Mental Health and Poverty Project

The Mental Health and Poverty Project is a ground breaking research consortium which aims to provide new knowledge on multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health in four African countries.

Submission to:
South African Human Rights Commission

Public Hearings on the Millennium Development Goals and the realisation of Economic and Social Rights in South Africa

Prepared by: Sarah Skeen, Crick Lund, Sharon Kleintjes and Alan Flisher
University of Cape Town

Mental health as a development issue

There is growing recognition that mental health is a crucial public health and development issue in South Africa. Latest reviews of disease burden in this country rank neuropsychiatric conditions 3rd in their contribution to the burden of disease, after HIV/AIDS and other infectious diseases[1]. For the first time a major representative epidemiological study has revealed that some 16.5% of South Africans reported having suffered from common mental disorders in the last year[2]. This figure does not include schizophrenia and bipolar mood disorder, which according to expert consensus, would affect 0.5-2.0% of the population during an average year[3].

The substantial burden of mental disorders is by no means unique to South Africa. In the year 2000, it was estimated that mental disorders contributed 12% of the global burden of disease and it is predicted that this will rise to 15% by the year 2020. Currently mental disorders make up 5 of the 10 leading causes of health disability, and by 2020 it is predicted that unipolar depression will be the second most disabling health condition in the world[4]. It is estimated that 1 in 4 people suffer from a diagnosable mental disorder during the course of their lifetime[5].

A recent study looking at psychological distress found that it was significantly more common among South Africans with low socio-economic status[6] lending further weight to a developing theme in recent research: that mental ill-health and poverty are locked in a vicious cycle[7].

In discussing the role of mental health in the Millennium Development Goals, Sachs and Sachs[8] suggest that strategies based in MDG initiatives can be used to achieve development objectives that are not specified in the Goals themselves. In spite of some debate over the omission of mental health (or indeed all non-communicable diseases) from the MDGs, it is our belief that mental health is intricately woven into the priority development issues outlined in the MDGs and the social and economic rights preserved in the South African Constitution. We would argue that not only will lack of progress in achieving these targets have a significant impact on mental health, but also that it is not possible to achieve some of these aspirations in the absence of addressing mental health concerns.

In this light, before presenting our assessment of South Africa's progress in achieving its developmental goals, it is important to note that there is good evidence that a range of clinical, social and economic interventions can benefit the mental health of our communities. Depression can be effectively treated with low cost antidepressants or psychotherapy; antipsychotic drugs are cost effective interventions for people with schizophrenia; hazardous alcohol abuse can be effectively dealt with by providing brief interventions by trained primary care workers; and for adults and children with chronic mental disabilities, community-based rehabilitative models can provide effective low-cost care.

In this submission, we will outline the strong relationship with mental health and the rights outlined in the South African Constitution and the Millennium Development Goals, consider the policy and legislative framework for each relevant Goal, and assess the progress that South Africa has made in achieving each goal from a

mental health perspective. The information in this article is largely adapted from the Mental Health and Poverty Project's South African Country Report[9] which was based on a number of semi-structured interviews held between August 2006 and March 2007 with a variety of stakeholders at national and provincial level, as well as quantitative information gathered for 2005 using the WHO AIMS instrument, which was developed to assess mental health systems.

Mental health and its role in achieving the Social and Economic Rights and Millennium Development Goals.

MDG 1: Poverty

There are a number of rights in the Bill of Rights that relate to the fight against poverty including sufficient food and water; health; social security; and education. Mental ill-health and poverty have been linked at all stages of economic development. People living in poverty are at increased risk of developing mental health problems due to societal factors such as increased levels of stress, exclusion, and reduced access to social capital, as well as physical factors such as malnutrition, obstetric risks, and exposure to violence[7]. Those with mental illnesses are more likely to slide into poverty due to stigma and exclusion from social and economic opportunities[7], the high cost of accessing treatment, or the loss of employment due to diminished productivity[10]. This relationship has been corroborated in several studies (in South Africa and other low and middle income countries) looking at mental health and a variety of poverty indicators including employment[11-13], income[14], social welfare[15], housing[16], education[17], food security[18], financial stress[19], and higher exposure to life events[20]. The implications of this are clear: in much the same way that social determinants of physical health are being increasing acknowledged[21] so too should it be recognised that mental ill-health forms a part of the lived experience of poverty for a considerable portion of the population. This has significant repercussions for the pathway to achieving MDG 1 and the social and economic rights in our country.

