms of the Theory of Collective Competence (Lingard 2012) in relation to this study.

4.4.5.4 Criticisms of the Theory of Collective Competence

The Theory of Collective Competence has been critiqued for assuming that collective competencies and effective teamwork are necessarily direct (Jamil 2015). The theory assumes that collective competence leads to effective healthcare. This theory does not cater for the fact that other factors, such as leadership and mutual trust, amongst other factors also contribute to effective teamwork. The theory does not include external factors that influence healthcare. For example, the mentally ill patient receives treatment from the medical treatment team, but social aspects such as family influence his or her

adherence to mental health treatment. As noted in chapter 3, involving family in the treatment process helps the mentally ill patient feel more comfortable in adhering to treatment. Charles and Samarasinghe (2019) argue that family support is essential for the physical and psychological well-being of the patient.

Family also provides the medical treatment team with information regarding the patient's medical history especially in a case where the mentally ill patient has cognitive impairment (Koren et al. 2018). For example, family can provide this valuable information when a patient has dementia. Therefore, mentally ill patients need family support during medical consultations and treatment sessions. This is especially important when considering the cultural needs of the patient (Murdoch et al. 2017). The patient and the family cannot be separated especially in a society such as South Africa, where people are guided by the principles of ubuntu (see a detailed discussion on ubuntu in chapter 5). Therefore, this theory is lacking because it excludes the input of family members in mental healthcare. The treatment and care of a mentally ill patient requires a comprehensive approach that includes, active participation of the patient's family (Dirik et al. 2017; Javed & Herrman 2017; Raingruber 2013).

Based on the literature reviewed above, it is evident that effective medical treatment teamwork is crucial towards providing mental healthcare in South Africa. However, in the teamwork models, the aspect of teamwork inclusion is inadequate for a SA context since these models do not consider the patient's family as part of the medical treatment team. Hence, this study suggests the decolonisation of mental healthcare.

Furthermore, it is important to note that all the teamwork models discussed above examine issues related to goals, conflicts, trust, and teaming skills. None of these models consider the socio-cultural factors that can influence team effectiveness. As discussed in chapter 3, the mentally ill patient is influenced by socio-cultural factors. The models and theories also do not consider socio-cultural aspects which are fundamental to mental treatment teamwork. As discussed above, the socio-cultural consideration is two-fold, that is, for the patients and for the HCPs. The medical treatment team need to have cultural knowledge, attitudes, or personal attributes to maximise respectful team relationships. They may have different cultural world views and this can generate conflict within the team (Morley & Cashell 2017). Therefore, members of the medical treatment team need to be tolerant of other team member's cultures in order to be able to work collaboratively to provide effective mental healthcare as explain in chapter 5.

Thus, even though the medical treatment team plays a fundamental role, it is not sufficient in a country like South Africa where 80 per cent of South Africans are influenced by socio-cultural factors. Researchers have noted that mental healthcare must be context specific (Charles & Samarasinghe 2019; Dirik et al. 2017; Kuo et al. 2018; Ndeti 2007; Tjale & de Villiers 2018; Zingela et al. 2019). Therefore, the medical treatment team must consider socio-cultural factors when treating mentally ill patients, in South Africa. Therefore, this study advocates for the decolonisation of mental healthcare in South Africa. Since decolonisation will allow the medical treatment team to cater for cultural diversity within the medical treatment team. By allowing collaboration between the medical treatment team and trained traditional healers, and also allow the medical treatment team to cater for the cultural aspects of the patient during mental healthcare. Furthermore, decolonisation will allow the medical treatment team to involve the participation of the patient's family (a socio-cultural element), and a medical treatment team of specialised HCPs in mental healthcare. Involvement of all these team members in a co-operative and co-ordinated manner is imperative to supporting mental healthcare (Morley & Cashell 2017).

4.5 SUMMARY

This chapter provided a discussion of selected teamwork models and theories. Criticisms of the selected models and theories were provided to indicate the constraints of these models in relation to mental healthcare in the South African context. As discussed in chapter 3, cultural factors also influence healthcare; therefore, cultural factors should be considered in mental healthcare. In the next chapter, the researcher diverges from teamwork approaches to discuss cultural and decolonial theories that relate to mental healthcare for the purposes of this study.

CHAPTER 5: LITERATURE REVIEW PART 2: CONTEXTUALISING HEALTH COMMUNICATION IN RELATION TO CULTURAL AND DECOLONIAL APPROACHES

5.1 INTRODUCTION

Discussions in the preceding chapter suggested that while teamwork factors influence the behaviour of mentally ill patients, socio-cultural factors must also be considered in healthcare since both culture and family inclusion plays a critical role in mental healthcare (Keikelame & Swartz 2019; Penson 2019). As discussed in chapter 3, South Africans use traditional medicine for healthcare prior to the era of colonialism and this is still ongoing to date (Cooper 2015; Keikelame & Swartz 2019; Nmutandani et al. 2018). After colonialism, healthcare was exposed to European culture. Europeans discouraged the traditional healing system and introduced the biomedical approach to healthcare (Van Rensburg 2012). Although traditional healing was relegated as inferior and ineffective, it survived as most South African use both traditional and biomedical approaches to mental healthcare (Abbo 2011; Coovadia et al. 2009; Nmutandani 2016; Van Rensburg 2012). This study argues that mental health care, that considers a collaborative approach and includes both traditional and biomedical medicine, could enhance mental healthcare in South Africa. Thus, there is a need for a comprehensive conceptual framework that covers the broader perspectives relating to mental healthcare. It is within this context that this chapter explores cultural theories in relation to mental healthcare in South Africa.

It was noted in chapter 3 that the decolonisation of mental healthcare could help enhance mental healthcare in South Africa, since decolonisation will allow medical treatment teams to consider culture, which is fundamental to mental healthcare (Keikelame & Swartz 2019; Nmutandani et al. 2018; Penson 2019). Decolonising mental healthcare is imperative as decolonisation offers different pathways for reconnecting indigenous nations like South Africa with their traditional and cultural practices (Morrow & Malcoe 2017; Pilon, Benoit & Maar 2019). To advance the argument on the decolonisation of mental healthcare in South Africa, this chapter provides a discussion of decolonial theories as applied to mental healthcare in a South Africa context.

In essence, this chapter consists of two sections, namely section one which explores selected cultural models/theories in relation to mental healthcare in South Africa. While section two provides a discussion on selected decolonial models in relation to mental

healthcare in South Africa. In the first section, the selected cultural models discussed include: The Theory of Cultural Care, Diversity and Universality (Leininger 1988), the PEN-3 Model (Airhihenbuwa 1989), The Culturally Competent Model of Care (Campinha-Bacote 1995), and Cultural Safety Theory (Ramsden 2002). These models/theories are discussed in order to acknowledge existing literature on cultural theories for the purposes of this study. This section also provides criticisms of these cultural models to contextualise the need for a comprehensive conceptual framework for mental healthcare in South Africa.

In the second section, the selected decolonial theories include: Decolonial Theory (Quijano 1990), Indigenous Standpoint Theory (Foley 2003), and Southern Theory (Connell 2007). The selection of these theories is based on the need to acknowledge existing decolonial theories and their implication for mental healthcare in South Africa. The exploration of these theories is done against the background of earlier discussions regarding the need to decolonise mental healthcare in the South African context. This section also provides criticisms of the decolonial theories to elaborate the need for a decolonised framework for mental healthcare in SA.

5.2 CULTURAL MODELS AND THEORIES

In chapter 3, it was noted that culture affects all aspects of health, interpretation, communication, social support, and ultimately overall healthcare and wellbeing (Nemutandani 2016; Sigida 2016). Zingela et al. (2019) argue that people from different cultural contexts seek healthcare based on the meaning that these different cultural backgrounds assign to suffering and healthcare. Therefore, to accurately diagnose and treat mentally ill patients, it is important to consider the cultural meaning of symptoms and mental illness in general (Ibrahim & Morrow 2015; Morrow & Malcoe 2017; Robb 2012). Thus, the medical treatment team should consider the cultural influences and health behaviours related to mental illness and recovery and translate that awareness into culturally congruent mental healthcare (Crawford et al. 2016; Morrow & Malcoe 2017). Providing culturally appropriate care eliminates health disparities, minimises risk, and decreases diverse patient safety incidents (Morrow & Malcoe 2017; Nemutandani 2016).

Cultural models and theories argue that culture plays a fundamental role healthcare (Iwelunmor, Airhihenbuwa & Newsome 2014). Thus, this study advocates for the inclusion of culture as one of the determinants of mental healthcare in the South African

context. The next section provides a discussion on selected models and theories. In the context of this study, these cultural models and theories are discussed to acknowledge existing cultural models and theories that have been applied in communication research. Furthermore, these models are explained because they provide a broader understanding of human behaviour.

The cultural models and theories draw attention to cultural factors which are absent or lacking in the teamwork theories and are, therefore, appropriate for this study because they have been used in communication research (Ashkinazy 2017; Isabelle 2014; McGough, Wynaden & Wright 2018; Portugal 2018). These models are discussed as they emerged in chronological sequence of development.

5.2.1 Theory of Cultural Care, Diversity, and Universality

The Theory of Cultural Care, Diversity, and Universality was developed by Leininger in 1988, with the goal of providing culturally congruent healthcare. According to the theory of Cultural Care, Diversity and Universality (1988), nurses must take into account the cultural beliefs of patients. Therefore, the medical treatment team must consider the different cultural backgrounds of the patients, in order to provide culturally congruent treatment to mental health patients in South Africa. Leininger (1991) contends that if professional healthcare ignores the culture of the patient, this might affect the patient's recovery and well-being and thus result in healthcare that is not culturally congruent with the beliefs of the patient. Moreover, this study argues that cultural consideration also extends to members of the medical treatment team. Owing to the cultural diversity in South Africa, members of the medical treatment team also need to cater for the cultures of other team members. In order to work collaboratively in providing effective culturally congruent care to individual patients. To provide culturally congruent healthcare, the medical treatment team must consider team members' cultures and link and synthesise generic and professional care knowledge to benefit the mentally ill patient (Leininger 1988; Jooste 2018). A graphical representation of the theory is presented in Figure 5.1.

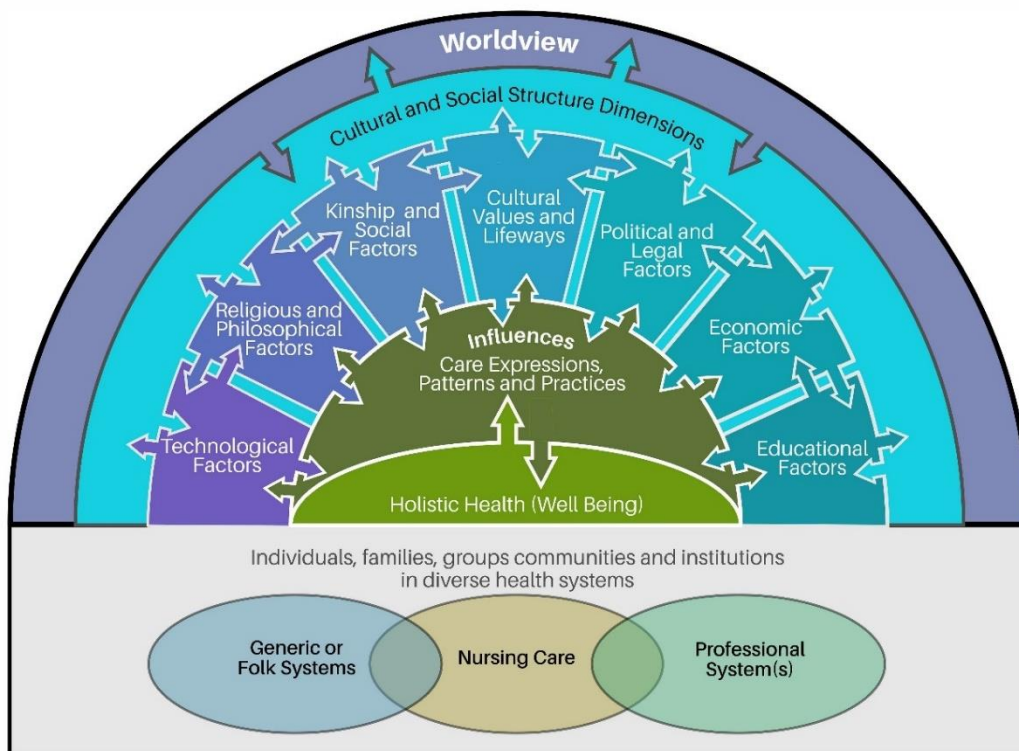


Figure 5.1: Theory of Cultural Care, Diversity, and Universality

(Source: Leininger 1997:46)

According to Leininger (1991), the following tenets are important in understanding the theory:

5.2.2.1 Nurses worldview and associated cultural and social structure

The theory begins with the nurse's world view and the associated cultural and social structure (Leininger 1988). The nurse's world view is influenced by their work environment (Leininger 1988). For example, education and availability of resources significantly influence the care practices of nurses. Furthermore, the values and beliefs of the culture within hospitals also influence mental healthcare practices. When the culture of the nurse prioritises the delivery of culturally competent care for patient, the nurse adopts these beliefs and values. Hence, this study argues that both the culture of members of the medical treatment team and the culture of the patients should be considered for mental healthcare, in the South African context. As discussed in chapters 2 and 3, one of the causes of non-adherence to mental healthcare is the failure of nurses

to recognise the patient's traditional beliefs (Batisai 2016; Bene & Darkoh 2014; Nmutandani 2016; Sigida 2016). Therefore, to provide effective healthcare, the medical treatment team needs to learn about their patient's interpretations of their health condition (Chichirez & Purarea 2018; Muth et al. 2014). This will help the medical treatment team to provide relevant information to help the patient to make sense of their healthcare. Without an understanding of the patient's traditional beliefs, the medical treatment team cannot provide culturally congruent care. Therefore, it is imperative for the medical treatment team to understand the patient's world view. This can be done by communicating with the patient's family.

According to this theory, the nurse needs to consider the experiences, care practices, and unique needs of the mentally ill patient in order to provide effective care to the patient. This knowledge provides meaning and expression to care. As noted in chapter 3, the medical treatment team needs to provide care that is relevant to the patient's unique needs since the patient's needs influence their adherence to mental health treatment. To obtain knowledge about the patient, effective communication between the medical treatment team and the patient's family needs to take place (Chichirez & Purarea 2018; Warnecke 2014). Therefore, effective communication is imperative to understand the unique needs of the patients.

5.2.2.2 The generic or folk care, professional care-cure practices, and nursing care practices

The next level is focus on the generic or folk care, professional care-cure practices, and nursing care practices. This allows for the recognition of similarities and differences, or cultural care universality and cultural care diversity (Leininger & McFarland 2006). According to the Theory of Cultural Care, Diversity, and Universality (1988), care decisions and care practices are strongly influenced and supported by the cultural environment. Therefore, HCPs who form part of the medical treatment team must consider the cultural environment of their mental patients.

5.2.2.3 Nursing care

The next level involves nursing care. According to the theory of Cultural Care, Diversity, and Universality (1988), nursing care must be delivered with decisions and actions that are culturally competent. Thus, the medical treatment team needs to deliver care with empathy, positive regard, and congruence. These three qualities may help patients face

their problems and thus motivate the patient to adhere to treatment (Monterio 2015; Zingela et al. 2019). There is consensus in the literature that nurses are the largest group of HCPs providing mental healthcare in South Africa (Halcomb et al. 2018). For example, in one study, it was found that nurses spent more time with the patients and were always available to receive the patients (McInnes et al. 2022).

5.2.2.4 Cultural care, preservation and maintenance

The next tenet is cultural care, preservation and maintenance. This tenet states that the action of nurses must support, assist, and enable mentally ill patients to recover from illnesses. An example would be to educate the patient's family members and involve them in their healthcare since family members support and assist patients during recovery. Green (2018) suggests that the medical treatment team should provide family members with information that can enable them carry out their caring role effectively. However, Hungerford and Richardson (2013) emphasise that this information should be tailored to the patient's specific experience and needs, as discussed in chapter 3. This discussion reinforces the need for the medical treatment team to include the family in mental health care in South Africa as reiterated throughout chapters 2, 3 and 4.

5.2.2.5 Actions by the HCPs that assist the mentally ill patients while respecting the patient's cultural values

This level involves actions by the HCPs that assist the mentally ill patients to change their life patterns and become healthier, while respecting the patient's cultural values (Leininger & McFarland 2006; Legg 2018; Ritchie & Roser 2018). Thus, it is important that mental healthcare is culturally relevant to the individual patients (Leininger & McFarland 2006). Next, the criticisms of the Theory of Cultural Care, Diversity, and Universality will be discussed.

5.2.2.6 Criticisms of The Theory of Cultural Care, Diversity, and Universality

Culture is one of the most important determining factors in healthcare. Thus, the need to consider cultural factors in healthcare is undeniable as discussed in chapter 3 (Leininger 2002). The Theory of Cultural Care, Diversity, and Universality caters for cultural aspects, but the model is still limited in acknowledging the role of the entire medical treatment team in mental healthcare. The theory only focuses on nurses providing culturally congruent care to patients (Leininger 2002). Even though nurses play a

fundamental role in healthcare, they also need to collaborate with other healthcare workers, such as clinical psychologists, clinical occupational therapists, medical officers, clinical managers, pharmacists, social workers, and psychiatrists in order to provide mental healthcare for patients. As noted in chapter 4, medical treatment teamwork is imperative to mental healthcare (Bene & Darkoh 2014; Wang et al. 2018). Nurses cannot work alone to provide effective healthcare in a mental healthcare context. They need the expertise of other HCPs. Nurses need to effectively communicate with other HCPs and work together as a team to provide effective patient healthcare (Bene & Darkoh 2014; Gautier 2015). Hence a comprehensive conceptual framework that caters for a diverse medical treatment team approach to mental healthcare is needed.

Moreover, the Theory of Cultural Care, Diversity and Universality only focuses on patient care in a cultural context (Lenardt et al. 2021; Mohamed 2019). The theory does not focus on medical symptoms or treatments (Mohamed 2019). However, medical symptoms and medical treatments are also imperative in healthcare (Legg 2018). As noted in chapter 2, a person needs to undergo a physical examination in which a doctor tries to determine the physical problems that cause symptoms, or via a laboratory test. For example, a screening for alcohol and drug addiction, or a psychological evaluation in which an HCP communicates with the person or the patient's family about their symptoms, feelings, and behavioural patterns to check for symptoms and determine a diagnosis for mental illness (Burns & Roos 2016; Legg 2018).

Thus, it is essential for the medical treatment team to ascertain the type of mental illness diagnosis in order to develop and implement an evidence-based treatment plan for the patient (Burns & Roos 2016; Legg 2018). Therefore, medical symptoms and treatment diagnosis are extremely important in managing mental healthcare. As discussed in chapter 3, even though 80 per cent of South Africans are influenced by their cultures, they also make use of biomedicine in their mental health treatment (Jacobs & Coetzee 2018). It is thus important to consider biomedicine in overall mental healthcare. This reinforces the need to develop a framework which considers a collaboration between both cultural and biomedical factors in mental healthcare. The following section discusses the PEN-3 model, as well as its constructs and criticisms in relation to mental healthcare in the South African context.

5.2.2 PEN-3 model

The PEN-3 Model was developed by Airhihenbuwa (1989) for health promotion in Africa. This is a health promotion model, but it also suggests a cultural approach to healthcare. Even though this model emerges from a health promotion background, it was explored in this study because the model emphasises cultural appropriateness, in relation to the beliefs and values of the patient and members of the medical treatment team. It emphasises the need for the medical treatment team to be culturally sensitive towards other team members and to provide culturally congruent care to mentally ill patients. Therefore, the PEN-3 Model is applied in this research context because this study advocates that the patient's culture plays a vital role in treatment and care of the mentally ill patient.

Airhihenbuwa (1989) suggests that healthcare should focus on cultural values that nurture the patient's behaviour. The model emphasises culture as a central determinant of human behaviour (Airhihenbuwa 1989). This is because healthcare that is culturally appropriate could enhance behavioural outcomes that would lead to effective mental healthcare (Jacobs & Coetzee 2018; Monterio 2015; Zingela et al. 2019). Thus, the model provides a guideline for ensuring that mental healthcare is culturally congruent (Cowdery, Parker & Thompson 2010). This model has been used to address healthcare interventions such as HIV/AIDS, Ebola, smoking, and stress (Dunleavy, Chudnovskaya, Phillips & McFarlane 2017; Olufowote & Aranda 2018; White, Garces, Bandura, McGuire & Scarinci 2012).

The model also emphasises the need for members of the medical treatment team to tolerate the cultural values of other team members. This is because cultural tolerance may improve patient healthcare as well as strengthen the HCP–HCP teamwork relationship. Therefore, members of the treatment team need to educate themselves with cultural knowledge about the patient, as well as be tolerant of the cultural values of other team members (Airhihenbuwa 1989; Crawford et al. 2016; Johnson et al. 2017). A graphical representation of the PEN-3 Model is presented in Figure 5.2.

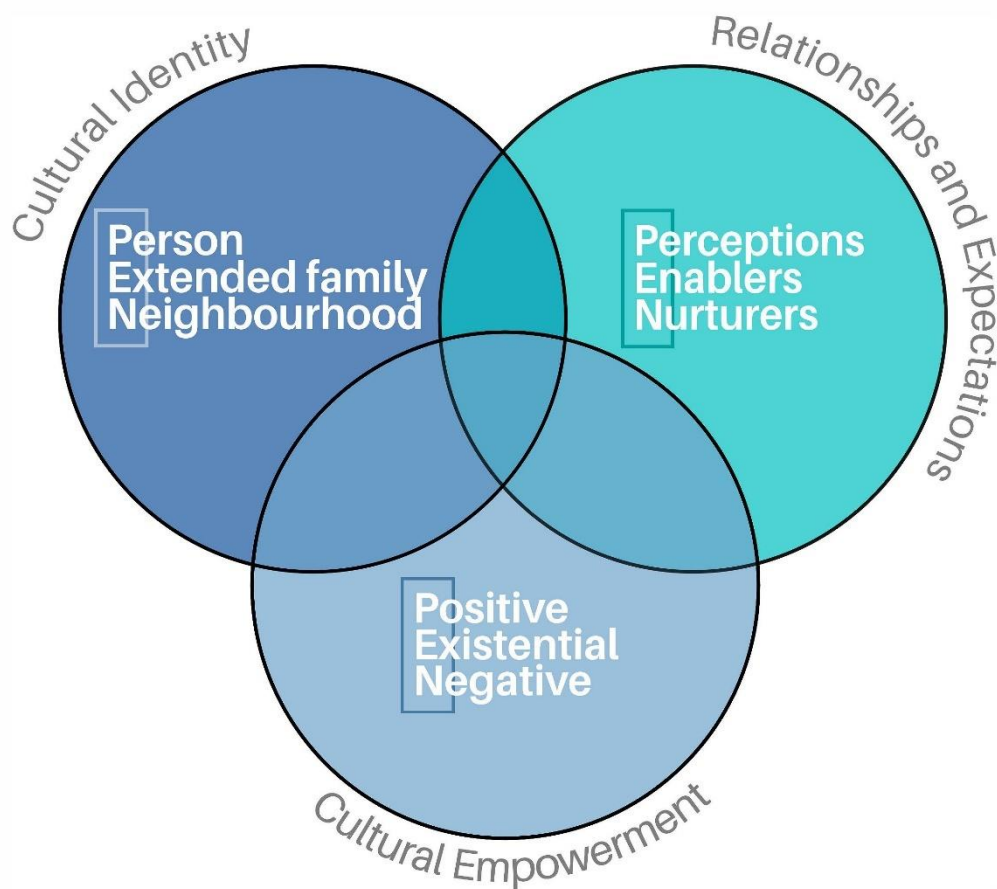


Figure 5.2: The PEN-3 Model

Source: Airhihenbuwa and Webster (2004)

The constructs of the PEN-3 Model are explained in the sections below.

5.2.2.1 Cultural identity

This construct is closely related to the ubuntu philosophy (as discussed in section 5.4) since it defines a person with reference to the community to which they belong (Molefe 2011; Nzimakwe 2014). The construct of cultural identity consists of the following domains: person, extended family, and neighbourhood (Airhihenbuwa 1989). The domain “person” can be referred to as the mental health patient who should be stimulated to make health decisions based on adequate information (Airhihenbuwa & Webster 2004). “Extended family” is referred to as the core family as well as important others who are perceived as family (Airhihenbuwa 1989; Chemuru & Srinivas 2015). Lastly,

“neighbourhood” can be referred to as the community or environment in which the patient lives. For the purposes of this study, the community members of the patient will include the patient’s family members and traditional healers who provide patient care.

According to Airhihenbuwa (1995), the community is a collective space in which mentally ill patients develop their sense of identity. Airhihenbuwa (1995) argues similar to the ubuntu philosophy, that a patient’s connectedness to community influences their behaviour. This is so especially in the context of a mental patient who can be in some cases cognitively impaired and therefore cannot make their own decisions (see a detailed discussion of ubuntu in section 5.4). Therefore, this construct suggests that persons, extended family, and neighbourhoods are determinants of a patient’s behaviour (Airhihenbuwa 1995; Airhihenbuwa & Webster 2004). As noted in chapters 2 and 3, effective patient care can be achieved if the medical treatment team collaborates with the patient’s family and the community. Therefore, this construct reinforces the need to decolonise mental healthcare in South Africa.

5.2.2.2 Relationships and expectations

This construct has three domains, namely perceptions, enablers, and nurturers (Airhihenbuwa & Webster 2004; Chmuru & Srinivas 2015). Airhihenbuwa (1989) suggests that perceptions, enablers and nurturers are determinants of health behaviour. “Perceptions” relates to aspects such as knowledge, attitudes, values, and beliefs that may promote or hinder behavioural outcomes. As noted throughout this study, patients’ family members can influence their mental healthcare. Thus, the medical treatment team can play a fundamental role by interactively communicating with the patient’s family in order to understand the patient’s perceptions of mental illness (Kiwala 2018). The team can also use these interactive sessions to educate the patient’s family on mental healthcare (Stacey et al. 2017). “Enablers” refer to environmental influences and resources that could enhance or limit behavioural outcomes (Cowdery et al. 2010). Examples of enablers are mental health education programmes, accessibility to mental healthcare providers, and all forms of support. The last domain, “nurturers”, includes partners, family, and community members who may influence a patient’s behaviour (Airhihenbuwa 1989; Kline 2007). In chapters 2 and 3, it was noted that perceptions, enablers (such as access to hospitals), and nurturers such as family influence mental healthcare. Thus, it is important to consider both the medical treatment team and the patient’s family members in mental healthcare.

5.2.2.3 Cultural empowerment

Airhihenbuwa (1989) argues that positive perceptions should be encouraged in healthcare. The discussion in chapter 3 suggested that the patient's family can contribute to the promotion of healthy behaviour of the patient. Mentally ill patients, especially those with severe mental illnesses, do not always follow their treatment plans (Kiline 2007; Papageogiou, Loke & Fromage 2017). Therefore, the patient's family can motivate them to adhere to treatment and help them through the treatment process (Al-Mandhari et al. 2009; Charles & Samarasinghe 2019; Papageogiou et al. 2017). The MHCA 17 of 2002 discussed in chapter 3 also acknowledges the role of the family in mental healthcare. Thus, the patient's family is considered part of the social structure that influences the patient's healthcare (Charles & Samarasinghe 2019; Dirik et al. 2017; Olasoji et al. 2017). The results from a study conducted by Al-Mandhari et al. (2009) suggested that a patient's adherence to treatment is associated with their cultural beliefs. Literature reviewed in chapter 3 suggested that the social aspect of the family should be considered in mental healthcare since families play an important role by supporting and motivating patients. Fanon (1965) argues that the family is the site of psychodrama and the place where cultural parenting and psychopathology emerge. Therefore, the social aspect of the family plays an important role in healthcare.

According to Airhihenbuwa (1989), the medical treatment team should focus on the good influence of culture in mental healthcare. The medical treatment team can play an important role in the health of the patient by providing care that considers the positive cultural values of the mentally ill patient (Olufowote & Arande 2018). In the next section, criticism of the PEN-3 Model is discussed.

5.2.2.4 Criticisms of the PEN-3 model

The PEN-3 Model neglects other factors such as socio-economic status, which influence mental healthcare (Jacobs & Coetzee 2018; Viviers 2017). As noted in chapters 2 and 3, socio-economic status influences healthcare choices in South Africa. Over 30.4 million South Africans still live in poverty (Statistics South Africa 2019). Therefore, many South Africans are struggling to earn a livelihood and lack access to hospitals and clinics. Many South Africans living in rural areas do not have the financial resources to pay for transport to visit hospitals. Therefore, traditional healers are the first point of call for people living in rural areas (Nemutandani 2016; Van Rensburg 2012; Zingela et al. 2019). There are many traditional healers throughout South Africa, and they are economically affordable.

Since most healers live in the community and patients do not have to incur transportation costs to consult with them (Batisai 2016; Morrow & Malcoe 2017; Nmutandani 2016; Tjale & de Villiers 2014). The decolonisation of mental healthcare could assist the mental healthcare of South Africans, especially those who are socio-economically disadvantaged (Jacobs & Coetzee 2018; Lovell 2009; Monterio 2015; Nmutandani 2016).

Furthermore, the PEN-3 Model assumes that health behaviours develop within a culture and that this culture will reinforce or resist these behaviours via systems such as, the family or traditional beliefs of the patient (Airhihenbuwa, 2004). Therefore, the model does not consider the fact that the medical treatment team can influence the behaviour of the patient by providing information, diagnosis, and treatment related to mental illness (Rosen et al. 2018). Hence, this study advocates that the medical treatment team should work collaboratively with the patient's family and traditional healers to provide mental healthcare, since all these stakeholders influence patient care. Furthermore, there is a need to propose a conceptual framework that considers the patient's family, the patient's culture, and a medical treatment team approach to mental healthcare. In essence, this study argues that socio-cultural context should be considered in mental healthcare. The socio-cultural context, in the context of this study, includes catering for medical treatment team diversity, patient cultural diversity, and family involvement in mental healthcare. This study advocates for the decolonisation of mental healthcare which includes three aspects: catering for the cultural diversity within the medical treatment team; medical treatment team collaboration with traditional healers; and catering for the individual patient's culture in a mental healthcare context. Thus, there exist a need for a conceptual framework which caters for all the above-mentioned aspects, that influence mental healthcare in the South African context.

5.2.3 The Culturally Competent Model of Care

The Culturally Competent Model of Care was proposed by Campinha-Bacote in 1995. Campinha-Bacote (1998) assumes that cultural competence is a process in which the HCP continuously strives to achieve the ability to work within the cultural context of an individual, family, or community from a diverse cultural or ethnic background. This assumption is in line with this study since it advocates for collaboration between the HCPs such as nurses, the family, and the community (traditional healers) in mental healthcare. This model is closely related to the PEN-3 Model (Airhihenbuwa 1989) since

it contains similar constructs which suggest that the family and community influence health behaviour of mentally ill patients. Thus, a need to decolonise mental healthcare in South Africa, since decolonisation will allow the involvement of the patient's family, the community, and the HCP team in mental healthcare.

In the context of this study, an awareness of cultural competence aims to provide safe and effective mental health services that are individualised to cultural needs (Augustus et al. 2019; Campinha-Bacote 2002; Walker, Schultz & Sonn 2014). For example, in order to deliver effective mental healthcare, such services have to develop a safe therapeutic environment, which relies on effective communication between members of the medical treatment and the patient's family. Therefore, in order to provide an effective and culturally responsive mental healthcare service to the multicultural population of South Africa, the medical treatment team needs to be culturally aware (Campinha-Bacote 2002).

Cultural competence includes five constructs, namely *cultural awareness*, *cultural knowledge*, *cultural skills*, *cultural encounter*, and *cultural desires* (Campinha-Bacote 2002). Together these five constructs lead to cultural competence. The first construct, *cultural awareness*, requires individuals to become sensitive to values, and cultural beliefs of patients. Therefore, nurses must examine their biases and prejudices towards patients from different cultural backgrounds. The second construct, *cultural knowledge*, requires the nurses to acquire an educational foundation with respect to various cultural world views. In the context of this study, the nurses needed to be aware of their own beliefs while being open to cultural beliefs of others. Thus, the theory argues for the need to have cultural knowledge in relation to the patient and other team members (Johnson et al. 2017). The third construct, *cultural skills*, involves the process of learning how to conduct an accurate cultural assessment. The fourth construct, *cultural encounter*, encourages the nurses to expose themselves in practice to cross-cultural interactions with clients of diverse backgrounds. The fifth construct, *cultural desires*, refers to motivation of the nurse to participate in the process of becoming culturally competent (Campinha-Bacote 1998, 2002; Jooste 2018; Sargent, Sedlak & Martsolf 2005). A graphical representation of this model is presented in Figure 5.3.

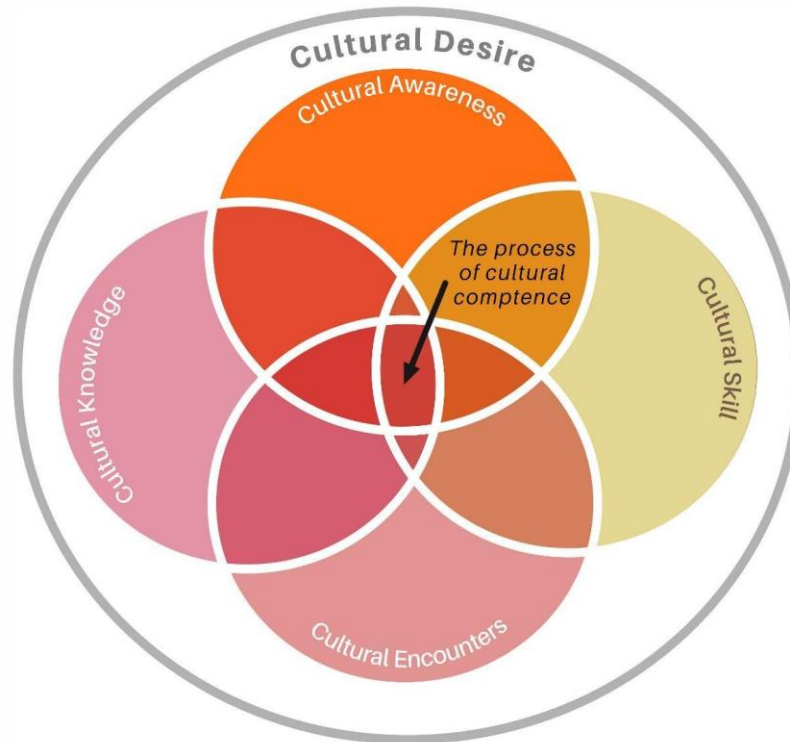


Figure 5.3: The Theory of the Culturally Competent Care

(Source: Sargent, Sedlak and Martsolf 2005: 215)

5.2.3.1 Criticisms of the culturally competent model of care

Although the Culturally Competent Model of Care has been used in health communication research, its application is limited (Clarke 2017; Louw 2016; Saha, Beach & Cooper 2010). Researchers have noted that this model is more applicable to a nurses' curriculum where nurses have to undergo multicultural training and education in order to provide culturally appropriate mental healthcare (Hartwell & Myhra 2018; McDowell & Hernandez 2010; Nelson & Prilleltensky 2010). Even though the Culturally Competent Model of Care caters for family and community perspectives to mental healthcare, the model is lacking in that it is limited to nurses. Thus, not applicable to other medical treatment team members such as, the clinical psychologist, medical officer, pharmacist, occupational therapist, psychiatrist, and social worker (Polaschek 1998). Therefore, a comprehensive conceptual framework that caters for all members of the medical treatment team (including nurses, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists) from a mental healthcare perspective. The next section presents a discussion on Cultural Safety Theory.

5.2.4 Cultural Safety Theory

Ramsden (2002) was the proponent of the Cultural Safety Theory. The term "cultural safety" encompasses the idea that mental health patients need to "feel safe" when accessing health care services (Anderson et al. 2003; McGough et al. 2018; Ramsden 2002). Ramsden (2002) argues that nurses need to consider the cultural values of the patient. Failure to do so risks alienation of the patient from health services and potentially places the patient at risk of a less than optimal treatment outcome (Anderson et al. 2003; Ramsden 2002; Yeung 2016). Kirmayer (2012) argues that consideration should be given to cultural safety in mental healthcare. Therefore, the nurses need to cater for the culture of the individual patient during mental healthcare.

At the centre of this theory is the acknowledgement that in any healthcare relationship two cultures are interacting. That is, those of the nurse and the patient's family because some patients may not be able to communicate or make decisions for themselves. In the context of this study, the purpose of this interaction is for the medical treatment team to learn about the patient's perception of mental illness. This interaction also enables the medical treatment team to provide the patient's family with necessary information, that can empower the family to make informed decisions about mental health treatment. Since some patients may not be clinically stable to make decisions for themselves. Therefore, the determinants of healthcare are defined by the family of the mentally ill patient together with the medical treatment team (Ramsden 2002). Cultural Safety Theory highlights the need for acceptance rather than assimilation of difference (DeSouza 2008; Mortensen 2010; Yeung 2016). Traditionally, nurses have based mental healthcare on their individual and professional definitions of "appropriate" care (Ramsden 2002). Cultural Safety Theory suggests that nurses should evaluate their beliefs and values and also recognise the potential for nurses imposing their beliefs on the patients (McGough et al. 2018; Ramsden 2002).

Ramsden (2002) adds that nurses should suspend their own cultural context and consider the needs of the patients in order to enhance patient healthcare (Chichirez & Purarea 2018; Muth et al. 2014), the need for mental health practitioners to practice cultural safety is vital in ensuring meaningful healthcare for mental health patients. Cultural Safety Theory is particularly relevant to mental healthcare as it seeks to promote cultural integrity (McGough et al. 2018).

Cultural Safety upholds the idea of decolonisation since it encourages nurses to consider the cultural of the patient during mental healthcare (DeSouza 2008; Mortensen 2010;

Ramsden 2002; Yeung 2016). The theory encourages respectful consideration of both the patient and the nurse as individuals with unique experiences, histories, and position in relation to the healthcare system (Anderson, Perry, Blue, Browne, Henderson, Khan & Smye 2003). Ramsden (2002) argues that the progression towards culturally safe practice includes three steps, namely *cultural awareness*, *cultural sensitivity*, and *cultural safety*. A graphical representation of Cultural Safety Theory is presented in Figure 5.4.

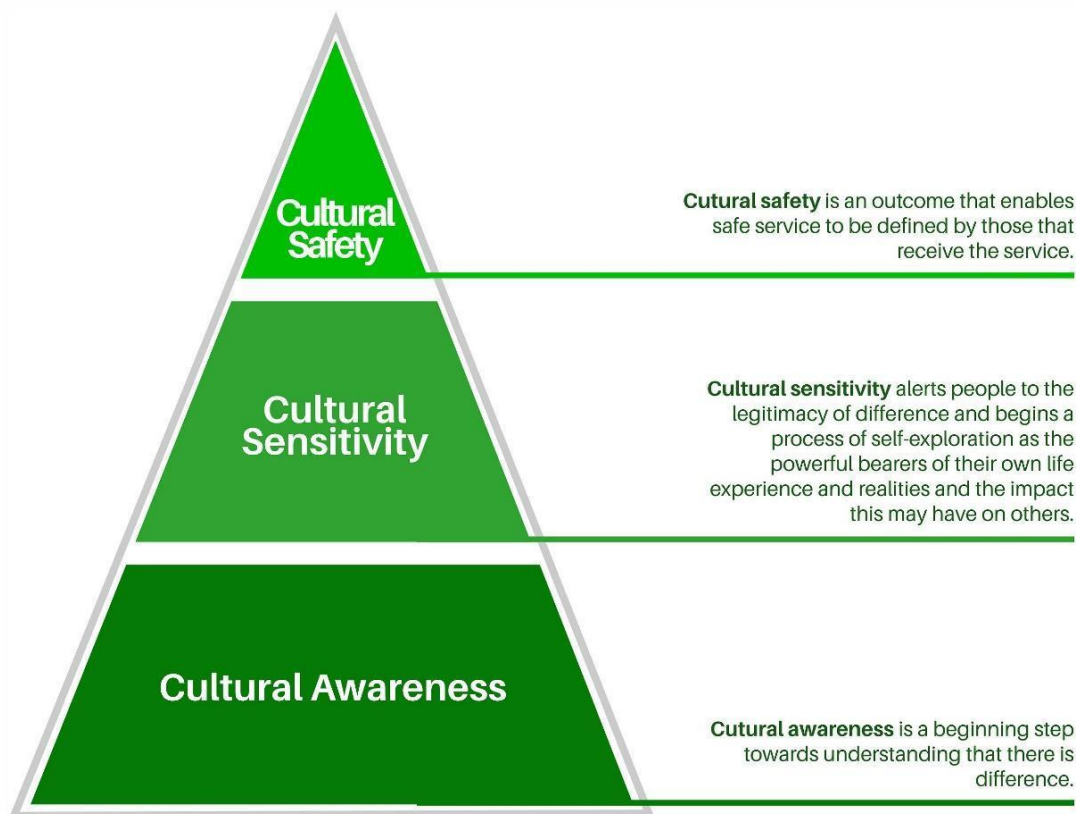


Figure 5.4: Cultural Safety Theory

(Source: Adapted from Ramsden 2002:117)

The three steps of the Cultural Safety Theory are discussed below.

