

Strengthening community-based recovery-orientated mental health services: stakeholder insights on recovery from severe mental health conditions

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Aim

Globally, severe mental health conditions contribute significantly to the burden of disease. In South Africa, there is a considerable treatment gap in the recovery of persons with severe mental health conditions. These persons are mostly treated on an in-patient basis in specialised psychiatric hospitals with limited access to community-based recovery-orientated services. Given the international drive to transform mental health services and reduce the treatment gap, especially in low- and middle-income countries, it is pertinent to understand how recovery from severe mental health conditions is conceptualised from multiple stakeholder perspectives, including those with lived experience of the condition. This qualitative descriptive study explores how diverse stakeholders understand recovery from severe mental health conditions, identifying possibilities for intersectoral collaboration.

Method

Seventeen purposively selected service providers from health services and non-profit organisations, four mental health service users, and three of their caregivers in Cape Town participated in the study. Data collected using semi-structured interviews, focus groups and visual participatory methods were thematically analysed.

Findings

Three themes identifying opportunities to implement intersectoral collaboration emerged: barriers to personal recovery; finding meaningful participation; and affirming agency. Health service providers primarily focused on medication adherence and symptom reduction in health settings. In contrast, mental health service users and their caregivers suggested that their recovery was facilitated by long-term relational support from a range of service providers, including non-profit mental health organisations. Additionally, mental health service users valued access to interventions outside health settings, promoting meaningful engagement in their living, learning, working and socialising environments.

Conclusion

Intersecting contextual, socio-economic, cultural, and spiritual factors beyond the health sector influence recovery. Appropriate services for severe mental health conditions are multi-dimensional and treatment considerations should accommodate this complexity.

Introduction

Severe mental health conditions (SMHCs) such as schizophrenia, bipolar affective disorders, substance use disorders, and major depression are significant contributors to global disease burden.^{1,2} In South Africa, the prevalence of SMHCs remains unknown. The South African Stress and Health (SASH) study is the primary source of the 12-month and lifetime prevalence of common mental health conditions in South Africa.³ Although the SASH study did not focus on SMHCs, it reported that the prevalence of reported hallucinations in the general population was 13%.⁴ Persons with SMHCs are mostly treated at in-patient specialised psychiatric hospitals with limited access to community-based services. Hospital admissions average 46 days and focus on managing acute symptoms.⁵

There are two main approaches to recovery in mental health. Clinical recovery, rooted in the biomedical model, focuses on symptom reduction and medication adherence to restore a person's previous level of functioning.^{6,7} However, this approach has been criticised for neglecting social determinants of health and outcomes that are meaningful to mental health service users (MHSUs).⁷ In contrast, personal recovery is self-driven, emphasising well-being beyond symptoms and enhancing identity, confidence, and community engagement.^{6,8} However, personal recovery is criticised for its highly individualistic focus, which may conflict with collectivist cultural values. It also does not take informal caregivers' roles into account.⁹ Consequently, there is a call for person-centred, human rights-based, recovery-orientated care that supports MHSUs' strengths and aspirations, valuing lived experience over biomedical dominance.¹⁰⁻¹³

Given the international drive to transform mental health services, it is pertinent to understand conceptualisations of recovery from multiple perspectives, including MHSUs, caregivers, and mental health workers. Aligned with the recovery movement and the World Health Organization (WHO) guidelines, MHSUs should be included in all aspects of mental health service transformation initiatives as experts by experience.¹⁴⁻¹⁶ The WHO proposes a model of community-based mental health services that consists of three focal areas: (i) mental health in general health; (ii) community mental health services, and (iii) mental health beyond the health sector.¹⁷ Here, community mental health services include: (i) community mental health centres and teams; (ii) psychosocial rehabilitation programmes; (iii) peer support services, and (iv) supported living services.¹⁷ Implementing this policy requires scaling up community mental health services and developing intersectoral collaborations within and beyond the health sector.

South Africa recently launched the National Mental Health Policy Framework and Strategic Plan 2023–2030,¹⁸ but attention should still be given to implementation guidelines.¹² This study explores stakeholder perspectives on recovery from severe mental health conditions and identifies opportunities for intersectoral

collaboration to improve community mental health services.

