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Mental Health Promotion: An Exploration of a Peer Community-Based Intervention in Cape Town

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DECLARATION

Mental Health Promotion: An Exploration of a Peer Community-Based Intervention in Cape Town is my own work. This dissertation was submitted for the degree of Master of Sociology at the University of the Western Cape and has not previously been submitted for a degree at the University or any other tertiary institution. According to the University requirements, secondary materials have been acknowledged and cited.

*L Moodie*_____ ……19 April 2023…….

Liezl Moodie **Date**

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ABSTRACT

The outbreak of COVID-19 in 2019 and the accompanying lockdown, social distancing and quarantine measures across the world separated individuals and families from their loved ones. This separation and social isolation also resulted in loss of jobs due to the closure of the hospitality industry and other sectors. It also caused loneliness and anxiety disorders in individuals with pre-existing vulnerabilities. The government of South Africa provided safety nets and social protection in the form of grants to vulnerable groups. Despite these interventions, most individuals who had suffered the worst impact of COVID-19 lockdown on their emotional wellbeing seemed to have been left without adequate access to treatments and coping resources. In the absence of sustainable resources and access to professional services, non-governmental organisations (NGOs) looked within communities to identify existing assets that could be leveraged and utilised for mental wellbeing management. This study examines the effectiveness of one such initiative. The study investigates the efficiency of a non-profit organisation (NPO)-led peer mentoring, social support, and mental health first aid services for young people in the city of Cape Town. Specifically, it examines the impact of a 13-week intervention programme on peer social support and mental health promotion carried out by an NPO in Cape Town. The research seeks to understand the extent and degree to which mental health management through peer social support and narrative therapy has been effective in filling the existing treatment gap within deprived communities in Cape Town through assessment of project evaluation reports, data, samples, workshop minutes and archival materials.

Key terms: Mental health management, health promotion, peer social support, Indima Yethu, social capital

DEDICATION

I dedicate this dissertation, ***Mental Health Promotion: An Exploration of a Peer Community-Based Intervention in Cape Town,*** to all those who continue fighting battles in silence, fear, and loneliness. To the peer mentors and every person who willingly participated in the programme, to those who embodied not only the desire to be there for others, but who have been empathic and willing to help, guide and support a stranger, thank you.

ABBREVIATIONS AND ACRONYMS

ABCD	Asset-based community development
ALGEE	Assess risk, Listen nonjudgmentally, Encourage appropriate help, and Encourage self-help
ASSIA	Applied Social Sciences Index and Abstracts
CMHT	Community Mental Health Team
CYP	Children and young people
DSM	Diagnostic and Statistical Manual of Mental Disorders
FGD	Focus-group discussion
GDP	Gross Domestic Product
HARP	Humanitarian Assistance and Resilience Programme
ICD	International Classification of Diseases
IHME	Institute for Health Metrics and Evaluation
IPV	Intimate partner violence
LMIC	Low- and middle-income countries
MBLS	Mental Health Beliefs and Qualifications Scale
MDD	Major depressive disorder
MHCP	Mental healthcare plan
MINDS	Mental Illness Needs Discussion Sessions
MHFA	Mental Health First Aid
MHQ	Mental Health Quotient
NGO	Non-governmental organisation
NIMHANS	National Institute of Mental Health and Neurosciences
NPO	Non-profit organisation
PSSM	Polysaccharide Storage Myopathy

RTA	Reflective Thematic Analysis
SAFMH	South African Federation for Mental Health
SST	Social Support Theory
TA	Thematic Analysis
UCDG	University Capacity Development Grant
WHO	World Health Organization
YMHFA	Youth Mental Health First Aid
YSN	Youth Safeguarding Network

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

South Africa is a middle-income country with a history that elicits emotional trauma for previously marginalised populations. The outbreak of COVID-19 in 2019 created new pathways for mental and emotional stress while exacerbating existing trauma and vulnerabilities. Bantjes et al. (2019) note that mental health is becoming more widely recognised as a significant public health concern in South Africa. The World Health Organization (WHO, 2018) explained that a variety of factors, including rapid social change, unpleasant working conditions, gender exclusion, social avoidance, a negative way of life, illnesses, and disease outbreaks, as well as other types of social discrimination and social injustices, could harm a person's psychological and mental well-being. Drawing on the WHO's (2018) explanation, the South African Federation for Mental Health (SAFMH, 2020) adds that other factors that exacerbate emotional stress include: joblessness, social disengagement or separation, biomedical health conditions, youth substance misuse leading to injuries, brutality or, lodging issues, social disservice, deprivation, and harm because of military encounters, being associated with a genuine mishap or fierce wrongdoing.

A national survey in South Africa revealed that the overall probable depression prevalence ranges from 14.7% to 38.8% (Craig et al., 2022). According to Craig et al. (2022), 25.7% of South Africans suffer from depression, and more than a quarter report moderate to severe symptoms. The results of studies conducted in South Africa, which revealed a diagnosis of major depressive disorder (MDD) in 9.7% of adults and a lifetime prevalence of 9.8%, have significant implications for paying for the costs associated with this curable condition (Craig et al., 2022). In fact, according to a recent poll, 18.3% of South Africans are now receiving therapy for depression (Stander et al., 2016). A third of the population in South Africa are youth aged between 18 and 34, which amounts to approximately 17.8 million people (Statistics South Africa, 2019). Since they comprise a sizeable portion of the population, South Africa's youths must be encouraged and given the tools they need to succeed. Supporting their mental health needs is part of this.

By the end of June 2022, 60.6 is the expected population estimate in South Africa (Statistics South Africa, 2022). Mortality measures show that by 2022, life expectancy at birth will have increased, rising from 61.7 years in 2021 to 62.8 years in 2022 (Statistics South Africa, 2022). As of 2022, 18.2 million people in South Africa lived in extreme poverty. Extreme poverty among vulnerable households increased, and as a result, pre-existing structural inequalities beyond the individual's control have contributed to inadequate access to social protection and safety nets, which social and economic capital can circumvent (Yingi & Hlungwani, 2022).

According to Mehmood, Jamal, and Sriram (2015), Putnam (1995) notes that social capital can contribute to mitigating the impact of social inequalities: in the context of health inequalities, *social capital* can be defined, for example, as 'features of social organisation such as networks, norms, and social trust that facilitate coordination and co-operation for mutual benefit' (Putnam, 1995, p. 67). The concept of social capital revolves around social relationships and includes social networks, civic engagement, reciprocity norms, and generalised trust.

By extension, social good fosters co-operation and collective action for mutual benefit, based on shared norms, values, beliefs, trusts, networks, social relationships, and institutions. Social capital can be structural, cognitive, bonding, bridging, or linking. In addition, it can also be strong and weak, or horizontal or vertical (Akram et al. (2016). These authors further suggest that social capital has become a pseudo social protection without safety nets. Researchers note that social capital is the web of connections between those who live and work in a society, which enables that society to function well. Social capital has been compared to a glue that ties society together by promoting cohesiveness and integration. Economic capital argues that physical resources can be directly transformed into money and may be established as property rights, which could further circumvent social inequities (Akram et al., 2016).

Thus, to ameliorate the effect of the country's political economy and social inequalities brought about by apartheid, many individuals rely on both their economic and social capital. An individual's socioeconomic status might afford them access to coping mechanisms, such as a professional network of people who can assist and offer much-needed help and guidance. For most, a professional network is not an option due to prevalent poverty, and as a result, mental health management becomes highly unattainable.

Similarly, membership in a medical aid scheme only guarantees immediate access to someone or a trained professional who can assist, listen, and guide when needed. Thus, an individual's social 'safety net' and lifeline becomes social support from peers or family structure, which they inadvertently and unknowingly have in place but perhaps are yet to maximise.

While Mental Health First Aid (MHFA) has been popular in other countries for improving mental literacy and well-being, its uptake in South Africa could be faster. MHFA's responsibility falls on communities and civil societies without a well-coordinated national strategy, guidelines, and agenda (Obuaku-Igwe, 2022). Organisations and communities designed and piloted MHFA training and adapted it from international research from the Global North. Due to this, MHFA training in South Africa needs help being perceived and understood as culturally appropriate (Obuaku-Igwe, 2022). A culturally adapted version of MHFA implemented by a South African non-profit organisation, Indima Yethu, incorporates spirituality and Ubuntu values. Indima Yethu is a non-profit organisation in Cape Town that focuses on youth mentoring, capacity development, health, and advocacy for youth (Obuaku-Igwe, 2022).

To this end, this study examines a community-based mental well-being program that centres on using social capital and social networks in mental well-being management to promote health. It does this by investigating how a non-profit organisation (NPO) in Cape Town utilises an asset-based approach to mental health promotion by implementing a 13-week peer mentoring programme. The research investigates the extent and degree to which mental health management through peer social support and narrative therapy has been utilised in a low-resourced context, by a non-governmental organisation (NGO), as a tool to fill the existing treatment gap within deprived communities in Cape Town. Specifically, this study examines the health promotion of an adapted form of mental health first aid (MHFA) among young people in Cape Town, South Africa.

1.2 Background

According to the WHO, a person is in good mental health when they can function well within their community setting, cope with daily stressors, and produce good work. Any person unable to function independently within their social environment is thus deemed unfit and experiencing poor mental health (WHO, 2019). Drawing on the WHO (2022) statements, Bromet et al. (2018) indicate that 73.8% of South Africans at some point in their lives have

either been exposed to or experienced at least one traumatic event, which suggests that most South Africans do not appear to be mentally healthy according to the WHO definition.

Since the end of apartheid in 1994, the South African healthcare system has experienced a series of policy reforms with more funding allocations and the introduction of national health insurance for all citizens (Obuaku-Igwe, 2015). These reforms have shifted from curative to preventative healthcare, prioritising health promotion at all levels (Bhayat & Chikte, 2019). However, mental health has been under-prioritised from national policy until the outbreak of COVID-19. Mental health is regarded as the orphan of the South African healthcare system, as it has previously not been a part of the policy imperatives in South Africa. Within this context, the South African Depression and Anxiety Group (SADAG, 2020) notes that mental health has been an orphan of the South African healthcare system, with less than four per cent allocation until recently.

SADAG (2020) estimates that 21.4% of teenagers have considered committing suicide due to a combination of issues, including relationship problems and trauma for various reasons, including but not limited to family issues, violence, emotional or sexual abuse, bullying, substance abuse, teenage pregnancy, and exam stress. Peer pressure also influences and contributes to drinking, smoking, and using drugs at an early age. However, 60% of teenagers do not seek assistance, mainly because they are unaware of available resources (SADAG, 2020). Young people's unwillingness to seek assistance or poor knowledge of where and how to access mental healthcare resources within South Africa brings to question the efficiency of mental health advocacy and promotion efforts. It begs the question: To what degree and extent are mental health advocacy efforts serving as a driving force in improving accessibility of preventative mental well-being healthcare and information faster, better, more accessible, and cheaper (Levy, 2012)?

Due to mental well-being management information constraints, NPOs and other community-based non-profit organisations have resorted to filling these gaps through advocacy. Thus, given the advocacy work of NPOs and community-based organisations (CBOs) in creating awareness of mental health, the quest to understand the efficacy and effectiveness of their programmes is needed. Even though an emerging body of work on mental health promotion has examined peer-led interventions and the impact of interpersonal relationships on mental health, there is still a need for further investigation to understand the extent to which communities and NPOs are utilising social capital, social networks, relationships among and

within individuals, and, among vulnerable populations such as young people in mental health promotion.

1.3 Rationale

The South African healthcare system has undergone several policy reforms since apartheid ended in 1994, including more funding allocations and the proposed introduction of universal healthcare (Obuaku-Igwe, 2015). In response to these reforms, health promotion has become more important at all levels, replacing curative healthcare with preventative healthcare (Bhayat & Chikte, 2019). As stated above, policy imperatives in South Africa will not exclude mental health. WHO (2021) warns that not addressing adolescent mental health can have long-term consequences.

The WHO (2021, p. 11) further notes that,

Numerous variables impact mental health. Multiple factors affect mental health. Adolescents exposed to more risk factors will have a more significant potential impact on their mental health. Globally, factors contributing to stress during adolescence include exposure to adversity, pressure to conform with peers and exploration of identity. Media influence and gender norms can exacerbate the disparity between an adolescent's lived reality and their perceptions or aspirations for the future. Other vital determinants include the quality of their home life and peer relationships. Violence (especially sexual violence and bullying), harsh parenting and severe and socio-economic problems are recognised risks to mental health (WHO, 2021, p. 11).

Furthermore, the WHO (2021, p. 11) contends that mental health promotion and prevention interventions are known to 'strengthen an individual's capacity to regulate emotions, enhance alternatives to risk-taking behaviours, build resilience for managing difficult situations and adversity, and promote supportive social environments and social networks.' However, 'these programmes require a multi-level approach with varied delivery platforms – for example, digital media, health or social care settings, schools or the community – and varied strategies to reach adolescents, particularly the most vulnerable' (WHO, 2021, p. 11).

Within this context, young people's unwillingness to seek assistance or knowledge of where and how to access mental healthcare resources within South Africa questions the role of community health promotion efforts as a driving force in making critical aspects of mental healthcare and information faster, better, more accessible, and cheaper (Levy, 2012).

Understanding the usefulness and effectiveness of their programs is required, given the advocacy effort done by NPOs and CBOs to raise awareness of mental health.

Even though an emerging body of work on mental health promotion has looked at the significance of peer-led interventions and the impact of interpersonal relationships on mental health, this field of study requires further exploration to find out how communities and NPOs in Cape Town are leveraging young people as assets in mental health promotion among their peers. Generally, the study investigates the approach of a Cape Town-based NPO to mental health promotion and advocacy, as well as its strategy and delivery platforms.

1.4 Research Question

Hunt, Pollock, Campbell, Estcourt, and Brunton (2018) indicate that to obtain helpful information, a researcher must adhere to specific criteria when framing their research question and trust that the selected question will lead them to helpful information. The primary aim of this study is to investigate mental health first aid (MHFA) as a form of mental well-being promotion strategy by looking at a peer community-based intervention initiative, focusing on the NPO, Indima Yethu, and exploring the effectiveness as well as the impact and value it has created for young people, aged 18–35 within their communities.

The research is thus undergirded by the following questions:

- How well have Indima Yethu's adapted MHFA guidelines, which focus on young people as assets, worked to change young people's attitudes, knowledge, and behaviour in general regarding mental health?
- Is Indima Yethu fostering a feeling of community among young people to advance mental health?
- How have Indima Yethu's peer mentorship program and collaborative social networks affected participants' physical and mental health?

Since the focus of this research is on how the selected NPO engages young people and utilises them as assets for mental health advocacy, attention will be on the content of the programme, the design, its effectiveness, the role of peer mentors, participant evaluations, and feedback from all stakeholders.

1.5 Research Objectives

According to researchers, South Africa's economy will continue to be plagued by growing income inequality, which also affects access to healthcare (Obuaku-Igwe, 2015). Within this context, the economy determines who gets access to what and when. Due to the political economy of the country and its historical trajectories, two decades after the end of apartheid, disparities in health and health outcomes persist and are patterned along gender, age, place, education, and racial lines.

Regarding the gross domestic product (GDP), South Africa's growth is at the top percentile of most African countries. However, health inequities persist due to low funding, particularly for previously marginalised indigenous or rural populations. Even though the country continues to make giant strides in ensuring that policy imperatives address gaps in health and access to healthcare, mental health remains grossly underfunded (Obuaku-Igwe, 2020). South Africa's recent update and launch of the 2013–2020 Comprehensive Policy Framework and Strategic Plan for Mental Health are considered its first officially endorsed mental health policy. However, this endorsement has done little to increase funding allocation for mental healthcare or its advocacy at the primary healthcare level, leaving South Africa with defective and ill-coordinated services and continued prioritisation of institutional care over community-based approaches (IHME, 2017a).

The issues surrounding mental healthcare in South Africa are multifaceted and complex. The Institute for Health Metrics and Evaluation (IHME, 2017a) notes that per capita spending on mental health for outpatient and inpatient care is twelve dollars (equivalent to R186 if controlled for inflation). In addition, while the national allocation to mental healthcare is 4.6%, provincial budgetary expenditure ranges between 2% and 7.7%, with over 86% of provincial spending directed towards inpatient care (IHME, 2017b). The IHME notes that the challenges of mental healthcare in South Africa will further become exacerbated by inefficient resource allocation systems, poor information systems to measure the actual burden of mental health conditions and the inability to reliably estimate the spending towards building more efficient care pathways and systems for mental health in community-based settings across the country (IHME, 2017b).

Due to poor prioritisation, mental health in South Africa is not fully understood. Consequently, data on the prevalence of mental illness in children and young people, advocacy, coping mechanisms, and interventions are scarce. Statistics South Africa (2017) and SADAG (2020)

estimate that approximately 30% of South Africans have suffered a mental health breakdown at a given time. In addition, over 65% of South Africans required mental health intervention during the COVID-19 lockdown (SADAG, 2020). The WHO (2018) estimates that by age 14, most young people will have suffered significant mental health problems, and daily stressors and social gradients, such as social protection and income, often exacerbate these problems. However, there are known preventative and protective factors that have the potential to decrease the onset and personal management of mental health problems. One such factor is social capital, which includes social networks (Obuaku-Igwe, 2020).

Within this context, communities and advocacy organisations utilise relationships and social networks as tools for interpersonal mental health promotion. It is, therefore, essential to identify and examine mental health initiatives that utilise social networks, interpersonal relationships, peers, and assets within communities so that they can be recognised and encouraged. The overarching goal of the proposed study is to examine the effectiveness of a peer mental health support group for young people in Cape Town.

1.6 Thesis Outline

Presented in Chapter One is the introduction to the research study. The chapter draws on the fact that South Africa is a middle-income country with a history that elicits emotional trauma in its population. In addition to exacerbating existing trauma and vulnerabilities, COVID-19 provided additional avenues for mental and emotional stress and exacerbated existing trauma and vulnerabilities. In addition, Chapter 1 also focuses on the contextual background of the research, providing a rationale for the research question and goals.

Chapter Two, the *Literature Review*, highlights the importance of existing research and debates in relation to mental health. The chapter explores existing bodies of work on mental health, and other academic literature on mental health management with the aim of highlighting the gaps within the field. The review focuses primarily on the different ways of dealing with mental health, the history of mental illness, followed by a discussion of the methods of data collection and the results. The goal of understanding mental health is to capture the meaning of the research literature found in relation to mental healthcare, management, and advocacy, and to find the thread that connects it to peer social support. Mental health management through intervention and advocacy is currently being researched. The chapter explores the importance of social capital, support, and networks to understand how an asset-based approach to mental health can be used as a key theoretical foundation for the research debate.

Chapter Three presents the *Theoretical Framework* that underpins the study. It provides a map of the various theories, concepts, and ideas used in the research process. The chapter also explores the relationship between several stressors in the lives of people and the psychological effects they have on them. It further discusses mental wellbeing within the framework of social capital, social networks, and support theories.

Chapter Four, *Research Methodology,* outlines the design and methodology that underpins the study. The chapter also describes methodological approaches to address secondary research objectives. This includes an explanation of the study design, methodology, the sampling frame, and techniques. It also highlights other methodological aspects, such as data collection procedures and techniques, methodological limitations, ethical considerations, study environment, and data analysis.

Chapter Five presents the *Data Analysis and Results*. The purpose of this chapter is to understand and see how the real-life experiences of mental health problems and mental illness of research participants can be understood in relation to social capital and the social support theory. This chapter covers three themes, each of which seeks to incorporate participants' experiences with mental health first aid. This chapter offers a presentation of the research study by discussing the main findings and insights that were obtained in the research study. The chapter examines the effectiveness of youth-focused mental health first aid training programmes in the context of appropriate youth policies implemented by Indima Yethu, an NPO based in the Western Cape province of South Africa. The purpose of this chapter is to interpret the evaluation and feedback questionnaires of the Writer's Clinic participants thematically and analyse them, considering relevant literature and theoretical directions regarding mental illness.

Chapter Six presents the *Discussion and Conclusion* by summarising findings and drawing together the results from the previous chapters and the discussion of the research study in Chapter 4. While emphasising how research has contributed to knowledge of mental health wellness, this chapter also summarises the key findings of research studies. Based on the research results, the chapter discusses possible recommendations for future research projects. It also describes limitations associated with research studies and implications for future research.

1.7 Summary

In conclusion, this chapter explains why mental health is becoming increasingly widely recognised. COVID-19 has further contributed to the existing mental and emotional stress people are experiencing. However, for most people, the existing mental and emotional stress has only been worsened because of pre-existing trauma and vulnerabilities. Osuch and Marais (2017) maintain that nearly one in six South Africans presents with anxiety, depression, or substance use disorders. One in six South Africans raises red flags about the driving forces. This research addresses individuals' difficulties, especially with their communities and daily realities. A scarcity in networks of relationships, better known and understood as social capital, is not readily available within all communities. Consequently, this hampers individuals from being empowered to become successful beings within their societies. As a result, in communities where social capital is non-existent, there needs to be an alternative solution.

The next chapter provides an extensive literature review relevant to the dissertation, identifies the limitations within this field of research, gears towards answering the research questions at hand, and considers the research objectives.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter focuses mental health social support and considers relevant existing research, debates, theories, and methodologies pertaining to mental health among young people, as a way of identifying gaps and providing context for the current research. The purpose of a literature review is to gain an understanding of the existing research and debates relevant to a particular topic or area of study, and to present that knowledge in the form of a written report. The framework for the researcher is provided by the ideas and work of others; it includes identifying methodological assumptions and data collection techniques. The ideas on how to structure the research into a format that is suited to a particular audience is one of the core principles (Hart, 2018).

This chapter reviews literature pertaining to mental health management and in doing so highlights the gaps between mental health management and mental health wellness. The focus of the review firstly considers the history of mental health by considering the medicalisation as well as zoom into the role played by religion. This is followed by a presentation of the various ways in which mental health has evolved over time. It then discusses the data collection methods and findings in relation to mental illness, mental health wellness as well as the impact of mental illness, both globally and locally, including within families and communities. The aim of understanding mental health is to capture the essence of the findings of the relevant research literature in relation to mental health as well as mental health management and overall wellness.

2.2 History of Mental Healthcare and Wellbeing Management

According to Burns (2008) describing persons with medical conditions or personality disorders by using terms such as deviant, incoherent, flawed, imbecile, or idiot is political incorrectness that stands in the way of twenty-first-century democracy in South Africa. However, there was a time when these terms appeared frequently in medical works between the 1880s and the 1950s when they were considered valid descriptions of individuals with mental health issues, also known as ‘problematic people’ (Burns, 2008). In policy designs, Western countries across the world have used these offensive terms to describe and identify individuals within these social groups, among their broader populations, in much of their foundational legislation (Burns, 2008). To manage difficult people, a new class of drugs known as neuroleptics was introduced in the 1950s. These medications allowed patients to be treated within their communities with

less disruption and economic impact. The assumption that community treatment could be achieved globally was fuelled by the application of such drugs, which seemed more inclined to control the most bizarre psychiatric symptoms (Chung, 2018).