5.2.4.1 Cultural awareness

Cultural awareness is defined as understanding that differences exist in what cultural beliefs? (Ramsden 1992). In the context of this study, the medical treatment team must gain knowledge and skills related to the patient's perception of mental illness and the patient's socio-cultural context. It is important to note that this construct is related to The Theory of Cultural Care, Diversity, and Universality (Leininger 1997) since it focuses on

the cultural, social, political, and economic factors that influence how the nurse delivers mental healthcare.

5.2.4.2 Cultural sensitivity

This construct suggests that nurses should not let their experiences influence healthcare (Ramsden 2002). The focus should be on providing culturally congruent care to the mentally ill patient. It is important to note that each medical treatment team member also needs to respect the culture and experiences of other team members in order for effective teamwork to take place (Cagiltay et al. 2015). South Africa has a diversity of cultures; thus, it is likely that the medical treatment team members may come from different cultural backgrounds. Cultural differences could potentially result in negative outcomes such as conflict and ineffective communication (Ramsden 2002). Therefore, members of the medical treatment team should use their cultural difference for synergy, rather than letting it become a cause for conflict (Harris & Moran 1996). The medical treatment team members should respect each other's cultures and not let their different experiences or cultural backgrounds impact negatively on teamwork.

5.2.4.3 Cultural Safety

This construct advocates for patient-centred care as per discussion in chapter 3. As noted in chapter 2 and 3, HCP's use the biomedical approach to healthcare which is an illness-centred approach. With the biomedical approach, the nurses determine which treatment is best for the patient. There is little or no input from the patient's family, in the context of mental healthcare. Cultural Safety suggests that this should not be the case. Cultural safety argues that the medical treatment team is required to provide treatment that is culturally, socially, and emotionally safe for patients and where there is no judgement or denial of the patient's needs (DeSouza 2008; Higgins 2010; Kim, Kim & Kelly 2006). Thus, decolonisation will enable the medical treatment team to cater for cultural diversity within the medical treatment team. By allowing collaboration between the medical treatment team and traditional healers, as well as enabling the medical treatment team to cater for individual patient culture, in mental healthcare. Decolonisation in the context of this study will also enable the medical treatment team to cater for the patient's socio-cultural context (that is involving the patient's family in mental healthcare). The next section provides a discussion on criticisms of Cultural Safety Theory in relation to the current study.

5.2.4.4 Criticisms of Cultural Safety Theory

Similar to the Culturally Competent Model of Care (Campinha-Bacote 1995), nurses have to undergo training and education in order to provide culturally safe healthcare (Papps 2005). Thus, Cultural Safety Theory is best suited for a nursing curriculum. Alison (2012) claims that Cultural Safety Theory relies on the individual nurse gaining enlightenment to alter them but does not focus on the sharing of this culture with other HCPs. Polaschek (1998) concurs by indicating that cultural safety needs to be reconstructed to be more inclusive of the organisational context, that is, by including other HCPs (such as medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, psychiatrists).

The Theory of Cultural Safety Theory (Ramsden 2002) is limited to nurses and is not applicable to other members of the treatment team, such as the medical officer, psychiatrist, clinical psychologist, and social worker (Polaschek 1998). In other words, Cultural Safety Theory does not cater for a medical treatment teamwork approach that is fundamental to mental healthcare (Alison 2012; Ramsden 2002). It was noted in chapter 4, that a medical treatment team approach is fundamental in mental healthcare, as teamwork results in positive patient outcomes (Kholed et al. 2017; Rosen et al. 2018; Salas et al. 2018). Furthermore, a theory that does not consider a holistic and diverse expertise teamwork approach to mental healthcare is lacking.

The literature reviewed in chapter 4 and section 5.2, clearly acknowledges a need for culture as a dimension to be incorporated into mental healthcare in South Africa. In order to consider culture in mental healthcare, healthcare needs to be decolonised (Connell 2014; Davar 2014; Green 2012; Morrow & Malcoe 2017; Mills 2014; Ndlovu-Gatsheni 2013). To advance the argument on the decolonisation of mental healthcare in South Africa, the following section provides a discussion of decolonial theories in relation to mental healthcare in South Africa, to provide further context to the gap identified in this study.

5.3 DECOLONIAL THEORIES

It was noted in chapters 2 and 3 that the South African healthcare system uses the biomedical approach to healthcare which is based on colonial ideology (Jacobs & Coetzee 2018). It is, therefore, suggested that the health system move away from Western perspectives and adopt a decolonial approach to healthcare, in order to cater

for the cultural diversity in South Africa (Nemutandani 2016). Decoloniality emerges within the context of African communities. Since decolonisation considers African cultures, which have been negated by the unfair elevation of Western cultures (Connell 2014; Morrow & Malcoe 2017).

As discussed in chapter 3, the biomedical approach has its limitations in a country like South Africa where the majority of the population still consults with traditional healers (Morrow & Malcoe 2017; Tjale & de Villiers 2014). This study argues that the decolonisation of mental healthcare will help improve treatment outcomes for mentally ill patients. Therefore, this section provides a discussion of decolonial theories which apply to mental healthcare.

The selected decolonial models and theories include Decolonial Theory (Quijano 1990), Indigenous Standpoint Theory (Foley 2003), and Southern Theory (Connell 2007). It must be noted that these decolonial theories do not address mental healthcare *per se* but promote emancipation of oppressed and marginalised cultures, societies, and countries, thus have been used in health communication research (Green 2019; Horril et al. 2018; Ramugondo et al. 2017; Urena 2019; Waterworth, Pescud, Braham, Dimmock & Rosenberg 2015). The following section provides a discussion on Decolonial Theory for the purposes of this study.

5.3.1 Decolonial Theory

Decolonial Theory problematises colonialism and its effects (Quijano 2000). Quijano (2007) contends that while colonialism may be an issue of the past, what is still firmly entrenched is, in fact, the unhealthy relationship between the West and the rest of the “formerly” colonised world. Scholars argue that the cultural relationship that exists between the West and the rest of the world indicates the continuation of colonial domination (Dastile & Ndlovu-Gatsheni 2013; Grosfoguel 2007; Quijano 2007, 2000; Wa Thiong’o 1986).

Ndlovu-Gatsheni (2013) adds that the minds and the mental universe are incessant as a result of colonialism. This is because colonality has allowed the continuous understanding of colonial forms of domination, after the end of the colonialism (Maldonado-Torres 2017). According to Grosfoguel (2007), peripheral nations (for example, African countries) remain in a colonial situation even though they are no longer under colonial rule. For example, South Africa uses the biomedical approach to

healthcare even though South Africa is not under colonial administration. As noted in chapter 3, the dominant West institutionalised the biomedical or Western approach to healthcare (Van Rensburg 2012). The dominant West assumes that psychological knowledge is universal. Thus, the biomedical or Western approach should be used for mental health treatment globally (Adams et al. 2019; Bhatia & Priya, 2018; Fay 2018; Mills, 2014).

However, knowledge from the West is not always in tune with cultural beliefs in peripheral zones, such as South Africa (Fay 2018; Mills, 2014). While biomedicine provides healing for some people, there are others who experience on-going symptoms and persistent disability, despite adhering to the recommended mental health treatment (Mill 2014). This underlines the fact that mental distress operates in a complex interaction between culture, context, and illness (Adam et al. 2019; Fay 2018). For some mentally ill patients, a non-biomedical explanation for persisting psychosocial disability is an important coping mechanism, in which case a traditional approach can be used for treatment. Thus, the decolonisation of mental healthcare is considered an important contribution to effective mental healthcare (Mills 2014). Therefore, Decolonial Theory seeks to engender consciousness and enlightenment with regard to knowledge from the peripheral zones (Ndlovu-Gatsheni 2016; Quijano 2007). A graphical representation of Decolonial Theory is presented in Figure 5.5.

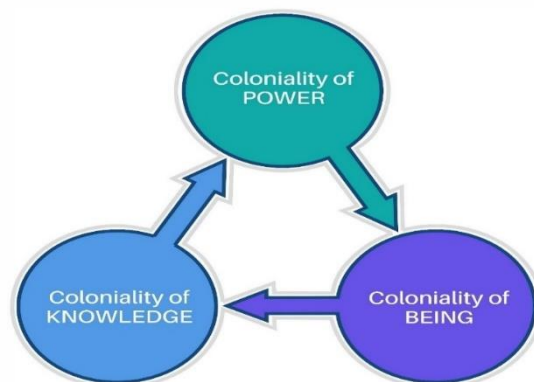


Figure 5.5: Grosfoguel's Model of Coloniality

(Source: Grosfoguel 2007: 203)

Decolonial Theory has three theoretical constructs, namely *coloniality of power*, *coloniality of knowledge*, and *coloniality of being*. These constructs will be discussed in the next sections.

5.3.1.1 Coloniality of power

The construct of coloniality of power is immensely relevant to this study as the South African healthcare system still operates from the legacies of the West. Thus, coloniality of power maintains and perpetuates the status quo of the contemporary healthcare system, with implications for the mentally ill patients (Fay 2018; Maldonado-Torres 2006). Decolonisation of mental healthcare is, therefore, a process of reversing the power impact of colonisation on the ex-colonised such as, South Africans. Decolonisation of mental healthcare is important because coloniality of power also relates to mental healthcare (Lagrange 2008).

In the context of mental healthcare, the service user (the patient) is the subordinate, whose values are undermined (Fay 2018; Fern 2005). Coloniality of power is an imperialist tradition which needs to be countered through the decolonisation of mental healthcare in South Africa. Dismantling the coloniality of power in mental healthcare, is a process of reversing the damage that is imbedded in the darker side of Western modernity. In essence, dismantling the coloniality of power will enable the medical treatment team to cater for cultural diversity within the treatment team. By allowing collaboration between the medical treatment team and traditional healers, and also allow the medical treatment team to cater for the culture of the patient, in the mental healthcare context.

Ramugondo et al. (2017) note that coloniality of power is a map in the relationship between the patient and the HCPs. This is evident during the process of diagnosis (biomedicine), which saliently maps out the power differentiation between the HCP and the patient (University of South Africa 2008). According to Moola (2015), immense power is afforded to the HCP as they hold the necessary skills and knowledge to locate the problem in the body and prescribe medication. Therefore, power often lies with the HCPs over the patient's family. Leader (2012) notes that the HCP who attempts to impose their own value system and view of normality onto the patient becomes like the coloniser who seeks to educate the indigenous people on what is wrong or right. Foucault (2008:174) concurs by arguing that "psychiatric power is therefore mastery, an endeavour to

subjugate". Therefore, the consultation process is an attempt for the HCP to tell the patient's family what the HCP thinks is right. The patient's family is rarely believed to know what could be wrong, both within and outside the body. This dialectic of power, characteristic of the HCP–patient relationship extends to the broader therapeutic milieu (mental healthcare) and is reinforced through the different roles played by different members of the medical treatment team (Basweti 2018; Kon 2010; Nimmon & Stenfors-Hayes 2016; Patel 2018).

Contrarily, the relationship between the traditional healer, the mentally ill patient and their family unfolds in ways that do not inscribe strict linear dynamics of power, that are usually seen in biomedicine. Where the HCPs can feel that they have more knowledge than the patient (Kon 2010; Nmutandani 2016; Patel 2018; Truter 2007). Consultation with the traditional healer often involves communication with ancestors and is dependent on the patient's family agreeing with the messages being transmitted through the traditional healer (Truter 2007). Thus, the patient's family is involved in the consultation and the healing process and power does not only rest in the hands of the traditional healer. Nmutandani (2016) asserts that traditional healers communicate with the patient's family during consultation and during the treatment process. This implies that traditional healers are holistic in their approach. This supports the argument that traditional healers cater for the needs of the patient by including the patient's family in the treatment process (Zingela et al. 2018). Thus, a need to develop a conceptual framework which caters for the socio-cultural context of the patient exists.

As discussed in chapter 3, the patient's family can play a vital role in mental healthcare (Chichirez & Purarea 2018; Muth et al. 2014). Acknowledging the complementary roles that the HCPs and the patient's family play in the healing relationship (healthcare) is fundamental to dismantling the coloniality of power. Therefore, the power relationship between the HCP and the patient's family must be decolonised. Foucault (2014) suggests that decolonisation of power relations can take place if both the patient's family and HCP play a role during consultation and treatment process.

It is important to note that in a case where some mentally ill patients do not have the cognitive ability to make sound decisions pertaining to their health, family members have the legal authority to provide consent on their behalf (Makgoba 2017; Roberson & Makgoba 2018). As noted in chapter 3, the MHCA 17 of 2002 specifically deals with informed consent. The Act stipulates that the patient's family should be consulted in

circumstances where the mentally ill patient is cognitively impaired. The Act also permits family members such as a spouse, a parent, a sister, or a brother to give consent to medical treatment for a mentally ill patient (Makgoba 2017; Republic of South Africa 2002). Therefore “significant others” such as family members play a significant role in the patients’ healthcare (Raingruber 2013:28). Therefore, mental health treatment requires a comprehensive approach that includes active participation of the patient and the patient’s family (Javed & Herrman 2017; Muth et al. 2014; Olasoji et al. 2017; Santana et al. 2018).

Research has suggested that not involving the patient’s family in their mental healthcare can have dire consequences (Makgoba 2017; Masweneng 2018; Robertson & Makgoba 2018). A case in point is the Life Esidimeni tragedy, which started to unfold in 2015 in South Africa, when the Gauteng Department of Health decided to terminate a contract with the Life Esidimeni Health Care Centre (Matlala & Chigome 2019). Makgoba (2018) asserts that 1,711 people were relocated from the mental health facilities operated by Life Esidimeni, in the South African province of Gauteng, to alternative facilities managed by non-governmental organisations. The result of the change in providers and the manner in which the transfers were managed led in the deaths of 144 mentally ill patients (Docrat & Lund 2019; Makgoba 2017; Meyer, et al. 2019). About 1 418 patients were also exposed to trauma and poor health outcomes due to this transfer (Docrat & Lund 2019; Makgoba 2017; Meyer, Matlala & Chigome 2019). The results from an investigation conducted by the Health Ombudsman (2018) revealed that the patients’ family members were not consulted before the patients were transferred. This tragedy suggests an abuse of power (power imbalance) as well as lack of communication between the health system and key stakeholders such as, the patients and their family members (Makgoba 2017). The Life Esidimeni tragedy also suggests that the healthcare system (a biomedical system) holds immense power over the majority of South Africans since most South Africans use the public healthcare system (Jacobs et al. 2018; Mkize 2019; Ned et al. 2017) This study therefore advocates for the dismantling of this power through the decolonisation of mental healthcare in South Africa. Coloniality is further manifested in coloniality of knowledge.

5.3.1.2 Coloniality of knowledge

Coloniality of knowledge imposes universal rationality of Western views, as the rightful reality and thus provincialises the hegemonic system of modernity. Hence, there is an

assertion that other knowledge is inferior (Quijano 2007). The imposition of Eurocentric knowledge has led to the underdevelopment of the Global South, as well as implications for their ontological existence (the humanity of these people is constantly questioned). For this reason, the colonised (for example, South Africans) are conditioned through a colonial lens and in the process entrench the hegemonic culture (Fay 2018; Maldonado-Torres 2006; Quijano 2007).

Sithole (2014:53) concurs with the above arguments by stating that the “knowledge systems are formulated and totalised by the Euro-North American and the African subject is silenced and excluded”. For example, knowledge from Africa and South Africa is undermined and considered to be inferior and useless (Ramugondo et al. 2017). In the context of this study, this construct explains why Western knowledge, that is, the biomedical approach, is valued while traditional approaches are viewed with scepticism as superstitions and being unscientific. A case in point is when Madagascar produced a COVID-19 medicine called umhlonyane. This medicine was never given the same attention as the trials of vaccines or medication from the West. The president of Madagascar, Rajoelina, noted, “If it were a European country which had discovered this remedy, would there be so many doubts?... The problem is that it comes from Africa” (Perelman 2020:1). In South Africa, medicinal plants such as *Artemisia*, olive leaves and *Nigella Sativa* are being considered as possible treatments for COVID-19. However, little or no attention was given to these herbal plants (Akindele et al. 2020). Instead, the international news headlines focused on the treatments from the West. Therefore, the colonialist patterns that centre Western knowledge systems have also shaped the response to the COVID-19 pandemic (Coates 2020; Hirsch 2020; Weller 2020). Therefore, knowledge from the West is always prioritised.

Decolonial scholars suggests that all knowledge has equal value and usefulness and thus must be considered as such (Bacchetta, Maira & Winant 2019; Dastile & Ndlovu-Gatsheni 2013; Maton & Moore 2010; Quijano 2000; Young & Muller 2013). Therefore, knowledge from HCPs and the cultural aspects of the patient should be considered for mental healthcare. In light of the above discussion, it is evident that a shift towards decolonisation of mental healthcare is required and will be beneficial to SA.

5.3.1.3 Coloniality of being

Coloniality of being exposes a hierarchy of identities (Ndlovu 2016). People are categorised and given identities. If all of humanity would be regarded as equal, regardless of all the differences in bodies, minds, colours, and social and economic statuses, there would be no hierarchical identities, no notion of “the other” and no inequalities (Quijano 2000). Relating the decoloniality of being specifically to mental healthcare entails reclaiming a sense of full humanness by recognising traditional healthcare practices as worthy contributions to mental healthcare. Therefore, all mental healthcare systems, that is, both biomedical and traditional, should be regarded as useful to mental healthcare. Thus, there is a need to decolonise mental healthcare in South Africa and ensure that collaboration takes place between members of the medical treatment team and traditional healers. In the next section, criticism of Decolonial Theory in relation to the current study will be examined.

5.3.1.4 Criticisms of Decolonial Theory

Decolonial Theory has been critiqued for its rather unrealistic notion of a society (coloniality of being) that cannot exist where there is equality of all (Vehmas & Watson 2014). Vehmas and Watson (2014) contend that a society without group differences is not a realistic possibility. However, relating specifically to mental healthcare, the focus is on providing culturally congruent mental healthcare. In other words, both biomedical and traditional medicine should be regarded as useful to mental healthcare. Decolonial Theory has also been critiqued for emphasising the need to “undo” colonialism (Bacchetta et al. 2019). Decolonial theory does not consider the biomedical approach to healthcare since it assumes that knowledge from the West is not applicable to Africans. However, this theory has been explored in this study, as it advocates for cultural and traditional consideration in relation to mental healthcare. While biomedicine does not provide treatment for some patients due to cultural barriers, other patients consider biomedicine for treatment, hence a collaborative approach is required for mental healthcare in SA (Adam et al. 2019; Fay 2018; Mills 2014). As noted in chapter 3, the majority of South Africans prefer to use both biomedicine and traditional medicine. Therefore, this model is lacking in that it does not consider the biomedical (Western) approach to mental healthcare. In the following section, Indigenous Standpoint Theory will be discussed in relation to the current study.

5.3.2 Indigenous Standpoint Theory (IST)

IST was developed by Foley in 2003. Indigenous knowledge is most commonly known as traditional or local knowledge (Foley 2003; Hogarth 2018). Foley (2003) argues that indigenous knowledge is often unique to particular cultures and societies (Foley 2003; Hartwell & Myhra 2018; Hogarth 2018; Lewis & Nakata 2017). Therefore, it is important for the treatment of mental illness to be meaningful to the patient in terms of their cultural context (Jacobs & Coetzee 2018; Mosotho, Louw & Calitz 2011; Nemitandani 2016; Sigida 2016; Zingela et al. 2019). Therefore, this study suggests that the medical treatment team should consider the cultural beliefs of the patient, in order to provide adequate patient-centred care.

As discussed in previous paragraphs, Africa has its own indigenous knowledge which is independent from Western knowledge. Therefore, knowledge from the West is not fully applicable to people in Africa (Hoppers 2002; Mills 2014; Mosotho et al. 2011). As discussed in chapters 2 and 3, South Africa's healthcare system predominantly leans towards the biomedical approach, which does not consider indigenous knowledge and healing systems (Davar 2014; Fernando 2012; Lang 2014; Lee 2014; Mills 2014). Jacobs and Coetzee (2018) note that many South Africans consult with both indigenous healers (traditional healers) and HCPs; therefore, healthcare needs to be decolonised to cater for collaboration between the two frameworks. Indigenous scholars have argued that healthcare must be decolonised to provide patient-centred care in South Africa (Nakata 2017; Murdoch et al., 2017; Ramugondo et al. 2017). Fernando (2011) reiterates this view by stating that the mental health system should provide psychiatric treatment that considers indigenous knowledge systems in relation to mental healthcare. Rentmeester (2012) concurs by noting that mentally ill patients should access treatment that is relevant to their context. Ramugondo et al. (2017) therefore suggests that decolonisation of healthcare can be done by considering the indigenous values and cultural practices of the South African people.

Morrow and Malcoe (2017) add that historical and current knowledge both contribute to the shape and form of both the popular and intellectual understanding of mental healthcare. This knowledge is based on the Western understanding of logic and rationality. Thus, IST proposes that the healthcare systems or HCPs should integrate indigenous (traditional) methods of treating mental illness into mental healthcare in order to make mental healthcare more relevant to indigenous people (Batisai 2016; Bene & Darkoh 2014; Grosfoguel 2013; Jacobs & Coetzee 2018; Nemitandani 2016; Tjale & de Villiers 2014).

According to Foley (2003), the indigenous knowledge (culture) of indigenous people needs to be respected. Within this context, collaboration with registered and trained traditional healers, family members, and community leaders becomes important to make treatment experiences culturally congruent, for the mentally ill patient (Choy & Woodlock 2007; Gelade & Stehlik 2004; Hogarth 2018; Nakata 2017). Foley (2003) suggests that IST offers a means for collaboration with indigenous people such as family members, traditional healers, and community members. This study therefore suggests that collaboration between the treatment team and the patient's family members could help enhance mental healthcare in South Africa. This collaboration could be achieved through effective communication (see chapters 2 and 3 for a detailed discussion on the need for collaboration between the HCPs and the patient's family members). In the next section, criticism of IST in relation to the current study will be examined.

5.3.2.1 Criticisms of Indigenous Standpoint Theory

Bhaba and Mbembe (2002) have critiqued IST by suggesting that it only focuses on indigenous systems of healing. Thus, IST is lacking in that it does not accommodate other systems of healing (different approaches to healthcare, such as the biomedical approach). As noted in chapters 2 and 3, both psychotropic medication (biomedical) and traditional approaches are essential for mental healthcare in South Africa since 80 per cent of South Africans use both approaches (Cooper 2015; Ellis & Alexander 2016; Keikelame & Swartz 2019; Nmutandani et al. 2018; Sandoiu 2019; Zingela et al. 2019). Therefore, this study argues that a complementary approach that considers both traditional and biomedical approaches to healthcare will meet the needs of mentally ill patients in South Africa. Thus, this study argues for the collaboration between the medical treatment team and traditional healers trained for mental healthcare.

It worth noting that even though IST does not consider other systems of healing, such as the biomedical system, the theory was reviewed for the purpose of this study, because it advocates that HCPs should consider the indigenous world views of the mentally ill patient. The current study concurs with the assumption of IST, that HCPs should consider the indigenous world views of mentally ill patients. The next section provides a discussion on the Southern Theory in relation to this study.

5.3.3 Southern Theory

Southern Theory was developed by Connell in 2007. Like the Decolonial Theory (Quijano 1990), the Southern Theory draws attention to the dynamics of how and where knowledge has been produced. As well as how it has been disseminated, and the relations of power inherent in and produced by this knowledge. These processes are part of the colonising story (Connell 2007). Southern Theory challenges the practices of production and circulation of knowledge across global regions (Connell 2014). Connell (2007) describes these regions as the Global North (also the metropole) and the Global South (also the periphery). According to Connell (2007:212), metropole pertains to mainly European and North American countries and peripheries pertain to poorer or developing countries which show patterns of dependence on, and paths of development from, European and North American countries.

Connell (2007) suggests that knowledge from peripheral and colonised societies has as much intellectual power as knowledge from metropolitan societies. Knowledge from metropolitan societies account for only a fraction of people of the world and, therefore, has limited validity on a world scale (Connell 2007). Therefore, both knowledge from the metropole and knowledge from the periphery can enhance mental healthcare. As discussed in chapter 3, South Africans consult with both the medical treatment team and traditional healers for mental health treatment. Therefore, the need exists for collaboration between HCPs (knowledge from the metropole) and traditional healers (knowledge from the periphery) for mental healthcare in South Africa. As noted in chapters 3 and 4, effective communication can enhance this collaboration.

Southern Theory (Connell 2007) also suggests that approaches to knowledge production need to consider the context and realities of the population (Connell 2014). Therefore, Southern Theory suggests that knowledge must be relevant to certain communities and population. For example, the knowledge (healthcare) used in South Africa should be relevant to the South African communities. Contrary to IST (Foley 2003), Southern Theory (Connell 2014) suggests that there should not be one monolithic benchmark for knowledge production. Rather, it should be about producing knowledge that is relevant to a specific context. For the purposes of this study, knowledge relevant to mental health should be generated from the metropole and the peripheries since mentally ill patients in South Africans consult with both HCPs and traditional healers (Jacobs & Coetzee 2018; Sigida 2016; Zingela et al. 2019).

The primary objective of Southern Theory (Connell 2007) is recovering the deep prior experiences of the subjection to globalising powers that are consequent to colonialism (Connell 2014). Therefore, Connell (2007) contends that the true future of global knowledge must involve a principle of unification. The principle of unification will involve connecting (considering) knowledge from the periphery and knowledge from the metropole. This is because knowledge creation occurs not only in metropolitan societies, but also in the periphery. In the context of this study, the future of effective mental healthcare lies in the collaboration of the biomedical and traditional approaches to mental healthcare. The literature in chapter 3 acknowledged the need for collaboration between the biomedical and traditional systems of healing as the majority of South Africans use both systems (Cooper 2015). Collaboration between the two systems will ensure that patients are provided care that is relevant to their cultural context. Research has emphasised the importance of context as enabling or limiting the efficacy of adherence to mental health treatment (Batisai 2016; Sigida 2016; Tjale & de Villiers 2014; Zingela et al. 2019). The biomedical approach to mental healthcare disregards the cultural context of the patient. As discussed in chapter 2, over 17 million South Africans are dealing with mental health problems (Jacobs & Coetzee 2018; Willie 2017). Lack of cultural considerations could hinder effective treatment. Therefore, collaboration between the biomedical and traditional system could enhance mental healthcare in South Africa. In the next section, criticism of Southern Theory in relation to the current study will be discussed.

5.3.3.1 Criticisms of Southern Theory

Even though the Southern Theory advocates for the unification of the Western and Afrocentric views (biomedical and traditional approaches in the context of this study) (Connell 2007), which is an important aspect of this study, the theory is limited in that it does not cater for the social aspect or inclusion of the family in healthcare. In the context of this study, the patient's family members play an important role in mental healthcare. Therefore, this is lacking since it does not cater for the social aspect of family inclusion in healthcare. Even though the Southern Theory (Connell 2007) is limited for the purposes of this study, this theory was included because it advocates for the collaboration of both European and African views, that is, the use of both biomedical and traditional treatments.

5.3.4 Summary of the selected decolonial theories: relation to mental healthcare

All the decolonial theories reviewed in this chapter acknowledge the persistence of knowledge inequalities, and self-consciousness challenges to the status quo (Quijano 2013; Rosa 2014). However, it is important to note that none of the selected theories focus on mental healthcare *per se* but have been used or applied to health communication research (Green 2019; Horril et al. 2018; Ramugondo et al. 2017; Urena 2019). Thus, the theories were reviewed to acknowledge existing literature on decolonial theories and were applied to mental healthcare accordingly, as per the context of this study. Therefore, a need to develop a conceptual framework that caters for or includes decolonial aspects, from a mental healthcare perspective within the South African context. This is important because when mental healthcare is addressed in ways that allow for a decolonial approach to mental health practice, different approaches to mental healthcare are allowed (Batisai 2016; Bene & Darkoh 2014; Tjale & de Villiers 2014). This is fundamental for a country like South Africa where people engage with both biomedical and traditional approaches to mental healthcare. Penson (2019) adds that a decolonial approach seeks to bring together and unify psychological, sociological, and biomedical perspectives on mental healthcare diagnosis and treatment. Therefore, the medical treatment team take their place as part of a larger, more integrated, patient-centred partnership to achieve effective mental healthcare. This partnership consists of the medical treatment team working closely with the patient's family and traditional healthcare practitioners to achieve patient-centred care (Fay 2018).

This study argues that there is a need to decolonise mental healthcare experiences and thus improve healthcare. It has been clearly demonstrated in reviewing the literature in this section that the decolonisation of mental healthcare could enhance mental healthcare in South Africa. As decolonisation de-centres Western perspectives by integrating traditional perspectives of mental healthcare (Bivins 2012; Crawford et al. 2016; Kelly 2015; Penson 2019; Zingela et al. 2019). A decolonial framework will allow the medical treatment team to cater for cultural aspects, relating to mental health care, in the South African context. Thus, a decolonial framework is included in the conceptual framework presented in chapter 6.

The decolonial approach to healthcare complements the African philosophy of ubuntu – “I am what I am because of who we all are” (Nemutandani et al. 2018:3). Ubuntu is

regarded as a key concept in decolonisation. The philosophy of Ubuntu was mentioned in earlier chapters (chapter/section?) and is elaborated in detail below.

5.4 THE AFRICAN PHILOSOPHY OF UBUNTU

Ubuntu is the epitome of Africanness; therefore, most South Africans are deeply entrenched in the African ubuntu cultural system (Chisale 2018; Madaka 2019; Molala & Downing 2020). As discussed in chapter 4, the cultural values of ubuntu influence mental healthcare. This is because ubuntu in the context of healthcare values collectivism and, when applied to the context of this study, refers to medical treatment teamwork collaboration rather than individualism. This study notes that mental healthcare in the South African context, should consider the principles of ubuntu.

The literature reviewed in chapter 4, acknowledged the need for a medical treatment team approach to mental healthcare. Literature reviewed in chapters 3 and 4 and sections 5.2 and 5.3, suggest that the treatment team needs to involve the community (the patient's family) as part of the medical treatment team. This implies that collectivism as opposed to individualism is required to improve mental healthcare in South Africa. Like the PEN-3 model, the philosophy of ubuntu argues that South Africans live a collective way of life, expressed through ubuntu. Ubuntu is an Nguni word which translates as human kindness (Downing & Hastings-Tolsma 2016). Ubuntu is a world view of African societies and it is passed down through the generations by shared communal life (Tutu 2004).

Louw (2016) states that at the core of Ubuntu is the expression "a person is a person through persons" which is translated from the Nguni phrase "umuntu ngumuntu ngabantu". This statement fits the purpose of this study, since it argues that the medical treatment team, which is made of HCPs should work collaboratively with both traditional healers and the patient's family, to provide mental healthcare to individual patients. In many South African cultures, the view of "personhood" denies that a person can be described solely in terms of their physical and psychological aspects. A person is rather defined with reference to the community in which they belong (Molefe 2011). Ubuntu is strongly based on the collective. It suggests that caring cannot be done independently, but it is a collective role (Letseka 2013). Thus, ubuntu indicates that HCPs must work as a collective (as a team) in order to provide effective mental healthcare (Molala & Downing 2020; Nzimakwe 2014; Sulamoyo 2010; Taylor 2014). Caregiving by community members is also a feature of ubuntu (Metz 2007). Therefore, the medical treatment team

must work with community members (such as family and trained traditional healers) to provide healthcare to the mentally ill patient.

The characteristics of ubuntu are contrary to Western views because “Western individualist democracy insists on freedom ... of the sacred self from intrusion by others” while in ubuntu “a person’s freedom depends for its exercise and fulfilment on personal relationships with others” (Christians 2004:243). Therefore, ubuntu is seen as a cultural philosophy that binds all members of a society and is integrated into all aspects of day-to-day life, including healthcare (Green-Thompson et al. 2017; Louw 2016; Madaka 2019). According to Taylor (2014), ubuntu cultivates a team spirit in healthcare. Therefore, members of the medical treatment team are expected to be in solidarity with one another especially during a time of need (Molala & Downing 2020). As per the context of this study, members of the treatment team are expected to cater for cultural diversity within the medical treatment team for patient care. In essence, ubuntu promotes cooperation and cultural tolerance amongst members of the medical treatment team, which helps in providing effective patient care (Nzimakwe 2014).

Ubuntu is a philosophy which embraces African culture (Madaka 2019; Molefe 2011), community, and family (Green-Thompson et al. 2017). Chisale (2018) indicates that it is important to engage the community when it comes to healthcare because the patient’s community members are regarded as the custodian of indigenous knowledge (Chisale 2018; Keane 2017; Letseka 2013; Letseka & Letseka 2017). Therefore, the medical treatment team should engage with the community (for example, the patient’s family and traditional healers from the patient’s community) to provide culturally appropriate healthcare. Considering the fact that South Africans are influenced by their culture, ubuntu becomes a decolonial ideology of dislodging mental healthcare from its Western-centric perspective (Penson 2019).

Ubuntu is best realised and manifested in deeds of kindness, caring, sharing, and solidarity (Nemutandani et al. 2018). People in the community are expected to be in solidarity with one another, especially during a time of need. Thus, in accordance with the principles of ubuntu, people with mental illness should be supported by their families. (Chisale 2018; Engelbrecht & Kasiram 2012; Ngondo & Klyueva 2022; Wilson & Williams 2013). In the context of this study, ubuntu philosophy underpins healthcare within the African context and the provision of effective mental healthcare is linked to an understanding and consideration of African culture. Thus, the principles of the African

ubuntu philosophy can play an important role in mental healthcare because it influences the behaviour of individuals or patients who live in an African environment. Research suggests that healthcare must consider the principles of ubuntu as these principles determine the formulation of perceptions which influence behaviour (Chisale 2018; Fox 2010; Green-Thompson et al. 2017; Louw 2016; Molala & Downing 2020; Sulamoyo 2010; Taylor 2014).

The above descriptions of the ubuntu philosophy bring to light that African society is, in general, humanistic and community-based. Nemitandani et al. (2018) assert that in order to acknowledge the humanistic and cultural aspects of South Africans, healthcare must be decolonised. Decolonisation is in line with the principles of ubuntu since decolonisation embodies the spirit of humanness, fairness, and justice for African values. Thus, there is a need to decolonise mental healthcare in South Africa.

5.5 SUMMARY

This chapter has discussed selected cultural and decolonial models and theories. The cultural models and theories help in explaining the impact of culture on behavioural outcomes. The chapter has also provided criticisms of the models and theories to indicate the constraints of these models in relation to mental healthcare in the South African environment.

In light of the discussion which has showed that individual and teamwork factors (chapter 4) and cultural and decolonial factors (chapter 5) have some determining influence on health behaviour and mental healthcare, it is now possible to turn attention to developing a comprehensive conceptual framework for a medical treatment team approach, to mental healthcare, in the South African context which is presented in the next chapter

CHAPTER 6: THE PROPOSED CONCEPTUAL FRAMEWORK

6.1 INTRODUCTION

In this chapter, a comprehensive conceptual framework for a medical treatment team approach to mental healthcare is presented. This framework takes into account elements that influence mental healthcare, namely medical treatment teamwork, decolonial factors, the socio-cultural context, and policy perspectives. This study has argued that a medical treatment team approach is required in South Africa, since a medical treatment teamwork approach to healthcare results in positive patient outcomes. As each member of the medical treatment team contributes expertise for effective patient care (Kholed et al. 2017; Rosen et al. 2018; Salas et al. 2018).

The discussions in chapters 3 and 5, also suggested that the decolonisation of mental healthcare will address the range of biological, psychological, and socio-cultural factors that affect mental healthcare; therefore, such is needed to advance mental healthcare in SA e (Jacobs & Coetzee 2018; Nmutandani et al. 2018). As noted throughout decolonisation is regarded as three-fold for the context of this study. First, members of the medical treatment team must cater for the cultural context of other team members. Secondly, there should be collaboration between the medical treatment team and traditional healers. Lastly, the medical treatment team should consider the cultural background of the patients during mental healthcare. Thus, the focal point of this chapter is to conceptualise, propose, and present a comprehensive conceptual framework that will assist in enhancing mental healthcare in South Africa. It is worth noting that this study consisted of two phases. In phase 1, the researcher developed the framework from the literature (see chapters 2, 3, 4, and 5) for mental healthcare in a South African context. While in phase 2, the researcher verified the framework during the fieldwork process. Thereafter the framework was re-worked based on the findings collected in the field.

This study has argued that mental healthcare is complex and can be understood from a socio-cultural perspective (Keikelame & Swartz 2019; Nmutandani 2016; Nmutandani et al. 2018; Penson 2019). As discussed in chapters 3 and 5, socio-cultural context influences mental healthcare. Hence, if mental healthcare is designed to influence human behaviour, then a comprehensive framework, that caters for the relevant socio-cultural factors is needed. Therefore, this chapter presents comprehensive conceptual framework that highlights socio-cultural aspects in mental healthcare.

For the purposes of this study, cultural consideration is regarded as two-fold that is, for both for HCPs and for patients. Cultural differences have the potential to hamper medical treatment teamwork. Thus, all members of the medical treatment team should be tolerant of each other's cultural differences within the team, in order to work collaboratively to provide effective patient care. For the purposes of this study, the medical treatment team is also required to provide comprehensive, quality mental healthcare services to patients. As noted in chapters 3 and 4, medical treatment teams need to involve the patient's family as part of the healthcare team, since some mental health patients may be too cognitively impaired to make rational decisions. Therefore, this framework proposed that mental healthcare should involve participation of the patient's family and a team of specialised HCPs (Kholed et al. 2017; Rosen et al. 2018; Salas et al. 2018; Yamada et al. 2017).

The literature in chapter 3 also suggested that policy plays a fundamental role in mental healthcare as it emphasises the shift from the colonial, apartheid to the decolonisation of healthcare in SA. Therefore, the medical treatment team should be guided by policies for mental healthcare (Van Rensburg 2012). Thus, both government and hospital mental health policies were included as elements of the proposed conceptual framework for mental healthcare in the South African context.

6.2 A CONCEPTUAL FRAMEWORK FOR MENTAL HEALTHCARE IN SOUTH AFRICA

This study argues that medical treatment teamwork is fundamental in mental healthcare. This is because HCPs, each with a different expertise, contribute knowledge which helps in providing individualised treatment plans for mentally ill patients (Rosen et al. 2018). In addition, the literature reviewed in chapters 4 and 5 clearly acknowledged the need for a decolonial approach to medical teamwork since 80 per cent of South Africans are influenced by their cultural beliefs (Keikelame & Swartz 2019; Penson 2019). Therefore, cultural factors need to be included in health communication models.

The decolonial theories reviewed in chapter 5 suggest that knowledge from peripheral and colonised societies has as much intellectual power as knowledge from metropolitan societies (Dastile & Ndlovu-Gatsheni 2013; Quijano 2007). These theories also indicate that knowledge from metropolitan societies account for only a fraction of people of the world and thus have limited validity on a world scale. It was noted in chapters 2, 3 and

5, that South Africa is more inclined towards the biomedical approach to healthcare. This approach is based on science and thus lacks consideration for any cultural aspects.

South Africa is a collective society; therefore, South Africans are influenced by their cultures. The collective, that is, the cultural nature of South African society, is shown through ubuntu. As discussed in chapters 4 and 5, caregiving is the epitome of ubuntu. Therefore, the patient's community, for example family members (in the context of this study), need to be part of the treatment process. To cater for the cultural needs of mentally ill patients in South Africa, knowledge from the periphery (culture) must be considered. Therefore, the notion of medical treatment teamwork in mental healthcare needs to be decolonised in order to empower and allow the patient's family to assist the medical treatment team, to provide effective patient care in the South African context. Furthermore, a need exists to develop a conceptual framework that caters for knowledge from both Western and colonised societies (that is, biomedical and traditional approaches to mental healthcare). However, none of the current decolonial theories refer to knowledge that is specific to healthcare and the need exists to develop a framework that incorporates decolonial knowledge, that includes cultural knowledge, from a healthcare perspective.

