



PATIENTS AS PARTNERS

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The barriers preventing effective treatment of South African patients with mental health problems

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Abstract

Background: Consumer research was last conducted among South African patients with mental health problems in 1997/8 by GAMAIN (The Global Alliance of Mental Health and Advocacy Networks). Respondents at the time suffered primarily from anxiety and/or unipolar depression.¹ Updated consumer research was conducted between February 2004 and April 2005 by Linda Trump of Cat Communications to find out how mental health patients were faring in the current South African environment and to determine which factors were mitigating most against their recovery. The study was funded by Cat Communications and partial grants from AstraZeneca, Eli Lilly and Solvay Pharma. **Method:** The survey questionnaire was developed by Linda Trump and checked by Charmaine Hugo of the Mental Health Information Centre (MHIC), Dr. Colinda Linde of SADAG, and Dr. Eugene Allers of the SA Society of Psychiatrists. It was distributed and posted with a self-addressed envelope and freepost address to leaders and members of SADAG, the SA Bipolar Association, Central Gauteng Mental Health, the Schizophrenic & Bipolar Disorder Alliance (SABDA) and the OCD Association. The questionnaire was also e-mailed to the Schizophrenia Foundation, some members of SADAG and members of the Johannesburg Bipolar Support Group. In addition, it was hosted on the Health 24 and SA Bipolar Association websites. **Results:** The sample comprised 331 respondents. 75% had a single diagnosis, with 25% having dual or multiple diagnoses. Diagnoses included unipolar depression (30%), bipolar mood disorder (40%) and schizophrenia / schizoaffective disorder (13%). 49% of respondents suffered from one or more types of anxiety. The median age of symptom onset for respondents was 26.5, with the median respondent waiting two years before seeking help. 69% of the cohort experienced a comorbid physical ailment, entailing chronic pain. 72% of the respondents saw two or more caregivers before receiving a correct diagnosis and it took more than a year for 55% of respondents to get a correct diagnosis. 74% of respondents received the correct diagnosis from a psychiatrist, with GPs, psychologists and social workers playing a minimal role in confirming diagnoses. 68% of respondents discontinued medication at some stage of their illness and only 46% of respondents ended psychotherapy because it had served its purpose. 40% of respondents did not know what type of psychotherapy they had. Only 20% of respondents could work adequately while ill and 19% of respondents became unemployed during the course of their illness. 26% (of 304 respondents) eventually separated or divorced as a direct result of their illness. **Conclusions:** Ongoing education is needed to inform the public about the hazards of delaying treatment for psychiatric symptoms. Doctors need to be more forthcoming about potential side-effects and how to manage them. GPs, psychologists and social workers may need additional psychiatric education. Psychologists need to tell patients what methodology they are using and they need to be more upfront in setting objectives and discussing the desired outcomes of therapy. Ideally, psychotherapy should include the patient's partner or family when there are significant domestic tensions. Stigma needs to be reduced in the workplace.

Editor's note: The following article was peer reviewed and accepted for publication as per *Journal* requirements. However, it was decided to publish the article in the submitted format as it seemed more appropriate for the "consumer research" approach adopted by the authors. Hence whilst meeting *Journal* requirements for publication, the style modifications that would have been required have been waived on the basis of ensuring the information is communicated.

Introduction

Mental illness is pervasive in South Africa. According to the SA Association of Psychiatrists, 58% of visits to general practitioners are due to conditions caused or exacerbated by mental or emotional problems. One in ten people will suffer from disabling anxiety and one in four will develop depression over the course of their lifetime. One percent of the population has Schizophrenia² and up to three percent has bipolar mood disorder.³

Mental health patients in South Africa nevertheless experience considerable stigma and discrimination not only socially and at work, but also in the treatment of their illness by some service providers and many medical schemes.⁴

Many patients do not receive adequate treatment due to the restricted benefits allocated by most medical schemes to mental health conditions. The limits imposed on psychiatric medication and hospitalisation are often discriminatory. Many medical schemes cap psychiatric and psychological consultations, thereby jeopardising the patient's overall recovery.⁵

Patients also experience discrimination in the workplace.⁶ Some employers refrain from employing people who have a history of psychiatric illness, or seek to terminate or demote an employee who becomes psychiatrically ill.