Method

A qualitative, descriptive research study¹⁹ was conducted with service providers, managers, male MHSUs, and caregivers.^{20,21}

Study context

This study was conducted in Cape Town, South Africa, where three psychiatric hospitals provide specialist services for SMHCs across different catchment areas. Typically, after a 72-hour assessment at a district hospital, MHSUs are either referred to their local community health centre (CHC) or admitted to a psychiatric hospital. Thereafter, MHSUs are discharged to the out-patient service of the psychiatric hospital or to their nearest clinic, where they collect their psychotropic medication. A few non-profit organisations (NPOs) in Cape Town offer community-based mental health services, including supported housing, access to employment, and day programmes.

Participant selection

Purposive sampling with maximum variation was used to select service providers and MHSUs¹⁹ using the characteristics described as follows.

Service providers

All service providers and managers in the public mental health and NPO sectors were eligible to participate. Invitation emails were sent to potential participants, and 17 diverse participants were recruited for the study. The majority were female (13), which is coherent with the profile of health and rehabilitation professionals in South Africa. Participants in the sample came from different disciplines and their corresponding identifiers consisted of: occupational therapists (OT), social workers (SW), psychologists (P), psychiatrists (D), nurses (N), community rehabilitation workers and a volunteer co-ordinator at an NPO.

MHSUs

MHSUs were recruited via an NPO. All MHSUs using public health services were eligible, and the inclusion criteria¹⁹ were: (i) males between 18 and 60 years; (ii) able to communicate in English or Afrikaans; (iii) diagnosed with an SMHC, and (iv) living in a community at the time of the study. More beds are allocated to men than women in the Western Cape, and to ensure maximum variation within the sample, other considerations were: race, residential circumstances, employment status, and time since the last hospital admission.²² Of the 12 MHSUs eligible to participate, four consented ([Table 1](#)). Participants chose their own pseudonyms.

Table 1. Demographic characteristics of mental health service users (n=4)

Participant	Age	Age at first psychiatric hospital admission	Last psychiatric hospital admission (Range 9–20 years)	Living arrangement	Race	Employment status	Relationship status	History of substance use	Caregiver involvement
Patrick	50	21	2005	In supported housing since 2006	Coloured	Employed (cook)	Single, never married	Yes	Parents (mother and father)
Globie	38	22	2012	Lives with parents and siblings	Coloured	Employed (shop assistant)	Single, never married	Yes	Mother
Siya	42	23	2008	In supported housing since 2012	Black	Unemployed	Single, never married	Yes	Declined to nominate
Reggie	50	23	2000	In supported housing since 2000	Coloured	Employed (supervisor in supported employment project)	Single, divorced	No	Declined to nominate

Source: Authors

Data collection

AA, a female occupational therapist, collected data using interviews and focus group discussions with service providers and caregivers. Visual participatory methods including community maps, life graphs and photo-elicitation interviews were used to collect data from MHSUs.²³⁻²⁷

Service providers

Eleven individual interviews were conducted once. Additionally, two focus group sessions were held for the six service providers who could not meet individually. This pragmatic approach to data collection allowed for flexibility to accommodate participants' availability in their natural work settings.^{19,28} Using an interview guide,¹⁹ participants were invited to share their views on: (i) the mental health services they offer to MHSUs; (ii) their understanding of clinical versus personal recovery; (iii) available services for SMHCs; (iv) accessibility of services; (v) caregiver inclusion in services, and (iv) benefits of and gaps in current services.

MHSUs

Participants were interviewed over six sessions, where they:

1. produced and discussed a life graph of significant events related to living with an SMHC^{23,24};
2. produced a community map to identify and discuss the places, people, and activities that helped or hindered their recovery²⁵; and
3. used photovoice methods²⁶ to capture contextually rich images of people, places and activities as part of their recovery stories. MHSUs explained their photographs through photo-elicitation interviews.²⁷ Before issuing the cameras, AA discussed ethical issues related to privacy and seeking consent to photograph different people.²⁷ During interviews, MHSUs were asked the following questions:

"What does this picture mean to you?" and "Would you like to say more about this picture?"

While MHSUs were capturing their photographs, AA conducted one-hour semi-structured interviews in the homes of consenting caregivers. Using an interview guide, AA elicited caregiver perspectives on: living with MHSUs; onset and duration of illness; availability of psychiatric services; conceptualisations of recovery, and access to caregiver support services.

