Scoping Child Mental Health Service Capacity in South Africa Disadvantaged Communities: Community Provider Perspectives

Abyshey Nhedzi, Research Associate, University of Johannesburg, South Africa; abyshey1@gmail.com

Sadiyya Haffejee, Senior Researcher, University of Johannesburg, South Africa; sadiyyah@uj.ac.za

Michelle O'Reilly, Associate Professor of Communication in Mental Health, University of Leicester, UK; mjo14@le.ac.uk

Panos Vostanis, Professor of Child Mental Health, University of Leicester, UK; Visiting Researcher, University of Johannesburg, South Africa; pv11@le.ac.uk

Abstract

Purpose: To establish the perspectives of community providers on challenges and enablers in developing child mental health capacity in disadvantaged communities in South Africa.

Design/methodology/approach: We involved 29 community providers operating in a large urban deprived area in the Gauteng Province, east of Johannesburg. Community providers had educational, social, and healthcare backgrounds. Their perspectives were captured through three focus groups, two participatory workshops and reflective diaries. Data were integrated and subjected to inductive thematic analysis.

Findings: Three interlinked themes were identified. Community mobilization was viewed as pre-requisite through mental health awareness and strategies to engage children, youth, and parents. Service provision should take into consideration contextual factors, predominantly inequalities, lack of basic needs and gender-based issues (domestic violence, teenage pregnancy, and single motherhood). Participants referred to severe mental health needs, and related to physical health conditions, disabilities, and impairments, rather than to common mental health problems or wellbeing. They proposed that capacity-building should tap into existing resources and integrate with support systems through collaborative working.

Practical implications: Child mental health policy and service design in Majority World Countries (MWC), should involve all informal and structural support systems and stakeholders. Contextual factors require consideration, especially in disadvantaged communities and low-resource settings, and should be addressed through joined up working.

Originality: Children's mental health needs are largely unmet in MWC disadvantaged communities. These findings capture the experiences and perspectives of various community providers on how to enhance mental health provision by mobilizing communities and resources.

Key words: child, mental health, services, stakeholders, capacity, Majority World Countries

Introduction

Meeting the mental health needs of children and youth under 18 years is an increasing global policy priority (World Health Organization, 2020). Despite recognition by international bodies, mental health provision remains limited in Majority World Countries (MWC), especially in disadvantaged communities (World Health Organization, 2018). There are several established reasons for the high level of child mental health needs in MWC.

Children's mental health needs in these contexts are complex and strongly associated with socioeconomic and environmental adversity. Risk factors or vulnerabilities are inter-linked and more pronounced in contexts of extreme disadvantage such as urban informal settlement communities (Bele *et al.*, 2015). These factors transcend the child's socioecology and include social determinants like poverty, child marriage, labour, gender inequity, maltreatment, and domestic violence; health indicators like malnutrition, developmental delays, communicable diseases, and substance misuse; and environmental determinants such as poor housing and sanitation, overcrowding and pollution (Azzopardi *et al.*, 2019; Rose-Clarke *et al.*, 2019). Challenges of parental ill mental health and impaired childrearing capacity can be negatively influenced by issues like unemployment. Exposure to gender-based and community violence are additional vulnerabilities for maltreatment and mental health. When older children have to contribute to family income and care arrangements, they can be susceptible to exploitation and be deprived of protective factors such as schooling and peer relationships (Reza and Bromfield, 2019).

Despite their higher levels of mental health need, children living in disadvantage have significant lower access to mental health support than those living in affluent areas, both in Minority and Majority World Countries. Inequalities are

reflected in limited access to various services and sources of support or protection, in terms of recognition, help-seeking, care pathways, travel, and competing economic pressures (Chisholm *et al*., 2006; Chisholm *et al.*, 2017; Harris and Wilson, 2018). For those reasons, disadvantaged children are more likely to seek support when in crisis, because of the lack of community-based services and preventive approaches (Garcia-Altes *et al.*, 2018).

In addition, there are substantive disparities between Majority and Minority World Countries in relation to infrastructure, specialist resources and skilled staff (World Health Organization, 2018). For example, in South Africa access to support is constrained by limited designated resources for children with mental health problems, and ongoing unequal access to existing resources (Tomlinson *et al.*, 2022). Consequently, psychosocial support in MWC is variably provided by a range of agencies such as schools, primary health, child and youth centres, non-governmental organizations (NGOs), and community volunteers or paraprofessionals (Patel *et al.*, 2018; Docrat *et al*., 2019a). Psychosocial response is thus often combined with functions like child protection, health promotion and life skills training (World Health Organization, 2014).

