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Mental Health Review Board Members' Perceptions Regarding Implementation of the Mental Health Care Act 17 of 2002: A Qualitative Study

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Abstract:

Introduction: The Mental Health Care Act 17 of 2002, referred to hereafter as the Act, is being implemented with significant difficulty in the majority of provinces of the Republic of South Africa. Effective Mental Health Review Boards (MHRBs) are essential to ensuring the Act is implemented efficiently. However, the majority of MHRBs in South Africa are dysfunctional, and some provinces lack them. The purpose of this study was to explore and describe the perceptions of MHRB members regarding the implementation of the Act in the North West Province (NWP) of South Africa (SA).

Methods: A qualitative-exploratory-descriptive and contextual research design was used to explore and describe the perceptions of MHRB members regarding implementation of the Act. Since there were only a few MHRB members in NWP, SA, a single Focus Group Discussion (FGD) was conducted with 6 MHRB members from the Substance Abuse and Mental Health subdirectorate of the North West Department of Health. Maguire and Delahunt's six steps of thematic analysis were used to analyse data.

Results: Two themes emerged from this study: factors contributing to poor implementation of the Act and strategies to improve its implementation.

Conclusion: The findings of this study highlight a critical disconnection between the legislative mandate and the capacity of the existing health system. The study suggests that without addressing systemic resource deficits and strengthening the structural independence of the MHRB, effective implementation of the Act and the protection of the rights of mental health service users will remain unattainable.

Keywords: Mental health review board, Mental healthcare practitioners, Perceptions, Implementation, Mental health care act 17 of 2002.

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1. INTRODUCTION

The implementation of the Mental Health Care Act (MHCA), referred to hereafter as the Act, is a serious concern globally. For instance, Ozrasit noted that the effective implementation of the United Kingdom (UK) Mental Health Bill 2025 will present challenges [1]. The same author mentioned that the success of community-based care models and the overall efficacy of the new mental health services framework will largely depend on adequate resource allocation. Without sufficient funding and infrastructure, these models may struggle to deliver their intended benefits. Furthermore, the expanded roles and responsibilities of mental health professionals necessitate comprehensive training and workforce development to ensure that they can effectively meet the demands of the reformed system [1].

On the other hand, Malhotra indicated that even five years after the establishment of India MHCA 17, the government has done little to fulfill its obligations as set out in the first part of the preamble. No efforts have been made post-MHCA to create, strengthen, or expand mental healthcare service infrastructure in India [2]. The same author mentioned that, unfortunately, many provisions of the MHCA 17 are borrowed from laws in the United Kingdom (UK) and Canada, which are inapplicable to the socio-cultural system prevailing in India. Based on the above challenges, the author concludes that the MHCA of India is unimplementable in letter and spirit. The experience so far reveals that the various provisions of India MHCA, purported to protect the rights of Persons with Mental Illness (PMI) during the delivery of treatment, are a hindrance in the delivery of treatment, thus depriving many of the necessary and timely treatment. This is a situation of compromising the right to treatment in exchange for the protection of rights during treatment. The India MHCA needs to be majorly amended if not repealed [2]. Although many studies focus on practitioners or PMI, the perspectives of Mental Health Review Boards (MHRBs) themselves, who are often "caught" between legal mandates and field realities, remain underexplored.

Regardless of their socioeconomic status, in South Africa (SA), mental health care users (MHCUs), their families, and communities have access to high-quality mental health care services [3]. However, authors, such as Sehularo, Chukwuere, and Sehularo [4], mentioned that the Mental Health Care Act 17 of 2002, hereafter referred to as the Act [5], is not well understood and there is insufficient training on this Act for relevant stakeholders, which results in a lack of or ineffective implementation of the Act in most provinces of the Republic of South Africa [4].

To oversee the appropriate implementation of the Act [5], MHRBs are appointed by the Members of Executive Councils (MECs) in all provinces of South Africa, including the North West Province (NWP), where this study was conducted. The role of MHRBs as watchdogs over mental health care services was highlighted in a recent study [6]. Therefore, if something goes wrong, someone should be held accountable; for instance, they might receive a notice to appear for an investigation, as required by Section 21(2) of the Act.

