

The background is a vibrant yellow with a dense pattern of white, hand-drawn scribbles and scattered letters. A central white rectangular frame is drawn with thick, expressive strokes, framing the main title text.

**HOW DEPRESSING:
POVERTY,
MENTAL HEALTH
AND
MUNICIPAL SERVICES
IN SOUTH AFRICA**

Municipal Services Project

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HOW DEPRESSING: POVERTY, MENTAL HEALTH AND MUNICIPAL SERVICES IN SOUTH AFRICA

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ABOUT THE PROJECT

The Municipal Services Project (MSP) is a multi-partner research, policy and educational initiative examining the restructuring of municipal services in South(ern) Africa. The Project's central research interests are the impacts of decentralization, privatization, cost recovery and community participation on the delivery of basic services to the rural and urban poor, and how these reforms impact on public, industrial and mental health.

The research has a participatory and capacity building focus in that it involves graduate students, labour groups, NGOs and community organizations in data gathering and analysis. The research also introduces critical methodologies such as 'public goods' assessments into more conventional cost-benefit analyses.

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SUMMARY

There have been dramatic changes to municipal services such as water and electricity since the end of apartheid in South Africa, with considerable research having gone into the impacts of commercialization and cost recovery on low-income households. The research has revealed a complex and often negative relationship between the marketization of these services and access and affordability for the poor. It has also been shown to have direct and very negative public health implications, most acutely in low-income township and rural areas.

Less obvious, and much less researched, have been the impacts of changes in service delivery on the mental health of low-income residents and household members. The fact that there is a relationship between poor mental health and poverty in general has now been well established. Common mental disorders (notably, anxiety and depression), while once thought to be the preserve of the rich who could afford the 'luxury' of worrying about emotional issues, have in fact been shown to have higher prevalence in low-income households. It has also been suggested that there is a cycle of vulnerability between poverty and marginalization, physical ill health, emotional distress, and mental disorder.

What, then, might be the links between poverty, mental health and the shift towards market-oriented reforms in basic services? This paper explores the relationship in the South African context with a detailed, ethnographic case study of ten low-income families in Cape Town coping with a serious mental disorder (schizophrenia). While the study is too small and too preliminary to lead to firm conclusions about service delivery and mental disorders in general, the outcomes do point to issues which bear further consideration and discussion. These include:

- Health and safety problems. Household members have difficulties in ensuring appropriate use of medication (due to lack of water), practising adequate hygiene, growing their own food, and with general comfort (such as being warm and dry). There are also concerns about being forced to use open fires, candles and paraffin stoves for cooking and warmth, leading to additional health and safety worries such as poisoning, fires, and respiratory infections.

- Time and energy. Considerable time and energy are spent searching for alternative sources of water and electricity and having to live with limited supplies of both.
- Social tensions. Respondents expressed concern with having to borrow money or water from neighbours and family members, leading to additional stresses in the lives of household members and often to tensions within families and neighbourhoods, exacerbating the stigmas typically attached to mental disorders.
- Social activities. Reducing service consumption has implications for people's social lives and household entertainment. Most of the households interviewed owned a television or radio, for example, but were reluctant to use them due to electricity costs. One family member reported being bored at home and therefore spending time with peers who encouraged him to use drugs. This has important implications for health, as comorbid substance abuse has been shown to play a role in relapse of schizophrenia as well as being implicated in the onset of psychosis.
- Relapse. The stress of not being able to afford adequate services, or having these services cut off or restricted, would appear to add considerable stress to the person with the mental disorder, possibly contributing to a worsening of the disorder and/or a relapse.
- Impact on caregiving environment. Inadequate services would appear to increase levels of stress and burden for the caregiver(s), with implications for their own mental health. This then impacts on the family member with the mental disorder as well as the household as a whole, as the caregiver's ability to care for the family may be compromised. Women appear to be the most affected by this as the primary caregivers.

All of the households interviewed experienced considerable financial hardship as a result of cost recovery strategies on basic services, with 29% of household income being spent on water and electricity on average,

and arrears on water and electricity bills as high as R18 200. Respondents expressed anxiety about this situation, noting that it added considerably to overall family stress.

A range of strategies were used by these households to minimize water usage, with the need to save water becoming a further source of anxiety and conflict. Similarly, concerns were raised about electricity usage and cutoffs, with disability grants being used to pay for fuel and basic services in many households.

Respondents did not necessarily draw direct links between experiences of service delivery difficulties and the onset or relapse of mental disorder, but it is clear that uncertainty about services in the context of poverty add to overall stress levels.

In summary, much remains to be done in terms of realizing the rights of people with mental disorders (and their families) in South Africa. Without considering the broader context of poverty and service delivery it will not be possible for them to adequately improve their lives.

INTRODUCTION

Since the end of apartheid, the South African state has built close to two million new homes for low-income households, provided water to some 10 million people who were previously unsupplied, and extended the electricity grid to about two million homes. There is still an enormous housing and infrastructure backlog in the country, particularly in rural areas, but large investments continue to be made in essential services at the national, provincial and municipal levels (Hemson and O'Donovan 2006).

These investments have been tempered, however, by the introduction of neoliberal policy reforms around cost recovery and commercialization. Municipal services such as water, sanitation and electricity have largely been hived off into stand-alone 'business units' which operate increasingly like a private company and/or outsource much of their operations to private companies. In some cases municipal services have been sold outright to private firms (Bond 1999; Marais 2001; McDonald and Pape 2002; McDonald and Ruiters 2005).

Charges for municipal services have been changing as well and are now expected to be 'cost reflective' in most sectors (i.e. covering the full capital and marginal operating costs of providing a service). This policy shift is due in part to the state's desire to reinvest revenues into service expansion but also by a commitment to running municipal services 'more like a business' and creating incentives for private sector investment.

As a result, many low-income households in South Africa find themselves paying for services that they once received for free (or at heavily subsidized rates) and many are unable to afford the services they need, despite having the necessary infrastructure in place. So widespread is this problem that millions of South Africans have experienced short- and long-term service cutoffs for non-payment of services, accumulating massive debts and even being evicted from their homes (McDonald 2002).

The South African state has responded to this crisis of affordability by introducing more progressive tariffs on services and free, 'lifeline' supplies of water and electricity (six kilolitres of water and 50 kilowatt hours of electricity per household per month). This free services policy has been criticized, however, for being inadequate for the actual needs of large, low-income families and because the free portion of services is often cancelled out by

high tariff rates in subsequent blocks of consumption (Ruiters 2005).

Service disconnections continue as a way of penalizing non-payment but are slowly being replaced by service restrictions (e.g. ‘tricklers’, which restrict the flow of water to a pre-set amount and/or at a reduced rate of flow) and prepaid meters (which require residents to purchase tokens for water or electricity in advance of using it). The latter ensures that consumers do not go into debt with a service provider and eliminates the need for politically sensitive service disconnections or restrictions. Prepaid meters would appear to be the way of the future for cost-recovery strategies in South Africa, with millions of prepaid water and electricity meters having now been installed throughout the country. South Africa has also become a major manufacturer of prepaid meters, exporting to countries around the world (Ruiters 2005).