Cultural and contextual factors can further compound children's access to sources of support. Stigma of mental health remains prominent within certain societies, institutions and even professionals, which may hinder early recognition of emerging difficulties and prevent help-seeking (Khalil *et al.*, 2020). Other factors include the conceptualization of mental health, childhood and gender roles; and the lack of culturally sensitive and acceptable interventions (Getanda *et al*., 2017).

Understanding the nuances and complexities associated with such factors can help maximize current resources, predominantly informal support networks of

extended families, schools and communities (Clark *et al*., 2018; Kohrt *et al.*, 2018). Providers of community support and services have unique knowledge and expertise of local needs, strengths, and priorities (Vostanis *et al.*, 2018). Recognising this epistemic value, therefore, means actively involving these key stakeholders in the co-production and planning of strategies to enhance capacity within their community. This requirement informed the rationale for this study.

Methodology

The aim of this study was to establish the perspectives of various community providers on challenges and enablers in developing child mental health capacity in disadvantaged communities in South Africa. This aim was addressed through the following research questions:

- How do community providers conceptualize child mental health needs and support within their communities?
- Which contextual factors should be taken into consideration in building child mental health capacity?
- Which are challenges and enablers in building child mental health capacity?

Context and participants

The study was located across the City of Ekurhuleni, east of Johannesburg, in Gauteng. With a population of 3,774,638, this urban area includes five of the 20 most populated townships in South Africa and is representative of other disadvantaged urban communities in South Africa (COGTA, 2020). The integration zones broadly include the townships of Tembisa, Wattville, Katlehong/Tokoza/Voslourus, Daveyton, and Kwa-Thema/Tsakane/Duduza. There is a concentration of informal settlements in the townships of Tembisa, Katlehong, and Daveyton/Etwarwa. Communities are faced

with poverty (34% of the population - COGTA, 2020), poor living conditions (such as lack of sewage infrastructure), overcrowding, and limited access to health and welfare services. Many residents provide their own shelters (shacks) in a spontaneous and unplanned way (Marutlulle, 2019), in sprawling informal settlement squatter camps, without sanitation, infrastructure or social amenities (Streek, 2001).

This paper presents the first scoping phase of a programme to enhance child mental health capacity through a train-the-trainer cascade approach. It was co-ordinated by a non-governmental organization (NGO), which provides psychosocial support to children in the wider area of Benoni (Gauteng Province, South Africa) such as children who experienced maltreatment and/or those who are living on the streets. The NGO identified five child practitioners (three female, two male), who would also act as trainers in subsequent phases of the programme to promote sustainability. Their professional backgrounds were social work (2), childcare and youth care work (2), and community development work (1).

These five child practitioners approached the main community service providers in contact with children in the target area, across health, welfare, education, community and religious organizations or groups, referred to as community-based organizations (CBOs). In total, 24 community providers agreed to be involved. These included community workers (2), childcare worker (1), early child development (ECD) principals (6) and teachers (13), mental health support group co-ordinator (1), and retired mental health nurse (1). The ECDs provide vulnerable young children with education, micronutrient and food supplementation, and referrals to other agencies. Ethical approval was obtained from the University of Leicester Psychology Research Ethics Committee, in the UK. Ethical issues were iteratively attended to with the support of local partners, to ensure implementation complied

with local cultural values and expectations. All participants (five child practitioners and 24 community providers) gave written informed consent.

Measures

We integrated three types of data collection approaches to help maximize engagement, support participant voice and empowerment, and opportunities of participation:

Focus groups engaged stakeholders in ‘collective conversations’ in relation to their experiences, insights, and perspectives (Onwuegbuzie *et al.*, 2009). The topic guide explored conceptualization of child mental health needs, available supports, challenges and enablers in meeting these needs, and recommendations of how capacity could be improved in the future. A researcher facilitated one focus group with child practitioners (n=5), and two focus groups with community providers through purposive sampling (n=14 and 10 respectively). Each focus group was held at a CBO venue, lasted for approximately 60 minutes and was audio-recorded.

Participatory workshops with community providers were facilitated by the child practitioners, to co-produce ideas and solutions, without researcher involvement. Two workshops explored solutions arising from the focus group discussions. They were attended by 14 and 10 community providers respectively. Workshops were also audio-recorded, using English and local South African languages, IsiZulu, Sesotho and Sepedi.