However, the majority of the MHRBs in South Africa are dysfunctional, and there are no active Review Boards in several provinces [7]. Ineffective MHRBs permit the mistreatment or neglect of MHCUs at facilities for mental health care [7]. This is also the case in NWP, which is why the researcher deemed it necessary to conduct the current study. Effective MHRBs are required to ensure the proper application of the Act and access to high-quality mental health treatment. Additionally, MHRBs need sufficient funds to ensure that MHCUs have access to additional resources [8].

Effective and independent MHRBs with standardised procedures are necessary to ensure the proper application of the Act and, when necessary, the protection of the rights of MHCUs. Furthermore, the Act cannot be implemented, and the rights of MHCUs would continue to be violated in the absence of functional MHRBs [9]. In addition to having significant decision-making authority over assisted and involuntary care, treatment, and rehabilitation services, the MHRBs also have the authority to review and approve transfers of MHCUs [10]. MHRBs are thus important for ensuring the effective implementation of the Act and achieving the objectives set out in it [3].

Sehularo, Chukwuere, and Sehularo [4], as well as Vine and Judd [3], are concerned about the implementation of the Act. Implementation of the Act is a serious problem in NWP, South Africa (SA), where admission forms are not completed correctly, MHCUs remain for extended periods within the 72-hour observation period, some mental health care practitioners do not understand the Act, and some MHRBs are non-existent. For this reason, the researchers deemed it necessary to conduct this study to explore and describe the MHRB members' perceptions of the implementation of the Act in NWP of SA.

2. METHODS

Research methodology is defined as the systematic investigation into and study of materials and sources to establish facts and reach new conclusions [11]. The research methodology determines how the investigation will take place and is also a means of systematically addressing the research problem, such as poor implementation of the Act [11].

2.1. Study Design

A qualitative-exploratory-descriptive and contextual research design was used to explore and describe the MHRB members' perceptions regarding the implementation of the Act in NWP, South Africa. Qualitative research is concerned with the meanings people have constructed, that is, how people make sense of their world and the experiences they have in it [12]. Qualitative researchers are interested in understanding how people interpret their experiences, construct their world, and attribute meaning to them [13].

2.2. Study Setting

This study was conducted in the Substance Abuse and Mental Health subdirectorate of the North West Department of Health. There is only one MHRB in the province, and all six members participated in this study. These members include two mental health care practitioners, two legal practitioners, and two community representatives. One of the legal practitioners is also a mental health care practitioner.

2.3. Population

A population is defined as a group of individuals with one or more characteristics of interest, and can influence research credibility on the basis of the researcher's understanding, definition, and choice of it [14]. The target population in this study was all MHRB members appointed under Chapter IV of the Act.

2.4. Sampling

A non-probability sampling approach was used to select study participants for a Focus Group Discussion (FGD) on the perceptions of MHRB members regarding the implementation of the Act. According to Elfil and Negida [15], a non-probability sampling approach is used to select research participants on the basis that they have the valuable information and knowledge required to answer research questions. The same authors further indicated that a non-probability sampling approach is used when the sample population is selected in a non-systematic process that does not guarantee equal chances for each subject in the target population.

A purposive, all-inclusive sampling technique was used to select all MHRB members in NWP, South Africa. According to Farrugia [16], purposive sampling techniques are used to select members of the target population who are knowledgeable about the topic and can provide valuable information that will meet the purpose of the study. All-inclusive population sampling is a technique in which the entire population that meets the criteria (for example, specific qualifications, skills, and experience) is included in the research study. All-inclusive population sampling is more commonly used where the population being investigated is relatively small [17]. In this study, there is only one MHRB in the North West Province, and all six members participated. The Board includes two legal practitioners who are admitted as Advocates of the High Court of South Africa, and one of them is also a magistrate of the court. There were also two mental health care practitioners and two community representatives. All of these MHRB members were appointed under Chapter IV of the Act.