To what extent do mental health consumers perceive themselves to be discriminated against? How are they faring in the current South African environment and what barriers are currently preventing effective treatment and mitigating against their recovery?

Research objectives

A consumer research study was conducted by Linda Trump of Cat Communications between February 2004 and April 2005 to determine the above. The research covered six key areas:

- Usage & rating of caregivers (doctors, specialists, psychotherapists)
- Medication usage and reasons for non-compliance (e.g. impact of capped benefits, etc.)
- Self-medication (usage of supplements, herbal remedies, essential fatty acids, homeopathic medicines) and any concurrent substance abuse
- Self-management (extent of the patient's knowledge and lifestyle management around mental health problems)
- The impact of mental health problems in the workplace and on the patient's productivity
- The impact of mental health problems on the patient's social and personal life.

The survey took the form of a self-completion questionnaire, distributed to a comprehensive list of support group members and leaders via post, e-mail, social workers at Central Gauteng Mental Health, and personal delivery. The questionnaire was also distributed via seven psychologists in private practice in Johannesburg and hosted on the Health 24 and SA Bipolar Association websites.

The questionnaire comprised 53 questions addressing the above six areas and data was collected from 331 respondents.

Results

Demographics (Table I)

The majority of respondents came from Gauteng (61%) and the Western Cape (16%). Although respondents were not asked to indicate their race, the researcher could identify that at least 34 of the 331 respondents were black (from surnames) or coloured (from Riverlea Clinic in Johannesburg).

Table I: Demographic characteristics

DEMOGRAPHICS	% OF RESPONDENTS (n=331)
SEX	
Male	36
Female	64
GEOGRAPHICAL REGION	
Gauteng	61
Western Cape	16
Eastern Cape	10
KwaZulu Natal	5
North-West	3
Free State	2
Mpumalanga	2
Northern Cape	1
AGE	
10 - 29	20
30 - 39	25
40 - 49	30
50 - 59	18
60 - 79	7
EDUCATION (YRS)	
0 - 11	10
12	25
13 - 15	32
16+	33
EMPLOYMENT	
Students	6
Students in jobs	2
Working	56
Homemakers	9
Retired	5
Unemployed	22
MARITAL STATUS	
Married	41
Separated/divorced	17
Widowed	3
Single	39

The mean age of respondents was 40.7 and the median 40.5. A high number of respondents (65%) had post school education.

Women dominated this study (64%), with men representing 36% of respondents.

This ratio is in line with several studies which have established that outside the US, the ratio of depressed women to men is three to one.⁷

In this study, 40% of respondents suffered from bipolar mood disorder and 13% from schizophrenia or schizo-affective disorder. With these illnesses, the ratio of men to women is approximately 1:1.⁸

Diagnoses (Table II)

49 (75%) respondents had a single diagnosis, with 81 (25%) having dual or multiple diagnoses. 49% of respondents suffered from one or more types of anxiety, with 22% of anxiety sufferers having a co-morbid psychiatric diagnosis.

Table II: Diagnoses of respondents (multiple choice)

Diagnosis	No of respondents	% of respondents (n=330)
Unipolar depression	100	30
Bipolar mood disorder	131	40
Generalised anxiety disorder (GAD)	71	22
Panic disorder	35	11
Social phobia / soc anxiety disorder	27	8
Obsessive Compulsive Disorder	25	8
Schizophrenia	28	8
Schizo-affective disorder	15	5
Eating disorder	12	4
Other	18	5

Delays in seeking treatment (Table III)

The median age of symptom onset for respondents was 26.5 and the median age for seeking treatment was 33.5 (mean age 31.8). The median respondent reported waiting two years before seeking treatment. (In the Seedat et al study conducted in the late 1990s, the median age of symptom onset was also 26 years. However, the median waiting period before seeking help was only one year.)

Only 45% of respondents sought help within the first year of experiencing symptoms, with 46% of the respondents waiting two years or more before seeking help. Particularly disturbing, is the fact that 31% of the respondents only sought help more than five years after the onset of their first symptoms.