Reflective diaries, sometimes referred to as ‘journals’, have been used to encourage reflection and to reinforce learning, with Boud (2001) noting that the use of diaries/journals is effective in reinforcing learning before, during and after exposure to a learning activity. Lutz and Paretti (2019) found that the act of journaling made training recipients more aware of the materials and through this may

aid in the development of skills 'needed to anticipate, respond to, and make sense of challenges as they arise in new contexts' (p.10). The five child practitioners were required to write down regular entries, whereby they were encouraged to personally reflect on the primary aspects of the project, over one month. This form of mental processing can be useful in community engagement and ongoing learning (Hayman *et al*., 2012). Practitioners thus wrote down thoughts, ideas and observations before, during and following the participatory workshops. The reason for only child practitioners completing the reflective diaries on a regular basis was their ongoing involvement. In contrast, we did not wish to add burden to other stakeholders, who were initially involved in this project through the participatory workshops and focus groups.

Data analysis

All audio-recorded data were translated into English, and transcribed. Transcribed audio recordings were checked for any missing data against the audio recordings by one researcher, to ensure trustworthiness. Verbal and textual data were read and re-read for familiarization by two researchers to obtain an in-depth understanding of its content. Reflexive organic thematic analysis was used to analyse data (Braun and Clarke, 2019). All data (focus groups and participatory workshops transcripts, and reflective diaries entries) were integrated in the coding process (Caillaud and Flick, 2017). This allows for recognition of the influence of a priori engagement with the literature, while primarily adopting an inductive and participant-centred approach to coding and ensuring some coder agreement through a multiple coding process (Braun and Clarke, 2021). This was facilitated by using the computer assisted qualitative data analysis (CAQDAS) Atlas.ti version 8 (Friese, 2019).

The analysis was completed in three stages: pre-analysis; material exploration; and treatment of results, inference, and interpretation. This process encompassed the development of initial codes, followed by identifying similar codes and considering themes implicit in these similarities, and then reviewing and defining the themes (Nowell *et al.*, 2017). Following Saldana (2009), all discrepancies were discussed until consensus was reached. The use of thick descriptions of the research contexts and data triangulation further ensured trustworthiness of the data (Nowell *et al.*, 2017). The data was merged into a final coding frame via a verification process and open dialogue.

Results

Themes and subthemes are summarized in Table 1. These were interconnected and informed each other. In summary, mobilization of youth, parents and communities through awareness, engagement and building trust were viewed as pre-requisites by both stakeholder groups. Community providers particularly raised how mental health interventions should be contextualized in relation to local needs and priorities, namely poverty, gender issues such as domestic violence and single motherhood, and incorporation of mental health into physical and disability services. Tailored approaches and knowledge would inform systemic changes. As mainly raised by community providers, mental health care provision should build on existing community supports and services. Both stakeholder groups promoted joint working and care pathways as enhancing access and maximizing resources. Themes are presented in more detail below, with supporting excerpts.

Insert **Table 1** here

Theme 1: Community mobilization

Enhancing awareness was highlighted by most participants as a pre-requisite step to mobilize, engage and inform action by communities. This was considered at different levels (end-user, community, policy), and predominantly for mental health conditions, although it was extended to other related vulnerabilities like special educational needs and risk behaviours like substance abuse. Participants advocated openness about mental health, drawing parallels with the more accepted and better understood physical health, and giving positive messages that dispel connotations of damage or violence. Several participants considered that awareness should start early in childhood, before beliefs and attitudes become entrenched. Education should be accompanied by promotion of positive mental health - rather than only prevention of illness - through dealing with life stressors and staying active.

"I just want to say that to have a mental illness is not the end. It's just an issue with your mind. But it shouldn't be a heavy burden. It's just about finding a balance, because everybody has a mind, and everybody has a body. It doesn't mean when we say you have a mental illness…"

Child practitioner 1, Female

"So, I think education, and luckily enough our children are much cleverer than we are. They do talk. They do talk about suicides, and there is this other thing that is getting into our community, that thing of cutting themselves. We never used to have that, but now you find that, kids are also attempting to cut themselves. So, I think we really need especially from the creches, and everywhere, we start them young, and we educate and educate."

Community provider 11, ECD Cleaner, Female

Mental health awareness was not viewed as the responsibility of mental health professionals only. All agencies, in particular schools, had an important role to

play, as well as people with lived experiences and their relatives. *"Going out into the community"* was viewed as essential in starting this dialogue.

"So, I was expecting to get more information that I can take out, give to them, relate to the situation wherever they are living…remember, when you are taking this word into the community or communities, many people start thinking, you know."

Child practitioner 2, Male

In terms of delivery of awareness programmes, suggestions included local, media and government campaigns; workshops; and resources such as leaflets or posters. These modes should be engaging, especially for children and youth, by using play and creative modalities. Campaigns could draw parallels with physical health issues such as HIV and the recent COVID-19 pandemic.

"We are having talk shows, where like you are walking on the street, and you are talking. Me, I am (name), I will talk about schizophrenia, but we are doing it like a play session. Yeah, a play session, because if you are not putting a play session inside then, they are becoming shy."