But despite growing awareness of this affordability crisis, efforts to collect the full (or near full) cost of service delivery continue in South Africa, creating enormous hardships for low-income residents. From the inconveniences of service cutoffs, to the stresses of borrowing money or water from neighbours, to the more serious health and safety risks associated with service substitutions (such as using paraffin for lighting and cooking, or drinking untreated water), cost recovery on services has proven to be a major source of anxiety for low-income families throughout South Africa.

One can assume, then, that low-income individuals and households coping with serious mental disorders would feel the strain of cost recovery even more acutely. Having one’s electricity cut off or worrying about the price of water is stressful at the best of times. For people dealing with mental disorder it can be that much more taxing.

But what kinds of additional anxieties are placed on mentally ill individuals and their caregivers by the push to recover service costs? How do they cope with service cutoffs and restrictions? What are the effects of trying to minimize service consumption in the hopes of reducing expenses?

This paper explores these questions with a detailed, ethnographic study of ten households in the city of Cape Town caring for a household member with a serious mental disorder. This is the first study of its kind in South Africa and, to our knowledge, internationally as well. Although there is a growing literature on the general linkages between poverty and mental health in countries in the South, there have been no studies looking directly at the impact of cost recovery and service commercialization on low-income mental health patients and the families trying to provide care in their homes.

As South Africa and other countries around the world move towards a more home-based model of mental health care – and as countries adopt neoliberal policies of privatization and cost recovery – detailed studies on the links between the two are essential to our understanding of health care

outcomes.

Importantly, we are not attempting to draw causal linkages between cost recovery and mental disorder (there are too many confounding factors for this). Rather, we are interested in understanding how cost recovery and access to basic services affects the ability of low-income households to deal with existing mental disorder. Our focus in this paper is on severe, clinically diagnosed mental disorders (schizophrenia in particular), but the results outlined here may apply to households and individuals dealing with less acute or less chronic mental health challenges. In addressing these questions we hope to contribute to the critical literature on neoliberal service reforms in South Africa in particular, and to the literature on poverty and mental health in general.

It should be noted as well that the sampling for this study was intentionally small and purposive and the results are intended to be indicative rather than statistically conclusive. This sampling method was chosen in part because of the novel, investigative nature of the research but also because of the qualitative methodological requirements of conducting research with households and individuals coping with mental health problems (more on this below).

Nonetheless, the results are sufficiently robust to suggest deep and systematic hardships associated with the commercialization of basic services in South Africa. These hardships impact on those with the mental disorder as well as their caregivers, leading to a wide range of social, physical and economic difficulties. In some cases these problems have spilled over into the community as well, creating tensions with neighbours and intensifying the stigma that many families experience with a mentally ill household member.

Just how widespread is this problem in South Africa? It is difficult to say for sure given that no national data exists on the prevalence of mental disorders in the country (Seedat et al. 2004), but studies conducted in specific regions of South Africa suggest a prevalence of mental disorder that is at least as high as, and possibly higher than, international norms (Bhagwanjee et al. 1998; Cooper et al. 1999; Kleintjies et al., in press; Robertson et al. 2001; Rumble et al. 1996). A study investigating the prevalence of post-partum depression in the township of Khayelitsha in Cape Town, for example, found a prevalence of major depression of 34.7%, a rate three times that found in British samples (Cooper et al. 1999). Another community-based epidemiological study in KwaZulu-Natal found a population prevalence for generalized anxiety and depressive disorders of 23.9% (Bhagwanjee et al. 1998). Rumble et al. (1996) found a community prevalence of psychiatric morbidity of 27.1% in a small town in the Western Cape.

Two other studies in the Western Cape found similarly high rates of prevalence. An investigation of psychiatric disorders among children and adolescents attending a primary health clinic found that 15.3% met the DISC-2.3 criteria for psychiatric disorder with impairment (Robertson et al. 2001) while another study of selected mental disorders among children, adolescents and adults found an overall prevalence of 25% for adults and 17% for children and adolescents (Kleintjies et al., in press).

Mental disorder is therefore a major concern in South Africa, with as much as a quarter of the country's population suffering from some form of mental health problem. Many of these people and their families are also struggling to survive on low incomes or disability grants, making the burden and stresses of cost recovery on essential services yet another concern to deal with.

The paper begins with an overview of the general literature on poverty and mental disorder, situating the debate on cost recovery within a larger analytical framework. We then provide an outline of the research methodologies employed in this study, followed by a review of the research results. This latter section is broken into an analysis of water and electricity services and examines how the commercialization of these services has affected households and individuals dealing with serious mental disorder. We conclude with a discussion of the impacts these service delivery reforms may have on the South African government's plans to deinstitutionalize mental health care.

Poverty and Mental Health

Mental disorders are increasingly recognized as a significant contributor to the global burden of disease and disability (Patel et al., in press; WHO 2001). It is now widely accepted that most mental disorders are multi-factorial in origin, with social, economic and cultural features (Patel et al., in press). It is also widely accepted that the burden of mental disorders impacts not only on individuals but also on their families and communities (Funk et al. 2004), making mental health both a personal and collective phenomenon. Economic burdens include the cost of treatment as well as indirect costs associated with unemployment and lost productivity. Social burdens include stigma, discrimination and the violation of human rights (WHO 2004).

There is increasing evidence, as well, of a significant and growing burden of mental disorders in developing countries, with studies indicating that the prevalence of mental disorders in the South is as high as, if not higher than, countries in the North (Becker 2004; Harpham et al. 2005; Lovisi et al. 2003; Patel et al. 1999, 2001; Patel et al., in press; Rahman and Hussain 2001; WHO 2001; Araya et al. 2001; Bhagwanjee et al. 1998; Cooper et al. 1999; Robertson et al. 2001; Rumble et al. 1996; Bahar et al. 1992; Patel and

Kleinman 2003; Saraceno and Barbui 1997).

One explanation for this high prevalence is poverty. There is much debate in the literature over whether the stressors associated with poverty can be implicated in the causation of mental disorder, or whether they simply prolong and intensify the disorder once it is being experienced (Saraceno and Barbui 1997; WHO 2001,). Either way, the argument that stressors associated with poverty lead to psychological distress is now well established in both the developed and developing world.

A strong predictor of mental disorder, for example, has been shown to be a lack of education (NAP 2001). Huge income inequality, un(der)employment and poor social welfare provision can lead to anger, hopelessness and despair (Patel 2001). The poor are also more likely to have inadequate access to health care, making it difficult to address their mental health needs. Finally, there is evidence to suggest that there is a greater prevalence of common mental disorders among the poor than the rich (Patel et al. 1999; WHO 2001), with increasing evidence showing a relationship between poverty and common and severe mental disorders in developing countries.