2.5. Data Collection

Before data collection, all participants were informed that the study was conducted by the first author for the sole purpose of obtaining a Doctor of Philosophy in Health Sciences with a Nursing Science specialization. A FGD was used in this study, a technique in which a researcher assembles a group of individuals to discuss a specific topic, aiming to draw on their complex personal experiences, beliefs, perceptions, and attitudes through a moderated interaction [18]. A FGD offers the opportunity to explore a wider range of perceptions in a single elicitation, as new information is gathered as participants build on their interactions with others. Furthermore, participants may find FGDs more stimulating and comfortable as they make them feel supported in sharing valuable information [19].

An FGD was held via Zoom with all six MHRB members, who voluntarily agreed to participate in the study. An audio recorder was used to capture all participants' responses. The researcher used Zoom to conduct the FGD due to the high risk of contracting COVID-19 at the time; the researcher had to prevent physical contact and ensure that participants and the researcher remained safe. The researcher collected data after building a trusting relationship with all the participants. The FGD session took approximately 45 minutes. The researcher collected data from the study participants until saturation was reached. This is when no new information emerged from the participants. The researcher asked all the participants to turn on their videos so he could capture all the field notes during and after the FGD. This was done to capture all non-verbal cues. Participants freely shared their perceptions regarding the implementation of the Act in the North West Province. The open-ended questions that participants responded to were as follows: What is your understanding of the Mental Health Care Act 17 of 2002? What are your perceptions regarding the implementation (putting MHCA into effect) of MHCA 17 of 2002 in North West Province? According to you, what should be put into place to improve the implementation of the Mental Health Care Act 17 of 2002? These questions were pilot tested with previous MHRB members.

2.6. Data Analysis

Data was analysed following Maguire and Delahunt's [20] six steps of thematic analysis. The researcher read the transcripts and interpreted the data to understand, make sense of, and become familiar with them. The researcher and the co-coder analysed the data separately, then made notes and established overall impressions, depth, thoughts, and the credibility of the data. Coding of the data was performed, with the data organised into small chunks (text or image segments). Both the researcher and the co-coder examined the codes and checked if they fitted together into themes. Codes were organised into broader themes that addressed and satisfied the research questions. The themes described in the data, relevant to the research questions, included different perceptions of MHRB members, supported by verbatim quotations. The researcher and an independent co-coder reviewed and modified the two themes that emerged from the findings of the study.

2.7. Trustworthiness

Credibility was ensured by prolonged engagement with MHRB members. The researcher spent time with all six of

the MHRB members before, during, and after the FGD. This was done to build trust and rapport with all MHRB members to understand their perceptions fully. Transferability was achieved by ensuring a thick description of the research methodology used to achieve the aim of this study. This was done to ensure that readers of this manuscript are able to assess the transferability of the findings of this study to their own contexts. To ensure the dependability of this study, all the research steps are described in detail to allow replicability. Confirmability was ensured by the involvement of an independent co-coder during data analysis. This was done to minimise any bias on the part of the first author, who is a PhD candidate under the supervision of the second and third authors of this manuscript.

2.8. Ethical Considerations

This study was approved by the Quality of Nursing and Midwifery (NuMIQ) Research Focus Area as well as the Health Research Ethics Committee of the North-West University (NWU-00338-21-S1).

3. RESULTS

Two themes emerged from the findings of the study: factors contributing to poor implementation of the Act, and strategies for improving the implementation of the Act. Table **1** shows the themes and sub-themes that emerged from the findings of the study.

Table 1. Themes and sub-themes.

Themes	Sub-themes
1. Factors contributing to poor implementation of the Mental Health Care Act	1.1 Shortage of staff in mental health care institutions
	1.2 Submission of incomplete documents to the Mental Health Review Board
	1.3 Inconsistencies from different mental health care institutions
	1.4 Challenges related to the independence of the Mental Health Review Boards
2. Strategies for improving implementation of the Mental Health Care Act	2.1 Community awareness campaigns
	2.2 Training and workshops for mental health care providers and Mental Health Review Board members
	2.3 Employment of more mental health specialists
	2.4 Building more mental health care institutions

3.1. Theme 1: Factors Contributing to Poor Implementation of the Mental Health Care Act

The first theme identified in this study was the factors contributing to poor implementation of the Mental Health Care Act. From this theme, four sub-themes emerged: staff shortages in mental health care institutions, submission of incomplete documents to the Mental Health Review Board, inconsistencies across mental health care institutions, and challenges related to the independence of the Mental Health Review Boards.