Ethical approval was obtained from the Faculty of Health Sciences Research Ethics Committee (HREC 655/2018) and the Western Cape Province's Health Research Committee (WC_201902_010). This study adheres to the tenets of the Declaration of Helsinki.²⁹

Analysis

Interviews were audio-recorded and transcribed verbatim. AA employed reflexivity, peer debriefing, and an audit trail to promote the findings' quality, authenticity, and truthfulness, thus ensuring trustworthiness.³⁰ Member checking was completed with all participant groups.³¹

Service providers

The framework approach was used to systematically analyse the data generated from the service provider aspect of the study.³² The analytical framework consisted of codes and categories developed from the research question, which were used to sift, chart, and sort the data.^{28,30}

MHSUs

Thematic data analysis was executed.^{22,33,34} Member checking occurred during the different stages of data collection.^{30,31,35}

Findings

This study presents three key themes that emerged in relation to recovery-orientated services: barriers to personal recovery; finding meaningful participation; and affirming agency.

Barriers to personal recovery

Participants highlighted some barriers to personal recovery. The two sub-themes that emerged were: service-related barriers, and difficulties with community integration.

Service-related barriers

Service providers acknowledged that their services lack a focus on personal recovery, often due to human resource limitations. Consequently, they shared mixed feelings about service delivery, as described:

I love the clinical work and the activism, which is an additional part, but I am feeling more despondent...now we are sitting with empty posts. So you end up doing the job of several people and having to fight for it. (D1).

Services were hampered by the shortage of "intersectoral collaboration and partnerships" (SW3) that could extend their work beyond clinical recovery:

We only do the stabilisation; outside the multi-disciplinary team are all the other sectors: social services, education, and labour. All those other departments speak to the recovery of the person, but we have not gotten there yet. (D2).

Related to this:

The psychiatric hospital is only one service point in the journey to recovery. There needs to be relationships de-

veloped between each service point across that continuum. (P2).

The lack of consistent long-term relational support for MHSUs was identified as a barrier to recovery:

Psychiatric patients want that reliable person. They want consistency. They don't want to repeat their story every time. (N1).

Another barrier to recovery was limited consideration of MHSUs' cultural beliefs, especially where service providers did not distinguish cultural practices from symptoms of mental illness:

In Xhosa culture, if you get ill and if you do strange things and behaviours, these symptoms could be directly correlated with schizophrenia, but it is viewed that the ancestors are calling you to be a sangoma [traditional healer]. So we actually have to do a little more investigation. (OT1).

Furthermore, barriers to integrating MHSUs into their communities were identified.

Difficulties with community integration

Service providers shared the difficulties faced once MHSUs were discharged to their communities. A service provider elaborated that:

How do you activate people whose illness is inactivating? It needs a revolution. Mental health care is actually about society. We need to look at people in their environments, then think what other interventions does this environment need? (D1).

While analysing interviews, AA noticed distinct differences between government and NPO service providers in how they supported MHSUs' access to services. According to P2:

Medication is an assistive device, but the rest of the service is not funded, and professionals do not see themselves as part of the continuum, so [MHSU] choice is left behind.

SW1 suggested that:

We need an MDT [multi-disciplinary team] at the CHC [community health centre] level because there is a gap in staffing. A medical person won't think about recovery. We need a CHW [community health worker] as a resource and an OT [occupational therapist] in the field.

NPOs supported MHSUs access to services, providing crisis care plans, which offered MHSUs: "different intensity of support at different times" (SW5). SW5 elaborated further:

The programme is a collective, but it is individually tailored because although we have 70 or 80 residents, we always have 70 or 80 services we render because one size does not fit all. We try to match their needs to what we can provide.

Finding meaningful participation

MHSUs found innovative ways to connect socially and engage meaningfully, with some using spirituality to make sense of their SMHCs: "I think religion helps" (Siya), and "God, you must have a plan for me" (Reggie). However, MHSUs reported being ostracised by congregants and representatives of their religious communities when seeking support, leading them to practise their faith in isolation.

Developing self-management strategies

MHSUs described recovery as an evolving process which required them to develop self-management strategies to facilitate their community integration. As part of their 'stigma endurance', some MHSUs resorted to humour to educate: "I would say I am 'schizofriendly', and they would ask what that is" (Reggie). Furthermore, MHSUs adopted a learning spirit and used support services, to access new opportunities, as explained by Globie:

Things that helped me in my recovery: joining Garden Place, delighted that staff are interested in me, meeting new friends, learning new skills, interacting with volunteers, travelling on my own, attending a full programme till 14h30, starting fresh...you must be willing to change.

MHSUs shared that self-management strategies helped them to build their mental endurance for new ways of being.