Policy framework

South Africa does not currently have a national Mental Health Policy to guide the development of mental health services for South Africans, but relies on the provisions for mental health developments set out in chapter 12 of the The White Paper on the transformation of the health system published in 1997[20], and on National Mental Health Guidelines developed by the department of health in the same year[22]   The Mental Health Guidelines refer to the relationship between poverty and mental ill-health in South Africa, but stop short of advocating a poverty-reduction framework for mental health. The more recent "Policy Guidelines for Child and Adolescent Mental Health"[23] strongly assert that those living in poverty are more vulnerable to mental health problems. The Government's most recent poverty-related publication, "Towards an Anti-Poverty Strategy for South Africa"[24] presents support for the notion that increased medical costs can force one to slide into poverty, and suggests that income support and basic services such as subsidised housing, water, electricity, refuse removal and sanitation are made available to those who are vulnerable due to disability, but fails to specify poor mental health as a particular risk factor.

There is thus some level of support for the social selection aspect of the poverty-mental health relationship in current South African policies but limited acknowledgement of the potential role of social factors associated with poverty leading to mental illness. Furthermore there is little recognition of the need for an inclusive approach to development that targets people with mental disabilities at the same level as other vulnerable groups.

Box 1:   Progress in achieving MDG 1 from a mental health perspective

- In South Africa there is evidence to suggest that the number of people experiencing poverty has slightly decreased in the face of significant economic growth[25].   In spite of growing GDP there is a continued disparity in distribution of wealth[26], which is significant for mental health as research suggests that people with disabilities are disproportionately poor in South Africa[27] as mental disorders may be more prevalent in conditions of inequality[16;28].

- In 4 provinces in South Africa (Western Cape, KwaZulu-Natal, Eastern Cape and Gauteng), only 1-20% of mental health facilities have access to programmes outside the mental health facility that provide outside employment for users with severe mental disorders while in the Free State 21-50% of mental health facilities have access to such programmes. The extent of these programmes in the remaining provinces is unknown.

- The percentage of people who receive social welfare benefits due to a mental disability is unknown. The Department of Social Development, which administers social welfare benefits, does not keep records of the distinction between physical and mental disabilities.

- Provincial societies of the SA Federation for Mental Health provide good examples of NGO-led programmes that have integrated an anti-poverty approach into their work. For example, The Cape Mental Health Society based in the Western Cape focuses strongly on building economic resilience in mental health care users through "*reducing vulnerability, enhancing adaptability, and creating opportunities*" and their programmes comprise of a variety of anti-poverty initiatives: developing work and coping skills, securing employment and other money-making opportunities, subsidised feeding, accommodation and transport, and increasing access to disability grants[29]. Societies in other provinces have similar examples of poverty alleviation projects focused on people with mental disabilities.

- Overall, in the absence of national level acknowledgement of the mental health-poverty link in policy or programme development, there is little to suggest that mental health care users are being fully protected from sliding into poverty, or that those in poverty are benefiting from targeted mental health promotion programmes on a large scale.

MDG 2: Universal Primary Education

Education for both adults and children is stipulated as a human right in the Bill of Rights. It is claimed, however, that the corresponding MDG 2, universal primary education, will never be reached without making provision for the large proportion of

learners with mental and emotional difficulties in low and middle income countries [30]. Emotional and learning disorders contribute substantially to drop out rates, class repetition and poor academic performance [31] while failure to attend school can also be related to mental illness in other family members or caregivers [32]. On the other hand, education has been linked to increased levels of mental health in several studies, through the following potential pathways: improving one's social status; providing opportunity for increased earning capacity; or by providing protection from mental disorders through optimal brain development during childhood [33].

Policy framework

Collectively, various government documents support the importance of education for those with mental disabilities, as well as the notion that education can provide some protection from risks associated with mental ill-health.

The Mental Health Policy Guidelines document[22] acknowledges the importance of school-based programmes for prevention of substance abuse, teenage pregnancy, HIV/AIDS, violence and women and child abuse, which could contribute to retention of pupils in school while the Child and Adolescent Mental Health (CAMH) Guidelines specify that schools should be assisting children who are not achieving academically. The educational needs of children with disabilities are addressed in the Children's Act[34] by giving due consideration to "*making it possible for the child to participate in social, cultural, religious and educational activities, recognising the special needs that the child may have*". The most recent Education policy on curriculum development echoes White Paper 6's[35] commitment to the education needs of children with disabilities: "*the special educational, social, emotional and physical needs of learners will be addressed in the design and development of appropriate Learning Programmes*". On the other hand, the Adult Basic Education and Training Policy[36] clearly sets an aim as achieving "*universal adult basic education*" but, while the reality of being denied education due to physical disability is acknowledged, the policy fails to mention mental disability.

Box 2:   Progress in achieving MDG 2 for people with mental disorders.