3.1.1. Shortage of Staff in Mental Health Care Institutions

According to the participants, there is a shortage of staff in mental health care facilities, and occasionally, there is only one licensed professional nurse in the psychiatric ward. Participants expressed the following:

> *Yes, is not properly implemented, and the thing is, we do not have we have this ... we talked about human resources and shortage thereof. So sometimes you find that there is only one professional nurse. Okay, he's qualified in psychiatric nurse, but if you check, this person has last dealt with a psychiatric patient, a mental health care user... a long time ago.* (Participant 3, male, legal practitioner)

> *Section 23 of this Act demands that the Review Board should be given a secretariat. But here we are supposed to be with the secretariat, but the Board does not have a secretariat; that is how the Department does not understand the Act. We insist on that, but they don't come to our understanding that the Act must be provided with the secretariat.* (Participant 2, male, legal practitioner)

3.1.2. Submission of Incomplete Documents to the Mental Health Review Board

Participants reported that mental health care professionals in the wards do not fill out documentation thoroughly and correctly, and they attribute this to a lack of in-service training. This is a significant practical challenge for the MHRB members, who stated as follows:

> *... some information is missing, we don't know whether the information was not there or because people are busy [so] they don't have time to look for the information. In the form where the ID numbers should be entered, there is no ID number – it is almost always the case – and other missing information, so it is not clear whether it is due to lack of training or people don't have time.* (Participant 4, male, mental health-care practitioner).

> *I think the Act is about 20 years now in force, but there are some practitioners who still lack knowledge. I don't know whether laziness is [at play] or what, in completing of necessary forms. So, as my colleagues*

> *already said, I don't know whether they lack in-service or what, or whether they lack interest. But there are some hospitals that are really trying to complete the forms accordingly, without unnecessary mistakes when we go through the forms as the Review Board*. (Participant 6, female, mental healthcare practitioner)

3.1.3. Inconsistencies from different Mental Health Care Institutions

Participants indicated that the implementation of the Act and the process for filling out admission forms are inconsistent. These discrepancies differ from one mental health facility to another:

> *... like for the health establishment documents that come, there is no consistency in completing the documents, there are issues from one institution to the other, some information is missing. We don't know whether the information was not there or because people are busy [so] they don't have time to look for the information. In the form where the ID numbers should be entered, there is no ID number ...* (Participant 4, male, mental healthcare practitioner)

> *... I think the act is about 20 years now in force, but there are some practitioners who still lack knowledge. I don't know whether is laziness [at play] or what, in completing of necessary forms. So as my colleagues already said, I don't whether they lack in-service or what, or whether they lack interest. But there are some hospitals that are really trying to complete the forms accordingly, without unnecessary mistakes when we go through the forms as the review board*. (Participant 6, female, mental healthcare practitioner)

3.1.4. Challenges related to the Independence of the Mental Health Review Boards

Participants expressed worry about the independence of MHRBs and claimed that the members lack the resources and expertise required to carry out their obligations:

> *I'm also worried about the independence of the Board. And the capacitation of the Board. ... they are not aware that they are breaking the law. They have to comply with those dictations of the Act. And then now you find the Board invested with that responsibility, and it's not capacitated as the Act dictates that they should have certain resources. They should have internet, they should have this ... You can't expect the Board to be accountable and effective without giving it what is expected. And at the same time, there is a blurring of lines, the independence of the Board is just on paper, but when it comes to reality, the administrators of the Department they make a mistake of thinking that the Board is a wing under their Directorate, or whatever*. (Participant 4, male, mental healthcare practitioner)

> *I think that when we speak about the independence of the Board, we speak about that the Board must be given funds to control. That is one of the requirements. But if the Board is not given funds to control, to maintain, to use independently, then we cannot say the Board is independent. And that is not taking place, and one can see it is not going to take place any time soon. That is, you can say the independence of the Board is lacking*. (Participant 2, male, legal practitioner)

3.2. Theme 2: Strategies for Improving Implementation of the Mental Health Care Act

The second theme identified in this study was the strategies for improving the implementation of the Mental Health Care Act. From this theme, four sub-themes emerged: community awareness campaigns, training and workshops for mental health care providers and Mental Health Review Board members, the employment of more mental health specialists, and the building of more mental health care institutions.

