NATIONAL MENTAL HEALTH POLICY FRAMEWORK AND STRATEGIC PLAN

2013-2020

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

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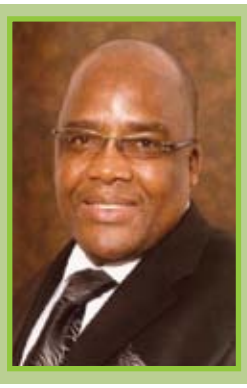
Contents

Foreword by Minister			**3**
Acknowledgements by Director-General			**5**
Glossary of terms			**6**
1.		**Introduction**	**9**
2.		**Context**	**11**
	2.1	Epidemiology	11
	2.2	Determinants of mental health and illness	12
	2.3	Costs of mental illness	14
	2.4	Evidence for promotion, prevention, treatment and rehabilitation	14
	2.5	Current service provision	15
	2.6	Recommended norms and standards	18
	2.7	Policy and legislation mandates	18
3.		**Vision**	**19**
4.		**Mission**	**19**
5.		**Objectives**	**19**
6.		**Values and Principles**	**19**
7.		**Areas for action**	**22**
	7.1	Organisation of services	22
	7.2	Financing	24
	7.3	Promotion and prevention	25
	7.4	Intersectoral collaboration	26
	7.5	Advocacy	26
	7.6	Human rights	27
	7.7	Special populations	27
	7.8	Quality improvement	27
	7.9	Monitoring and evaluation	28
	7.10	Human resources and training	28
	7.11	Psychotropic medication	28
	7.12	Research and evaluation of policy and services	29
8.		**Roles and responsibilities**	**29**
	8.1	Minister of Health	29
	8.2	Director-General	30
	8.3	Provincial Departments of Health	30
	8.4	District health services	30
	8.5	Designated Psychiatric Hospitals, Care and Rehabilitation Centres ...	31
	8.6	Other sectors	32
	8.7	Non-governmental organisations	32
National Mental Health Strategic Plan 2013-2020			**32**
		Appendix 1: Terms of Reference for key structures	40
		Appendix 2: Intersectoral roles and responsibility	44
		Appendix 3: The Ekurhuleni Declaration on Mental Health - April 2012	48
10		**References**	**52**



Foreword by the Minister

This National Mental Health Policy Framework and Strategic Plan 2013-2020 marks an important milestone in our ongoing efforts to transform health in this country. In line with the values and principles of the Alma Ata Declaration we reassert here the principle that mental health is an integral element of health and that improved mental health is fundamental to achieving government's goal of a "Long and Healthy life for all South Africans".

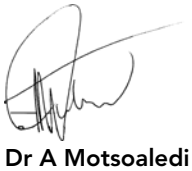
While reports show that there has been good progress made in enacting and implementing mental health legislation and policy since 1994, many challenges that require our intervention still remain. These include continuing high prevalence of mental disorders (linked to social determinants such as poverty, unemployment, violence, substance abuse and other adversities that increases the vulnerability of South Africans to mental disorders); high co-morbidity between mental and other diseases; a substantial gap between demand and supply of mental health services; inequity of services and mental health system weaknesses.

This Mental Health Policy Framework and Strategic Plan 2013-2020 was developed through an extensive consultation process with relevant stakeholders. All nine Provinces held summits to review the state of mental health and mental health services in their provinces, to identify best practices and to generate a roadmap for improving mental health. These consultations culminated in a national mental health summit where a draft of this Policy Framework was discussed and a declaration (The Ekurhuleni Declaration on Mental Health April 2012) was adopted.

The Policy Framework and Strategic Plan 2013-2020 identifies key activities that are considered catalytic to further transforming mental health services and ensuring that quality mental health services are accessible, equitable, comprehensive and are integrated at all levels of the health system, in line with World Health Organization (WHO) recommendations. The contents are consistent with key activities that form part of the broader health sector transformation process that are currently being implemented in South Africa including the re-engineering of primary health care, implementation of national health insurance, human resource development and infrastructure revitalization. In addition it is recognized that in order to achieve mental well being of the nation, sectors in the socioeconomic, political and health spheres must work together to implement multidimensional interventions. Civic organizations, non-governmental organizations, labour, employers, faith based organizations and traditional healers are all identified as partners to achieve this ambitious plan.