79% of respondents indicated that they had delayed seeking help. The primary reason for delayed help seeking was the belief that they would recover without medical or therapeutic intervention (46%). (In the previous Seedat et al study, only 30.9% of respondents wanted to handle the problem on their own.)

Ignorance was the second highest reason for delayed help seeking, with 44% of respondents indicating that they did not know that their illness was a disorder known to doctors. This ignorance was corroborated by 17% of respondents not knowing who to consult and 16% indicating that they did not know that effective or safe treatment existed for their problem.

Table III: Delays in diagnosis, treatment drop-out & perceived efficacy of treatment	
MEDIAN AGE OF SYMPTOM ONSET	% OF RESPONDENTS
26.5 years	
MEDIAN AGE TO SEEK TREATMENT	
33.5 years	
TIME TAKEN TO CONSULT A HEALTHCARE PROFESSIONAL	
0 – 1 year	45
2 years	9
3 – 5	15
6 – 10	11
11 – 20	13
21 – 40	7
NUMBER OF CAREGIVERS SEEN BEFORE GETTING A CORRECT DIAGNOSIS	
1	28
2	20
3	20
4	11
5 plus	26
TIME TO GET A CORRECT DIAGNOSIS	
More than 2 years	41
1 – 6 months	35
1 – 2 years	11
6 – 12 months	7
Not yet received a correct diagnosis	7
TREATMENT DROP OUT RATES	
Medication	68
Psychotherapy	54
TREATMENT PERCEIVED AS MODERATELY OR HIGHLY EFFECTIVE	
Medication	89
Psychotherapy	67
Vitamins/supplements	37
Herbal products	21
Homeopathic medications	29

Delays in receiving a correct diagnosis (Table III)

72% of the respondents saw two or more caregivers before receiving a correct diagnosis. (In the Seedat et al group, this figure was 75%). 52% of the group saw three or more caregivers prior to receiving a correct diagnosis (43.4% in the Seedat et al group).

Only 35% of respondents were diagnosed within six months of presenting their problem to a caregiver. A disturbingly high 41% of respondents waited for more than two years before receiving a correct diagnosis.

Diagnosticians

85% of respondents consulted a psychiatrist at some point in their illness, with 74% of respondents receiving a correct diagnosis from a psychiatrist. 73% of respondents consulted GPs. However, only 19% of the 240 GPs approached, confirmed the diagnosis.

Usage and perception of caregivers and doctors

The majority of respondents (229, or 69%) saw three or more types of caregiver, with 9% of the sample seeing only one caregiver, and 19% seeing two caregivers only. Use of alternative practitioners, namely homeopaths (17%) and naturopaths (3%), was relatively low compared with allopathic practitioners. 9% of respondents had used reflexology.

73% (241) of the cohort indicated that they switched doctors during treatment.

The most frequent reasons for switching doctors were pragmatic: i.e. either the doctor (22%) or patient moved location (29%), or the prescribed medication (28%) or diagnosis (22%) appeared to be wrong. One in five respondents also indicated problems with their doctors' attitudes – i.e. that they weren't taken seriously (21%) and that the doctor didn't listen properly (18%).

Usage and perception of psychologists and social workers (Table IV)

68% of doctors recommended psychotherapy to their patients and 82% of respondents had psychotherapy over the previous five years. However, only 27% of respondents stayed with one therapist, with a third of the group (35%) seeing three or more therapists.

Table IV: Types of therapy used		
Types of therapy	No.	% of respondents (n=289)
Psychodynamic / psychoanalytic	63	22
Person centred	78	27
Cognitive / cognitive behavioural therapy	95	33
Other (just talked/unsure)	116	40

83% of respondents tried only one type of therapy over the course of five years. However, 40% of respondents were not sure what type of therapy they had.

30% of respondents had therapy for two years or more and 89% of these patients had psychodynamic therapy. 29% of patients had less than 10 sessions of therapy.

Reasons for terminating psychotherapy

Only 46% of respondents ended therapy because it had served its purpose. 32% indicated that they did not find the type of therapy particularly helpful.

It is significant to note that 119 (46%) of 256 respondents stopped psychotherapy due to financial constraints. Sixty-five (25%) of the 256 respondents indicated that the funds available from their medical schemes for psychotherapy had been exhausted.