2.2.1 History of mental healthcare and wellbeing management in South Africa

In South Africa's early history, functional boundaries were blurred between hospitals, prisons, and detention areas for the destitute. Prisons often acted as infirmaries for patients deemed dangerous to others, and hospitals were often places of detention for the poor and drunk. Some patients were institutionalised because they were homeless but nonetheless, classified as mentally deranged (Egan & Hons, 2015). Moreover, prior to 1916, various local 'insanity' laws were enacted, with little uniformity in the process. In addition, the involvement of physicians in the management of the mentally ill was low, and this lack of individualisation provided further grounds for discriminatory treatment. Egan and Hons (2015) noted that this social categorisation later led to the development of separate institutions for Black and white mental health patients.

During the twentieth century, it was more common to control and eliminate the mentally disabled clinically for the sake of safety, convenience, and economic benefit to a larger population than more stringent options (Chung, 2018). In addition, there was a general perception that the burden placed on the national government could be relieved by reducing the cost of caring for the mentally ill in institutions. For context, a seminal text on institutionalism written by Erving Goffman in the 1960s, transformed the concept of mental illness into mainstream discourse. A critique of clinical mental health practices common in the West was introduced simultaneously in Foucault's *Birth of the Clinic* and *Madness and Civilization*. Furthermore, the philosopher Thomas Szasz introduced a critique of Western mental health clinical practice in which he argued that the process of involuntary confinement in psychiatric hospitals and forced administration of psychiatric drugs constitutes a denial of the right to liberty and autonomy, the most basic human right (Szarz, 2009).

Globally, the ideals of preventative treatment and community-based care were developed during the 1960s when human rights became a popular cause and a public cry due to the works of these theorists (Szarz, 2009). As a result, welfare states emerged in the West in the mid-1960s, paving the way for government intervention regarding social concerns and rights. Most of the resolutions that emerged from these legislative reforms aimed at helping the disabled, the mentally ill, and other mentally disabled individuals. It was through such movements that

psychiatry became more prominent in the public eye. Throughout the world, politics and social history have played an important role in the development of psychiatry. Szasz (2009) also noted that social and political power were derived from the coercive nature of psychiatry, which manifested in its ability to impose its will on members of the community. However, others opined that psychiatry is not subversive or politically motivated, nor does it intend to harm. While mentally ill individuals were and are still stigmatised and generally perceived to be dangerous in most societies, it is the responsibility of the healthcare system to provide treatment for the mentally disabled, the intellectually disabled, and the pathologically dangerous and difficult (Szasz, 2009). According to Ross (2006) the negligence of these individuals by the health system has exacerbated fear among the public about these people and the effects that they may have on their immediate communities. Clinical control and elimination of the mentally ill for reasons of safety, convenience, and economic benefit to a larger population compare favourably with other, more stringent options. Politically and socio-historically, psychiatry has had a difficult road, both in South Africa and abroad. Social and political power are derived from the coercive rights exercised by psychiatry over members of the community and society at large. The medical speciality of psychiatry is not inherently subversive or politically motivated, and it does not aim at harming patients. However, it is the communities' responsibility to treat the mentally ill, the intellectually disabled, and the pathologically dangerous and difficult with care. They are generally feared by the public due to their effects on the immediate community. When compared to other, harsher measures, this method of clinical control and removal is the most attractive (Ross, 2006).

The mid-twentieth century solution for mental illness was institutionalisation, often for life. Other more radical ideas that were widespread and acceptable included the permanent exclusion and extermination of these people from society. The idea of clinically treating individuals who deviate from the norm and relieving their pain and suffering seemed attractive to biomedicine (Egan & Hons, 2015). Harsh as it was perceived, it was a serious consideration for most national governments largely, in the interest of functioning and a voting public. Ventures into social manipulation led psychiatry to human rights violations, euthanasia, sterilisation, and political persuasion and control; such people were in constant need of resources, containment, and in some cases, governmental intervention to prevent harm to themselves or the wider community. In addition, there were involuntary treatment procedures and laws that facilitated forced exclusion from society (Egan & Hons, 2015).

Ross (2006) noted that psychiatry assumed the role of a state agency to ensure that appropriate treatment was provided but in a coercive environment. Psychiatry, perhaps more than any other medical practice, had an inherent dual loyalty: in general, psychiatrists have a duty to their patients and a duty to protect society. Psychiatrists must protect both the interests of their patients and those of society within the limits of the law. Unlike moral code, the scale of the law varies with time and place. This allowed one to identify the non-altruistic aspects of psychiatry (Ross, 2006).

Herman et al. (2009) mention that in the past, many countries weaponised and abused mental health practices, using it as a political tool to control opposition. These practices were both punitive and beneficial. They were also used to maintain institutional hierarchies and power structures. These power structures have sustained the political status quo and maintained the means of protecting established institutions and power structures. Within the context of South Africa, for example, the apartheid government weaponised mental illness as a political tool by using the code phrase 'in the best interests of society' as a cover for the incarceration of political dissidents. Herman et al. (2009) explained that human rights violations and other forms of structural discrimination inflicted on people of colour in South Africa were perpetrated under the guise of mental healthcare management and interventions. Disciplines such as the social sciences equally played an important role in developing the discriminatory principles that formed the basis of apartheid. Herman et al. (2009) further explained that the roles and functions of professionals entrusted with assessing the mental health and mental illness of others also played a role in human rights violations.

The abuse and weaponisation of psychiatry as a political tool have historical links to social and political structures in the Global North, in countries such as Russia, France, Brazil, the United States, Germany, China, and Japan (Ross, 2006). By the end of apartheid in 1994, approximately 15,000 people were institutionalised in mental health hospitals across South Africa (Ure, 2009). Many of these people had been separated from their families and communities for over 47 years. These people were institutionalised and had their social and other skills irreparably impaired so that they could not be released into the community. Many were misdiagnosed or undiagnosed, according to Ure (2009). Given the international trend of weaponising mental health as a policy tool and the historical trajectories of South Africa, this practice was ridden with gross human rights abuse. It is thus useful to consider South Africa's

mental health policy and current practices in their socio-political and historical context, highlighting relevant legislation (Ure, 2009).

2.2.2 Mental health: The medicalisation of deviance in apartheid South Africa

Medicalisation occurred when previously non-medical problems are labelled and treated as medical problems, typically in terms of an illness or disorder. How particular types of deviant behaviour came to be recognised and treated as medical and psychiatric issues will be better understood by establishing the historical context. Studies have shown that the most common ailments among Cape Town settlers from the early 1600s to the mid-1700s were hypervitaminosis, alcoholism, fatigue, and venereal illness. (Conrad & Slodden, 2012).

Conrad and Slodden (2012) mention that for many of these ailments, mental illness followed. Minde (1974) noted that the population was too small to justify special facilities for 'maniacs', as they were labelled at the time and that due to the conditions in the colony, many slaves, and the constant arrival of psychotic sailors arriving in port, they reluctantly tolerated being labelled 'crazy' (1974, p. 2232). The mentally ill were placed in slave huts at the Robben Island prison camps, or in regular general hospitals. However, people were generally insensitive to the suffering of psychotic patients and often became physically hostile (Minde, 1974).

The large numbers of slaves and Black African inhabitants in the colony far outnumbered whites. Arguably, increased aggression and hostility towards these two groups were common to stay in power, with the excuse that both groups were considered animalistic, in line with the ideology of the time. There was no legal retaliation for this type of behaviour. Differences in behaviour and lifestyles that are now considered socially acceptable were often deemed unacceptable for religious reasons (Minde, 1974). During the apartheid regime, biomedicine served dual purposes – an extension of both the ideological and political endeavours of the time, which were the culmination of class ideas and practices in colonial politics. Through socio-political exchanges with Europe, European medical advances had far-reaching social impacts on South Africa. For example, the use of Western medicine in colonies has been criticised as harmful to the colonised people. According to Egan and Hons (2015), this was due to the unequal treatment of slaves and people of colour in comparison to those who got white support and access to healthcare. On the other hand, some advances of Western medicine in technology benefitted both the early white settlers and, to a lesser extent, the slaves, and the Black African masses.

Colonial medicine was perceived as laden with both negative and positive values. It was also considered harmful to tribal people because it paved the way for culturally diverse and often unsatisfactory and unacceptable therapeutic approaches. On the one hand, it was deemed ethically necessary, even on racist grounds, to provide the colonised population with the help and care they needed. Local practices in mental healthcare paralleled those practiced elsewhere in the Western world, in favour of colonial ideologies. Because drunkenness and homosexuality were never considered heinous crimes in the colonies, even accusations of sodomy often resulted in death, as explained by Minde (1974). According to Conrad and Slodden (2012) the likelihood that psychiatric disorders would be prevalent in South Africa is supported by several factors dating back to its historical trajectories. Yet, there is rarity of information about the incidence of psychiatric disorders in South Africa; this information has been missing from the national archives. Nonetheless, there seems to be high rates of gender inequality and criminal violence which are presumably linked to mental healthcare organisation and management of the apartheid government. These complex intergenerational stressors are linked to the historical trajectories of South Africa and its political economy; and seemingly linked to current structural discriminations that shape and drive mental illness among previously marginalised groups (Conrad and Slodden, 2012).

Structural and systemic stressors that perpetuate inequities to access to resources such as racial discrimination and political violence have been persistent in the past and persist to date, serving as causal pathways to multiple mental health disorders. In other low-income countries, where poverty is still a major issue, it is likely to increase the risk of developing common psychiatric disorders. However, characteristics of South African society may indicate a more nuanced picture. Due to the socio-economic history of the nation, each ethnic group has a unique socio-economic profile, with the white minority (who make up less than 12% of the population) being more advantaged than the Black population (Conrad & Slodden, 2012). While studies have shown that socio-economic privilege may offer protection from stressors and a lower prevalence of mental disorders, the majority of Black Africans, who make up 80% of the total population, may never enjoy such benefits and social protection due to systemic discrimination embedded in the very fabric of the country (Conrad & Slodden, 2012).

During the apartheid regime, Black Africans and white patients were always treated differently in psychiatry as a speciality, with theoretical scientific support for this only coming in the very late 1800s (Koren, 1912; Ure, 2009). One of the theories that emerged, for instance, reported that because Black patients have lower intellectual development capacities than white patients,

they do better with physical therapy than psychological therapies (Albino, 1954; Ure, 2009). Many of these theories originated from places where medical professionals frequently treated Black patients, and where these discriminatory actions were frequently and repeatedly reinforced by the surrounding circumstances, the conditions of the facilities, and socio-economic and political factors (Egan & Hons, 2015).

In South Africa's early history, the distinctions between hospitals, prisons, and holding facilities for the homeless poor were often blurred. Prisons frequently served as hospitals for patients deemed to be a danger to others, and hospitals frequently housed the poor and alcoholics (Egan & Hons, 2015). Some patients were placed in institutions because of their homelessness while others who were considered a threat to their 'privileged' neighbours were reported to the authorities and institutionalised based on such third-party diagnosis. Prior to 1916, numerous and various provincial 'lunacy' laws were also passed, with little consistency in the procedure. Additionally, biomedical physicians took a less hands-on approach, and this lack of individualisation gave rise to additional justifications for discriminatory treatment. Later, because of this social grouping, separate facilities for mentally ill Black and white patients were created (Egan & Hons, 2015).

2.2.3 Race, religion, and mental healthcare in South Africa

South Africa's religious institutions also played a role in shaping social norms as well as the construction and subsequent labelling of the mentally ill. There seemed to be a clear-cut division of labour and overlap between the roles of religious institutions and the apartheid government when it came to mental health management. For example, from the 1920s, the Dutch Reformed Church in South Africa began to play an increasingly political role in developing racist negative perceptions of the mentally ill. Such perceptions were grounded in religious ideology and included overt political moves to improve the lives of poor white South Africans over Black Africans, which resulted in many Black Africans leaving to escape the depressed economic situation in search of survival (Lelyveld, 1985; Ure, 2009). In their analysis Egan and Hons (2015) noted that in the early days of apartheid in South Africa, the issue of mental illness or 'madness' as it was often regarded, has always been a contextually complex part of social life. Interpretations and social constructions of mental illness have spanned centuries from crime, evil, and rejection of social distinctions to madness. Within certain ethnicities in the South African society, 'madness' has been revered and sought after as an indicator of one's ability to predict the future or convey important messages from the gods.

It should come as no surprise that before the rise of religious ideology, the mentally ill and those who deviated from the social norms of the time were referred to churches for treatment, especially if they were Black, homeless, or poor (Egan & Hons, 2015).

For example, when the person's actions and the consequences of their actions were not contained by charity, prayer, and love, they were referred to laws and correctional institutions to protect society. Randomly violent behaviour provided the basis for the belief that demons resided in individuals exhibiting insanity. Demons representing evil fell largely into the realm of religious issues. Throughout South Africa's history, ideas such as demonic possession and racial superiority at the hands of powerful social institutions have helped shape treatment of the mentally ill and mental health legislation. Psychiatry, unlike other fields of physical medicine in which imperfections and illnesses are most often visualised, has always included aspects of moral judgements of good and evil, along with socio-cultural perceptions of the symptoms of mental illness. These and their changes depended on interrelationships and changes in the socio-political and institutional structures of the time. Good and evil as basic building blocks – the same value judgements used in psychiatry and science – have always been the guiding influence of various religious orders.

2.3 Mental Wellbeing and Sociology: Perspectives

2.3.1 Mental health – Overview

The origins of mental health are traced back to developments in public health, clinical psychiatry, and other branches of knowledge. Technical references to mental health as a field or discipline were not found before 1946, even though references to mental health as a 'state of being' could be found in the English language. The International Health Conference held in New York decided to establish the World Health Organization in 1948, while the Mental Health Association was founded in London in 1949. There were references to the concept of mental hygiene in English literature in the nineteenth century, and an examination of the intellect and passions designed to illustrate their influence on health and duration of life (Bertolote, 2008).

The first objective of public health in a draft law submitted to the Berlin Society of Physicians and Surgeons in 1849 was the healthy mental and physical development of the citizen (Bertolote, 2008). The first International Congress on Mental Health took place in London in 1948, a year after the creation of the WHO. Mental health and mental hygiene were defined at the second session of the WHO's Expert Committee on Mental Health as follows: 'Mental hygiene involves all the activities and techniques that promote and maintain mental health.

Mental health can be affected by biological and social factors; it allows the individual to achieve satisfactory synthesis of his own potentially conflicting, natural drives; to form and maintain harmonious relations with others, as well as to participate in constructive changes in his social and physical environment' (WHO, 1951, p. 4).

Mental health is related to emotional, psychological, and social wellbeing. As individuals experience daily living and cope with life, their emotional, psychological, and social wellbeing ultimately affects how they think, feel, and act. For this purpose, mental health first aid is important and necessary, as outlined by the pioneer WHO policy framing. For example, consider a person who has lost a loved one and is dealing with the financial consequences, recognising the source of their emotional and psychological distress. Being fully aware of the implications and managing to make a choice, deal with stress, and relate to people when under pressure is part of mental health management, which is the sole goal of mental health first aid. Studies have shown that mental wellbeing and emotional balance are important in every stage of life, from childhood to adulthood. When an individual experiences mental health problems, their thinking, mood, and behaviour could change over time. While biological factors embedded in an individual's genes and ancestry could contribute to mental health problems, sociological and psycho-social factors are known to influence mental wellbeing.

Sociological factors that shape and drive mental health ranged from life experiences, that include trauma or abuse and include history of mental health problems in the family. The WHO (2007) noted that mental wellbeing tends to be negatively affected when demands are placed on an individual that exceed their resources, capacity, or coping skills. Additionally, a person's mental wellbeing could have been shaped or influenced by exposure to economic hardships, poverty, underemployment, and unemployment (WHO, 2007). As such, a consistent regimen of mental hygiene is required.

Tengland (2001) divided mental health into categories: self-realisation, sense of mastery over the environment, and ability to identify, confront, and solve problems. Tengland (2001) established the notion of positive mental health, arguing that it can be understood as an enduring personality trait or as a less permanent function of personality and social environment. The concept of mental health emphasises specific aspects of a person's personality. Self-acceptance, self-confidence, and self-reliance are all phrases used to indicate a mentally healthy attitude towards oneself, each with slightly different connotations (Tengland, 2001). Self-

acceptance suggests that a person has learnt to live with themself, accepting both their limitations and their capabilities. Self-esteem, self-confidence, and self-respect have a more positive slant; they communicate the judgement that the self is 'good', capable, and strong in balance. The term 'self-reliance' implies self-assurance as well as independence from others and internal initiative. Environmental mastery as a criterion for mental health is more important than the individual's reality orientation and efforts at environmental mastery. There are six aspects of human functioning that were distinguished: (a) the ability to love; (b) adequacy in love, work, and play; (c) adequacy in interpersonal relationships; (d) efficiency in meeting situational requirements; (e) capacity for adaptation and adjustment; and (f) efficiency in problem solving (Tengland, 2001).

The culture that defines current approaches to mental health, mental healthcare organisation and management strategy is influenced by this definition of mental wellbeing. Tengland (2001) further argued that individuals with good mental health are not always happy but also become unwell and tend to experience feelings of sadness, anger, or unhappiness and this is part of a fully lived life for a human being. Other authors Waterman, Schwartz, and Conti (2008) also emphasise that a balanced mental wellbeing is marked by feelings of happiness and a sense of mastery over the environment. For this reason, positive functioning and emotions are included in the WHO definition of mental health, in line with Tengland (2001) arguments for categorisation of core components and scope of mental wellbeing.

Keyes (2006) also identified three components of mental wellbeing: emotional, psychological, and social wellbeing. Emotional wellbeing includes happiness, interest in life, and satisfaction, while psychological wellbeing includes liking most parts of one's own personality, being good at managing the responsibilities of daily life, having good relationships with others, and being satisfied with one's own life. Since differences in values, cultures and social background may hinder the achievement of a consensus on the concept of mental health, Galderisi et al. (2015) propose an inclusive definition, avoiding restrictive and culture-bound statements. In their definition, Galderisi et al. (2015) indicated that mental health is a dynamic state of eternal equilibrium that allows individuals to use their abilities in harmony with society's universal values. They noted that basic cognitive and social skills, as well as empathising with others, flexibility, and ability to cope with adverse life events, and a harmonious relationship between the body and mind are significant components of mental wellbeing.

The implication of these definitions is that mental illnesses and mental health interventions and treatments are equally viewed and approached within these ranges, with emphasis on sociological factors that shape or drive each aspect of an individual's emotional or social wellbeing. Sociological approaches place a unique emphasis on how processes like life events, social circumstances, social roles, social structures, and cultural systems of meaning affect mental states (Horwitz, 2010). Social perspectives presuppose that people in similar situations will all have comparable levels of mental illness. In this regard, Holmes and Rahe (1967) noted that how people feel depends not only on their own personalities or brains, but also on the kinds of social circumstances they encounter. These conditions vary a great deal in time and space, and within and across various social classes, races, ethnicities, gender, societies, and historical periods. How frequently people experience stressful life events is one important social factor. Dohrenwend (2000) adds that these occurrences include things like getting divorced, losing a valuable job, getting into a serious car accident, learning you have a serious physical illness, or losing a close relative.

According to Turner (2013) particularly potent causes of poor mental health outcomes included extremely serious stressors like being the victim of a violent crime, a natural disaster, or physical or sexual abuse as a child. Any person's mental health was likely to be in worse shape the more frequently and seriously such events occur. Other social factors that contribute to poor mental health include enduring living conditions, which are ones that do not just appear at one point in time and disappear later. People are more likely to experience psychological distress if they live in social settings with high rates of poverty, neighbourhood instability, crime, dilapidated housing, and broken families, for instance. Other long-lasting stressful situations include strained marriages, oppressive workplace environments, or unreasonable parents. Over and above the characteristics of the specific individuals who must deal with these situations, sociological perspectives predict that particularly burdensome living conditions, duties, and relationships are associated with low levels of psychological wellbeing (Turner, 2013).

2.3.2 Mental healthcare and social epidemiology in South Africa

According to studies, South Africa's mental health is in poor shape. In addition, it is shaped by societal characteristics that affect other patterns of disease and health distribution. For example, reports from SADAG (2020) indicated that one in every six South Africans suffered from anxiety, depression, or drug abuse issues. Furthermore, approximately 40% of HIV-positive patients in South Africa had a diagnosable mental condition (SADAG, 2020). According to a

study conducted by the University of Cape Town's (UCT's) Department of Psychiatry and Mental Health, one in every three women in low-income and informal settlements surrounding Cape Town suffered from postnatal depression, while research from rural KwaZulu-Natal showed that 41% of pregnant women are depressed, which is more than three times the prevalence in developed countries (SADAG, 2020).

Only 27% of South Africans with severe mental illness are ever treated. This means that approximately three-quarters of these people are not obtaining any sort of mental healthcare at all (SACAP, 2019). Mental health is a significant aspect of wellbeing, and it comprises an individual's emotional, psychological, and social wellbeing. However, mental health illnesses remain unreported and undiagnosed, particularly in low- and middle-income nations such as South Africa. Depression, anxiety disorders, drug addiction disorders, and mood disorders are the most common mental illnesses in South Africa and individuals suffering from these common mental illnesses frequently encounter neglect in the healthcare system, as well as stigma and discrimination, which results in poor health outcomes, isolation, and high suicide rates (SACAP, 2019).

The South African government developed the National Mental Health Policy Framework and Strategic Plan in 2013 to integrate mental health into its health system and reduce the treatment gap and burden (Matlala et al., 2018). Part of the approach to implement this strategy was that during the month of October, the government sets out to educate and raise awareness regarding mental health. However, mental health advocacy and promotion should be continuous and sustainable, throughout the year. According to the Mbalo Brief (Statistics South Africa, 2017) worldwide nearly 400 million people either suffer from psycho-social problems or neurological or mental disorders and these require continuous and sustainable interventions. Although South Africa is a middle-income country, there are inequalities in wealth and access to healthcare resources. Within the health sector, there are differences between private and public health provisions. Private healthcare, funded through private health insurance and out-of-pocket payments, serves 16% of the population, compared with 84% of public healthcare (Statistics South Africa, 2017).

Individuals, irrespective of their age, gender, socio-economic status, or vocation life will experience emotional and psychological stress and would require good coping mechanisms. For individuals who have experienced higher stressors during their early childhood, the need for access to mental healthcare resources becomes more significant (Kumar & Preetha, 2012).

For example, young individuals in low-income households are more vulnerable to stressors, attributable mostly to poverty and a lack of social capital, whereas young people in high-income households may face the stress of keeping up with others in their socio-economic class. This is where mental health education and promotion are required. The role of health education and health promotion in mental health are two phrases that are used interchangeably in some circumstances. Health education is tied together with offering wellbeing data and information to people and networks and giving skills to empower people to receive good practices consciously (Kumar & Preetha, 2012).