Community provider 2, Retired mental health nurse, Female

"Take, for instance, COVID is a recent thing, but a child knows that you need to put on a mask, you need to sanitize, you need to do all those kinds of things, but when it comes to our mental health, we are never."

Community provider 12, ECD Principal, Female

While raising awareness and mental health promotion were viewed as foundational, participants recognised the need for greater action that is child-centred and child-focused. They recognised that, after raising awareness, it was necessary to develop strategies in engaging children. Participants described approaches to

encourage children to feel comfortable, share, open up and talk about emerging mental health concerns.

"…you try by all means to ask her different kinds of questions, and you, as a teacher or a caregiver, or something like that will become young. You become young in such a way that when she looks at you or when he looks at you, it is like you are equal…in that way, she is going to feel comfortable, or he is going to be comfortable. So, when that happens, he or she is going to share each and everything with you, the challenges that he or she is facing. He will be like, or she will be like you know, teacher, my mother was beating me yesterday or the father, she is calm now."

Community provider 10, ECD Teacher, Male

"You cannot force people to speak out until the day comes, and then she can talk. After that day comes, she was relieved. She started crying, cry and cry. It's good to cry."

Child practitioner 4, Female

To achieve engagement, some participants highlighted professional skills such as nor being judgemental or punitive, and respecting confidentiality. The latter was especially important within a closely knit community. These would lead to establishment of trust, the cornerstone of every professional-end user therapeutic relationship.

"Bring them close to you, make them trust you, make them to be comfortable with you and then, once they are comfortable with you, it is easier for them to open up and tell you their problem. And then that is when you start helping them."

Community provider 14, ECD Principal, Female

"I think of how, if you see someone who's been depressed or who's been discriminated, you must be calm and then talk to that person, but if you will be harsh

to that person, then they won't open up. So, I think about how you interact with that person, because that's why they say actions speak louder than words."

Community provider 6, Volunteer ECD Teaching Assistant, Female

Participants described several techniques in dealing with difficult situations such as preventing of de-escalating distress (*"not to bottle things up"*) and dealing with self-harm ideation. Interestingly, therapeutic space was perceived as helping children create their own solutions (*"involving them, so that they can find solutions themselves"*), rather than giving advice (although some interviewees also referred to guidance), hence the importance of child participation in decision-making.

"So, I had to talk him out of it from 11 pm to about 4 am, just talking, but the thing is, I am glad he didn't commit suicide."

Community provider 6, ECD Volunteer Teaching Assistant, Female

Participants recognized that children are not functioning in isolation from their other systems and felt that the familial influence was important in attending to child mental health need. They emphasized the importance of actively involving parents as early as possible, by sharing concerns and information about their child, for example liaising with teachers (*"a parent of the child must be there, if you like it or not"*). It was acknowledged that such approach should not focus on negative parenting issues, otherwise parents would disengage from services.

"If you come across such a situation, as especially at (ECDs)*, and you have to be calm and call the parents. Advise the parents because there are some hot-headed."*

Community provider 5, Community worker, Female

Instead, examples of positive parenting skills through activities, and setting up behavioural programmes were provided. If the child's difficulties were related to

underlying family relationships issues or conflict, other family members should be involved too (*"take the whole family to the counselling session"*).

"I think something I don't, I just want to engage that maybe could help. Especially we, as we are working with the children, our parents, they used to know one another. So, I think we should do an activity that will involve the parents. Like, maybe as we are sitting here, we get some papers that you write something that you like about someone. That will cheer people up, and you feel special about that."

Community provider 4, ECD Principal, Female

"Yep, I think practical. Activities on a certain issue. For example, for display, let's say your child was five minutes to come in the house. How about you tell tomorrow? You are not going out or do you go out if you cause for two hours, you can go for one hour and come back. That's, I think, it's a practical form of discipline."

Community provider 2, Childcare worker, Male

For children whose mental health problems were not resolved through community interventions, professionals stated that they should be working collaboratively with parents whilst signposting to mental health services, thus prepare the ground by demystifying fears of mental health. Regular parent forums were viewed as pro-active opportunities.

"So, maybe if you say hi, Mama, maybe we should take the child to the clinic, and maybe they can refer him. Let them do the tests, and maybe they will be able to determine and see that maybe the child has these mental issues. Maybe they will assist him with calming him down, because there are those children that you can see that no man. This child is way too hyperactive."

Community provider 20, ECD Principal, Female

"…is to call the parents. To call the parents to the workshop…and let them have the more info about the mental health."