- There are estimates which suggest that around 288 000 South African children with disabilities are not attending school[37]. A recent study in Orange Farm showed that 44% of children with disabilities who were sampled were not in school and that, compared to physical disorders, children with mental disability were far less likely to receive rehabilitative services[38].
- In terms of support for child and adolescent mental health, the percentage of primary and secondary schools with either a part-time or full-time mental health professional is unknown.
- The Free State, Gauteng and North West province indicated that 1-20% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. In the Western Cape 51-80% of schools have such activities. No other provinces indicated any school-based promotion or prevention activities.
- Basic education for adults with mental disabilities, which is essential for development of employment skills, is not being prioritised, and people with mental disabilities are often excluded from disability employment schemes due to the invisibility of their difficulties.

> - An initiative to include children with disabilities into education systems has been developed by the Department of Education. The 30-30-30 programme is testing a model of development in 30 districts by upgrading 30 special schools and 30 mainstream schools.
> - In spite of a generally supportive policy environment and a promising Department of Education initiative, mental health, and particularly psychiatric disorders, are still very low on the list of priorities in Government. There is also a lack of data about enrolment of children (and adults) with mental disabilities in education programmes, while evidence suggests that their enrolment rates are likely to be lower than children with physical disabilities. This population will thus require significantly more attention to ensure that that MDG 2 is met.

MDGs 3 Child mortality and MDG 4 Maternal health

Child survival is reflected in the right to life and children's right to basic nutrition, shelter, basic health care services and social services in the Constitution [39]. Miranda and Patel[40] hypothesise that child mortality and maternal mental health are linked due to the fact that mothers' poor mental health has been shown to be associated with a host of indicators negatively associated with child development: poor nutrition, stunting, early cessation of breastfeeding, and diarrhoeal disease[41;42]. Incompletion of immunisation regimes for children has been even linked to poor maternal mental health [31], which is particularly pertinent to Target 4.3 of the goals: to increase the *"proportion of 1 year old children immunised against measles"*.

Maternal health, of course, goes beyond the impact on the child. Women consistently present with higher rates of depression and anxiety than men in LMIC studies [43]. It is, in fact, possible that the negative poverty-mental health relationship has a more significant impact on women than men due to gender specific social factors that women experience in poverty including isolation, powerlessness, low education levels and economic dependence[44]. Depressed women are also more disabled than others and are less likely to care for their own needs [40] and suicide rates are disproportionately high for young women in South Africa compared to other age groups[45].

Policy framework

Following the first free and fair elections, the Government put women and children's health at the top of the health agenda[46]. In the absence of a national policy, the Mental Health Policy Guidelines identify women as an at-risk group and recommends that they receive specially targeted programmes. This document also recognises the role that maternal mental health plays in child development and asserts that community-based early intervention initiatives can assist with empowering mothers to prevent emotional and learning difficulties in their children. The CAMH Guidelines state that the rights and status of women are inextricably linked to the rights of the child. The South African Infant and Young Child Feeding Policy [47] states that infants with "*mothers who are incapable of caring for them due to ill health or mental disabilities*" fall into the category of "*children in exceptionally difficult circumstances*" requiring special care. Once again, while there are aspects

of policies that indicate broad support for the maternal mental health and child health link, priority areas of intervention are not identified.

This MDG also corresponds closely with the Right to Health Care, reiterating the importance of accessible treatment for mental health care users, which is strongly supported in relevant policy and legislative documentation. The White Paper for Health[48], on which most current health policy is based, clearly asserts the need for equitable, accessible services with emphasis on vulnerable groups. The Mental Health Care Act[49] focuses strongly on improving access to services providing the least restrictive form of care, and thus moves away from the model of in-patient service provision in specialised institutions, while the Policy Guidelines promote integration of mental health into wider primary health care.

Box 3: Progress in achieving MDGs 3 and 4: the impact of maternal mental health.

- Child mortality statistics have been the subject of great debate and controversy in South Africa. A recent report from UNICEF[50] shows that South Africa's 2008 child and infant mortality rates have decreased only slightly since 1990. This is in spite of 93% of the population accessing better water, 59% better sanitation (up to 66% in urban areas), and 100% of routine vaccinations being financed by the Government, (leading to immunisation coverage of more than 97% for most diseases except measles at 83%).
- It is currently impossible to assess the role of maternal mental health in these figures but in light of the strong relationship with child health noted above it is alarming to note the prevalence of maternal mental health disorders in South Africa. A study in rural KwaZulu-Natal in 2006 showed that 41% of a sample of pregnant women were depressed[51], while high levels of maternal substance abuse mean that foetal alcohol syndrome is a significant local public health concern: a recent study revealed that 1 in ten children presented with features of FAS in areas of the Northern Cape[52].
- Access to mental health care services remains a challenge in South Africa. Mental health services continue to rely heavily on mental hospitals: there are 23 mental hospitals in the country, and 56% of mental health beds are located in these facilities. Mental hospitals are geographically inaccessible, particularly to people in rural areas, and they attract a high level of stigma, making them unlikely choices for mental health care for most South Africans.
- Accessibility has also been affected by the lack of integration of mental health into broader health services. Progress that has been made has been driven to a large extent by the Mental Health Care Act. For example, according to Department of Health officials, there are 131 district hospitals, 28 secondary hospitals, 14 tertiary hospitals (comprising 53% of all hospitals) that have been listed to provide 72 hour assessments of psychiatric emergency cases, in keeping with the provisions of the Act. However, there remain major concerns about the capacity of staff and facilities to provide adequate mental health care in these hospitals. There is also a need to extend the integration of mental health into primary health care clinics at the district level.
- An example of successful integration of mental health into broader health services is the PeriNatal Mental Health Project, based at Mowbray Maternity Hospital in Cape Town, which aims to provide a holistic mental health service at the same site at which women receive obstetric care. To date the Project