3.2.1. Community Awareness Campaigns

The population is largely unaware of most of the activities taking place around mental health. According to the participants, this is because outreach activities to raise awareness of mental health are not broadcast on television or radio. Participants claimed that by raising community awareness, those in need of help will be able to be found and be helped:

> *Mostly in the health facilities, in their workshop and trainings, the society or the community is not aware of most of the things. The outreach programmes are not on media or radio to educate people about mental health, so that they can be able to assist even the system to identify those at home, because there are users who are not receiving treatment. Some are just kept at home because of the belief that they are bewitched, some believe the mothers did something when they were pregnant, so we*

still need outreach programmes to make it active, and for the Act to get the results. (Participant 4, male, mental healthcare practitioner)

So you know, when a client comes in, and he has relapsed from home, then it's very difficult for family, ... this person is a reluctant to deal with such person and sometimes find that you do not know how to deal with such people, especially if they are a bit violent or so. We apply physical pressure. We beat them up. Ko spetlele re ne re re o a mo potetsa [at hospital, we used to say you take them around the corner]. (Participant 3, male, legal practitioner)

3.2.2. Training and Workshops for Mental Health Care Providers and Mental Health Review Board Members

Participants agreed that in-service training and workshops are necessary to equip mental health care professionals and MHRB members with the knowledge and abilities they need to execute the Act successfully:

Like I said, a person qualifies. Then 5-10 years into the whole thing, he has never attended any in-service any workshop, or he has not read, he's not studying, is doing absolutely nothing to increase knowledge in that field ... (Participant 3, male, legal practitioner)

Yes, I was talking about the training, to give all the training practitioners to be trained well, more especially when it comes to filling of the forms. Maybe if there can be people from national or wherever that can assist them on how to fill in the forms, I think they [will] get the forms in the right condition. And again, there should be one person to be appointed to double-check the form before we receive them. I think that will help, more especially when it comes to forms being rejected unnecessarily. (Participant 5, male, community representative)

3.2.3. Employment of more Mental Health Specialists

Participants stated that to execute the Act successfully, it is necessary to hire and train mental health professionals and make sure that mental health care facilities have appropriate resources and staff:

I think I can see what is, there is a need for training ... they need to be trained – more specialists. (Participant 5, male, community representative)

I don't think the implementation of the Act is rocket science, it is not rocket science. Anyone can implement the Act. So, as my colleague has eluded, number one is capacitating, human capital, employ and deploy enough human resources and capital resources ... (Participant 1, male, community representative)

There are posts that are funded but unfilled. That is not to say there are no people who qualify for the post. You can go out and headhunt for the person who can fill that post. So filling of the funded posts and creating posts where there is shortage, because there is shortage. And you said you are going to interview coordinators. There are a number of coordinators who are acting at this point in time. There are areas where there are no coordinators. (Participant 3, male, legal practitioner)

3.2.4. Building of more Mental Health Care Institutions

Participants stated that there are not enough mental health facilities to provide 72 hours of observation and reduce the workload of the mental health facilities that are already accessible:

... we still appeal to the Department to increase the 72-hour observation units, because they are not enough. And this is made worse by the fact that we do not have institutions like Bophelong in numbers which can take care of users coming from the community. So it's sometimes good if they are stabilised, maybe from the 72 hours observation units, because there's a possibility that some might be sent home from the summit to observation unit. So it will relieve pressure on the both Bophelong and Witrand. (Participant 3, male, legal practitioner)