This study argues that the majority of South Africans are influenced by their socio-cultural context. Moreover, the medical treatment teamwork models and theories discussed in chapter 4 are limited in the context of this study since these models do not consider the cultural aspects that influence mental healthcare (Kuo et al. 2018; Steinberg & Angelopulo 2015; Zeleke 2015; Zingela et al. 2019). Cultural aspects are important from both patient and HCP perspectives. In essence, HCPs need to have cultural knowledge, attitudes, or personal attributes that maximise respectful relationships with each other. As noted in chapters 4 and 5, members of the medical treatment team may have different cultural world views and this can generate conflict within the team (Morley & Cashell 2017). It is, therefore, imperative that HCPs cater for and understand the cultures of other team members. The medical treatment team should also collaborate with traditional health practitioners. Since the majority of South Africans consult with both the medical treatment team and traditional healers for patient care (Johnson et al. 2017). Furthermore, HCPs should be aware that patients are culturally diverse and thus they should be open-minded and embrace cultural differences. Therefore, the HCPs need to individualise healthcare to cater for the needs of the patient and provide patient-centred care (Johnson et al. 2017).

The cultural models reviewed in chapter 5 emphasise culture but do not fully consider other factors (such as the family) that influence human behaviour. They also do not consider the role of the medical treatment team in mental healthcare. Thus, the cultural models are lacking in that they do not consider medical treatment teamwork, which is fundamental in providing effective mental healthcare to patients. As noted in chapter 4, medical treatment teamwork is an important aspect for treatment of illnesses such as mental illness because no single HCP can treat a mentally ill patient on their own (Gautier 2015). To successfully treat a mentally ill patient, the nurse, medical officer, clinical psychologist, occupational therapist, pharmacist, social worker, and psychiatrist must all work together as a team to provide effective patient care in the spirit of ubuntu as a collective team (Kholed et al. 2017; Salas et al. 2018; Yamada et al. 2017). Moreover, teamwork models or theories need to take the core principles of effective teamwork into account. Even though teamwork models such as the GRPI Model (Rubin et al. 1977) and the Lencioni Model (2002), both reviewed in chapter 4, acknowledge the importance of medical treatment teamwork in healthcare, most of the models do not cater for nor provide the core principles of effective teamwork. Therefore, the conceptual framework includes these core principles such as, effective communication and empowerment.

Even though policies on mental healthcare exist, there is a need to fully implement these policies in order to cater for the needs of mentally ill patients, in the South African context. For example, there is a need to fully implement collaboration between the medical treatment team and traditional healers in order to cater for the needs of the patient. Hence, policy was included as an element of the proposed conceptual framework.

From the previous literature in chapters 2, 3, 4 and 5, the researcher developed a conceptual framework for a medical treatment team approach to mental healthcare in South Africa. The framework is designed in such a manner as to highlight elements such as, medical treatment teamwork, decolonial context, socio-cultural context, and policy aspects that influence mental healthcare context. The conceptual framework is presented in Figure 6.1. It is important to note that all the elements included in this framework contribute to effective mental healthcare.

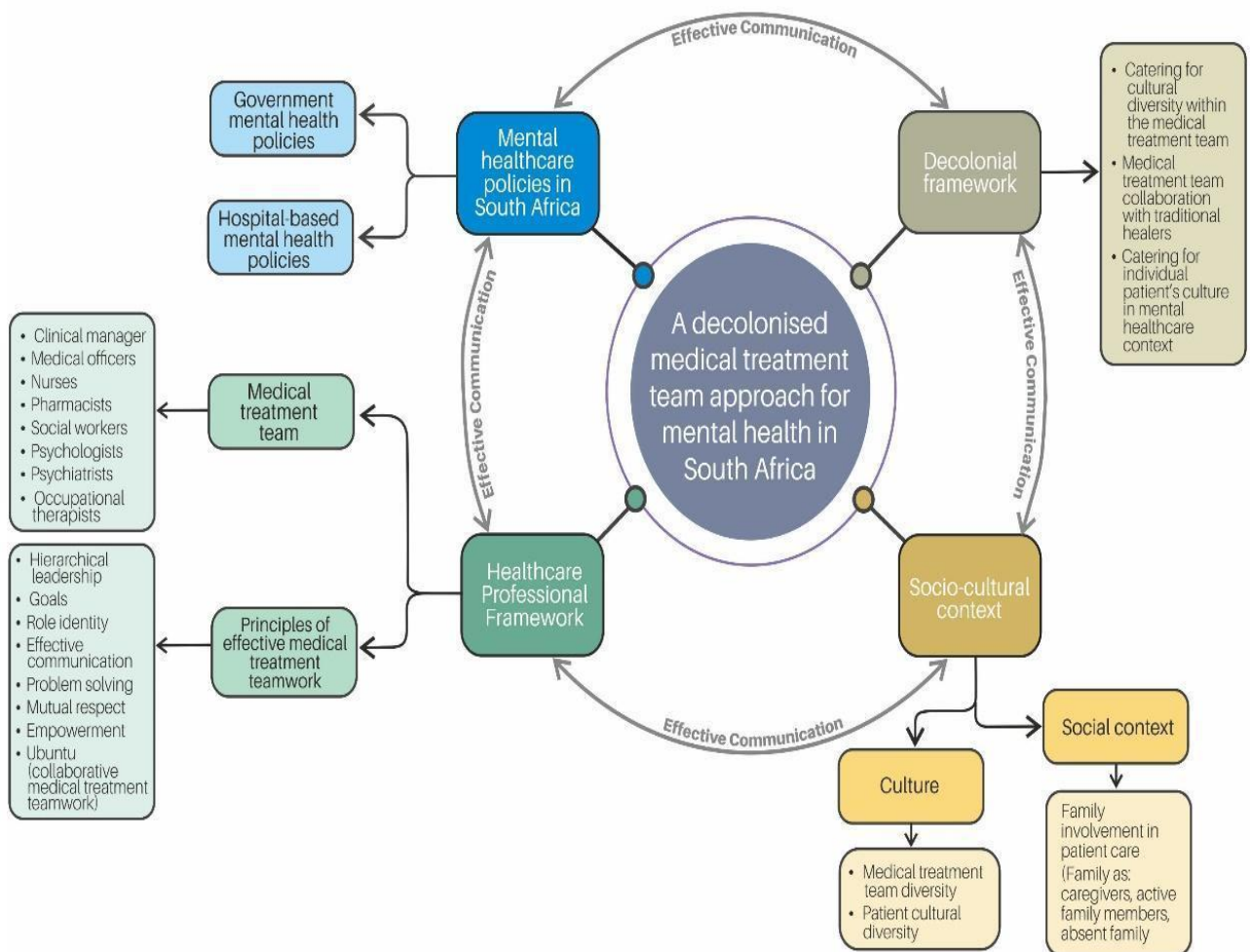


Figure 6.1: Conceptual framework for medical treatment team approach to mental healthcare

The framework displayed in Figure 6.1 identifies four elements that contribute to effective mental healthcare: (1) medical treatment teamwork; (2) decolonial factors; (3) socio-cultural factors; and (4) policy. These elements are interrelated since they are all considered to be essential elements of mental healthcare. The proposed conceptual framework could be viewed as a decolonial approach to medical treatment teamwork for

mental healthcare, or a departure from completely embracing the Western biomedical approach to mental healthcare. The elements of this framework are discussed next.

6.3 HCP FRAMEWORK AND PRINCIPLES OF EFFECTIVE MEDICAL TREATMENT TEAMWORK

HCPs play a fundamental role in mental healthcare, with the medical treatment team working collaboratively to develop care plans and provide quality care for individual patients (Bene & Darkoh 2014; Gautier 2015). The following section provides a discussion on aspects of the HCP framework in relation to mental healthcare.

Medical treatment teamwork is the core of this conceptual framework since medical treatment team teamwork is globally recognised as fundamental to effective mental healthcare (Bene & Darkoh 2014; Gautier 2015; O’Leary et al. 2012; Salas et al. 2018). Therefore, teamwork between the HCPs is fundamental to mental healthcare. This element has several components, namely hierarchical leadership, empowerment, goals, role identity, effective communication, problem-solving, and mutual respect. These components are crucial in ensuring effective medical treatment teamwork and hence effective patient care. As noted in chapter 4, ubuntu is in line with these teamwork principles since ubuntu requires team members to collaborate, co-operate, share, and support all team members to provide patient-centred care (Molala & Downing 2020; Taylor 2014). Since ubuntu values collectivism rather than individualism, the medical treatment team should also involve the patient’s family members in the treatment process. The principles of effective teamwork are discussed below.

6.3.1 Hierarchical leadership

Hierarchical leadership enables team effectiveness by coordinating member interactions and defining the roles of each treatment team member (Chou, Halevy & Van Kleef, 2012). Hierarchical leadership in a team structure may facilitate conflict resolution by creating order and improving coordination (Xu et al. 2021). Most of the teamwork models reviewed in chapter 4 do not consider leadership as a determinant for successful medical treatment teamwork. However, leadership is important for any successful team because every team needs proper guidance from the team leader to develop an effective medical treatment team that can provide patient-centred care (Swart 2017). As discussed in chapter 4, understanding the different cultural backgrounds of team members is critical to effective teamwork. Some dynamics of teamwork such as the approachability of the

leader and reluctance to express concerns among team members may be influenced by different cultural beliefs (Betancourt 2016; Fleury et al. 2017; Kumra, Hsu, Cheng, Marsteller, McGuire & Cooper 2018). Therefore, the team leader needs to ensure that all members of the medical treatment team trust their ability to address and tolerate cultural differences. When the members of the medical treatment team feel confident in the leader's ability to address cultural differences, they may feel more empowered to express their opinions and concerns. Therefore, it is imperative for the team leader to have cultural tolerance and lead in the spirit of ubuntu.

6.3.2 Empowerment

The literature in chapter 4 suggested that empowerment is one of the core principles of an effective healthcare team. Since an empowered team makes collective decisions through their participation in negotiated decision-making, which ultimately leads to effective healthcare (Barry et al. 2019; Delany et al. 2017). Empowering the medical treatment team has benefits such as job satisfaction, staff retention, and ultimately patient-centred care (Barry et al. 2019; Delany et al. 2017; Hector & Manz 2016).

It was also noted in chapter 4 that the medical treatment team needs to empower the patient's family since this helps to facilitate decision-making and encourage alignment between the patient and the goals of the HCPs (Craig et al. 2020). The medical treatment team can empower the patient's family by educating them on treatment adherence. Therefore, empowerment has been included in the proposed framework since empowering the medical treatment team and the patient's family contributes to effective mental healthcare.

6.3.3 Goals

Goals focus on the medical treatment team's task and specify how the team can achieve effective patient-centred mental healthcare (Marlow et al. 2017). Literature in chapter 4 suggested that individual HCPs should tolerate the cultural values of other team members as well as that of the patient. (Kholed et al. 2017). In chapter 4, it was noted that team empowerment can help the team to achieve its goals (Barry et al. 2019). Knowledge-sharing and collaboration leads to team empowerment. Therefore, the treatment team needs to work collaboratively to achieve its goals (Delany et al. 2017; Wåhlin et al. 2010). Hence, there is a need for members of the medical treatment team to agree upon and set goals collaboratively to achieve effective patient care. Therefore,

each team member, such as the psychiatrist, clinical psychologist, clinical manager, nurse, occupational therapist, medical officer, pharmacist, psychiatrist, and social worker need to understand the goals of the team and work towards achieving these goals (Mitchell et al. 2013; Rosen et al. 2018). For the purpose of this study, the medical treatment team must organise their goals to enhance mental healthcare. Most of the teamwork models reviewed in chapter 4 acknowledge the need for teams to have goals, thus it was included in the proposed conceptual framework

6.3.4 Role identity

Each team member takes up a role (Benishek et al. 2016; Rosen et al. 2018). If not, a team cannot be expected to achieve effective patient care. For example, in the context of mental healthcare, the psychologist focuses on the patient's emotional state and assesses the patient's overall mental state. While the psychiatrist handles the medical treatment and focuses on the effects of the treatment on the patient's body. Therefore, HCPs need to perform different roles in order for the team to be effective. Thus, this element has been included in the proposed framework. As noted in chapters 4 and 5, the individual HCPs can perform their respective roles effectively if they practice cultural tolerance. The HCPs also need to motivate and mobilise team members to perform their roles as this leads to team empowerment (Barry et al. 2019). Overall, the team should be guided by the principles of ubuntu, in keeping with decolonisation of mental healthcare in South Africa.

6.3.5 Effective communication

As noted in chapter 4, the effectiveness of healthcare teams is dependent on effective communication between the team members. This component suggests that the success of a medical treatment team is primarily dependent on effective communication. The medical treatment team can hardly succeed if communication is ineffective. Therefore, this component suggests that there should be genuine, on-going interaction, dialogue, and consultation between HCPs to ensure effective patient care. In keeping with a mental health care context, different HCPs need to interact and communicate effectively so that patient-centred care can be achieved. Thus, team performance is heavily dependent on effective communication, including proper information exchange. Especially between the diverse representation of a variety of differently qualified HCPs, who form part of the medical treatment team for mental healthcare. Therefore, team members (HCPs who deal with mental health patients as per the context of this study) need to communicate

with each other, as well as merge their observations and expertise to optimise effective patient care (Amiri et al. 2018; Wang et al. 2018). This can be done by holding meetings so that information can be shared and decisions can be made collectively (Neuhaus et al. 2020; Rosen et al. 2018; Wang et al. 2018).

However, effective communication amongst HCPs can be strained because of cultural barriers such as, race, values, and lack of interprofessional respect amongst other challenges (Rosen et al. 2018). Therefore, the medical treatment team need to be cognisant of the cultural beliefs of both team members and patients and be respectful thereof. Yet it is important to note that these barriers can be overcome through effective communication. As discussed in chapter 4, effective communication also needs to take place between the HCPs and the patient's family members. The patient's family play an important role in healthcare; thus, the medical treatment team needs to communicate effectively with them in order to achieve patient-centred care.

6.3.6 Problem-solving between team members

Problems and differences can occur when professionals from different multidisciplinary backgrounds work together since they come from different backgrounds and hold different world views. Therefore, HCPs are encouraged to work through their differences in order to achieve effective patient care. The medical treatment team need to be collegial to ensure that effective patient care is the core goal of the medical treatment team. Differences can be resolved when members of the team express their views and opinions freely (Krietner & Kinicki 2014). Therefore, effective communication between members of the medical treatment team can play a critical role in problem-solving. This reinforces the need for effective communication in medical treatment teams.

6.3.7 Mutual respect

As discussed in chapter 4, mutual respect between the medical treatment team members enhances effective teamwork (Lankhof 2018; Morgan, Pullon & McKinlay 2015; Swihart 2016). Cultural diversity in medical treatment teams may result in lack of mutual respect as a result of their differences from a cultural perspective. Cultural tolerance amongst team members can help mitigate these differences and thus enhance mutual respect in the team. Individual team members should be open to the talents and beliefs of other HCPs and the patients in addition to their professional contributions (Augustus et al. 2019). This is because HCPs and patients represent different values and beliefs, which

have an effect on communication and interpretation thereof (Kholed et al. 2017). Therefore, members of the medical treatment team must consider cultural diversity when communicating with team members and patients. To establish mutual respect, HCPs need to establish good interpersonal and working relationships with their team members and the patient's family, while respecting and accepting cultural differences. Thus, decolonisation of mental healthcare is imperative.

Working in a medical treatment team and having mutual respect for team members is the best method for integrating the contributions of all members to achieve effective patient care. Acknowledging cultural diversity also enables the team to consider the patient's needs in mental healthcare (Muth et al. 2014). Lankhof (2018) adds that participation in team tasks and effective communication can build up team spirit and trust of other members (namely other HCPs). Mutual trust is fundamental in medical treatment teams and thus was included in the comprehensive conceptual framework.

6.3.8 Ubuntu: collaborative medical treatment teamwork

Ubuntu promotes cohesion, cooperation, interdependency, and reciprocal values amongst HCPs (Nzimakwe 2014). Taylor (2014) suggests that ubuntu cultivates a team spirit towards healthcare. Hence, every member of the medical treatment team must view teamwork from a perspective of interdependence and interpersonal connections as stipulated by ubuntu philosophy. Therefore, a decolonial approach to mental healthcare fits well with the African philosophy of ubuntu which focuses on a collective approach for mental healthcare. Ubuntu encourages caring, cultural tolerance, and interconnectedness (Molala & Downing 2020). The values of ubuntu contribute to effective healthcare (Fox 2010; Sulamoyo 2010; Taylor 2014). Therefore, all members of the medical treatment team must practice the values of ubuntu since these values can positively influence medical treatment teamwork and mental healthcare.

6.4 DECOLONIAL FRAMEWORK

It was argued in chapters 3 and 5 that decolonisation of mental healthcare can support mental healthcare in South Africa. Since a decolonial approach takes into consideration cultural factors, which are fundamental to healthcare (Keikelame & Swartz 2019; Nmutandani et al. 2018). The South African healthcare system considers mental illness from a medical perspective and does not consider cultural aspects in mental healthcare. The biomedical approach is lacking since it is based on colonial ideology. As mentioned

previously, the decolonial framework is three-fold. It suggests that the medical treatment team should cater for cultural diversity within the team in order to work in harmony and provide effective patient care. The decolonial framework also proposes that the medical treatment should collaborate with trained traditional healers in order to provide holistic care to the mentally ill patient. The decolonial framework also suggests that HCPs should consider the patient's cultural beliefs in mental healthcare. The principle of collaboration between the medical treatment team and traditional healers is discussed in the following section.

6.4.1 Collaboration between the medical treatment team (biomedicine) and traditional practitioners for mental healthcare

This construct suggests that the biomedical and traditional approaches should collaborate in order to provide holistic mental healthcare to patients. As discussed in chapter 3, the majority of South Africans consult with both traditional healers and HCPs on mental health issues (Jacobs & Coetzee 2018; Zingela et al. 2019).

It was also argued in chapters 3 and 5 that the biomedical approach is based on Western understanding of logic and rationality and thus excludes indigenous knowledge, also known as traditional knowledge. Therefore, the biomedical approach is problematic since it is often based on Western ideology. The proposed conceptual framework suggests that both the biomedical and traditional knowledge systems should be considered in mental healthcare, because mentally ill patients require healthcare that is tailored to their needs. Thus, these patients should be allowed to receive treatment that includes both biomedical and traditional approaches where need be. Therefore, the medical treatment team should consider a decolonial approach to healthcare. As noted in chapters 3 and 5, a decolonial approach considers indigenous aspects such as culture. A complementary approach that considers both Western and traditional approaches will provide holistic healthcare to the patient. Since a complementary approach is neither exclusively traditional nor fully Western.

6.5 SOCIO-CULTURAL FACTORS

In the context of this study, socio-cultural consideration is two-fold (that is for both patients and HCPs). Cultural differences have the potential to hamper treatment teamwork. Therefore, HCPs need to be tolerant of other team member's cultural diversities to be able to work in harmony with them and thus provide effective treatment

for the patient (Johnson et al. 2017). In the context of this study, the medical treatment team is required to provide quality mental healthcare service to mentally ill patients. Therefore, the medical treatment team needs to interact with the patient's family in order to cater for the patient's socio-cultural needs. In essence, the medical treatment team can cater for socio-cultural aspects if they tolerate the diverse cultures of both the patient and other team members. Consideration for socio-cultural factors will enable the provision of effective mental healthcare. Thus, socio-cultural factors have been included in the conceptual framework. This element has two components, namely culture and family. These components are discussed in the following sections.

6.5.1 Culture

As noted in chapters 3 and 4, culture is a major determinant of effective patient care because South Africans are influenced by their cultural norms and beliefs (Nemutandani 2016; Sigida 2016; Zingela et al. 2019). Therefore, the medical treatment team needs to cater for the culture of the patients when providing mental healthcare. It is essential for HCPs to understand the patient's knowledge and culture about mental illness (Warnecke 2014). Only through an understanding of the patient's interpretation of mental illness will it be possible for the medical treatment team to provide culturally appropriate mental healthcare. Failure to do so is likely to result in inadequate understanding of the patient's culture and, as a result, the patient may not adhere to treatment.

The HCPs also need to be aware of their own cultural beliefs while tolerating the cultural beliefs of other team members. Cultural tolerance may improve collaborative medical treatment teamwork for patient care. Therefore, HCPs need to acquire cultural knowledge about the mentally patient as well as their own personal biases with regard to how they view cultures of other team members (Crawford et al. 2016; Johnson et al. 2017). It is evident from the discussion in chapters 3 and 5 that culture is an important factor in understanding mental health issues. It is, therefore, imperative to acknowledge culture as a factor that influences mental health treatment.

6.5.2 Family

This component involves a patient's social support system such as the family, especially in a situation where the patient is cognitively impaired and cannot make rational decisions as explained throughout the preceding chapters. As discussed in chapter 3, the patient's family members also need to be involved in their mental healthcare in order

to achieve effective patient care. This is because family members can positively influence a patient's treatment by providing support and encouragement to the patient. Family involvement in healthcare results in significant benefits for both the individual and the healthcare system. Therefore, mental healthcare requires a comprehensive approach that includes active participation of the patient's family in the South African context. Therefore, the medical treatment team should work together with the family members to achieve effective patient care for mental illnesses.

6.6 MENTAL HEALTH POLICY

Mental health policy has been included as an element of the conceptual framework as policy guides the laws of a nation and hence plays a critical role in reaching the goals of effective mental healthcare (Cooper 2015; Mulutsi 2017; Sibanyoni & Maritz 2016). As discussed in chapter 3, South Africa promulgated the new MHCA 17 of 2002. However, despite the extensive provisions of the Act, mental health services are found lagging. The lack of adequate infrastructure, inadequate numbers of HCPs, and poor support from government are some of the reasons that undermine the successful implementation of mental health policies. Additionally, while there is growing interest in policymaking, less attention is paid to the question of the individual and socio-cultural factors that can help in the development and implementation of the mental health policy in South Africa. This further explains why this construct has been included in this conceptual framework. This construct proposes that the government should consider following:

- Cultural beliefs and values when developing policies
- Government policy should ensure that HCPs (medical treatment teams) and traditional health practitioners are involved when developing the policy
- Family therapy guidelines should form part of the policy to address how families should be involved in mental healthcare
- Hospital mental health policies should also consider and promote a teamwork approach to mental healthcare
- Policymakers should ensure that HCPs and traditional leaders are involved during policy development

6.7 SUMMARY

The focus of this chapter was to develop a comprehensive conceptual framework for a medical treatment team approach to mental healthcare in the South African context.

Thus, this chapter has conceptualised and proposed a comprehensive conceptual framework for mental healthcare in South Africa. The conceptual model was developed from the literature reviewed in the preceding chapters. This comprehensive conceptual framework has been developed as the contribution of this study to the field of health communication. The framework proposes four elements, that is, a medical treatment team, decolonial aspects, socio-cultural aspects, and policy, which must be considered in mental healthcare. Hence, the proposed framework argues that all the above-mentioned factors must be considered to effectively contribute to mental healthcare in South Africa. The next chapter describes the methodology that was used to verify the proposed framework in the field.

CHAPTER 7: METHODOLOGY

7.1 INTRODUCTION

It was noted in chapter 1 that this study aimed to develop a comprehensive conceptual framework for a decolonial medical treatment team approach to mental healthcare in the South African context. The literature in chapters 2, 3, 4, and 5 were synthesised to build a conceptual framework that was proposed in chapter 6. The conceptual framework was empirically verified in the field to determine whether the elements of the proposed conceptual framework were accepted, amended, and/or rejected. Thus, this chapter provides an explanation of the research methodology that was used to empirically verify the proposed conceptual framework. A qualitative multiple case study research design was used to verify the framework at specific settings, namely Cecilia Makiwane Hospital and Fort England Psychiatric Hospital. The data collection methods included, document analysis, observation, face-to-face semi-structured interviews and FGDs. The conceptual framework presented in chapter 6 was then modified as a result of the findings generated from the data and is presented in chapter 9.

This chapter explains the qualitative multiple case study design underpinned by Yin (2018), Braun and Clarke (2006), Creswell (2013), Hancock and Algozzine (2011), Kiliç and Firat (2017), La Rossa and Bennett (2018), Lincoln and Guba (1985), Sarantakos (2013), Stake (2006), Tavakol and Dennick (2011), and Van Eeuwijk and Angehrn (2017). This chapter explains the research methodology adopted in the study, starting with the research design, research paradigm, multiple case study approach. As well as the background to the case study settings, population, units of analysis, sampling used. The data collection methods are then explained namely, document analysis, observation, face-to-face, semi-structured interviews and FGDs. Thereafter the procedures used for the data analysis, validity and reliability, and ethical considerations of the study are explained. The structure of the chapter is summarised in Figure 7.1.

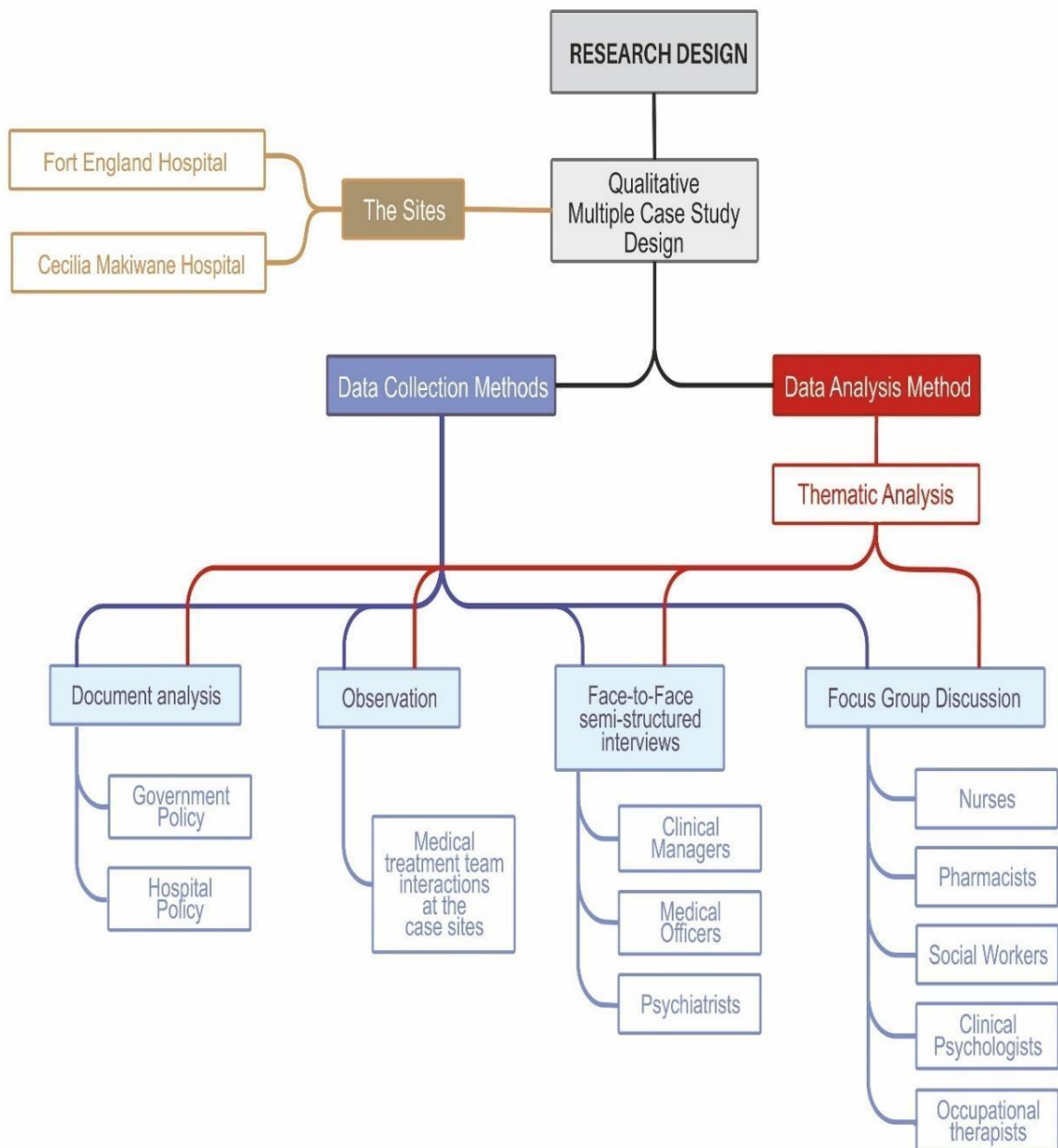


Figure 7.1: Structure of chapter 7

7.2 RESEARCH DESIGN

There are two types of research design, namely quantitative and qualitative (Creswell 2013; Yin 2018). Quantitative research design focuses on measuring and quantifying data, while qualitative research focuses on gaining rich text, insights, and in-depth understanding of a phenomenon (Moyo 2015). This study adopted a qualitative multiple

case study research design. A qualitative multiple case study research design was selected because it allowed the researcher to explore detailed information pertaining to the decolonisation of mental healthcare and the role of the medical treatment team in mental healthcare in South Africa (Rapport, Hogden, Faris, Bierbaum, Clay-Williams, Long, Shih, Seah & Braithwaite 2018; Yin 2018). This was done by conducting a document analysis of government and specific hospital mental healthcare policies; observation (that is, the observation of medical treatment team interactions for patient care); face-to-face, semi-structured interviews with clinical managers, medical officers, and psychiatrists; and FGDs with different medical treatment team members, including nurses, clinical psychologists, occupational therapists, pharmacists, and social workers.

The selected hospitals have a hierarchical management system and that the medical treatment team have a hierarchical structure. For example, the clinical managers supervise the overall function and management of the medical treatment team and ensure that all members of the treatment team implement policies and procedures accordingly (Jeevanie 2012). The medical officers lead the HCPs by clearly defining the roles and responsibilities of the medical treatment team members. They also ensure that the medical treatment team members implement the treatment plan for mentally ill patients accordingly (WHO 2018). The team structure represents the different roles that each treatment team member has in enhancing mental healthcare (Stanley 2012). Therefore, it was important to gather data from all the above-mentioned medical treatment team members in order to have a detailed understanding of a medical treatment team approach to mental healthcare. The next section highlights some of the characteristics of the qualitative research design relevant to this study.

7.2.1 Qualitative research design

Brink (2017) argues that unlike quantitative research which focuses on measuring, the role of qualitative research is to gather data that relates to the experiences of research participants. Therefore, using a qualitative methodology enabled the researcher to gain a detailed understanding of the experiences of HCPs, interactions, knowledge, values, and opinions with regard to a medical treatment teamwork approach to mental healthcare, at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital. This was achieved through the process of document analysis, observation, face-to-face, semi-structured interviews and FGDs conducted by the researcher in the research

setting (Check & Schutt 2012). Results from the data collected determined whether the elements of the proposed conceptual framework would be accepted and/or rejected.

Brinkmann (2017) further suggests that qualitative research seeks to explore a phenomenon within its natural setting. In the context of this study, natural setting refers to the hospital environment where the medical treatment teamwork took place. A qualitative research approach was, therefore, appropriate since this study aimed to explore a medical treatment team approach consisting of HCPs (including nurses, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists) in a natural setting. Based on the two cases, that is, Cecilia Makiwane Hospital and Fort England Psychiatric Hospital. Thus, data collection occurred in its natural settings. Furthermore, a qualitative design was adopted as qualitative research is inductive in nature, that is, the researcher uses a systematic set of procedures to analyse data that produces reliable and valid results (Creswell 2013). In the following section, the application of the qualitative research design in a mental healthcare context is discussed to further contextualise the use of qualitative design in the current study.

7.2.1.1 Application of qualitative research design in a mental healthcare context

It is important to note that the researcher also adopted a qualitative research design because it is highly effective for research in mental healthcare specifically. As well as and for research in a medical setting such as hospitals and clinics since it can provide new insights and knowledge related to a medical treatment teamwork approach to mental healthcare (Rugkåsa, Tveit, Berteig, Hussain & Ruud 2020; Sobekwa & Arunachallam 2015). Below are examples of studies conducted using qualitative research in the context of a medical treatment teamwork approach to mental healthcare. These studies are discussed to further justify the use of a qualitative research design for this study.

Sobekwa and Arunachallam (2015) employed a qualitative design to explore the experiences of nurses caring for mental healthcare users in an acute, that is short-stay, admission unit at a psychiatric hospital in the Western Cape, South Africa. The results revealed both positive and negative experiences. The positive experiences included witnessing the recovery of mentally ill patients and experiencing teamwork amongst staff members. The participants emphasised the need for medical treatment teamwork in mental healthcare. The negative experiences were the nurses' feelings of being

unappreciated by the management of the hospital. Furthermore, Deacon and Cleary (2013) made use of a qualitative research design to explore the reality of teamwork in a mental health ward in the United Kingdom. Findings from this study revealed that medical treatment teamwork contributed to effective patient care. The findings also indicated that mentally ill patients required interpersonal relationships with all members of the medical treatment team because they all contributed, through teamwork, to the patients' recovery.

Furthermore, Rugkåsa et al. (2020) used a qualitative design to explore collaborative care for mentally ill patients in Oslo, Norway. The HCPs in the study included nurses, psychiatrists, physiotherapists, pharmacologists, and occupational therapists. The study found that the HCPs who worked together benefitted from each other's expertise and this improved patient care. The HCPs also expressed the view that the complementary skills in the medical treatment team helped them to attend to the patients' needs. Furthermore, Liyanage (2012) used a qualitative design to explore a medical treatment team approach to mental healthcare in two community hospitals in the United Kingdom. The results of this study revealed that medical treatment teamwork brought great healthcare benefits to the patients since each professional brought their own expertise to the team. These findings suggested that a qualitative research design could be used to explore a medical treatment teamwork approach to mental healthcare at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital.

Qualitative studies are often associated with the interpretative paradigm since the interpretive paradigm allows the researcher to collect rich and in-depth data in a contextual setting (Luchembe 2020; Pharm 2018; Tehereni et al. 2015). As noted above, the aim of this study was to collect data for medical treatment team approach to mental healthcare in a hospital environment. Therefore, in this study, the qualitative research design was guided by the interpretative research paradigm. The next section provides a discussion on the interpretive paradigm for the purposes of this study.

7.3 RESEARCH PARADIGM

There are four main types of paradigms, namely positivist, critical theory, post-positivist, and interpretative (Mittwede 2012; Roller & Lavrakas 2015). Qualitative research is a form of interpretative inquiry; therefore, this study adopted the interpretative paradigm (Luchembe 2020; Pham 2018). According to Allen and Wright (2014), the interpretive paradigm aims to observe, understand, and interpret an issue or phenomenon from the

perspective of the participants. Therefore, the interpretative paradigm was particularly relevant to this study since this research aimed to gain an understanding of a medical treatment team approach to mental healthcare from the perspectives of the participants, namely the HCPs who formed part of the medical treatment team. Detailed information was collected through the above-mentioned data collection methods.

The interpretative paradigm seeks to understand and interpret the world in terms of interaction between individuals such as members of the medical treatment team, that is, between the nurses, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists in a hospital environment (Enwald 2013; Pham 2018; Uhan 2013; Wanyoike 2011). Thus, the interpretive approach was appropriate in that it helped the researcher to uncover the social reality of the HCPs, in relation to how they experienced interactions, challenges, and encounters when working as a team to treat mentally ill patients. The following section explains a multiple case study design for the purposes of this study.

7.4 A MULTIPLE CASE STUDY DESIGN

There are generally two types of case studies, namely single and multiple. A case study is a research method that investigates a contemporary phenomenon in a specific setting (Brink 2018; Yin 2018). A single case study is an in-depth analysis of one case, while a multiple case study involves the in-depth analysis of more than one case (Sarantakos 2013; Yin 2018). For the purposes of this study, a multiple case study was deemed more appropriate because analytic conclusions from a multiple case study are robust and substantial (Brink 2018; Creswell 2013 Stake 2006; Yin 2018).

The data from the two case study sites aimed to generate substantial information to help in the understanding of the medical treatment teams' approach to mental healthcare. Yin (2018) adds that conclusions drawn from case study design are likely to be more valid and reliable if different sources of data are used to corroborate the same phenomenon. Hence, this multiple case study ensured validity by collecting data through four different methods, namely document analysis, observation, face-to-face, semi-structured interviews, and FGDs of the medical treatment team and HCPs' interactions. The use of four data collection methods enabled triangulation of the study's findings (Liamputtong 2013). Triangulation of the research results enabled the researcher to obtain a rich and deep understanding of how the different HCPs worked together to treat mentally ill

patients (Brink 2018; David & Sutton 2011; Pantidi 2013; Sarantakos 2013; Stake 2006; Yin 2018).

According to Creswell (2013), a multiple case study allows the exploration of a real-life multiple bounded system. A bounded system in the context of this research refers to the case under study, which was a treatment team approach to mental healthcare at the selected research sites. Thus, by using a multiple case study, the researcher explored two bounded cases which enabled a wider exploration of the research phenomenon (Brink 2018; Yin 2018). The detailed information gathered from these two cases were analysed to determine if the elements of the proposed conceptual framework based on literature and theory could be supported, amended and/or rejected. Having considered the appropriateness of a multiple case study design for this study, the next section provides a brief background to the case study settings.

7.5 BRIEF BACKGROUND TO THE MULTIPLE CASE STUDY SETTING

Data were collected from two cases, namely Cecilia Makiwane Hospital and Fort England Psychiatric Hospital. Both these sites are located in the Eastern Cape province of South Africa. According to Statistics South Africa (2019), the province has a population of about 6.5 million people. The Eastern Cape has six district municipalities and two metropolitan municipalities (Global Africa Network 2020). Cecilia Makiwane Hospital is located in East London in the BCMM while Fort England Psychiatric Hospital is located in Grahamstown in the Sarah Baartman District Municipality (Global Africa Network 2020). As discussed in chapter 2, the Eastern Cape is one of the least economically developed provinces in South Africa (Statistics South Africa 2019). The unemployment rate of 35.6 per cent contributes to low economic development in the province (ECSECC 2019). Thus, unemployment and poverty contribute to the prevalence of mental illnesses in the Eastern Cape (Andersson, Schierenbeck, Strumper, Kranz, Topper, Backman & Van Rooyen 2013; Ellis 2018; Sukeri 2015). As indicated in chapter 2, the Eastern Cape has a high prevalence of mental illness. This was the reason for selecting these case studies in this province. The following section provides background information on the selected case studies.

7.5.1 Site A: Fort England Psychiatric Hospital

Fort England Psychiatric Hospital is located in Grahamstown in the Eastern Cape province of South Africa. This hospital was set up in 1894, therefore, it is one of the

oldest mental health hospitals in South Africa. This hospital is a 300-bed psychiatric hospital which provides healthcare services such as psychiatry, occupational services, rehabilitation services, ARV treatment services, and post-trauma counselling services. The hospital has catered for patients with mental illnesses since 1894 (TravelGround 2021). During an interview conducted on 10 February 2022, Dr Seshoka confirmed that Fort England Hospital only caters for mentally ill patients. Dr Seshoka added that the hospital was a long-stay hospital and the only forensic psychiatric hospital in the Eastern Cape (T Seshoka 2022, personal communication, 10 February). Fort England Psychiatric Hospital also has a maximum security ward which caters nationally for mentally ill, sentenced offenders who have been referred by courts. It is important to note that Fort England Hospital is a long-stay hospital. A long-stay hospital focuses on patients who stay more than an average of 25 days in the hospital for mental healthcare (Sukeri 2017). Thus, this hospital provides long-term psychiatric care to mentally ill patients.

7.5.2 Site B: Cecilia Makiwane Hospital

Geographically, Cecilia Makiwane Hospital is situated in the Mdantsane township of East London. Cecilia Makiwane Hospital is a public (that is, government owned) hospital that was first opened in 1974. The hospital provides many healthcare services, including psychiatry, paediatrics, post-trauma counselling, an OPD, surgery, gynaecology, internal medicine, an ARV clinic for HIV/AIDS in adults and children, occupational services, anaesthetics, paediatric surgery, dermatology, pharmacy services, otolaryngology (ENT), and ophthalmology amongst others (TravelGround 2021). Cecilia Makiwane Hospital also has a mental care unit that was opened in 1974 and is made up of wards 11-15.