Our aspiration for "a Long and Healthy life" requires us to invest in mental health so that we not only reduce the substantial burden of untreated mental disorders, but we reach levels of mental health that are higher than the mere absence of disease or infirmity. Good mental health will no doubt contribute substantially to our social and economic development.

On behalf of all South Africans, I extend our heartfelt appreciation to the efforts of all those that played a critical role in developing the Mental Health Policy Framework and Strategic Plan 2013-2020. The work has just begun. I call upon all to work with us to realize this visionary policy and plan.



Dr A Motsoaledi , MP
Minister for Health

Acknowledgements by the Director General

The landmark adoption and publication of the Mental Health Policy Framework and Strategic Plan 2013-2020 marks a significant turning point for all South Africans, especially those people who may not be getting the mental health care that they need, suffering silently and alone, stigmatized and excluded by society from enjoying the basic rights enshrined in the Constitution of the Republic of South Africa.

The Mental Health Policy and Strategic Plan 2013-2020 is the culmination of a number of processes and activities that were undertaken over time. A review of existing mental health policies, services and systems was conducted using a variety of methods. Data was gathered through a collaboration with the Mental Health and Poverty Project funded by the DFID Research Programme. Interviews with key informants selected from the different spheres of government were conducted. The International guidance materials by the World Health Organization informed both the content and format of the Mental Health Policy Framework and Strategic Plan 2013-2020.

The Provincial and National Mental Health Summits that were convened by the Honourable Minister of Health Dr Motsoaledi, the Deputy Minister of Health, Dr G Ramokgopa and Members of the Executive Councils in provinces in 2012 engaged stakeholders to review progress that had been made to transform mental health services since 1994, identify best practice that had emerged, identify challenges that bedevil the system and make recommendations on actions that should be undertaken to further strengthen mental health services.

More than 4000 stakeholders participated in the provincial and national mental health summits. Representatives were drawn from research groups, academia, professional associations and statutory health institutions, the World Health Organization, non-governmental organizations, mental health care user groups, clinicians, national and provincial departments that play a role in mental health. Various papers were presented and robustly discussed at the summits covering a wide range of topics in mental health.

The National Mental Health Summit concluded by adopting a declaration and delegates resolved that the outputs from the summit be used to finalize the Mental Health Policy Framework and Strategic Plan and committed to assist with its implementation.

From the long list of priorities that the Summit adopted, it was imperative that further selection of key activities be done. Under the stewardship of the Deputy Minister the task team that had been appointed by the Minister to organize the National Mental Health Summit was reconvened to integrate inputs from the Summit and finalize the Mental Health Policy Framework and Strategic Plan 2013-2020.

On behalf of the National Department of Health, I would like to thank all those people who participated in the process of consultation. We appreciated the leadership that was provided by the Members of the Executive Councils, Heads of Departments and provincial mental health coordinators in leading the provincial consultations. The papers that were presented by all the researchers, academics, mental health care users and clinicians at both plenary and workgroups sessions provided invaluable insights. We appreciated the support from and participation by Dr Shaker Saxena, the WHO Director for Mental Health and Substance Abuse; Dr Francis Kasolo, the acting WHO country representative at the time; Dr Sebastiana Nkomo, the Mental Health Regional Advisor for AFRO; and the Honourable Mr Justice Jody Kollapen, Judge of the Northern High Court.

I would like to thank the task team that organized the national mental health summit and was reconvened to finalize the Mental Health Policy and Strategic Plan: Prof Melvyn Freeman, Prof Solomon Rataemane, Prof Leana

Uys, Dr Eva Manyedi, Prof Crick Lund, Prof Nhlanhla Mkhize, Prof Tholeni Sodi, Dr Thomas Sutcliffe, Dr Ian Westmore, Dr Emmanuel Tlou,

Ms Bharti Patel, Mr Sifiso Phakathi and all the officials within the national department who coordinated and facilitated these processes.