... the system itself is clocked because now we see that already there is a lot of increase in the number of mental health patients. Which are clocking the system at the same time when they are observations; it takes time to get people that report back to the system, so now that's where we need to institutionalise. You take somebody, you put them in a psychiatric hospital, is like the person is in the holding cell, it is hindering with that person's right to privacy, dignity, and security. So now the system must be efficient so that we don't keep a person waiting for a bed, to be assessed or evaluated for 30 days, and be in the facility for 3 years, like inmates. Sometimes they

> *get injured and contract diseases there, so those are the things that I mean by institutionalisation.* (Participant 4, male, mental healthcare practitioner)

4. DISCUSSION

This study explored and described the perceptions of MHRB members regarding the implementation of the Act in NWP, South Africa. According to the researchers' knowledge, this is the first qualitative-exploratory-descriptive and contextual research study to be conducted in NWP of SA. Therefore, contributing important information to the province and globally. Two main themes emerged from the findings of the study, namely, factors contributing to poor implementation of the Act, as well as the strategies for improving implementation of the Act.

Most of the participants indicated that there is a shortage of staff in mental health care institutions. This finding is supported by a recent study conducted by Aprilia and colleagues, who indicated that healthcare workers with excessive workloads are prone to burnout and abnormal stress, and that these psychological conditions may reduce their administrative compliance with the mandates of the Act [21]. The finding is also consistent with those of Sobekwa and Arunachallam [22], who discovered that nurses working in psychiatric institutions face a number of challenges, including the need to care for MHCUs and a severe shortage of mental health care professionals in those institutions. This results in a high workload and low job satisfaction for those who provide mental health care. According to Maila and colleagues [23], in KwaZulu-Natal Province, nearly 70% of mental health care facilities lacked the skilled nursing and medical personnel necessary to provide mental health services, leaving the mental health care professionals emotionally and physically spent. Sehularo [24] adds that despite the qualification in mental health nursing being in existence for 40 years, there is a severe shortage of advanced mental health nurse specialists in South Africa.

The participants have also indicated a serious concern of submission of incomplete documents to the MHRB. Swanepoel and Mahomed articulate that the documents required by the Act are not completed correctly by mental health care practitioners, with omission of some information, such as identity numbers of MHCUs, and this leads to non-compliance by mental health institutions [6]. This creates problems for the MHRB members, as they cannot review them on time [6]. Madlala and Sokudela [25] argue that when documents and forms relating to the Act are not completed properly, then admission of the user is illegal and technically treatment ought not to be granted without the patient's consent. Moreover, the MHRB members and the mental health care facilities face challenges due to a lack of thorough and legal documentation [25].

The participants have noted inconsistencies from different mental health care institutions. This finding concurs with those of other authors. For instance, Zwart [26] noted that the objectives and successful execution of the Mental Health Care Act are undermined by anomalies in accurately completing the admission forms. According to Raphalalani and colleagues [27], the Mental Health Care Act is being implemented inconsistently, since mental health care units are sometimes forced to accept patients for extended periods of time without properly completed paperwork being submitted.

The participants interviewed in this study have raised challenges related to the independence of the MHRBs. Chapter IV of the Act [5] mandates that each MHRB member must act independently while using their authority. However, scholars like Swanepoel and Mahomed [6] stated that MHRBs must administer their functions independently and may choose their own ways of doing business unhindered, within the bounds of their legal authority. Due to inadequate hospital staff training and a lack of resources, MHRBs are still having trouble getting institutions to fully comply with the Act's requirements [6].

One of the strategies that was mentioned by the MHRB, which can be used for improving the implementation of the Act, was community awareness campaigns. Social media and mass media awareness campaigns can be utilised to improve the perceptions of those with mental illnesses, by highlighting success stories and lowering stigma in local communities [28]. According to Srivastava and colleagues [29], community involvement and addressing stigma surrounding mental illness are key components of successful mental health awareness initiatives. Additionally, community-based mental health programmes play an important role in raising community awareness of and knowledge about mental health [29].