Cecilia Makiwane Hospital is the only hospital in the BCMM that offers mental healthcare services to the entire BCMM and Amathole district of the Eastern Cape province, which has a combined population of 1,674,637 people living in the region. During an interview conducted on 26 February 2022, Dr Aboobaker stated that Cecilia Makiwane Hospital was an acute hospital that had a mental health unit (A Aboobaker 2022, personal communication, 26 February). Thus, contrary to Fort England Hospital, Cecilia Makiwane Hospital is a short-stay (acute) hospital with a mental health unit as part of the hospital.

Both hospitals have medical treatment teams who treat mentally ill patients; hence these hospitals were selected for the purposes of this study. The following section provides a discussion on the population, units of analysis, research permission, and sampling that was used for this study.

7.6 POPULATION, UNITS OF ANALYSIS, RESEARCH PERMISSION, AND SAMPLING

7.6.1 Population

David and Sutton (2011) define population as being the total number of cases that meet specified criteria. For every research study, there is a target and an accessible population. In the sections that follow, the target and accessible population for this study are discussed.

7.6.1.1 Target population

The target population refers to the “totality of units” from which the sample is drawn (Daymon & Holloway 2011:209). The current study had three sets of target population namely, HCPs (including, nurses, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists); clinical managers (who were also HCPs but held a managerial position); and documents (namely the mental healthcare policies of both government and hospital).

- The target population for HCPs

The target population for the study was the HCPs who formed part of the medical treatment team that treated mentally ill patients at the two selected hospitals. The medical treatment team members included nurses, medical officers, clinical psychologists, occupational therapists, social workers, pharmacists, and psychiatrists. These HCPs were selected as the target population for this study because they had adequate knowledge of the medical treatment team approach to mental healthcare at the selected case study sites (Cleary et al. 2014).

- The target population for clinical managers

The target population for the clinical managers included all the HCPs who held a managerial position at the selected sites. A clinical manager is a healthcare worker who has received additional training in management and leadership (Clavel & Pomey 2020).

The clinical managers were selected as the target population because the clinical managers plan, coordinate, manage, and evaluate the activities of a multidisciplinary treatment team to ensure the delivery of high-quality mental healthcare to patients (Jeevanie 2012). Each case site had one clinical manager. Thus, the clinical managers (one from Site A and one from Site B) at the case sites were targeted to determine how the medical treatment team functioned. As well as how the medical treatment team implemented both government and hospital policies, in everyday mental healthcare work (Clavel & Pomey 2020; Weller et al. 2014).

- The target population for documents

The targeted population for the documents included all governmental mental healthcare policies that were developed after apartheid. These policies were analysed because policies prior to democracy were discriminatory and not inclusive (Van Rensburg 2012). Mental healthcare policies during apartheid were not culturally relevant to the majority of South Africans (Van Rensburg 2012). Therefore, after apartheid there was a need to cater for patient diversity as per the South African Constitution (Jacobs & Coetzee 2018), hence policies were developed which aimed to dismantle or redress the injustices in mental healthcare inherited from the apartheid government (Szabo & Kaliski 2017; Van Rensburg 2012) and needed to cater for the needs of all South Africans citizens. As noted in chapter 3, most South Africans are influenced by their culture (Penson 2019; Zingela et al. 2019). Therefore, it was necessary to analyse the post-apartheid mental health policies, to determine whether the health policies in a democratic South Africa contribute to catering for mental healthcare diversity.

The targeted population for the hospital policies included, all policies that guided mental healthcare at the selected hospitals. It should be noted that these hospitals used both government and hospital mental healthcare policies developed after apartheid related to mental healthcare. A total of 14 documents (two mental healthcare policies and 12 hospital policies) were analysed for the purposes of this study. In the sections that follow, the accessible population for this study is discussed.

7.6.1.2 Accessible population

Du Plooy (2009) suggests that an accessible population for a research study constitutes a sub-group of the target population. This study included three sets of accessible populations as explained below.

- HCPs who formed part of the medical treatment team at the selected research sites, which included nurses, medical officers, clinical psychologists, occupational therapists, pharmacists, social workers, and psychiatrists.
- Clinical managers: these are HCPs who held a managerial position at the mental healthcare units at the selected sites. The accessible population included the two clinical managers who were available to participate in the study during the time of data collection. One clinical manager was interviewed at each case study site.
- Policy documents: these included both governmental and the respective hospital policies related to mental healthcare.

As noted above, this study included both government and hospital policies. The government policy documents included two mental health policies, the MHCA 17 of 2002 and the NMHPF. The hospital documents included 12 hospital policies that were relevant to this study namely,

- Multidisciplinary team
- Guidelines for the rights and duties related to the MHCA and family
- Medical errors
- Transfer of patients to other institutions
- Transfer of involuntary patients to Fort England Hospital
- Discharge and follow-up of patients
- Seclusion of mental healthcare users
- Admission to Cecilia Makiwane Hospital and Fort England Hospital
- Emergency referrals to Cecilia Makiwane Hospital and Fort England Hospital
- Care of sedated patients
- Disability grant assessment
- Policy on seclusion of mental healthcare users
- Policy pertaining to ward rounds

7.6.1.3 Population parameters

- Population parameters for HCPs

The criteria used for the selection of HCPs were as follows:

- HCPs were employees of Cecilia Makiwane Hospital and Fort England Psychiatric Hospital

- HCPs were part of the medical treatment team that treated mentally challenged patients
- HCPs had to provide consent to voluntary participation
- HCPs were of any race and were aged between 18 to 50 years
- HCPs had to be able to communicate in English, since all the face-to-face, semi-structured interviews and FGDs were conducted in English
- Population parameters for clinical managers

Clinical managers had to be HCPs who held a managerial role. Therefore, all the population parameters listed for HCPs as per section 7.6.1.3 is also applicable for clinical managers.

- Population parameters in relation to policies

Policies which were developed after apartheid were inclusive, fair, and tolerant to all races; this included mental healthcare (Van Rensburg 2012). As discussed in chapters 2 and 3, the apartheid government adhered to a biomedical mental healthcare approach in which socio-cultural aspects such as cultural/traditional remedies and the role of the family in mental healthcare were not considered. After democracy, the ANC government implemented new mental healthcare policies. Therefore, post-apartheid policies were analysed in order to establish whether current mental healthcare policies recognised socio-cultural inclusion in mental healthcare. All policies that were analysed were written in English.

7.6.2 Units of analysis

The unit of analysis refers to the “who” and “what” that were analysed in this research (Cole 2018). In this study, the unit of analysis included HCPs (members of the treatment team), clinical managers (who were managers of the mental healthcare units at the sites) and both government and hospital policies related to mental healthcare.

7.6.3 Permission to conduct research at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital

In order to conduct this study, permission was obtained from the following stakeholders namely, the University of South Africa (UNISA, Department of Communication Science); Cecilia Makiwane Hospital (under the supervision of Mr Mthetheleli Matshoba); Fort

England Psychiatric Hospital (under the supervision of Dr Thupana Seshoka); and the Eastern Cape Department of Health.

The process of obtaining ethical permission included applying for ethical permission from the university. Thereafter approval was obtained from the Eastern Cape Department of Health. After obtaining approval from the Department of Health, the researcher contacted the area manager of the mental health unit at each of the case study sites to request permission to conduct research at these hospitals. Letters of permission were granted from both hospitals (see appendix B and C). Once permission was granted, the area managers of the mental health units assisted the researcher with recruiting HCPs who formed part of the medical treatment teams. Only HCPs who were part of the medical treatment teams were selected since this study aimed at empirically verifying the proposed conceptual framework amongst members of the medical treatment team. The next section provides a discussion on the sampling strategy applied to this study.

7.6.4 Sampling strategy

Purposive sampling was used to select participants for the FGDs, face-to-face, semi-structured interviews, and documentation. Selecting different participants for the different data collection methods enabled triangulation of the research findings (Patton 2002). For the purpose of this study, purposive sampling was selected for two reasons. First, case study designs use purposive sampling to collect data because they aim to explore a phenomenon in its natural setting (Yin 2018). Therefore, purposive sampling was appropriate for this study since this research aimed to explore a medical treatment team approach to mental healthcare in a hospital environment (natural setting), where HCPs worked collaboratively to provide patient care. Collecting data in the healthcare setting allowed the researcher to obtain insights into how the team members interacted and worked with each other to treat mentally challenged patients. Secondly, purposive sampling allowed the researcher to select HCPs who had experience and vast knowledge in relation to the medical treatment teamwork (Bryman & Bell 2014; Cleary et al. 2014; Creswell 2014; Liamputtong 2013; Pascoe 2014). Thus, only the HCPs who formed part of the medical treatment teams were selected to participate in the study.

With regard to policies, the researcher purposively selected post-apartheid government policies that were related to mental healthcare. Access to the hospital policies that dealt with mental healthcare was provided to the researcher by the area manager of the mental

health unit at both the research sites. Purposive sampling was also used to select clinical managers for this study. Clinical managers have an in-depth understanding and knowledge on how a mental healthcare treatment team should function (Jeevanie 2012). As noted in chapter 3, after apartheid there was a need to decolonise mental healthcare in order to cater for diversity, as per the South African Constitution (Jacobs & Coetzee 2018). Therefore, the clinical managers ensured that the medical treatment team complied with all relevant mental healthcare policies for the treatment care of patients. The following sections provide a detailed discussion on the four data collection methods that were used for this study.

7.7 DATA COLLECTION

Yin (2018) recommends that three or more sources of evidence should be used in case study research. Hence, this study made use of four data collection methods, namely document analysis, observation, face-to-face, semi-structured interviews and FGDs. As discussed in section 7.4 above, the use of four data collection methods enabled triangulation of the research findings as well as ensuring that credible and valid data was sourced for this study (Patton 2002; Stewart-Withers et al. 2014; Yin 2018).

The researcher commenced the data collection process by analysing the selected government and hospital policies to gain an in-depth understanding of the policy guidelines informing mental healthcare. By analysing these policies, the researcher was able to determine if these policies supported the transition towards the decolonisation of mental healthcare. The second phase of the data collection process was observation. The researcher had to book appointments with the medical treatment teams at both sites to conduct face-to-face, semi-structured interviews and FGDs. However, it must be noted that observation was a continuous process that carried on throughout the data collection period. The researcher observed the overall functioning of the medical treatment team in terms of interactions during patient care. Face-to-face, semi-structured interviews were conducted with the clinical managers to verify the policies and discuss policy implementation at the selected sites. Hereafter, medical officers were interviewed since they were the team leaders of the medical treatment teams. The last phase involved conducting FGDs with all other HCPs who formed part of the medical treatment teams. The researcher followed the same data collection process at both sites. The data collection in the field is summarised in Figure 7.2.

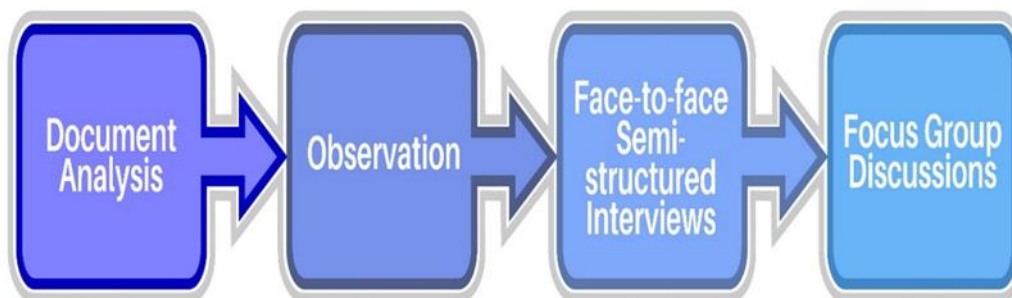


Figure 7.2: Data collection process at Fort England Hospital and Cecilia Makiwane Hospital.

The four data collection methods employed in this study are explained in the following sections.

7.7.1 Documentation

This study collected data from documents that included both government and hospital policies related to mental healthcare. Yin (2018:115) suggests that the “most important use of documentation is to corroborate and augment evidence from other sources.” Therefore, the researcher used the above-mentioned policies to cross-check evidence from the observation, face-to-face, semi-structured interviews and FGDs. From a methodological standpoint, document analysis is an important way to enhance the quality of case studies and to ensure their validity and reliability (Yin 2018). To ensure validity of the results, triangulation was implemented by using the four data collection methods mentioned above. Credibility was also achieved through multiple reviews of the documents, the voice recordings (from face-to-face, semi-structured interviews and FGDs) and observation notes taken during data analysis (Babbie & Mouton 2001).

As mentioned above, the researcher analysed post-apartheid government and hospital policies that were related to mental healthcare. Since these policies were developed in a democratic South Africa and these policies also link to the research context of decoloniality. The literature in chapter 3 suggested that the main objectives of post-apartheid mental healthcare policies were to promote human rights in South Africa since

policies during apartheid were inhumane (Van Rensburg 2012). Therefore, it was important to analyse the post-apartheid mental healthcare policies to determine if these policies supported or acknowledged the shift towards a decolonial approach to mental healthcare in South Africa. The post-apartheid policies needed to cater for the cultural needs and diversity of all South Africans (Van Rensburg 2012). As noted in chapters 3, 4, and 5, most South Africans are influenced by their culture. The NMHPF and Strategic Plan 2013-2020 stipulates that varying cultural expressions and interpretations of mental illness should be respected (Department of Health 2013).

The MHCA 17 of 2002 permits a parent, spouse, sister, or brother to give consent to the medical treatment of a mentally ill patient (Republic of South Africa 2002). Therefore, the medical treatment team needed to cater for the needs of mentally ill patients (Penson 2019; Zingela et al. 2019). It was therefore assumed that the post-apartheid policies would have sufficient information to enable the researcher to glean key insights to integrate into the proposed framework. The purpose of this study was to gain an understanding of the decolonisation of mental healthcare and the role of the medical treatment team in assisting such a shift, to cater for treatment team diversity, patient diversity, and family inclusion in patient mental health care amongst other aspects as noted in the previous chapters. Thus, issues such as medical treatment teamwork, cultural context, and the role of the patient's family members in mental healthcare were explored in the selected policies.

7.7.2 Observation

Observation is described as a naturalistic inquiry that takes place in a setting such as a hospital environment, as per this research focus (Mathews & Ross 2010; Yin 2018). According to Yin (2018), observing participants interacting in their daily activities makes research results more reliable. The objective for using this data collection method was to observe,

- The everyday processes of the treatment team, within their selected hospitals.
- How the members of the medical treatment team worked collaboratively to provide mental healthcare to individual patients.
- Each and every aspect of the team's work routine.
- How the medical treatment team communicated with each other within the team, and with their patients.

- The conversations related to the medical treatment team approach to mental healthcare such as treatment team sessions and consultations with patients. During consultations (patient care communication).
- If the patient's socio-cultural needs were catered for and if the decolonisation of mental healthcare was occurring as per mental healthcare policy.
- Team diversity and cultural dynamics in teams for patient care were also observed.

Observation was carried out on a daily basis for a period of two weeks per selected hospital. The researcher used an observation schedule during the sessions (see Appendix G). The observation schedule was informed by various elements (medical treatment teamwork, decolonial aspects, socio-cultural context, and policy) from the proposed conceptual framework, as well as literature and theories used in this study. The researcher referred to patients as A and B, when discussing observations as to how the team collaborated to treat individual patients. The observations were documented in field journals and kept for analysis. The next section provides a discussion of the face-to-face, semi-structured interviews as applied to this study.

7.7.3 Face-to-face, semi-structured interviews

Yin (2018) argues that an interview is the most important method for collecting data in case study research, since most case studies focus on human affairs or actions. Thus, knowledgeable individuals can provide substantial information into such affairs or actions. In the context of this study, face-to-face, semi-structured interviews were selected since they allowed the researcher to explore the participants' (that is, both clinical managers' and medical doctors') experiences and narratives with regard to their role played in the mental healthcare team approach for patient care (Rule & John 2011). Face-to-face, semi-structured interviews were also used because they enabled the researcher to obtain in-depth information by asking the above-mentioned participants semi-structured, questions (Rule & John 2011). In addition, this method allowed the researcher to probe for responses to gain a detailed understanding of a medical treatment teamwork approach to mental healthcare (Cohen, Manion & Morrison 2007; Rule & John 2011). The subsequent discussion provides details on why face-to-face, semi-structured interviews were conducted with the selected participants.

7.7.3.1 Clinical managers

The clinical managers as mentioned above include HCPs who held managerial positions in a hospital (Stanley 2012). Their key responsibilities were to plan, coordinate, manage, and evaluate the activities of the medical treatment team to ensure the delivery of effective mental healthcare to patients (Jeevanie 2012). As noted above, the selected hospitals had a hierarchical management system. Therefore, face-to-face, semi-structured interviews were conducted with the clinical managers because they were the heads of the mental healthcare units. Each case site had one clinical manager (one from Site A and one from Site B). Face-to-face, semi-structured interviews were carried out with the clinical managers to gain in-depth information about how the treatment team functioned in relation to providing patient care.

As noted in chapter 3, mental health policies in a democratic South Africa have placed considerable emphasis on the need for multidisciplinary teamwork, as well as consideration for cultural context, and the role of the family in contributing to the support and care of mental health. The case sites also had their own mental healthcare policies and guidelines which encouraged a medical treatment teamwork approach to mental healthcare. Therefore, the objective of the in-depth interviews was to gather qualitative data on how both government and hospital policies were implemented at the sites. It must be noted that the clinical managers were also HCPs, therefore, the clinical managers who took part in the face-to-face, semi-structured interviews did not participate in the FGDs.

7.7.3.2 Medical officers and specialist psychiatrists

Medical officers and specialist psychiatrists are also HCPs. It must be noted that doctors in the context of a public hospital are called medical officers (T Seshoka 2022, personal communication 10 February). The medical officers in a mental healthcare context and the specialist psychiatrist were interviewed because they were the leaders of the medical treatment teams. The team leaders or ward leaders planned and supervised the implementation of care and treatment plans by other members of each medical treatment team (Hean, Clark & Adams 2006; Weller et al. 2014; WHO 2018). Therefore, it was important to interview the medical officers and psychiatrists, in order to obtain in-depth information related to the medical treatment team approach to mental healthcare at the sites.

Furthermore, these HCPs were interviewed because in South Africa there is a shortage of doctors in the public healthcare sector (Stanley 2012). As noted in chapter 3, about 12 per cent of medical officers work in rural provinces such as, the Eastern Cape where this study was conducted (Mulutsi 2018; The Rural Mental Health Campaign 2015; WHO 2014). Therefore, the researcher decided to conduct face-to-face, semi-structured interviews with medical officers and psychiatrists but not to include these HCPs in the FGDs due to the limited number of doctors available at the case sites. Thus, the researcher individually interviewed the medical doctors and psychiatrists who formed part of the medical treatment team, to determine their role in the treatment team approach to mental healthcare.

7.7.3.3 The process of face-to-face, semi-structured interviews

As noted in the previous sections, face-to-face, semi-structured interviews were carried out with the clinical managers and medical doctors sampled at both Cecilia Makiwane Hospital and Fort England Psychiatric Hospital. One of the objectives of this study was to empirically verify the proposed conceptual framework in the field. Therefore, the semi-structured interview questions conducted with the different samples were informed by the proposed conceptual framework presented in chapter 6, as well as the literature and theories used in chapters 4 and 5. At Site A, five medical officers, one clinical manager, and one psychiatrist were interviewed. While at Site B, three medical officers, one clinical manager, and one psychiatrist were interviewed.

The researcher used an interview schedule which consisted of open-ended questions since these types of questions allowed leeway for the participants to provide detailed responses. During the face-to-face, semi-structured interviews, the researcher explained that participation was voluntary, and that the information provided was confidential. The researcher took notes during the face-to-face, semi-structured interviews which served as back-up information and also jotted down non-verbal cues to facilitate the data analysis processes (Bolderston 2012; Yin 2018). After the interviewees had answered all the questions, the researcher concluded the interview and thanked the interviewees for participating. The recording was saved for transcription. The next section provides a discussion on FGDs as applied to this study.

7.7.4 Focus group discussions

According to Van Eeuwijk and Angehrn (2017), FGDs are a data collection method which allows a group of people (as per research context, different HCPs who formed part of the treatment team) to discuss a given issue or topic (such as mental healthcare as per this research focus) in-depth in a natural setting (such as a hospital environment). As discussed in previous sections, this study developed a conceptual framework for a medical treatment teamwork approach to mental healthcare from the literature and theory. Thereafter the conceptual framework was verified in the field with the sampled medical treatment teams in a hospital environment, at both the case sites. Thus, FGDs were appropriate for this study since they allowed for the exploration of the conceptual framework amongst HCP treatment team members which included nurses, clinical psychologists, pharmacists, occupational therapists, and social workers. In addition, FGDs enable the medical treatment team members to interact as a team of experts and share their knowledge and experiences related to the medical teamwork approach to mental healthcare in a group collaboratively (Luchembe 2020; Wong 2008).

In this study, the FGDs were carried out with the nurses, clinical psychologists, occupational therapists, pharmacists, and social workers who formed part of the mental healthcare team at both hospitals. The above-mentioned participants were selected to participate in the FGDs because they formed part of the medical treatment team and were also in close daily contact with the mentally challenged patients (Doherty 2013). The FGDs were carried out with these participants in order to determine their experiences in a mental healthcare teamwork approach.

During the process of conducting the FGDs, the researcher had a moderator's guide which consisted of about six open-ended questions (see Appendix H) (Liamputtong 2015). Questions in the guide were structured according to the elements of the conceptual framework in chapter 6, as well as literature and theories used in chapters 2, 3, 4, and 5. This study targeted a maximum of eight focus group participants for each FGD. Since all FGDs discussion require between six and eight participants in order to generate valid data (Luchembe 2020; Patton, 2002). Three FGDs were carried out at each site with the nurses, clinical psychologists, occupational therapists, pharmacists. The first FGD included one occupational therapist, two professional nurses, one social worker, one psychologist, and one pharmacist. The second FGD included one occupational therapist, three professional nurses, one social worker, and one psychologist. The third FGD included three professional nurses, three assistant nurses, and two enrolled nurses. Prior to the FGDs, the researcher provided an overview of the

research topic. Each participant signed an informed consent form. Permission was obtained from participants to record the FGDs. The FGDs lasted between 30 minutes and one hour (Van Eeuwijk & Angehrn 2017).

It must be noted that a total of 27 HCPs participated at Site A and a total of 25 HCPs participated at Site B. The inclusion of different HCPs enabled the researcher to obtain an in-depth understanding of a medical treatment team approach to mental healthcare from the perspectives of the different team members. Hence, a total of 52 HCPs participated in this study. The 52 HCPs who participated in this study worked either in the psychiatric wards where treated mental patients who had been admitted or in the OPD. The OPD is a section of the hospital where patients receive mental healthcare but do not require admission or overnight care. The HCPs who participated in this study are listed in Table 7.1.

Table 7.1: Summary of the data collected through document analysis, observation, face-to-face, semi-structured interviews, and FGDs

CASE STUDY SITE	Document analysis	Observation	HCPs who participated in face-to-face semi-structured interviews	HCPs who participated in FGDs
Site A (Fort England Hospital)	Government and hospital policies listed above (two government policies and 12 hospital policies)	Observation was carried out on a daily basis at both sites for a period of two weeks	<ul style="list-style-type: none"> • 5 medical officers • 1 clinical manager • 1 psychiatrist 	<ul style="list-style-type: none"> • First FGD included 1 occupational therapist, 2 professional nurses, 1 social worker, 1 psychologist, and 1 pharmacist. • Second FGD included 1 occupational therapist 3, professional nurses, 1 social worker and 1 psychologist. • Third FGD included 3 professional nurse, 3 assistant nurse, 2 enrolled nurses
Site B (Cecilia Makiwane Hospital)	Government and hospital policies listed above (two	Observation was carried out on a daily basis for a	<ul style="list-style-type: none"> • 3 medical officers 	<ul style="list-style-type: none"> • First FGD included 1 occupational therapist, 2 professional nurses,

	government policies and 12 hospital policies)	period of two weeks	<ul style="list-style-type: none"> • 1 clinical manager • 1 psychiatrist 	<ul style="list-style-type: none"> • 1 social worker, 1 psychologist, and 1 pharmacist • Second FGD included 1 occupational therapist, 3 professional nurses, 1 social worker, and 1 psychologist • Third FGD included 3 professional nurses, 3 assistant nurses, and 2 enrolled nurses
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The next section provides a discussion on how the data were analysed and interpreted.

7.8 DATA ANALYSIS AND INTERPRETATION

This study made use of thematic analysis. The approach used to analyse the data collected is consistent with the steps provided by Braun and Clarke (2006). The steps are explained as follows.

7.8.1 Familiarisation with the data

According to Braun and Clarke (2006), this phase involves becoming familiar with the data collected. This phase is one of the most important phases in thematic data analysis since content of the policy documents, observation, face-to-face, semi-structured interviews and FGDs have to be read repeatedly to obtain an overall understanding of the data (Braun & Clarke 2006; Braun, Clarke & Terry 2015; Rubin & Rubin 2011). Thus, the researcher transcribed the face-to-face, semi-structured interviews and FGDs and read through the transcripts repeatedly. The selected policies and observation notes were also read repeatedly to achieve immersion.

7.8.2 Generating initial codes

The researcher began this phase by creating a preliminary list of ideas related to the data (Braun & Clarke 2006; Javadi & Zarea 2016). Next, the researcher arranged the data into significant groups and generated initial codes from the data. Coding continued until no further codes were found. The codes that were generated were matched with

excerpts that demonstrated that code. In essence, all the codes were generated from the data during this phase.

7.8.3 Searching for themes

Themes display a pattern or meaning related to data sets (Braun & Clarke 2006; Javadi & Zarea 2016; Saldana 2013). Thus, to extrapolate the meaning from the data, the researcher had to identify recurring themes within the data generated from the policy analysis, observation, face-to-face, semi-structured interviews, and FGDs. Braun and Clarke (2006) note that during this phase, codes are grouped (categorised) to form manageable themes or sub-themes. Braun and Clarke (2006) suggest that there should be a relationship between the codes that are grouped into themes or sub-themes. The data were coded manually to identify themes.

7.8.4 Reviewing the themes

During this phase, the researcher reviewed the initial themes to determine if the themes had enough supporting data (Braun & Clarke 2006). After this review, themes without sufficient data were able to be merged with other themes. This displayed flexibility, which is a major advantage of using thematic analysis (Braun et al. 2015). During this phase, the researcher had a good idea of what differentiated the themes and what excerpts from data were used to support the themes.

7.8.5 Refining and naming themes

During this phase, the researcher refined the themes and also determined if each theme had a sub-theme (Braun & Clarke 2006). After refining the themes, the researcher named the themes, that is, working titles were assigned to the themes. The names provided for each theme were clear and accurate and also reflected what the theme was about. At this stage, the researcher also determined if themes were in line with elements of the proposed conceptual framework.

7.8.6 Producing the report

This stage entailed presenting an accurate, consistent, logical, and non-repetitive report related to the themes generated from data. At this stage, for the purpose of this study, entailed presenting the findings. A report on all the themes emanating from the data will

be presented in the next chapter. The next section provides a discussion on issues of validity and reliability in the context of the current study.

7.9 VALIDITY AND RELIABILITY

Validity is concerned with the meaningfulness and accuracy of the research components while reliability is concerned with the ability of an instrument to measure consistently (Liamputtong 2013; Sarantakos 2013; Yin 2018). Thus, the main aim of validity and reliability is to establish whether the findings of a study are meaningful (Babbie 2013; Liamputtong 2013; Noble & Smith 2015). To enhance validity and reliability in qualitative research, Yin (2018) proposes the following principles of data collection: using multiple sources of evidence; creating a case study database; maintaining a chain of evidence; and exercising care when using data from social media sources. Hence, the researcher adhered to these principles in order to enhance validity and reliability. These principles are discussed in the next sections.

7.9.1 Using multiple sources of evidence

According to Yin (2018) using multiple sources of evidence can enhance validity and reliability of any research study. Therefore, in this study, four sources of evidence were used, namely document analysis, observation, face-to-face, semi-structured interviews and FGDs. Yin (2018) adds that using multiple sources of evidence enables the researcher to corroborate findings across data sets and this enables triangulation. Patton (2015) adds that triangulation can be used to increase validity and reliability within a qualitative research context. Thus, this study used data triangulation by using four data collection methods and theoretical triangulation by exploring 12 theories in order to enrich data and validate the research findings.

7.9.2 Create a case study database for data collected

The goal of validity and reliability is to minimise the errors and bias in a study (Babbie 2013). Thus, Yin (2018) proposes that all data collected from the case studies should be kept in a case study database. Therefore, all data collected were kept safely in a locked file cabinet.

7.9.3 Maintain a chain of evidence

This study maintained a chain of evidence by following guidelines from a case study protocol by Yin (2018:58). Moreover, a chain of evidence was maintained since the literature reviewed in chapters 2, 3, 4, 5, and 6 was consulted to analyse and interpret data from document analysis, observation, face-to-face, semi-structured interviews and FGDs. The following paragraphs provide a discussion of trustworthiness as applied to this study.

7.10 TRUSTWORTHINESS OF THE STUDY

Lincoln and Guba (1985:289–323) propose four criteria that must be used to ensure trustworthiness in a research study. These four criteria are credibility, transferability, dependability, and confirmability. Credibility refers to the accuracy of the interpretation of the data (Lincoln & Guba 1985). As noted above, the researcher triangulated data from four data sources to enhance the credibility of the research findings. Transferability refers to the degree to which the results and analysis can be applied to other situations and contexts. The aim of this study was not to apply the findings to other contexts but instead to provide an in-depth analysis of the medical treatment teamwork approach to mental healthcare at the case sites (Liamputtong 2013; Sarantakos 2013). To enhance dependability, thematic analysis steps provided by Braun and Clarke (2006) were used to analyse the data. Finally, with regard to confirmability, the researcher provided evidence that corroborated the findings (Lincoln & Guba 1985; Sarantakos 2013). In this study, confirmability was achieved by using data triangulation. As previously mentioned, four data collection methods were used in this study. Thus, these four methods allowed the researcher to cross-check data from multiple sources. The researcher checked the interview and FGD transcripts meticulously, constantly comparing them to the voice recordings and to the notes made during observation. Reflexivity is considered an integral aspect of qualitative research (Sarantakos 2013). Therefore, the next section provides a discussion on reflexivity as applied to this study.

7.11 REFLEXIVITY

According to Reay (2007), reflexivity focuses on giving as full and honest an account of the research process as possible. Researchers who use a qualitative research design must not allow their personal backgrounds and experiences to influence the interpretation of the research findings (Anney (2014; Creswell 2014; Liamputtong 2013). In this study, the researcher enhanced reflexivity by collecting and interpreting the data accurately and without bias. This is demonstrated in the results of the study in which the

verbatim transcriptions of the face-to-face, semi-structured interviews and FGDs have been presented. Thus, the researcher provided clear links between the data and the interpretations. The researcher also avoided bias by cross-checking the data generated from the four data collection methods used in this study.

7.12 ETHICAL CONSIDERATIONS

As discussed above in section 7.6.3, the researcher obtained ethical permission from the relevant stakeholders in order to conduct this study. To address participation and confidentiality issues, La Rossa and Bennett (2018) suggest that research participants need to be provided with the necessary knowledge that will help them decide either to participate or not to participate in a study. Hence, the participants were informed about the study's aims and purpose from the outset. The researcher also informed the HCPs that their participation was completely voluntary and that they were free to withdraw from the study at any time, if they wished to do so (Kiliñç & Firat 2017). The HCPs were also required to sign an informed consent form in order to participate in the research. Consent to use a digital recorder during the face-to-face, semi-structured interviews and FGDs was obtained from participants. Confidentiality was guaranteed by not referring to participants by their names; instead, professional titles such as nurse, occupational therapist, and medical officer were used to report the findings. The participants were assured that all the data collected would be treated in the strictest confidence (Babbie 2008; Beardsley 2017).

7.13 SUMMARY

In this chapter, the methodology that was used in conducting this research has been discussed. The qualitative research, research paradigm, multiple case study design, background of the case study settings, population, units of analysis, and research permission have been discussed. Purposive sampling strategy and qualitative data collection methods have also been explained. A discussion on thematic analysis has been provided. Issues of validity and reliability as proposed by Yin (2018) have also been discussed. Finally, this chapter has provided a discussion on the ethical considerations for this study. The next chapter provides a discussion on the data analysis and empirical findings of this study.

CHAPTER 8: FINDINGS AND ANALYSIS DATA FROM THE FOUR SOURCES OF EVIDENCE

8.1 INTRODUCTION

The previous chapter highlighted the methods that were used to empirically verify the conceptual framework, which was developed from the literature reviewed in chapters 2, 3, 4, and 5. The proposed conceptual framework has multiple elements which were synthesised from literature review. It is important to provide clarification about the difference between elements and themes as these two concepts are used to explain the findings of this study. Elements, in the context of this study, refers to aspects of the proposed conceptual framework such as, medical treatment teamwork, decolonial context, socio-cultural context, and policy that must be considered in mental healthcare in the South African context. A theme, on the other hand, is the outcome of analytic reflection (Saldana 2013). Therefore, themes emerged from the analysis as per the step of Braun and Clarke (2006). In essence, elements of the proposed conceptual framework were verified at the case study sites, namely Fort England Hospital and Cecilia Makiwane Hospital. Thus, the researcher collected data from members of the multidisciplinary team (MDT) which included: psychiatrists, clinical psychologists, social workers, nurses, occupational therapists, pharmacists, and medical officers who formed part of the treatment team at both Sites.

Therefore, this chapter presents the findings obtained from the document analysis which included both the government and hospital policies on mental healthcare, the hospital observations conducted at both sites. As well as the face-to-face, semi-structured interviews, and the FGDs. The findings from the above-mentioned data collection methods will be reported according to the elements of the proposed conceptual framework, namely (1) medical treatment teamwork (2) decolonial factors (3) socio-cultural factors, and (4) policy. Throughout the presentation and discussion of the findings, the hospital site of Fort England Hospital is referred to as Site A, while Cecilia Makiwane Hospital is referred to as Site B.

Triangulation enhances the reliability and validity of qualitative research studies (Ito 2018; Stewart-Withers et al. 2014; Yin 2018). This study made use of data triangulation and theoretical triangulation. In this chapter, data was triangulated by cross-checking the results from all four data collection methods. Theoretical triangulation occurred by using tenets from the various theories discussed and the literature to substantiate the research

results. Therefore, triangulation of the theories and different sources of data is discussed throughout this chapter.

In essence, the findings are organised under five main sections.

- The first section presents the demographic data of the HCPs.
- The second section provides a summary of the data collection process.
- The third section presents the themes that were generated from the data collection methods used for this study, namely document analysis, observation, face-to-face, semi-structured interviews and FGDs. These themes are presented in relation to elements of the proposed conceptual framework.
- The fourth section provides a summary of the triangulation of findings from all data collection methods.
- Lastly, a summary of the chapter is provided.

8.2 DEMOGRAPHIC PROFILE OF HCPS

The HCPs who participated in the study were qualified HCPs who formed part of the medical treatment team for mentally ill patients at both case sites. Hence, the researcher selected HCPs with specific professional backgrounds, namely clinical managers, psychiatrists, clinical psychologists, social workers, nurses, occupational therapists, pharmacists, and medical officers as per the criteria mentioned in methodology chapter. As observed by the researcher the individual HCPs carried out the following roles and responsibilities:

- The clinical manager coordinated all the healthcare activities in order to provide a management plan for the patient. For example, the clinical manager supervised all team members. Clinical managers made sure that the team members did their work on time and implemented the correct policies for patient care.
- The psychiatrists ensured that all the patients were diagnosed with proper psychiatric conditions.
- The medical officers carried out the physical assessment of the patients and devised provisional diagnoses for them. Doctors in the context of a public hospital are called medical officers. However, most HCPs referred to the medical officers

as doctors; thus, verbatim quotations throughout this chapter will include the word doctor (but HCPs are referring to medical officers).

- Clinical psychologists counselled and provided psychotherapy to patients. Psychotherapy is an activity aimed at counselling and providing mentally ill patients with a sense of relief and comfort in situations of extreme stress (Adam & Agnieszka 2020).
- Occupational therapists (OT) carried out neurocognitive assessments. These are assessments that done to determine which functions of the brain have been disrupted due to mental illness. The OT also assessed functional capacity evaluations, that is, assessments which are carried out to determine if a patient is cognitively impaired (Cysique, Lojek, Cheung & Cullen 2021).
- Pharmacists ensured that the patients obtained the correct medication. They also explained the possible side effects of the medication to individual patients.
- Social workers provided social support and also obtained collateral information from the patient's family.
- Nurses ensured that patients obtained quality nursing care by monitoring and addressing their daily care and needs. There were three different nursing categories namely, category one professional nurses, who in the context of this study, were HCPs who had completed a basic nursing education programme and were licensed in South Africa to provide professional nursing to mentally ill patients. Secondly, assistant nurses who provided individualised mental healthcare under the supervision of a professional nurse. Thirdly, the enrolled nurses were supervised by the professional nurse and worked as part of the medical treatment team, since they were competent in the provision of individualised mental healthcare (Vandali 2017).

The researcher adhered to the ethical requirements by ensuring that the ages of the HCPs ranged between 18 and 50 years. The length of the professional experiences of the participants at site A and B ranged between 3 months and 25 years. The ethnicities of the HCPs included Black African, White, Indian and Coloured. The literature reviewed in chapter 4 suggested that members of the medical treatment team came from diverse cultural backgrounds, and this was visible at the sites (Johnson et al. 2017). At the time

of data collection, Fort England Hospital (site A), had one clinical manager, one psychiatrist, eight medical officers, 18 psychologists, six occupational therapists, five social workers, eight pharmacists and 127 nurses. While Cecilia Makiwane Hospital (site B) had one clinical manager, one psychiatrist, two occupational therapist, two social workers, four psychologists, four medical officers, four pharmacists and 46 nurses. The following section presents the findings of this study in relation to the proposed conceptual framework.

8.3 FINDINGS OF THE STUDY IN RELATION TO THE PROPOSED ELEMENTS OF THE CONCEPTUAL FRAMEWORK

This section presents the themes which emerged from the document analysis, observation, face-to-face, semi-structured interviews and FGDs in relation to the proposed framework. Table 8.1 provides a summary of the themes that emerged from the elements of the proposed conceptual framework.

Table 8.1: A summary of themes and sub-themes that emerged from the elements of the proposed conceptual framework

Elements of the proposed conceptual framework	Themes and sub-themes that emerged from the data
Element 1: Healthcare professional framework (HCP–HCP medical treatment teamwork)	<ul style="list-style-type: none"> ● Collaborative teamwork for holistic mental healthcare ● Sub-theme: Effective communication between the treatment team members for collaborative medical teamwork
Element 2: Decolonial framework (Three-fold: caters for cultural diversity within the medical treatment team, medical treatment team collaboration with traditional healers, and for individual patient’s culture in mental healthcare)	<ul style="list-style-type: none"> ● Towards decolonising mental healthcare: demonstration of cultural sensitivity and cultural competence for mental healthcare ● Cultural tolerance medical treatment teams: catering for cultural differences in the mental healthcare teamwork ● Use of Western versus traditional medicine to treat mental illness in South Africa ● Sub-theme: Western versus traditional interpretation of the causes of mental illness in South Africa

	<p>Sub-theme: collaboration between the medical treatment team members and traditional practitioners to treat mental illness.</p> <ul style="list-style-type: none"> • Ubuntu-centred approach to mental healthcare teamwork in South Africa
<p>Element 3: Socio-cultural context that influences mental healthcare (Two-fold: caters for medical treatment team diversity and patient cultural diversity, and family involvement in patient care)</p>	<ul style="list-style-type: none"> • Positive and negative role of the family in mental healthcare: family as caregivers, active family members, absent family members
<p>Element 4: Mental health policy (includes both government and hospital policies)</p>	<ul style="list-style-type: none"> • Policy implementation at the case sites by HCPs from the medical treatment team
<p>Element: OTHER (includes elements which emerged after verification of the proposed conceptual framework in the field)</p> <ul style="list-style-type: none"> • A patient-centred approach for mental healthcare in South Africa from a medical treatment team approach • Challenges in mental healthcare delivery 	<ul style="list-style-type: none"> • Main focus of the medical treatment team is to provide mental healthcare treatment to individual patients • Challenge of staff shortages: limited number of mental HCPs • Language barrier: a major communication challenge faced at the case study sites

It is important to note that the element “other” in Table 8.1 above, encompasses information that were not initially included in the proposed framework in chapter 6. However, these themes emerged after the proposed framework was verified in the field. Hence the themes that emerged in “other” element category were included in the revised conceptual framework (see chapter 9).