There is evidence as well of an association between urbanization and poor mental health in developing countries (Gillis et al. 1991; Desjarlais et al. 1995; Harpham 1994, 1997; Blue and Harpham 1996; Harpham and Molyneux 2001; Ludermir and Harpham 1998). Daily and long-term stressors include factors such as poor physical environments and inadequate basic services leading to increased burdens on families. Life events may involve loss of employment, reduced social support and an increase in single parent households. Urban migration can also be a factor, with social and cultural change resulting from moving from a rural setting to an urban setting being considered highly stressful (Bhugra 2004; Mumford et al. 2000).

Urban environments with high levels of poverty are associated with high levels of violence and crime, a further risk factor for mental ill health (Seedat et al 2004; Stein et al. 2002; Ward et al. 2001). In many cases urban living places greater burden on women due to greater participation in the workforce and an increase in female-headed households and workloads (Ruel et al. 1999).

Despite this growing body of research, “[t]he relationship between poverty and mental health is a topic which, at best, inspires cautious scepticism, and at worst, dismissal from public health practitioners in developing countries” (Patel 2001, 247). This may be blamed, in part, on the fact that countries in the South often do not have the resources to combat mental health problems, particularly with the myriad of other pressing needs on their (shrinking) public budgets (McKenzie et al. 2004). Governments have also tended to prioritize ‘big killer’ health challenges such as HIV/AIDS, malaria

and infectious diseases (Blue and Harpham 1996).

Research spending is a concern as well, with enormous gaps between funding provided for mental health research in wealthier countries as compared to that of low-income countries (Patel and Sumathipala 2001). This has been referred to as the 90/10 gap, where only 10% of research and funding takes place in the South despite the fact that these countries experience 90% of the global mental disorder burden and where the unmet need is the greatest (Maj 2005; Patel and Sumathipala 2001).

South Africa is essentially a microcosm of this global phenomenon, with all of these factors having been identified as contributors to mental disorders. Rapid rates of urbanization, high levels of un(der)employment, unequal gender relationships, substance abuse and widespread poverty all factor into both the prevalence and intensity of mental disorder in the country (Govender and Killian 2001; Hirschowitz and Orkin 1997; Kaminer et al. 2000; Bhana et al. 2002; Flisher et al. 2003).

Until recently, spending on mental health in South Africa, as with all social spending, was also heavily skewed – largely along race and class lines (Thom 2004). Mental health budgets were quite small relative to other health spending, and this has not changed. As a result, the screening and identification of mental disorders continues to be inadequate despite what would appear to be a growing need.

The high burden of physical illness in South Africa – such as HIV/AIDS and tuberculosis – has further implications, as many people with mental disorders have significant physical co-morbidity (Els et al. 1999; NAP 2001; Patel 2001). The HIV/AIDS pandemic in particular has massive implications for mental health in South Africa in terms of the emotional impact of the epidemic, the psychiatric side effects of medication and because a proportion of people with AIDS will develop brain disorders (Freeman 2004).

Research Methodology

Despite our growing understanding of the general linkages between poverty and mental health we know relatively little about the specific nature of this relationship. What, for example, is the link between poor housing and inadequate service delivery in countries in the South? How does the price of water affect a low-income person with a mental disorder?

As noted earlier, this study is an attempt to provide some preliminary insights into a fairly narrow set of poverty-related questions. It is also an attempt to find the best ways of investigating and understanding these complex relationships. With no previous research examples to draw on, we were forced to develop our own research frameworks, drawing on the conceptual and methodological expertise of people working in the field of

mental health as well as those working on the political economy of service delivery.

The end result is a focused, qualitative study of a small group of households with a known mental disorder. Although not necessarily generalizable, the intent of the study was to generate rich, in-depth, descriptive and exploratory data to identify themes and areas that might be useful in informing policy debates on service delivery as well as further research in the area of mental health.

It was decided that a series of 10 qualitative, household case studies would be the most appropriate way to address the research questions and purpose. We then developed a series of semi-structured interviews to be conducted with various household members. This allowed for flexibility in responses yet ensured that the interviews covered key areas determined to be relevant to specific policy debates on cost recovery and service commercialization as well as the broader literature on poverty and mental health. Interviewing different household members also contributed to a multi-dimensional understanding of the household experience.

Open-ended questions, meanwhile, provided an opportunity for issues to arise that were unexpected and/or did not form part of the original research propositions, allowing interviewers to follow up on these issues and opinions in more depth as required.

The research team developed a number of strategies to enhance reliability of the data. This included data triangulation, such that two interviewers were present at all times, allowing for different interpretations of the data, and information was always backed up by more than one source (e.g. data on service rates and billing methods). We also kept extensive field notes backed up by transcribed digital recordings of all interviews (subsequently coded using a qualitative software package, Atlas ti). All research outcomes were then discussed by the research team as a whole.

Household Profiles

The 10 households that were selected to participate in the study were chosen on the following basis:

- a combined household income of less than R4000 per month
- known to be caring for a household member with a serious psychiatric disorder (confined to schizophrenia, in this case, due to access to these patients through our research and clinical linkages)
- access to water and electricity in their homes or on their immediate property (e.g. yard taps)

- living in low cost or RDP-type housing

The intent was to select as homogenous a group as possible, holding constant as many social, economic and cultural criteria as we could. For this reason we chose households from only two townships in the city of Cape Town. One was Klipheuwel, a low-income, peri-urban 'coloured' township of some 150 homes located 25km northeast of the central part of the city. The second site was Khayelitsha (specifically the Makhaza, Harare and Site B sections), a large and mostly African township located about 40km southeast of the city core. Klipheuwel was selected because it is one of the few areas in Cape Town where households access both their water and electricity with prepaid meters. Khayelitsha was selected because it is one of the poorest and most remote townships in the city.

In Klipheuwel, households were identified through clinical files of patients with schizophrenia. Researchers visited each household three to four times and conducted interviews in Afrikaans (the households' first language). Seven households in Khayelitsha were identified through a schizophrenia support group run by one of the researchers. Several visits were made to each of these households as well and interviews were conducted in Xhosa. Interviews in both locations were conducted over several months in mid-2005.

The aims and objectives of the research were explained to participants and other household members, and written consent to participate in the study was obtained. The anonymity of participants was guaranteed through the use of pseudonyms. Permission to conduct the interviews in the Klipheuwel area and access the files at the Durbanville Clinic was granted by the Manager of Quality Assurance and Specialised Services at the City of Cape Town's Health Head Office. Permission to conduct the interviews in Khayelitsha was obtained from the Regional Director of the District Health Services.

Each household ranged from three to eight members. Total household incomes (including social grants) varied from R780/month to R4100/month, with an average household income of R2000/month. Of the 10 households, six had members who were employed, with salaries ranging from R850/month to R2200/month. Some members had casual jobs paying up to R50 a day. None of the household members who had a mental disorder were employed, though eight out of ten were of employable age.

Seven of the households were receiving social grants of some kind, with five relying solely on disability grants (see Table 1 for full details). Of the seven households receiving grants, four reported delays in payment each time the grant came up for review, with several reporting that their grants were suspended for up to six months. Although in most cases this money

was paid once the grant was renewed, it left patients without any income for the period. Households also reported that during these suspension periods the mentally ill household member was more likely to relapse: “He gets sick when his grant gets stopped”, said one interviewee.