Health education is a combination of learning encounters intended to help people and networks improve their wellbeing, by expanding their insight or impacting their perspectives, while health promotion adopts a more far-reaching strategy and focused on advancing health by including different players as well as utilising multi-sectoral approaches. Health advancement had a much broader perspective, and it was designed to respond to changes that have had an immediate or abnormal impact on health, such as disparities, changes in usage examples, conditions, and social convictions (Kumar & Preetha, 2012). Petersen et al.'s (2016) study's goal was to create a South African district mental healthcare plan (MHCP) that integrates mental healthcare for depression, alcohol use disorders, and schizophrenia into chronic care. The MHCP was developed using a mixed-method approach that included a situation analysis, contextual key informant interviews, theory of change workshops, and piloting of the plan in one health facility.

A recent study (Obuaku-Igwe, 2022) indicated that young people in South Africa are experiencing heightened stressors due to post-pandemic disorder and the political economy of the country. Obuaku-Igwe (2020) noted that these daily stressors drive negative stimuli, which influence mental health outcomes. Due to inequities in access to healthcare resources in the country, most of these young people who are at risk of mental breakdowns are unable to access the care they need. The implication is that most of them seek out friends to empathise with them or resort to other coping mechanisms such as smoking, drinking, etc. (Obuaku-Igwe, 2020).

When access to resources is limited, individuals tend to rely on one another for support, guidance, and love, specifically, in rural areas or other marginalised communities. The implication here is that interpersonal peer social support and narrative therapy could provide young people with the opportunity to overcome their current elevated levels of daily stressors

and by doing so are then able to provide young people with a much more positive outcome. As the pandemic era closes, it becomes imperative to look ahead and beyond, and consider that social networks have been integral and will continue to play a role in health promotion, especially when it comes to de-stigmatisation, which is socially constructed during social interaction. Several studies had examined the effect of stigma on access to mental healthcare and how it was mitigated through social capital and interpersonal health promotion (Obuaku-Igwe, 2020).

One out of eight people around the world, or 970 million people, suffered from mental disorders in 2019 (IHME, 2017a). The most common disorders were anxiety and depressive disorders, which increased significantly. The number of people suffering from anxiety and major depressive disorders has increased by 26% and 28%, respectively, in just one year (IHME, 2017a). Despite the availability of effective prevention and treatment options, most people with mental disorders do not have access to such care. There are also many people who are stigmatised, discriminated against, and have their human rights violated (IHME, 2017a).

Gyamfi et al. (2017) explored stigma, discriminatory beliefs, and self-stigma among people with mental diseases in a qualitative study. Stigma and prejudice frequently have an impact on the mental health and wellbeing of persons suffering from mental diseases, sustaining poor self-perceptions. Even if support systems and public views are important causes of stigma, the beliefs, and opinions of people with mental illnesses influence their reactions to the circumstances they encounter. In the study, a semi-structured interview guide was used to perform a narrative, descriptive approach. This was done to elicit participant perceptions of stigma, bias, and personal characteristics that may have influenced their experiences (Gyamfi et al., 2017). Twelve Ghanaian clinic outpatients were questioned. Field notes were used to enhance the thematic content analysis. Other participants' viewpoints, on the other hand, served as a buffer in the face of stigma and discrimination in the environment. Stigma is a complicated, socially sanctioned phenomenon that can have serious effects for people suffering from mental diseases. As a result, addressing stigma on a societal level, as well as its potential impacts on overall health outcomes for people with mental illnesses, required coordinated efforts among public decision makers, legislative authorities, and healthcare providers (Gyamfi et al., 2017).

Thornicroft (2008) explained that the effect of stigma and discrimination against people who either suffer or have been diagnosed with a mental illness have serious consequences. He argues that stigmatisation presents challenging 'barriers both to social inclusion and to proper

access to mental healthcare' (2008, p.17). In addition, factors that increased the likelihood of treatment avoidance or long delays before seeking treatment include: (a) a lack of knowledge about the characteristics and treatability of mental illnesses; (b) ignorance about how to obtain assessment and treatment; (c) prejudice against people with mental health illnesses; and (d) expectations of discrimination against people with a mental illness diagnosis (Thornicroft, 2008). Socio-political transformation can be achieved if inequalities in mental healthcare are addressed, especially in countries with a history of educational exclusion.

As part of the WHO World Mental Health International College Student Initiative, Bantjes et al. (2020) investigated inequalities in mental healthcare utilisation among first-year students at two historically white universities in South Africa. Data was collected via a web-based survey from first-year university students to assess 12-month mental healthcare utilisation, common mental disorders, and suicidality. The research results revealed that 18% of students used mental healthcare in the past year, with only 28.9% of students with mental disorders receiving treatment (Bantjes et al., 2020). Of those who received treatment, 52% used psychotropic medication, 47.3% received psychotherapy, and 5.4% consulted a traditional healer; 25.4%, 41.6% and 52.9% were the treatment rates for suicidal ideation, plan, and attempt, respectively (Bantjes et al., 2020). The research results also indicated that first-year university students in South Africa had low mental healthcare treatment utilisation and that campus-based interventions were needed to promote mental healthcare use (Bantjes et al., 2020).

2.3.3 Mental health determinants: Socio-economic status and other factors

Mental health, illness and diseases are determined by multiple, complex, and interacting social, psychological, and biological factors. Studies have shown that socio-economic status, place, income, and poor housing are associated with a higher risk of mental illnesses in both developed and developing countries. Among these factors that explain the vulnerability of disadvantaged people to mental illness are the experience of hopelessness, rapid social change, and the risks of violence and physical ill-health. In their review of determinants of health, Allen et al. (2014) discussed the relationship between mental health and low socio-economic status and then proceeded to look at the life course perspective of mental health outcomes and environmental contributors. They discussed examples of interventions from around the world that work in conjunction with each other to promote and support mental health for people and where implications appear, the necessary action was provided. Many common mental diseases include risk factors that are strongly linked to social disparities, with the bigger the gap, the

higher the risk. The poor and disadvantaged bear a disproportionate share of the burden, but individuals in the middle of the social spectrum are also impacted (Allen et al., 2014).

Knollmann, Reissner, and Hebebrand (2019b) examined the relationship between mental health and poverty and socio-economic status, particularly the problems associated with school attendance and mental health. Although mental illness symptoms may be camouflaged by physical ailments, they often indicated a wide range of problems that are educational, social, family, legal, medical, and even psychiatric in nature. Their study examined all aspects of the disease, such as its prevalence, characteristics, causal factors, outcome, and management (Knollmann et al., 2019b).

In another study, Anakwenze and Zuberi (2013) reviewed the literature in relation to the recurring association between mental health and urban poverty. The social order theory was a viewpoint developed from Karl Marx's ideas, which saw society as split into groups competing for social and economic resources. Domination maintains social order by concentrating power in the hands of those with the most political, economic, and social resources. Theories are used to investigate the factors that link social order, crime, and mental health issues in urban settings. There is discussion of joblessness and underemployment, as well as neighbourhood instability, crime and insecurity, urban violence and victimisation, self-efficacy, trauma reactions, and lowering access barriers. The authors proposed a proactive approach to mental healthcare that includes young people and urban areas to break poverty cycles and improve outcomes for low-income individuals. To promote mental health, the WHO (2007) maintained that socio-economic and environmental factors influence mental health.

2.3.4 Determinants of access to mental healthcare and health-seeking behaviour

Eisenberg et al. (2007) conducted a web-based survey with a random sample of 2,785 university students attending a large, Midwestern, public university to determine how they access mental healthcare. The authors found that students who had positive screens for either anxiety or depression had not accessed nor attempted to access any available services due to poor access to information, the lack of knowledge of services, and non-existent insurance coverage. In addition, race/ethnicity, and low socio-economic status as well as cynicism about the effectiveness of the treatment all contributed to students' inability to access mental health services (Esenberg et al., 2007). The findings of this research study demonstrate that students who had seemingly suffered from a mental disorder had not received the much-needed treatment and that to improve access to mental healthcare for students there needs to be greater

efforts made to implement a variety of initiatives, which will produce and ensure better benefits in relation to mental health and associated outcomes.

A study conducted by Cook (2007) at Bloomsburg University of Pennsylvania's Department of Nursing noted the prevalence and severity of mental health issues among university students. The author stated that the number of counsellors at most universities is limited. In addition, students are less likely to seek counselling services due to a lack of awareness, which is often worsened by stigma and the fact that some students tend to be in denial of mental health symptoms. Cook alluded that untreated mental health problems account for high failure, drop-out and suicide rates. The author argued that nursing mental health facilities could be useful in mental health education within the context of providing courses on mental health issues and skills to advocate and educate (Cook, 2007).

Researchers had hypothesised that interpersonal peer-led interventions could contribute to managing stigma, which has the potential to improve health-seeking behaviour among individuals. Others have also argued that focusing on biomedical interventions and medicalisation of persons with mental health symptoms could be tantamount to overlooking nuances of health communication and other cultural factors that affect mental health wellbeing.

2.4 Mental Healthcare: Factors Affecting Access

2.4.1 Disproportionate distribution of human resources for mental health in Africa and South Africa

Barrow (2016) observed that access to mental healthcare remained a major problem globally but was more evident in developing countries, including the Gambia, the focus of their study. In general, although recognised as a major contributor to the global burden of disease, mental illness receives little attention at the global, regional, and local levels compared to other diseases, such as communicable diseases. Barrow asserts that access to mental healthcare in the Gambia deserved urgent attention. While no recent study has been conducted to examine the prevalence rate and treatment gap, the available data show that 90% of mentally ill patients who require treatment do not receive it (Barrow, 2016). The aim of their study, according to Barrow (2016) contributed to improving access to mental health services by exploring factors affecting access to mental health services in the Gambia using a qualitative research design. Their research team conducted in-depth interviews with 15 mentally ill patients using the community mental health services and five focus group discussions with members of the

general population in the same health region. The results of their study highlighted multidimensional and layered factors that shape access to mental health services for people with mental illness in the Gambia. Among the most important factors Barrow listed were perceptions of and suspected causes of mental illness, the lack of biomedical services for most of the population, resulting in patients and their families taking advantage of what is available and reaching services over long distances (Barrow, 2016). In addition, the lack of satisfaction with these services also led to the use of different treatment systems, combined with high treatment costs and neuroleptics. The results further show that the patient's family had the responsibility to provide the necessary financial resources for treatment and medication, but also decided where the treatment came from. The author concluded that efforts to improve access to mental health services should be approached holistically as they are influenced by social, family and health system factors. This study provided a basis for action to improve access to mental health services. Collaboration with traditional healers, the provision of mental health services through the community mental health team, and a long-term anti-poverty plan improved access to mental health services in the Gambia (Barrow, 2016).

Rural areas in South Africa frequently lack psychiatrists or psychologists, relying instead on general practitioners, occupational therapists, and nurses for mental health interventions. Work by Versteeg and Couper (2011) mention that if a person requires the services of a psychologist or psychiatrist, they are frequently referred to the nearest city, which sometimes was difficult to reach. The implication, according to Versteeg and Couper (2011), was that South Africa's internally acclaimed state-of-the-art, rights-based Mental Healthcare Act is a good illustration of a health policy that aimed to improve access to mental healthcare at the local level but was challenging to implement due to it being unfamiliar.

Lund et al. (2010) stated that in rural South Africa, mental healthcare services are scarce. The South African Rural Mental Health Campaign Report, published in 2015, noted that the situation was 'dehumanising'. Rural areas, which account for nearly half of the country's population, are still the most underserved and marginalised, according to the report. In South Africa, there was a disparity in the distribution of mental health human resources between urban and rural areas. The data revealed that the density of psychiatrists in or near the largest city is 3.6 times greater than the concentration of psychiatrists throughout the country. De Kock and Pillay (2016) similarly noted that there is a major concern about the scarcity of these nurses in the country's rural areas. In their situational analysis they revealed that the lack of medical

officers in rural areas who prescribed medication had resulted in the task being delegated to mental health nurses. However, only 38.7% of the 160 facilities employed mental health nurses, for a total of 116 (De Kock and Pillay, 2016). These nurses served over 17 million people, implying that mental health nurses are employed at a rate of 0.68 per 100,000 people in rural South Africa (De Kock and Pillay, 2016). This is against the backdrop of a general shortage of mental health human resources, with South Africa having fewer workers than any other low- and middle-income countries (LMICs). These human resource challenges are most noticeable in rural areas.

2.4.2 Mental health advocacy: The role of communities and NPOs

Maura and De Mamani (2017) conducted research concerning community mental health teams that have been generally suggested for the management of severe mental illness. The researchers evaluated the benefits of mental health team management in instances of severe mental illness via a systematic review of community mental health team management associated with other standard approaches. The research results indicated that with community team management involvement, prolonged admission at inpatient psychiatric treatment facilities is much shorter, hospital admission has lessened, and most suicides could be avoided. The model of care, notably the enthusiasm for community care, as mentioned by Maura and De Mamani (2017) has been effective and warrants further support. The community mental health team management results also mention the effectiveness of CMHT accompanied by standard care (Maura & De Mamani, 2017).

Kleintjes et al. (2010) are researchers at the University of Cape Town and the University of KwaZulu-Natal within the School of Psychology and the Department of Psychiatry and Mental Health respectively. Their study involved the completion of 96 semi-structured interviews conducted with various stakeholders on national, provincial, and district levels between August 2006 and August 2009. Results indicate that a need for inclusion of mental healthcare user viewpoints would largely impact policy processes as well as lead to better policy development and implementation. The findings further specify that consultation pertaining to policy development and implementation has largely been restricted for approximately 16 years since the advent of democracy in South Africa (Kleintjes et al., 2010). The findings demonstrate that should the necessary strategies be in place for user participation, it would directly reduce the current stigma and instead advocate for the acceptance of the rights of all mental healthcare users, which would ensure that providers are better equipped and that policymakers strive to

support inclusion (Kleintjes et al., 2010). Brown and Calnan's (2012) case study focuses on local mental health services and explores aspects of trust and need. The study finds that trust plays a meaningful role at the beginning as well as during constant encounters with service users and ensures that communication and co-operation with professionals are made possible. The authors note that trust within a mental healthcare framework is often hindered by cultural pressures imposed on professionals as well as previous experiences during inpatient care (Brown & Calnan, 2012). This is because of the shift in public policy wherein risk largely has been the focus and the interests and needs of service users have been outperformed. The authors, researchers from the Universities of Kent and Amsterdam, collected qualitative data in Southern England in 2010. They used an observed research method to conduct semi-structured interviews with service users, experts, and managers across three community-based services that had all been designed to ensure that the needs of those individuals experiencing psychosis are attended to. The authors provide an exposition of what the exact process of trust is and how the role of trust expedites meeting needs and managing risk. The results of the research suggest that existing concentrations of risk are at times ineffective.

The research by Maura and De Mamani (2017) showed that it was imperative to shift the focus from not only providing standard care to individuals but to consider more than one predetermined avenue when it involves mental health promotion. Kleintjes et al. (2010) suggested that implementation of proper strategies to ensure mental healthcare was further strengthened through early access to treatment and support. The importance of a trust relationship is crucial when considering working with people within their lived realities and communities (Brown & Calnan, 2012).

2.5 Mental Health Policy Imperatives and Interventions

Niemi et al. (2010), researchers at International Mental Health Policy and Services Project used the Mental Health Country Profile tool to inform policymakers, stakeholders and other professionals regarding important issues that need to be taken into consideration in the mental health policy development. The Mental Health Country Profile encompasses four domains: (a) inclusive of the mental health framework (b) resources; (c) provision; and (d) outcomes. The intentional purposes of the four domains were to generate a mental health country profile for Vietnam, to draw attention to the strength and limitations of the Vietnamese mental health situation, and to advise future restructuring efforts and decision-making. The study used a snowball sampling research method that was done to identify informants for generating a

mental health country profile for Vietnam. It also used semi-structured interviews and collected relevant reports and documents to gather the relevant data (Niemi et al., 2010).

Petersen et al. (2016), researchers at the University of KwaZulu-Natal, University of Cape Town, King's College London, and the London School of Hygiene and Tropical medicine London, conducted research on mental health promotion, using data collected via secondary sources at national and district levels. They applied a mixed-method approach, using situation analysis and held qualitative formative interviews. Additionally, they held workshops to work towards producing theory of change and, in doing so, piloting a plan that would inform the development of a mental healthcare plan. The results included the design of collaborative care packages for three conditions: depression, alcohol use disorders, and schizophrenia. This was supported by human resource mix and implementation tools, at community levels. They noted the practicality of large-scale deployment as a potential impediment (Petersen et al., 2016).

The studies of both Niemi et al. (2010) and Petersen et al. (2016) focus on mental health promotion. Limitations to healthcare exist; however, Niemi et al. (2010) push for policy improvement to successfully promote mental health wellness. Likewise, Petersen et al. (2016) suggest that improving service delivery platforms would mean mental health interventions occurring on various levels, and a combination of resources could mean that stigma will be lessened.

2.6 Impact of Mental Illness on Young People and Livelihoods

In addition to genetics and family history, childhood experiences and even big social issues like violence, discrimination, or poverty, so many factors influence our mental health. It is also possible that these factors will change over time and how they affect us. Defined mental health as being emotionally, psychologically, and socially healthy; a person's thoughts, feelings, and actions are influenced by it. In addition, it affects how we relate to others, deal with stress, and make decisions. Mental health is vital in childhood, adolescence, and adulthood. Children and young people could struggle to succeed in school, which can disrupt families and communities (Knifton & Inglis, 2020). If left unaddressed, mental health problems can negatively impact homelessness, poverty, employment, security, and the local economy.

2.6.1 The impact of mental illness: Institutional, community, and family

According to a survey, there were 792 million mental health issues worldwide in 2017. This equals 10.7% of the entire global population (Ritchie et al., 2021). Complex mental health disorders come in many different forms. A serious underreporting of mental health problems

persists. In 2019, there were 12.01% mental health illnesses in South Africa and 16.96% in the United States (Ritchie et al., 2021). Africa places a low priority on mental health, despite the high prevalence of mental illness. In a paper by Bird et al. (2011), the authors present a comparison of stakeholder perspectives in Ghana, South Africa, Uganda, and Zambia. Emphasis is placed on government priorities for mental health at the national, regional, and provincial levels. In addition to conducting semi-structured interviews with key stakeholders, they used a two-stage analysis approach. They analysed frameworks in each study country, then they analysed country data in comparison.

The impact of mental health at an institutional level, for example a school, will spill over not only within our communities but also in our families. When students arrive at school, they do not leave their mental health at the door. A student's mental health is crucial to how they think, feel, interact, conduct, and learn, from wellness to catastrophic illness. A strong basis and framework for efficiently delivering mental health services in schools that safeguard students' wellbeing, foster learning, lessen stigma, and enhance access have been established over many years of research and experience. It is advantageous for students, their families, educators, the community, and society to offer mental health services, ideally in a multitiered system of support.

School reform initiatives are mostly concentrated on teacher quality and instruction; thus it has fallen short of the objective of having all students succeed in school, at home, and in life only once the role of mental health in learning is considered important (Rossen & Cowan, 2014). It takes time and effort from the school system and community organisations to overcome barriers to create effective school–community partnerships. While attempting to implement each component of successful school partnerships at once may seem burdensome, doing so is vital to ensure that the partnership is genuinely collaborative, successful, and improves the outcomes for young people's mental health (Vaillancourt & Amador, 2014).

2.6.2 Mental health promotion and advocacy: National, regional, and provincial government intervention efforts

There is no doubt that mental disorders are widespread. Improving health should therefore involve increasing awareness, recognising, supporting, and treating these disorders (IHME, 2019). Mental disorders are prevalent among 792 million people in 2017. South Africa's population with mental health disorders numbered 6.51 million in 2019, up from 3.96 million in 1990 (IHME, 2019). As of 2019, 36.41 million Brazilians suffered from a psychological

illness, which is an increase from 21.39 million, as reflected in the 1990 Global Burden of Disease study (IHME, 2019). The study by Dattani et al. (2021) described the latest estimates of mental health prevalence and how 10.7% of the world's population is affected by mental disorders (Dattani el al., 2021).

Depression, anxiety, bipolar disorder, eating disorders, and schizophrenia are all examples of undiagnosed mental disorders. Mental disorders affect 16.93% of the population in the United States, 16.72% in Brazil, 12.01% in South Africa, and 12.21% in Africa (IHME, 2019). Given the prevalence of underdiagnosis, these estimates are based on medical records, national databases, epidemiological data, and surveys (IHME, 2019). According to Weiss et al. (2001), India's mental health problems affect approximately 10 to 20 per 1,000 people in that country, with approximately 10 million people suffering from serious mental illness (IHME, 2019). When common mental disorders such as depression, anxiety, and somatoform (psychosomatic) disorders are included, the prevalence is two to three times higher. Mental health has been a neglected issue across the spectrum of health priorities; failure to recognise the nature of mental illness and the fact that much of it is treatable has contributed to this neglect.

However, in recent years, according to IHME (2019) there has been a greater awareness of the prevalence of mental disorders, as well as the suffering and disability caused by them, and policymakers have begun to respond to the need for effective mental health services. India has been an active participant in international mental health research, particularly with regards to promoting the establishment of general hospital psychiatry units, community psychiatry, and, more recently, district mental health planning. Recognising the significance of illness prevention and mental health promotion as components of mental health policy is a relatively new development. These trends reflect a greater awareness of and influence over local conditions in communities, health services in a complex public-private mix, and clinical practice features. A more self-assured national policy and a less intrusive global policy enable a more balanced approach to mental health that is better informed by an appropriate mix of global and local experience and data (IHME, 2019).

Advocacy is needed to ensure that mental health is not overlooked during development activities and other national priorities (Weiss et al., 2001). According to new research by Newson et al. (2021) based on 223,000 responses from 34 nations in four languages, including Spanish-speaking Latin America, the Arab world, Spain, France, Europe, and Africa, the 2021 Mental State of the World Report was created. The Mental Health Quotient (MHQ), a 47-item

online assessment questionnaire that includes both assets and problems, provided the data for the study. South Africa, with over 11,887 respondents, earned the lowest MHQ score (46%) (Newson et al., 2021) The United Kingdom (UK) and South Africa had the lowest ratings at 46, while Venezuela surprised everyone by ranking first with an average MHQ of 91. According to the research, at least eight of the top 10 nations are from countries with big English-speaking populations, such as South Africa and India.

Newson et al., (2021) reported that at national, regional, and provincial levels in Ghana, South Africa, Uganda and Zambia, mental health is largely considered a low priority. To determine priority, they identified nine factors, which were divided into three categories: legitimacy, feasibility, and support. The respondents shared a variety of experiences and suggestions for boosting mental health priority. Finally, they made broad suggestions about how mental health can be prioritised, to help inform advocacy for increased mental health priorities in Africa. These suggestions are particularly relevant as mental health becomes a priority on the international agenda.

2.7 Mental Health Management: Current Discourses and Practices

Young people are faced with many challenges; even though they are developing physically, they also experience a variety of emotional changes while having to acquire new skills and abilities on the education front. As if this is not enough strain, most young people are facing strain and stress due to a lack of access to resources, poverty, domestic issues and so much more that none dare to speak of. The fear of being labelled or deemed an outcast among their peers keeps them silenced and feeds a growing monster of either depression, anxiety, or shame. The huge need for acceptance from others and feeling loved either drives them to one another or steers them deep within their own thoughts and being. Research from SADAG (2020) showed that 20% of South African youths are suffering from depression. According to the WHO (2019), between 10–20% of youths at one point in their lives experience mental health conditions which are either depression or anxiety. Depression can lead to self-harm and suicide, which occur as a direct result of a mental disorder known as depression (WHO, 2019).