As discussed in chapter 7, A total of 52 HCPs participated in this study from both sites, hence ample data was collected. The HCPs in both the face-to-face, semi-structured interviews and the FGDs generally had similar opinions on most of the elements of the proposed framework. The verbatim quotations of some of the HCPs in the face-to-face, semi-structured interviews and focus groups are used as examples to support the findings. As almost all the HCPs generally agreed on the elements that were verified, the researcher easily reached data saturation (Cleary et al. 2014). However, in a case where there was a different view or difference of opinion from the HCPs, the researcher

presented this view by presenting this information verbatim. In the following section, a brief overview of each element is provided and, thereafter, the themes that emerged from each element are explained in detail.

8.3.1 Healthcare professional framework (HCP–HCP medical treatment teamwork)

This element argues that medical treatment teamwork is essential in providing effective mental healthcare. One theme and two sub-themes emerged from this element. The main theme is “collaborative teamwork for holistic mental healthcare” while the sub-theme is “effective communication between the medical treatment team members for collaborative medical teamwork”. The theme and sub-theme will be discussed in the following paragraphs.

8.3.1.1 Collaborative teamwork for holistic mental healthcare: multidisciplinary team

Collaborative teamwork for holistic mental healthcare is one of the themes that emerged from all four data collection methods. Thus, this theme supports the proposed conceptual framework that was presented in chapter 6. In the context of this study, collaborative teamwork involves more than one HCP providing treatment to the patient. Therefore, this theme encompasses the idea that HCPs must work collaboratively as a team to provide effective patient care. In essence, this theme includes a discussion on how different HCPs (which includes psychiatrists, clinical psychologists, social workers, nurses, occupational therapists, pharmacists, and medical officers) who formed part of the treatment team at both Sites A and B, played complementary roles to provide healthcare for the mentally ill patient. The main objective of this study was to explore a medical treatment team approach to mental healthcare. As discussed in chapter 4, medical treatment teams have been established as best practice for optimal mental healthcare (Oflax et al. 2019; Rosen et al. 2018). Therefore, teamwork is fundamental to the proposed conceptual framework in chapter 6. Medical treatment teamwork is considered effective for patient care, since it allows HCPs with specialised knowledge to work collaboratively (Allen 2021).

The literature reviewed in chapter 4 suggested that a medical treatment team approach to mental healthcare offers great benefits such as improved coordination, continuity of care, and delivery of high-quality mental healthcare (Allen 2021; Gautier 2015; Rosen et

al. 2018). However, these benefits can only be achieved if the different HCPs who form part of the medical treatment team assume complementary roles and cooperatively work together to implement treatment plans for the mentally ill patients (Allen 2021; Lyubovnikova & West 2017). The conceptual framework, indicates that HCPs must undertake different tasks and are expected to work collaboratively through effective communication, to provide effective services for the mentally ill patients. Thus, all the HCPs who formed part of the medical treatment team at Sites A and B, contributed relevant information that would help in patient treatment. This information contributed to a mental health treatment plan which results in effective treatment for the patient. Thus, a collaborative effort between members of the medical treatment team is necessary in mental healthcare and it is imperative for all HCPs who form part of the medical treatment team to work collaboratively to provide patient care.

In support of the proposed conceptual framework that teamwork is imperative for mental healthcare, all the HCPs during the face-to-face, semi-structured interviews in both Sites A and B reported that collaborative teamwork enhanced mental healthcare. Majority of the HCPs who participated in face-to-face, semi-structured interviews at both sites argued that collaborative teamwork was essential in mental healthcare. Below are examples from two HCPs who spoke about how the team worked collaboratively for ensuring effective patient care.

The doctor will prescribe the treatment and check for side effects. The nursing staff will give treatment and be involved in daily activities of the patient and the monitoring. Then the social worker will get collateral from home and later on when patient is better will facilitate home visits and family meetings to ensure improved stability of patient support once discharged. Occupational therapy (OT) works with patient in the ward and able to assess level of functioning and the way the patient engages with others and if the patient is able to plan and organise tasks and so on. Psychologist can meet with patients and offer variety of psychotherapy. (Medical Officer, Site A)

The main objective of the multidisciplinary team (MDT) is to ensure that the patient receives a comprehensive management or care for example if a medical doctor is managing a patient alone and not involving other team members, chances are the patient will not receive the comprehensive care. The OTs, social workers and nurses and other members of the team are also very important. So,

the main objective is that we close all the gaps, for example, if there are social issues that are presented by the patient, that needs to be addressed by the social worker, if there are issues that needs the clinical psychologist for example, a patient presents with depressive episodes or we send the patient for psychotherapy ... We ensure that we give a comprehensive care to our patients.
(Forensic psychiatrist, Site A)

The above quotes emphasise that collaborative teamwork is necessary for mental healthcare. As noted in the literature in chapter 4, a comprehensive management plan for individual patient care is developed by several members of the healthcare team. As evident in the above quotes, each team member, namely psychiatrists, clinical psychologists, social workers, nurses, occupational therapists, pharmacists, and medical officers assumed responsibility for creating and disseminating the care plan for the mentally ill patients. It is difficult to treat a mentally ill patient without input from different team members. As established in the hospital policy on multidisciplinary teamwork, HCPs who form part of the medical treatment team must collaborate to provide effective mental healthcare. This policy stipulates that:

optimal and appropriate treatment for psychiatric patients will only be achieved with the full corporation of every team member. Lack of certain disciplines within the team can seriously compromise the treatment and outcomes of the patients i.e. (that is) the lack of for instance an occupational therapist. (Eastern Cape Department of Health 2019:1).

Hospital policy on multidisciplinary teamwork further confirms the need for collaborative teamwork by stipulating that:

the psychiatrist provides total treatment programme i.e. (that is) diagnosis, admit, refer, transfer and discharge of patients... while the psychologist often will assist the team by using their diagnostic tests in the case of complex diagnosis and to confirm clinical diagnosis (example mental handicap or learning disorders), clinical interviews and psychometric testing. Nurses organise and integrate ward activities and appointments of patients when referred to other departments or team members. (Eastern Cape Department of Health 2019: 2).

Thus, policies embrace collaborative teamwork for mental healthcare by encouraging collaboration between members of the medical treatment team. Other HCPs such as the

medical officer and psychiatrists at Site B, provided examples of situations where the team worked collaboratively for patient care. According to the medical officer at Site B:

The benefits of working as a team are enormous; for example, we had a patient and I thought the patient was psychotic but after investigation by the social worker, we realised that the patient husband was having an affair and there was some abuse going on as well, so the social worker investigated that and was able to find out this patient is not psychotic, that these things really are happening. So, coming together and working together really helped.

Similarly, the psychiatrist at Site B also noted that working as a MDT is imperative. Since medical treatment team members cannot work alone and must depend on the expertise of other team members, for patient care. The psychiatrist stated:

I can't treat a patient alone and not have, for example, the nurse or psychologist assist me because we do have our individual roles and we can't do it alone. For example, I was seeing a patient yesterday, who is actually a colleague, and he is not doing well at all so I needed the social worker involved and she played a bigger role than I would, so I totally depended on her more than my own clinical skills at that moment. There are other times where I depend on the OT, maybe, for a neurocognitive assessment in order to make a diagnosis on how to treat the patient. Similarly, the other team members will depend on me for other issues related to patient care. So, we work together in this way and the patient benefits.

The above responses from different HCPs at both Site A and Site B, implied that members of the medical treatment team were interdependent, and this was beneficial for patient care. These responses are in line literature reviewed in chapter 4, which suggests that there should be interdependency amongst team members. The Theory of Collective Competence (Boreham 2004), which was discussed in chapter 4, suggests that a medical treatment team must constitute members who are interdependent. These members must work interdependently to achieve collective competence with regard to mental healthcare. The Theory of Collective Competence (Boreham 2004) assumes that mental healthcare cannot be addressed by any one existing HCP. Therefore, for the mentally ill patient to benefit, each member of the medical treatment team should provide specialist knowledge that should be incorporated into care provision (Rosen et al. 2018). In summary, the findings from the face-to-face, semi-structured interviews at both Site A

and Site B, suggested that collaborative teamwork was essential for mental healthcare. Therefore, this finding ties into the overall context of this research since treatment teamwork is considered imperative for mental healthcare.

During observations at both Site A and Site B, it became evident that, in practice, the medical treatment team worked collaboratively for patient care. This was evident during multidisciplinary ward rounds at both Site A and Site B. The researcher observed a ward round at Site A, where all members of the team were present and contributed to the care of Patient A. During this session, the medical officer read the file of the patient detailing that the patient was suffering from dementia (see chapter 2 for a discussion on dementia as a mental illness). After this, the patient was brought in, and each HCP asked the patient questions that related to their expertise. After the interview (question-and-answer session) with the patient, the patient was taken back to the ward and the team deliberated on a way forward. The medical officer asked the professional nurse if the patient was taking his medication well and they responded by saying, "*Sometimes the patient does not want to take his medication, we try to talk to him but he does not want.*"

The social worker proposed that she would invite the patient's daughter to come and visit him at the hospital. The clinical psychologist suggested that the patient needed psychotherapy. The occupational therapist noted that the patient did not want to exercise with the other patients and that he would continue to try to convince him to exercise. The doctor mentioned that injections should be given to the patient since he was refusing to swallow medication. This observation was a clear case where multiple team members collaborated for an individual patient's care.

In addition, the researcher observed a ward round at Site B, where the psychiatrist coordinated the ward round. The file of Patient B was also read by a medical officer. Patient B, was an involuntary patient who was suffering from SUD, which is one of the mental illnesses discussed in chapter 2 of this study. The nurse mentioned that the patient was taking his medication but would sometimes crave dagga. The social worker mentioned that the patient's family had visited him several times to explain to him why they had brought him to the hospital and also motivated him to adhere to treatment (this finding relates to the theme of the role of the family in mental healthcare discussed in section 8.3.3.1). The psychiatrist stated that she had re-assessed Patient B and he was still unstable. The occupational therapist noted that he had tried individual and group therapy sessions with the patient but that the patient needed extended care. All the

members of the medical treatment team concluded that Patient B was not ready for discharge and needed further care.

The above observations relate to the GRPI Model (Rubin et al. 1977) reviewed in chapter 4 of this study. According to the GRPI model, medical treatment teamwork can only be effective if different team members provide different inputs for patient care (Rubin et al. 1977). Furthermore, this result is also consistent with Tuckman's Teamwork Model (Tuckman 1965) which assumes that effective teamwork can be achieved, if members of the medical treatment team complement each other, by providing different information that enhances care. Hence, this result is in line with the literature and theories reviewed in chapter 4, which state that medical treatment teamwork is fundamental to mental healthcare. Thus, a need exists for a conceptual framework that clearly differentiates the important role of a medical treatment team approach to mental healthcare.

The data from both the face-to-face, semi-structured interviews and observation were supported by all the HCPs who participated in the FGDs, at both Site A and Site B. All the HCPs at both sites expressed the view that collaborative teamwork helped them to provide adequate patient care. For example, a clinical psychologist at Site A, stated:

It is beneficial to work as a MDT, for example, a social worker will be bringing a different angle on how to manage a patient which is different from a medical doctor or a psychologist, so that on its own is quite helpful. Sometimes the problem that the patient is presenting does not actually need therapeutic or medical intervention but needs more of a social intervention and if we had not been sitting there together as a team, we will not be able to pick that up and we might be pumping the patient with medication when at that point in time it is not necessary. I remember one case where the psychologist did some psychological test because we thought this patient was on a low intellectual functioning or spectrum, so we needed to find out what is going on. But at the end of the day, we discovered that the patient did not have proper education and that is why they performed so poorly in the psychological test. So having that information from the social worker that the patient has poor educational background, that helped, so we ended up using the occupational therapist to do a functional assessment where we looked more at the adaptive functioning of the patient and that actually made us come to better conclusions on how to manage the patient.

Similarly, a social worker at Site B, expressed that collaborative teamwork facilitated the treatment of a patient who was suffering from bipolar disorder.

This patient had bipolar [disorder]. The doctor did the medical and physical diagnosis of the patient. This patient was a defaulter of medication hence everything was sky high [the social worker is implying that the patient had stop taking their prescribe medication]. Now the psychiatrist has to come in to check this patient. The social worker also has to come in because this patient has defaulter medication so the social worker has to call the family to book a meeting with the family and during the meeting, I got collateral. The psychologist was also necessary in that point in time to find out why the patient didn't take her medication. The psychologist picked up that this patient was sexually abused and the time that she came in she was not corporative in terms of saying she must go to OT. She was here for about a week and the second week we invited her for an occupational therapist just to see how she can stimulate the skills to see how she does things and she managed to do things fine and that help to take her out from her state of mind because she was so isolated in the ward. Once she started with the OT, she started to engage, and co-operate ... We all played a part and she was really stable. (Social Worker, Site B)

It can be inferred from the above quotes that mental healthcare requires collaborative teamwork since one HCP alone can treat the patient. The above quotes imply that each HCP provided expertise and medical knowledge that assisted when treating individual patients. The MHCA 17 of 2002, concurs by stating that more than one healthcare practitioner such as, “*the psychiatrist, or registered medical practitioner, or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services*” should care for the patient (MHCA 2002:10). Therefore, effective mental healthcare requires collaborative teamwork. Another HCP mentioned that working collaboratively as a medical treatment team had enabled her to learn from other team members which enhanced her ability to detect mental illnesses and also assist other colleagues.

Ah I have learnt a lot yooh [laughs]... when the patient comes to us, sometimes you just know what is already wrong with them ... As we are working together, you learn from your colleagues, you see what the OT will do and what social worker will do and you learn ... Sometimes maybe the social worker is not here at

work but you can help the patient before she comes back. (Enrolled nurse, Site B)

The above quote by the enrolled nurse at Site B, suggests that teamwork also provides learning opportunities for team members. As noted in section 8.2 above, an enrolled nurse is a HCP who provides basic nursing care and support to patients. Enrolled nurses are not licensed to practice independently since they are still studying to become professional nurses (Vandali 2017). Hence, this finding suggest that medical treatment teamwork provides these nurses the opportunity to obtain hands on experience and learn from peers. Other team members also learn from the complementary skills of team members and can therefore, assist each other when a team member is unavailable. Learning from other team members and helping is so important in South Africa where there is shortage of HCPs (Benjamin et al. 2021; Booysen et al. 2021).

According to the Department of Health (2019), healthcare professionals who work in mental health facilities, in South Africa make up 9.3 per 100 000 population. Viviers (2016) adds that the majority of the HCPs work in the private sector which only serves 17 per cent of the South African population. Thus, the shortage of HCPs at public hospitals is dire as at these case sites. According to Booysen et al. (2021), majority of the South African population rely on public healthcare services. Thus, the need for collaborative teamwork for mental healthcare cannot be overemphasised. Hence, this study proposed a conceptual framework that includes medical treatment teamwork as core to the provision of mental healthcare in the South African context. The challenges facing these case study sites, in delivering mental healthcare is elaborated on in section 8.3.5.1.

It is also important to note that the perspectives of the HCPs in both the face-to-face, semi-structured interviews and FGDs, links to the literature on empowerment theory, as discussed in chapter 4. In the literature, it was noted that a medical treatment team approach requires the team members to draw on individual expertise while emphasising collaborative teamwork that will benefit the patient (Barry et al. 2019). Also, Delany et al. (2017) argue that opportunities for knowledge-sharing and collaboration lead to team empowerment. The views of the HCPs at both Site A and Site B, suggest that members of the medical treatment team should share knowledge and collaborate to treat the patient. Thus, in the context of this study, empowerment takes place when medical treatment team members share expertise and knowledge with one another.

The views from the discussion of HCPs mentioned above, also link to the theme of an ubuntu-centred approach to mental healthcare teamwork, which is discussed in section 8.3.2.4 below. The theme of an ubuntu-centred approach to healthcare teamwork demonstrates how medical treatment team members support and depend on other members of the medical treatment team for patient care. Thus, collaborative teamwork also entails team members assisting each other (Klyueva 2022; Molala & Downing 2020; Ngondo & Zvomuya, 2020). As noted in chapter 5, ubuntu principles suggest that HCPs should have a team spirit by sharing experiences and expertise with other team members for patient care (Chigangaidze, Matanga & Katsuro 2022). Therefore, ubuntu values collectivism (collaborative teamwork) rather than individualism. Hence, the decolonisation of mental healthcare is core since ubuntu is regarded as a key concept, in decolonisation of healthcare in the South African context (Nemutandani et al. 2018). South Africa needs to address mental healthcare by taking into account the need for a medical treatment team that is anchored within the principles of ubuntu. Hence, the conceptual framework includes a decolonial approach to mental healthcare, in the South African context. Therefore, this finding supports the conceptual framework proposed in chapter 6.

From the above discussion emanating from the face-to-face, semi-structured interviews, observation, FGDs, and document analysis, it becomes clear that collaborative teamwork is crucial to achieving effective mental healthcare. This finding is in line with the literature reviewed in chapter 4 which suggests that all members of the medical treatment team should work collaboratively to provide effective mental healthcare. Wan et al. (2018) note that mental illness can be acute, relapsing, and chronic. Therefore, providing mental healthcare is a task that requires professionals from diverse disciplines to work collaboratively to treat mentally ill patients. Such functional diverse teams are thought to optimise patient care by capitalising on the different perspectives and skills of team members to deliver effective patient care (Allen 2021; Oflax et al. 2019). The finding from this team supports scholarly views by Oflax, Ancel and Arslan (2019) and Rosen et al. (2018) which state that collaboration amongst team members for patient care is an essential way in which HCPs adopt complementary roles and work together in delivering efficient mental healthcare. Thus, this result supports the element of medical treatment teamwork in the conceptual framework. In the discussion below, a sub-theme that emerged in relation to aspects of medical treatment team collaborative teamwork for holistic mental healthcare are examined. The proposed conceptual framework also

argued that effective communication is key to achieving collaboration in medical treatment teamwork. Hence, a discussion on the sub-theme of effective communication in collaborative mental healthcare teamwork is discussed below.

8.3.1.2 Effective communication between the treatment team members for collaborative medical teamwork

This theme encompasses the idea that effective communication between members of the medical treatment team is needed to ensure the delivery of effective and safe patient care. Therefore, this theme is in line with the proposed conceptual framework which emphasises that effective communication and medical treatment teamwork, which are closely related, are necessary for the provision of individualised mental healthcare. In the context of this study, effective communication is defined as, effective interaction or information exchange between members of the medical treatment team who treat mentally ill patients. As per the need for a decolonial approach to mental healthcare in the South Africa context, effective communication also extends to communication between the medical treatment team and traditional healers. As well as the medical treatment team and the patient's family members. Thus, the proposed conceptual framework argued that effective communication needs to take place between the medical treatment team and the patient's family, and the medical treatment team and traditional healers. However, this theme primarily focuses on effective communication between treatment team members for patient care (refer to section 8.3.2 for themes on the decolonial framework and section 8.3.3.1 for a discussion on the role of communication between the medical treatment team and the patient's family and traditional healers).

The literature in chapter 4, suggested that effective communication provides the benefits of problem-solving between members of the treatment team members and, further, facilitates the development of a comprehensive healthcare plan for the patients (Jacobs & Mkhize 2021). The literature in chapter 4, also suggested that it will be difficult for the medical treatment team to succeed if communication is ineffective (Wang et al. 2018). Also, communication failures are the leading cause of medical errors as mentioned previously (Rosen et al. 2018). Medical errors may occur when there is ineffective communication between members of the medical treatment team, even in a cohesive team (Gautier 2015). Medical errors can also occur because of ineffective communication between HCPs because of cultural differences. Hence, this study argues for a decolonial medical treatment team that caters for diversity between members of the

treatment team, encourages collaboration between the members of the medical treatment team and traditional healers, and also caters for the cultural diversity of individual patients during mental healthcare (Rosen et al. 2018). In essence, communication effectiveness may be affected by the different cultural backgrounds of the team members (Cagiltay et al. 2015). As discussed in chapter 3, South Africa has different cultures, hence the need for a decolonial approach to medical treatment teamwork. Since members of the medical treatment team may have different cultural backgrounds and diversity in their cultural beliefs, which may impact effective medical treatment teamwork (Johnson et al. 2017). Therefore, each HCP must acquire knowledge about the cultural values of the other medical treatment team members, through effective communication with them (Johnson et al. 2017).

Effective communication also offers the potential for effective performance and the promotion of multicultural understanding between team members (Rosen et al. 2018). In essence, the cultural differences between team members can be minimised through effective communication. Therefore, in order for effective communication to take place between members of the medical treatment team, HCPs need to accept and be tolerant of the cultures, of other team members (Ahmed, Al-Qarni, Alsharqi, Qalai & Kandi 2013). Thus, the need to propose a decolonial framework that caters for the cultural aspects of HCPs, since culture affects effective communication amongst team members. In essence, effective communication amongst team members will minimise cultural differences, minimise medical errors, and enhance patient care. This sub-theme links to the theme of patient-centred care discussed in section 8.3.5.1, which emphasises that patient-centred care is core and can easily be achieved through effective communication, amongst members of the medical treatment teams.

In line with the proposition of this study, that communication is vital in medical treatment teamwork, all the HCPs (that is, the entire sample) in the face-to-face, semi-structured interviews and FGDs at both sites, highlighted the critical role of communication. The importance of effective communication was also confirmed via the observation sessions and in the policy documents. During the face-to-face, semi-structured interviews at both Site A and Site B, it was evident that medical treatment team communication played a fundamental role in facilitating teamwork for patient care. All 12 HCPs at both sites (seven at Site A and five at Site B) emphasised that the medical treatment team could not function and achieve its goals, without effective communication between its

members. The following verbatim quotations from the forensic psychiatrist at Site A and medical officer at Site B are examples that support the above argument:

We cannot work without communicating with each other. Communication helps us to really work very efficiently with each other. Effective communication is where our strength is; we allow each member to explore and feel that they are appreciated to perform their duties without any hindrances or maybe one trying to limit them and that happens properly simply because our communication is up to standard. (Forensic psychiatrist, Site A)

Multidisciplinary healthcare largely depends on effective communication between team members so without communication, the MDT cannot function ... If the MDT does not communicate, I do not see how teamwork can take place. We need to communicate so we can provide the best care for our patients. (Medical officer, Site B)

From the above verbatim quotations, it is evident that the effectiveness of medical treatment teams depends on effective communication between team members. Teamwork on its own is not enough to provide effective care to individual patients. The essence of medical treatment teamwork is centred on ensuring that team members share information for patient care. In relation to the literature in this study, effective communication ensures that the team members obtain quick, accurate information regarding all patients (Buljac-Samardzic et al. 2020). This finding relates to the overall context of this study which suggests that effective communication between members of the medical treatment team is imperative in mental healthcare. This finding, therefore, supports the element of effective communication in the proposed conceptual framework presented in chapter 6.

The observational data was consistent with the findings from the semi-structured interviews. This is because observation of the team meetings and ward rounds at both Site A and Site B, revealed that communication facilitated patient care. In general, team meetings and ward rounds had an agenda which was formally written and circulated before the meeting or ward round. Hence, every team member knew beforehand what would be discussed in a team meeting or ward round. During the ward rounds and team meetings, interaction between the team members was responsive, supportive, and participation was equal. The researcher observed that ward rounds and team meetings

provided the main opportunity for communication between all members of the medical treatment team. Thus, the observational data correlates with the policy on MDTs, which suggests that “the ward round as well as the academic meetings will facilitate discussions and feedback regarding patients between disciplines” (Eastern Cape Department of Health 2019:3). This finding relates to the literature which argues that ward rounds and team meetings enable information exchange, provide opportunities for effective communication in the MDT, and enhance collaboration between team members (Vietz, Mráz, Lottspeich, Wölfel, Fischer & Schmidmaier 2019). Zamanzadeh, Orujlu, Beykmirza and Ghofrani (2021) add that ward rounds and team meetings provide sufficient opportunities for team members to communicate on issues relating to the patient’s treatment progress. It is important to note that the medical treatment teams’ communication strategies at both Site A and Site B included telephone calls, clinical folders and files, WhatsApp groups, diaries, rosters, referral letters, team meetings, and ward rounds.

For example, a social worker at Site A stated, “We also use telephones to communicate and also speed dials,” and an occupational therapist at Site B noted, “We have medical data in our folders,” referring to the documents that contained a patient’s treatment history. A psychiatrist at Site B noted, “I definitely use a lot of WhatsApp communication with the MDT, it is just convenient.” However, team meetings and ward rounds were most important for the purposes of this study since all the team members were present during the team meetings and ward rounds. Interview and observational data were corroborated with data from the FGDs, which suggested that effective communication between members of the medical treatment team was imperative for effective patient care.

Communication helps us as the MDT to provide optimal care for the patient because you work with the psychiatrist, the OT, the doctors, the nurses, the psychologist, the social workers and the pharmacist. We have to talk about the patient amongst ourselves ... we need to communicate well so that we can take good care of the patient. (Professional nurse, Site A)

The above quotation from the professional nurse at Site A emphasises the need for communication between team members. The quotation conforms with the hospital policy on MDTs, which states that members of the medical treatment team should share information that they receive from patients with other team members. This policy specifically states that “patients may discuss certain problems only with a particular staff

member and it is the responsibility of that staff member to inform other members” (Eastern Cape Department of Health 2019:3). Therefore, it is important for team members to share information since information exchange will facilitate and improve patient care. As discussed in the literature review in chapter 4, mental healthcare requires the expertise of all the treatment team members since each team member plays a different role. Hence, the HCPs need to share information so that all members of the team can contribute to a comprehensive management plan for the patient. The above discussion suggests that effective communication between members of the medical treatment team is required in mental healthcare.

According to all the HCPs who took part in the FGDs at both Site A and Site B, communication also facilitated the changing of shifts. They noted that the night staff had to communicate with the day staff on a daily basis, so that the night staff would become aware of what had occurred during the night and vice versa. The HCPs argued that this information exchange about the patients also made it easier to arrange appropriate cross-over when someone was unavailable. Below are verbatim quotations to support this argument:

The first thing we do in the morning is “hand over communication”, that is, from night staff to day staff. This communication will help the staff who are coming in to understand and know what has been taking place. If we do not do this then colleagues who are starting their shift will not know what has happened.

(Professional nurse, Site B)

We need to write down what we did or how the patient reacted in the night so that the person taking over already knows what we have done with that patient ...

Even if someone was not there and comes back after a few days, they will know what happened with the patients. (Assistant nurse, Site B)

A professional nurse and an enrolled nurse at Site B, noted that communication between members of the medical treatment team helped to avoid medical errors. This view is consistent with literature reviewed in chapter 4, which argued that medical errors and other adverse events may be avoided if the team members communicate effectively (Amiri et al. 2018; Wang et al. 2018). The literature reviewed states that poor interaction amongst members of the medical treatment team is the most frequent cause of adverse effects and medication errors (Zamazadeh et al. 2021). Therefore, effective

communication is important in countering medical errors occurring in the hospital environment. Good interaction between HCPs has positive effects on patient health outcomes (Rosen et al. 2018). Therefore, the need for a conceptual framework that caters for effective communication amongst medical treatment team members cannot be overemphasised.

When we communicate, we will avoid hazards because you will tell your colleague that this person has already had this injection and you report to the next person that I have done A, B, C, D so that the treatment cannot be repeated again which could cause overdose or harm to the patient. So, we have to record all what we have done to avoid damage to our patients. (Professional nurse, Site B)

Because we talk to each other, there will be no errors on the patient's treatment and there will be no harm because we are here not to harm but to help our patients and if there is no good communication then the patient will not get what is necessary to treat them and we will not actually meet the needs of the patient and at some point, we are going to harm the patient. But if there is communication definitely the quality of care will improve. (Enrolled nurse, Site B)

From the results of all four data collection methods and, in line with arguments in the literature review, it can be inferred that effective communication is imperative to effective treatment teamwork for patient care.

In summary, this finding implies that effective communication facilitates adequate medical treatment teamwork for patient care. The overall discussion of this theme relates to the theme of collaborative teamwork for holistic mental healthcare discussed in section 8.3.1.1. This theme notes that all team members have different roles and must work collaboratively through effective communication to provide effective patient care. As evident in the above discussion, collaboration and communication are crucial for the delivery of quality, safe, and reliable healthcare to patients. This finding conforms with earlier research which states the importance of information sharing in teams and suggests that members of the medical treatment team should focus on working collaboratively and communicate effectively in order to provide effective patient care (Jacobs & Mkhize 2021; Rosen et al. 2018). The results from this theme tie to the overall context of this study which states that team collaboration through effective

communication is indispensable to providing essential mental healthcare. Thus, the proposed conceptual framework emphasises the need for effective communication between members of the medical treatment team. The next sub-section provides a discussion of the themes that emerged from the element of decolonial framework.

8.3.2 Decolonial framework for mental healthcare in South Africa

Decoloniality emerges within the context of African communities as decolonisation considers African cultures which had been negated by the unfair elevation or dominance of Western cultures as explained in chapters 3 and 5 (Connell 2014; Morrow & Malcoe 2017). Thus, the inclusion of this element in the conceptual framework in order to address diverse cultural aspects that support mental healthcare. For the purpose of this study, the decolonial framework is three-fold as explained in chapters 1, 3 and 5.

As discussed in chapters 2, 3, and 5, the South African healthcare system considers mental illness from a biomedical perspective, even though the policy developed post-apartheid stipulates otherwise (Mabunda et al. 2022; Van Rensburg 2012). The biomedical approach is lacking since it is based on colonial ideology (Booyesen et al. 2021; Zingela et al. 2019). Biomedicine is informed by Western knowledge and Western medicine. Thus, the biomedical approach has its limitations in a country like South Africa, where the majority of mentally ill patients consult with both the medical treatment team and traditional practitioners (Nemutandani et al. 2018). Mentally ill patients consult with both health systems because cultural beliefs influence mental healthcare in the South African context (Jacobs & Coetzee 2018). Therefore, mental healthcare needs to be aligned to the cultural needs of the patient (Kotera et al. 2021). Thus, the need exists to decolonise and indigenise mental healthcare in South Africa. Hence, the proposed conceptual framework emphasises the need for the medical treatment team to cater for cultural aspects in mental healthcare treatment, in the South African context. Four main themes and two sub-themes emerged from the findings relating to a decolonial framework which are explained below.

8.3.2.1 Towards decolonising mental healthcare: demonstration of cultural sensitivity and cultural competence for mental healthcare

This theme highlights how the HCPs need to consider the cultures of patients when providing mental healthcare. Cultural aspects also help determine what constitutes a mental disorder in the South African environment (Gopalkrishnan 2018; Mabunda et al.

2022). The literature reviewed in chapters 3 and 5 suggested that the majority of South Africans are influenced by their cultures for healthcare and treatment purposes (Jacobs & Coetzee 2018). In relation to the literature, when the treatment does not cater for cultural aspects, patients may not adhere to such treatment (Kotera et al. 2021; Mabunda et al. 2022). Thus, members of the medical treatment team are required to have an understanding of the patient's cultural beliefs, to be able to provide culturally sensitive mental healthcare. In essence, mental healthcare needs to be decolonised since this will allow the medical treatment team to provide culturally congruent care for patients.

Demonstration of cultural sensitivity and cultural competence is one of the themes that emerged from the face-to-face, semi-structured interviews, FGDs, and document analysis. In the context of this study, cultural competence refers to the ability of the HCPs to understand and integrate the patient's values and beliefs into the patient's treatment plan since these influence patient care (Ogundare 2020). The conceptual framework in chapter 6 proposed that HCPs should be aware that patients are culturally diverse and thus be open-minded and embrace cultural differences (Mabunda et al. 2022). This theme specifically highlights that HCPs at both sites considered the culture of their patients during mental healthcare sessions. Therefore, this theme is in line with the element of culture in the proposed conceptual framework. All the HCPs from both sites noted that they considered the patient's culture during the healthcare sessions. The following verbatim quotations by the HCPs from the face-to-face, semi-structured interviews, support the above argument: We try to understand that our patients are predominantly isiXhosa people so we provide leave of absence for patients to go perform the umgidi (a rite of passage for young Xhosa men). (Medical officer, Site A)

There was recently a situation where we had a patient who was mentally unwell in the sense that he was [an] intellectually disabled, mentally retarded patient and was approaching 18 and had to go for his traditional circumcision and it was difficult because as a doctor I want to say no, you cannot go for this because you will not take your medication, you will smoke cannabis and it is going to cause a problem. But I finally asked one of my Xhosa colleagues to step in and we finally came up with a negotiation that the uncle will go and stay with the boy and make sure he takes his medication and will not leave him at all in the bush during the circumcision. Even though this was difficult for me, I had to consider the culture of this boy. (Medical officer, Site B)

It can be inferred from the above quotations that the HCPs considered the culture of the patients by granting them leave of absence to carry out traditional ceremonies. The literature reviewed in chapters 3 and 5, revealed that members of the medical treatment team should demonstrate cultural competency and sensitivity. This can be achieved by acknowledging that traditional practices are a way of life, in the African context. South Africa is known to be the “rainbow nation” with diverse cultural practices (Phasha 2020). Therefore, different South African communities carry out different cultural practices. For example, *nyaluso ya vhana* (childrearing) is a ceremony carried out in Vhavenda, while *umhlonyane* (a ceremony to celebrate a girl's first menstruation) is carried out by the isiZulu community. Thus, culture is deeply embedded in the lives of South Africans, and it influences adherence to mental health treatment (Zingela et al. 2019).

It is important to note that the above quotations correlate with the sub-theme of a patient-centred approach to mental healthcare discussed in section 8.3.5.1 above. The sub-theme of a patient-centred approach to mental healthcare emphasises that the medical treatment team prioritises the patient. This is evident in the above verbatim quotations confirming leave of absence for their patients. Thus, a patient-centred approach that encompasses cultural and social aspects should be considered in mental healthcare, to cater for patient diversity. It is imperative that the medical treatment team should consider the cultural and social context, as stipulated by the PEN-3 Model. The PEN-3 Model argues that healthcare that considers socio-cultural aspects facilitates treatment adherence, since care would be relevant to the patients (Airhihenbuwa 1995).

The above quotations are also congruent with the Theory of Cultural Care, Diversity, and Universality discussed in chapter 5. According to the Theory of Cultural Care, Diversity, and Universality (Leininger 1988), the treatment team should deliver mental healthcare that preserves, accommodates, and restructures culturally competent care. Therefore, consideration of the cultural norms of the patients along with providing culturally appropriate care is crucial in addressing mental healthcare in South Africa. This finding ties in with the context of this study, which suggests that mental healthcare should be decolonised in order to cater for the culture of the patient.

It must be noted that the quotation by the medical officer at Site B, correlates with the theme of the role of the family in mental healthcare discussed in section 8.3.3.1 below. The theme on the role of the family suggests that family members play a fundamental role in mental healthcare. This is evident in the response provided by the medical officer

at Site B, when she emphasised that the patient's uncle had to accompany the patient to the circumcision ceremony to ensure that the patient would adhere to his/her treatment. Therefore, the data generated from the face-to-face, semi-structured interviews at both Site A and Site B, suggests that the socio-cultural context must be considered in mental healthcare.

The FGDs at both Site A and Site B, reiterated that the medical treatment team members were culturally sensitive. One hundred per cent of the HCPs from both Site A and Site B argued that there should be cultural consideration during diagnosis. Below are verbatim quotations to support the above argument:

A patient may come in wearing like a sangoma and the hair is dreadlocks, if you are using a medical eye, you will say she was dressed inappropriately but if you incorporate cultural understanding, you will know that it is not because she is mentally ill that she is dressed like that, it is because she is [a] practising sangoma. So, you need to consider a patient's culture otherwise you may do a misdiagnosis, because if you say she is dressed inappropriate then you will think that she is mentally ill which is not correct, so we must know and consider the culture during diagnosis and mental status exams. (Occupational therapist, Site A)

A nurse wanted to give injection to a Muslim patient, and he was uncomfortable and jump up and the healthcare worker may diagnose that there was a paranoia or something, forgetting that [in] some cultures touching is not appropriate especially if you did not also explain to the patient and that could also lead to misdiagnosis and say the patient is paranoia. So, it is good to understand the culture of the patient. (Social worker, Site B)

The above verbatim quotations are consistent with literature reviewed in chapters 1 and 3, mentally ill patients come from different cultural backgrounds. Therefore, without considering the culture of the patient, there could be a misdiagnosis and inappropriate treatment might be provided to the patient (Gopalkrishnan 2018). Ogundare (2020) argues that lack of cultural consideration during assessment of mentally ill patients can lead to misdiagnosis of the patient. Gurung (2019) adds that healthcare practitioners can misdiagnose a patient if they do not consider the patient's culture because culture impacts how some patients manifest symptoms, communicate their symptoms and how

they adhere to treatment. For example, the above findings indicated that the medical treatment team may misdiagnose a patient wearing beads or being dressed in a cultural way, if they do not understand the culture of the patient (as noted by the occupational therapist at Site A).

Furthermore, diagnosing and caring for Muslims patients requires knowledge of their cultural beliefs (as noted by the social worker at Site B). Thus, when treating Muslim patients, the treatment team need to be aware of issues of privacy and touch (Attum, Hafiz, Malik & Shamoona 2022). Cultural factors therefore play an important role in the diagnosis and treatment of mentally ill patients (Mabunda et al. 2022). As such, in the South African context, it is important that the treatment team understands and considers the culture of the patients during diagnosis. The conceptual framework emphasises that the medical treatment team must provide culturally congruent care. Therefore, this finding links to the overall context of this study, since the elements support the decolonisation of mental healthcare.

The majority of HCPs (90 per cent at Site A and 100 per cent at Site B) also noted that patients were given leave of absence, so they could go perform traditional ceremonies. Below are some examples from the HCPs to support the above argument:

And sometimes leave of absence is given for patients to go and do traditional rites like ukuthwasa [a process undergone by someone who has a calling from ancestor to become a sangoma]. (Clinical psychologist, Site A)

Our people do ulwaluko [traditional circumcision and initiation from childhood to adulthood]). Some patients want to do this and we allow them to go and do it and come back. (Professional nurse, Site B)

The above quotations from the clinical psychologist at Site A and the professional nurse at Site B, concur with the interview data which suggested that the medical treatment team provided leave of absence for patients to carry out traditional rites (Nemutandani 2018). The quotations are also consistent with the theme of the patient-centred approach to mental healthcare discussed in section 8.3.5.1. The medical treatment team provide patient-centred care by catering for the needs of the patient (for example, by providing leave of absence so that patients could go and carry out traditional ceremonies). This finding suggests that mental healthcare that considers the cultural beliefs of the individual patient is an effective strategy in motivating patients to adhere to treatment (Jacobs &

Coetzee 2018; Mabunda et al. 2022). In essence, this finding suggests that in developing a conceptual framework for mental healthcare in the South African context, the cultural context of the patient should be catered for.

Furthermore, data (100 per cent) from FGDs at both sites revealed that the medical treatment team considered the culture of the patients during their stay at the hospital. An occupational therapist at Site B, noted that patients were allowed to wear beads in the wards. Usually in the wards, beads are not allowed in terms of suicidal ideas from patients, but we allow the patients who say they are sangomas to wear their beads while in the wards. (Occupational therapist, Site B)

Furthermore, an occupational therapist at Site A, also stated that team members even considered the cultural beliefs when it came to dietary requirements, saying, *“Some patients do not eat pork and they will be given chicken instead.”*

From the above quotes from the face-to-face, semi-structured interviews and FGDs at both Site A and Site B, it can be inferred that the medical treatment team considers the patient's culture when providing mental healthcare. This finding is confirmed by the NMHPF and Strategic Plan 2013–2020 which clearly stipulates that *“there are varying cultural expressions and interpretation of mental illness, which should be respected insofar as they protect the human rights of the mentally ill”* (NMHPF 2013:21). Therefore, the NMHPF and Strategic Plan 2013–2020 is instrumental in allowing the medical treatment team to consider cultural aspects when treating patients. This finding is in line with the element of policy in the proposed conceptual framework.