In one household, the suspension of a grant caused the member with the mental disorder a great deal of stress because he felt that his grant was supporting the whole family. He would try to borrow money for the family, but noted that “[It is very stressful] to have to ask other people for money. You

Table 1: Characteristics of Surveyed Households

Number of household members	Location	Household income per month	Number of household members employed	Social grants
3	Klipheuwel	R780	0	1DG*
3	Klipheuwel	R4100	2	0
7	Klipheuwel	R3800	2	0
7	Khayelitsha	R1400	1	1DG*
5	Khayelitsha	R780	0	1DG*
6	Khayelitsha	R1860	1	1DG*
5	Khayelitsha	R3360	1	2DG*
4	Khayelitsha	R1560	0	1DG*; 10AP**
4	Khayelitsha	R800	1	0
8	Khayelitsha	R1560	0	1DG*; 10AP

DG = Disability grant (R780); ** OAP = Old Age Pension (R780)
\$1US was approximately 6.8 Rand in mid-2005

have to ask for money until you get paid again". A community member in Klipheuwel who was helping this family access their grant told us that while his grant was suspended he would come to her house every day to ask if she had heard anything about the money. In her view he was very agitated and distressed and during this time he relapsed and had to be re-admitted to psychiatric hospital.

It should be noted that these households do not represent the poorest of households in Cape Town (with about a third of the city's population living on less than R1500 per month (CCT 2005)) but life is nonetheless extremely difficult, with basic necessities such as food and clothing often in short supply. One interviewee, for example, apologized repeatedly to the interviewers, expressing her shame and embarrassment at not being able to offer tea or coffee. Another commented on the fact that she constantly had to borrow money and other supplies to get by: "I used to get stressed when we didn't have sugar for the child's tea bottle. Then my mom would say, go and ask this or that auntie. Now, a person feels really bad...you feel very unhappy if you have to go and ask other people all the time. Then I'll say, no, I'm not going to ask. But then my mom says, just go and ask for a little so you can give it to the child. Don't worry about us. We are grownups. Just get something for the child's bottle. But that little bit won't last for the whole of the next day, and then I must go and ask again! That is when I get stressed".

Thankfully, all of the households we interviewed were receiving some sort of support and treatment for the mentally ill person in their home, either through health clinics or support groups. There was also a considerable amount of emotional support for the patient within the family.

Both of these factors mean that our sample is better off than the average low-income family coping with mental disorder in South Africa, making the difficulties discussed below all the more worrying in households without this kind of familial and/or institutional support.

Experiences with Service Provision

In terms of service provision, all of the sample households in Klipheuwel had piped water in their homes, via prepaid meters, and all had in-house flush toilets. In Khayelitsha, six households had piped water in their home and one had piped water in the yard. Only one household had a flush toilet in the house while the others had flush toilets on site in a separate structure. All of the sample households in Khayelitsha pay for their water through credit meters (i.e. billed at the end of each month). All households in both locations had electricity in their homes, via prepaid meters.

In terms of service costs, household expenditures on water and electricity varied greatly across the sample, from a low of 3.2% of total monthly income

to a high of 29.5%. So, too, did the scale of arrears for unpaid water and electricity bills vary, ranging from a modest R198 (though still a quarter of that household's total monthly income) to an astronomical R18,200 (almost a full year's income for that household) (see Table 2).

Not surprisingly, most of the households in the sample reported that they were unable to pay their arrears on water and electricity, though some made small payments on a monthly basis. Some households were under the impression – incorrectly as it turned out – that their arrears had been written off and that they were not expected to pay these amounts because they were now on a prepaid meter system.

High and unaffordable service costs and arrears are not uncommon amongst low-income families in South Africa, with many households finding themselves unable to pay their bills on a regular basis, and being forced to make difficult decisions between buying food, clothing and water (Fiil 2001, McDonald and Pape 2002).

Importantly, these are not decisions that households make lightly. In contrast to the all-too-popular notion that there is a “culture of non-payment” amongst low-income families when it comes to paying for basic services, there is a growing recognition that it is an “inability to pay” that is at the root of the arrears problem. Even the South African Cities Network – a research and lobby group representing the largest municipalities in the country – acknowledges this concern, arguing that “over time it has become clearer that inability to pay, rather than unwillingness to pay, lies behind poor payment compliance” (SACN 2004, 91).

The same would appear to apply to the households interviewed for this research, with efforts being made to pay as much of the service bills and arrears as possible. One household head spoke of arranging with the municipality to pay R50 per month towards her arrears, but even this amount has proved to be too difficult for her. Other households have attempted to make payments when they have the finances available: “I go through to the centre and pay about R30 something towards my bill. I don't do that on a monthly basis though”; “I'm a terrible payer because I struggle. The thing is my daughter goes to school, so I don't pay regularly”. “He doesn't work, I'm the only one who works, the older child goes to technikon, so often I have to work in order to pay for his travelling ticket, and I don't make that much money from the people I work for. My big daughter is now doing her third year at the technikon, so it's very difficult to pay for these services”.

Although most of those surveyed continue to work towards paying off their service arrears, some feel a sense of hopelessness, saying that they feel swamped by the debt, and that no matter how much they pay the bills keep increasing. Some see no way to ever being able to pay off their debt:

“We once attempted to pay, but the amount was too much. It was a lot of money, there’s no way we could have afforded to settle that amount; it was about R9000. So that doesn’t make us relax at all, because at the back of our minds we are aware of the possibility that it [water] might get switched off, but we cannot afford to pay it, not at all”. In one household they have stopped opening their bills altogether, having given up on the possibility of paying their arrears: “I throw them away nowadays because the more I pay, the more the bill escalates”.

For all of the households interviewed service payments and arrears are a constant source of worry and fear: “It bothers me a lot”, one respondent said, “especially regarding the uncertainty and possibility of losing my house. I wouldn’t know where to begin or what to have as surety if I were to ever get summons to go to court. Let me just say that things are really not easy for me”.

Caregivers appear to feel a particularly strong sense of burden in this regard, as they see it as their responsibility to provide for the household. And yet they feel that they are constantly forced to make choices between such essentials as food and water, knowing that if they do not pay for the latter they could end up losing their homes or having their services cut off: “If I don’t pay they cut my water off”, said one respondent.

Table 2: Service Costs and Arrears for Municipal Services

Household location	Percentage of household income spent on water and electricity	Total arrears for unpaid water and electricity
Klipheuwel	6.4%	R198
Klipheuwel	N/A*	N/A
Klipheuwel	3.2%	R394
Khayelitsha	18.4%	R13,000
Khayelitsha	6.4%	R16,000
Khayelitsha	16.4%	R9,100
Khayelitsha	N/A	N/A
Khayelitsha	8.3%	R1,067
Khayelitsha	29.5%	R4,200
Khayelitsha	25.6%	R18,200

N/A* = bills were not available for these households

In two cases where the member with the mental disorder was a son in the family, this person expressed the stress they feel as a result of the inability of their household to pay service bills. One was worried that there would not be enough food for the family as a result of paying for water and electricity: “[I feel] terrible because all the money goes there and leaves us with little to eat here at home. Having to pay for rent and services takes out a lot of money and leaves us with a shortage here at home”. Another reported that “I feel hurt” as a result of seeing his mother worry about service bills and arrears.