Community provider 24, ECD Teacher, Female

Theme 2: Contextual issues

Stakeholders, especially community providers, extensively discussed how child mental health interventions and services should understand and relate to local needs. These included tackling inequalities (poverty and lack of basic needs), gender-related issues such as domestic violence and single motherhood, and the focus of existing services on physical illness and disability.

Children living in disadvantage faced regular economic hardship and related lack of basic needs such as nutrition, housing, and sanitation. Participants highlighted these basic needs and how they were often related to the development or exacerbation of mental health problems. In addition, children did not have equitable access to support as those living in affluent areas. Inequalities were evident in available infrastructure and resources, like schoolbooks, uniforms, and skilled practitioners.

"Yeah, so we've been. I mean all over between the period of COVID-19 providing them with some food parcels. Yeah, we have seen. Yeah, I can say a lot of changes but also encouraging them not to give up."

Child practitioner 2, Male

"I think this is a good opportunity for us to take this to the location, because the white people they have got all the resources that we don't have in our creches."

Community provider 21, ECD Principal, Female

Community providers emphasized the common occurrence of gender-related vulnerabilities, which they linked both with mental health conditions and other moderating risk factors. Vulnerabilities could negatively impact on young women's mental health from an early age, with intergenerational cycles of abuse, teenage pregnancy, HIV infections, and domestic violence. Hence, the highlighted importance of safeguarding, welfare and mental health services being provided in conjunction.

"… teenage pregnancy…remember, these kids are kids who have been abused. They grow up here because they all…they, they were in need of protection and care."

Community provider 2, Childcare worker, Male

"With mental health, everything starts in the head. Gender-based violence, if people would talk about their issues, or if some of the issues would be encouraged to be discussed, especially with young men."

Community provider 22, ECD Principal, Female

"Once they leave, they've got kids and those kids they can have their own children, because they are unable to support them. Now it's a cycle that comes back, so those kids will end up here or will end up in other homes. Same thing, so we've got this challenge, so it's repetition, it's a repetition of events happening."

Community provider 2, Childcare worker, Male

Single mothers were reported as often being isolated, lacking social support, and experiencing mental health problems that affected their parenting capacity, consequently their children's wellbeing. For this reason, participants advocated those services should address single mothers' own mental health needs and equip them with parenting and resilience-building skills on top of material provision.

"We need to engage single mothers more. OK, there's a lot of mothers raising children, I know. I was once that mother, I went for maintenance. It never helped."

Community provider 5, Community worker, Female

"Where do I go for support now that I'm depressed and I'm raising all these kids, how do I raise this? Where do I start to pick up the pieces? So, we need single mothers to heal and to be able to speak up, so that they can get help. And, well, I don't know what we're going to do about people who are judgmental of mental illnesses, cause that on its own is a disease."

Community provider 5, Community worker, Female

Community providers extensively referred to children and adults with physical conditions (epilepsy and HIV infections), physical or learning disability, sensory impairment, and associated special educational needs. The context of these statements varied. Some participants appeared to identify or attribute mental health problems to disability, whilst others referred to the common concurrence between the two or drew parallels in facing societal barriers such as stigma. It is plausible that the identification of mental health with illness explained why these participants conflated the nature of different kinds of children's health experiences.

"Yeah, yeah, that's how ways disabled and mental health children" (context: similarities in facing difficulties).

Community provider 12, ECD Principal, Female

"OK, in our areas, there are lots and lots, and lots of disabilities and disabilities are broad. It's not a small thing, there is lots and lots of disabled people. Intellectual, bipolar, schizophrenic, depression, anxiety is there, stress is a disabled thing, because if you cannot take care of your stress, you will somewhere somehow become disabled."

Community provider 17, ECD Teacher, Female

Participants' references to physical health and disability also had a pragmatic focus, as existing health services and schools largely supported these groups, hence offered opportunities in extending to mental health input too. For example, mental health strategies could contribute to the management and reduction of physical symptoms, and the enhancement of end-users' quality of life. One participant described a support group that involved people with a wide range of mental health and neurological conditions.

"But we know that she has schizophrenia plus epilepsy. So, when we tell you as the family that 'don't just see her like this, she has epilepsy and schizophrenia'. If you turn it into a joke, that is your own issue."

Community Provider 1, Childcare worker, Female

Theme Three: Systemic changes

Participants adopted a broader perspective on how mental health service provision could be improved. Strategies were inter-linked with previous subthemes, in terms of engaging children and families, and integrating mental health interventions with existing support services. Effective use of limited resources required collaboration between agencies, and establishment of care pathways. Available community support was considered as an opportunity for resilience-building among children and youth, recognition of mental health problems, integrated interventions, and initiation of referrals. Some churches and religious forums already had links with services, including contribution of volunteers. Participants valued the role of sports and creative activities like music and dance in engaging vulnerable children and equipping them with coping strategies.