The results from this theme suggest that mental healthcare seems to be progressive by embracing the fact that South Africans are influenced by their cultural beliefs. Furthermore, this theme links to the literature and theory discussed in chapters 2, 3 and 5. Indigenous Standpoint Theory (Foley 2003) assumes that Black African people should be treated within the framework of their culture and belief systems. According to the Theory of Cultural Care, Diversity, and Universality (Leininger 1988), the medical treatment team must consider the different cultural values of the patients in order to provide culturally congruent treatment. The Theory of Cultural Competence Model of Care (Campinha-Bacote 1995) also emphasises that HCPs should strive to provide healthcare that is within the cultural context of the patient. While the Cultural Safety Theory (Ramsden 2002) also assumes that the HCPs need to consider the cultural

beliefs of the patients because failure to do so might potentially place the patient at risk of misdiagnosis and also place the patient at a risk of a less than optimal treatment outcome. Decolonial Theory argues that mental healthcare should be aligned with the cultural realities of peripheral zones such as South Africa (Quijano 2000). In essence, this finding supports the decolonisation of mental healthcare, since decolonising mental healthcare will ensure that the medical treatment team provides mental healthcare that is culturally congruent (Kelly 2015; Penson 2019; Zingela et al. 2019). Cultural competence also includes the ability of members of the medical treatment team to consider the culture of other team members, for example, health beliefs and cultural practices (Johnson et al. 2017). Thus, this result supports the proposed conceptual framework. The next sub-section provides a discussion on the theme of cultural tolerance in medical treatment teamwork.

8.3.2.2 Cultural tolerance medical treatment teams: catering for cultural differences in the mental healthcare teamwork

A decolonial framework for mental healthcare suggests that all members of the medical treatment team should be tolerant of each other's cultural differences. That is, within the team in order to work collaboratively and provide effective patient care. This theme encompasses the idea that medical treatment team members acknowledge and respect the culture of other members. Thus, this theme relates to the context of this research since cultural tolerance amongst team members is considered an important aspect of the proposed conceptual framework for mental healthcare, in the South African context.

The literature in chapter 4 suggested that South Africans have diverse cultures; hence, members of the treatment team may have different cultural beliefs (Jacobs et al. 2020). According to Davidaviciene, Vida, and Khaled (2022), the lack of consideration of the beliefs and values of other team members often leads to misunderstandings amongst team members. MacDonald and Oliver (2017) state that a culturally competent medical treatment team creates a positive environment for teamwork for individualised patient-centred care. As noted in the discussion on the sub-theme of effective communication in collaborative mental healthcare, in section 8.3.1.2, cultural tolerance for other team members reduces barriers to collaborative teamwork for mental healthcare. Therefore, the members of the treatment team need to tolerate their team member's cultural differences in order to work in harmony. Since this will facilitate effective communication with each other, to provide effective patient care.

The face-to-face, semi-structured interviews and FGDs demonstrated that the members of the medical treatment teams from both Site A and B, were culturally competent. During the face-to-face, semi-structured interviews, all the HCPs stated that the members of each of the medical treatment teams had different cultural backgrounds. Hence, they also considered each other's cultural values and were thus tolerant of the differences of other team members. For example, a medical officer at Site A stated:

If you are working in a diverse team like ours, you must consider other people's cultures otherwise there will be a lot of disagreement. We try our best to accommodate and respect the cultures of other colleagues. We even participate in some festivities of different cultures. (Medical Officer, Site A)

They [colleagues] tell us that they have a calling because they know we will support them because at the end of the day, each one of us have different cultural practices. (Medical officer, Site B)

We have a colleague who is a professional nurse and a practising sangoma. He has a mental illness of bipolar disorder. When he is becoming manic and unwell, the calling and the need to become a sangoma is elevated so we try to understand and give him space to go through his stuff and other colleagues help to do his duties sometimes. And once he is well, he is a professional nurse and we see that the cultural things come in when he is relapsing so we always try to understand and not judge him and give him space when we see he is going through that stuff. (Medical officer, Site B)

The above quotations suggest that the members of the medical treatment team came from diverse cultural backgrounds. Thus, they accommodated and acknowledged the diversity of cultures within their teams. The researcher observed that at both Site A and Site B, the team members came from different cultural backgrounds such as isiXhosa, isiZulu, English and Afrikaans. The literature reviewed in chapters 3 and 5 revealed that members of the medical treatment team should demonstrate cultural competency and sensitivity. By also acknowledging that members of the medical treatment team are diverse and thus have different traditional practices. The above quotations confirm that the medical treatment team was indeed diverse and that members of the team demonstrated cultural competency, by accommodating and respecting the cultural needs of team members. This is evident when the medical officer at Site A and medical officers at Site B, clearly stated that they respected the cultures of other team members and gave

them space to deal with cultural issues when need be. Therefore, the above verbatim quotations are consistent with literature reviewed in chapters 3 and 5 and with the proposed conceptual framework, which emphasised the need to acknowledge and respect the cultures of other team members.

The findings from the above verbatim quotations also relate to the theme of the ubuntu-centred approach to mental healthcare, which is discussed below. An attribute of Ubuntu was evident when the medical officer at Site B, noted that *“other colleagues help to do his duties sometimes”*. This implies that other team members helped the colleague who was a sangoma when he was not feeling well. This finding ties in with the overall context of this study which emphasises the need for cultural aspects to be considered in terms of mental healthcare and between members of the medical treatment team. Mental healthcare needs to evolve and move away from the colonial, Western systems towards a decolonial approach to mental healthcare (Jacobs & Coetzee 2018).

All the HCPs from the FGDs at both Site A and Site B, concurred with the interview data which suggested that members of the medical treatment team considered the cultures of other team members. For example, an occupational therapist at Site A noted, *“if you want to work as [a] MDT, you must learn to respect everyone’s opinion ... and I mean including their culture.”* While an enrolled nurse at Site B added, *“we do a lot ... there are colleagues that when they are fasting, we know that we cannot do this or that ... for me that is respecting someone’s space and their culture.”*

The findings above are consistent with the interview data presented which argues that members of the medical treatment team acknowledge, accommodate, and respect the cultures of other team members. In essence, the above quotations are particularly relevant to the overall context of this study, as these quotations promote respect for the cultural values of other team members (McGough et al. 2018).

Thus, the researcher proposed a decolonial framework that caters for two-fold cultural aspects of the South African environment that is: medical treatment teamwork and patient care. Although the face-to-face, semi-structured interviews and FGDs from both Site A and Site B, showed that the participants considered the cultures of the other team members, the majority of the HCPs at both sites also emphasised the need to put aside their cultural values and instead focus on the culture of the patient. This view is in line with Cultural Safety Theory (Ramsden 2002) which was discussed in chapter 5. Cultural

Safety Theory (Ramsden 2002) argues that HCPs should suspend their own cultural views in favour of the needs and preferences of the individual patient, since considering the needs of patients could enhance their mental healthcare (Chichirez & Purarea 2018). This view also relates to the theme of a patient-centred care approach to mental healthcare, which emphasises that the primary objective of the medical treatment team is to serve the patient (Santana et al. 2018). Below are examples of verbatim quotations from the HCPs, in support of the team members needing to prioritise the patient's culture:

We have Indians, we have Africans, we have Whites, and we are not saying that one must not share their cultural beliefs, we are quite diverse, we allow everybody to present what they feel need to be presented. We are not undermining any culture or cultural belief but when it comes to patient, unfortunately I cannot say because I am a Pedi from Limpopo I believe in this and another person says I am so and so we must treat the patient like this or that. The patient is the focus. (Forensic psychiatrist, Site A)

Generally, we do respect the cultures of our members in the team but we also respect and obey the laws of the hospital so our cultures do not really matter, we put our beliefs aside and do what is best for the patient. (Medical officer, Site B)

These verbatim quotations reiterate the diverse cultural background of South Africans. Thus, the need exists for a decolonial framework that caters for the cultural aspects of mental healthcare. Therefore, this finding ties into the overall context of the research since the cultural context of the patients are central to the proposed conceptual framework.

The professional nurse at Site A and the social worker at Site B, also noted that cultural consideration in medical treatment teamwork was beneficial to the team, because they helped each other to understand the cultural backgrounds of different patients:

I do my best hey ... I have seen that some colleagues at times will understand a patient better than me because the patient and him are from the same culture ... I just ask the colleague to explain to me so that we can help the patient. (Professional nurse, Site A)

The MDT have different professionals so we have different cultural backgrounds but we know that the culture of the patient is important so we even help each

other to under[stand] the culture of patients so that we avoid misdiagnoses. For example, there was a patient who came here and she was Xhosa, the psychiatrist saw the patient and thought the behaviour was abnormal and then I tried to make her understand that in our Xhosa culture, this is what happens and the psychiatrist took it into consideration. (Social worker, Site B)

As suggested by Cultural Safety Theory, each member of the medical treatment team needs to respect the culture and experiences of other team members for effective teamwork to take place (Ramsden 2002). The findings from this theme are aligned with the concept of decolonisation since cultural aspects are considered in medical treatment teamwork for patient care.

In summary, the findings from this theme are consistent with the literature and the proposed conceptual framework since cultural aspects of team members are considered. This was evident from face-to-face, semi-structured interviews and FGDs at both Site A and Site B. Hence, triangulation occurred from two data sources. Cultural considerations in mental healthcare also link to the theme of the use of Western versus traditional medicine to treat mental illness, since both themes focus on cultural aspects in mental healthcare. Therefore, this is discussed in the next section.

8.3.2.3 Use of Western versus traditional medicine to treat mental illness in South Africa

Western versus traditional medicine is one of the themes that emerged from face-to-face, semi-structured interviews and FGDs at both Site A and Site B. This theme discusses the idea that mentally ill patients use both Western and traditional medicine for mental healthcare. In South Africa, both the medical treatment team and traditional health practitioners play a fundamental role in mental healthcare. Thus, the majority of South Africans seek the services of both Western (the medical treatment team) and traditional health practitioners (Zingela et al. 2019). As noted in chapters 1, 2, 3, and 5, traditional healers are the first point of call for many mentally ill patients in South Africa. The reason for this is that South Africans are influenced by their culture with regard to mental illness, as indicated previously. Thus, they use both traditional and Western medicine for mental healthcare (Morrow & Malcoe 2017). As discussed in chapters 2 and 3, the medical treatment team prescribes psychiatric medication, such as antidepressants, anti-anxiety medications, antipsychotic medications, and hospital and residential treatment programmes, for patients mental healthcare (Legg 2018; Sandoiu

2019). On the other hand, traditional mental health treatments, used by mentally ill patients in South Africa include, ritualised divination and herbal medication (muti) which is made from animal or plants (Legg 2018). Purification practices, which include bathing, steaming, and enemas, are also carried out (Keikelame & Swartz 2019). Rituals are performed by dancing, chanting, playing drums, offering sacrifices to appease the ancestors, and burning plants like imphepho (*Helichrysum Petiolare*) (Busia 2016). In this way, traditional health practitioners provide psychosocial treatments, which are aimed at relieving distress for mental illnesses such as anxiety and depression (Mbwayo, Ndeti, Mutiso & Khasakhala 2013). The patient's culture is an important aspect of mental healthcare. Thus, this study proposed a decolonial framework that collaboratively caters for both biomedical and traditional approaches to mental healthcare, in the South African context.

The above argument was supported by all (100 per cent) the HCPs who participated in the face-to-face, semi-structured interviews at both Site A and Site B. Examples of verbatim quotations from the face-to-face, semi-structured interviews and FGDs that constituted this theme are discussed below:

We are Africans and most of our people still believe that traditional medicine can assist in managing some of the psychiatric conditions. Before they can even come to us about 70 per cent, if not more, of our people [South African citizens], they will consult with the traditional healers. (Forensic psychiatrist, Site A)

A large number of patients in our community have already either consulted with a traditional healer by their own volition or taken by family or community member by the time they come to us. (Medical officer, Site B)

...people turn to go to sangomas, after sometime, they can still come to the hospital, it is a normal practice with many people. (Medical officer, Site B)

The above quotation by the forensic psychiatrist at Site A and the two medical officers at Site B, noted the use of both Western and traditional medicine for mental health treatment. As discussed in chapter 3, many people consult with traditional healers for mental health treatment because of their cultural beliefs (Zingela et al. 2019). Therefore, both traditional and Western medicine should be considered in mental healthcare as explained above.

The data generated from the FGDs at both Site A and Site B, were consistent with the findings from the face-to-face, semi-structured interviews, as all the HCPs at both sites suggested that most South Africans used both Western and traditional medicine to treat mental illnesses. Below are examples from the HCPs to support this argument:

Some patients come to us but later they will go put umqombothi (it is a traditional beer) on their head ... They say it also heals mental illness. (Social worker, Site A)

Most of our people [South Africans] go for sangoma, then they come to the hospital. (Occupational therapist, Site B)

The above verbatim quotations from the social worker at Site A and occupational therapist at Site B, reiterate that mentally ill patients use both Western and traditional medicine. The literature in chapter 3 argued that traditional healers treat mentally ill patients with herbs like *Rauwolfia Vomitoria*, which has tranquilising effects similar to those of psychotropic medications used by the treatment team (Prince 2009). They also use therapies and psychotherapies (in different forms) to treat mentally ill patients (Morrow & Malcoe 2017). Patients use these traditional treatments because of their cultural beliefs (Zingela et al. 2019). It is evident from both the interview data and FGDs at both Site A and Site B, that mental healthcare which only uses a single medicinal system is unlikely to accommodate the needs of mentally ill patients, in the South African context (Adam et al. 2019). Therefore, an understanding of the patient's culture is critical in providing effective mental healthcare. This is consistent with the overall purpose of this study which emphasises culture as an important factor that influences mental healthcare.

8.3.2.3.1 Western versus traditional interpretation of the causes of mental illness in South Africa

This sub-theme highlights that the medical treatment team and patients interpret the causes of mental illnesses differently. This sub-theme was generated from the face-to-face, semi-structured interviews, FGDs and documents at both sites. As noted in chapter 3, 80 per cent of South Africans believe that mental illness is caused by a conflict between an individual and the ancestors or a witch, spirit, or sorcerer (Ross & Deverell, 2010). As a result of these beliefs, the majority of South Africans interpret the causes of mental illness differently from HCPs. The literature in chapter 3 revealed that some South

Africans are influenced by their cultural beliefs. Herselman (2004), for example, notes that depression or mental distress is possibly caused by a guilty conscience about harm caused to others. This highlights the need for a decolonial approach to mental healthcare in South Africa because Western views (biomedicine) of mental illness cannot summarily be applied to a culture, with a different view of life and perception of psychiatric illness (Batisai 2016; Bene & Darkoh 2014; Morrow & Malcoe 2017).

The majority of the HCPs (90 per cent) at both sites also suggested that the majority of South Africans interpret the causes of mental illness differently from HCPs. This is confirmed by the NMHPF which states that *“there are varying cultural expressions and interpretation of mental illness”* (NMHPF 2013–2020: 21). This view also is supported by Nwoye (2015) who argues that the African conception of mental illness is embedded in indigenous ways of knowing and this differs from the Western interpretation of mental illness. According to Botha and Moletsane (2012), a conflict between individuals and their ancestors can lead to chronic psychotic states. Herselman (2004) also adds that depression or mental distress can also be caused by ancestors. Therefore, due to these beliefs regarding the causes of mental illnesses, some South Africans interpret the causes of mental illness differently from the HCPs.

The following examples from the HCPs at both Site A and B, support the above argument:

Patients who are presented with signs and symptoms for an example schizophrenia, will tell you that they are hearing voices and these voices is from their ancestors and they are telling them to do certain things or they must become traditional healers. We see that a lot and we try to convince them no, what you are hearing is not actually what you think it is, but ordinary hallucination and it is part of the mental illness. (Clinical manager, Site A)

There was a patient who kept saying ukuthakathwa (which means to be bewitched). The patient feel that their illness has been induced by suspicious circumstances, but we know that what they are experiencing is just symptoms of mental illness. (Medical officer, Site B)

The above quotations imply that both members of the treatment team and the patients have a particular understanding of mental disorders, and that culture plays a key role in the conceptualisation and interpretation of mental illness, by both the HCPs and the

patients (Duane, Phumeza & Grant 2021). The quotations reveal that some patients in South Africa attribute mental illness to witchcraft. As a result of these strong beliefs, some patients also consult with traditional healers for mental healthcare. Culture thus played a fundamental role in mental healthcare in the South African environment. Thus, a decolonial conceptual framework that caters for cultural factors, that affect mental healthcare should be considered. This finding also implies that even though the medical treatment team and the patients sometimes interpret the symptoms of mental illnesses differently, the medical treatment team still strives to cater for cultural factors that influence mental healthcare. This is evident in the discussion on the theme of cultural sensitivity and cultural competence for mental healthcare as discussed in section 8.3.2.1, where the HCPs cater for cultural aspects of the patient, by granting leave of absence for patients to carry out traditional ceremonies and/or allowing sangomas to wear beads in the wards during treatment.

All the HCPs in the FGDs at both sites (100 per cent) agreed with HCPs in the face-to-face, semi-structured interviews, arguing that the treatment team and patients interpret the causes of mental illnesses differently. Below are examples to substantiate this argument:

Mental illness according to our culture, you will find that people see it as witchcraft, but to us when somebody starts to talk about spiritual and traditional things, it is a sign to us that that person is mentally ill. (Professional nurse, Site A)

There was a case here where the patient was having schizophrenia and having visual hallucinations and auditory hallucinations and the family of the patient belief that their son had amafufunyana (it is believed to be bugs that are ingested into the sufferers' body by means of black magic) and they say they want to take him to traditional healer. (Social Worker, Site B)

The verbatim quotations exemplify that the HCPs interpreted mental illnesses from a Western perspective (biomedicine). While some of the patients interpreted the causes of mental illnesses from a cultural perspective. Thus, collaboration between the medical treatment team and traditional practitioners is needed as per the element of the conceptual framework presented (Nemutandani 2018). Collaboration between the HCPs and traditional healers already occur for illnesses such as, HIV/AIDS and tuberculosis

(Nemutandani 2016; WHO 2018). Thus, the conceptual framework aims to advance this much needed collaboration for mental healthcare in SA.

The findings from this theme correlate with IST (Foley 2003) and Southern Theory (Connell 2007) discussed in chapter 5. According to IST (Foley 2003), there are varying interpretations of mental illness, hence the patient's cultural context must be considered during diagnosis. Southern Theory argues that knowledge from peripheral (Western) medicine and colonised societies, has as much intellectual power, as knowledge from metropolitan societies (traditional medicine) (Connell 2007). These theories argue that both Western and traditional medicine should be considered in mental healthcare. This finding implies that the decolonisation of mental healthcare can positively contribute to effective patient care. The following theme discusses collaboration between the medical treatment team and traditional practitioners.

8.3.2.3.2 Collaboration between medical treatment team members and traditional practitioners for mental healthcare

This sub-theme highlights the need for collaboration between the medical treatment team and traditional practitioners for mental healthcare. This sub-theme is linked to the theme of Western versus traditional medicine discussed in section 8.3.2.3 above as it focuses on the cultural aspects of mental healthcare. This sub-theme also relates to the aspect of collaboration between the medical treatment team and traditional healers in the decolonial element of the proposed framework in chapter 6. In the context of this study, collaboration refers to the process of working together, in a climate where the medical treatment team and the traditional practitioners acknowledge, respect, and provide mutual assistance to help attain the common goal, of providing effective mental healthcare (Nemutandani 2016). The sub-theme supports the literature which states that collaboration between the medical treatment team and traditional healers can enhance mental healthcare. Hence this sub-theme is consistent with the proposed conceptual framework. Data from the face-to-face, semi-structured interviews, FGDs, and document analysis from both Site A and Site B, emphasised the need for collaboration between the two health systems. Majority of the HCPs, at both sites, argued for collaboration between the two healthcare systems.

The literature reviewed in chapter 3 suggested that although traditional medicine was relegated to an inferior and covert position during the colonial and apartheid period, the majority of South Africans still continued to seek healthcare from traditional healers (Van

Rensburg 2012). The Western approach to mental healthcare has never replaced traditional African healing. Since most South Africans still make use of both Western and traditional medicine for mental healthcare (Batisai 2016). This is because biomedicine does not offer cultural explanations for mental illness, which forms a crucial part of majority of South African's understanding of mental illness (Jacobs & Coetzee 2008).

As discussed in the literature, biomedicine provides tremendous value in the treatment of mental illness. However, biomedicine is inadequate in providing holistic care within a patient's broader cultural context (Saha et al. 2021). Thus, this study has proposed a decolonial conceptual framework which caters for both psychiatric treatment and traditional healing. The proposed conceptual framework emphasises that culturally appropriate care can be achieved if there is cooperation between the medical treatment team (biomedical practitioners) and traditional healers, as per the findings in this study. It is worth noting that collaboration can be achieved through effective communication (Nemutandani 2016). This theme links to the theme of effective communication in collaborative mental healthcare teamwork discussed in section 8.3.1.2 above. The theme of effective communication in collaborative mental healthcare teamwork emphasises the need for effective communication between members of the medical treatment team. As per the findings, the members of the medical treatment team should include the traditional practitioners in mental healthcare, since patients also consult with them. Hence, the medical treatment team and traditional healers need to effectively communicate about the patient's cultural needs (Penson 2019). The information obtained through collaboration can, therefore, be used to provide the patient with culturally relevant care (Jacobs & Coetzee 2018).

The following examples from the interview data support these arguments:

Collaboration with the traditional practitioners will be good because we get to know what they are giving the patients or have given the patients. (Medical officer, Site A)

The services of both the healthcare practitioners and the traditional healers should be recognised ... we need to work together. The platform for collaboration between these two parties need to be created where both parties will be invited to discuss the treatment of our patients. For example, they can meet once in six

months to iron out their differences and find a common ground to better patient outcomes. (Clinical manager, Site B).

I think that is fine, so let us collaborate with the traditional healers. (Medical officer, Site B)

The above verbatim quotations suggest that sharing of knowledge through collaboration between the medical treatment team and traditional practitioners is important to ensure effective patient care. This finding calls for a significant shift in mental healthcare which is encouraging collaboration that will provide culturally relevant care. Therefore, rather than only focusing on biomedicine, the medical treatment team can have a collaborative relationship to provide the best care for the patients. The treatment team and the traditional healers together can offer a more comprehensive, holistic, patient-centred approach to mental healthcare, which can encompass a patient's cultural beliefs (Saha et al. 2021). Collaboration between the two systems as complementary, ties into the overall context of the research because Western and traditional mental healthcare are emphasised in the proposed conceptual framework, in providing culturally congruent mental healthcare.

The findings from the FGDs reiterate the need for collaboration between the two healthcare systems. The majority of the HCPs in the FGDs (80 per cent) also stressed the importance of collaboration between the medical treatment team and traditional health practitioners since this is crucial for effective patient care:

Collaboration will be nice so that they can also teach us about their practice and we can also teach them about our practice so that the treatment that we give the patient should not contradict. If they can avail themselves [to] educate us with what they do and we also share our information it will help us. (Occupational therapist, Site A)

Working with the traditional healers is a good thing because our patients like to use them also. (Professional nurse, Site A)

I think the two systems can collaborate by stating that the traditional healers refer the patients to us. I will give an example of a patient who was sick and then was taken to the traditional healers and that patient was not completely cured by the traditional healers and then the person was referred to us as a healthcare

institution by the traditional healer. I think if they can work together, it can help.

(Clinical psychologist, Site B)

For us to collaborate, traditional medicine must be registered with SAHPRA (South African Health Products Regulatory Authority). Traditional medicines will need to be regulated and we can collaborate for the sake of the patient.

(Pharmacist, Site B)

As can be seen from the face-to-face, semi-structured interviews and FGDs, the theoretical argument states that collaboration between the medical treatment team and traditional healers is a factor that is essential for effective patient care. In line with the face-to-face, semi-structured interviews and FGDs, the NMHPF mental healthcare policy is also strongly advocates for collaboration between the treatment team and traditional practitioners, by stipulating, “*The Department of Health will pursue partnership between traditional health practitioners and the Department of Health*” (NMHPF and Strategic Plan 2013:32). The NMHPF and Strategic Plan 2013–2020 (NMHPF 2013:41) also states that links between the medical treatment team and traditional practitioners should “*encourage implementation of the Traditional Health Practitioners Act by facilitating links between mental health services and traditional healers ... at local district levels, including appropriate referral pathways in both directions*”.

Thus, mental health policies encourage the decolonisation of mental healthcare, by encouraging collaboration between the medical treatment team and traditional health practitioners. This finding is consistent with the element of policy, in the proposed conceptual framework.

Even though majority of the HCPs at both sites recommended that there should be collaboration between traditional healers and the medical treatment team for mental healthcare, a few HCPs (20 per cent) emphasised that the treatment from the HCPs and traditional healers should be taken at different times because there may be negative side effects if the patient combines both. Hence, collaboration is advised so that aspects such as these can be catered for to best benefit the patient and avoid harm, as per the verbatim discussions below:

We do not want the patient to take traditional medicine and our medication at the same time is because some of them may have what we call drug interaction and

that can be adverse and adversely affect the patient, for example, causing some liver problems and kidney problems. (Forensic psychiatrist, Site A)

Patients can take traditional medicine if they want but we advise them not to take it with our medication at the same time. It can hurt them. We are concerned about the interaction. It will not be good. We advise them to give time apart between our treatment and treatment from traditional healers. (Professional Nurse, Site B)

This finding implies that the lack of collaboration between the two systems is detrimental to the patient. Therefore, the need exists for a decolonial framework in the South African context, that will allow the medical treatment team to collaborate with traditional healers and engage in communicative sessions so that patient benefit can occur for collaboration with the least harm (Nemutandani 2016). Collaboration between the two health systems will enable an understanding of the side effects of both Western and traditional medicine. Since a lack of knowledge of either, can lead to possible negative side effects for patients who are already merging the two forms of treatment for mental healthcare (Booyesen et al. 2021). Understanding the side effects of both Western and traditional medicine will address challenges such as, side effects and treatment overdose (Ncube 2014). This finding implies that there is a need for the medical treatment team to collaborate with traditional healers, so that patients are not negatively harmed by medication side effects. Since most patients tend to consult with both traditional healers and the treatment team for mental healthcare.

From the above quotations emanating from the face-to-face, semi-structured interviews, FGDs, and document analysis, it becomes clear that collaboration between the HCPs and traditional practitioners is welcomed and a necessity. The proposed conceptual framework in chapter 6, suggests that the biomedical (medical treatment team) and traditional approaches (traditional healers) should unify in order to provide holistic mental healthcare to patients. Hence, this finding ties to the overall context of this study). Zingela et al. (2019) add that collaboration between these healthcare systems can help to reduce mistrust and lead to a coordinated approach for mental healthcare in South Africa.

8.3.2.4 An Ubuntu-centred approach to mental healthcare teamwork in South Africa

This theme explored and described how HCPs supported and depended on other members of the medical treatment team for patient care. The decolonial approach to mental healthcare fits well with the African philosophy of ubuntu, which focuses on a collective approach for mental healthcare. Ubuntu is regarded as a key concept which stands for “I am because we are” (Ngondo & Klyueva 2022). In essence, there is no “I” without the “we” as discussed in chapter 5 (Chigangaidze 2021). Hence, ubuntu encompasses a spirit of oneness and harmony. Therefore, this theme correlates with previous themes such as:

- A patient-centred approach to mental healthcare
- Demonstration of cultural sensitivity and cultural competence for mental healthcare
- Catering for cultural differences in mental healthcare teamwork
- The use of Western versus traditional medicine to treat mental illness in South Africa
- Collaboration between the medical treatment team members and traditional practitioners to treat mental illness

All the above-mentioned themes focus on the need for a collective and holistic approach in providing culturally congruent care to all mentally ill patients. This is in line with the African philosophy of ubuntu, which respects humanity in all its totality and emphasises holistic conceptualisation of phenomena such as mental healthcare (Chigangaidze 2021).

As discussed in chapters 4 and 5, Ubuntu is best realised and manifested in deeds of kindness, caring, sharing, interdependency, generosity, support, solidarity, and consideration towards other HCPteam members (Ngondo & Klyueva 2022). Therefore, members of the medical treatment team are expected to be in solidarity and collaborate for individualised patient care (Molala & Downing 2020). The data from this study indicated that members of the team practiced an Ubuntu-centred approach to teamwork, as explained in the theme of cultural tolerance in the medical treatment team. The theme clearly explains how members of the team help colleagues when need be. A case in point, was when other members of the team had to step in and help a professional nurse who was a sangoma when he became sick due to his ancestral calling (this case was discussed in detail in section 8.3.2.2). Thus, an Ubuntu-centred approach in the context of this study refers to, members of the medical treatment team working collaboratively

and helping each other to provide effective teamwork and support. The face-to-face, semi-structured interviews, observation, and FGDs findings demonstrated the attributes of Ubuntu such as, interdependency and support between members of the treatment team.

Data from face-to-face, semi-structured interviews at both Site A and Site B, demonstrated a sense of interdependency amongst the treatment team members. This is evident in the quotations from the clinical manager at Site A and the psychiatrist at Site B:

No one knows it all, we depend on other colleagues for solutions. (Clinical Manager, Site A)

I am new in the department and I am still learning skills so I depend on the clinical manager to guide me through things I do not understand. I call him anytime I need help and he is always there to assist. (Psychiatrist, Site B)

The above quotations imply that members of the medical treatment team depended on each other for assistance relating to patient care. The Ubuntu philosophy argues that a HCP depends on other members of the medical treatment team, just as other team members depend on them (Mabvurira, 2020; Van Breda, 2019). Zvomuya, (2020) argues that in medical treatment teamwork, interdependence surpasses independence. Hence, every member of the medical treatment team must view teamwork from a perspective of interdependence and interpersonal connections, as stipulated by the ubuntu philosophy. The above quotations also relate to the Theory of Collective Competence discussed in chapter 5, which assumes that competence is teamwork that can be accomplished if there is interdependence amongst the team members (Boreham 2004).

The interview data was consistent with data from the FGDs. During the FGDs, all the HCPs at Site A and Site B, confirmed that the team members adhered to the principles of Ubuntu by supporting and assisting other team members to the best of their ability. This was for teamwork support as well as, obtaining patient care. As noted in chapter 5, ubuntu portrays a spirit of oneness. It reflects the human characteristic of generosity and caring. According to Chigangaidze (2021), Ubuntu means “we are in this together” – your problems are also our problems – and therefore we help one another. Hence, the Ubuntu approach allows members of the medical treatment team to strive towards becoming caring and understanding. Van Breda (2019) argues that HCPs who truly practice Ubuntu

always make themselves available to help others. Zvomuya (2020) adds that a spirit of Ubuntu allows the HCPs to help other team members, with the aim of achieving the team's goal of effective mental healthcare.

The following verbatim quotations of HCPs during focus group discussions at both Site A and Site B, support the above arguments:

You can never feel that you are alone, we help each other, even when a colleague is confused, we advise them on what to do. (Professional nurse, Site A)

In the team, we know that this one needs me, I need this one and that is how it is. (Social Worker, Site A)

Even though we allocate duties, we still assist each other, it does not mean that you cannot help someone because it is not your duty. If I finish what I am doing and I see that my colleague needs help, I will assist even if I was not allocated there. We want the ward to run smoothly so we assist each other. (Assistant nurse, Site B)

The above findings imply that the Ubuntu philosophy enabled the members of the medical treatment team to achieve a common goal by caring and helping other team members when need be. In summary, the face-to-face, semi-structured interviews, observation, and FGDs, at both Site A and B, illustrated the spirit of ubuntu, of caring, and the values of tolerance, compassion, and kindness amongst the medical treatment team members. This finding suggests that in medical treatment teamwork, the existence of Ubuntu as a shared value system implies that team members should strive towards assisting other team members, which consequently helps to avoid medical errors and enhance team performance (Mabvurira, 2020; Van Breda, 2019; Zvomuya, 2020). This finding is in line with literature reviewed in chapter 5, which suggests that medical treatment teamwork should be based on collectivism as opposed to individualism (Zvomuya 2020). This finding is also in line with results from a study conducted by Regine (2009) which revealed that the principles of Ubuntu lead to cooperative and collaborative teamwork because team members are encouraged to help and support all other team members. Similarly, a study conducted by Chigangaidze et al. (2022) established that patients can benefit if a treatment team considers the principles of ubuntu in teamwork. Researchers also argue that medical treatment team members such as psychologists

and social workers have called for the adoption of an Ubuntu-centred approach in healthcare (Mabvurira, 2020; Mkabela, 2015; Mupedziswa et al., 2019; Van Breda 2019; Zvomuya 2020). Hence, the principles of the ubuntu philosophy should be practiced in a medical treatment teamwork approach for mental healthcare.

However, the literature reviewed in chapters 4 and 5 argued that Ubuntu can only be achieved through effective communication between members of the medical treatment team. Hence, this theme relates to the theme of effective communication in collaborative mental healthcare teamwork as discussed in section 8.3.1.1. Results under the theme on effective communication in collaborative mental healthcare teamwork, revealed that effective communication amongst team members was needed to achieve effective mental healthcare. Thus, the members of the medical treatment team needed to communicate effectively in order to support the other team members. This ties in with the proposed conceptual framework since effective communication between members of the medical treatment team is an element in the framework. The concept of Ubuntu also relates to the socio-cultural inclusion in mental healthcare. It is a cultural philosophy that binds all members of a society together (Nzimakwe 2014). Therefore, the Ubuntu philosophy also encourages family involvement in mental healthcare (Engelbrecht & Kasiram 2012). The next sub-section provides a discussion on the theme which emerged from the element of socio-cultural context that influences mental healthcare.

8.3.3 Socio-cultural context that influences mental healthcare

The socio-cultural context includes both the aspects of family and culture that impact patient care (Tjale & de Villiers 2018). For the purposes of this study, socio-cultural consideration is two-fold (that is for both for HCPs and for the patients). All members of the medical treatment team should be tolerant of each other's cultural differences, that is within the team, to work collaboratively and to provide effective patient care. For the purposes of this study, the medical treatment team is also required to provide culturally congruent mental healthcare. The medical treatment team should also involve the patient's family in their care, in order to cater for social factors in mental health.

This element argues that the medical treatment team should consider the socio-cultural context of the patient when providing mental healthcare. Literature in chapter 3, suggested that the medical treatment team can provide culturally appropriate care if mental healthcare is decolonised. Hence, the medical treatment team needs to consider

the socio-cultural requirement of patients. The conceptual framework proposed that socio-cultural factors are imperative for effective patient care, in the South African context, in order to cater for patient diversity. The verification of the proposed framework occurred through face-to-face, semi-structured interviews, observation, FGDs, and document analysis at both sites revealed that the socio-cultural needs of the patients were considered. This was evident in most of the themes discussed above:

- Collaborative teamwork for holistic mental healthcare: multidisciplinary team
- A patient-centred approach to mental healthcare
- Demonstration of cultural sensitivity and cultural competence for mental healthcare
- Catering for cultural differences in mental healthcare teamwork
- The use of Western versus traditional medicine to treat mental illness in South Africa
- Collaboration between the medical treatment team members and traditional practitioners to treat mental illness

All the above-mentioned themes covered some socio-cultural aspects in mental healthcare. However, this theme focused specifically on the role of the family in mental healthcare: family as caregivers, active family members, and absent family members. Considering the above insights, the following paragraphs provide a discussion on the above-mentioned theme.

8.3.3.1 The positive and negative role of the family in mental healthcare: family as caregivers, active family members, absent family members

This theme encompassed the need for considering the patient's family in mental healthcare. Data from the face-to-face, semi-structured interviews, observations, FGDs, and policy analysis at both Site A and Site B, supported the proposition of this study that the patient's family plays a fundamental role in their mental healthcare. This data was supported by the literature and theory discussed in chapters 3 and 5 accordingly. Hence, this theme is in line with the social element of the proposed conceptual framework presented in chapter 6. The patient's family influences a patient's adherence to mental healthcare by providing support and encouragement to the patient (Amela et al. 2021). Therefore, the proposed conceptual framework advocates that the critical role of the family should be recognised and the medical treatment team should include the patient's family in mental healthcare. The PEN-3 Model discussed in chapter 5 also suggests that

the patient's family should be involved in their care, especially in the African context (Airhihenbuwa 1989; Molala & Downing 2020). For the majority of the HCPs at both Site A and Site B, the patient's family played a fundamental role in their mental healthcare diagnosis and treatment.

According to all the HCPs interviewed at both Site A and Site B, the family was an important source of information because they provided information related to the patient's history, side effects from the medication and the cultural background, amongst other factors. The HCPs such as the clinical manager, the psychiatrist, and the medical officer stated that the family members motivated and supported the patient to adhere to treatment. Below are some verbatim quotations from the face-to-face, semi-structured interviews to support the above argument:

Some patients may not even have the insight about their condition, they may not even notice when something is wrong with them, for an example if somebody is experiencing side effects from the medication, they may not know that if they are having this abnormal involuntary movement that is side effects of the medication and it needs to be reported so that he/she can be given something to counteract those side effects or at least switch and change their medication altogether ... That kind of information can come from family members. (Clinical manager, Site A)

The family plays such a huge role we could even call them part of the MDT. The patient can only be an outpatient for that day, and the patient can only be an inpatient for a certain number of weeks and then after that the family helps in monitoring the medication, side effects, making sure the patient is getting better and eating, exercising. So, at home the family member will be the doctor, the psychologist, nurse, the social worker and the occupational therapist. The family is very important. (Psychiatrist, Site B)

Based on the above findings from the clinical manager at Site A and the psychiatrist at Site B, one can infer that the patient's family played a fundamental role in his/her mental healthcare. The quotation from the psychiatrist at Site B, links directly to the context of this study since the psychiatrist mentions that the family could be seen as part of the MDT.

The literature in chapters 1, 2, 3, 4, and 5 emphasised the need for the patient's family to be part of the treatment since the family encourages and supports the patient during healthcare (Amela et al. 2021). Thus, the notion exists for the decolonisation of the medical treatment team, in order to empower and allow the patient's family to support and provide effective patient care, in the South African context (Chichirez & Purarea 2018).

A medical officer at Site B stated,

The patient prefers to bring a relative as a support and to ensure all information about illness, treatments and reviews is understood. Patients do not always remember what the doctor tell them so family is important.

This finding suggests that family members are an important source of information for the treatment team. This is supported by the hospital policy titled Disability Grant Assessments which stipulates that the patient should be "accompanied by family for collateral information" (Eastern Cape Department of Health 2019:2). In essence, the above verbatim quotations suggest that mental healthcare requires the treatment team to communicate effectively with the patient's family members to ensure that the patients' informational, emotional, and decisional needs are met (Warnecke 2014). The above quotation thus relates to the theme of effective communication in collaborative mental healthcare teamwork discussed in section 8.3.1.2.

As discussed in chapter 4, it may be challenging to provide individualised mental healthcare without effective communication between the patient's family and the medical the treatment team (Chichirez & Purarea 2018; Warnecke 2014). This is because effective communication between the medical treatment team and patient's family ensures that the patient's needs are met. Therefore, the need for effective communication between the medical treatment team and the patient's family was catered for in the proposed conceptual framework.

Observational data revealed that family members actively cared for their loved ones. The researcher observed a team meeting at Site A, where a patient's family member was invited to the meeting to discuss issues relating to the treatment of the patient. This observation correlates with the statement made by the psychiatrist at Site B, who noted that the family could even be considered a part of the MDT. As observed, the patient's

family was practically part of the MDT, having been invited for a treatment team meeting to discuss issues related to the care of the patient. Hence, the need for a decolonial conceptual framework that caters for the role of the family, in mental healthcare cannot be overemphasised. At Site B, the researcher observed how almost all the patients in the OPD were accompanied to the hospital by their families. The researcher also observed how family members visited patients in the wards and brought them essential items such as, toiletries amongst other essential needs.

Furthermore, the researcher observed a conversation relating to the role of the family between the two treatment team members, that is, a professional nurse and a pharmacist at Site B. The conversation related to some patients who were unwilling to go to the hospital and collect their medication. The verbatim conversation is shown below:

Professional nurse: His father has come to get his medication, he says that this morning ... he gave him food, crushed his medication gave him and told him to wait for him to bath so that they can come for his review. He came back and did not see him.

Pharmacist: He always runs away sometimes, his aunty told me that last month, she promised to buy him KFC [Kentucky Fried Chicken] before he agreed to come here to collect his medication ... His aunty will come and collect it for him when he does not want to come.

The above finding relates to the PEN-3 model, which assumes that patient family can play a role in their care, by motivating and supporting them through the treatment process (Airhihenbuwa & Webster 2004). Additionally, the PEN-3 Model assumes that the neighbourhood influences mental healthcare. Neighbourhood for the purposes of this study refers to the patient's family members (Airhihenbuwa 1995). This assumption is evident in the above verbatim quotations. The role of family as caregiver was also confirmed in the MHCA 17 of 2002, which stipulated that in a case where a patient was incapable of making an informed decision regarding care, treatment, and rehabilitation "the spouse, next of kin, partner, associate, parent or guardian of a mental health care user" could help make decisions for the patient (Republic of South Africa 2002: 30). This is evident in the above quotations where the father and aunt of the patients had to make decisions relating to the collection of medication for patient care. The above quotations also link to the literature reviewed in chapter 3, which argued that families provided

nurturing and care and served as gatekeepers to healthcare (Kuo et al. 2018). Therefore, it is imperative to consider the role of the family as an important factor that influences mental healthcare. This finding is in line with the context of this study, since the proposed conceptual framework emphasises the need to include family members in mental healthcare, in the South African context.