In an effort to reduce these service bills, most of the households interviewed have developed strategies to minimize their use of water and electricity. This next section looks specifically at coping strategies around water usage, followed by a look at electricity.

Strategies to minimize water usage

In Klipheuwel, households prepay for their water and had several strategies in place to minimize their water use in an effort to ensure that their allocation of free water would last as long as possible (the prepaid meters allow a flow of 6kl of water per household per month but then shut down after that if no further consumption is paid for and entered into the computer system). Although six out of the seven households in the Khayelitsha area are not paying for their water at all (though they receive bills for their water), many of these households also have use reduction strategies in place to minimize the accumulation of payment arrears. Despite these strategies, none of the households was able to keep their water usage to the free six kilolitres of water provided each month (as confirmed by a review of household bills).

Households described, for example, how they would use their dirty washing water to flush the toilet. Others described how they did their laundry: “I use one tub for washing and one tub for rinsing and make sure that I don’t spill any water in the process. But then you can only rinse everything once. You have to be careful with how you use the water. Ja, you can’t do the washing everyday”; “We don’t have small children that need to be bathed and all that kind of thing. It’s only the three of us here. She does the washing only every two weeks”; “She does the washing on a Friday, and once she’s done, that dirty water goes on the flowers again. We don’t just water everything. We use the water sparingly because it’s a lot of money”. Two of the households in Klipheuwel had very strict bathing arrangements. Rather than a bath they would put water in a bucket and share that to wash themselves: “We seldom have a bath. We’ve got a bucket that we wash in.... The two who are working with the coal, they are very black, so they both wash with the same water. And when Davie and I wash ourselves, we share the same water. Tanya and Anthony use their own water”.

Another household in Klipheuwel reported that they put a bowl of water out at the beginning of the week for people to wash their hands in: “Ja, we always have a bowl of water for washing hands. We put it there on a Monday morning maybe. It’s just for washing your face and your hands”.

Another common theme was that households were not able to have their own gardens to grow their own vegetables for fear of large water bills: “These children spoke about growing vegetables that side, but the problem is, garden maintenance will use up a lot of water. With more free water I’d be able to plant crops”. In Klipheuwel one household was attempting to grow vegetables by using their old washing water to water the garden. “You can’t waste that water. Ja, once you’ve done the washing up, you can use it again to water the flowers”.

This strategy did not provide enough water for the vegetables to be able to grow, however, and the household decided to abandon the project.

Another household in Klipheuwel, although they reported that they were conscious of their water usage and did not waste their water, was not as strict with consumption. They reported that “when we bath we can use a lot of water. It’s not like we’re scared that the water is going to run out”. Although this household also reported having great financial stress, they were slightly better off than the other two households in that community in our sample, with their financial concerns related primarily to saving for tertiary education and school-related expenses.

One of the women from a household in Khayelitsha was involved in a garden project where she was able to grow vegetables that she could bring home to the family or sell. She reported that there were problems with the water, though, and that the garden project members may be expected to pay for the water that they used. If this happens she said that she would not be able to continue with the project as she would not be able to afford the water.

Impact of limitation of water usage

In all cases, the impact of high water costs and strategies to reduce water usage was one of increased levels of stress. One household in Klipheuwel spoke of the stress related to having to prepay for water: “When there is no water, what can we do? We can’t go to other people [in our neighbourhood] and ask them for water. We have to go to the white people and ask them for a little water. There are little kids here and they need to have water”.

In another of the Klipheuwel households, where the member with the mental disorder was the father, the impact of service costs appeared to be severe and he would worry a great deal about paying for water and electricity as he felt it was his responsibility to provide for the family: “Ja, I do

sometimes get stressed about the water; the kids waste a lot of water. I get angry. I don't hold anything back. I let everything out. But then I calm down and I'm fine again. They keep on using the water.... they drink and wash.... all those little things".

His wife's view was similar. She described how he would get very angry with the children for using any water and electricity and how this would increase her husband's levels of stress as a result of his illness. She also reported that it increased her own levels of anxiety: "I get very angry when he gets stressed like that, because he was in the hospital for that schizophrenia of his. Now, he stresses a lot, and then I just keep quiet because I know it's due to his illness. He gets angry very quickly".

In another household in Klipheuwel, the member with the mental disorder described how his pills make him always feel thirsty and how he would become frustrated when the water would run out and he would have to go and borrow water from neighbours to alleviate his thirst.

Sometimes, tensions with neighbours would be in reverse. One household spoke of stress and conflict caused by their neighbour's using their outside tap when there was no one home during the day: "We are unable to [save water] because we have this tap outside. Some people save their own water and make use of our tap outside....It does [cause conflict] and forces one into arguments".

With regards to the free allocation of water, all of the households interviewed were aware that they received a free monthly supply. However, only one household knew the amount of this free block of consumption and none were aware of the block tariff system (whereby prices increase as consumption increases) and were shocked to hear of the rapid rates increases above six kilolitres per month. The common view was that the free basic amount provided by the municipality was by no means sufficient for them to lead dignified lives, even with their strategies to conserve.

Water cutoffs

Although water disconnections are less common in Cape Town than they were up to 2002 (before which tens of thousands of low-income households in the city experienced water cutoffs of various durations due to non-payment of water bills (McDonald and Smith 2004)), one of the households in the Klipheuwel area had experienced a water disconnection due to non-payment before the prepaid meters were installed. Notably, this was the result of a water pipe that had broken without their knowledge and which had resulted in a massive, one-time water bill. Despite this they had to pay a deposit of R300 to have the water turned back on as well as arranging to pay the R850 water bill over the following months.

In Khayelitsha, three of the seven households interviewed indicated that they had experienced a period of time where their water supply was disconnected due to non-payment of service bills. There were inconsistencies in recollections of these experiences, however. In one household the husband told us about how the water had been cut off for a week and the strategies employed by the household in order to access water during this time. When we spoke to his wife, however, she did not recall ever having their water cut off. It is possible that the husband could have fabricated the story. On the other hand, his wife could have been denying the cutoff out of shame, as she was very concerned about what the interviewers thought of her economic status and kept apologizing about the state of her home.

In the other two Khayelitsha households reporting water cutoffs, one reported that their water had been disconnected for “about a week” and the other household reported that it was disconnected for a day.

Strategies to access water during cutoffs

During the water cutoffs these households had different strategies in place to access water. One household collected water from a prepaid tap in an informal settlement located about one kilometre from their home. Another person spoke of trying to get water from neighbours’ taps that were “still dripping”, or borrowing water from those whose taps had not been disconnected: “Not everybody’s water supply got disconnected, so we asked the ones who still had water within the neighbourhood to supply us with some. Others used drops of water coming out of people’s taps”.