Further research from Jorm (2000) reported that first aid training is a well-established method of improving the public's response to medical emergencies. However, such training typically ignored mental health issues. Nonetheless, there are several reasons why this approach should be extended to mental disorders. First, the prevalence of mental disorders is so high that almost

everyone in the community can be expected to either develop a mental disorder or have close contact with someone who does. Second, the public frequently lacks mental health literacy. They are unable to identify specific disorders or types of psychological distress, and their beliefs about the causes of mental disorders and the most effective treatments differ from those of mental health experts. Third, there are widespread stigma associated with mental illnesses, which adds to the burden on sufferers. These factors cause delays in recognition and help-seeking, impede public acceptance of evidence-based mental healthcare, and prevent people with mental disorders from receiving effective self-help and appropriate community support (Jorm, 2000).

Jorm's (2000) study presented the data for the initial 210 students in open courses. Evaluation forms were distributed at the start of the courses, at the conclusion, and at the 6-month follow-up. The researchers examined the data, utilising an intention-to-treat strategy. The course increased participants' ability to identify a mental disorder in a vignette, altered their beliefs about treatment so that they more closely resembled those of medical professionals, lowered their social distances from those who suffered from mental illnesses, boosted their confidence in helping those suffering from mental illnesses, and increased the amount of help given to others. Training in mental health first aid (MHFA) appeared to be a practical way to raise mental health literacy levels (Jorm, 2000).

According to research, MHFA is a standardised, psychoeducational programme designed to provide the public with the knowledge, attitudes, and behaviours required to approach, support, and refer to people in distress. Hadlaczky et al. (2014) state that the goal of their paper was to conduct a meta-analysis of published evaluations of the MHFA programme to estimate its effects and potential as a public mental health awareness-raising strategy. According to the findings, MHFA increases participants' knowledge about mental health, decreases negative attitudes, and increases supportive behaviours towards people with mental health problems. According to Hadlaczky et al. (2014), health promotion programmes have been efficient. The study investigates the effectiveness of the Writer's Clinic, an MHFA project run by a community organisation and highlights the importance of mental health management and mental health first aid, concentrating on how the MHFA programme appears to be appropriate for public health action.

In the absence of a national guide to mitigate the mental health crises in South Africa, NGOs in South Africa have been working towards the implementation of mental health first aid, which

aids communities that are most vulnerable in accessing mental healthcare at the most basic level. Mainstream mental health management is not for everyone, thus, NPOs and other non-governmental organisations have gone the extra mile to develop and implement self-funded new approaches that are not championed by the government. Indima Yethu, a non-governmental organisation in Cape Town championed such a mental health management initiative. To that end, the present study examines the extent and degree to which a 13-week youth-led mental health social support in conjunction with narrative therapy, has offered young people a much-needed tool to ensure that their own mental health wellness remains of the highest priority. The pre-existing social inequalities in South Africa have prevented most individuals from accessing the resources they need to manage their mental well-being. As such, an individual's socio-economic status might afford or not afford them access to a professional network of people who can assist and offer much-needed help.

Additionally, for most individuals, a professional network is not an option and as result, access to mental health management becomes highly unlikely. Also, belonging to a medical aid scheme does not guarantee immediate access to someone who is able to assist, listen and guide when it is really needed. The implication is that the closest person to an individual thus becomes their lifeline if they are exposed to triggers because of daily psycho-social stressors. For most individuals, their closest lifeline becomes their peer social support structure, which they unknowingly already have in place but perhaps could not leverage.

2.8 Asset-based Approaches to Mental Health Advocacy and Interventions

Assets have positive effects on wellbeing and future orientation has a direct role in the relationship between assets and wellbeing, according to the conceptual framework suggested by Michael Sherraden in 1991. Sherraden suggests that income poverty and asset poverty need to be fixed to enhance the wellbeing of economically vulnerable individuals, families, and communities.

Green and Haines (2015) mention that an asset-based approach involved the tangible and intangible resources of a community, viewing it as a place with assets to be preserved and enhanced, not deficits to be repaired. The concept of asset-based community development (ABCD) draws on appreciative inquiry, the recognition of social capital, and the principles of empowerment and ownership (Green & Haines, 2015). According to Green and Haines (2015), in Kretzmann and McKnight (p. 25, 1993), *assets* are defined as individuals' gifts, skills, and capacities. The assumption here was that individuals are essential assets within a community.

The authors questioned what a community would be without residents. Based on this belief, they viewed assets within an economic context comprising property, shares and bonds, and cash. Also, that assets could be seen as capital within a community context and acknowledges many forms of assets within a community. Green and Haines (2015) mentioned that researchers Kretzmann and McKnight (1993) developed the approach stated that a needs-based analysis and intervention could be devastating to a community at worst, or at the very least, undermine or compromise existing community capacity-building efforts.

Boyd et al. (2008) also looked at ways in which the resources of rural communities could be utilised for the benefit of youth welfare and to improve mental wellbeing in rural areas. The authors focused on applying an ABCD strategy in establishing a rural community youth service. The authors mentioned that the ABCD framework is an alternative to needs-based approaches in which agencies, universities, or other donor groups intervene on behalf of a community to fix problems. Outside agencies tend to view communities as a collection of needs, problems, and deficiencies rather than recognising a community's inherent strengths and existing resources (Boyd et al., 2008).

The ABCD is an approach and a set of strategies to identify and mobilise community assets for change. The first strategy is to establish relationships with residents; this is the first step in ABCD. It would be necessary to include people with personal experience of receiving treatment for mental health problems in the context of a rural community to establish a rural youth service (Boyd et al., 2008). The knowledge and experience of these natural leaders in participation and governance of the initiative would be vital to identify mental health champions within any rural community. Identifying the network of associations and local groups is the second step in ABCD. The third, fourth, and fifth steps in ABCD involve expanding the asset map to include local organisations and creating partnerships between these groups. Professional expertise, workforce, infrastructure, land, and other assets are likely to be included at this level. The authors presented evidence that rural communities had high and diverse amounts of social capital and argued that collective approaches to youth mental health in rural communities should be considered superior to individualism (Boyd et al., 2008). As indicated by the proponents, it varied from one rural town to the other, with smaller towns having poor and inadequate levels of formal mental healthcare provision, particularly in child and adolescent mental health, for some time (Boyd et al., 2008).

According to McLean et al. (2017), asset-based approaches have been used within a community-led sector for several decades and were merely done to create safe supportive places that enable individuals and communities to take more control over their health and lives. The assets of people and communities are the focus of an asset-based approach. A study done by Cassetti et al. (2020) searched four databases (Medline, PsycINFO, CINAHL and ASSIA) and papers were included if the interventions were explicitly adopting an asset-based approach. Thirty articles were part of the systematic review and data was gathered on the type of assets built upon, how assets were mobilised, the expected outcomes and the evaluation methods. The key characteristics of asset-based interventions to promote health in communities were synthesised in a framework. According to the literature, there are three main approaches to mobilising assets: connecting assets, raising awareness of assets, and enabling assets to thrive. It is argued that asset-based approaches to health promotion make it difficult to anticipate outcomes and to evaluate interventions. The framework could be used to better understand how asset-based approaches work in practice to promote health and reduce inequalities (Cassetti et al., 2020).

2.9 Interpersonal Health Promotion and Social Capital

Story and Glanville (2019) stated that social capital remains one of the most popular sociological concepts to study in population health. Evidence linking social capital to lower mortality levels and better self-rated health continues to grow. However, only some studies on social capital and health focussed on low and middle-income countries (LMIC) (Agampodi et al., 2015), and those that include LMICs rarely examine the differential association between social capital and health outcomes in low- versus high-income countries. The general definition of s*ocial capital* is the benefits that individuals and groups accrue through their social relationships.

Eriksson (2011) mentioned that a systematic literature review of 42 papers in total looked at the link between social capital and health. The study revealed that strong associations exist between individual social capital and health for the most part between cognitive components of social capital and self-rated health. In research by Eriksson (2011) a survey was done concerning social capital in Northern Sweden, and it revealed a similar association between individual social capital and self-rated health. Results indicated that those who had access to structural and cognitive social capital had better chances at excellent self-rated health in comparison to those individuals who had zero access to any forms of social capital. These studies revealed that access to social capital is associated with excellent self-rated health and

that strengthening individual social capital could be a great health promotion strategy (Eriksson, 2011).

Valaitis et al. (2018) examined Canadian key informants' perceptions of intrapersonal and interpersonal factors that affect positive primary care and public health teamwork. An interpretive descriptive study was done using key informants. Service providers, policymakers, and management formed part of the key informants. The researchers conducted 74 telephone interviews to explore the perceptions that key informants held pertaining to the influences on successful primary care and public health collaboration. The telephone interview transcripts were analysed using Nvivo 9. The findings revealed that five interpersonal factors influence public health and primary care partnerships: (a) decision processes; (b) effective communication; (c) shared values; (d) role clarity; and (e) shared values, beliefs, and attitudes. Factors that have an influence at an intrapersonal level are: (a) personal values, beliefs, and attitudes; and (b) personal qualities, skills, and knowledge. Collaboration, therefore, needs to occur both on an intrapersonal as well as at an interpersonal level for primary care and public health to be sustained (Valaitis et al., 2018).

2.9.1 Interpersonal, peer, and youth-led mental health interventions

A study by Druss et al. (2010) developed a health and recovery peer-led intervention programme to survey how it could improve medical self-management for persons with serious mental illness. These researchers utilised a six-session manualised intervention method that mental health peer leaders presented. They found it to be effective as it helped participants manage their chronic illnesses. The pilot trial made use of randomised sampling, which consisted of consumers who had one or more chronic medical illnesses and who required either usual care or the Humanitarian Assistance and Resilience (HARP) programme. The results after a six-month follow-up found that participants within the HARP programme had made greater improvement than those in usual care. The researchers further found that peer-led self-management can improve health outcomes for mental health consumers with chronic health conditions.

A study by Obuaku-Igwe (2020) examined students' experiences of social isolation during the pandemic lockdown and the effect of peer-led support and mental health promotion groups. The study aimed to find out the impact of a peer-to-peer mental health support group during COVID-19 lockdown, level five. The author found that human beings embody a natural tendency to react mercifully to shared trouble and that peer social support is like very well-

coordinated social capital – for giving and getting help. In addition, peer support and narrative therapy helped individuals in processing trauma. The author noted that narrative therapy during group sessions enabled individual participants to reflect on and assess the many unheard and unspoken reflections which, through interpersonal peer social support and narrative therapy, could become an option to aid other young people facing mental health difficulties. Obuaku-Igwe (2020, p. 58) further report that individuals yearn for a physical connection through which they feel a sense of belonging, and its absence during the lockdown elicited mental health symptoms. However, peer-led interpersonal health promotion and social support served as a coping mechanism. In the absence of a physical relationship with others, they thrive on a social one irrespective of its platform. The realisation that someone out there understands and wants to help already births hope and resilience. Obuaku-Igwe's study (2020, p. 60) also reveals that mere acknowledgement of one's existence ensures that one feels loved, needed, and wanted.

2.10 Summary

This chapter showed that mental health wellness could become more attainable by reaching within ourselves and realizing our strengths and capabilities and how what we already embody and have access to within our reach could very well be the answer to sowing seeds in the hope that each tiny seed will evolve and grow and birth greater holistic wellness for all, irrespective of social class, community, race, or gender. This chapter presented an overview of mental health from a global and a local perspective. It discussed various studies and research findings concerning mental health to understand the possible factors hindering mental health wellness. This chapter also discussed the various concepts linked to mental healthcare.

Furthermore, the chapter discussed social class position as a possible reason people are discouraged from accessing or seeking mental healthcare when needed. The chapter explored the concept of interpersonal health and how social capital could be of more significant benefit when attention is given to asset-based approaches to provide interventions and, in doing so, successfully advocate for mental health wellness. The next chapter addresses the theoretical framework to understand the research approach undertaken to meet the objectives and answer the following research questions:

a) How well have Indima Yethu's adapted MHFA guidelines, which focus on young people as assets, worked to change young people's attitudes, knowledge, and behaviour in general regarding mental health?
b) Is Indima Yethu fostering a feeling of community among young people to advance

mental health?

c) How have Indima Yethu's peer mentorship program and collaborative social networks affected participants' physical and mental health?

Indima Yethu's programme aimed to achieve the following:

a) Create a culture of acceptance and reduce stigma around mental illness.
b) Promote openness about mental health challenges among participants.
c) Increase participants' empathy and willingness to help and support people with mental health challenges in their communities.
d) Increase participants' utilisation of professional services by influencing their health-seeking and utilisation behaviours.

CHAPTER 3: THEORETICAL FRAMEWORK – SOCIAL SUPPORT AND SOCIAL CAPITAL

3.1 Introduction

This chapter discusses the development of a logically developed theoretical framework relevant to the current study. According to Varpio et al. (2019) a theoretical framework reflects the work a researcher engages with to use a theory in any given research study. This study is theoretically framed with the Social Support Theory (SST) and the Social Capital Theory (SCT). The SST originates from work done in the field of sociology of mental illness, with the preliminary research indicating how social support limits the effects of stressors on existing mental illness (Braithwaite, 1986). The last twenty years have seen an explosion in the number of studies exploring the relationship between several stressors in the lives of people and the psychological effect it has on them. These studies have their origin in several fields and points of departure. Many of these studies have explored the impact of these stressors and specific health outcomes. The researchers also explored how life and health stressors could be better managed, when biological, behavioural, and situational factors can be better anticipated and subsequently handled.

A particular variable identified in many research endeavours is social support. In essence, this theory suggests that communities and neighbourhoods that have fewer support structures in place, will experience mental illness prevalence (Orrick et al., 2011). A huge difference exists among researchers, where this 'support' should come from – whether it should be 'supported' by family or friends. Others have asked whether it be paid-for or charitable support, to see large-scale effects.

3.1.1 Theories: Social Capital, Support, and Networks – History and background

The work of Bourdieu, Coleman, and Putman has contributed to the literature on social capital dating back as far as the 1980s. Bourdieu (1986; 2011) was concerned about the dynamics of power in society. Bourdieu's conception of social capital was based on the idea that capital is not solely economic and that social exchanges are not solely based on self-interest.

Human, physical, and social capital were some of the interests that Bourdieu and Coleman (1988) were interested in. Coleman maintains that the value of social capital has both economic and non-economic outcomes. Social capital is beneficial for the entire population because it benefits the investors who invest in the formation of various associations or networks. Social capital is defined by Coleman by its functions, and it is not considered a single object. However,

it involves a variety of different entities. These entities are different societies within communities that all have different interests. Coleman views social capital as fundamentally residing within the social structures of the relationships people have with one another and whereby the actions of individuals benefit the entire community.

Coleman introduced three forms of social capital, namely: obligations and expectations, information channels, and social norms. An example of social capital observed by Coleman (1988), is the establishment of a neighbourhood watch group. The purpose of the group is to ensure the safety of its residents, including life and property. In most cases, some residents are not even fully aware of what the neighbourhood group ensures. For most, it is there because it is there. In this sense, social capital is productive, even if all are not aware of it, yet benefitting from it being in place. Coleman (1988) states that social capital is not as tangible as it could be, but that it exists within the changing relations of individuals and communities. Major theorists like Bourdieu, Coleman, Putman, and Portes present social capital theories. Social capital is based on locality and makes sense from each theorist's viewpoint. Regardless of where in the world it is located, social capital needs a reliable and dependable network to succeed.

The relationships and values people embody are fed off by networks. In addition to the interconnectedness that holds people together and what it demands from one another, it is important how a relationship is formed as well as how a relationship is harvested and formed. The significance of human sociability and connectedness as well as the associations to the individual and social structure draw our attention to the concept of social capital. Social capital can be raised from an individual to the aggregate level to ensure exclusiveness. Aggregate measures of social capital can lead to a lack of reliability, and rationality, and then become inconsistent with the theory (Tzanakis, 2013). According to Claridge (2004), the sociology of education and public policy are Coleman's main interests. It benefits investors who invest in associations and networks but is beneficial for the whole population.

3.1.2 Social Capital Theory

The theory of social capital draws our attention to the significance of human sociability and connectedness as well as the associations to the individual and social structures. Claridge (2004) states that social capital should benefit all within a specific group, whether privately or publicly and should not only be advantageous to those who invest in organising the associations of networks. Social capital guarantees individuals' access

to the available resources at their disposal and through improvements made within organisations. Gelderbloem (2018) observes that generally theorists all agree that social capital involves social connection. Social capital is defined as the 'resources that are accessed by individuals as a result of their membership of a network or a group' (Kawachi and Berkman, 2014, p. 174).

A dizzying number of variations have been offered in the social sciences – from sociology to economics, to political science and population health.

There are two defining characteristics of social capital, according to most definitions: (a) it is a resource; and (b) it is generated through social networks and connections, and it could be leveraged for peer-led advocacy to reduce stigma. Social capital is an umbrella wherein social support, social cohesion, social integration, or participation are often grouped together. Categorising and measuring both social capital and mental health remain problematic (McPherson et al., 2014). Boyd et al. (2008), however, state that although there are debates over the operationalisation of the construct, theorists believe that social capital is the glue that holds society together and that there is strong evidence of a positive relationship between social capital and mental health outcomes. The ability of community members to form strong social connections is one way in which social capital can be operationally defined. The psychological sense of community involves a feeling of emotional connection – the belief that one's needs can be met within the community, and a sense of belonging or mattering to the community.

3.1.3 Social Support and Network Theory

The first attempts to define social capital began in the late 1980s and early 1990s. Bourdieu, Coleman, and Putman are often referred to as early theorists of social capital, and their approaches have influenced how social capital is viewed in the field of health sciences today.

Bourdieu was interested in the distribution of social capital in society and explains that it was like economic capital or cultural capital, but it was distributed differently among individuals and groups. Coleman and Bourdieu both emphasised the importance of looking at social networks in their approach to social capital (Bassett & Moore, 2013). Putman focused on the factors of trust and reciprocity instead of considering the structural measures suggested by Bourdieu or Coleman. There has been a divide between those who follow approaches that are in line with Putman's work and those who support Bourdieu or Coleman's definitions of social capital. The approaches have led to differing dimensions of social capital (Bassett & Moore, 2013).

Mishra (2020) describes social support as a resource exchange between two individuals that the supplier or the recipient believes is meant to improve the recipient's wellbeing. The web of social relationships that surround individuals is referred to as the social network, and one of the most important functions of social relationships is the provision of social support. The term social network refers to the relationships between people that may or may not provide social support and those that may or may not serve functions other than providing support. The term social capital has been used to describe certain resources in social networks (Mishra, 2020). Baron (2015) argues that the idea that the social support theory is rooted in how structured organisations of connected people could assist others in helping meet both instrumental and expressive needs limits mental illnesses that emanate from lack of interaction or stigma. Societies, where there are organised efforts to offer support, will have minimal possibilities of recurring crime.

In her essay about the impact of peer-led mental health promotion, Obuaku-Igwe (2020) argues that social capital can be considered as a form of capital or asset and utilised in low-resource settings where access to professional care is inadequate. Quoting Bourdieu on forms of capital, Obuaku-Igwe adds that there are tangible resources embedded in social relationships, available for members to access. That is, when young people hang out with their friends, they may be simply having a good time, but at the same time, their network connections are also available for them to draw on material and psychological resources. For this reason, social capital is sometimes referred to as 'network capital' (Obuaku-Igwe, 2020, p. 55). The author summarises that social support, together with a community's willingness to respond to stigma, psycho-social stressors, and delinquent behaviour among young people, destigmatises mental health and improves health-seeking behaviour. She continues that the type of communities with strong cohesion, social structures, and a willingness to teach their members social and moral obligations, also seek mental health intervention (Obuaku-Igwe, 2020). Ultimately, communities that promote non-economical and altruistic ideals will be more effective to limit crime and criminal behaviour (Ellis et al., 2019).

3.2 Early Contributions of Social Capital, Networks, and Support in Mental Health Management

Recent discussions of social capital are based on older literature. According to Hellermann (2006), the role of friendship networks for families in urban areas was examined by Bott in the 1950s. According to Wellman (1979), social networks can be spread far beyond local communities. Hellermann (2006) states that the basis for further differentiation and

specification of their function, composition, and spatial location can be found in the early research that indicates some key characteristics. Rather than using a generalised notion of social capital and assuming an equivalency with social networks, it might be useful to distinguish between the different types and levels of social support and resources that networks provide. The social network we reside in has an intricate, powerful web of influences and risks. We are both independent and connected. Our health is dependent on the goodwill of others around us, regardless of whether we are aware of it or not. People are victims of the consequences of other people's behaviours, for example, second-hand smoking and drunk driving, according to Sun (2014).

3.3 Health Promotion

The WHO defines health promotion as the process of enabling people to increase control over and, in doing so, improve their health. According to the Ottawa Charter (1986), health promotion is more than just the responsibility of the health sector but goes beyond healthy lifestyles to wellbeing. According to Tannahill (2009), health promotion has been applied to measures aimed at assisting individuals in their efforts to change unhealthy habits or activities aimed at promoting good health. As a result, Tannahill proposed a model for health promotion in which three overlapping areas of action — health education, prevention, and health protection — are understood as intertwined. The model proposes that health education is a communication activity aimed at enhancing wellbeing and preventing or diminishing ill-health in individuals and groups, through favourably influencing the knowledge, beliefs, attitudes, and behaviour of those with power and of the community at large. Those with power include health professionals and policymakers. Furthermore, health promotion is the idea of reducing the risk of occurrence of a disease process, illness, injury, disability, handicap, or some unwanted event.

The four focal points for preventative action are: (a) prevention of the first occurrence of a given illness or another unwanted phenomenon; (b) prevention of avoidable consequences of an illness or other unwanted state can be accomplished through early detection; (c) early detection is the most important preventative step; it is important to prevent avoidable problems of an irreversible disease; and (d) prevention of the occurrence of an illness or phenomenon. Health protection, defined within the model as the voluntary codes of practice aimed at the prevention of ill-health or the positive advancement of wellbeing, is an example of legal or fiscal control (Tannahill, 2009).

Additionally, an ecological model for health promotion focuses attention on both individual and social environmental factors as targets for health promotion interventions, which is what (Golden et al., 2015) propose in their article. The ecological model addresses the importance of interventions directed at changing organisational, community, and public policy factors that support and maintain unhealthy behaviours. The model assumes that appropriate changes in the social environment will produce changes in individuals and that the support of individuals in the population is important for implementing environmental changes. The authors add further detail by grouping factors into five levels of influence. They are beliefs, values, education level, skills, and other individual factors included at the individual level. Interpersonal relationships between individuals are included at the second level.