has screened over 6000 pregnant women for mental health problems. Although formal services providing perinatal mental health care have shown considerable success in many other parts of the world, this project is the only known service of its kind in South Africa[53].

- While there is thus some level of acknowledgement of the role of maternal mental health for both mother and child, there is very little action to suggest that this aspect of health is being prioritised at any level.

MDG 6: HIV and other diseases

As demonstrated above, links between physical and mental health are complex. For example, there are two pathways through which mental health and HIV are linked. Firstly, there an increased vulnerability to HIV through mental illness or substance abuse related behaviours, and secondly, a greater risk for developing mental disorders, such as depression or anxiety, following confirmation of one's HIV status [54]. There are also mental health sequelae associated with disclosing one's status to family and friends, providing care to a family member infected with the virus and loss of close family members[55].

Policy framework

The Mental Health Policy Guidelines do not mention any relation between HIV and mental health. The Child and Adolescent Mental Health Guidelines, however, mention several aspects of the link, including increased mental health concerns due to the impact of illness on children or their family members, HIV infection as a biological risk factor for poor mental health, those with poor mental health as being more vulnerable to contract HIV due to increased high-risk behaviours, and intravenous drug use as a possible mode of HIV transmission. The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011[56] is the only policy document reviewed for this submission that not only acknowledges the connection between a Goal and mental health but also makes substantial recommendations to address this issue, such as making interventions accessible to people with disabilities, mainstreaming provision of psychological care and support services to people living with HIV and their families, and increasing the number of districts with accessible social and mental health services to support child and adult victims of sexual violence.

Box 4:   Progress in achieving MDG 6

- A recent study across 5 provinces revealed that 43.7% of people with HIV sampled also presented with a mental disorder[57], indicating that there is likely to be a high level of co-morbidity across South Africa.
- Mothers2Mothers provides an example of an HIV organisation that is integrating aspects of mental health into their work. Peer education is used to address social, emotional and psychological barriers to improved medical treatment for HIV positive mothers[58].
- While the links between HIV and mental health are increasingly being acknowledged in policy, limited access to mental health care in certain areas of the country, as documented in Box 3, means that implementation of suggested recommendations is not yet happening. It is clear that in light of HIV/AIDS affecting so many people and families, further efforts to reduce the

> psychological burden of such a major public health issue are crucial to the well-being of many South Africans.

MDG 7: Ensure environmental sustainability

So far, the mental health relationship with many of the above goals could be considered as bidirectional. For example, failure to reduce the HIV prevalence rate could result in continued high levels of mental illness, while continued mental morbidity could in turn maintain the HIV prevalence rate. Some one-way relationships are also evident: failure to achieve even the seemingly unrelated target 9 of MDG 7 (which refers to the preservation of the environment in much the same terms as the Constitution) may have an effect on population mental health. Bird[59] argues that in spite of a paucity of attention on this issue, climate change has the potential to pose a significant threat to our mental health through extreme weather events (such as was demonstrated after Hurricane Katrina) and long term climate change which could lead to increased vulnerability of those living in extreme poverty.

Target 11 of this MDG relates to improving the lives of slum dwellers, which loosely corresponds to South Africa's Right to Adequate Housing. Links have been established between mental ill-health and structural elements of housing. Furthermore, Jenkins[31] asserts that the type of living conditions experienced in informal settlements can lead to increased exposure to toxins and infection that can be the basis for developmental delays and epilepsy. For mental health care users, becoming ill can lead to the loss of one's housing through reduced income, stigma in communities, or in the absence of a supportive housing agenda for people with mental illness.

Policy framework

Environmental policies for South Africa tend to focus on environmental health issues and there is currently no Mental Health Disaster Management Plan in South Africa. In terms of housing, while 2008's Social Housing Act[60] states that "*special priority must be given to the needs of women, children, child-headed households, persons with disabilities and the elderly*" and prohibits discrimination "*against residents on any of the grounds set out in section 9 of the Constitution, including individuals affected by HIV and AIDS*" it does not identify mental disorders specifically.