Data from the face-to-face, semi-structured interviews and observations were in line with data generated from the FGDs at both Site A and B. The majority (95 per cent) of the HCPs at both sites argued that the patient's family played a vital role in providing vital information that facilitated mental healthcare. Below are examples of quotes from the FGDs at Site A and Site B:

Family plays a very important role because the patient at times when they come in, they are giving their own side of the story but before you make any further management, you need collateral from the relatives immediately when the patient comes in. At times the team cannot do anything without knowing the family history to find out if there is any other person in the family having mental illness ... When the patient goes for leave, we also need the report from the family to know how the patient was behaving. So, the family also helps in managing the patient. (Professional nurse, Site A)

If they are unable to collect medication or [are] unstable, the family members accompany the patient or collects for them in their absence. (Pharmacist, Site A)

However, a professional nurse at Site A noted that some family members were absent in the care of the patient. The professional nurse at Site A, argued that the family members of one of the patient did not want to be involved in her care because the patient allegedly murdered her two-month-old baby:

You see family is important but some families are hurt. The patient hurt them. There is a woman in the ward, we have tried to involve her family but they say they want nothing to do with her because she killed her [own] child. Now we can't force them, you see. (Professional nurse, Site A)

An occupational therapist at Site B, had mixed views when he stated:

I can say yes or no. In terms of yes, there are some of the family members who care for the patients, they supervise their medication. On the other side, no, some of the families they don't even visit the patient, some of the families they aggravate the situation of the patient making the patient more depressed to such an extent that the patient even does not want to be discharged. Maybe they even want to be discharged to rather go to a centre. For example, recently we have a patient here, he got a problem with his siblings at home so he doesn't want to go there, he wants another place to stay without the family.

While it was acknowledged that not every patient had supportive family members and some patients did not want their families to be involved in their care, the HCPs at both Site A and Site B (except for one professional nurse at Site A and one occupational therapist at Site B) argued that the patient's family had an important role to play in the provision of mental healthcare. This idea was supported by the literature reviewed in chapters 3 and 5 of this study.

In essence, mentally ill patients need support from their families during treatment. A study conducted by Papageorgiou et al. (2017) argues that mentally ill patients, especially those with severe mental illnesses, do not always follow their treatment plans and need the help of their families. The results from a study conducted by Koren et al. (2017) revealed that the family could make the patients calmer and more cooperative during consultation. Thus, the patient's family is considered a social structure that plays a fundamental role in mental healthcare (Dirik et al. 2017; Maybery 2021). Furthermore, the NMHPF, stipulates that "the Department of Health should engage with family associates in policy development and implementation as well as the planning and monitoring of mental healthcare services" (NMHPF 2013:27). This policy strongly advocates that family members should be involved in all issues relating to healthcare. This is also included in policy development, implementation, planning, and monitoring of healthcare. Crandall et al. (2019) argue that the family should be involved in policy development and implementation since the family promotes healthy choices, encourages behaviour change, and contributes to public health interventions. Therefore, the role of the family in mental healthcare is supported and required. This theme correlates with the theme of Ubuntu-centred approach to healthcare discussed above. The next section provides a discussion on the findings from the element of mental health policy.

8.3.4 Mental health policies: government and hospital

Mental health policy is one of the elements that was included in the proposed conceptual framework in chapter 6. This element was included because policy and the laws of a nation play a critical role in promoting efforts to reach set goals for effective mental healthcare (Mulutsi 2017; Sibanyoni & Maritz 2016). Policy implementation at the case sites emerged as a theme from this element and is discussed below. For the purposes of this study, policy implementation relating to medical treatment teamwork, decolonial aspects, and socio-cultural aspects in mental healthcare were focused on.

8.3.4.1 Policy implementation at the case sites by healthcare professionals from the medical treatment team

One of the objectives of this study was to explore if both government and hospital policies either encouraged or discouraged the decolonisation of mental health care at Site A and B. Even though the researcher triangulated the findings throughout this chapter regarding how both government and hospital policies favoured the decolonisation of mental healthcare in South Africa, it is also important to present the findings with regard to how the medical treatment team implemented these policies practically at the sites. Hence, this theme highlights how both government and hospital policies were implemented at the case sites in a shift to decolonise mental healthcare.

As discussed in chapter 3 of this study, mental health policies during the apartheid period were discriminatory and unequal for all races. According to Van Rensburg (2012), the developments following democracy in 1994, aimed to redress the injustices in mental healthcare inherited from the apartheid government. The data generated from the document analysis, face-to-face, semi-structured interviews, and FGDs from both Site A and B suggested that both the hospital and government policies, that were developed post-apartheid favoured the decolonisation of mental healthcare. All the HCPs were generally positive regarding the role of the existing policies in decolonising mental healthcare. Most of the HCPs emphasised that they had implemented government and hospital policies in order to provide the best possible mental healthcare to all their patients. In essence, this finding suggests that the existence of mental health policy is an integral tool in the promotion of mental healthcare (Mulutsi 2017). The above finding supports the proposition of this study that mental healthcare policies guide the functioning of any mental health institution (Mulutsi 2017). Thus, the need to consider

policy, that is both government and hospital, as one of the elements in the proposed conceptual framework.

In terms of policy implementation, all the HCPs in both the face-to-face, semi-structured interviews and FGDs recognised the existence of mental healthcare policies that encouraged medical treatment teamwork. The following verbatim quotation from a social worker at Site A, supports the above argument:

If you see the policies, you will see that the government is asking us to work with our colleagues. In the MDT, we have all the disciplines, the psychiatrist, social worker, psychologist, OT (occupational therapist) and so on. So, we work together as the policy says we must do. We do ward rounds...so we work together. (Social Worker, Site A)

It can be inferred from the above quotation that mental health policies advocate for medical treatment team collaboration, as per the principles of Ubuntu as well support the shift towards a decolonial approach to mental healthcare. The literature in chapter 3 suggested that mental health policies permit HCPs with experience in psychiatry, together with a range of allied health professionals (for example, nurses, social workers, clinical psychologists, pharmacists, occupational therapists, medical officers, and psychiatrists), to have a potential role in the assessment of the mental state of a mentally ill patient (Republic of South Africa 2002). Therefore, the above quotation is in line with the literature that emphasises the need for a medical treatment team approach to mental healthcare.

The above verbatim quotation also links to the theme of collaborative teamwork for holistic mental healthcare discussed in section 8.3.1.1. The theme of collaborative teamwork for holistic mental healthcare highlights that all HCPs must work as a team to provide individualised mental healthcare. This finding relates to the Theory of Collective Competence, discussed in chapter 4, which suggests that mental healthcare requires professionals from interdisciplinary backgrounds to combine their unique skills and knowledge to provide effective healthcare (Boreham 2004). Therefore, The Theory of Collective Competence upholds the notion that mental healthcare should be based on effective medical treatment teamwork (Reilly 2018). This finding is in line with the focus of this study since the primary aim of this study aimed to propose a decolonial framework which considers a medical treatment team approach to mental healthcare.

Furthermore, according to all the HCPs at both sites, the policies guided them in providing the best possible care for the patient, that is, working to achieve patient-centred care. This is consistent with the findings from the theme of patient-centred approach to mental healthcare care discussed in section 8.3.5.1 which emphasises that the primary objective of the medical treatment team is to provide effective care to the patient, while treating patients with respect and dignity (WHO 2018). An enrolled nurse noted:

The apartheid policies were very oppressive to our patients. Patients were not treated nicely and that is why the law was replaced with this Mental Healthcare Act. This one guarantees the right of the patient, their safety and all that stuff. That is why, if someone is admitted here involuntarily, the person who is an applicate [sic] must state his name and state the reason for applying for the patient and also go in front of the Commissioner of Oaths and state the reason. That is how we abolish those apartheid laws to a more democratic one. We like these policies so we use them to work nicely as team from different discipline to help our patients. (Enrolled nurse, Site B)

This finding from the enrolled nurse at Site B, suggests that the HCPs respected patients' rights and provided them with best possible mental healthcare. As discussed in chapter 3, mental healthcare policies prior to democracy were discriminatory and not inclusive (Van Rensburg 2012). The apartheid period was characterised by repression and human rights (Coovadia et al. 2009). Blacks were denied professional health services (Sibiya & Gwele 2013). After apartheid, South Africa was in need of policies that protected human rights (Van Rensburg 2012). Hence, the MHCA 17 of 2002 was developed and the NMHPF and Strategic Plan in 2013 were developed to move away from the harsh unequal policies that existed. These policies emphasised the need for the medical treatment team to respect all patients and provide them with the best possible care. Hence, the above-mentioned policies encourage the decolonisation of mental healthcare.

The majority (95 per cent) of the HCPs at both sites, stated that they involved the patient's family members, as stipulated by the policies. This supports the literature that the patient's family should be involved in their mental healthcare. The need for family involvement is also confirmed by the MHCA 17 of 2002, which stipulates that if the "user is below the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user" (Republic of South Africa 2002:18).

The following verbatim quotation from a professional nurse at Site A supports the above argument:

The policies are also telling us that we cannot discharge patients if they can harm themselves. We had one patient in our ward and the patient was saying that they want to go home but I talked to the doctor. We realise that we cannot discharge that patient even though they want to go because they are mentally unstable to make decisions ... We told the family because they are mentally stable, they can go to the court and appeal if they are not fine with our decision and if they get a court order, that is when we can discharge. The family says we should not discharge the patient. It is policy that helps us in situations like this. (Professional nurse, Site A)

The above quotation links to the theme on the role of the family discussed in section 8.3.3.1, as it emphasises the role of the family in mental healthcare. According to the literature, the patient's family plays a fundamental role in encouraging the patient to adhere to treatment (Amela et al. 2021). Therefore, considering family influences and involving family members in mental healthcare by the medical treatment team may be a more effective strategy for mental healthcare in South Africa (Charles & Samarasinghe 2019). This is because mental healthcare that involves the patient's family is culturally relevant and could enhance patient behavioural outcomes (Zingela et al. 2019). The majority (75 per cent) of the HCPs from both sites noted that they implemented policy by considering the patient's culture during healthcare. The following verbatim quotation from a professional nurse at Site B supports the above argument:

When we see that the patients have some ceremonies to do, we let them go. Many boys want to go for their circumcision in December, so we give them medication and tell them to go and do it and then come back. (Professional nurse, Site B)

The above quotation from the professional nurse links to the theme of cultural sensitivity in mental healthcare discussed in section 8.3.2.1. This theme highlights how members of the medical treatment team considered the cultures of patients during mental healthcare. In relation to the literature, the medical treatment team should consider the culture of the patient in order to provide culturally appropriate mental healthcare (Mabunda et al. 2022). Since cultural aspects determine adherence to mental health

treatment (Gopalkrishnan 2018). Thus, culture was a core element in the proposed conceptual framework for mental healthcare in the South African context. The next section explains the element “other” category that emerged after verifying the framework at Site A and Site B.

8.3.5 Element: “Other” that emerged during the fieldwork process

As noted in the introduction of this chapter, the element “other” encompasses information that was not included in the proposed framework but emerged during the fieldwork. These themes include: a patient-centred approach to mental healthcare in South Africa from a medical teamwork approach, and challenges faced or experienced in mental healthcare delivery from the perspective of the medical treatment team. The following paragraphs provide a discussion on emergent themes.

8.3.5.1 A patient-centred approach to mental healthcare in South Africa from a medical treatment team approach

This theme encompasses the idea that the medical treatment team prioritises effective patient care. In the context of this study, patient-centred care is an approach that prioritises effective, individualised patient care. In the context of this research, decolonisation of mental health can enhance patient-centred care by catering for the patients’ socio-cultural factors. The WHO (2018) supports this view by arguing that the primary objective of the medical treatment team is to serve the patient by providing effective healthcare. Patient-centred care is now recognised as an important component of effective healthcare (Muth et al. 2014; Santana et al. 2018; WHO 2016). This is because patient-centred care provides a more holistic approach to care by acknowledging the needs of the patient. Research demonstrates that patient-centred care improves the patient care experience and leads to effective mental healthcare (Babiker et al. 2014; Bháird et al. 2016; Oflax et al. 2019).

The findings from this team also link to Lencioni (2002)’s Model, discussed in chapter 4 of this study. According to the Lencioni Model effective patient care can only be achieved if all members of the medical team provide patient-centred care (Lencioni 2002). The results from this theme relate to the theme of the Ubuntu-centred approach to teamwork discussed in section 8.3.2.4. Ubuntu revolves around oneness, kindness, fairness and justice (Kgatla 2016). Chigangaidze et al. (2022) argue that ubuntu is also about respecting human dignity and ensuring quality care to all patients. Therefore, the findings

from this theme suggest that the medical treatment team consider the principles of Ubuntu in patient care.

During the face-to-face, semi-structured interviews all with the clinical managers, psychiatrists, and medical officers of the medical treatment team at both Site A and Site B, it was mentioned that patient-centred care was the most important factor in mental healthcare. This links to the theme titled, demonstration of cultural sensitivity and cultural competence for mental healthcare discussed in section 8.3.2.1, in which members of the medical treatment team noted that the patient was the primary focus of the team. Hence, the culture of the patient takes priority in mental healthcare. According to members of the medical treatment team, the primary objective of the medical treatment team is to serve the patients; hence, the medical treatment team worked together to provide the best possible care for all patients. Below are some examples taken from face-to-face, semi-structured interviews at both Site A and Site B, to support this sub-theme:

Our core business is patient care, so we do everything as a team to ensure that we provide the patient high-quality care. (Clinical manager, Site A)

Our focus is to treat our patients. The team assist the patient to regain their level of optimal functioning and to develop coping skills. The team works together in a collaborative effort to help the patients. Multidisciplinary ward rounds are held where the patient is interviewed to identify the problems that need attention of team members and referrals to team members are made accordingly. We really care for our patients. (Medical officer, Site A)

Everyone here understands that we need to work extra hard to care for our patients because these patients really need our care. (Psychiatrist, Site B)

All the members of the medical treatment team at both sites, supported patient-centred care. They used terminology such as “high-quality care”, “emotional support”, “physical comfort”, “motivate them to take medication”, “put a smile on their faces”, and “giving them a seat” to describe how patients were treated at both sites. Based on the above discussion, the HCPs at both sites practiced a patient-centred approach to mental healthcare. The quotations revealed that the priority of the team was to ensure that all patients received the best possible care. The literature reviewed states that patient-centred care is supported by the World Health Organization, World Psychiatric Association, and other professional and patient bodies (Jed & Subhodh 2020). Adopting

a patient-centred approach can also improve mental healthcare (Ahmad, Ellins, Krelle & Lawrie 2014). Patient-centred care also allows the medical treatment team to treat patients with dignity and respect and it considers the needs of the patients. According to Oflax et al. (2019), patient-centred care allows the team to consider the needs of the patient. When related to this study, the medical treatment team needs to consider the socio-cultural needs of the patient (see chapter 3 for a detailed discussion on the need for socio-cultural consideration in mental healthcare). The findings of this study thus emphasise that the medical treatment team must prioritise the patients when providing healthcare. Thus, the conceptual framework emphasised the need for the medical treatment team to prioritise the patient in mental healthcare.

During the face-to-face, semi-structured interviews, the HCPs also noted that the medical treatment team provided patient-centred care by providing individual care plans for patients. Below are three examples to support the above argument:

Like I was saying, a patient who has dementia cannot be on the same care plan like the one who has depression ... the care of our patients depends on their illness. (Forensic Psychiatrist, Site A)

I mean each patient has a different mental illness and has a different treatment plan. The objective of the team is to work together to make sure that the patient gets the best care possible. (Medical officer, Site B)

Patient care is our priority. Patients are treated as unique individuals. For example, an individual care plan is drawn for each patient. Each patient is given unique attention. (Clinical Manager, Site B)

The above quotations argue that every patient's treatment is different; hence, the treatment team provides an individual care plan for each patient. According to Coffey et al. (2019), providing individual care plans is one of the ways of providing patient-centred care. As per the literature review in chapter 4, each team member contributed expert knowledge to the development of a care plan for the patients (Mary 2011). In the context of this study, the members of medical treatment team (that is, the clinical psychologist, medical officer, social worker, psychiatrist, nurses, OT, and pharmacist) contributed to the patient's care plan. The above team members all worked together to provide patient-centred care.

In line with the face-to-face, semi-structured interviews, all the HCPs from the FGDs also emphasised that the treatment teams aimed to provide efficient patient-centred mental healthcare:

At the end of the day, it is about the well-being of the patient, providing care for our patients. (Social worker, Site A).

Patients are treated with dignity; we refer to them as Mr or Mrs. (OT, Site A)

We cannot send a patient home until we are sure that when we do, there will be no need for him to come back here. We always make sure that the patient receives the best care. (Professional nurse, Site A)

The findings from the face-to-face, semi-structured interviews and FGDs were confirmed by the MHCA 17 of 2002, the NMHPF 2013-2020 and the hospital policy pertaining to ward rounds as these policies also advocated for patient-centred mental healthcare (Eastern Cape Department of Health 2019). It is worth noting that the MHCA 17 of 2002, has dedicated an entire chapter to healthcare for mentally ill patients. The MHCA 17 of 2002, states that patients should be respected and provided with the best possible care, treatment, and rehabilitation. For example, the MHCA 17 of 2002, states that, mental healthcare should be provided in a manner that

makes the best possible mental health care, treatment, and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources (Republic of South Africa 2002:8).

Data from the NMHPF is consistent with the MHCA 17 of 2002, because the NMHPF states that “*mental healthcare users should be provided with the least restrictive form of care*” (Republic of South Africa 2013:20). Furthermore, the hospital policy pertaining to ward rounds stipulates that “all patients should be seen at least once a week and an entry should be made in the folder to indicate such” (Eastern Cape Department of Health 2019:1). The above quotes from the MCHA, NMHPF and policy on ward rounds suggest that the treatment team should strive to provide the best possible care to all patients. This finding correlates with literature reviewed in chapter 3 which states that the primary objective of the medical treatment team is to provide effective patient care. The results from this theme also correlate with the theme of policy implementation at the case sites

by HCPs from the medical treatment team discussed in section 8.3.4.1. The results under the theme, policy implementation at the case sites by health care professionals from the medical treatment team, revealed that the treatment team implemented both government and hospital policies, in order to provide healthcare that protected the rights and interests of all the patients, hence patient-centred care was implemented.

In summary, the researcher triangulated data from the document analysis, face-to-face, semi-structured interviews, and FGDs (from both Site A and Site B) and the findings suggested that the medical treatment teams at both sites provided or catered for patient-centred care. This finding is consistent with the results from studies conducted by Oflax et al. (2019) who found that the primary aim of the treatment team was to provide patient-centred care.

The literature in chapter 3, also emphasised that developing countries like South Africa should prioritise patient-centred care. This is an important aspect of the decolonisation of healthcare because individual patient's cultures need to be catered for and respected in the South African context (Nemutandani 2018). Hence, this sub-theme ties in with the overall context of the research because the proposed conceptual framework argues that prioritising patient-centred care is an integral component that medical treatment teams must consider when providing mental healthcare. The next sub-section provides a discussion on challenges in mental healthcare delivery.

8.3.5.2 Challenges in mental healthcare delivery

As discussed in chapters 2 and 3, South Africa experiences major healthcare challenges (Ned et al. 2017; Van Rensburg 2012). Although there has been significant progress with regard to public healthcare since the dawn of democracy, the public healthcare system still faces many challenges in the delivery of healthcare (Viviers 2016). These challenges were generated from data through observation, face-to-face, semi-structured interviews, and FGDs namely, staff shortages and language challenges. These two sub-themes will be discussed in the following paragraphs.

8.3.5.2.1 The challenge of staff shortages: limited number of mental HCPs

The literature discussed in chapter 2, suggested that there were limited numbers of HCPs to provide care for mentally ill patients (Booyesen et al. 2021). The Department of Health (2018) concurred by stating that the HCPs who worked in mental health facilities

in South Africa constituted 9.3 per 100 000 of the population in 2018. Viviers (2017) adds that most of the HCPs work in the private sector which only serves about 17 per cent of the South African population. Hence, there is a severe staff shortage, especially in public hospitals, as confirmed at the case sites. During the face-to-face, semi-structured interviews, 100 per cent of the HCPs at both Site A and Site B, noted the lack of adequate staff as one of the challenges that the hospitals faced. The psychiatrist and clinical manager at Site A, and the medical officer at Site B emphasised the shortage of HCPs stating:

We do not have enough staff and this is a serious challenge, for an example, there is only one psychiatrist in this hospital and, as I speak to you, we have close to 300 patients that are admitted in the wards. Staff in the MDT are not enough. (Clinical manager, Site A)

Shortage of staff, particularly specialised personnel. For example, we have one psychiatrist and very few nurses with advanced psychiatric nursing. (Medical officer, Site B)

The above HCPs stated that a shortage of staff such as, psychiatrists was a major challenge. As noted in the literature, the shortage of staff has been cited as a major problem in the South African public healthcare system and specifically specialist HCPs such as psychiatrists. About 85 per cent of South Africans use public health facilities and there is an increasing need for more HCPs to assist patients (Conmy 2018; Mahlathi & Dlamini 2017). In line with the data from the face-to-face, semi-structured interviews, the HCPs in the FGDs at both Site A and Site B, confirmed that a shortage of HCPs existed.

This hospital is the only forensic hospital in the Eastern Cape, and we only have one psychiatrist, just one. (OT, Site A)

We are very, very, very much short [of] staff because we are covering a large catchment area, attending to some hospitals like Frere Hospital and also the clinics around East London up to Fort Beaufort, former Transkei area. (Clinical psychologist, Site B)

The above verbatim quotations reiterate that there are a “very” limited number of HCPs at both Site A and Site B, and in South Africa in general (Booyesen et al. 2021). This finding is consistent with the results of a study conducted by Benjamin et al. (2021) which

argued that there is a shortage of HCPs to provide care for the mentally ill patients in South Africa. It can be inferred from this finding that decolonisation of mental healthcare is imperative. Decolonisation will not only increase access to mental healthcare, that is, access to both the treatment team and traditional practitioners, but will also ensure that patients receive healthcare that is culturally congruent. Hence, patient-centred will be practised or achieved fully since the cultural beliefs of the patient will be addressed (Jacobs & Coetzee 2018). Any intervention that is geared towards improving mental healthcare in the South African context must consider all aspects of the existing healthcare system. Hence, the need exists for a decolonial conceptual framework for mental healthcare in the South African context. The next section provides a discussion on the sub-theme of language barrier.

8.3.5.2.2 Language barrier: a major communication challenge faced by the medical treatment team at the case study sites

South Africa is a multiculturally diverse society with 11 official languages (Adams & Rother 2017). As discussed above, treatment team members and patients both come from different cultural backgrounds and thus speak different languages. Members of the medical treatment team are faced with the challenge of overcoming language barriers, by ensuring that quality care is provided to the patient. A challenge that exists here is that ineffective communication can negatively affect the patient's treatment, as per the findings under the theme of effective communication between the treatment team members for collaborative medical teamwork.

The face-to-face, semi-structured interview, observational data, and FGDs suggested that the language barrier was a major challenge. Triangulation of data from different sources occurred for this theme. Almost all the HCPs at both sites mentioned that language was a major challenge in patient care. According to Shamsi et al. (2020), the language barrier poses a challenge to effective patient care. The medical treatment team members stated that they had to rely on other team members for translation during ward rounds where the patient could not communicate in English. Participants also mentioned that meaning got lost in translation. During the face-to-face, semi-structured interviews, a psychiatrist at Site B, noted that most of the patients spoke isiXhosa and that posed a language barrier to some colleagues who did not understand the language. Hence colleagues who understood the language had to interpret for other team members, as these verbatim quotations revealed:

I have been working here for more than 5 years and I can tell you that I do not still understand isiXhosa...we have to wait for other people to tell us what the patient is saying. (Medical officer, Site A)

In the treatment team, we have members from Xhosa culture, Zulu culture [sic], English and Afrikaans cultures. Our patients are mostly Xhosa people and they communicate in their language. We allow patients to communicate in the language that they are most fluent and comfortable with ... this means that only colleagues who understand the language will understand and then interpret to us. (Psychiatrist, Site B)

Data obtained from the FGDs echoed the same sentiment as the interview data:

In the ward round situation, we get so caught up that we forget that there are people who need interpretation, so communication becomes a challenge and, at times, those who are interpreting do not follow the correct way of doing it. They do more of translation than interpreting and a lot gets lost and misinterpreted in that process and also it becomes time consuming because now you have to keep moving from one language to another and at times this results in misunderstandings. (Clinical psychologist, Site A)

We are four psychologists here and the challenge is that one is English speaking and the population here is predominantly isiXhosa speaking Sometimes even in ward rounds she may not understand what the patient is saying and the person translating to her and the other MDT members who do not understand isiXhosa tries to summarise what the patient has said because of time, so she might end up not even completely understanding what is going on. (Clinical psychologist, Site B)

The above quote from the clinical psychologist at Site B, links to the theme of collaborative medical treatment teamwork for holistic mental healthcare (discussed in section 8.3.1.1) and the theme of an Ubuntu-centred approach to mental healthcare teamwork in South Africa (discussed in section 8.4.2.4). The quotation clearly demonstrates how members of the medical treatment team worked collaboratively by helping each other when there were language barriers. The language barriers were evident during observations of the ward rounds at both Site A and Site B. The researcher observed that team members at both sites were diverse, that is, they came from different

cultural backgrounds. In the observed interactions between the medical treatment team members at both sites, the researcher noted that the patients were interviewed in a language with which they were most comfortable. The case sites were located in the Eastern Cape province where the dominant language of the patients is isiXhosa (Hazel 2018; Pludderhmann, Mbude-Shale & Wababa 2005). Therefore, the team member who understood the language of the patient needed to translate what was said to the other team members, after interacting with the patient. This occurred in cases where the patient was not fluent in English. The members of the medical treatment team also had to ask their questions to the patient, through the colleague who understood the language spoken by the patient.

Even though the NMHPF (2013:39) states that all mental HCPs, such as “psychiatrist, psychologist, social workers, OTs receive training in an indigenous African language as part of their mental health training”, the policy does not specifically stipulate that the HCP must learn all 11 official languages in South Africa. This implies that the HCPs may receive training in an indigenous language, yet still experience a language barrier. This was the case at both sites as observations, face-to-face semi-structured interviews, and FGDs at both sites suggested that some members of the team at both Site A and Site B, could not speak the mother tongue of the patients. Hence, other team members who understood the language of the patient had to translate for some of the team members.

The findings from this study are in line with literature discussed in chapter 4, which argued that communication challenges can impede effective patient care if the HCP cannot understand the patient and vice versa. This finding also suggests that the Department of Health should provide resources to train administrative staff in translation, or employ professional interpreters for the provision of language services, to facilitate a treatment team approach to mental healthcare. But the challenge of staff shortages, as mentioned in section 8.3.5.2.1 can hinder this idealism. Hence, the medical treatment team, at the case study sites, conquered these challenges by supporting and assisting each other, as per all the findings in this chapter.

In summary, the results from this theme suggest that even though there has been some progress in this democratic era in terms of providing healthcare to all South Africans, there are still major challenges that the healthcare system face such as, staff shortages and language barriers. These challenges may result in the patient not being provided with the best possible care, as stated by the mental healthcare policies, that were

analysed for the purposes of this study. Hence, there is a crucial need for the South African government to employ more staff, encourage collaboration between the medical treatment team and traditional practitioners, and employ trained professional interpreters who can assist the medical treatment team, in cases where the team members do not understand the language of the patient. The provision of all the above resources for the public health sector will facilitate the provision of mental healthcare that protects the rights and dignity of all mental healthcare users. Based on these findings, challenges in healthcare delivery were included in the proposed conceptual framework for mental healthcare under the element “other”.

8.4 SUMMARY

The aim of this chapter was to present and interpret the findings from the data collected. Findings were presented from the four data collection methods and triangulation occurred within the data presentation per theme and sub-theme discussed in this chapter. The findings suggested that collaborative medical treatment teamwork through effective communication is important for mental healthcare. The results also revealed that decolonisation of mental healthcare could support medical treatment teamwork for patient care in a South African context. The next chapter will conclude the overall study.

CHAPTER 9: CONCLUSIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

This study set out to propose a conceptual framework for the decolonisation of medical treatment teamwork approach for mental healthcare in South Africa. This chapter concludes the study by drawing conclusions and making recommendations on a medical treatment teamwork approach to mental healthcare. It is important to note that salient elements from the literature and theories were synthesised to develop a conceptual framework for a medical treatment team approach to mental healthcare in South Africa. To determine whether the elements, that is, medical treatment teamwork, decolonial factors, socio-cultural context, and policy of the proposed framework could be accepted, amended and/or rejected, the framework was empirically verified through a multiple case study approach at Fort England Hospital and Cecilia Makiwane Hospital. The revised conceptual framework, which emerged after the empirical verification from the field, is presented in this chapter. The research questions are also answered in this concluding chapter. Furthermore, a discussion on the contribution of the study, as well as the limitations of the study are discussed. The chapter also provides recommendations based on findings from this study. Lastly, the chapter provides the concluding remarks of the study.

9.2 ANSWERING THE RESEARCH QUESTIONS: THE RESEARCH FINDINGS

In the next sections, the research questions are answered.

9.2.1 Research Question 1: How does communication between the HCP medical treatment team facilitate effective patient care?

The findings from this study have demonstrated how effective communication between the medical treatment team members facilitated the treatment of mentally ill patients at both case study sites. This was evident in the following themes namely: “collaborative teamwork for holistic mental healthcare”, “effective communication between the medical treatment team members for collaborative medical teamwork”, an “Ubuntu-centred approach to mental healthcare teamwork in South Africa”, and “a patient-centred approach to mental healthcare in South Africa”.

The theme of “collaborative teamwork for holistic mental healthcare” focused on how the medical treatment team (which included psychiatrists, clinical managers, clinical

psychologists, social workers, nurses, occupational therapists, pharmacists, and medical officers) at both Site A and Site B, worked collaboratively through effective communication to provide effective patient care. In the discussion of this theme, numerous examples were provided on how the medical treatment team members communicated the needs of each patient in order to provide a comprehensive management plan. The data that constituted this theme emphasised that information exchange between the medical treatment team members facilitated patient care.

The theme of “collaborative teamwork for holistic mental healthcare” can be associated with the teamwork models and theories discussed in chapter 4, namely, the Theory of Collective Competence (Boreham 2004), Tuckman’s Teamwork Theory and Model (Tuckman 1965), the GRPI Model (Rubin et al. 1977), the T7 Model of Team Effectiveness (Lombardo & Eichinger 1995), and the Lencioni Model (Lencioni 2002). It was argued that members of the medical treatment team should combine their unique skills and knowledge and communicate effectively to treat mentally ill patients. The above-mentioned theories and models upheld the notion that collaboration through information exchange facilitates patient care (Lingard 2012, Reilly 2018; Wang et al. 2018).

Furthermore, the theme of “effective communication between the medical treatment team members for collaborative medical teamwork”, clearly explained how effective communication between members of the medical treatment team facilitated patient care. Discussions on this theme focused on how communication facilitated the development of a comprehensive healthcare plan for individual patients (Jacobs & Mkhize 2021). This links to the theme of “a patient-centred approach to mental healthcare” which emphasised that the medical treatment team should worked together, through information exchange, to help the patients. Members of the medical treatment team from both sites shared scenarios where information exchange had facilitated effective patient care. For example, the medical treatment team members from both the sites, noted that the night staff had to communicate with day staff, on a daily basis, so that the day staff were knowledgeable about what had occurred during the night and vice versa. A case in point was when a professional nurse at Site B, explained how the HCPs had to “hand over communication” to enable the other team members to understand what medication a patient had been given during the night shift duty (see chapter 8 for a detailed explanation on some of these examples).

Furthermore, the theme of “an Ubuntu-centred approach to mental healthcare teamwork in South Africa”, emphasised how members of the medical treatment team communicated and supported each other to achieve effective patient care. This theme revealed that the team members could communicate with other team members and ask for help when the need arose. For example, the psychiatrist at Site B, was new and she mentioned that she always communicated and asked for help from other team members. A professional nurse at Site A, also noted that the team members always asked for advice when they were confused about how to treat a patient (see chapter 8 for more examples). Obtaining support from other team members could only be achieved through communication or information exchange. Hence, this theme also demonstrated how the medical treatment team members communicated with other team members, to facilitate effective patient care.

Triangulation of all four data collection methods revealed themes that suggested how information or communication exchange between the medical treatment teams at both sites, facilitated effective patient care. In line with the above discussion, it can be concluded that effective communication between members of the medical treatment team, facilitated care for mentally ill patients. This finding relates to previous studies highlighted in chapter 4, which indicated that effective communication should be considered an attribute and guiding principle of a medical treatment team (Jacobs & Mkhize 2021; Neuhaus et al. 2020; Rosen et al. 2018). Therefore, the results from this study are consistent with the literature reviewed in chapter 4 and theoretical triangulation was explained throughout the findings in chapter 8. The data generated from all the data collection methods explained how communication between members of the treatment team facilitated effective patient care. Thus, a need exists for a comprehensive conceptual framework which considers effective communication between members of the medical treatment team, as a factor that contributes to effective mental healthcare, in the South African context.

9.2.2 Research Question 2: What communication challenges affect medical treatment teamwork at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital?

This research question is closely related to first research question (discussed above), as it focuses on the communication that occurred between the members of the medical treatment team to maintain effective patient care. The aim of this research question was

to determine whether there were any communication challenges experienced that affected the medical treatment teamwork, at the case sites. The results revealed that there were no major communication challenges noted or experienced between these HCPs. The majority of the HCPs at both sites suggested that communication assisted the medical treatment team to work collaboratively in obtaining patient care. This was evident in the following themes namely: “collaborative teamwork for holistic mental healthcare”, “effective communication between the medical treatment team members for collaborative medical teamwork”, an Ubuntu-centred approach to mental healthcare teamwork in South Africa”, and “a patient-centred approach to mental healthcare in South Africa”. The above-mentioned themes emphasised that communication between medical treatment team members assisted the team members to provide adequate patient care. For example, a social worker could share information that they had gathered from a patient’s family, while a nurse could explain how the patient was doing after taking their medication. During this information exchange sessions, the members of the medical treatment team learnt more about each patient’s treatment. Thereafter they used this information to provide holistic mental healthcare to the patient (Wang et al. 2018).

Furthermore, the findings of the study indicated that effective communication assisted the medical treatment team to avoid medical errors. The discussion on the theme of, effective communication between the medical treatment team members for collaborative medical teamwork emphasised that medical treatment teamwork could not succeed without effective communication. Team members were aware of the need to communicate with other. For example, the psychiatrist at Site A and the medical officer at Site B, emphasised that collaborative medical treatment teamwork could not function effectively if effective communication did not take place between members of the medical treatment team. This view is consistent with the literature reviewed in chapter 4, which argued that effective communication was fundamental to medical treatment teamwork for patient care (Amiri et al. 2018; Wang et al. 2018; Zamazadeh et al. 2021). Effective interaction between HCPs has positive effects on health outcomes (Rosen et al. 2018). Thus, the need for a conceptual framework that caters for effective communication amongst members of the treatment team members was presented to address this gap.

However, the majority of HCPs from both sites noted that there was a challenge with regard to the limited number of staff available at public hospitals. Thus, caused HCPs to be overwhelmed by the pressure of providing mental healthcare. The HCPs did not state that these staff shortages negatively affected their teamwork spirit, in providing mental

healthcare to patients. The aspect of language barriers emerged as a communication challenge faced by the HCPs, at the case study sites. According to Shamsi et al. (2020), concurs that language barrier poses a challenge to effective medical treatment teamwork. As mentioned previously, the sites were located in the Eastern Cape where the dominant language of the patients was isiXhosa. Therefore, members of the medical treatment team who understood the language in which that the patient communicated, were able to translate/interpret and assist other treatment team members. The HCPs noted that meaning in some cases would be distorted during the translation process. They overcame this by constantly communicating and ensuring that all the medical treatment team members understood all the decisions that were made with regard to patient care. The language barrier for patient care was the only communication challenge that was mentioned by the medical treatment team at both sides. The HCPs from both sites generally acknowledged that communication between the medical treatment team members was fair and this assisted the team in achieving their goal of providing effective mental healthcare to all patients equally.

9.2.3 Research Question 3: How do both government and hospital policies at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital encourage or discourage the shift towards the decolonisation of mental healthcare?

The aim of this research question was to analyse if both government and hospital policies encouraged or discouraged the transition to the decolonisation of mental healthcare. To address this research question, the researcher analysed post-apartheid government and hospital policies that related to mental healthcare. The researcher also conducted face-to-face semi-structured interviews, observations, and FGDs with the medical treatment teams at both sites, to determine whether the sampled mental health policies were in favour of decolonisation of mental healthcare in South Africa and at the case study sites. The HCPS were also questioned on their implementation of such policies in their mental healthcare service delivery to patients.

The findings of the study indicated that members of the medical treatment team were generally positive regarding the role of policies in decolonising mental healthcare. The majority of the HCPs emphasised that they implemented both government and hospital policies, in order to cater for the socio-cultural needs of the patient during mental healthcare sessions. This was evident in the following themes namely: policy

implementation at the case sites by HCPs from the medical treatment team; towards decolonising mental healthcare; demonstration of cultural sensitivity and cultural competence for mental healthcare and cultural tolerance in the treatment team; catering for cultural differences in mental healthcare teamwork; and the positive and negative role of the family in mental healthcare: family as caregivers, active family members, absent family members. In essence, the results of the study suggests that the existence of mental health policy is an integral tool in decolonising mental healthcare in South Africa. The above finding supports the proposition of this study, that mental healthcare policies guide the functioning of a mental health institution such as, the case study sites (Mulutsi 2017).

The findings from the above-mentioned themes reflect the ideas presented in the literature, which indicate that mental health policies are a key strategy to improving mental healthcare (Mulutsi 2017; Sibanyoni & Maritz 2016). In summary, with regard to the 14 documents (two government mental healthcare policies and 12 hospital policies), observation, face-to-face semi-structured interviews, and FGDs at both sites, this study concludes that post-apartheid mental healthcare policies were in favour of the transition towards the decolonisation of mental healthcare. Hence, this study proposed a conceptual framework that enables the medical treatment team to consider policies, that favour the transition to decolonisation of mental healthcare in the South African context.

9.2.4 Research Question 4: Does the inclusion of socio-cultural aspects support mental healthcare at Cecilia Makiwane Hospital and Fort England Psychiatric Hospital?

The findings from this study suggest that the medical treatment team at each of the two sites supported and incorporated socio-cultural aspects in mental healthcare. In the context of this study, socio-cultural consideration is two-fold, (that is for both patients and for HCPs). The HCPs need to have cultural tolerance with regard to other team members because the team members come from diverse cultures. In essence, HCPs need to have cultural knowledge, attitudes, or personal attributes to maximise respectful team relationships. As noted in chapters 4 and 5, the members of the medical treatment team members may have had different cultural world views and this could generate conflict within the team (Morley & Cashell 2017). Therefore, the HCPs needed to tolerate team members' cultures, to be able to work collaboratively to provide effective mental healthcare. The findings from this study suggested that members of the medical

treatment team considered the cultures of other team members, when working collaboratively for patient care. This was evident in the theme of, “cultural tolerance in medical treatment teams: catering for cultural differences in mental healthcare teamwork”. All the medical treatment team members from both sites noted that members of the medical treatment team acknowledged, accommodated, and respected the cultures of other team members. For example, a medical officer at Site B noted that team members always respected and accommodated one of their colleagues who was a sangoma.

The literature in chapter 4 suggested that South Africa has diverse cultures and, hence, the members of the medical treatment team held different cultural beliefs. According to Davidaviciene & Maizoub (2022), lack of consideration of the beliefs and values of other team members often leads to misunderstandings amongst team members. MacDonald and Oliver (2017) state that a culturally competent medical treatment team creates a positive environment for teamwork for individualised patient care. Thus, this study concludes that the medical treatment team members were culturally tolerant of other team members cultures. Hence, the need for a conceptual framework, which caters for cultural aspects in medical treatment teamwork approach to mental healthcare, in South Africa.