The framework and plan affirms our belief that "for all individuals, mental, physical and social health are vital strands of life that are closely interwoven and deeply interdependent, and that mental health is crucial to the overall well-being of individuals, and our society". Mental health is central to the department's efforts towards achieving "a long healthy life for all South Africans".

MS M P Matsoso
Director-General: Health

Glossary of terms

Assisted care, treatment and rehabilitation: The provision of health interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions.

Assisted Mental Health Care User: A person receiving assisted care, treatment and rehabilitation.

Associate: A person with a substantial or material interest in the well-being of a mental care user or a person who is in substantial contract with the user.

Care and Rehabilitation Centres: Health establishments for the care, treatment and rehabilitation of people with intellectual disabilities.

Community-based care: Care that is provided outside of institutional and hospital settings, as near as possible to the places where people live, work and study.

Community health worker: Any lay worker whose primary function is to promote basic health or the delivery of basic health services within the home or primary health care facility.

Constitution: The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996).

Correctional Centre: A centre as defined in section 1 of the Correctional Services Act.

Correctional Services Act: The Correctional Services Act, 1998 (Act No. 111 of 1998).

Court: A court of law.

Disease Prevention: Interventions that not only prevent the occurrence of disease, such as risk factor reduction, but also arrest its progress and reduce its consequences once established.

Health: A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.

Health Care: Outpatient and inpatient, medical care, dental care, mental health care, acute and chronic care provided by registered health care professionals.

Health Care Professionals: These are individuals registered with the various health related Statutory Bodies who render health and any related care to improve and maintain the health status of all health care users within the Department of Health (as stipulated in the National Health Act no 61 of 2003).

Health Establishments: The whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services. This includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals.

Health Promotion: Actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy lives and those that create living conditions and environments that support health.

Involuntary Care, Treatment and Rehabilitation: The provision of health interventions for the period during which people are deemed incapable of making informed decisions due to their mental health status and who refuse health interventions but require such services for their own protection or for the protection of others.

Involuntary Mental Health Care User: A person receiving involuntary care, treatment and rehabilitation.

Medical Practitioner: A person registered as such in terms of the Health Professions Act, 1974 (Act No. 56 of 1974) as amended.

Mental Health Care Practitioner: A psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services.

Mental Health Care Provider: A person providing mental health care services to mental health care users and includes mental health care practitioners.

Mental Health Care User: A person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of this person. This includes a user, state patient and mentally ill offender and where the person concerned is below the age of 18 years or is incapable of taking decisions, in certain circumstances may include:

1. A prospective user;
2. The person's next of kin;
3. A person authorized by any other law or court order to act on that person's behalf;
4. An administrator appointed in terms of the Mental Health Care Act, 2002 (Act No.17 of 2002); and
5. An executor of that deceased person's estate.

Mental Health Status: The level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis.

Mental Illness: A positive diagnosis of a mental health related illness in terms of diagnostic criteria made by a mental health care practitioner authorized to make such diagnosis.

Mentally Ill Offender: An offender as defined in section 1 of the Correctional Services Act in respect of whom an order has been issued in terms of section 52(3) (a) of the Mental Health Care Act to enable the provision of care, treatment and rehabilitation services at a health establishment designated in terms of section 49 of the Mental Health Care Act.

Perinatal period: The period during pregnancy (antenatal/prenatal), labour and up to one year after birth (postnatal).

Primary Health Care: Essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable (Alma Ata Declaration, 1978). This approach is organised to reduce exclusion and social disparities in health, is people-centred, intersectoral, collaborative, and promotes the participation of all stakeholders.

Primary Level Services: The first level of contact for individuals seeking health care.

Psychiatric Hospital: A health establishment that provides care, treatment and rehabilitation services only for users with mental illness.

Psychiatrist: Means a person registered as such in terms of the Health Professions Act.

Psychologist: Means a person registered as such in terms of the Health Professions Act.

Psychosocial rehabilitation: Mental health services that bring together approaches from the rehabilitation and the mental health fields, combining pharmacological treatment, skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities.