Some spoke of filling containers with water and storing it, as they had been warned that their water would be disconnected: “Because our brother worked for the committee, he advised us to save big portions of water in big containers, because he was aware that they were going to cut it off. The disconnection hardly lasted a week and fortunately I have a big blue drum which I filled up with water, as well as all the big pots. That’s how we managed to save up for water”.

Other strategies included fetching water from the neighbourhood school where the water had not been disconnected.

In general households described this time as a stressful one, filled with uncertainty and worry: “It was hard when it got disconnected”; “It causes a lot of stress because my concern was that it doesn’t last up to a week or two, because really, what would one do without water”; “We struggled”. Households also described problems with the water they had stored in containers. “You know how water gets when it stands there for a long time, it’s no longer fresh after sometime, even the taste is different, but what could we do”.

The group that felt the biggest impact of water cutoffs were those with a mental illness: “It was indeed [a hard time], because one couldn’t even do laundry from those drops, one could only use them for cooking purposes. I begged them to reconnect stating that I couldn’t even take my medication...it was so bad I even cried, then one man took note of my sickness and the effect this could have towards my health and asked them to open the water for me. The next day it was reconnected”.

This impact seemed to be even more pronounced in the case where the ill member was the father in the household: “He suffered the most in terms of stress and I think what made matters worse is that he is already in the state he is in and is a male on top of that, so it was more stressful for him”.

Stories of the events following the cutoffs are very similar as well. Households described how they went to the municipal office to protest and negotiate with the council to have their water reconnected: “Everyone in the community toyi toyied [protested]”.

Households also expressed confusion around the arrangements made following the negotiations. Many felt that it had been agreed that the arrears would be written off (which did not happen): “We went to the office and they suggested that we make payment arrangements. The arrangement was that we paid bit by bit. At the same time there had been a meeting arranged by the community, where it was concluded that we shouldn’t pay because of an enormous account. We then had to start afresh in terms of payment and ignore the previous debt. From there onwards the people were not paying, then water was reconnected again. The council thereafter agreed on the idea of not paying the previous balances and starting a fresh account. We waited for the council to come back to us and verify the agreement but they never came back”.

Strategies to minimize electricity usage

With respect to electricity, households employed a number of strategies to keep their consumption to a minimum with this service as well. None of the households interviewed used electric heaters for warmth as these were seen to consume too much electricity. Many used paraffin heaters, but as paraffin is also expensive many used an open flame for warmth or had no source of heating in the house.

Notably, most of our interviews took place during winter. One household had placed pieces of newspaper in the gaps between the roof and the walls in an attempt to keep the wind out. The roof was an open tin structure with no insulation. In two households the front doors would not close properly and would constantly blow open, allowing gusts of wind and rain to enter. In another house, the member with the mental disorder was so cold during his

interview, and his teeth chattered so much, that he was barely able to speak. The family walked around the house in blankets to keep warm.

Households also reported that they would use a two plate burner stove for cooking, but towards the end of the month when money was not available for the prepaid electricity meter they would switch to cooking on a fire: “Look, when she’s using that little stove and we see the electricity is getting low, we just stop using the stove because that’s where all the electricity goes. She then makes food outside for us”. Others used a gas stove and some reduced their cooking altogether: “We don’t cook that much, and I would make enough at night so that it lasts throughout the day. The same applies to bread. We also didn’t use the two burner stove often. Foods that take longer to cook such as samp and beans are cooked in the paraffin heater to save on electricity”.

Seven of the households in Khayelitsha and Klipheuwel described having to borrow money for electricity from their neighbours or family: “She does that a lot. Often she’ll go visit her friends in order to borrow money for electricity or paraffin”. Many described feelings of embarrassment at having to borrow money for this purpose but said they did not have a choice: “Yes [I feel embarrassed and ashamed] because some people get quite rude at times”; “Hey, I do feel bad but I really can’t help it, there’s nothing I can do”.

Households in Khayelitsha also informed us that their electricity meters had been replaced with new versions to prevent tampering. Two of these households said that the new meters were not secured to the wall properly and had fallen down shortly after being installed. When they contacted the council to complain of the problem they were informed that they would have to pay R500 for it to be fixed: “Mine isn’t properly mounted. This person came alone here and couldn’t drill a hole in the wall because the bricks are tough. I asked why it’s skew and he said ‘No it’s stable, there’s nothing wrong with it’”.

In one of these households, the household head was the member with the mental disorder and the fact that the box was not properly secured was a source of great stress and worry for her: “One other thing that will make me sick is that box over there, can you see it. That box was not tightened properly on the other end. I reported it. They promised to come. I even sent my youngest grandchild to report it and they said I should pay R500. The person who put it there didn’t tighten it up properly hence we have to use other measures to balance it”. She had been to the council office on several occasions herself to complain about the box as she was terrified that the children could be electrocuted while she was out of the house: “Can you see that this box is in a hazardous position and can cause danger? If I had a baby that crawls someone would have been badly hurt”. In the end, she hired a

private contractor to come in and secure the box at a cost of R250 – almost one third of her monthly disability grant.

Impact of limitation of electricity usage

One household in Khayelitsha spoke of the impact of these electricity limitations on the children: “Children would be happier in being able to switch on the TV whenever they like as opposed to visiting other homes at night to watch TV. Their mother has promised to buy them a cassette radio. They would be able to stay at home. It’s hurtful for children. It hurts to me as well”. Another household spoke of being worried about the amount of times the member with the mental disorder made himself tea and coffee: “With him, he cooks water in the kettle every minute for tea”.

In a household in Klipheuwel where the member with the mental disorder was the father, he said worrying about paying for electricity caused him great stress, noting that he would get very anxious whenever the children used the electricity, resulting in family fights: “The same thing happens with the electricity as well – I stress very quickly....They’ve got the TV and everything else turned on. They don’t want to listen when I speak to them”.

In one instance in Khayelitsha where the member with the mental disorder was the son, he spoke of being worried and upset seeing his mother struggle to pay the electricity bills. He spoke of feeling hurt and worried by this. He described how he would take steps to try and keep the electricity usage of the household down: “I switch the refrigerator off.... I usually do in order to save up on electricity”. His mother became very tearful during the interview as well when speaking about her difficulties making ends meet financially.

With regards to free electricity all of the households interviewed were aware that the city had a policy but none were aware of the amount they received. They all agreed, however, that the free allocation was insufficient (50kwh per month will power two 60 watt light bulbs for four hours a day). Even with the strategies they had in place to minimize their electricity usage they said they still had to pay a substantial amount every month towards electricity: “It’s not sufficient, I bought some yesterday and it’s already finished now”.

One household illustrates the challenge. There are five members in the main house and two additional people living in a shack next door. Until recently the household only used electricity for one light bulb in the lounge and the kettle to heat up their bathing water: “I don’t even have a stove, all I use is the kettle”. They used a fire to cook with and to heat the house. Despite this, the household still had to supplement their electricity use from their disability grant.