The organisational level covers how relevant institutions are organised and managed. Professional networks, associations, neighbourhoods, community attitudes, and the relationship among different community institutions are included at the community level. According to Scriven (2017) health promotion is made up of five main approaches, namely: medical, behaviour change, education, client-centred, and societal change. The medical approach is an effective way of health promotion to prevent disease. As a result, responsibility is taken away from the individual. Strategies have been developed scientifically with trials to prove effectiveness, so people can trust the method. Breast cancer detection is an example of a trusted method. Ensuring knowledge and understanding of health issues is one of the goals of the educational approach. Information about health is presented and people are encouraged to explore their values and attitudes to make their own decisions. Various health education programmes are an example. The main aim of the societal-change approach is to effect changes on the physical, social, and economic environments to make them more compatible with good health (Scriven, 2017). The focus is on changing society rather than individuals. Changing people's attitudes and behaviour to adapt a healthy lifestyle is the aim of the behaviour-change approach. The aim of the client-centred approach works with clients to help them identify what they want to know about and act on, to make their own decisions and choices according to their own interests and values. There are three types of health promotion: (a) primary, which is concerned with preventing ill health from occurring at all; (b) secondary, which is detecting illness and treatment; and (c) tertiary, which involves preventing an existing condition from worsening (Scriven, 2017).

A study carried out by Tang et al. (2003) focused on improving the evidence base of health promotion. Improving the evidence base of health is high on the agenda of the international health promotion community, and it is becoming more apparent that evidence is needed by practitioners for effective health promotion interventions. With quality findings from intervention studies, practitioners can make better decisions to achieve the effectiveness of their interventions. It may be difficult to get policy support if there is no evidence of effective health promotion. There are two main issues regarding health promotion evidence: the strength of the evidence, and its implications for research, practice, and policy development. The validity and effectiveness of efforts to minimise bias are some of the issues that affect the strength of evidence.

Tang et al. (2003) found that when health promotion practice and health promotion interventions are aligned the effectiveness is guaranteed. Increasing the health status of individuals and communities is what health promotion is about. Promoting health in the health context means improving, furthering, supporting, encouraging, and placing health higher on personal and public agendas. A fundamental aspect of health promotion is that it aims to empower people to have more control over aspects of their lives that affect their health because they are often outside of individual or collective control (Scriven, 2017). The public policy addresses health factors such as income, housing, food security, employment, and quality working conditions to promote health. Health promotion, therefore, is the behaviour motivated by the person's desire to increase wellbeing and health potential (WHO, 2019).

A wide range of challenges that adversely impact the quality of healthcare in South Africa have been identified by Maphumulo and Bhengu (2019). In addition to reducing errors and delays in care delivery, improving efficiency, increasing market share, and reducing costs, quality care results in more efficient processes. In South Africa, the public has lost trust in the healthcare system due to a decline in quality healthcare. Identifying current challenges in healthcare practice that compromise quality was the purpose of their study. Additionally, the study examined government strategies to improve healthcare quality. The literature search resulted in 74 articles being selected from 1,366 retrieved. In these articles, quality care delivery problems in South Africa are quantified, as well as strategies to improve the healthcare system. According to the findings, many quality improvement programmes were initiated, adapted, modified, and tested, but did not achieve the desired level of quality service delivery. Since achieving an enduring quality improvement system in healthcare appears to be a challenging

task, the government of South Africa must implement National Core Standards to ensure the desired health outcomes (Maphumulo & Bhengu, 2019).

3.4 Asset-based Approach to Mental Health Promotion and Advocacy

According to Mathie et al. (2017), an asset-based framework can be used to reverse the previously internalised powerlessness felt by communities in the face of health challenges and to strengthen opportunities for shared activities that help in building local capacity for action (Mathie et al., 2017). An asset-based approach provides a means of positively contributing to transition and works for the greater good of all people. It centres pre-existing capacities, strengths, skills, talents, and knowledge systems that were either ignored or underutilised within communities. This is achieved through focusing on the given strengths, abilities and skills already embodied and then applying them in a constructive manner. The implication is that such communities, instead of prioritising material aspects and resources, centre their human resources – people, other individuals, family units, social capital, trust capital, and other available resources within these relationships. The approach has a rather positive outlook and focuses on the strengths and opportunities available within communities that lack professional amenities or services, while also acknowledging the reality of the situation.

3.4.1 Interpersonal health promotion

Golden, McLeroy, Green, Earp, and Lieberman (2015) argue that social relationships affect how individuals cope with stress, the number of health behaviours that individuals engage in, the risk of mental illness, the ability of adolescents to cope with pregnancies, and the risk of morbidity and mortality. They note that social relationships are an important part of social identity and important social resources, including emotional support, information, access to new social contacts, and tangible aid and assistance in fulfilling social and personal obligations and responsibilities (Golden et al., 2015). These social resources, often referred to as social support, are an integral component of overall wellbeing. Although the influence of interpersonal relationships on the health of the individuals is widely recognised, health promotion interventions that use interpersonal strategies have typically focused on changing individuals through social influences, rather than changing the norm or social group (Golden et al., 2015). Over the past decade, Kok et al. (2008) notes that ideas about environmental change have evolved, and health promoters have turned their attention to empowering community members to make changes. Environmental changes such as a natural disaster, for example an earthquake which leads to the loss of life and property, can negatively impact people within their lived communities, which would most likely affect their mental wellbeing.

Individuals' health is influenced by interpersonal networks, organisations, communities, societies, and supranational systems in which they live.

Interpersonal relationships are composed of the relationships with the individuals and small groups with whom at-risk individuals associate, like their family and friends. Individuals' health promotion behaviours and outcomes may influence their interpersonal goals and motivations. When someone has high interpersonal goals, incredibly compassionate ones based on caring for others, they may be more motivated to engage in health-promoting behaviours. It is then possible to achieve better health outcomes by implementing these health-promotion behaviours. Ryan (2009) asserts that people's behaviours, notably their lack of health participation habits, are to blame for 50% of all illnesses. People's interpersonal connections with their family, friends, neighbours, co-workers, and acquaintances all significantly impact their health. An example would be the decision to visit a physician for non-emergency care, and family, friends, and significant others influence the timing of doctor visits. According to Hoying (2020), interpersonal goals and motivation may affect an individual's health-promotion behaviours. People who are concerned for the welfare of others may feel more inclined to engage in behaviours that promote their health. If these health-promotion behaviours are supported, better health outcomes will be possible. The goals connected with interpersonal connections may significantly motivate people to engage in behaviours that promote health and ward off sickness.

3.4.2 Participatory health approach

The role of people in managing their health or healthcare has changed dramatically over the last decade. Individuals have moved from being passengers in the health journey to more active, engaged, and empowering partners in the shared decision-making process with their health professionals. Participatory health is a new way of creating, developing, and consuming healthcare goods and services. Participatory health focuses on patient-centred initiatives to empower individuals to make more informed health decisions where the patient is at the centre of any related health initiative (Denecke et al., 2019).

3.4.3 Mental health promotion

The Sustainable Development Goals (SDGs) of the United Nations represent a global commitment to give mental health the attention it deserves when funding health and development. Detailed and locally derived estimates of current mental health system resources

and constraints are required when low- and middle-income countries (LMICs), like South Africa, consider scaling up their mental health systems in conjunction with universal health coverage-related health system transformations. In recent decades, due to a lack of information, the burden of scaling-up efforts to reduce mental health disorders has been limited. According to Docrat et al., 2019, the government spent approximately 30% of its budget on mental health (Docrat et al., 2019).

During the 2016/17 financial year, South Africa's public mental health budget was USD 615.3 million, equivalent to 5.0% of the total public health budget. Approximately half of the mental health costs were incurred at psychiatric hospitals, representing 86% of mental healthcare expenditures (Docrat et al., 2019). Public health systems spend an estimated USD 112 million annually on readmissions after mental health hospital discharge. Rough estimates show that only 0.89% and 7.35% of the uninsured population requiring care received some form of public inpatient and outpatient mental healthcare during the study period patients received (Docrat et al., 2019).

In addition, the availability of human resources, infrastructure and drug supply for mental health are significant obstacles to implementing the country's progressive mental health legislation. This study provides a nationally representative account of mental health spending for the first time. It sheds light on the inefficiencies and limitations resulting from existing mental health investments in South Africa (Docrat et al., 2019).

3.4.4 Community and NGO-led mental health advocacy interventions

Many low- and middle-income countries, where mental health services, infrastructure, and policies are underfunded and low priority, have documented the importance of mental health professionals. According to McDaid et al. (2008), NGOs are essential in funding, coordinating, and delivering mental health services. Their work focuses mainly on strengthening the case for mental health investment in low- and middle-income countries through economic evidence. Furthermore, McDaid et al. (2008) note that a pressing need also exists to expand the use of economic analysis in considering non-health sector interventions that can directly or indirectly assist with mental healthcare uptake and maintenance and that evaluating how services are delivered is crucial. The authors argue that NGOs are critical in funding, coordinating, and service delivery. The understanding of the cost-effectiveness of specific mental healthcare interventions within the healthcare system needs to be improved if their overall work is to be improved.

Compared to other health conditions, mental illness presents relatively low direct costs to global economies regarding direct and indirect costs per person. According to Trautmann et al. (2016), mental disorders cost the global economy 2.5 trillion dollars in direct and indirect costs per year. According to the survey, 45.7 million people had depression, and 44.9 million had anxiety disorders.

In India, nearly 150 million of its citizens require mental healthcare interventions. However, less than 30 million seek help, according to the National Institute of Mental Health and Neurosciences (NIMHANS) Mental Health Survey 2015–2016. India has inadvertently accelerated the mental health time bomb due to the unrelenting pandemic. However, the intervention of community-led organisations and NPOs has improved knowledge and treatment options within the country. Live Love Laugh Foundation was founded in 2015 by actor Deepika Padukone to give hope to people suffering from stress, anxiety, and depression. The foundation uses its visibility and extensive network to increase awareness, normalise conversations, and reduce the stigma associated with mental illness. Information is carefully curated and disseminated by combining knowledge and domain expertise into easily consumable formats. However, they do not work in isolation. Partnerships and collaborations with similar organisations working in the mental health field have been integral to the foundation's programmes (Live et al. Foundation, 2018).

NGOs have a significant impact in areas where participatory approaches have been used. This is done by co-designing programmes for either intervention or implementation and are being considered with the at-risk community. There are different types of NGOs, each of which contributes in their own unique way to making a significant difference in many areas. Another NPO that has been at the centre of mental health advocacy in India is MINDS. Lodha (2021) notes that, MINDS provides support based on the MHFA aims to eradicate stigmas and provide education, medical support, and moral support for individuals with mental illnesses. As part of its efforts to expand mental health education, the foundation also conducts ongoing research and curriculum development. In India, MINDS has improved mental health education and treatment, overcoming many of the challenges of rural health. Through MINDS, social workers provide community-wide education in each village, provide treatment to anyone who wants it, and assist each patient in reintegrating into the community after treatment (Lodha, 2021).

Ogbe et al. (2020) report that intimate partner violence (IPV) is a significant public health concern, with a wide range of physical, sexual, and emotional effects for victims. Several studies have demonstrated that social support reduces and regulates IPV effects and enhances

health outcomes. This study aimed to discover and evaluate network-oriented and support-mediated IPV therapies aimed at improving mental health outcomes among IPV survivors. Most of the research resulted in better social support and mental health outcomes for survivors. However, there was little indication that they affected IPV decrease or healthcare utilisation. Extensive evidence shows that IPV therapies strengthen survivors' access to social support by advocates with solid ties to community-based structures and networks, resulting in better mental health outcomes. More robust and high-quality research is needed to determine in what settings and for whom these interventions function better than other IPV interventions (Ogbe et al., 2020).

Developed in Australia, mental health first aid (MHFA) is a public education programme that helps non-psychiatric professionals to recognise, understand and respond to people with symptoms of mental illness and addiction (Kitchener & Jorm, 2002). MHFA adoption in the United States has grown exponentially. Mental Health, First Aid Intervention is an 8-hour educational programme aimed at helping the public identify, understand, and respond to the signs of mental illness and addiction. The number of first-aiders trained in all 50 states exceeded a million in 2018. Since 2014, the Administration of Substance Abuse and Mental Health Services has awarded more than USD 15 million to state and local educational institutions, providing MHFA to adults who interact with school-age youths to help them reach school-age status—increasing mental health awareness and service capacity among adolescents who might be experiencing mental health problems (Banh et al., 2019).

Banh et al. (2019). MHFA training courses conducted across the United States have assessed the impact of MHFA using a theoretically and psychologically useful metric known as the Scale of Mental Health Beliefs and Qualifications (MBLS). The study used online MBLS surveys taken before MHFA training, three weeks after training, and six months after training. In total, 662 trainees participated, and 273 (41%) returned to the previous survey. Of these, 63% completed the following survey, and 35% completed the six-month survey; 76 people responded to three surveys (Banh et al., 2019). MHFA-related constructs exploiting positive beliefs, confidence, intention, and mental health literacy exhibited significant short- and long-term changes. MBLS has noted that the strong positive effects of PSSM training are most significant among those without mental health training, the intended goal of MHFA (Banh et al., 2019).

3.5 Interpersonal Health Promotion and MHFA in South Africa: Indima Yethu's Practice in Perspective

Since 2018, Indima Yethu has been working with children and young people (CYP) to deliver participatory health promotion interventions and culturally appropriate MHFA training, recognising the complex mental health issues young people in South Africa faced during and after the lockdown. This NPO developed a 13-week Youth MHFA programme for over 1,000 young people between 18 and 34 in South Africa's Western Cape province, serving as first responders to their peers in crisis. Researchers in South Africa identified the types of assets associated with mental health. According to the authors, loneliness, social isolation, and mental illness were determining factors that shaped and drove mental illness among young people. There was also agreement that strong social and community ties enhance an individual's sense of belonging, identity, and connection (Obuaku-Igwe, 2020).

Indima Yethu's programme aimed to achieve the following:

a) Create a culture of acceptance and reducing stigma around mental illness.
b) Promote openness about mental health challenges among participants.
c) Increase participants' empathy and willingness to help and support people with mental health challenges in their communities.
d) Increase participants' utilisation of professional services by influencing their health seeking and utilisation behaviours.

As with other mental health-related policies in South Africa, MHFA has experienced slow national adoption despite its growing popularity as a method of improving mental literacy and well-being. Mental health literacy is currently the responsibility of civil society and communities without well-coordinated national MHFA strategies, guidelines, and agendas. Based on assumptions derived from international research from the Global North, these organisations and communities designed and piloted nationally adapted MHFA training. However, there needs to be more perceptions and understandings of whether MHFA training is culturally appropriate in South Africa. An NPO, Indima Yethu, implemented a culturally adapted version of MHFA in South Africa (which included spirituality and Ubuntu values). Through a post-training feedback interview of YMHFA (Youth MHFA) participants in Cape Town, the current outcomes assessment is part of a broader effort to build evidence of YMHFA's effectiveness in South Africa (Obuaku-Igwe, 2022).

Since 2018, Indima Yethu has provided culturally adapted MHFA training and participatory health promotion interventions to children and young people. For over 863 young people aged 18–34 across the Western Cape province in South Africa, the NPO developed a 13-week YMHFA programme to equip them as first responders to their peers in crisis due to the complex mental health issues faced by their peers during and after lockdown. Students and young people are at risk for anxiety, panic attacks, paranoia, and depression, according to Indima Yethu's Youth MHFA programme. The foundation of Indima Yethu's MHFA programme for youth was a needs assessment that found that many factors put students and young people at risk for anxiety, panic attacks, paranoia, and depression. These factors include mismatched expectations, low socio-economic status, and unequal ratios of psychologists to students at various South African universities. Building on this foundation, its YMHFA training programme for Indima Yethu aims to create an informal peer mental health mentoring and support group to bridge the gap (Obuaku-Igwe, 2022).

MHFA training programmes, according to Obuaku-Igwe (2022), are based on wealth-based theory and participatory health research frameworks to improve writing skills, manage mental health, and improve the mental health of colleagues who are inaccessible. It gives them space to manage their mental wellness by providing professional support with shared narrative therapy and mental health first aid. The methods and intervention tools used by Indima Yethu are backed by research, stating that writing, journalling, and storytelling therapy impart coherence and increase mindfulness and that peer support is cathartic and reduces anxiety. As such, Indima Yethu's YMHFA training sessions are conducted both online and offline (on-site at its Cape Town office) once a week, two hours each, for 13 weeks.

The YMHFA broader objectives are summarised as follows:

a) Creativity: Unleash and let students' creativity flow as they learn to express themselves.
b) Self-discipline and willpower: To assist students in problem solving by documenting personal patterns of behaviour, being honest with themselves about what they feel each day and why and being their first critic in a safe environment – their journals.
c) Enhance problem-solving skills: By journalling, writing personal narratives, and receiving peer support, students can get rid of toxic emotions and clarify the next steps they should take, all the while looking back on their writing to see how far they have come, how they dealt with obstacles, and what personal patterns have become obstacles in their personal and professional lives.

d) Students should cease allowing their ideas to negatively influence them to reduce stress and improve their memory. For them to have a goal-oriented mindset and allow their goals to motivate them to take small actions that would ultimately lead to success in all facets of their lives.
e) Self-awareness and mindfulness are necessary for students to understand what they can manage and what is out of their control and, as a result, to identify the causes of their uneasiness and unhappiness with life.

3.6 Summary

In concluding this chapter, it is essential to note that in a bid to understand mental well-being within the South African context, it is crucial to (re)centre asset-based approaches to its promotion and advocacy to understand how communities are co-constructing and collectively building safe spaces in response to the psycho-social stressors young people are facing because of the political economy of their country. The first section of this chapter discussed the social capital, support, and network theories. Social support has been a particular variable identified by many other researchers in their research endeavours. In the work of Orrick et al. (2011), the social support theory suggests that lived communities and neighbourhoods with fewer support structures will be subjected to mental health incidences. An asset-based framework approach provides communities and neighbourhoods with an opportunity to positively contribute to the change so that all people can benefit from it by being made aware of resources they have already harvested but for too long focused on the material aspects, which resources are said to present (Orrick et al., 2011).

The chapter also considered health promotion, participatory and interpersonal health promotion, and their impacts on mental health wellness. In the work of Tannahill (2009), health promotion ultimately assists people in changing unhealthy lifestyles to promote good health. A model proposed by Tannahill suggests that health promotion needs to occur in three overlapping areas of action: (a) health education; (b) prevention; and (c) health protection. Health prevention is reducing the risk of a disease or illness. The next chapter discusses the methodology for the chosen research study.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 Introduction

According to Walliman (2017), research is an activity that involves finding out systematically things you did not know. A methodology describes the framework or foundation for conducting research. A research methodology must be most appropriate to achieve the research objectives. Thus, it should be possible to replicate the methodology used in other studies (Gerring, 2011). The methodological approach or research techniques aim to guide the researcher or investigator in deciding what is appropriate or not for a specific research endeavour. The purpose of this chapter is to investigate and illuminate the research process. This chapter outlines the research design, data collection methods, source, sampling, and data analysis.

4.2 Research Design

A research design is a framework for action that bridges the gap between research questions and the implementation of the research. The purpose of the research design is to combine relevance to the research purpose with economy in procedure. Laher (2008) compares a research study to the design of a building. It is a good idea to plan a house before one build it. When builders do not have the plan to work from, they may make ad hoc decisions, such as forgetting about a toilet or needing more windows. The builders may start constructing a vast house, but they must abandon the mansion as an incomplete shell if they need more money and bricks. In an era where large volumes of data are being collected and maintained by researchers worldwide, the feasibility of employing existing data for research is becoming more common.

4.2.1 Secondary Data Analysis

Secondary data analysis examines data collected by someone else for another primary reason. Pre-existing data provides a realistic option for researchers with limited time and resources. *Secondary analysis* is an empirical exercise that follows the same basic research principles as primary data studies and requires the same stages as any other research approach (Ishtiaq, 2019b).

4.2.2 Benefits and Limitations

According to Doolan and Froelicher (2009), the most significant benefits of secondary analysis are its cost-effectiveness and convenience. The researcher could spend financial resources on something other than data collection, as the previous researcher collected data. Researchers can

acquire access to and use high-quality larger datasets, such as those organized by funded studies, when good secondary data is accessible. Access to this form of data provides opportunities for all researchers, even rookie or unfunded researchers, thereby equalizing opportunities and creating capacity for empirical study in research. Using existing data sets can improve the pace of research by eliminating some of the most time-consuming processes of a typical research project, such as measurement creation and data gathering (Doolan & Froelicher, 2009). Secondary data analysis opens numerous possibilities for expanding research through replication, re-analysis, and re-interpretation of existing research.

One significant downside of using secondary data is that the secondary researcher did not participate in the data collection process. The secondary researcher needs to learn how well it was collected and if the data are affected by problems such as low response rate or respondent misunderstanding of specific survey questions (Doolan & Froelicher, 2009).

The context for the current research study is an NPO, Indima Yethu, located in Cape Town, whose work focuses on youth mentoring, capacity development, health promotion, and advocacy. For the successful completion of the proposed objectives, the researcher undertook secondary research to understand a) How well have Indima Yethu's adapted MHFA guidelines, which focus on young people as assets, worked to change young people's attitudes, knowledge, and behaviour in general regarding mental health? b) Is Indima Yethu fostering a feeling of community among young people to advance mental health? c) How have Indima Yethu's peer mentorship program and collaborative social networks affected participants' physical and mental health?

Since this research focuses on how the selected NPO engages young people and utilises them as assets for mental health advocacy, the study foregrounds the content of the programme, the design, its effectiveness, the role of peer mentors, participant evaluations, and feedback from all stakeholders.

4.3 Data Collection Procedure and Technique

Given the prevalence of quantitative data on MHFA, the current study utilised a secondary data analysis to follow up mixed methods and participatory research to help explain the linkages and mechanisms in the asset-based models and other causal theories, such as the status of social networks/capital, established by Obuaku-Igwe, (2020; 2022) in her pilot study.

In this regard, a secondary data source is one that has already been collected or was collected for use in another way. Given that the effectiveness of human interactions cannot be quantified or captured with existing measures due to race, gender-related or other forms of individual differences, this study utilised the analysis of secondary data and narrative research to convey a more comprehensive understanding of the social problem, which provides the data needed to answer the research questions (Mohajan, 2018).

Using information collected by Obuaku-Igwe (2022), this study drew data which had already been collected at Indima Yethu. The secondary documents used by the researcher were the 12 participant feedback questionnaires which had been completed by particpants who part of the Writer's Clinic at Indima Yethu's peer-mentoring program had been. multiple other sources, documents, and archival material. As Pernice (in Bryman, 2016) argues, should a researcher only employ quantitative approaches during research, the researcher's understanding of the problem at hand may be limited.

A key objective of the present study was to examine how the peer social support, networking, and mentoring models of Indima Yethu effectively leverage young people as assets, specifically from a participatory perspective. The researcher analysed participant feedback on the Indima Yethu programme and their weekly workshops to answer this question. Upon completion, the analysis of the weekly discussions and topic guide with questions developed and led by the researchers to ascertain various aspects of well-being available mental health promotion services, issues with and experience of using mental health services, and what young people consider assets, how those assets were used or measured, and how access to mental well-being management advanced through their 13-week peer participatory programme. The researcher analysed the findings from the study using reflective thematic analysis.