"So, I think that the local churches, one thing that I forget to say, I'm a pastor in the church, so we also have kids who are coming. I'm also running a children's ministry in the church, so sometimes the kids have problems at home. They come to me and report their cases. So, if I see this one needs the social worker or this one needs a clinic, I refer those people to those places."

Community provider 8, ECD Principal, Female

"Like a camp, camping if you take a youth to the camping site, it's where you can see the different kinds of young people. The camping site is where everything is exposed. You sit there, you look the way they walk, you look the way they talk, you look the way they listen, because listening is a skill, and then after that, you sit down and talk."

Child practitioner 5, Female

Support groups were valued in battling stigma, sharing experiences, providing peer support, and demystifying mental health. A 'support committee' was described as providing first line response, co-ordination with other agencies and further referral, where appropriate. This interesting model was initially set up as community outreach for people with mental health problems. Subsequently, ECDs and other CBOs established similar structures for children and parents. Nevertheless, participants again highlighted the uneven distribution of these resources and opportunities, compared with affluent areas.

"We do have a support committee that supports the parents and the kids…if you have got a child that needs help and support in the classroom…you always write a report about that kid. You will state which supports did you give to their child. Each time you help that child, you write it down in the report, and if the child cannot be helped, then that is when you refer the child to the (name) *committee. And the*

(name) *committee will try and see if they cannot help the child. If they cannot cope, that is when they take it further."*

Community provider 16, ECD Principal, Female

Collaborative working was appreciated by community providers. Forums within and across organizations were viewed as valuable in sharing information and concerns on children they were in contact with. Discussions should ideally recognize the intersections across welfare, education, and health needs. This was particularly important for vulnerable and mobile groups such as migrant children. These forums could evolve to host training for frontline professionals.

"We try, like if we go to training like the social workers have invited us. We will sit down. So, we ask them if they have time, they should come and train us."

Community provider 23, ECD Principal, Female

Community providers had positive experiences of outreach clinics for physical and mental health problems. These, however, so far lacked specialist (psychology and psychiatry) input. An interesting recommendation was the development of a community 'helper' role, to act as first contact point and liaise between agencies. Such a person would be more likely to be accepted by the community, thus promote the importance of mental health.

"So, we also have social workers at our center. So, the social workers help to identify those children that need a help like mentally, and so on. So, at our organization, I mean if we identify any child with maybe mental health problem or maybe suffering from school, schoolwork (challenges) *or maybe playing with other kids, we usually refer them to the right people and places for the children."*

Community provider 15, ECD Teacher, Female

"What I would say is that I would like to be just a community helper in any area that could help them in. I wouldn't say a teacher, I wouldn't say your principal, I wouldn't say a doctor or a social worker, but to be there as a helper to everyone who needs help with mental health, and just to help them, yeah."

Community provider 4, ECD Principal, Female

Information sharing and joint working were linked with care pathways. Some community providers were familiar with existing services, usually through their own agency. Care pathways appeared better established for child protection and education rather than mental health. Although there was no protocol or joint system for referrals, schools often signposted children to other services.

"The mother was called in, and the principal told her she needs to take the child to a clinic, just for her to be checked out if everything is well. The mother took the child to the clinic, and it was confirmed that the child has mental issues."

Child practitioner 5, Female

"Yeah, if you find a child that you see that this child has a problem, then you can refer to the clinic or to the police station or you call the social workers to come that I, I think there's a problem…they, I think, you may intervene and try to see what's the problem."

Community provider 4, ECD Principal, Female

In the target community, a mental health clinic provided by social workers offered first level response (assessment and brief interventions). Despite its outreach function, this was not viewed as easily accessible by some professionals and families they were in contact with, maybe because of associated stigma. Specialist child and adult mental health settings were located outside the community, usually in

advantaged areas. These compounded barriers of having to travel a long distance to a socially unfamiliar environment.

"We have clinics here, and we know that there are clinics, because everyone here mostly goes there, you know. The clinic is the first step of getting someone help. We will usually say, please, can you go there to get help. So, it all begins at the clinics. From the clinics, they will get referrals. To go to the different places they need to go to, until they get the actual help they need."