Explaining Poor Health and Relapses

As noted at the outset, it is not our intent to draw direct, causal linkages between municipal services and mental health. Our sample is not large enough and there are too many confounding factors for such direct connections. Nevertheless, it is worth reviewing the various explanations provided by the households interviewed with regards to why they feel the mental disorder in their household first arose and why relapses occur.

One of the explanations given for why a household member had originally become ill is *amafufunyana*, a form of spirit possession experienced amongst Xhosa and Zulu speakers (Swartz 1998). "We thought perhaps he started seeing things and assumed it was the bad spirits", said one respondent. "Its *amafufunyana*", said another. "Someone inflicted him with *amafufunyana* because he would see them calling him".

Others explained the illness in terms of a reaction of the brain to substance abuse, either alcohol or cannabis: "The doctors said he smoked *dagga* [marijuana] and his system could not handle it".

In terms of relapse, the most common explanation was a lack of adherence to medical treatment: "Not getting treatment would cause a relapse"; "Since he now takes his medication regularly he's fine, but as soon as the treatment is finished he relapses".

The explanations provided by the patients themselves are much the same. Some attributed their illness and relapses to substance abuse: "It's substances like *dagga* that cause one not to have common sense, because the mind goes backwards". One patient attributed their illness to a previous head injury.

The most common explanation, however, was that their disorder had arisen (and relapses occurred) because of stress: "When I'm stressed then I get sick. That is why I have to stay on the tablets"; "What gets me admitted in hospital is usually when things don't go right at home; that has a very stressful effect on me. I don't even disclose that to my sister sometimes. I hold it in so as to maintain peace amongst my siblings and not sound as if I'm badmouthing anyone and cause a fight. I remain quiet and that's wrong because I strive to forget. Then it stays in me and as a result I get sick sometimes". Stress has been indicated in other research to play a role in relapse in schizophrenia in particular (Bergen et al. 1998).

The stress of dealing with a mentally ill family member is also considerable. Households spoke of the pain and heartbreak they experienced when the member first became ill and when they relapse: "When he started getting sick we were heartbroken because we knew how nice this guy is"; "[I feel] very sore. I don't know how somebody else feels – but my heart is very sore"; "He affects the family, it's painful for us, we are aware of his sickness when he behaves in certain ways. When he's not sick he's a very nice guy who talks

about love and peace all the time. The family knows him the way he is. We have to be sensitive and easygoing towards him as a family”.

Others spoke of their shock and disappointment: “I was completely shocked because he was very clever at school. I thought he would study and be successful at school. I worked so hard for his success. But when he was at school he began to see things, would often get scared and see people following him and had amafufunyana. I’ve consoled myself now because I have a heart disease. I don’t have a lot of children but my grandchildren at least give me hope. I now believe in them”.

Others have been completely devastated by the illness: “That broke my heart. I was convinced I was going to get sick as well because I had nerves all the time. I dreamt that he was going to be somebody. It broke my heart so badly that I ultimately gave up on it”.

All of the households spoke of the difficulties of living with the person when they were ill, indicating that the person could be aggressive and physically attack family members: “I was hurt, extremely hurt, badly hurt, it was so painful because he used to physically attack me to a point of getting swollen, whenever I took him to hospital. When coming back from hospital he would kick me and continue doing so until he goes back again”.

The children from one household in Klipheuwel spoke of the impact of their mother’s mental disorder and hospitalization on them: “It was very difficult when my mother was in the hospital. My dad had to look after us. It was very difficult. We never went to visit my mum. I went once...and it was very difficult for me to see the people in a place like that! It was not very nice and I was just so glad that my mum could come home again”; “It was one of the most difficult times in my life. I thought I was never going to see my mother again. And I don’t know how I survived it. It was terrible. ... What really hurt me a lot was when I went to the hospital to see her and she didn’t recognize me. It was painful. But I’m just glad she came out”.

Medication side effects are also a concern, influenced as they are by life experiences (Bergen et al. 1998). Patients in our study described a variety of side effects of their medication, including drowsiness (though some also reported that this was a side effect that they welcomed as they would otherwise struggle to sleep), dryness of mouth (“I just have to take a drink of water and it’s fine again, but I have to drink a lot of water”), shakes (“It’s this one leg of mine. I can’t put all my weight on it because it’s a bit wobbly”) and irregular bodily functions (“I find that it makes me dribble a bit”).

Finally, there is the stigma of mental disorder. All but two of the households interviewed reported experiences of stigmatization as a result of the mental disorder. This problem is most acute for the person with the mental disorder, however, with several of those interviewed reporting that they were either

teased at school or in the streets and in one case even by a family member: “It was terrible. Some of the kids at school made jokes about it. I can still remember one girl said, ‘Your mother looked in the mirror and got scared of a ghost’. Ja, that was really painful”; “The feeling stays and remains stressful inside. It remains in my heart even after a while, the fact that so and so makes fun of me in front of others because of my disorder”; “Even my own brother called me a mad hatter when we were discussing rent issues. That stressed me out because he is my blood yet he made fun of me”. In one case the fear of being stigmatized was so great that the member did not wish to apply for a disability grant for fear of being singled out and labelled.

It would appear reasonable to argue, then, that the struggle to pay for water and electricity and the fear of service cutoffs may worsen a mental disorder and/or bring on a relapse for the patient, as well as making life that much more stressful for caregivers and other household members. It may also deepen the stigmatization of a patient and/or their caregivers in their community if families are regularly forced to ask for water or money from friends and neighbours, decreasing the potential for positive support and care for the ill person from household and/or community members and contributing to intra- and inter-household tensions.

Not surprisingly, there is a strong gendered dimension to these dynamics. All 10 of the households studied were headed by women, and in two cases this person was a single mother, caring for a member with a mental disorder and working for a low wage. The stresses and anxieties related to service payment, and the worries about the consequences of non-payment, together with the burden of having to make arrangements for alternative sources of electricity and water when unable to afford these services, clearly added considerable additional anxiety to these women’s lives. When added to the difficulties that black women in general face in South Africa this mental health challenge is all the more overwhelming.

Implications for Mental Health Care in South Africa

What are the implications of these findings for mental health care in South Africa more broadly? We conclude with a brief discussion of how policies around municipal service delivery would appear to be undermining efforts by the South African government to deinstitutionalize mental health care – i.e. moving patients out of institutions and into homes in the community. The Mental Health Care Act of 2002 aims to redress inadequacies in the mental health care system in South Africa, and in particular to address concerns around human rights issues for people with mental disorder (Freeman 2002; Thom 2004). The plan is to integrate mental health services into the Primary Health Care System, part of a larger reorganization and

reprioritization of mental health and substance abuse within the country's health services.

The legislation emphasizes a community-based rehabilitative model of mental health care and is in line with international trends in this sector (Thom 2004). The intent is to integrate mental health into other health services and to destigmatize and normalize mental disorder (Freeman 2000).