The researcher collected the data for this study from the Indima Yethu Youth Mental Health First Aid Programme with ethics number HS21/5/65 from the University of the Western Cape. In addition, more data was extracted from the pilot study, *Kick out COVID-19: An alliance to improve the online and offline health and welfare of vulnerable and disadvantaged children and young people living in Rwanda, Zambia, Sierra Leone, and South Africa – Youth Safeguarding Network (YSN) study*, with the same ethics number, HS21/5/65. The YSN funded this study, which was conducted at Indima Yethu, an NPO in the City of Cape Town, by Principal Investigator (PI), Dr Chinwe Obuaku-Igwe (University of the Western Cape, South

Africa) and Dr Darren Sharpe (Institute for Connected Communities, University of East London, UK). Every organisation has their own data records, which become internal sources of data and these records represent a potential source of valuable secondary data. An NPO in Cape Town, Indima Yethu has its own data records, which represent a potential source of valuable data. For instance, this NPO's Writer's Clinic holds records of a 13-week intervention programme on peer social support and mental health promotion.

4.4 Methodological Limitations

The participant evaluation questionnaires completed by a small group of participants might have had a more significant impact if more persons had been able to participate. The most significant limitation at the start of this research study was the impact of COVID-19. Physical contact with participants was not allowed due to lockdown restrictions. Due to a scarcity of resources and lockdown constraints, more participant involvement was lacking during the 13-week intervention programme. One significant limitation of this study was that most participants could only partially participate due to a lack of electronic devices and Internet connection. For example, some participants discontinued the intervention programme due to personal circumstances, such as a lack of noise-cancelling headphones, personal space, and privacy.

4.5 Sample and Sampling Characteristics

Patton (2002) notes that the sample size does not represent the population but that the selected participants have an in-depth understanding and knowledge of the subject. The standardised approach, therefore, necessitates that a technique such as purposive sampling focuses on a group of individuals who share similar experiences or interact similarly; this allows the researcher to do an in-depth study. This study seeks to understand the effectiveness of Indima Yethu's intervention programme: How well have Indima Yethu's adapted MHFA guidelines, which focus on young people as assets, worked to change young people's attitudes, knowledge, and behaviour in general regarding mental health? Is Indima Yethu fostering a feeling of community among young people to advance mental health? How have Indima Yethu's peer mentorship program and collaborative social networks affected participants' physical and mental health?

The preliminary study involving undergraduate university students consisted of a sample size of 1,000 young people who became assets and mental health advocates at Indima Yethu while

participating in its Writer's Clinic MHFA programme. The pioneering study recorded 865 participants' participation in peer mentoring pods/clusters of 12 people per session. For this study, the focus was on a cluster of 12 participants.

The process through which the community recognises its economic, physical, cultural, associational, institutional, and individual assets is known as asset mapping. Community members define a community's boundaries, map, and catalogue the community's resources, compile an inventory of the resources, and create a physical or conceptual map of the community's resources that also emphasises the connections and relationships between the resources—resulting in community interventions that directly capitalise on its resources. Asset mapping focuses on positive strengths concerning a needs assessment, which initially starts by considering what is missing from a negative perspective (Green & Haines, 2015).
Its sole purpose was determining what is essential to young people regarding mental health and well-being management. They found that young people's self-esteem, self-concept, and self-definition contribute to psycho-social stressors, while mental health is stigmatised. The primary studies' preliminary findings show that young people value educational success, material well-being, professional success, positive relationships, housing, and participation in meaningful activities.

The present study piloted this study based on the main study. The sample size for the present study is 12 young people between 18 and 34 who completed YMHFA through Indima Yethu between December 2019 and June 2022. The overall response rate was 98%. There were 66.6% women (n=8), 33.3% men (n=4), with a median age of 21.5, 87.2% were single, and 41.6% were coloured (n=5), with 50% Black Africans (n=6) and approximately 8.3% (n=1) white. All participants (n=12) had high school diplomas and were enrolled at various universities in the Western Cape as social science and humanities undergraduate majors without previous healthcare experience. There were almost no participants who had not experienced mental illness or had not had a close family member or friend who had. Approximately 83.3% of participants (n=12) reported annual household incomes below R100,000.

4.6 Ethical Considerations and Challenges

Secondary analysis is governed by ethical considerations such as non-maleficence and confidentiality. According to Heaton (2008), informed consent cannot be assumed in secondary analysis, and the researcher cannot rely on vagueness in the consent form. The secondary research questions derived from the primary research were directly related to the primary research's intention, and thus the content gained from the primary research was sufficient to conduct the secondary analysis presented here.

The non-profit organisation, Indima Yethu, approved the application for access to their secondary data collected during the preliminary and piloted study. The previously collected data in other studies had ethical clearance. The necessary data for the current investigation was acceptable but reasonable due to the limited sample size (Tripathy, 2013). The material obtained from Indima Yethu, a non-profit organization, was encrypted and password-protected softcopies. The data accessed was anonymous, as it only contained the participants' demographical information.

4.6.1 Advantages

Using current data is a viable option for researchers with limited time and resources. They are often deemed a low risk from an ethical standpoint because they do not include a direct connection with human subjects. The most evident advantage of secondary data analysis is its low cost. There may be a fee to gain access to such databases, but it is nearly always a fraction of what it would cost to do an original study (Tripathy, 2013).

4.6.2. Disadvantages

A researcher must remember that every research begins to address a particular research issue. When using data from a previous research study, it is essential to carefully assess how well the present study's goals and research questions correspond with those of the earlier study. The data might not be ideal for the research subject under consideration in the current project. Initially, researchers collected for a different reason. Due to the inherent nature of the secondary analysis, the gathered available data is to answer a specific research question or to test a particular hypothesis. Some significant third variables frequently were not accessible for the analysis. Not all interested geographic areas or demographic subgroups will have their data collected. The fact that often the researchers studying the data differ from those involved in

data collecting is a significant constraint to the analysis of current data. Researchers must be aware of details of flaws unique to the study that may affect how certain variables interpret the dataset (Tripathy, 2013).

4.7 Research Setting

4.7.1 The Writer's Clinic Programme: Background

The Writer's Clinic was piloted for the first time in what is now known as the Department of Sociology at University of the Western Cape, in 2016 as part of the Sociology of Health – Soc232 and Soc312 – Health and Population curriculum development project. The originator of the concept, Obuaku-Igwe (2020) indicated that it was formally integrated into both modules in 2017 and remained an extracurricular adjunct and pedagogical tool until 2020 when it was scaled and implemented within the broader University community as part of student mental wellbeing management tools during the lockdown (Obuaku-Igwe, 2017).

A generous University Capacity Development Grant (UCDG) provided by the Faculty of Arts allowed the project to be piloted as a Teaching and Learning intervention. An assessment needs laid the groundwork for the first undergraduate Writer's Clinic (Obuaku-Igwe, 2017). During the study, preliminary findings indicated that students were at risk of anxiety attacks, paranoia, and depression because of several factors that were linked to and shaped by their ethnicity/race, early childhood, socio-economic status, social network, parental support, uneven student-psychologist ratio, among other complex factors. It was noted that the University of the Western Cape has an uneven ratio of psychologists to students and mismatched expectations (Obuaku-Igwe, 2017). Thus, the Writer's Clinic focused on creating an informal peer mentoring and mental health support group to fill those gaps. With a participatory health research framework and an asset-based theoretical framework, the Writer's Clinic offered undergraduate health students the opportunity to develop their writing skills, manage their mental health, as well as the mental health of their peers who do not have access to professional support through an adapted version of a Mental Health First Aid programme based on ALGEE (Assess risk, Listen nonjudgementally, Encourage appropriate help, and Encourage self-hep). Following student testimonials, Dr Obuaku-Igwe proposed the Writer's Clinic as an intervention and research project. In response to her inquiry, the funders responded positively (Obuaku-Igwe, 2017).

A broader community-based writer's clinic was being piloted. It was done in collaboration with the University of East London, a South African NGO, Rwanda, Sierra Leone, Zambia, and India. As part of the partnership, purposefully tailored COVID-19 and other resources were co-designed, co-produced and tested to promote the health, welfare, and wellbeing of children and young people living in adverse circumstances and settings in the participating sites before and after the pandemic (Obuaku-Igwe, 2017). Youth peer mentors were developed across various sites in Cape Town through her facilitation of the Writer's Clinic and the nominated NGOs. A partnership between the department and the NGO focused on research and intervention was underway. Students in the Honours and Third Years of the health courses were trained to serve as peer mentors. A mental health first aid app was downloaded, and brochures were distributed to them. To accomplish their goal of offering population-focused solutions, they planned to hold 13 sessions of the Writer's Clinic from the project's beginning until December 2021 (Obuaku-Igwe, 2017).

The project, which was piloted by Indima Yethu – The Writer's Clinic, draws on Dr Obuaku-Igwe's pioneering work on peer-led participatory mental health intervention/advocacy and an MHFA course-based intervention programme. The goal is to enable young people and communities to maintain and manage their mental health through peer (peer-to-peer) social groups. Peer networking, mentoring, social support, and first-aid facilitation for the mental health and wellbeing of children and adolescents aged 12–35 (Obuaku-Igwe, 2017).

Through research, they identified the types of assets associated with mental health among young people in South Africa. An organisation in Cape Town implemented the Writer's Clinic Programme to provide peer-to-peer support for young people experiencing online and offline challenges to their health and welfare that had been caused and/or exasperated by COVID-19 restrictions on those vulnerable and disadvantaged (Obuaku-Igwe, 2020). The author notes that social support from peers and 'spending spare time with friends' are the strongest protective factors against mental disorders among young people, and individuals with fewer contacts feel lonely compared to others. Loneliness, social isolation, and mental illness are strongly linked, according to the authors. There was also an underpinning that 'strong social ties and relationships with the community improve an individual's sense of belonging, identity, and attachment' (Obuaku-Igwe, 2020, p. 59).

The Writer's Clinic was simultaneously scaled across Indima Yethu in South Africa as well as other NPOs in Zambia, Sierra Leone, and Rwanda. The recruitment and data collection in South Africa were led by Indima Yethu. A pilot study was conducted in Cape Town, and participants completed three types of data collection: (a) a baseline survey, the WHO and Warwick wellbeing scale; (b) qualitative focus groups; and (c) interviews. The Youth Safeguarding and The Writer's Clinic project, run by Indima Yethu in Cape Town, South Africa emphasised surveys and weekly focus groups. The project consists of approximately 3,000 young people who complete coping mechanisms and wellbeing questionnaires every month. Researchers did not allow participants who were not members of the Writer's Clinic or Indima Yethu peer mentoring network to participate in the study. Furthermore, smart phones and Internet connectivity were required, as well as the ability to remain 100% committed to tasks using the Sentinel App. Study duration was one year and a secure, password-protected location was used to store all surveys and focus-group discussion (FGD) data (Obuaku-Igwe, 2020).

4.7.2 Implementing an asset-based peer-led participatory MHFA programme

A 13-week intervention programme on peer social support and mental health promotion was carried out at the Indima Yethu NPO premises in Cape Town. The aim of Indima Yethu's programme was to achieve the following:

a) to reduce the stigma and shame associated with mental illness;
b) to increase participants' openness about mental health challenges;
c) to increase participants' capacity for empathy and willingness to help and support with mental health challenges within their communities;
d) to increase participants' utilisation of professional services among participants by influencing their health seeking behaviour.

The broader goal of Indima Yethu's MHFA programme was to identify skills and competencies at all levels that could be leveraged for mental health promotion, particularly at the individual level (these skills and capacities were regarded as community assets that could contribute to servicing the mental wellbeing needs of young people in the shortage of professional services). In this context, young people, their social networks, and their sense of belonging to their community were identified as key non-professional resources that can be adapted and incorporated into MHFA interventions. A review of Indima Yethu's training resources revealed that, as a community organisation, they were opposed to what they considered a 'deficit

approach to MHFA'. The deficit approach defines communities by their problems and what they lack. Furthermore, the implementation of the project focuses on token schemes that are reactive and make the community highly dependent on professional care providers/professional services. In addition, such programmes target specific groups through data analysis, but it is disempowering, reduces independence, creates a sense of poverty, and is unsustainable (Obuaku-Igwe, 2020).

Additionally, by adapting participatory and wealth-based principles, Indima Yethu has assessed what works well for particular social groups and directed its resources to reinforce those principles. In the MHFA project, young people and their friends were considered assets, and friendship bonds and trust capital were similarly strengthened and identified as important resources to be channelled into mental health interventions. Indima Yethu assessed what worked well with specific social groups and leveraged its resources to strengthen and out-scale them. Young people and their friends are viewed as assets in the most current MHFA project, and friendship ties or trust capital are similarly recognised as significant resources that need to be strengthened and channelled towards mental health interventions (Obuaku-Igwe, 2020).

In leveraging and strategically placing young people as peer MHFA instructors/tutors, Indima Yethu prioritised four key questions to inform the design of the 13-week MHFA course content: The first question they considered was: What makes young people strong? This was followed by What makes them healthy and of a sound mind. Then, what kind of stressors do they experience, and how do they respond to, cope or deal with these stressors and negative events? Lastly, what are the communities doing to improve the health of these young people when resources are scarce or limited? Through weekly discussions, interviews, workshops, and surveys with participants, Indima Yethu identified health-promoting resources and understood how they could be utilised as tools to promote health. Post-survey reflection and discussion with participants focused on other questions such as: When was the last time you checked-in to find out how your friends and co-workers were doing? How do you build sustainable access to social support and strategies for coping with everyday problems? What do you do when a friend experiences a hard time, suffers a panic attack, or seems unable to cope? How can mental health services be strategically designed or deployed? If you were to change one thing about mental health and healthcare in South Africa, what would it be? Do we need a mental health first-aid kit (does the idea of a first-aid kit for the mind seem feasible?) Following the survey, participants and programme coordinators together drafted a Mental Health First Aid, and social

support for young people to jointly develop an intervention plan that culminated in a 13-week programme.

Table 1: Indima Yethu's weekly intervention programme themes

WEEK 1	WEEK 2	WEEK 3
● Set personal short-term and long-term goals and work with a responsible partner	● Identify and address key areas of development related to career, academics, spirituality, and relationships	● Collaborate with fellow mentors and established accountability partners to support you along the path to achieving set goals
WEEK 4	**WEEK 5**	**WEEK 6**
● Practice self-expression and consistency through daily journalling	● Support your peers or enlist the support of family and friends in answering self-awareness questions (weekly instant questions available upon request)	● Map your energy by observing when you are most productive each day and doing one little thing that pushes you out of your comfort zone
WEEK 7	**WEEK 8**	**WEEK 9**
● Practice mindful living by observing your breathing for 10 minutes each day	● Have fun writing about your breathing and reading at least one page of your favourite book	● Practice active, empathetic listening ● Practice empathetic listening exercises
WEEK 10	**WEEK 11**	**WEEK 12**
● Find your voice through blogs, support young people, and enable others to do the same	● Define what success and peace mean to you and take small steps in that direction, celebrate yourself	● Get at least 30 minutes of moderate physical activity most days of the week ● Keep a journal and let us know how you feel before and after this exercise
WEEK 13		
● Through our six-step strategy, 'reach out, offer emotional support; offer affirmations and appraisal; offer informational support; offer instrumental support; and share points of view,' mentor at least one person in your community and enable peer access to social support		

4.8 Data Analysis

According to Byrne (2021) in Braun and Clarke (2012) mention that reflexive thematic analysis (RTA) is a simple and conceptually flexible interpretative technique for qualitative data analysis that allows for the identification and study of patterns or themes in a data collection (Braun & Clarke, 2012). Braun and Clarke distinguish RTA from other types of thematic analysis by distinguishing three effective methods of TA: (1) coding reliability TA, (2) codebook approaches to TA, and (3) the reflexive approach to TA (Braun et al., 2019).

The reflexive approach to thematic analysis (TA) emphasizes the active involvement of the researcher in knowledge development (Braun & Clarke, 2019). Codes indicate the researcher's judgments of meaning patterns in the dataset. Regarded as a reflection of the researcher's interpretive analysis of the data performed at the junction of (1) the dataset; (2) the theoretical assumptions of the analysis; and (3) the researcher's analytical skills/resources (Braun & Clarke, 2019). "The researcher's reflective and thoughtful engagement with their data, as well as their reflexive and thoughtful engagement with the analytic process" (Braun & Clarke, 2019, p. 594). The coding and theme generation process is flexible and organic and frequently evolves throughout the analytical process (Braun et al., 2019). As the analysis progresses, more familiarity with the data is gained, which may lead to identifying new patterns of significance.

Coding is a flexible and organic procedure that frequently evolves throughout the analytical process (Braun et al., 2019). As the analysis progresses, more familiarity with the data is gained, which may lead to identifying new patterns of significance. Coding contrasts the use of codebooks, which can frequently predefine themes before coding. The reflexive technique does not use established themes to 'discover' codes. Themes are generated instead by organizing codes around a relative core commonality, or 'central organizing notion,' which the researcher interprets from the data (Braun et al., 2019). A researcher using an inductive or 'data-driven' approach may want to create codes entirely reflective of the data's content, free of preconceived theory or conceptual framework. In this situation, data are 'open-coded' rather than coded to match a pre-existing coding frame to convey meaning better as participants communicate (Braun & Clarke, 2013).

The research applied deductive analysis to ensure that the open coding produced themes significant to the research questions and that the respondent/data-based meanings highlighted were relevant to the research questions. Codes serve as the foundation for what will eventually become themes. The coding procedure creates concise, brief descriptive or interpretive labels for information relevant to the research questions. A recommendation is that the researcher combs through the entire dataset systematically, giving equal treatment to each data item and finding elements of data items that are intriguing and may be relevant in establishing themes. Codes should be concise yet provide enough content to stand alone and communicate the underlying commonality among constituent data elements. Any data coded could help answer the study questions. The researcher can find which codes are helpful in deciphering themes and can reject them through multiple repetitions of coding and additional familiarization. The

researcher should document their progress through coding iterations to follow the evolution of codes and possible themes. RTA is a recursive process, and it is uncommon for a researcher to take a straight line through the six phases (Braun and Clarke 2014). When coding, it is usual for the researcher to follow a specific train of thought only to hit a snag where multiple interpretations of the data emerge. It may be required to investigate each of these potential possibilities to choose the best course of action.

For this study, the process of data analysis entailed putting together and organising textual data and transcripts from post-project interviews for analysis. After sorting the data, through a process of coding, it was further condensed and reduced into themes and eventually represented in a discussion and figures. According to Miles and Huberman (1994), the core elements of a systematic approach to this kind of data analysis involves reducing the data into meaningful segments, assigning labels for each segment, then combining the codes into broader themes as well as displaying them and making comparisons in various forms, such as tables. They also note that the process of data analysis must include writing marginal notes and noting relationships among themes. The current study took cognisance of these core elements of data analysis and went a step further to form a description of the study data and relating same to the theoretical perspective and literature review.

According to Lincoln and Guba (1985), secondary data analysis and interpretation entail drawing 'the lesson learnt'. In addition, making sense of the data involves the use of insights, intuition, and hunches. For the current study, the same principle was applied, and it took the form of stepping back and forming larger meanings of what went on in the Indima Yethu sites. Spradley (2016) notes that the final stage of data analysis and interpretation for a study of this kind entails presenting the data, by packaging what was found in the form of text, figure, or tabular format.

The process of coding and content analysis allowed for the highlighting of similarities in experience. This process has made it possible to generate important themes. The researcher also analysed the pilot study that preceded the current study (Obuaku-Igwe, 2015; 2017; 2020; 2022) to generate baseline information on factors that protect the mental health of young people in South Africa. It is expected that the present study will provide further information on the effectiveness of MHFA as a protective factor in the management of the mental health of people in informal settlements in the Western Cape, for further studies on the social welfare and social protection of children and young persons in South Africa.

In column A, rows 2 through 17, the reference code labels PAR01 to PAR12, which were given to each participant individually, were recorded. Kuckartz (2014) proposes incorporating interpretive text analysis into the analysis of qualitative data. The researcher analysed the qualitative data in this study using reflective thematic analysis. There are six stages in the data analysis process, according to Braun and Clarke (2006). Getting familiar with the data is step one. Steps two through six involve finding themes, examining themes, describing themes, labelling themes, and producing outcomes.

The researcher determined codes based on the phrases that often featured in the 12 participant assessment forms from the Writer's Clinics. This was included in the initial coding. The 13 questions were typed in columns B to N of the Excel Worksheet. Each participant's response to the related question was then listed in rows 1 through 13. The responses were entered into Microsoft Excel and colour-coded to distinguish between and identify similar responses and codes while also familiarising myself with the data to discover themes. The process yielded 86 codes.

NVivo Benefits and Drawbacks - According to Dollah et al. (2017) NVivo is an application software that assists researchers in managing large sets of data; it assists researchers in identifying themes; it assists with generating relationships among themes. The researcher also made use of the NVivo 12 Plus Programme and uploaded the 12 participant evaluation questionnaires to cross-reference it with the researchers previous coding process. Closed-ended questions were made into attributes and each response was uploaded as a case. The open-ended questions were developed as codes, which meant that each response to a particular topic was assigned its own code. There were 115 codes found. Further delving into the NVivo application software was hindered due to the NVivo application software limitations: it required time to understand and learn. It is time-consuming; many researchers use manual data analysis. In the least developed and underdeveloped countries, researchers cannot afford it. Despite NVivo having a free version for one month`s trial, it is not enough time for many researchers. When it comes to data interpretation, most researchers claim that it does not help much in terms of data interpretation (Dollah et al., 2017).

4.9 Summary

According to Indima Yethu's programme, the NPO aimed to achieve the following: (a) creating a culture of acceptance and reducing stigma around mental illness; (b) promoting openness about mental health challenges among participants; (c) increasing participants' empathy and

willingness to help and support people with mental health challenges in their communities; and (d) increasing participants' utilisation of professional services by influencing their health-seeking and utilisation behaviours.

The first section of the chapter discussed the research design, and the collection of data as well as the source of the data for this research study. The researcher chose a secondary research design using both quantitative and qualitative data to generate the most efficient data analysis and results for this research topic.

CHAPTER 5: RESULTS

5.1 Introduction

This study examines the effectiveness of a youth-focused mental health first-aid training programme in the context of an adapted youth policy implemented by a non-governmental organisation in the Western Cape province of South Africa. The study represents a preliminary attempt to build the evidence base of MHFA in South Africa by assessing its perceived impact on trained people. The sample included young people from 18 years to 35 years living in the Western Cape. Overall, the findings of this study suggest that MHFA is emerging as a protective factor in South Africa. Participants in the current study reported that MHFA training benefited them, their friends, and family. Most participants said that learning new information about mental health during their training changed their perception of mental illness and gave them more confidence in helping others in their social network.