Box 5:   Progress in achieving MDG 7 and the Right to Adequate Housing

- Currently, people with identified mental health problems cannot access standard government housing due to difficulties with contractual issues resulting from the belief that people with mental disabilities are not competent to enter contractual agreements.
- There are currently 63 community residential facilities available for mental health care users in the country (of which 47% are provided by the SA Federation for Mental Health). These facilities provide a total of 3.6 beds per 100,000 population. The Department of Health does not keep a record of gender distribution in these facilities. Neither the SA Federation for Mental Health nor the Department of Health could provide information on the number of children and adolescents in these facilities.

- Some provincial Departments of Health or Social Development have policies around transferring payments for funding of non-governmental organisations' residential accommodation in group homes. These NGOs regularly lobby for increases to these transfer payments which only cover a small proportion of the required funding for this essential community-based service.
- There is a need for a wider engagement with the Department of Housing regarding policies to address the housing needs of people with mental disabilities both in terms of the provision of supported residential accommodation managed by NGOs, and independent access to housing as home owners and tenants.

Monitoring and evaluation of budgets, expenditure and planning.

The lack of health related data is a pervasive problem in South Africa, while the quality of almost all the South African data provided by different agencies to assess the progress in attaining the MDGs has been debated at some level. The same is true for mental health. Quantitative mental health information that is of good quality is difficult if not impossible to access. The District Health Information System (DHIS) is the primary structure used to collect health data in South Africa. As reported in the MHaPP South African situation analysis[9], 4 of the 9 provinces indicated that there is no formally defined minimum data set of items to be collected by mental health facilities (Western Cape, KwaZulu-Natal, Northern Cape and Mpumalanga) while the remaining 5 provinces reported that a formally defined list of individual data items exists that ought to be collected by all mental health facilities. The provincial Health Departments receive data from all mental hospitals and all psychiatric inpatient units in general hospitals. While some provinces are also receiving data from all mental health outpatient facilities the Western Cape, KwaZulu-Natal and Limpopo only receive data from 67%, 23% and 89% of outpatient facilities, respectively. Even when information is transmitted, however, the indicators included are not necessarily useful. For example, no provinces were able to report a breakdown by gender, age or diagnosis of the mental health service users who enter any mental health facilities. Additionally, no report was produced on the data transmitted to the government Health Department in any province except North West. More recent information shows that there is currently only 1 common mental health indicator collected on the DHIS in all nine provinces again highlighting the lack of standardisation of information across the provinces.

Preliminary results from recent interviews held in the Northern Cape and KwaZulu-Natal as part of an intervention to strengthen mental health information systems (unpublished data, 2008) indicate that in the absence of a well-developed formal reporting system, managers and planners in the Department of Health are relying heavily on informal information, collected on both a regular and ad hoc basis, for management and budgetary decisions.

One of the challenges facing the mainstreaming of mental health into development initiatives, which will be further looked at below, is low expenditure on mental health. The percentage of government Health Department expenditure devoted to mental health is not known at a national level, with only 3 of the 9 provinces able to report on health expenditure on mental health care as a percentage of the health budget: Northern Cape 1%, Mpumalanga 8% and North West 5%. Many provinces are not

able to report on this indicator because budgets for mental health are integrated into general health budgets, particularly at primary care level. In addition to reporting on budgets, reporting on actual expenditure appears to be extremely difficult, as no provinces were able to provide these data. Only 4 of the 9 provinces were able to report on the proportion of mental health expenditure devoted to mental hospitals[9] It is thus apparent that there is a currently considerable difficulty associated with measuring mental health care, as no structured reporting systems are in place. The implications of this for the upscaling of mental health initiatives are very significant.

Specific challenges experienced in achieving the MDGs and the realisation of social and economic rights and recommendations.

Sen's[61] definition of development as a means to achieving political freedoms, economic facilities, social opportunities, transparency guarantees and protective security has restructured our understanding of what it means to develop as a nation. In the South African context, economic facilities and social opportunities remain severely curtailed in certain groups while a lack of protective security, particularly in some communities, is evident in our high crime rate. These contextual aspects are important to understand our country's developmental progress as elevated exposure to significant and frequent traumatic life events, limited individual or community assets, and poor institutional support have all been identified as factors which can both diminish and maintain one's low socio-economic status(62).

There are global challenges related to achieving the MDGs beyond the South African context, such as the scale of the tasks involved, competition for limited resources, and lack of capacity. For South Africa's own social and economic rights, the notion of progressive realisation is realistic for the setting, but we feel that mental health initiatives are lagging behind other issues in South Africa and that mental health problems are not being treated a real threat to the health and well-being of people, and as a means to achieve developmental goals.