There is, however, concern as to how effectively these policies are being implemented, given the under-resourced and under-developed nature of mental health services in South Africa in general (Lazarus 2005; Thom 2004). Problems associated with the implementation of these policies include shortages and inequitable distribution of mental health personnel, ineffective management of resources, the ongoing stigmatization of mental disorders, and competing priorities on an already overburdened health care system (Freeman 2000; Lund and Flisher 2002; Lazarus 2005).

Concerns have also been raised in South Africa regarding the process of deinstitutionalization (Dartnall et al 2000; Lazarus 2005), echoing concerns raised internationally. These include:

- Pressures to reduce hospital beds resulting in indiscriminate discharges without careful consideration of patient readiness;
- Inadequate family and community preparation and support, including availability and administration of medication, disability grants, emergency assistance, etc.;
- Inadequate household and community resources in caring for a member with a mental disorder;
- Inadequate continuity of mental health care leading to increased chances of relapse;
- Revolving doors where patients are neither adequately treated in hospital nor effectively integrated into the community;
- Neglect and abuse within families and other placement options;
- Homelessness, as people with chronic mental disorders are more likely to be evicted from their homes or unable to access shelter.

The ability of families to provide adequate support is perhaps the biggest concern, and has been investigated in some detail (Freeman et al. 1999; Hamber 1997). In some cases family members have had to leave employment to care for the member with the mental disorder, impacting on household income as well as social relationships with family members and friends.

Underfunding of primary health care clinics has also been a problem. Most of the households interviewed for this study had complaints about the clinics they were using for the mentally ill person in their home, noting that they had to travel long distances and wait in long queues in order to collect medication. Some reported being mugged while waiting in these queues. As a result, some of the people interviewed said they would sometimes leave the clinic before collecting their medication, or modify their dosage in order to visit the clinic less often. Both have serious implications for rates of relapse.

In some cases, family members interviewed appeared ill-informed about mental disorder and strategies to support people with these conditions. They also seemed poorly informed about legal issues such as the certification of people who are mentally ill.

Studies from other developing countries suggest these findings are not unique to South Africa. In the 1970s, Brazil shifted its mental health policy emphasis from hospital-based to community-based care for mental disorders, for example, but the implementation of community-based services was slow to develop and patients were discharged from hospitals before adequate care was in place. A recent study in Brazil has shown a high prevalence of mental disorders among the homeless as well as a history of previous hospitalization for a mental disorder (Lovisi et al. 2003).

Nonetheless, there have been some successes with deinstitutionalization in South Africa. Despite some complaints most of the households interviewed for this study were satisfied with the clinic-based services they received and most were happy to have the ill household member living at home. There are, therefore, grounds for optimism in this regard.

But what effects might the inaffordability and inaccessibility of basic services such as water and electricity have on these deinstitutionalization plans? If the experiences of the households described in this paper are anything to go by, placing someone with a serious mental health condition into a low-income household in an effort to offer them greater personal dignity and improved protection of their basic human rights may have some exact opposite effects, as both patients and caregivers alike struggle to access the most basic necessities of life.

Paradoxically, then, long-awaited efforts by the health sector to improve the lives of those suffering from mental disorder in South Africa may be undermined by the very act of placing them into household and community care in low-income settings.

CONCLUSION

None of these findings are unique to people with mental disorders, of course. There are millions of low-income South Africans without formal homes, running water or electricity, and millions more that have services but cannot afford to purchase the quantity and quality of services they would like. In this sense, the experiences of the households in this paper mirror that of low-income families in general in South Africa.

What we hope to have contributed to is a better understanding of the particularities of being poor and living with a mental disorder in South Africa and how this is affected by neoliberal reforms in the municipal services sector. Although the sample is small and only indicative in its conclusions, the evidence lends support to the growing understanding that economic stress plays an important role in common mental disorders (Patel et al. 1997), with implications for caretaking patterns within the family (Richter 1994).

The cost and availability of basic municipal services such as water and electricity may be only one aspect of the poverty/mental health equation, but would appear to play a large part in the daily, practical lives of people, making what is already a difficult life even harder.

A summary of the difficulties associated with mental health and municipal services are as follows:

- Health and safety problems. Respondents identified difficulties in taking their medication, practicing adequate hygiene, growing their own food, and with general comfort (such as being warm and dry). Respondents also noted their concerns with being forced to use open fires, candles and paraffin stoves for cooking and warmth, leading to additional health and safety concerns such as poisoning, fires, and respiratory infections.
- Time and energy. Respondents indicated spending considerable time and energy searching for alternative sources of water and electricity and having to live with limited supplies of both.
- Social tensions. Respondents expressed concern with having to borrow money or water from neighbours and family members, leading to additional stresses in the lives of household members and often to tensions within families and neighbourhoods. These

tensions were often exacerbated by stigmatizations related to the mental disorder.

- Social activities. Reducing service consumption also had implications for people's social lives and household entertainment. Most of the households interviewed owned a television and radio, for example, but were reluctant to use them due to electricity costs. One family member reported being bored at home and therefore spending time with peers who encouraged him to use drugs. This has important implications for health, as comorbid substance abuse has been shown to play a role in relapse of schizophrenia (Bergen et al. 1998) as well as being implicated in the onset of psychosis (Verdoux et al. 2005).
- Relapse. The stress of not being able to afford adequate services, or having these services cut off or restricted, would appear to add considerable stress to the person with the mental disorder, possibly contributing to a worsening of the disorder and/or a relapse.
- Impact on caregiving environment. Inadequate services would appear to increase levels of stress and burden for the caregiver(s), with implications for their own mental health. This then impacts on the family member with the mental disorder as well as the household as a whole, as the caregiver's ability to care for the family may be compromised. Women appear to be the most affected by this as the primary caregivers.

Addressing these concerns will require consideration across a wide range of policy fronts. From funding for disability grants, to the price of municipal services, to the allocation of free water and electricity supplies, to policies on prepaid meters and service restrictions, to dealing with the stigmatization of mental disorder, improving the situation for low-income households with mental health concerns will not be an easy or simple task and will require substantial interdepartmental collaboration as well as interdisciplinary research and dialogue.

Nor should addressing the kinds of problems associated with service prices and accessibility discussed here be restricted to households with mental disorder. With millions of South African households coping with HIV/AIDS, tuberculosis, diarrhoea and other illnesses that require basic services such as water and electricity, access and affordability have far-reaching health implications in the country.

We hope that this paper has shed some light on the specific challenges

of being poor and living with a mental illness in South Africa, perhaps contributing to a broader awareness of these challenges in the mental health sector and amongst South African policymakers more broadly.

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ENDNOTES

¹RDP refers to the Reconstruction and Development Programme introduced by the South African government in 1994, part of which focused on subsidized low-income housing. These houses are typically very small (about 20m²) and have been heavily criticized for being poorly constructed and for being located in remote, peripheral areas of cities.

²All names are pseudonyms.

³The R500 fee was confirmed by the researchers by phone calls to the city's electricity hotline.

⁴The high prevalence of substance use in schizophrenia is widely recognized (Hamera et al. 1995). This raises the question of a connection between psychosis and substance use, as cannabis is hypothesized to induce psychosis (Verdoux et al. 2005).

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