Comorbid ailments

69% of the cohort experienced one or more comorbid physical ailment with their psychiatric disorder, with 58% of the group experiencing two or more co-morbid conditions.

Almost half of the cohort (45%) suffered from migraines or tension headaches, followed by 42% suffering from gastric/stomach problems. Back pain (27%) and spastic colon (21%) affected more than one in five respondents.

This finding corresponds with another local research study conducted in South Africa by Dr Eugene Allers as part of a global study by the World Federation for Mental Health. Dr Allers found that 66% of the depressed South African subjects suffered from chronic pain symptoms as well. (I asked Dr Allers a couple of times for a reference, but did not receive one. No paper appears to have been published yet. Please drop this paragraph)

Medication usage and non-compliance

91% of the cohort took prescribed medication during their illness. The majority of the respondents (81%) had been taking medication on a chronic basis for more than 12 months.

55% of the cohort had used generic drugs, with half (49%) of these respondents indicating that their doctors had recommended generics. The majority of respondents (59%) using generic drugs gave financial reasons for doing so. 34% of generic drug users indicated that their medical schemes did not provide adequate funding for non-generic drugs.

The majority of respondents (68%) discontinued medication at some stage of their illness. Their four top reasons were the belief that they could handle the problem on their own; the fact that they did not want to become dependent on drugs; that they felt better and stopped medication without consulting a doctor; and that they didn't like the side-effects of prescribed medication.

Approximately one in four respondents (23%) stopped taking medication due to financial problems. 13% stated that they had discontinued taking prescribed medication due to medical aid capping.

Side-effects of prescribed medication

The most frequently listed side-effects rated by respondents as affecting them "quite a bit", or as being intolerable, were the following:

Fatigue and low energy was ranked by all respondents as one of their three worst side-effects. This side-effect affected 59% of respondents with schizophrenia, 52% of respondents with bipolar mood disorder and 41% of respondents with unipolar depression/anxiety.

Loss of concentration was listed by both respondents with bipolar mood disorder (51%) and schizophrenia (49%) as their second most debilitating side-effect. 31% of respondents with unipolar depression and anxiety experienced this problem.

Low libido was listed by both respondents with unipolar depression (47%) and bipolar mood disorder (50%) as a critical problem. This side-effect was noted by less patients with schizophrenia or schizo-affective disorder (30%).

Sexual performance problems were the third most distressing symptom for respondents with unipolar depression and bipolar mood disorder (39% for both groups). This problem was noted by far less respondents with schizophrenic/schizo-affective disorder (19%).

Sleep disturbances were a problem for all three groups: 42% of those with bipolar mood disorder, 38% of respondents with unipolar depression and 31% of respondents with schizophrenia/schizo-affective disorder.

Anxiety was experienced by 33% of respondents with schizophrenia, 36% of respondents with bipolar mood disorder and 32% of respondents with unipolar depression.

Having a dry mouth bothered all three groups significantly. It was experienced by 39% of respondents with bipolar mood disorder, 32% of respondents with schizophrenia and schizo-affective disorder; and 35% of respondents with bipolar mood disorder. In some cases, this may have been a transient symptom.

Self-medication and the use of alternative/complementary products

It is significant to note that 62% of the cohort took vitamin/mineral supplements. However, only 22% of respondents using complementary products acted on the advice of their doctors. (This represents 15% of the cohort).

One of out five respondents (20% of the cohort) tried homeopathic medicine, with almost as many (22%) trying herbal products (i.e. St. John's Wort and Kava Kava).

Perceived efficacy of treatments (Table III)

Nine out of ten respondents (89%) rated medication as moderately and highly effective. Psychotherapy was not as heavily endorsed, with 67% of respondents rating it as moderately or highly effective. A small number of respondents rated herbal products (21%) and homeopathic medications (20%) as either moderately or highly effective.

Substance usage

Almost half the cohort (47%) used alcohol while mentally ill, 34% moderately or a lot. The percentage of marijuana users (14%) was less and equivalent to that of stimulant users. Some respondents did, however, assume that relatively 'benign' stimulants like caffeine qualified as stimulants. At 8%, usage of street drugs applied to almost one in ten respondents.