Community provider 19, ECD Teacher, Female

"Maybe I will, this day I will go to (name of mental health service A) *to support them. Next time I will go to* (name of mental health service B)*. Next time I will go to* (name of mental health service C)*, and* (C) *is where you will find most of the white people…*(C) *is in Pretoria* (located 60 km from the target community)*.* (C) *is dealing according to the mental stages that people they have, but that one they get help."*

Mental health practitioner 5, Female

Discussion

This study presents evidence on how service providers conceptualize child mental health needs and support within disadvantaged communities in South Africa, as well as important factors for capacity-building. Key findings related to the importance of mental health awareness, understanding of and addressing contextual issues such as gender and disability, before instigating systemic changes. These perspectives are broadly consistent with the literature from Majority World Countries on the importance of mental health provision needing to build on and integrate with existing systems and resources, rather than solely rely on development of specialist services and non-contextualized application of western psychological interventions (Cullins and Mian, 2015; Kohrt *et al.*, 2018). The contribution of this study was to

capture the voices and tap into the expert knowledge of a range of community providers in resource-constrained settings on how mental health capacity should be strengthened. It was particularly interesting to find that community providers endorsed the promotion of interdisciplinary working and integrated care pathways, which supports international 'top-down' policy and research guidelines for MWC (Patel *et al.*, 2018; World Health Organization, 2010 and 2014).

The findings indicate that there still exists a lack of parity of esteem between physical and mental health (Royal College of Nursing, 2019). Despite the limited resource for mental health, there was a commitment to improving provision and support in the region, and recognition of some of the barriers to achieving that. Providers were familiar with concepts and services for children and adults with a range of physical conditions, disabilities, and impairments, which they sometimes appeared to identify with mental illness. In contrast, there was limited consideration of mild to moderate common child mental health problems, even less so of positive child mental health and wellbeing.

Awareness was viewed as essential by participants in challenging stigma, and in improving early recognition of emerging child mental health problems, help-seeking and service user engagement. Incorporating mental health into existing health promotion and safeguarding within schools and communities could be a cost-effective and stepwise process. Awareness was also linked to enhancing services and workforce capacity, by targeting professionals and policy makers, to attend to, fund and research mental health on an equal footing to physical health. In recent years, positive steps in South Africa included the reformation of legislation and development of a national mental health strategic plan (Department of Health, 2013), although was not fully implemented or updated. A national survey showed that

meagre financial resources were dedicated to mental health, with budget allocation ranging between 2.1-7.7% This contrasted with the World Health Organization's recommendation of 5-10% of a country's health budget, whilst there continues to be a heavy focus on in-patient rather than community care (Docrat et *al.*, 2019b). The report (Docrat et al., 2019b) also revealed that only one in ten uninsured South Africans has access to the mental healthcare services they need.

Children and youth have even higher levels of unmet mental health needs (World Health Organization, 2018). Although there is a national child mental health policy in South Africa, this is usually not replicated at province level, with child mental health being addressed through general health policies (Mokitimi *et al*., 2018). Identified challenges include societal stressors, silo working, limited infrastructure and resources, and lack of dedicated funding (Mokitimi *et al*., 2019). Mental health care is minimal for children living in disadvantaged communities such as informal settlements. In this study, for example, children only had access to limited outreach input by two mental health social workers, otherwise they had to travel long distances to attend specialist services. It is well established that barriers of transport and associated costs are almost prohibiting in low-resource MWC settings, unless necessitated by parents facing serious physical health concerns about their child (Vostanis *et al.*, 2021).

Although available information and policy are usually based on specialist settings, participants viewed children's mental health as everyone's responsibility within their communities. This is consistent with previous research in, e.g., Kenya (Tamburrino *et al.*, 2020), and highlights the importance of involving communities in co-production of solutions, especially in disadvantaged areas. Socioeconomic and gender-based needs (violence, teenage pregnancies, HIV, and single parenthood in

the face of adversity) were viewed as priorities for services, as South Africa has amongst the highest rates of sexual violence in the world. Contextualizing and addressing mental health in conjunction with local issues can engage children, youth, and parents, as well as maximize resources and support systems. In previous research in multiple MWC, including South Africa, we found that children, youth, and parents valued service integration with informal support involving extended family, peers, schools, religious and community groups (Haffejee *et al.*, 2022; Vostanis *et al.*, 2020). Community providers in this study viewed sports, creative and social activities, and support groups as opportunities for awareness, initiation of help-seeking and interventions.

Participants demonstrated the importance of cross-agency learning. If some of the systems are working relatively well there, then lessons can be found in communication and dialogic events across 'new' systems such as mental health provision. Despite the paucity of mental health resources in our target area, child protection and education had developed guidelines, protocols, and care pathways. Schools and community centres can thus serve as hubs for the establishment of interdisciplinary networks, involving both informal and structural support (Uduku, 2011). They can also provide focal points for interdisciplinary training and service planning (Vostanis *et al.*, 2019). Overall, community providers endorsed working collaboratively and building onto existing services and support teams, in this case dealing with physical child health, disability of special educational needs. Joined up services, however, need to be supported by policy and associated funding. Child mental health is often framed only in terms of specialist settings and workforce, or without delineating service models on how mental health professionals would maximize impact through outreach functions that also involve consultation and

training to a range of providers. National and local policy should instead adopt a broader interdisciplinary framework to addressing children's mental health needs, particularly in areas of disadvantage.