Securing places and activities that promote mental health

A few NPOs featured strongly as places offering MHSUs interventions to facilitate their community integration. NPOs offer interventions, including psycho-education, supported housing, daily activity-based programmes, support groups, skills development programmes, and access to employment opportunities. Mental health education and awareness programmes for different stakeholders are also offered, as NPOs regard mental health literacy and stigma prevention as being important facilitators of recovery.

Affirming agency

Affirming agency through maintaining relational support and making meaningful contributions was identified as a core element of mental health services that promote recovery within SA. One of the caregivers explained:

With the support of his family and with help from Garden Place... Garden Place was a blessing because I needed to understand what was wrong with him (Patrick's mother).

For Patrick, a participant, accessing places and activities outside of hospital settings was deemed crucial for finding meaningful participation among those with SMHCs. He said: "I have moved from a gangster to a pro-

ductive member of society. A job gives you meaning and purpose.”

Co-ordination between NPOs and hospital staff should affirm this agency and support MHSUs when accessing health care.

Maintaining relational support

MHSUs indicated that ongoing support was not available from psychiatric hospitals after their discharge. However, NPO staff offered access to long-term supportive relationships even after multiple relapses, as described by two participants: “My life, it’s my job, where I live, the people I live with, my home” (Patrick), and: “My family, Garden Place, the social worker and God” (Globie).

Supported housing offered access to a stable support network through communal living to those MHSUs who had conflictual relationships with their families.

Making meaningful contributions

NPOs in this study supported MHSUs in finding work opportunities which helped them to contribute financially to their families and friends. Access to work helped MHSUs such as Patrick to have hope and “look forward” to new possibilities despite their condition.

The themes capture diverse views on the resources and range of stakeholders from different sectors supporting MHSUs in living meaningful lives as active citizens in their communities of choice. In this study, a few NPOs provided services that offered long-term relational support to MHSUs across their cyclical, non-linear recovery journeys.

Discussion

The study highlights multiple stakeholder perspectives on barriers to recovery from SMHCs in South Africa. It reveals a reliance on hospital admissions in public health services, underscoring the need for stronger intersectoral collaborations between government and NPOs. The biomedical focus of the health system leaves a gap in services that support MHSUs’ recovery goals post-discharge. Gamielidien, Galvaan and Duncan³⁶ highlight the complex recovery needs of MHSUs, shaped by intersecting social, economic, cultural and political factors. Addressing these needs requires access to diverse services within co-ordinated multi-sectoral and inter-sectoral systems.^{21,37}

The de-institutionalisation process emphasised the need for community-based mental health services that promote the community re-integration of persons with SMHCs.¹² In South Africa, the dearth of community-based mental health services has been highlighted.¹⁸ Recent reflections by Sorsdahl et al.³⁸ suggest that the absence of effective community-based mental health services focuses treatment provision on clinical recovery rather than on personal recovery. Frequent re-admissions and limited post-discharge opportunities to take up valued roles hinders MHSUs’ recovery and community in-

tegration.³⁶ Although literature shows that recovery in low- and middle-income countries (LMICs) often begins post discharge, primary healthcare services remain focused on medication adherence and clinical outcomes, with limited emphasis on psychosocial rehabilitation and personal recovery.³⁹

Despite the centrality of intersectoral collaboration in South Africa’s National Mental Health Policy Framework and Strategic Plan 2023–2030,¹⁸ implementation remains constrained by limited expenditure on mental health care.⁴⁰ Meaningful collaboration requires more than alignment in principle. It demands strengthened relationships, consistent communication and formalised agreements between sectors, including education, social development, labour, justice, human settlements, and NPOs.^{18,41} According to Addo et al.⁴² MHSUs and their families face multiple barriers which fall beyond the ambit of the Department of Health. Barriers include inadequate caregiver support, unemployment, food insecurity, and inequitable access to housing, social assistance, transport and education. Departments operate in silos, but investing in co-ordinated systems is essential for developing community-based recovery-orientated services which alleviate poverty, strengthen community supports, and promote social inclusion for MHSUs.³⁷

The study found that NPOs play a pivotal role in co-ordinating care for MHSUs by assigning key support workers who track and respond to MHSUs’ evolving needs and recovery goals. Developing advance directives with MHSUs can help bridge the gap between NPOs and government departments.⁴³ Advance directives — although challenging to implement — promote agency and inclusion by ensuring that MHSUs are consulted in mental health care decisions.⁴³

In this study, a few NPOs facilitated MHSUs’ re-integration into their living, learning, working and socialising environments.²⁰ These services have reduced relapse rates, decreased community stigma, and supported MHSUs in discovering new social identities beyond their diagnosis.^{44,45} Given these findings, mental health integration into primary health care must be paired with the development of services for SMHCs beyond the health sector.