Six out of ten substance users (31% of the cohort) were already doing so by the time they became mentally ill. One out of ten respondents (11% of the cohort) said that they used alcohol or another substance to "boost" the effects of prescribed medication.

Patients' level of knowledge

It is encouraging to note that 47% of respondents knew a lot about the treatment options available to them, despite initial ignorance.

The majority of doctors (77%), generally psychiatrists in this sample, explained diagnoses and treatment options to their patients. However, 39% of doctors did not discuss possible side-effects of medication with patients and 52% did not discuss how to manage side-effects.

For most respondents (64%), the psychiatrist was the primary source of information. This was followed closely by psychologists (49%), books (48%), information booklets (41%) and the Internet (39%). 31% of respondents felt that support groups had significantly helped them to understand their condition (not all respondents were support group members).

49% of respondents said that they were inspired and encouraged by information they read in books, magazine articles and information booklets, or by interviews heard on radio or television.

Lifestyle and self-management (Table V)

44% of respondents listed their own spiritual beliefs as having been an aid to recovery.

The most frequently listed self-help activity was prayer, used by four out of ten (42%) respondents. However, fewer respondents (31%) had actually approached clerics for help.

Approximately four out of ten respondents identified the negative beliefs which were exacerbating their condition (39%), stuck to daily routines (38%), attended a support group (37%) and continued seeing friends (41%). (Table V)

Table V: Lifestyle interventions used by respondents		
Lifestyle Intervention	No	% of Respondents (n=320)
I took my prescribed medication.	252	79
I found out all I could about my illness.	190	59
I consulted a psychologist / social worker.	182	57
I continued working to stay functional.	158	49
I used prayer as part of my healing process.	133	42
I continued seeing my friends.	131	41
I identified my negative beliefs.	126	39
I stuck to my daily routines.	123	38
I attended a support group.	117	37
I ate a balanced and healthy diet.	109	34
I went to church, shul, mosque regularly.	105	33
I pursued hobbies and interests.	103	32
I sought religious and spiritual guidance.	100	31
I did regular exercise.	86	27
I practiced a relaxation technique.	72	23
I did volunteer work; community activities.	66	21
Other	9	3

The impact of mental health problems in the workplace

Half the respondents (48%) did not divulge that they were mentally unwell to their managers. Disclosure to colleagues (58%) was 6% higher than that to managers. However, six out of ten managers (62%) did not disclose their mental health status to their employees.

Only 16% of employees who disclosed their condition perceived their manager as being intolerant. At least one in three of the disclosers (35%) described their manager as being concerned and supportive.

Perceived intolerance from managers doubled (32%) in the group who did not disclose their illness. Only 8% of the non-disclosers perceived their managers to be concerned and supportive.

Productivity was substantially affected by mental illness, with only one in five (20%) respondents claiming that they managed to continue working adequately. Nearly three out of ten (28%) respondents worked with great difficulty, with the same number working less quickly and effectively than formerly. 20% stated that they could eventually not work at all.

Absenteeism: 77% of the working respondents took sick leave, with 33% of these respondents taking more than a month to recover. It is also significant that 16% of respondents worked less hours per day in order to cope.

Work consequences of mental illness were similar for all diagnostic categories in this study. The majority of respondents (58%) believed that their illness adversely affected promotion or future job opportunities. 16% were demoted and a high 41% of working respondents left their jobs as they could no longer cope (21% of the cohort). 18% of respondents were fired or retrenched (9% of the cohort).

The impact of mental illness on respondents' personal and social lives

Respondents rated spouses, family and friends as significantly more supportive towards them than people in the workplace.

52% of respondents said that their illness caused tensions with their spouse or partner. When one considers that 135 respondents were married at the time of sampling, with 44 being divorced and 10 separated (this represents 57% of the cohort), then one can conclude that almost every marriage or partnership was adversely affected. 80 respondents (26%) did, in fact, record that their illness led either to separation or divorce.

One out of two respondents (49%) reported that their illness negatively affected family relationships with parents, siblings and children. 53 respondents (17% of cohort) also stated that they were unable to take care of their children while ill.