Certain limitations need to be acknowledged in the interpretation of the findings. Notably, end users (children, youth, and parents) were not included in the sample. Juxtaposition of their experiences and recommendations with those of providers are essential for capacity-building, especially in improving engagement and help-seeking (Getanda *et al.*, 2017). Specialist mental health professionals such as psychologists and psychiatrists did not participate either. As all practitioners in contact with children were invited to participate, this gap possibly reflects service fragmentation on the ground. The target area may not be representative of other disadvantaged sociocultural contexts within South Africa, or other MWC. As contextual factors and available resources are likely to differ, local perspectives should be sought before implementing available evidence. Capacity-building is a dynamic rather than static process, therefore, a parallel evaluation plan should be built in from the outset, to also capture community voices whilst service provision evolves (Hanlon *et al.*, 2018).

Nevertheless, the findings arising from community providers' expert knowledge can be valuable in informing capacity-building and service design in resource-constrained settings. These findings raise several implications for policy, service development and research in MWC resource-constrained settings. The integration of mental health provision into existing systems will be facilitated by joined up policy and pooled budgets, both at national and local government level (Patel et al, 2021). Training in an interdisciplinary context can help practitioners extend their knowledge and competencies within their existing roles. Community

volunteers (or paraprofessionals) and youth peer educators can play an important role in parallel community awareness and participation. Such programmes should extend the focus from mental illness to include child wellbeing and common mental health problems. Community actors, including children, youth and parents, should be involved in the design and monitoring of both services and research. Future studies should particularly evaluate the impact of evolving service initiatives on early recognition of child mental health problems, help-seeking, access and engagement with interventions. A multi-methods approach, such as adopted in this study, can capture community providers' expert knowledge by integrating stakeholder discussions, co-production events and reflective activities.

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Author Biographies

Dr Abyshey Nhedzi is Research Associate at the University of Johannesburg in South Africa. He is a research and workplace consultant, and a qualified public relation practitioner (PRP) affiliated with the Public Relations Institute of Southern Africa (PRISA). Abyshey's research interests include conducting qualitative and quantitative research in the fields of brand linkage, online remote education, digital media, marketing communication and generational use of media. Abyshey's research is three-fold in the fields of branding, media, and education. His research focuses on strategic communication as a whole, and the practice, and adaptation to Fourth Industrial Revolution (4IR) technology.

Dr Sadiyya Haffejee is mental health practitioner, and senior researcher at the Centre for Social Development in Africa, University of Johannesburg. She works at the interface of research, practice, and policy. Her areas of interest include child and youth trauma, resilience, and well-being. Sadiyya draws on participatory visual methods in her research.

Dr Michelle O'Reilly is Associate Professor of Communication in Mental Health and Chartered Psychologist in Health for the University of Leicester, UK. Michelle is also a Research Consultant and Quality Improvement Advisor for the Leicestershire Partnership NHS Trust. Michelle specializes in undertaking qualitative research with children and youth, often using discourse and conversation analysis. Michelle has expertise in self-harm and suicide prevention, and neurodevelopmental conditions. She undertakes research exploring the relationship between digital media and mental health.

Panos Vostanis is Professor of Child Mental Health. He has published extensively on the impact of trauma on child mental health, and the evaluation of interventions and services for traumatized children. He has longstanding clinical experience with vulnerable children and youth. Panos is Research and Training Director of the World Awareness for Children in Trauma (www.wacit.org), which provides capacity-building, service transformation and evaluation for children in contexts of conflict and disadvantage. To this effect, he is involved in several projects with NGOs and academic centres in Asia, Africa and Latin America.

Implications for policy and practice

- Child mental health in MWC should be incorporated within existing welfare, health, education, and development policies at national and local level.
- Child mental health awareness programmes should involve communities and professionals and extend beyond mental illness to the promotion of mental health and wellbeing.
- The design of child mental health interventions and services should be contextualized to local sociocultural needs and priorities, through co-production with community stakeholders.
- Child mental health service provision should build on and be integrated with existing informal and structural support systems.

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Table 1

Emerging themes and subthemes

Themes	*Subthemes*
Community mobilization	Awareness Engaging children, youth, and caregivers Empowering caregivers
Contextual	Tackling inequalities Gender-related issues Mental health incorporation with physical health and disability
Systemic	Integration with community support Joint working Care pathways