5.2 Data Handling and Analysis

Indima Yethu, an NPO in Cape Town, funded the Writer's Clinic's 13-week intervention programme, which included a community-based mental well-being intervention and an asset-based approach to mental health. Participants completed an evaluation questionnaire at the end of the 13-week intervention programme. There were 13 open-ended questions on the evaluation questionnaire; 12 participants completed the questionnaires in their own time and returned them electronically. The researcher collected the data between April and July of 2021. The data consisted of 12 electronic participant evaluation questionnaires completed by participants actively involved in the programme.

Each participant was assigned a unique reference code label: PAR01 – PAR12, which was recorded on an excel spreadsheet where column A; rows 2 – 17 contained PAR01 to PAR12. Kuckartz (2014) suggests doing interpretive text analysis as part of qualitative data analysis.

The researcher used reflective hematic analysis to analyse the qualitative data in this study. Braun and Clarke (2006) identify six levels in the data analysis process. They are: (a) acquainting yourself with the data; (b) generating initial codes; (c) searching for themes; (d) examining themes; (e) describing and naming themes; and (f) producing the results. Based on the words that frequently appeared in the 12 Writer's Clinic participant evaluation questionnaires, the researcher identified codes.

As part of the initial coding, the following applies. Aiming to answer the research questions, the process assisted in developing themes. The researcher entered the 13 questions across the Excel Worksheet, ranging from column B to column N. Rows 1 to 13 contained each participant's answer to the corresponding question. Using Microsoft Excel, the researcher inserted the responses and colour-coded them to differentiate and identify similar responses and identify codes while at the same time familiarising herself with the data to identify themes. There were 86 codes identified. The researcher used the NVivo 12 Plus Programme to cross-reference the work and uploaded the 12 participant evaluation questionnaires. The researcher uploaded each response as a case and created closed-ended questions as attributes. The researcher created the open-ended questions as codes, meaning that the researcher grouped all the responses to a specific question under a single code and identified 115 codes.

Furthermore, the researcher used reflective thematic analysis to identify themes from the existing data. The researcher developed themes linked to the effectiveness of the Writer's Clinic Programme and whether the collaborative social networks and the peer mentoring programme of Indima Yethu impacted their participants' physical and mental well-being. The researcher identified the following themes: Theme 1: Protective factors of mental health; Theme 2: Challenges faced by the Writer's Clinic participants; Theme 3: Mental health advocacy success; Theme 4: The Writer's Clinic success attributed.

5.3 Demographic Characteristics of Participants

In total, 12 young people aged 18 to 34 took part in the study, having completed the YMHFA programme through Indima Yethu between December 2019 and June 2022. The overall response rate of all participants was 98%. With a median age of 21.5, 66.6% were females (n=8), 33.3% were men (n=4), 87.2% were single, and 41.6% were colored (n=5), with 50% Black Africans (n=6) and approximately 8.3% (n=1) white. All participants (n=12) had high school degrees and were predominantly social science and humanities undergraduate majors enrolled at several universities in the Western Cape with no prior experience in healthcare at the time of the training. Almost all the participants had either suffered from mental illness or had a close family member or friend who had. Approximately 83.3% (n=12) of participants stated that their annual household income was less than R100,000.

Table 2: Participants' lived experience of mental disorder before MHFA (N = 12)

Mental illness	N	%
Anxiety/Depression	12	100
Bipolar	5	41.6
Eating Disorder	4	33.3

Table 3: Participants' coping mechanism for mental illness prior to MHFA (N = 12)

Coping mechanism	N	%
Music	12	100
Weed	5	41.6
Energy Drink	7	58.3
Alcohol	10	83.3

5.4 Protective Factors of Mental Health within Indima Yethu's Curriculum

The data analysis suggests that participants' attributes contributed to the effectiveness of Indima Yethu's MHFA programme. Attributes such as the capacity and discipline to problem-solve, manage adversity, cope with stress, and stick through a process that requires stoic determination helped build mental toughness throughout the 13-week programme. Throughout the 13-week mental health management programme, all respondents described their intentional health behaviours and daily engagement in physical activities as part of what contributed to their ability to complete the programme. All respondents described the inseparable links between mental and physical well-being.

A 20-year-old Black-African respondent shared:

> I started journalling daily and I noticed that it helped with my anxious thoughts. However, when I started taking daily walks and doing breathing exercises, I noticed that my energy levels increased. When my mom saw the progress, she bought me magnesium vitamins and that went a long way. I feel so alive and can now manage my panic attacks.

Strengthening an individual's capacity to handle daily stressors and minimise the risk of mental illness or substance use was a crucial part of Indima Yethu's programme. Nearly all respondents described a decline in their utilisation of weed, and energy drinks, as part of the coping mechanism they were used to. The involvement of their friends and families as accountability partners was at the core of their resilience and a vital part of the process involved in building good emotional, mental, spiritual, and physical well-being.

A coloured female respondent shared:

> Having my boyfriend as an accountability partner helped in keeping a positive attitude. I also realised that the programme brought awareness to some beliefs and values I needed to work on as an individual. As a matter of fact, the programme-built conflict resolution skills I never knew I had in me.

Setting personal goals was the hallmark of the 13-week programme, negotiating socio-cultural biases and religious socialisation in the process of destigmatising or making mental health decisions, with half of the respondents have experienced a form of mental illness. The responsibility of renegotiating their mental health beliefs is a burden young people must carry, different from what they were previoulsy socialised into believing. In addition, they also must negotiate spaces and places where their mental health challenges are not stigmatised or misunderstood.

Another 21-year-old coloured respondent described:

> When I joined the Indima Yethu's programme, the first thing I had to unlearn was that my mental illness was not a spiritual attack and that no one was after me. I also had to learn to set personal goals. I got to understand that not achieving those goals or falling short of my parents' expectations was not the end of life. We live to try again another day [I mean] a living dog is better than a dead lion.

As this respondent highlighted, social, cultural, spiritual, psychological, and other factors influence young people's mental well-being. Indima Yethu took cognisance of these factors in designing and implementing their MHFA course. Asking course participants to identify and

address critical areas of development related to career, academics, spirituality, and relationships in week two contributed to higher self-awareness and changed perceptions of failure. Nearly all respondents described that before the programme, they were unaware that their social networks were assets that could contribute to their physical and emotional well-being.

A 22-year-old black male respondent shared that:

> I know my buddy always helped each time I was short of fare to campus. I mean, we also talk about girls, but I never knew that I could share deeper things with him. I took stock of my career and relationship status [during our privilege mapping exercise] and realised that I needed more authentic friends and a tribe of people I can be honest with about my struggles. I also realised that I needed new friends who will be willing to grow with and always hold me accountable. I don't need to panic now. I can decide to change things I don't like in my life and be patient with myself as I take baby steps.

As this respondent highlighted, a significant benefit of Indima Yethu's programme that contributed to increasing protective factors and lowering risks such as self-destructive behaviours was stock-taking, concrete support, and emotional and social competence/honesty. During the programme, an awareness of their emotions and perceptions was built in every aspect of their lives, creating an opportunity for compassion for self (and others), personal accountability, and stewardship. Respondents felt that friendships and relationships must be for economic benefits gain. Taking stock of various aspects of his life helped him be accountable and take steps to fix things or change whatever he did not like. Changing his perceptions also helped in the effectiveness of the programme.

Even though most of the respondents are social science majors who did not participate in the university-based pilot programme, they reported using what they learned to help their classmates. Participants stated that adapted and culturally appropriate MHFA training guidelines for young people de-centred neediness and a token system that made young people heavily reliant on specialised services. When implemented in a culturally appropriate manner, the findings suggest that MHFA is a protective factor that could act at several levels, including individual, family, community, structural, and population—observed positive changes in behaviour and attitudes following Indima Yethu's MHFA training point to the role of including culturally competent strategies in programme implementations. The primary goals of Indima

Yethu's MHFA programme are: to create a culture of acceptance and reduce stigma around mental health illness; to promote openness about mental health issues among participants; to engender empathy and motivation among participants to help and support those with mental health issues in their community as well as to participants' utilisation of professional services by influencing their health-seeking behaviour.

5.5 NPO-Led MHFA: Challenges Experienced by the Writer's Clinic Participants

The themes falling under theme two focused on hindrances experienced by the participants. Notable challenges expressed by some of the participants were difficulty in accessing online platforms.

A white female respondent (PAR02), age unknown, responded that:

> To be completely honest, online discussions over Zoom were a bit of a challenge due to the network connection, so maybe meetings in person would be preferable, but now due to COVID, it is understandable and safer to conduct meetings online.

A Black African female participant (PAR04) shared that:

> I was in a place where there was no Wi-Fi and therefore, I could not attend.

Further, challenges faced were finding an ideal space within their setting to participate without any hindrances. Internet connectivity challenges were recorded for 33.3% (n=4) of participants.

Respondent (PAR04) shared that:

> The unreliability of network connectivity when using Zoom. The virtual meetings didn't work for me due to network connectivity.

A Black African male participant (PAR06) shared that:

> Session missed due to Internet connection being unavailable.

A Black African female participant (PAR04) described that:

> I was in a place where there was no Wi-Fi and therefore, I could not attend.

A coloured female participant (PAR12) shared that:

> We had a power shortage, and I didn't have data to attend.

All participants experienced mental health difficulties. The experience of being involved with the programme made them aware that what they brushed off as just another rough day or experience needed a deeper look. Awareness of their experiences ensures that mental health wellness is possible and achieved. A total of 41.6% (n=5) raised their difficulties and challenges concerning the online discussions being conducted via the Zoom platform, instead preferring, and favouring face-to-face meetings.

A Black African female respondent (PAR09) was in favour of face-to-face meetings and responded:

> The virtual meetings didn't work for me. I liked the face-to-face sessions because we were so free, and we were able to talk about anything.

A coloured female respondent (PAR05) shared that every week she looked forward to:

> The group of people I got to see every week.

5.6 Mental Health Advocacy Success

The themes falling under theme three focused on what transpired during the 13-week peer mentor intervention programme at Indima Yethu. All the participants (n=12) shared that mental health prioritisation is essential, and they need to ensure they practice self-love, self-reflection, and self-care, most of which had been previously seriously neglected. Respondents agreed that the Writer's Clinic advocated for mental health.

A coloured female respondent (PAR12) agreed that the intervention programme worked and shared the following:

> Mental health and breaking down the stigma of what mental health is and who can have it.

A Black African male respondent (PAR11), was also in agreement and explained that:

> The Writer's Clinic is equipping students with finding ways to deal with mental issues. The platform is enabling us to understand the importance of communicating or voicing

out what is inside. Let go of emotions and feelings that could cause harm to us. On the other hand, learning skills on how to balance our ways of communicating e.g., reciprocate.

A Black African female respondent (PAR04) described that:

> Assisting students and fellow students to know that they are not alone, creating an outlet for them to breathe and cultivate themselves and take care of their emotional and mental health.

A Black African female respondent (PAR09) shared that:

> The Writer's Clinic gives people a chance to speak about themselves and talk about the challenges that they face.

A Black African male respondent (PAR06) described that,

> 'Self-awareness, self-acceptance, and mental health prioritisation' was what he felt the aim of the Writer's Clinic Programme had been advocating for.

The 13-week peer mentor intervention programme enabled young people to understand their mental well-being and health better. They taught young people how to practice self-love and care, highlighting the things they might have previously overlooked. One can find healing and ease a heavy burden by talking to others.

For most participants, especially (PAR09) a Black African female described that:

> The Writer's Clinic gives people a chance to speak about themselves and talk about the challenges that they face.

Respondent (PAR04) a Black African female shared that at the Writer's Clinic peer mentors were:

> Assisting students and fellow students to know that they are not alone, creating an outlet for them to breathe and cultivate themselves and take care of their emotional and mental health.

Respondent (PAR05) a coloured female shared that:

> It has been an overall great experience and I have learnt many things about myself as well as my surroundings. I have also learnt different

> ways to cope and improve my mental health which I feel would benefit everyone.

This response was shared by the respondent (PAR03) a coloured female:

> The writer's clinic has been a very good experience overall. And it really allows you to be vulnerable to the activities that were set out. It allows you to dive into yourself and introspect.

5.7 Factors for Success: The Writer's Clinic MHFA

The findings outline success factors, such as incorporating ALGEE: Assess risk, listen non-judgmentally, give reassurance and information, encourage appropriate help, and Encourage self-help. Themes highlighted by respondents under the success factors indicate that the adaptation of ALGEE to Indima Yethu's training programme does not teach individuals to become therapists but instead emphasises self-stewardship and the provision of initial support. In addition to respondents' reflections on the challenges they encountered during the programme, they also noted some factors responsible for the programme's success. In addition to the ALGEE, the daily step-by-step approach – reach out, offer emotional support; offer affirmations and appraisal; offer informational support; offer instrumental support; share points of view; mentor at least one person in the community; enable peer access to social support – were of the most rewarding aspects of the course delivery. Other aspects were the contents of week 9, which required participants to practice active and empathetic listening.

Some respondents (75%; n=12) participated in the training to find their own voice through blogging, define what success and peace meant to them, and take small steps towards it; 41.6% (n=5) engaged in moderate-intensity physical activity for at least 30 minutes almost every day, kept a diary, and asked how they felt before and after each session and discussed with the trainer how they felt; 82,3% (n=10) kept a diary but did not engage in any physical activity; and 33,3% (n=4) did not keep a dairy or exercise but reported breathing daily. Observing their most productive hours each day, and in doing so pushed them out of their comfort zone by doing one small thing daily. A good number of participants, approximately 83% (n=10), indicated that before the 13-week programme they were not aware of MHFA, and only 16.6% (n=2) indicated that they were aware of MHFA as a concept. All participants indicated that they used Indima Yethu's six-step approach – 'reach out; offer emotional support; offer

affirmations and appraisal; offer informational support; offer instrumental support; and share points of view' – in helping others.

A large majority of the participants (83.3%) reported that the most positive aspects were those related to supporting their peers, linking up with an accountable partner to help them along the way to achieve their goals, practising self-expression and consistency through daily journalling, identifying and work on key development areas related to career, education, spirituality, and relationships, seeking support from family and friends to answer self-awareness questions using weekly reminders provided by Indima Yethu. A small number of participants (16.6%, n=2) who found the programme less supportive indicated that the negative aspects were those related to setting short-term personal and long-term goals in conjunction with an accountability partner who will be responsible for them. They said it strained their sanity and did not help them.

Table 4: Themes and participant responses

Theme	Response
Challenges faced by the Writer's Clinic participants	To be completely honest, online discussions over Zoom was a bit of a challenge due to the network connection; so maybe meetings in person would be preferable, but now due to COVID it is understandable and safer to conduct meetings online (PAR02). I was in a place where there was no Wi-Fi and therefore, I could not attend (PAR04). Session missed due to Internet connection being unavailable (PAR06). We had a power shortage, and I didn't have data to attend (PAR012). The unreliability of network connectivity when using Zoom. The virtual meetings didn't work for me due to network connectivity (PAR010). I used the Sentinel App; however, I love writing with a normal pen and paper and in my own diary and so I used that more (PAR04). Too many commitments and responsibilities (PAR011). I began to journal, which was great, but I still feel unprepared to write (PAR012).

Mental health advocacy success	Writer's Clinic is equipping students with finding ways to deal with mental health issues. The platform is enabling us to understand the importance of communicating or voicing out what is inside. Let go of emotions and feelings that could cause harm to us. On the other hand, learning skills on how to balance our ways of communicating e.g., reciprocate (PAR011). The Writer's Clinic gives people a chance to speak about themselves and talk about the challenges that they face (PAR09). Advocating for those who have challenges opening up about mental health issues because it's often stigmatised (PAR02). Assisting students and fellow students to know that they are not alone, creating an outlet for them to breathe and cultivate themselves and take care of their emotional and mental health (PAR04). Mental health and breaking down the stigma of what mental health is and who can have it (PAR012). I would say that the Writer's Clinic advocates for mental health by providing a safe space and effective training in these virtual sessions (PAR010). Before I joined this programme, I was focused on my goals but hadn't thought of a plan to achieve them; so, once I joined this group, I became more motivated and mentally stronger. Joining this group assisted me in becoming more confident and helped me with my communication skills; physically getting involved in exercise daily was also on my list and by joining this 13-week programme I managed to become more involved in achieving my goals without any hesitation (PAR02). The weekly task helps you to leave your comfort zone and be out there. For example, the mental health interview, I had to go out and talk to people, invite them over to the Zoom meeting. I was not comfortable at first due to social anxiety, but I pushed myself and challenged myself to get it done, which really helped in my growth (PAR06).
The Writer's Clinic success attributes	Engaging in the weekly tasks, openly communicating with my accountability partner (discussing goals, how to achieve them, achieving our physical fitness and being there for one another), conducting video interviews and asking people their perspectives on mental health issues and its awareness; and lastly, understanding that mental health is a serious issue especially when it is being stigmatised dramatically as an unstable condition (PAR02). It has been an overall great experience and I have learnt many things about myself as well as my surroundings. I have also learnt different ways to cope and improve my mental health, which I feel would benefit everyone (PAR05). The Writer's Clinic has been a very good experience overall. And it really allows you to be vulnerable to the activities that were set out. It allows you to dive into yourself and introspect (PAR03). Being assigned an accountability partner and sharing each other's experiences and opinions, giving advice (PAR01).

	Becoming comfortable in sharing my deeper thoughts and feelings to a genuine group who cared and provided a safe space (PAR010). The exercises we did during the sessions and discussions that took place there allowed us to feel comfortable with one another and comfortable with ourselves, getting to know ourselves deeper (PAR06). Every week I was granted the opportunity to connect with others and once I started, I honestly thought that I was alone in my daily experiences and that no one would understand what I was going through whether it be emotionally, mentally, or physically but knowing that there was someone rather a whole group of individuals going through the same situation made me feel stronger and more courageous (PAR02). Fear of being judged is what many people go through; so, honestly, being able to openly speak about my struggles helped me cope with them (PAR02). For me, I'd recommend this because as I've said in the above, you'll never be alone, and you'll have an accountability partner as well, so it has been an amazing experience (PAR02). It created an engaging space for the members of the clinic to vent, discuss how we felt or battles we faced and create a safe space in doing so (PAR07). The Writer's Clinic creates a safe space where we could talk, share, and engage with one another. I really enjoyed it and kind of miss the camaraderie (PAR012). The weekly conversation about how we really are. Everyone goes through daily challenges, and we rarely get asked about how we really are internally and if we are mentally okay as well as emotionally. Knowing that there was a platform to openly discuss what was bothering me helped me cope with pain a lot (PAR02).

5.8 The Writer's Clinic: Impact Evaluation by Participants

The researcher used reflective thematic analysis to analyse the Writer's Clinic participant evaluation questionnaires. The researcher organised the 12 participant evaluation questionnaires and compared each response. The researcher attempted to identify words and phrases that frequently appeared throughout the 12 participant evaluation questionnaire responses. All 12 participants completed the same set of questions. However, as the researcher read through the responses, it became evident that many participants shared similar experiences. Questions to which participants had similar responses were all organised. Emerging themes related to answering the research questions became increasingly evident. The themes developed linked to the effectiveness of the Writer's Clinic Programme and whether the collaborative social networks and the peer mentoring programme of Indima Yethu impacted their participants' physical and mental well-being.

- How well have Indima Yethu's adapted MHFA guidelines, which focus on young people as assets, worked to change young people's attitudes, knowledge, and behaviour in general regarding mental health?
- Is Indima Yethu fostering a feeling of community among young people to advance mental health?
- How have Indima Yethu's peer mentorship program and collaborative social networks affected participants' physical and mental health?

Although the purpose of the evaluation was to focus on the programme itself, some of the participants mentioned in their responses that which could be viewed as moderately negative and positive for them personally, which then signifies their own concerns and individual mental wellness (see Table 5).

Table 5: Participant responses

Question	Response
Question 3: Please state your reasons for missing the sessions.	First session missed was due to the Internet connection being unavailable (PAR06). We had a power shortage, and I didn't have data to attend (PAR012).
Question 6: In your opinion, what kind of advocacy work are we doing at the Writer's Clinic?	Advocating for those who have challenges opening up about mental health issues because it's often stigmatised (PAR02). Let go of emotions and feelings that could cause harm to us (PAR011). Mental health and breaking down the stigma of what mental health is and who can have it (PAR012).
Question 7: What did not work? What kind of lessons did you learn and how would you like to share them?	The virtual meetings didn't work for me (PAR09). I began to journal, which was great, but I still feel unprepared to write (PAR012). The unreliability of network connectivity when using Zoom (PAR010).
Question 9: Did you use the Sentinel App? What do you think of it?	I did in the beginning and after a while my phone space was running low and I had to delete it. However, I disliked that I could not see my previous posts (PAR05). Yes, I did, but not for a long time because I became busy with school. But I really liked it because I never had a diary in my life it was the first platform where I could write my random thoughts and feelings (PAR08).
Question 12: Would you recommend the programme to others? Why?	Yes, because it helped me learn more about myself in a short amount of time and distracted me from personal struggle (PAR010).

Question 13: Do you think there is a link between the weekly activities and changes in your welfare, physical, social, and emotional growth, or wellbeing? If yes, explain.	I was not comfortable at first due to social anxiety, but I pushed myself and challenged myself to get it done, which really helped me in growth (PAR06).

Table 6: Responses viewed moderately positive

Question	Response
Question 4: What aspects of the Writer's Clinic worked?	Engaging in the weekly tasks, openly communicating with my accountability partner (discussing goals, how to achieve them, achieving our physical fitness, and being there for one another); conducting video interviews and asking people their perspectives on mental health issues and its awareness; and lastly, understanding that mental health is a serious issue especially when it is being stigmatised dramatically as an unstable condition (PAR02). I really enjoyed it and kind of miss the camaraderie (PAR012).
Question 5: What did you like most?	I really enjoyed the weekly check-ins with everyone (PAR01).
Question 7: What did not work? What kind of lessons did you learn and how would you like to share them?	To be completely honest, online discussions over Zoom were a bit of a challenge due to the network connection; so maybe meetings in person would be more preferable, but at the moment due to COVID it is understandable and safer to conduct meetings online (PAR02). I have learnt that journalling helps, because sometimes you can only truly turn to a diary at any moment and your diary helps you to keep track of how you are doing, and I can see that I have been able to take on certain aspects of my life much easier now (PAR04).
Question 9: Did you use the Sentinel App? What do you think of it	Yes, I did. However, I love writing with a normal pen and paper and in my own diary and so I used that more (PAR04). I used it a few times and found the breathing exercises to be quite effective (PAR07). Yes, I did, but not for a long time because I became busy with school, but I really liked it because I never had a diary in my life. It was the first platform where I could write my random thoughts and feelings (PAR08).
Question 10: What made a change or impact in your life?	And therefore, you are able to be more confident and I was able to receive help (PAR04). Allowing myself to be vulnerable to people I have never met before in person, but still creating a great and genuine bond (PAR010).
	I would absolutely love to, if possible (PAR010).