Although 47% of respondents lost friends, 29% gained friends. This may have been facilitated through attendance at support group meetings.⁹

Although 62% of respondents said that mental illness was a destructive experience for them, half the respondents (51%) also felt that their self-knowledge had improved. Four out of ten respondents (42%) described mental illness as "a sobering experience which helped me to grow as a person". Half the respondents (52%) experienced a loss in self-confidence.

Discussion

The high number of respondents with post school education (65%) could be due to several factors: firstly, the fact that participants were sourced primarily via support groups in urban areas, healthcare providers in private practice and Internet sites.

The length of the self-completion questionnaire demanded at least a Standard Eight level of literacy and the researcher and participating social workers assisted some respondents with education below matriculation level to complete their questionnaires.

However, with 65% of respondents having some level of post matric education, their initially high level of ignorance about mental health conditions and available treatments is disturbing.

Public ignorance about psychiatric conditions led to significant delays in help seeking and this highlights the importance for ongoing publicity on mental health.¹⁰

Although 73% of respondents consulted GPs, only 19% received a diagnosis from their GP. Although some GPs may have referred patients directly to psychiatrists, this statistic also suggests that GPs require additional training in psychiatric diagnosis.

The same observation applies to psychologists. 239 respondents (73%) consulted psychologists, yet only 9,5% said that a psychologist confirmed their diagnosis. Similar statistics apply to social workers: 23% of respondents consulted social workers, with only 7% playing a role in the confirmed diagnosis.

69% of respondents saw three or more caregivers and this points to the complex nature of mental illness and the fact that patients rarely find a completely satisfying diagnosis and/or treatment from one caregiver or discipline only.

It is noteworthy that 25% of respondents sought religious help (25%), spiritual/psychic counselling (10%) or traditional healing (2%).

Western medicine and psychology address only the physical and emotional wellbeing of patients. Yet approximately one third of respondents in this cross-cultural sample clearly demonstrated that their emotional and mental wellbeing included spiritual wellness and the need to obtain healing and/or reassurance from caregivers representing the religious/spiritual realm.

It is significant that 44% of respondents were able to draw positively on their own spiritual beliefs, although only 17% indicated that support from a religious cleric had actually helped them to get better. Religious clerics were also rated by only 8% of respondents as having assisted significantly in the understanding of their illness.

This suggests that more effort could be made by support groups and the mental health fraternity to educate the clergy on the symptoms and treatments available for mental illness.

Surprisingly, 38% of respondents reported that their belief in God had strengthened as a result of the illness, with far less (25%) feeling that God had abandoned them. As this was a multiple-choice question, 18 respondents (5% of cohort) checked both options. In some instances, they indicated that they had initially felt abandoned by God, but then regained their religious beliefs once their condition improved.

A high 78% of respondents labeled the attitude of their current doctor or primary caregiver as being concerned and supportive. This suggests that a good bedside manner is a critical criterion for mental health patients who are able to choose their service providers. This assumption is supported by the fact that 21% of respondents switched doctors due to not being taken seriously.

It is a concern that 39% of respondents said that their doctors did not discuss possible side-effects of medication with them, particularly as some side-effects lessen with time or can be managed. Many doctors (52%) did not discuss how to manage side-effects with their patients, potentially increasing the risk of them discontinuing medication. 34% of respondents with bipolar mood disorder and 23% of respondents with unipolar depression discontinued taking prescribed medication due to side-effects.

It is also disturbing that 40% of respondents did not know what type of psychotherapy they had and this suggests that many therapists are not discussing their methodologies with their patients. As cognitive and cognitive behavioural therapy (CBT) therapy tend to be more outcome based than other forms of therapy, it was encouraging to see that 33% of the respondents were exposed to this methodology.

Surprisingly, TV and videos were ranked by 59% of respondents as having played no role at all in the understanding of

their illness. Most respondents to this study would have TVs and given the increase in exposure to mental health issues on programmes like *Three Talk* and *Dr. Phil*, this figure is a little disappointing.¹¹

Although they played a secondary role, it is important to note that family practitioners (34%), family and friends (33%) and newspapers / magazines (33%) helped respondents a little, or moderately, to understand their conditions better.

In many instances, co-morbid ailments are caused directly, or intensified by the psychiatric distress experienced by the patient. However, many patients seek medical attention for co-morbid conditions before receiving psychiatric help. One reason for this may be the limited number of psychiatric and psychological consultations available to many medical scheme members.