The participants interviewed in this study suggested training and workshops for mental health care providers and MHRB members. This result supports those of earlier investigations; for instance, Madlala and Sokudela [25] note that greater ongoing training of mental health care professionals at mental health care institutions is necessary for them to better comprehend and apply the Act. Additionally, good communication and documentation can help to avoid unfavourable medical outcomes [25]. According to Philip and colleagues [30], MHRBs must be continuously trained and equipped to guarantee that the Act is implemented effectively, that progress is tracked, and that the rights of MHCUs are upheld.

Most of the participants have also suggested that there is a need for emplyment of more mental health specialists. According to Butryn and colleagues [31], the lack of mental health specialists and others who are nearing the end of their careers leads to the increased burden on and burnout of the remaining mental health specialists. Additionally, there is a need for more mental health professionals because the current deficit is hindering implementation of the Act [31]. The availability of mental health care services is directly impacted by the lack of mental health specialists [32]. Additionally, the lack of ongoing training and staff development at mental health care facilities might be blamed for the paucity of mental health specialists [32].

Lastly, participants suggested that there is a need to build more mental health care institutions. To increase access to mental health care and lessen the overcrowding and workload at existing mental health care institutions, Torrey and colleagues [33] state that there is a need for additional mental health care facilities for MCHUs. According to Ohtani and colleagues [34], it is critical for MHCUs to have access to mental health services, and there should be mental health care facilities that will make sure that more services, such as 72 hours of observation, are provided.

5. LIMITATIONS

This study was conducted in only one province of South Africa, and was carried out at the NW Department of Health's Substance Abuse and Mental Health subdirectorate. Again, purposive and all-inclusive sampling techniques were used to select all 6 MHRB members in NWP, South Africa, for only one FGD. The rationale for this small sample size was that there are only 6 members of MHRB in the NWP, South Africa, and the participants were comfortable being interviewed in a group after their board meeting. Accordingly, although the results of this study can be utilised, they cannot be generalised to the other eight provinces or other directorates outside of the Substance Abuse and Mental Health subdirectorate in the NW Department of Health.

CONCLUSION

This study aimed to explore and describe the MHRB members' perceptions on the implementation of the Act. The study concluded that the Act is not being implemented effectively in the NWP, South Africa. Participants were free to share their perceptions regarding the factors contributing to poor implementation of the Act. This study makes several contributions to the field of psychiatry and mental health, making it possible for all mental health care practitioners to be able to use the findings of the study. The study contributes to the body of knowledge on the subject and urges further investigation into the application of the Act, in order to improve the application of the Act and provide the implementers with the tools they need.

RECOMMENDATIONS

This study recommends that policymakers review Chapter IV of the Act and emphasize the independency of the MHRB. The mental health directorate in NWP should ensure that the MHRB receives proper orientation and training with regards to the MHCA. The NW Department of Health should employ more mental health specialists and build more mental health care institutions.

AUTHORS' CONTRIBUTIONS

The authors confirm their contribution to the paper as follows: L.A.: Study conception and design; M.M.M.: Data analysis or interpretation; T.P.M.: Draft manuscript. All authors reviewed the results and approved the final version of the manuscript.

LIST OF ABBREVIATIONS

FGD	=	Focus Group Discussion
MHCA	=	Mental Health Care Act
MHCUs	=	Mental Health Care Users
MHRB	=	Mental Health Review Board
NuMIQ	=	Quality of Nursing and Midwifery
NWP	=	North West Province
NWU-HREC	=	North-West University Health Research Ethics Committee
PMI	=	Persons with Mental Illness
SA	=	South Africa
UK	=	United Kingdom

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

This study was approved by the Quality of Nursing and Midwifery (NuMIQ) Research Focus Area as well as the Health Research Ethics Committee of the North-West University (NWU-00338-21-S1).

HUMAN AND ANIMAL RIGHTS

All human research procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national), and with the Helsinki Declaration of 1975, as revised in 2013.

CONSENT FOR PUBLICATION

Informed consent was obtained from the participants.

STANDARDS OF REPORTING

COREQ guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

All the data and supporting material are available within the article.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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