Specific challenges to incorporating mental health into development efforts include its low level of prioritisation in the Department of Health and beyond, the lack of a holistic formal mental health policy which places mental health at the crossroads of several different government sectors, and slow implementation of the Mental Health Care Act. The South African Country report of the MHaPP project[9] outlines several recommendations for strengthening the mental health system and promoting mental health in South Africa:

Increasing prioritisation of mental health

Firstly, intensifying recognition of mental health as a significant development issue is key to increasing the pace at which the Goals are being met. This can be achieved through various mechanisms including lobbying for political support for mental health on the public agenda, public education, and exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health being used to change discriminatory attitudes toward mental disability. This work should be framed within the provisions of the UN Convention of the Rights of Disabled Persons and the human rights based framework of South African law.

The mechanisms of interaction between mental health and poverty and potential strategies to address the link should be brought to the attention of policy developers to promote the integration of this focus area into policies and programmes of all sectors involved in poverty alleviation and community upliftment. This requires evidence-based support to promote recovery and inclusion of people with mental disability in community life, such as access to education and skills development, income generation opportunities for users, reasonable accommodation provisions for employees and where income generating work is not possible social support, housing and transport. Finally, decreasing human rights violations experienced by those with mental health disorders can be achieved through the development of a mental health user lobby, ensuring participation of people with mental disability on the broader disability, development and public health agendas.

Developing a national mental health policy and strategic plans

Current efforts to develop a national mental health policy need to be finalised following a thorough process of consultation and consensus building with a range of stakeholders throughout the country. Various aspects have been identified as vital for inclusion in such a document, and again link closely with priority areas identified in the Goals: child and adolescent mental health, gender issues, intellectual disability, HIV/AIDS and the link between mental health and poverty. Provincial strategic plans for mental health which are based on the national policy but including specific strategies, targets, timelines, budgets and indicators are also needed.

Increase implementation of the Mental Health Care Act

Overcoming obstacles associated with implementation of the Act will involve developing clearer guidelines for mental health services at local hospitals, developing infrastructure for emergency admissions at district level, and commitment to increasing services that are available and accessible in communities, such as community residential care, day services and outpatient services.

The shadow of mental health as a vertical health programme hangs over much of the mental health care available in South Africa and integration into mainstream primary health care is still a challenge. Examples of best practice, such as the PeriNatal Mental Health Project in Box 3, need to be studied and expanded into other settings across the country.

Building intersectoral collaboration for mental health and development

With mental health firmly established as a cross-cutting development issue, in much the same way as HIV has been, multi-sectoral development efforts are thus recommended. There are various intersectoral initiatives that have started in South Africa: a national forum on forensic psychiatry, to be convened by the Department of Health, with the South African Police Service (SAPS), the Department of Justice and the Department of Correctional Services. Some provinces have also established such inter-sectoral forums for mental health. The Department of Education and Correctional Services have both developed relevant policies, while the SA Police have initiated a process to set out guidelines for police in relation to mental health

issues. Finally, it is becoming increasingly apparent that development efforts in our country require the participation of local communities to assist with the implementation of policies at a local level.

Develop monitoring and evaluation mechanisms, and a mental health and development research agenda

It is clear that at all levels the considerable lack of information about mental health, the burden of disease, patterns of treatment and care, and available resources are all contributing to the slow pace at which mental health care services are improving in South Africa. There is a dire need for a national mental health information system based on a set of nationally agreed indicators.

Linked to this, further research and information about mental health and various development issues, through the setting of a national research agenda, will allow for development agencies and policy-makers to incorporate mental health aspects into their projects.

Conclusion

While moving forward to 2015 and beyond, it will be crucial for South Africa to keep vulnerable and hard-to-reach populations in mind if they are to reach their goals. Unless mental health is mainstreamed into social and economic programmes, people with mental health problems risk slipping through the 'development net'. It is becoming apparent that development efforts in our country will require the participation of local communities and resources to assist with the implementation of policies at a local level. Improving population mental health could mean that we, as citizens, will be in a better position to contribute to development processes, through increasing our participation in communities, providing for our children, and achieving improved levels of education.

Reference List

(1) Bradshaw D, Norman R, Schneider M. A clarion call for action based on refined DALY estimates for South Africa : editorial. South African Medical Journal 2007;97(6):438-40.

(2) Williams DR, Herman SDJ, Heeringa SG, Jackson PBMHKRC. Twelve month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Survey. Psychological Medicine 2007;38:211-20.