As discussed in chapters 3 and 5, socio-cultural aspects need to be incorporated into mental healthcare in order to achieve effective patient care (Kuo et al. 2018). This is because mental well-being is determined by socio-cultural factors such as, culture and family involvement in mental healthcare (Lake & Turner 2017). According to Raingruber (2013), family members can positively influence a patient’s treatment by providing support and encouragement to the patient. Therefore, the treatment and care of a person living with a mental illness requires a holistic approach, that includes active participation of the patient’s family (Dirik et al. 2017; Olasoji et al. 2017). Hence, the need exists for a conceptual framework that caters for the role of the family in mental healthcare in the South African context. This is because support from the family helps in the physical and psychological well-being of the mental patient (Kuo et al. 2018; Maybery 2021). Thus, the medical treatment team needs to include the patient’s family as part of the MDT. This inclusion aims to address the socio-cultural aspects of the patient (Kaved & Herrman 2017; Olasoj et al. 2017).

Maybery (2021) argues that if treatment recommended for a mentally ill patient does not reflect their cultural beliefs, they may not adhere to it. It is, therefore, important for the treatment of mental illness to be congruent with the patient's culture. Therefore, socio-cultural factors that contribute to illness and health care are as important as aspects such as physiological, sociological, and psychological causes of illness (Tjale & de Villiers 2018). The cultural and decolonial models discussed in chapter 5, namely, the PEN-3 Model, Theory of Cultural Care, Diversity, and Universality, the Culturally Competent Model of Care, Decolonial Theory, and IST offer a culture-centred approach to health, that extends the analysis to the totality of the contexts that either inhibit or nurture the patient (Campinha-Bacote 1995; Foley 2003; Grosfoguel 2007; Iwelunmor et al. 2014). Thus, the need to decolonise and indigenise mental healthcare in South Africa exists and these socio-cultural aspects were therefore included in the conceptual framework.

The majority of the themes generated from the face-to-face, semi-structured interviews, observations, FGDs, and document analysis suggested that the treatment team at both sites incorporated socio-cultural aspects in mental healthcare. For example, the theme titled, "the positive and negative role of the family in mental healthcare: family as caregivers, active family members, absent family members", supported the proposition of this study, that the patient's family plays a fundamental role in mental healthcare. The majority of the HCPs at both sites emphasised the need to include family members in mental healthcare. The findings indicated that the medical treatment team involved the patient's family in their care. For example, a psychiatrist at Site B, noted that the family could even have been considered part of the MDT. As observed, the family was practically part of the MDT as the patient's family was invited to a treatment team meeting to discuss issues related to the care of the patient. Hence, the need for a decolonial conceptual framework that caters for the role of the family in mental healthcare cannot be overemphasised.

In addition, the theme, "policy implementation at the case sites by HCPs from the treatment team" demonstrated how the treatment team at both sites implemented socio-cultural aspects in mental healthcare. Furthermore, the theme "demonstration of cultural sensitivity and cultural competence for mental healthcare" provided examples of situations where the patient's culture was considered during mental healthcare. In addition, the theme "cultural tolerance in the treatment team: catering for cultural differences in mental healthcare teamwork" showed how team members considered the cultures of other team members, during teamwork for mental healthcare. The theme, "the

use of Western versus traditional medicine to treat mental illness in South Africa” also demonstrated the need for considering both biomedicine and traditional medicine in mental healthcare. Lastly, the theme” collaboration between the medical treatment team members and traditional practitioners to treat mental illness” emphasised the need for the treatment team to collaborate with traditional practitioners to provide culturally appropriate care to mentally ill patients. Thus, it was noted that the medical treatment team at both sites aimed to decolonise mental healthcare, by incorporating socio-cultural aspects when providing mental healthcare to the patients. This ties into the conceptual framework as the contribution of this study. Thus, the researcher developed a decolonial framework that caters for socio-cultural aspects relating to the medical treatment teamwork approach and for effective patient care in the South African context.

9.3 THE REVISED CONCEPTUAL FRAMEWORK FOR A MEDICAL TREATMENT TEAM APPROACH TO MENTAL HEALTHCARE IN SOUTH AFRICA

As noted throughout this thesis, the proposed elements included the (1) medical treatment teamwork, (2) decolonial aspects, (3) socio-cultural factors, and (4) policy for mental healthcare. The conceptual framework was synthesised from the literature and theories to develop the proposed conceptual framework in chapter 6. These elements were thereafter verified in the fieldwork process, at both the case sites. Based on the findings from the document analysis, observation, face-to-face, semi-structured interviews, and FDGs the proposed framework was refined and is presented in Figure 9.1. The graphical representation of the proposed conceptual framework provided in chapter 6 (Figure 6.1) was revised after the fieldwork verification and is presented below in Figure 9.1. The element “other” was included and caters for the following two categories namely, public healthcare challenges, which include aspects such as language barrier and staff shortages, and a patient-centred approach to mental healthcare teamwork in South Africa. Hence, these aspects were included in the revised framework.

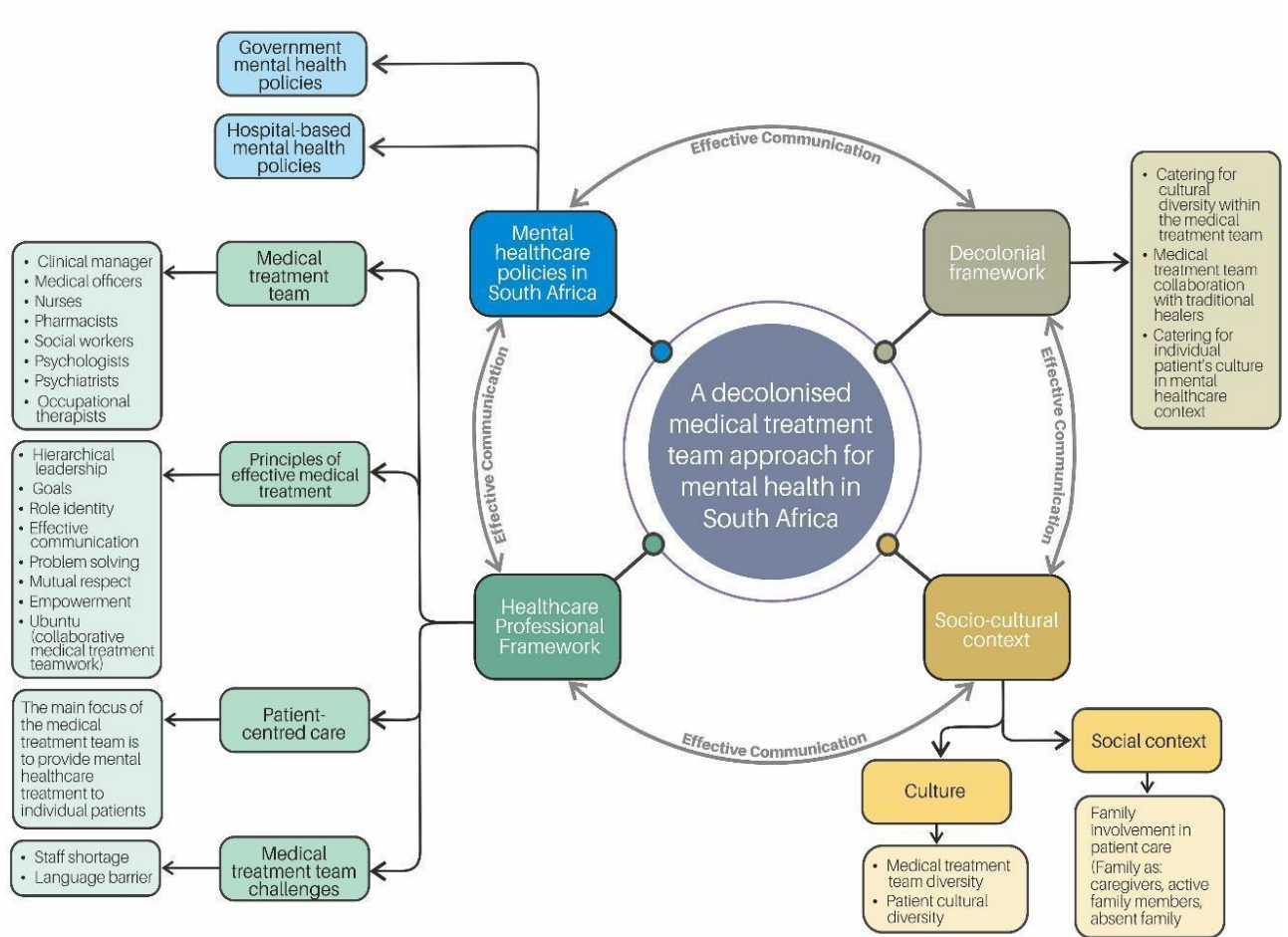


Figure 9.1: A conceptual framework for medical treatment team approach to mental healthcare

As noted throughout this thesis, a decolonial medical treatment team approach can help support patient diversity in South Africa. Hence the revised framework presented in Figure 9.1 above lists the principles that guide effective medical treatment teamwork in the South African context. These include, hierarchical leadership, goals, role identity, effective communication, problem-solving, mutual respect, empowerment, and Ubuntu in aiming towards collaborative medical treatment teamwork. These principles guide effective medical treatment teamwork. A decolonial medical treatment teamwork approach is required for mental healthcare in South Africa because members of the medical treatment team, and the majority of South Africans are influenced by their cultural beliefs. Furthermore, the majority of South Africans still consult with both the

medical treatment team and traditional practitioners for mental healthcare diagnosis and treatment options (Jacobs & Coetzee 2018).

Thus, in Figure 9.1, the revised conceptual framework for a medical treatment team approach to mental healthcare, includes decolonial aspects which are three-fold, namely catering for cultural diversity within the medical treatment team, medical treatment team collaboration with traditional healers, and catering for patient culture in mental healthcare. The three-fold decolonial aspects link directly to the socio-cultural context which is two-fold, in relation to cultural (medical treatment team diversity and patient cultural diversity) and social (the patient's family as caregivers, active family members, absent family members) aspects, as per the findings of this study. Effective communication must also take place between the medical treatment team, the traditional healers and the patient's family, in order to cater for the shift towards a decolonial medical treatment teamwork approach, in South Africa. All the above are guided by mental healthcare policies in South Africa which include both government and hospital policies. Additionally, other elements, namely challenges in mental healthcare delivery and patient-centred care, which were not included in the initial framework in chapter 6, emerged in the field thus these categories were included in the final conceptual framework. All the elements displayed in the revised framework contribute to a decolonised medical treatment team approach to mental healthcare, in the South African context.

All four elements of the conceptual framework were generally supported by data generated from the four data collection methods. The majority of the medical treatment team members at both sites, supported all the included elements of the framework which was synthesised from literature and theories. This was evident in the findings that were presented in chapter 8. The medical treatment team only mentioned staff shortages and the issue of a language barrier, as challenges that the medical treatment team encountered. As noted in the literature, there is no single existing model or theory that caters for these important aspects that influence mental healthcare in the South Africa context. Thus, the aim of this study was to address this gap identified, by proposing a conceptual framework which caters for these important elements that influence mental healthcare. The conceptual framework could be viewed as decolonial approach or a departure from embracing the fully Western biomedical approach, to mental healthcare, as a whole. Since it caters for aspects such as socio-cultural factors that influence mental healthcare in the South African context. This it can be concluded that elements of the

conceptual framework that were synthesised from the literature and theories were generally supported during the fieldwork process, by medical treatment team members at both case study sites.

9.4 CONTRIBUTION OF THE STUDY

This study makes an important theoretical contribution to the limited research on the decolonisation of the medical treatment teamwork approach, for mental healthcare, in the South African context. There has been limited research on the medical treatment team approach to mental healthcare from a decolonial perspective. Most studies on mental healthcare in the South Africa have focused on community-based mental health service, policy implementation, and mental health screening studies (Dube & Uys 2016; Modula 2016; Mulutsi 2017; Ramlall 2012). Therefore, a research gap exists in the context of a medical treatment team approach, to mental healthcare. Hence, the need exists for research on the medical treatment team approach to mental healthcare in South African context. This research, therefore, filled significant gaps and contributed to the body of knowledge on the medical treatment teamwork approach to mental healthcare in a decolonised context. This study, addressed a decolonial medical treatment teamwork for mental healthcare in the South African context, thus adds to the scant research on decolonial medical treatment teamwork as a whole.

The study contributes to research on the medical treatment teamwork for mental healthcare. By using a multiple case study approach, an in-depth understanding was gained with regard to how the medical treatment team catered for the socio-cultural needs of individual patients. Which helped to provide effective or favoured mental healthcare, considering the South African context. Furthermore, the research makes a significant contribution to the communication discipline, and more specifically to health communication and the decolonisation of healthcare, for mental health through the development of a comprehensive conceptual framework presented.

As per the literature discussed in chapters 2, 3, 4, and 5, the researcher developed a decolonial conceptual framework for a medical treatment teamwork approach for treating and caring for patients, who suffer from mental illness, in the South Africa environment. The conceptual framework has been designed in such a manner, as to indicate and highlight the need for a diverse country such as South Africa, to move towards and cater for a decolonial approach to medical treatment teamwork, in order to holistically treat mentally ill patients. It must be emphasised that all the elements included in this

conceptual framework contribute to a holistic approach to mental healthcare (as verified by the literature/theories and fieldwork process). Thus, if used collectively these elements can positively contribute to mental healthcare in South Africa. Hence, the findings of this study can be used by medical treatment teams, in mental healthcare hospitals, as a guide to maintaining effective teamwork and in aiming to provide holistic patient-centred care.

This study also contributes to the limited research on mental health as an illness, which is not usually given enough attention compared to other illnesses such as, HIV/AIDS, cancer, and tuberculosis (Jacobs & Coetzee 2018; Tomlinson 2012). It was noted in chapters 1 and 2 that mental illnesses such as depression, bipolar disorder, anxiety, and schizophrenia contribute to the high mortality rate worldwide. One in four people in the world suffer from some form of mental health problem hence more attention is needed for this illness as well (Jenkins 2011; MacGill 2017; Viviers 2016; WHO 2018; Worden 2018). However, efforts in acknowledging mental issues are noted, such as World Mental Health Day, which is celebrated every year on 10 October. In the following section, the limitations of the study are discussed.

9.5 LIMITATIONS OF THE STUDY

This study used a qualitative method which was limited as it only represents two mental healthcare hospitals in South Africa. The findings from this study cannot, be generalised to all mental healthcare hospitals in South Africa. However, a suggestion is that the conceptual framework can be applied to the African context in general because of the core need to cater for socio-cultural inclusions, in Black African mental healthcare. However, the aim of the study was not to generalise the findings, rather, it was to carry out an in-depth analysis of, first, communication between members of the medical treatment team for patient care and, second, the move towards the decolonisation of mental healthcare in South Africa. In essence, this study aimed to gain an in-depth understanding of how the medical treatment team communicate for patient care in a mental healthcare context.

The study further explored how the medical treatment team worked collaboratively and catered for the socio-cultural aspects, when providing individualised patient-centred care to patients. In order to enhance the trustworthiness of the study, the researcher used methodological and theoretical triangulation and drew conclusions based on the data collected from multiple sources, namely document analysis, observation, face-to-face,

semi-structured interviews, and FGDs (Yin, 2018). The above-mentioned data collection methods were used at the two case sites, and this validated and enhanced the credibility of the study. This is in line with Yin's (2018) argument that conclusions drawn from case study design are likely to be more valid and reliable if different sources of data are used to corroborate the same phenomenon. Therefore, the use of different data collection methods enhanced the findings of this study.

In addition, this study was only limited to members of the medical treatment team at both case study sites. Although the study proposed a conceptual framework for a medical treatment team approach to mental healthcare, which was developed from literature and verified amongst members of medical treatment team at the sites, future research could include the family members' or caregivers' perspectives on a medical treatment team approach to mental healthcare. As per the findings from this study, the medical treatment team communicated with family members and involved these family members in mental healthcare for the patient. Hence, it is valuable to obtain the perspectives of the patient's family members in relation to a medical treatment team approach to mental healthcare and the decolonisation of mental healthcare in the South African context. Despite potential limitations, the findings that emerged from this study have significant implications for understanding a medical treatment team approach in the South African context. Therefore, the following section provides a discussion on the recommendations from this study.

9.6 RECOMMENDATIONS FOR FUTURE RESEARCH

The study was conducted at two mental healthcare institutions in the Eastern Cape; thus, the sample was confined to only two mental healthcare institutions in a single province, in South Africa. It is recommended that further research be conducted on a larger scale with more case sites (more hospitals) across South Africa, that provide treatment for mentally ill patients. Since this study only focused on public hospitals, it is recommended that future research be conducted at private hospitals in order to obtain the opinions and thoughts of private medical treatment teams related to the shift towards a decolonial approach to mental healthcare in SA. Another inclusion in further research, could be trained traditional healers within the treatment team to judge the collaborative appeal, in support of achieving a holistic, patient-centred approach to mental health care in SA.

9.7 CONCLUDING REMARKS

“Mental health professionals are increasingly dealing with a multicultural patient population and there is an urgent need for awareness of the influence of culture in understanding patient’s expression of distress, assigning symptoms to a diagnostic category and planning treatment in culturally appropriate ways. Cultural bias can lead to misdiagnosis and have devastating consequences on patients.” (Ogundare 2020:23).

A medical treatment team approach to mental healthcare offers great benefits for patient care, such as improved coordination and continuity of care and delivery of high-quality mental healthcare (Rosen et al. 2018). However, the medical treatment team needs to include the patient’s family in mental healthcare since the patient’s family can motivate and encourage patients to adhere to mental health treatment (Craig et al. 2020). The medical treatment team also needs to cater for cultural aspects when providing mental healthcare, in the South African context (Keikelame & Swartz 2019; Nmutandani et al. 2018; Penson 2019). This is because the socio-cultural context influences mental healthcare in South Africa (Jacobs & Coetzee 2018). Therefore, as suggested by literature in chapters 2, 3, and 5, the decolonisation of mental healthcare will address the range of socio-cultural aspects that affect mental healthcare. Therefore, a decolonial shift is important in mental healthcare, in the South African context (Nmutandani et al. 2018). Post-apartheid mental health policies also influence health outcomes (Mulutsi 2017). Hence, these must also be taken into consideration when caring for the mentally ill patient (Van Rensburg 2012).

Therefore, relying on previous literature (in chapters 2, 3, 4, and 5), the researcher initially proposed a conceptual framework for a medical treatment teamwork approach, for mental healthcare, in South Africa which was synthesised from literature and theories. To determine whether the elements of the proposed conceptual framework could be accepted, amended and/or rejected, the framework needed to be empirically verified, in the field. Thus, the conceptual framework was verified through a qualitative multiple case study. The fieldwork process assisted to verify the proposed conceptual framework constructed from the literature and theories. Thereafter a revised conceptual framework for mental healthcare in the South African context was presented in this chapter, as the contribution for this study. The framework, as displayed in Figure 9.1, identifies the essential elements which include (1) medical treatment teamwork, (2) decolonial aspects, (3) socio-cultural factors, and (4) policy, that contribute to mental healthcare in the South African context. The main contribution of this study is probably best explained

by the words of Mosotho et al. (2011:447) who state, “Africans are neither Americans nor Europeans ... African people should be treated within the framework of their own culture and belief systems”. These words capture the very essence of this study. In conclusion, the conceptual framework can be implemented in the African and South African healthcare systems for holistic mental health care.

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APPENDICES

APPENDIX A: ETHICAL CLEARANCE LETTER FROM THE UNIVERSITY OF SOUTH AFRICA (UNISA)



COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

14 December 2021

Dear Mrs Acha-Anyi Asongu

Decision:
Ethics Approval from 14 December 2021 to 14 December 2026

NHREC Registration # :
Rec-240816-052
CREC Reference # :
43321763_CREC_CHS_2021

Researcher(s): Name: Mrs Acha-Anyi Asongu
Contact details: 43321763@mylife.unisa.ac.za
Supervisor(s): Name: Dr Moola
Contact details: moolas@unisa.ac.za

Title: A communication conceptual framework for treatment team approach to mental healthcare.

Degree Purpose: PhD

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for five years.

The *low risk application* was reviewed by College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the



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APPENDIX B: LETTER OF APPROVAL FOR RESEARCH AT FORT ENGLAND HOSPITAL



Fort England Hospital • York Road • Grahamstown • Eastern Cape
Private Bag X 1002 • Grahamstown • 6139 • REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)46 802 2900 • Fax: +27 (0)46 822 7000 • Website: www.ecdh.gov.za

Enquiries: Dr. TN Seshoka

Date: 10 February 2022

Mrs. Asongu Acha-Anyi
PhD Student (Researcher)
University of South Africa

A communication conceptual framework for treatment team approach to mental healthcare

Dear Mrs. A. Acha-Anyi

Fort England Hospital would like to inform you that your request to conduct a study/research for the above-mentioned research topic has been approved.

You are requested to follow the submitted protocol with ethical approval presented to the facility and also ensure that you observe and respect the rights and culture of the research participants and maintain confidentiality of their identities at all times.

You are also requested to adhere to the conditions for the approval of your research by the Eastern Cape Department of Health & EC Health Research Committee.

Your compliance in this regard will be highly appreciated.

Dr. TN Seshoka
Psychiatrist & Head: Clinical Department
Fort England Hospital

Cell: 076 253 5557



Angaphela, mahlaba (the health system) forward!

Hand prevention 076 253 5557
24 hour Call Centre: 0960 430 364
Website: www.ecdh.gov.za



**APPENDIX C: LETTER OF APPROVAL FOR RESEARCH AT CECILIA MAKIWANE
HOSPITAL**



Office of Senior Manager Medical Services • Cecilia Makiwane Hospital
Private Bag X 9047 • East London •5200 •South Africa

Tel: 043 708 2132

Email: bongiwe.yose-xas@echealth.gov.za: website:
www.ecdoh.gov.za

03 February 2022

RE: A COMMUNICATION CONCEPTUAL FRAMEWORK FOR TREATMENT TEAM
APPROACH TO MENTAL HEALTHCARE. **(EC_202201_003)**

Dear Mrs. A. Acha-Anyi

Permission is hereby granted for you to conduct the above-mentioned research study at
Cecilia Makiwane Hospital subject to the following:

1. Complying with the provision of the permission letter dated 25 January 2022.
2. Complying with your Research Methodology Plan as approved by the relevant ethics committees.
3. Introducing yourself to the relevant management division of the hospital and providing the necessary documentation showing permission and approval of research study to be conducted at the hospital.
4. Ensuring minimal disturbance to the day-to-day operations of the relevant department of the hospital.
5. Observe the confidentiality of information and participants.

Your compliance in this regard will be highly appreciated and wishing you all the best in
your research study.

Dr BA Yose-Xasa Date

Senior Manager Medical Services

**APPENDIX D: LETTER OF APPROVAL FROM DEPARTMENT OF HEALTH,
EASTERN CAPE**



Enquifisa: Yvonne Gixela

Tel no: 073 074 3859

Email: Yvonne.Gixela@ec.health.gov.za / yvixela@crail.com

Date: 25 January 2022

**A communication conceptual framework for treatment team approach to
mental healthcare. (EC_202201_003)**

Dear Mrs. A. Acha-Anyi

The department would like to inform you that your application for the above mentioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress update on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE



TOGETHER MOVING THE HEALTH SYSTEM FORWARD

**APPENDIX E: FACE-TO-FACE, SEMI-STRUCTURED INTERVIEW SCHEDULE:
CLINICAL MANAGERS**

Background information

1 What is your professional background?

Nurse

Psychologist

Occupational therapist

psychotherapists,

Counsellor,

Social worker

2 How many years have you been in your current post?

3 Kindly explain a clinical manager's job designation in relation to mental healthcare for patients? As well as for a mental health care treatment team approach?

4 Most healthcare teams have a hierarchical structure. What is the structure of the treatment team? What is the hierarchical order of the team? Kindly explain.

4.1 Who leads the treatment team?

4.2 What is the role of the doctor in the treatment team?

4.3 Please identify members of the mental healthcare treatment team? Please list them.

4.5 The Mental Health Care Act, No 17 of 2002 emphasise that all health workers have an important role to play in mental healthcare (Van Rensburg 2012). Please explain the roles and responsibilities of members of the treatment team. How does the team work together to provide mental healthcare?

4.6 What is the primary aim of the treatment team? Please also elaborate on how the treatment team achieves its aim.

4.7 Are treatment team members from diverse cultural backgrounds? If yes, do the team members cater adequately for diversity in team relations? Please explain and provide examples.

4.8 Do treatment team members communicate effectively with each other? Please explain/provide examples.

4.9 Are there any specific factors in the hospital that impede teamwork? Please explain and provide examples.

4.10 Are the activities of the treatment team assessed, to ensure the delivery of high-quality mental healthcare to patients? If yes, how is it achieved, please explain.

4.11 Kindly elaborate on any strengths and/or challenges faced, in the mental healthcare teamwork? Please explain with examples.

5 After apartheid, the ANC government aimed to decolonise healthcare in South Africa by providing care that caters for the needs of the individual patient (Republic of South Africa 2002).

- Thus, the Mental Health Care Act, No 17 of 2002 (MHCA) and National Mental Health Policy Framework and Strategic Plan 2013-2020 (NMHPF) requires the hospitals to consider aspects such as teamwork, family involvement in mental health, culture and patient-centred care when treating patients.
- The hospital policies also require that HCPs consider the aspects above, in/for mental healthcare.
- Thus, how do HCPs consider the following factors when treating the patients namely:
 - Medical teamwork as a means of enhancing mental healthcare. Please elaborate and kindly provide an example/s.
 - Focus on cultural aspects that influence mental healthcare. Please elaborate and provide an example/s.
 - Patient-centred care in relation to mental healthcare: Please elaborate and provide an example/s.

- Family involvement in mental healthcare for patient support and care. If possible, please elaborate and provide an example/s.

5.1 Mental healthcare in this hospital, is guided by hospital policies such as Patient's Rights and Duties Related to MHCA & Family, Multidisciplinary Team, Management and Care of Psychotic patients, Management of patients who may be a danger to themselves, Policy for prescribing medication in the mental health unit, and pain management in Psychiatric unit.

- Please kindly explain how these hospital policies are implemented in mental healthcare.

5.2 Please explain the importance of implementing government and hospital mental healthcare policies on site, for effective patient care.

5.3 What are some of the challenges encountered, in trying to achieve the decolonisation of mental healthcare in South Africa at your hospital?

5.4 Kindly provide some suggestions, on how to improve the implementation of government and hospital healthcare policies within this hospital?

6 Majority of South Africans consult with both traditional healers and HCPs for mental healthcare (Jacobs & Coetzee 2018). How can HCPs collaborate with traditional healers to provide patient-centred care?. Please kindly elaborate your opinion/idea/thoughts on this matter as per your managerial position at this hospital.

6.1 Please describe measures that can be instituted in order to enhance the collaboration between these two health systems, namely medical and traditional health systems?

7 Are there any other comments you will like to make/add or suggest?

Thank you for participating in this study.

**APPENDIX F: FACE-TO-FACE, SEMI-STRUCTURED INTERVIEW SCHEDULE:
MEDICAL OFFICERS AND PSYCHIATRISTS**

Background information

- 1 What is your professional background?
Medical doctor.
Psychiatrist.
- 2 For how long have you worked at this hospital?
- 3 Kindly explain a team leader's job designation in relation to mental healthcare for patients? As well as for a mental health care treatment team approach?
- 4 How is the team structured? Please explain.
- 5 What is the role of the clinical manager?
- 6 What are the major objectives of the treatment team approach to mental healthcare?
- 7 What are the goals of the treatment team? Do teams rotate? how are they devised and by whom?.
- 8 Does every team member have a specific role to play and do they clearly understand their roles? Please explain and provide examples.
- 9 Do members of the treatment team share a common purpose, which is to provide safe and effective care to mentally ill patients? Please explain.
- 10 Please elaborate on how relationships are developed with other team members to ensure the team is achieving the same goal?
- 11 Is there a sense of interdependency amongst team members? Please explain with example/s.
- 12 How does the team leader (the medical doctor/psychiatrist) communicate with other team members in order to provide healthcare to the patient? Please explain and provide an example.
- 13 Does the treatment team communicate effectively to provide patient care? Please elaborate and provide examples.

14 What role does the team leader play in enhancing team effectiveness? Please explain.

15 What are the processes and procedures that are followed to treat the patient? Who attends for the patient first? Please explain.

16 How do team members work together to provide patient care? Kindly explain with example/s.

17 Open communication is central to good team dynamics (Rosen et al. 2018). Do members of the treatment team communicate effectively? Do team members listen to other members and consider their thoughts and opinions for patient care? Kindly explain and provide example/s.

18 How do you mitigate conflict amongst members of the treatment team? Please provide example/s.

The Mental Healthcare Act, No 17 of 2002 states that medical practitioners such as GP and psychiatrists should assist in administering care, treatment and rehabilitation services to the patient (Van Rensburg 2012).

19 What role do GPs play in the treatment team? Please explain.

21 What are some of the major strengths of treatment team approach to mental healthcare? Please explain and provide example/s.

22 What are the major challenges of a treatment team approach to mental healthcare? Kindly explain and provide example/s.

23 Does the use of both government and hospital policies (for mental health care) at this hospital enhance patient care? Please kindly explain.

24 Do the patients prefer to come to the hospital with a family member? why so? Do they support their health care and treatment process?

National Mental Healthcare Policy Framework and Strategic Plan 2013-2020 state that families of those with mental illness should be included in mental healthcare in order to broaden the network of support and care (Department of Health 2013).

25 Does the patient's family members contribute in decisions pertaining to their healthcare? (especially in a case where some mentally ill patients do not have the

cognitive ability to make sound decisions). Please explain. Kindly provide an example of a situation where the patient's family member contributed in decisions pertaining to their healthcare?

26 Kindly describe the role of the patient's family in mental healthcare? Please elaborate and provide examples.

27 Kindly provide some suggestions on how the treatment team can collaborate with the patient's family to discuss effective healthcare?

The National Mental Health Policy Framework and Strategic Plan 2013-2020 (NMHPF) stipulates that varying cultural expressions and interpretations of mental illness should be respected (Department of Health 2013).

28 Please explain how team members consider the cultural beliefs of the patient in order to provide patient-centred care? Please provide an example/s of a situation where the culture of the patient was considered in their treatment plan.

29 Do patients consult with both traditional healers and HCPs for mental healthcare? Kindly explain.

30 How often do patients communicate that they have consulted with traditional healers?

31 What are some of the cultural beliefs patients associate to mental healthcare? Please provide examples.

32 Does the culture of the patients affect or contribute to their healthcare treatment process? how so/how not?

33 Do members of the treatment team share the same cultural values? Please explain. Are the teams made up of diverse members?

34 Based on your experience with the HCPs. Can a treatment team approach to mental healthcare be recommended for patient care?

35 Is there any additional information that you would like to share about a treatment team approach to mental healthcare?

Your participation in this interview is much appreciated

APPENDIX G: OBSERVATIONAL **SCHEDULE**

- 1 Who receives the patient when they arrive at the hospital?
- 3 What is the general routine teamwork routine in/at the hospital?
- 4 Are the treatment team member from diverse backgrounds?
- 5 Who is the treatment team leader? What is the role of the team leader? Observe.
- 6 Who are the clinical managers? What are their roles/responsibilities?
- 7 What is the role of the medical doctor? General practitioners and psychiatrists? Observe.
- 8 What is the role of other team members such as: nurses, psychologists, occupational therapists, psychotherapists, counsellors and social workers?
- 9 How does the clinical manager communicate with treatment team members? Is it via the team leader, or with the entire treatment team (group) at once?
- 10 Who does the medical doctor interact with mostly on a daily basis? Observe.
- 11 How does the medical doctor communicate with other team members (especially the nurses)?
- 12 How often is the medical doctor available to treat patients? Why is this so? (Example availability/scarcity as per public health care system constraints etc).
- 13 Do members of the treatment team appear to understand the roles and responsibilities, of other members of the team? Observe examples.
- 14 Do members of the treatment team tolerate and display confidence in each another? Provide/observe examples.
- 15 How do treatment team members interact with one another? Do team members engage in friendly/adequate communication interactions, with each another to provide care? Observe/note examples.
- 16 Do treatment team members work cooperatively with each other? /Observe/Provide an example.

17 How do team members share relevant information (for patient care) with other team members, in order to accomplish team goals? Provide/observe examples.

18 How do the treatment team members resolve conflict? Provide/observe examples.

19 Do treatment team members listen and pay attention to each other?

20 How do treatment team members collaborate with each other, for patient care?

21 Describe one aspect of team-based care that was observed?

22 Do treatment team members communicate effectively, with one another?

23 Does the healthcare team consider the cultural and social context, of the patient in mental health treatment?

24 Does the treatment team involve the family, of the patient in healthcare?

25 Which policies/guidelines does the treatment team use, when treating patients? How does the team implement these policies?

26 Are the cultural inclusions of these policies applied, in daily healthcare for patients and between the treatment team members interactive sessions?

27 Do the treatment team members implement the decolonisation of mental healthcare at the hospitals, as per the mental policy requirements?

28 What are the challenges and strengths of healthcare teamwork? Provide examples.

In general, the researcher will observe the following:

- Verbal and non-verbal communication between team members observed.
- How treatment team members work together, to provide adequate mental healthcare to patients.
- Observe and take note of each and every aspect of the treatment team's work routine.
- Observe how treatment team members interact with each other daily during interactive communication sessions (generally).
- Observe HCP–HCP communication, interactive sessions.

- Observe the everyday general rules, as well as the policies and regulations that are followed by the hospitals.
- Observe team diversity.
- Observe cultural dynamics, in teams, for patient care.
- Observe if the decolonisation of mental healthcare, has occurred, as per mental policies (government and hospital policies).

APPENDIX H: MODERATOR'S GUIDE

Background information

1 What is your job designation and medical teamwork duty?

2 How long have you been employed at this hospital?

3 Question related to a medical teamwork approach to mental healthcare.

- This study advocates for a medical treatment team approach to mental healthcare (Rosen et al. 2018). The MHCANo 17, 2002 permits HCPS with experience in psychiatry together with a range of allied health professionals (for example, doctors, nurses, social workers, psychologists, psychotherapist) a potential role in assessment of the mental state of a mental patient (Republic of South Africa 2002).
- The Act further permits that a mental healthcare patient should receive professional attention from psychiatrists, medical practitioners, nurses, occupational therapists and social workers who have been trained to provide prescribed mental health services.
- The Act also emphasises that teamwork is a central component of the health system (decolonial aspects as per teamwork).

3.1 How does the treatment team work together to provide patient care as per the mental health policies stipulation above? Please explain.

3.2 What are some of the benefits of working together, as a medical team to treat mentally ill patients? Please explain. Please provide example/s of a situation that made you feel it was important to work as a team for the patients benefit.

3.3 Does the team have a leader and which HCP fulfils this role? If yes, what is the role of the team leader?

3.4 How do HCPs communicate with other team members, in order to medically treat patients? Please provide examples of situations to explain your point here?

3.5 Does working as a team, help provide optimal treatment for the patient? If yes, please provide example/s of how working as a team helped, facilitate patient treatment.

3.6 What role does effective communication play in the treatment team? Please explain/elaborate.

3.7 Do team members communicate effectively to enhance patient care? If yes, please explain a situation where effective communication, amongst treatment team members enhanced patient care.

3.8 What are some of the communication challenges you might have encountered when communicating to other team members? Please provide examples.

3.9 What can be done to improve communication amongst members of the treatment team?

3.10 Is there a “team spirit” amongst team members? Do team members display high levels of cooperation and mutual support? Please explain and provide examples.

3.11 Does each team member know their role and responsibility in the team?

3.12 What is the role of the clinical manager?

3.13 What is the role of the medical doctor?

3.14 Does the team leader communicate with team members, to clarify each member’s responsibility in executing, components of a patient’s treatment plan?

3.14 Does each member of the treatment team understand their role and responsibility?

3.15 Does the mental healthcare team members display respect and accommodate each other’s culture? Why do you say so?

3.16 Please describe your day-to-day activities? (per HCP present in the group-discussion to follow/probe where necessary).

3.17 Please identify some of the challenges encountered whilst working in the medical healthcare treatment team? Please elaborate with examples?

4 Questions related to the role of socio-cultural context in mental healthcare (decolonial aspects).

- The Mental Health Care Act N0 17 of 2002 stipulates that the spouse, next of kin, partner, parent or guardian of the patient can assist in mental healthcare (especially in a case where the patient is not clinically stable or when the patient is below the age of 18 years) (Republic of South Africa 2002).

4.1 Do the treatment team members involve the patient's family in mental healthcare? Please explain and provide examples. Please explain how they (family) are involved, in the treatment and health care process?

- The National Mental Health Policy Framework and Strategic Plan 2013-2020 (NMHPF) stipulates that varying cultural expressions and interpretations of mental illness should be respected (Department of Health 2013).

4.2 Does the treatment team consider the cultural aspects of the patient? Please provide examples of situations, where the team considered the cultural values of the patient.

4.3 Does culture or cultural beliefs affect treatment in/with patients? how so/how not? Please provide examples of such cases?

4.4 Do family members mention or approach the aspect of cultural beliefs, when their significant others are being treated for mental health care issues? Please explain and provide examples.

4.5 Kindly elaborate on examples of cultural beliefs, that patients or family members hold, in relation to mental illness care and treatment options.

4.6 Does the team (as an individual treatment team member/or group) consider these cultural beliefs, when designing the patient's treatment plan? if yes, please provide an example, of a situation, where the patient's cultural beliefs were considered, when designing their treatment plan

4.7 Are the treatment team members from diverse cultural backgrounds? If yes, do the team members respect/cater for/accept the cultures of other team members adequately? Please explain and provide examples.

4.8 Do the different cultural backgrounds/diversity of team members affect teamwork? Please explain.

5 Questions related to collaboration between HCPs and traditional healers.

- Studies (Jacobs & Coetzee 2018; Tjale & de Villiers 2014; Batisai 2016) have revealed that about 80% of South Africans consult with both HCP's and traditional healers for mental healthcare. The Traditional Health Practitioners Act of 2007, recognises traditional health practitioners as a health profession (Van Rensburg 2012).

5.1 How can the two systems collaborate adequately to provide mental healthcare?

5.2 What are the possible challenges and how can they be addressed?

6 Questions related to the role of policy in mental healthcare (as per decolonial focus of policies)

- The Mental Health Care Act, No 17 of 2002 states that every organ of state responsible for health services must determine and co-ordinate the implementation of mental health policies in a manner that ensures the provision of effective mental healthcare (Department of Health 2013: 10).

6.1 How does the team implement the mental healthcare policies (both government and hospital policies) in order to provide adequate patient care? Please provide example/s of a situation where the team implemented these policies.

6.2 How helpful are government mental health policies, in guiding the team in their duties? Please explain.

6.3 How helpful are the policies of this hospital, in guiding the treatment team in providing patient care? Please explain.

6.3 How do the hospital policies, assist the treatment team in carrying out their duties, in a teamwork/collaborative framework? Please explain.

6.5 Is there any additional information that you would like to share, about a medical teamwork approach to mental healthcare?

Your participation is much appreciated.

APPENDIX I: INFORMED CONSENT FACE-TO-FACE, SEMI-STRUCTURED INTERVIEWS

INFORMED CONSENT FORM TO PARTICIPATE IN THIS STUDY

I, _____ (participant name/ optional to add in), confirm that the person asking my consent to take part in this research has informed and educated me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to willingly participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of this interview.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..... (please print/
optional) Contact Numbers/email address : optional

Participant Signature.....Date.....

Researcher's Name & Surname.....(please print
/optional)

Researcher's signature.....Date.....

APPENDIX J: INFORMED CONSENT: FOCUS GROUP DISCUSSION

Good morning/afternoon/evening

Welcome to our focus group discussion session. Thanks for taking time to participate in this discussion session. My name is Acha-Anyi Asongu and I am doing research for my PhD at Unisa. The purpose of my research is to gain an in-depth understanding on the decolonisation of mental healthcare, and the role of the medical treatment team in mental healthcare in South Africa. You have been invited because you are an HCP who treats mentally ill patients at this hospital. There are no wrong answers but rather differing points of view. Please feel free to share your opinions and experiences regarding medical treatment team approach to mental healthcare.

DATE:

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name/ optional to add in), confirm that the person asking my consent to take part in this research has informed and educated me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to willingly participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of this focus group discussion.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..... (please print/
optional) Contact Numbers/email address : optional

Participant Signature.....Date.....

Researcher's Name & Surname.....(please print
/optional).

Researcher's signature.....Date.....