Question 11: Would you like to register for a certificate in the Writer's Clinic Programme?	
Question 12: Would you recommend the programme to others? Why?	Yes, I would, primarily because I knew that every week, I was granted the opportunity to connect with others. And once I started, I honestly thought that I was alone in my daily experiences and that no one would understand what I was going through whether it be emotionally, mentally or physically. But knowing that there was someone, rather a whole group of individuals, going through the same situation made me feel stronger and more courageous (PAR02). Yes, because like most students we truly do things on our own and that is where we become depressed and feeling as though we cannot accomplish things anymore. However, if we now open a space, and a safe space where other students share how they are feeling, we are able to collectively make each other better and lift each other up (PAR04). I would recommend the programme to others because it's very fruitful and it changes the way we see certain things as negative, and we see them in a positive way (PAR09).
Question 13: Do you think there is a link between the weekly activities and changes in your welfare, physical, social, and emotional growth, or wellbeing? If yes, explain.	Yes, before I joined this programme, I was focused on my goals but hadn't thought of a plan to achieve them. So once I joined this group, I became more motivated and mentally stronger (PAR02). Absolutely, you cannot grow within the parameters of your comfort zone. You have to be stretched to grow and therefore, being given tasks weekly aids in you focusing on areas about yourself that you put on the side lines just because you are swamped with academic deadlines. But taking care of yourself is very important in order for you to be able to put your best (PAR04).

5.9 Summary

This data analysis and discussion chapter aimed to explore topics related to the effectiveness of the Writer's Clinic Programme and whether Indima Yethu's shared social network and peer mentoring programme impacted the physical and mental health of participants. The researcher set out to achieve this while staying true to the research objectives, questions, literature review, and main theoretical underpinnings of the study.

The study intended to provide a summary and highlight and summarise some critical points discovered. The researcher found all the key ideas highlighted in this section based on secondary data obtained from the Writer's Clinic intervention programme at Indima Yethu. The study only used 12 participant-assessment questionnaires. Hence the results cannot be generalised.

CHAPTER 6: DISCUSSION AND CONCLUSION

6.1 Introduction

This chapter provides conclusions and the identified research limitations. The researcher carefully considered the conclusions and limitations to provide further insight into future research within the field of mental health wellness, together with their own learning experiences of the overall dissertation. The theoretical chapter provides an understanding of the various theories, concepts, and ideas used in the research, investigating the relationship between various stressors in people's lives and the psychological effects they have on them. It examined mental health through the lenses of social capital, network, and support theories. The methodology chapter discussed the methods used to examine well-being by looking at an asset-based and participatory approach to youth mental health promotion in South Africa. Based on the findings, this chapter recommends future research studies on mental health wellness. Like any other research endeavour, this chapter also highlights applicable and relevant limitations. The final discussion centres on personal reflection.

6.2 Discussion

According to Johnson et al. (2016), mental illness is a significant public health problem, with up to one-third of adults and one-fifth of children and adolescents meeting the diagnostic criteria for a mental disorder. However, many people with mental illness remain unidentified and untreated, eventually allowing mild problems to develop into more serious and incurable illnesses. Identifying these people early when they have the disease or are at risk of developing such problems and referring them to appropriate interventions can reduce the burden they may experience.

The 13-week intervention programme at Indima Yethu focused on a variety of themes. These broad themes were the focus of the programme. They would ultimately guide young people to grow while discovering themselves, learning to feel better about themselves and overcoming and conquering current and future challenges or obstacles.

Weeks 1–4: The programme covered themes and implemented them, as outlined below.

Theme 1: Set personal short-term and long-term goals and work with a responsible partner.

Theme 2: Identify and address key areas of development related to career, academics, spirituality, and relationships.

Theme 3: Collaborate with fellow mentors and established accountability partners to support you along the path to achieving set goals.

Theme 4: Practice self-expression and consistency through daily journalling.

Themes 1–4: Guidance was given to participants concerning self-introspection, finding out who they are and where they envisage themselves both on a short-term and long-term basis, discovering their own goals and finding ways to make them a reality. It also included figuring out what areas in the individuals needed growth or development. Participants were encouraged to team up with other mentors so that a support function existed and would aid them in achieving set goals. Teaming up with mentors meant someone had their back and would check in regularly.

Weeks 5–8: The programme covered themes and implemented them, as outlined below.

Theme 5: Support your peers or enlist the support of family and friends in answering self-awareness questions.

Theme 6: Map your energy by observing when you are most productive each day and doing one little thing that pushes you out of your comfort zone.

Theme 7: Practice mindful living by observing your breathing for 10 minutes each day.

Theme 8: Have fun writing about your day and reading at least one page of your favourite book.

Themes 5–8: By creating awareness of being able to express oneself, participants who had never journaled started writing and discovered how much lighter they felt by putting pen to paper. It was a form of therapy. Most participants realised when they were feeling overwhelmed and drained and what they could do to make better use of those periods, perhaps steering from it so they would not feel overwhelmed and irritated later when they feel pressured by not having met specific goals or deadlines.

Weeks 9–13: The programme covered themes and implemented them, as outlined below.

Theme 9: Practice active empathetic listening. Practice empathetic listening exercises.

Theme 10: Find their voice through blogs, support them, and enable others to do the same.

Theme 11: Define what success and peace mean to them and take small steps in that direction, celebrate yourself.

Theme 12: Get at least 30 minutes of moderate physical activity most of the week. Keep a journal and tell us how they feel before and after this exercise.

Theme 13: Through our six-step strategy, 'reach out; offer emotional support; offer affirmations and appraisal; offer informational support; offer instrumental support; and share points of view', mentor at least one person in their community and enable peer access to social support.

Themes 9–13: The Sentinal application is a cellular mobile phone application used by Indima Yethu's intervention programme to assist participants in breathing exercises. The Sentinel application assisted them in learning to journal their thoughts, feelings, and experiences. Peer mental health support meant that participants would do daily check-ins to enquire how the other was doing or holding up. It was given to participants if support was needed, and thoughts were shared.

There is strong evidence that MHFA training improves knowledge about supporting people experiencing mental health problems (Morgen et al., 2019). Further evidence is that MHFA training improves knowledge about supporting people experiencing mental health problems. The sooner a person receives support or intervention, the more likely they will recover from a mental illness. The NPO Indima Yethu implemented its 13-week intervention programme, successfully improving attitudes, knowledge, and general mental health behaviours among Cape Town young people (Obuaku-Igwe, 2022). MHFA is an adaptation of physical first aid training for responding to emotional or mental health emergencies. It was born out of needing immediate support for those experiencing a mental health crisis. MHFA includes a six-step process for contacting people experiencing a mental health crisis. MHFA includes assessing and providing support during the crisis; listening and communicating without prejudice; providing support and information; encouraging the person to seek appropriate professional help; promoting other forms of support (Kitchener & Jorm, 2008).

Feedback obtained from participants who participated in the 13-week Indima Yethu intervention programme shared the following:

Participant PAR02 said that the intervention improved his focus and ultimately led to the development of skills that helped improve the way he previously communicated poorly. It has contributed to my becoming mentally more assertive and focused.
Participant PAR11 noted the development of the skills acquired in the Writer's Clinic Programme and how it helped them express previously unspoken matters. You realise the importance of voicing your feelings and saying what you are going through, both good and bad. In general, all the participants agreed that being a part of the 13-week intervention programme helped them identify issues on an individual level that are of mental health concern.

In developing countries like South Africa, more research is needed Sorsdahl et al. (2012) observed a growing body of literature on internalised stigma from developed countries.A lack of social capital within low-income communities was the common cause of why most young people were struggling physically, emotionally, and mentally. Smith-Frigerio's (2021) study in the United States found that the pervasive stigma around mental health problems prevents individuals from seeking treatment, creating a public health crisis in that country. Indima Yethu, in partnership with the Writer's Clinic, worked tirelessly to ensure that the stigma of health matters surrounding mental health matters gets broken down. One of the participants, PAR012, believed that mental health advocacy was slowly breaking down the stigma of mental health within their community.

Kutcher, Wei, and Morgan (2016) comment that many young people face difficulties related to livelihoods, emotional security, education, and violence and suggest that these concerns need attention. Addressing the mental health needs of young people is critical to reaching their potential and contributing fully to the development of their communities (Kutcher et al., 2016). Creating a safe place for young people is one of the goals that Writer's Clinic was trying to achieve with the help of Indima Yethu. There were comfortable sharing moments when young people felt safe and comfortable. Participants PAR01 and PAR12 each stated at some point that they felt safe and did not even feel criticised, so they could easily share the challenges they faced with others.

Participants PAR05 and PAR03 indicated that they had learnt different ways of coping with daily challenges to realise their potential and be fully involved in their communities, while ultimately becoming more confident in their ability to cope. They agreed that they needed to do some introspection to improve their mental state and their overall health.

6.3 Summary of Findings

When summarising the main findings of the research study, one must consider the research objectives. The primary goal of this research study was to investigate mental health promotion by exploring the impact and value of a peer community-based intervention initiative for young people in their communities. The participants' lived experiences could be understood using an asset-based and participatory approach to mental health promotion. The interpretation of the study's discovery should add to the current literature on the sociology of mental health wellness.

One of the research objectives of this study aimed to examine the effectiveness of a peer mental health support group for young people in the city of Cape Town. Specifically, the study examined the impact of a 13-week intervention programme on peer social support and mental health promotion carried out by an NPO, Indima Yethu, in Cape Town.

The research sought to understand the extent and degree to which Indima Yethu adapted mental health management through peer social support and narrative therapy to fill the existing treatment gap within deprived communities in Cape Town. The program shifted to an online platform due to the COVID-19 pandemic. As a result, the participants' evaluation of the 13-week program mentioned the positive and negative aspects. Based on the participants' evaluation questionnaires, the researcher found many participants highlighted their concerns about privacy, hindrances, and time constraints at home. They were struggling to participate amidst having other responsibilities. Due to the online platform, most participants had connectivity concerns due to data restrictions or the inability to connect to a reliable Wi-Fi source.

The research investigated how Indima Yethu uses young people's social networks and sense of belonging to a community to promote mental health. While participating on the online platform, most students had application issues or a need for more resources at their disposal. The research sought to comprehend how Indima Yethu's collaborative social networks and peer mentoring program have influenced their participants' physical and mental well-being. Based on participant feedback, the evaluation questionnaire revealed that most participants were unaware of their mental health before the peer mentoring program. The peer mentoring program awakened their sense of self. It aided them in identifying and successfully applying the tools they provided to ensure they remained constantly aware of their mental health and well-being.

Based on the participants' evaluation questionnaires, the researcher found that most young people dismissed experiences and feelings, as they were not fully aware that their experiences, good or bad, impacted their mental health and well-being. All the participants confirmed that they benefitted from the 13-week intervention program and had become much more aware of their needs and values. However, a serious concern was that most participants needed a pre-existing support structure and that the peer-mentoring option became a lifeline none knew they needed. The 13-week programme assisted the participants in identifying the much-needed skills they needed to carry forward to ensure their well-being long after the programme had ended. Daily normalising what participants had been experiencing provided them with a safe space to share with others – reiterating the importance of feeling a sense of belonging within your circle and relying on others as our primary pillar of support.

6.4 Implications for Practice

According to Jannach and Adomavicius (2016), it is possible to divide recommendations into two categories: (a) recommendations applied to practice or action; and (b) recommendations applied to future research efforts. Despite the possibility of application to action or practice, the results of this study suggest areas for future research. Throughout the theoretical framework chapter, this study used the asset-based approach to mental health promotion and advocacy. The researcher realised that this research study's design could allow for fascinating recommendations. The explored recommendations provided in this section resulted from what was in the theoretical chapter, methodology chapter, data analysis, and findings chapters – all guided by the social capital, support, and network theory.

Indima Yethu has demonstrated its commitment to promoting mental health wellness among young people by implementing preventative measures against mental illnesses. Considering the prevalence of mental health problems among young people and adolescents and the potentially devastating effect of the COVID-19 pandemic, it is imperative to identify and implement cost-effective novel interventions.

Overall, the study results suggest that the Writer's Clinic Programme can improve positive psychological, social, and emotional functioning, thus increasing protective factors that can prevent mental illness and suicide in the future. Research could focus on face-to-face interventions closer to young people's homes, allowing them to participate in their communities. In addition to removing external barriers, like the lack of access to an electronic

device, Internet access, and transportation difficulties, a face-to-face programme would allow more youth to participate. Ultimately, the current study provides valuable insight into an understudied area with significant potential.

6.5 Limitations

The researcher found that sources of sociological literature concerning mental health wellness were scarce. Most literature only spoke to the nature of mental health illnesses; therefore, the lack of practical research studies could be considered a severe limitation. More participants would have had a more significant impact on the participant evaluation questionnaires if they had completed the evaluation questionnaire in more significant numbers. Initially, the biggest limitation of the research study was the impact of COVID-19. As a result of lockdown restrictions, participants were not allowed to make physical contact with each other. The 13-week intervention programme had limited participant participation due to virtual reality. A significant limitation of this study was the need for Wi-Fi connectivity to allow participants to participate fully. A lack of Internet connectivity space and privacy forced some participants to leave the intervention programme.

6.6 Personal Reflexivity

Motari (2015) encourages researchers to reflect deeply and to be more than mere technicians. Becoming technicians implies that they should reflect on the practical acts of research and the mental experiences that construct meanings about practice. Privately and professionally, reflection is an essential mental activity.

Learning reflection is a fundamental skill to gain an awake stance about one's lived experience. In the field of research, reflection is a crucial cognitive practice. Research procedures are legitimated and validated through reflexivity, which is common in qualitative research. The purpose of reflection is to explain the epistemic acts developed during the inquiry process and by which the world becomes meaningful. The object of analysis is when the mind thinks about itself. The subject engaged in reflective practice plays the role of a matter that reflects the position, which then becomes the object of the analysis. It is precisely by making oneself the thing of self-inquiry that a person truly becomes the subject of their experience (Motari, 2015).

Before the commencement of this research study, the researcher had constantly been concerned and troubled by how many young people face mental health issues. Over the past few years, the researcher has encountered many young people suffering from an already undiagnosed or

diagnosed mental health disease. Several factors influenced and motivated my decision to pursue this research topic.

To guide, assist, and mentor has been a massive part of me for the longest time. To offer support to troubling individuals without fearing being judged or made to feel like an outcast. The researcher tried to understand what caused the researcher to be different from the next person while asking questions about my inner strength and abilities, my will to get up each day despite troubles, concerns, and fears for the unknown and questioned me about what, as a researcher, I am doing differently. Why am I still able to stand amidst my battles? Why have I not given up or surrendered to the feeling of wanting to quit, wanting not to go on, wanting not to face another day because it is just too darn complicated? Having witnessed so many young people sharing their challenges, fears, and concerns, whether it had been academically or personally, made me scarily aware of the fact that mental health wellness needed to become a much more critical core focus if we are to ensure our future generation can mitigate their way through the ups and downs life brings. As a researcher, I am enormously grateful to everyone at Indima Yethu for allowing me to participate in this study by making data available for my research study. I am thankful to all those participants who willingly participated in the Writer's Clinic; without them, my research study would not have been possible.

It makes all the difference in the world to remain professional within the bounds of research while empathically allowing what was shared at the Writer's Clinic to be used to steer other young people to participate in future programmes. My only desire is for programmes such as the Writer's Clinic to continue reaching more young people, to skill and equip them for their futures, to help heal and ensure they are mentally healthy to embark on whatever course their lives take.

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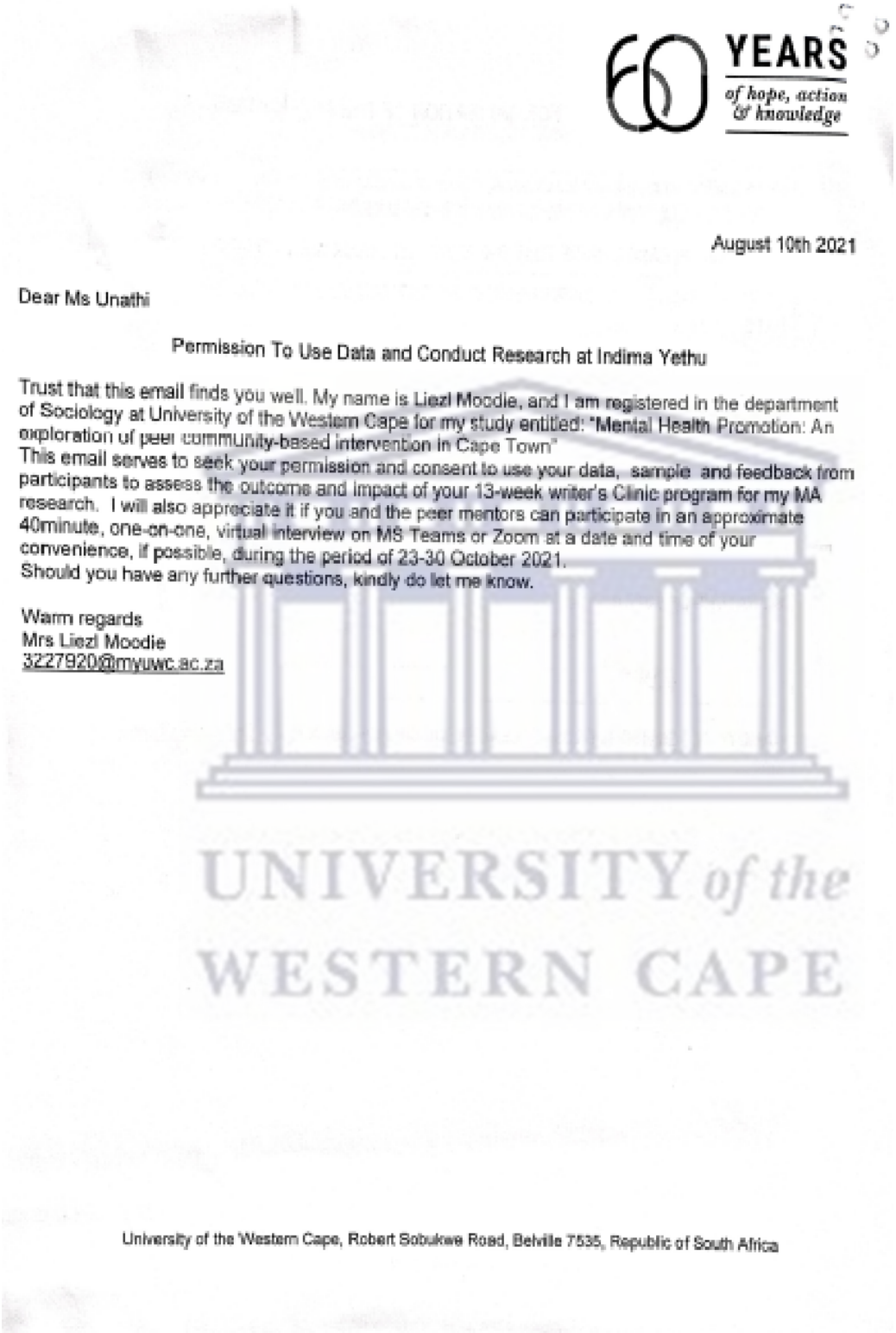
ANNEXURES

Annexure A: Permission letter to use data and conduct research at Indima Yethu



60 YEARS
of hope, action & knowledge

August 10th 2021

Dear Ms Unathi

Permission To Use Data and Conduct Research at Indima Yethu

Trust that this email finds you well. My name is Liezl Moodie, and I am registered in the department of Sociology at University of the Western Cape for my study entitled: "Mental Health Promotion: An exploration of peer community-based intervention in Cape Town"
This email serves to seek your permission and consent to use your data, sample and feedback from participants to assess the outcome and impact of your 13-week writer's Clinic program for my MA research. I will also appreciate it if you and the peer mentors can participate in an approximate 40minute, one-on-one, virtual interview on MS Teams or Zoom at a date and time of your convenience, if possible, during the period of 23-30 October 2021.
Should you have any further questions, kindly do let me know.

Warm regards
Mrs Liezl Moodie
3227920@myuwc.ac.za

University of the Western Cape, Robert Sobukwe Road, Bellville 7535, Republic of South Africa

Annexure B: Permission letter for use of data, samples and venue – Indima Yethu

INDIMA YETHU

Indima Yethu Office – 23, Bloemhof, Bellville – Cape Town 7530
Website: www.indimayethu.com Email: info@indimayethu.com

DATE: 18th August 2021
TO: Mrs Liezl Moodie
FROM: Indima Yethu Consults & Dr Darren Sharpe
SIGNATURE: U Mahlasela
RE: PERMISSION FOR USE OF DATA, SAMPLES and VENUE
TITLE: Mental Health Promotion: An exploration of peer community-based intervention in Cape Town

This serves to grant you permission to analyse the data, samples and use of workshop minutes, peer mentors feedback and evaluations collected during the Project "Kick Out COVID-19: An alliance to improve the online and offline health and welfare of vulnerable and disadvantaged children and young people living in Rwanda, Zambia, Sierra Leone and South Africa: Youth Safeguarding Network (YSN), with Ethics number ETH2021-0159, expressly for the thesis project titled, "Mental Health Promotion: An exploration of peer community-based intervention in Cape Town".
For this work, Indima Yethu, the PIs, Dr Darren Sharpe and our research team at UEL subcontracted other organizations which are based in Zambia, Sierra Leone and Rwanda. Indima Yethu led the recruitment and data collection in South Africa with the project and data collection instruments designed by Dr Obuaku-Igwe of the University of the Western Cape. The pilot study was conducted in the City of Cape Town and participants completed three types of data collection (a) a baseline survey, the WHO and Warwick wellbeing scale (b) Qualitative FGDs and (c) interviews in the form of weekly workshops
While there are no personal identifiers in the data to be provided, archival materials and other weekly workshop related data contain identifiers of our peer mentors and other project participants. You are required to uphold the highest ethical standards by maintaining confidentiality of all concerned.
You May proceed with the research as soon as your institutional permission referencing the above project is granted. Kindly contact me if you need access to further resources of persons.
Yours sincerely,

Unathi M

Annexure C: Questionnaire – The Writer's Clinic: Evaluation by participants

Participant: …….

Good day everyone

We are measuring the progress of the writer's clinic to allow us to optimise and adjust optimise and improve our results for upcoming programmes. We will appreciate it if you can reflect on what we have achieved and what strategies have been effective. We will appreciate your feedback to know whether our call to action is doing well and how can we do more of that?

Question 1: Have you missed any sessions of the Writer's Clinic?

Question 2: If yes, how many?

Question 3: Please state your reasons for missing the sessions.

Question 4: What aspect of the Writer's Clinic worked?

Question 5: What did you like most?

Question 6: In your opinion, what kind of advocacy work are we doing at the Writer's Clinic?

Question 7: What didn't work? What kind of lessons did you learn and how would you like to share them?

Question 8: What were the best practices?

Question 9: Did you use the Sentinel App? What do you think of it?

Question 10: What made a change or impact in your life?

Question 11: Would you like to register for a certificate in the Writer's Clinic Programme?

Question 12: Would you recommend the programme to others? Why?

Question 13: Do you think there is a link between the weekly activities and changes in your welfare, physical, social, and emotional growth, or wellbeing? If yes, explain?