(3) Kleintjes S, Flisher A, Fick M, Railoun A, Lund C, Molteno C et al. The prevalence of mental disorders among children, adolescents and adults in the Western Cape. South African Psychiatry Review 2006;9(3):157-60.

(4) Lopez DA, Mathers DC, Ezzati M, Jamison TD, Murray JLC. Global Burden of Disease and Risk Factors. New York: Oxford University Press and The World Bank.; 2006.

(5) WHO. Prevention of mental disorders: effective interventions and policy options. Geneva: WHO; 2004.

(6) Myer L, Stein DJ, Grimsrud A, Seedat S, Williams DR. Social determinants of psychological distress in a nationally-representative sample of South African adults. Social Science & Medicine 2008 April;66(8):1828-40.

(7) Patel V. Poverty, inequality, and mental health in developing countries. In: Leon DAWG, editor.Oxford: Oxford University Press; 2001. p. 247-62.

(8) Sach SE, Sachs J. Mental Health in the Millennium Development Goals: Not Ignored. PLoS Medicine 2007;4(1).

(9) Lund, C., Kleintjes, S., Campbell-Hall, V., Mjadu, S., Petersen, I., Bhana, A., Kakuma, R., Mlanjeni, B., Bird, P., Drew, N., Faydi, E., Funk, M, Green, A., Omar, M., and Flisher.A.J. Mental health policy development and implementation in South Africa: a situation analysis. Phase 1 Country report. Cape Town: Mental Health and Poverty Project. 2008.

(10) Saraceno B, Levav I, Kohn R. The public mental health significance of research on socio-economic factors in schizophrenia and major depression. World Psychiatry 2005;4:181-5.

(11) Ludermir AB, Lewis G. Informal work and common mental disorders. Social Psychiatry & Psychiatric Epidemiology 2003 September;38(9):485.

(12) Patel V, Todd C, Winston M, Gwanzura F, Simunyu E, Acuda W et al. Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors. The British Journal of Psychiatry 1997 July 1;171(1):60-4.

(13) Vorcaro CMR, Rocha FL, Uchoa E, Lima-Costa MF. The Burden of Social Phobia in a Brazilian Community and its Relationship with Socioeconomic Circumstances, Health Status and Use of Health Services: The Bambui Study. International Journal of Social Psychiatry 2004 September 1;50(3):216-26.

(14) Ludermir AB, Lewis G. Informal work and common mental disorders. Social Psychiatry & Psychiatric Epidemiology 2003 September;38(9):485.

(15) Plagerson, S., De Silva M, Harpham T, Patel V. Can cash transfers and loans to the poor alleviate the global burden of common mental disorders? Bulletin of theWorld Health Organisation 2007;in press.

(16) Patel V, Araya R, de Lima M, Ludermir A, Todd C. Women, poverty and common mental disorders in four restructuring societies. Social Science & Medicine 1999 December;49(11):1461-71.

(17) Araya R, Lewis G, Rojas G, Fritsch R. Education and income: which is more important for mental health? (Research Report). Journal of Epidemiology & Community Health 2003 July 1;57(7):501.

(18) Sabin M, Lopes Cardozo B, Nackerud L, Kaiser R, Varese L. Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. JAMA 2003;290:635-42.

(19) Patel V, Todd C, Winston M, Gwanzura F, Simunyu E, Acuda W et al. Outcome of common mental disorders in Harare, Zimbabwe. British Journal of Psychiatry 1998;(172):53-7.

(20) Myer L, Stein DJ, Grimsrud A, Seedat S, Williams DR. Social determinants of psychological distress in a nationally-representative sample of South African adults. Social Science & Medicine 2008 April;66(8):1828-40.

(21) WHO. Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: WHO; 2008.

(22) Department of Health. National health policy guidelines for improved mental health in South Africa. Pretoria: Department of Health; 1997.

(23) Department of Health. Policy guidelines for child and adolescent mental health. Pretoria: Department of Health; 2008.

(24) South African Government. Towards an Anti-Poverty Strategy for South Africa. Pretoria: South African Government; 2008.

(25) Mattes R. The material and political bases of lived poverty in Africa: insights from the Afrobarometer. Working paper 98, Afrobarometer . 2008.
Ref Type: Generic

(26) Statistics SA. Income and expenditure of households 2005/2006: Analysis of Results. 2008.
Ref Type: Generic

(27) Woolard, I. An overview of poverty and inequality in South Africa. 2002.

(28) Lorant V, Deliege D, Eaton W, Robert A, Philippot P, Ansseau M. Socioeconomic Inequalities in Depression: A Meta-Analysis. Am J Epidemiol 2003 January 15;157(2):98-112.

(29) Cape Mental Health. Economic Resilience: Cape Mental Health Annual Review 07/08. 2008.