The WHO’s global drive to close the treatment gap includes involving persons with lived experience^{46,47} in scaling up community-based mental health services aligned with person-centred, human rights-based, recovery-orientated care.^{17,38} In South Africa, the Global Mental Health Peer Network (GMHPN) promotes lived experience leadership and demonstrates that MHSUs can be meaningfully employed as part of the mental health workforce.^{46,47} The Cape Consumer Advocacy Body, hosted by Cape Mental Health, is another model which empowers MHSUs to take an active role in their care and advocate through various platforms.⁴⁸ These examples, together with the findings of this study, show that MHSUs’ lived experience can inform how services are strengthened.

In LMIC contexts, traditional healers and spiritual advisors form part of the unacknowledged informal mental health care pathway⁴⁹ due to their perceived knowledge about traditional medicine, cultural practices, and spiritual beliefs.^{38,50} Given the treatment gap in LMICs, caregivers often turn to spiritual advisors and traditional healers before accessing formal mental health services. Collaborating with these practitioners can help service providers to gain a better understanding of how cultural practices and beliefs shape recovery from SMHCs.

While religious groups can be a source of social support, stigma can limit the integration of spirituality into recovery-orientated services.⁵¹ Research highlights a 'religiosity gap' between MHSUs, their caregivers, and service providers,⁵¹ reflecting differing views on the role of spirituality in recovery. This gap can limit understanding of how engagement in religious and spiritual occupations supports wellbeing and health outcomes.⁵² One way to advance intersectoral collaboration efforts is to formally integrate faith-based organisations and traditional healers into health services in South Africa.⁵³ Additionally, traditional healers and spiritual advisors are valuable resources who can offer caregivers and MHSUs the long-term relational support needed throughout their recovery journeys.

Literature findings support assertions that recovery-orientated care packages should take a life course approach and promote collaboration between MHSUs, caregivers, service providers, local leaders, religious leaders, and traditional healers across sectors to facilitate community integration.⁵⁴

Recommendations

This study highlights the urgent need to strengthen intersectoral collaboration as a key strategy to support the personal recovery of MHSUs and reduce the persistent treatment gap in mental health care.

Practice-level and system-level recommendations

While healthcare practitioners play a vital role, broader systemic support is essential. At the practice level, health professionals should reflect on the limitations of the biomedical model and prioritise psychosocial rehabilitation and recovery-orientated practices beyond hospital settings. Forming partnerships with NPOs can support more holistic care.

To make collaboration feasible, health practitioners must be supported with clear mandates, manageable workloads, and institutional structures that facilitate engagement beyond the clinical setting. Strategic partnerships should be encouraged through district-level co-ordination mechanisms that include government departments such as those of Social Development, Justice, Housing, Education, and Economic Development.

Referral pathways must be clearly defined and operationalised, with community health workers playing a

bridging role between hospital-based and community services.

At the system level, interdepartmental policies and budget allocations should enable shared responsibility for recovery-orientated mental health services. Leadership from national and provincial levels is required to embed intersectoral collaboration into planning, staffing and accountability frameworks.

Healthcare providers, including occupational therapists, should also collaborate with religious organisations and peer-led advocacy groups such as GMHPN, to ensure that MHSUs are empowered as mental health champions and integral members of the mental health workforce.

Future research

Mental health researchers should prioritise knowledge co-production to ensure that MHSUs and caregivers are actively involved in research. A participatory approach involves persons with lived experience to ensure the relevance and applicability of research to real-world recovery-orientated care.

Researchers should also engage with community-based stakeholders, including faith-based organisations and traditional healers, to co-develop, offer and evaluate spiritually based interventions. This can support the integration of spiritual dimensions into recovery-orientated mental health services, acknowledging the holistic needs of MHSUs.

Conclusion

This study highlighted the importance of foregrounding MHSUs' lived experience in mental health service reform. Extended relationships can unlock their potential, pointing to the need for interventional research on diverse community-based networks. Scaling up services requires ongoing exploration of intersectoral collaborations across the full continuum of care within and beyond the health sector.

Abbreviations

Abbreviation	Description
CHC	community health centre
GMHPN	Global Mental Health Peer Network
LMICs	low- and middle-income countries
MHSUs	mental health service users
NPO	non-profit organisation
SASH	South African Stress and Health
SMHCs	severe mental health conditions
WHO	World Health Organization

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