The 2004 white paper addressing mental health stigma in South Africa comments that "The effective treatment of patients with severe depression results in a markedly diminished rate of visits to doctors for non-psychiatric services."¹²

Lifestyle management can play an important role in recovery, yet only three out of ten (34%) respondents ate a healthy and balanced diet, with even less (27%) doing regular exercise, or some type of relaxation technique (23%). Perhaps medical schemes should be motivated to reward mentally ill patients for adopting healthy lifestyle interventions, as they are currently doing for other major illnesses like hypertension and diabetes.

It is interesting to note, however, that Omega 3 was taken by 23% of the cohort, suggesting growing awareness of the use of this essential fatty acid for alleviating depression.^{13,14}

Stigma in the workplace is still a significant problem. Of the employees who did not disclose their condition, 43% claimed that their managers did not notice that they were mentally ill. This suggests that these managers were generally ignorant and did not recognize the signs and symptoms of mental illness.¹⁵

Employees who disclosed their condition in the workplace perceived their managers to be significantly more tolerant than employees who chose to conceal their illness. There are two possibilities here. Possibly, the managers of the disclosers were more tolerant in the first place, making it easier for their employees to open up to them. Alternatively, it is also possible that disclosure generally leads to a more understanding and tolerant response from managers once they know that there is a genuine problem. It also makes sense for employees to disclose their condition to their employers if they wish to obtain fair and equitable treatment.

Only 8% of respondents were unemployed prior to becoming mentally ill, with a high 27% being unemployed after their illness. As 22% of respondents were still unemployed at the time of sampling, it seems as if only 5% were able to find employment again after experiencing mental illness. However, 64% of the unemployed respondents were functioning satisfactorily or well after experiencing mental illness.

Conclusions and recommendations

This study has identified that the following areas in mental health require attention:

- It took some time for patients to obtain a correct diagnosis, with 65% of diagnoses being made after more than six months. General practitioners, psychologists and social workers played a minimal role in confirming diagnoses, suggesting that their knowledge and ability to identify psychiatric conditions is inadequate. Additional training in diagnostic skills would be helpful.

- More education needs to be given to medical practitioners and the general public about the prevalence of comorbid conditions with psychiatric problems, so that they treat the cause (i.e. the mental health problem) instead of its physical symptoms.
- In order to reduce the high dropout rate due to side-effects, psychiatrists and GPs need to be more upfront about discussing potential side-effects with patients and how to manage them.
- With 40% of respondents not knowing what type of psychotherapy they had, psychologists need to be more upfront about the methodology(ies) they use and the objectives of therapy and outcomes desired. Doctors, support groups and health editors could also educate mental health consumers more about the types of therapy available to them and what they should expect from psychotherapy.
- It is significant to note that financial constraints led to 23% of respondents stopping their medication, and to 46% of respondents stopping psychotherapy. This suggests that doctors and psychologists may not always be referring private patients to public healthcare facilities and NGOs when their financial resources are exhausted.
- Due to medical aid capping, 13% of respondents discontinued taking prescribed medication, and 25% of respondents discontinued psychotherapy. 34% of generic drug users indicated that their medical schemes did not provide adequate funding for non-generic drugs. These statistics need to be shared with medical schemes by SADAG and SASOP as part of their lobby to obtain better benefits for psychiatric patients.
- With only one third of respondents eating a healthy diet, GPs and psychiatrists need to recommend healthy eating and suitable supplementation to psychiatric patients.
- More information needs to be given to patients on the hazards of mixing alcohol and illegal substances with prescribed medication. (One out of ten respondents (11% of the cohort) used alcohol, marijuana or another illegal substance to "boost" the effects of prescribed medication.)
- Workplace problems will be lessened if employees are educated to seek medical and therapeutic intervention as soon as they experience psychiatric symptoms.
- Unemployed patients need to be assisted by their therapists or social workers on how to present themselves to employers after being ill. The stigma around psychiatric illness also needs to be addressed in the workplace.
- The high number of separations and divorces strongly suggests that doctors and therapists should include spouses, partners and close family members in the treatment process. It is also important that they recommend marital or family therapy whenever appropriate.

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