(30) Patel V, Flisher AJ, Nikapota A, Malhotra S. Promoting child and adolescent mental health in low and middle income countries. Journal of Child Psychology and Psychiatry and Allied Disciplines 2008 March;49:313-34.

(31) Jenkins R, Lopez C, Mubbashar M. Mental & Neurological Health, Gender and the Millennium Development Goals. 2004.

(32) Das D. Mental health problems and Millennium Development Goals: A few more associations. A response to 'Achieving the millennium development goals: does mental health play a role? PLoS Medicine . 2006.
Ref Type: Internet Communication

(33) Araya R, Lewis G, Rojas G, Fritsch R. Education and income: which is more important for mental health? (Research Report). Journal of Epidemiology & Community Health 2003 July 1;57(7):501.

(34) The Children's Act, No. 38 of 2005, Republic of South Africa, (2005).

(35) Department of Education. Education White Paper 6: Building an inclusive education and training system. Pretoria: Department of Education; 2001.

(36) Department of Education. Policy Document on Adult Basic Education and Training. Pretoria: Department of Education; 2009.

(37) South Africa: The Good News. South Africa dedicates R9.5bn to special needs education. South Africa: The Good News 2008 Dec 8.

(38) Saloojee G, Phohole M, Saloojee H, Ijsselmuiden C. Unmet health welfare and educational needs of disabled children in an impoverished South African peri-urban township. Child Care Health and Development 2007;33(3):230-5.

(39) Constitution of the Republic of South Africa, Republic of South Africa, (1996).

(40) Miranda JJ, Patel V. Achieving the Millennium Development Goals: Does Mental Health Play a Role? PLoS Medicine 2005;2(10):291.

(41) Rahman A, Iqbal Z, Bunn J, Lovel H, Harrington R. Impact of Maternal Depression on Infant Nutritional Status and Illness: A Cohort Study. Archives of General Psychiatry 2004;61:946-52.

(42) Adewuya A, Ola B, Aloba O, Mapayi B, Okeniyi J. Impact of postnatal depression on infants' growth in Nigeria. Journal of Affective Disorders 2008;108(1-2):191-3.

(43) Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR et al. No health without mental health. The Lancet 2007;370(9590):859-77.

(44) Moultrie A, Kleintjes S. Women's mental health in South Africa. In: Health Systems Trust, editor. South African Health Review.Durban: Health Systems Trust; 2006.

(45) Burrows S, Laflamme L. Suicide mortality in South Africa. Social Psychiatry and Psychiatric Epidemiology 2006 February 1;41(2):108-14.

(46) King MS, Mhlanga RE, de Pinho H. The Context of Maternal and Child Health. In: Health Systems Trust, editor. South African Health Review.Durban: Health Systems Trust; 2006.

(47) The South African Infant and Young Child Feeding Policy, Department of Health, (2008).

(48) Department of Health. White paper for the transformation of the health system in South Africa. Pretoria: Government Gazette; 1997.

(49) The Mental Health Care Act, No. 17 of 2002, Republic of South Africa, (2002).

(50) UNICEF. The State of the World's Children 2009: Maternal and Newborn Health. 2009.

(51) Rochat TJ, Richter LM, Doll HA, Buthelezi N, Tomkins A, Stein A. Depression among pregnant rural South African women undergoing HIV testing. JAMA 2006;295:1376-8.

(52) Urban M, Chersich M, Fourie L, Chetty C, Olivier L, Viljoen D. Fetal alcohol syndrome among Grade 1 schoolchildren in Northern Cape Province: Prevalence and risk factors. SAMJ 2008;98(11).

(53) The PeriNatal Mental Health Project. 2009.
Ref Type: Internet Communication

(54) Freeman M, Patel V, Collins P, Bertolote J. Integrating mental health in global initiatives for HIV/AIDS. The British Journal of Psychiatry 2005 July 1;187(1):1-3.

(55) Patel V, Flisher A, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. The Lancet 2007;369:1302-13.

(56) Department of Health. HIV & AIDS and STI Strategic Plan for South Africa 2007-2011. 2007.

(57) Freeman M, Nkomo N, Kafaar Z, Kelly K. Factors associated with prevalence of mental disorder in people living with HIV/AIDS in South Africa. AIDS Care 2007;19(10):1201-9.

(58) mothers2mothers. 2009.
Ref Type: Internet Communication

(59) Bird P. Young Voices in Research for Health: Climate change and health: research challenges for vulnerable populations.Geneva: Global Forum for Health Research; 2008.

(60) The Social Housing Act, No. 16 of 2008, Republic of South Africa, (2008).

(61) Sen A. Development as Freedom. Oxford: Oxford University Press.; 1999.

(62) Chronic Poverty Research Centre. Policy brief 1: Chronic Poverty, an introduction. 2007.
Ref Type: Generic