Recovery model: An approach to mental health care and rehabilitation which holds that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.

Secondary Care: Specialist Care that is typically rendered in a hospital setting following a referral from a primary or community health facility.

Task shifting: The use of specialist mental health staff in training and supervisory roles to non-specialist health workers, as a mechanism for more efficient and effective care.

Tertiary Care: Specialist care that is rendered at central hospitals.

1. Introduction

The time is ripe for the development of a new mental health policy in South Africa. Since the demise of apartheid, and the election of the first democratic government in 1994, a number of important reforms have taken place in mental health policy and legislation. In keeping with the new constitution, the White Paper for the Transformation of the Health System was published in 1997.[1] This document set out the provisions of a new mental health system, based on primary health care (PHC) principles. It was accompanied by Mental Health Policy Guidelines, which gave further detail to this vision of a new mental health system.[2]

Subsequently, South Africa set about reforming its outdated apartheid-era mental health legislation, and in 2004 the Mental Health Care Act (No 17 of 2002) was promulgated. This legislation was a major departure from the past. Among other things, it enshrines the human rights of people with mental disorders, providing specific mechanisms for the protection and promotion of those rights, and broadens the range of practitioners and other stake holders, including mental health care users, who can contribute to improving the mental health status of South Africans. The Act also improves access, makes primary health care the first contact of mental health care with the health system, and promotes the integration of mental health care into general health services and the development of community-based services.

However, despite these important reforms, there remain several ongoing challenges that face mental health in South Africa:

- Until the development of this document, there has been no officially endorsed national Mental Health Policy for South Africa;[3]
- Mental health care continues to be under-funded and under-resourced compared to other health priorities in the country,[4;5] despite the fact that neuropsychiatric disorders are ranked third in their contribution to the burden of disease in South Africa, after HIV&AIDS and other infectious diseases;[6]
- There is enormous inequity between provinces in the distribution of mental health services and resources;[5]
- There is a lack of public awareness of mental health and widespread stigma against those who suffer from mental illness;
- There is a lack of accurate routinely collected data regarding mental health service provision;[5]
- Mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on psychiatric hospitals;[7] and
- While the integration of mental health into PHC is enshrined in the White Paper and the Mental Health Care Act, in practice mental health care is usually confined to management of medication for those with severe mental disorders, and does not include detection and treatment of other mental disorders, such as depression and anxiety disorders.[8]

There is therefore an urgent need to develop a national mental health policy that reflects the opinions and priorities of a wide range of mental health stakeholders; is based on sound evidence; and provides a blueprint for action on mental health in South Africa. The purpose of this policy is to give guidance to provinces for mental health promotion, prevention of mental illness, treatment and rehabilitation. The policy is intended to be comprehensive in its scope, addressing the full age range, and covering all mental disorders, including co-morbid intellectual disability and substance use disorders.

This Mental Health Policy has been developed through a number of processes:

- Data were gathered from a review of current mental health policy and service literature in South Africa, and a situation analysis of the mental health system in South Africa, which included semi-structured interviews with over 100 key stakeholders;[9]
- International guidance materials, provided by the WHO,[10;11] were used to inform both the content and format of the policy;
- The policy was aligned with the current 10-point plan of the Department of Health (2009-2014); and
- An extensive public consultation process was undertaken, during which the draft mental health policy was made available for provincial and national consultations, through the Provincial Heads of Health. A full list of stakeholders consulted is provided in the appendix.

Scope

1. Substance abuse

Historically, in South Africa substance abuse treatment services have been provided by both the Department of Social Development and the Department of Health. The policy and legislative framework for this area is set out in the Prevention and Treatment of Substance Abuse Act (2008) and the National Drug Master Plan (2006). There are important issues of co-morbidity between substance use and mental disorders, and hence a need to coordinate services. Substance use disorders are to be covered by this policy insofar as there is co-morbidity with mental disorders. The Department of Health committed itself during Parliamentary debate of the Prevention and Treatment of Substance Abuse Act (2008) to provide care, treatment and rehabilitation for those users that present with co-morbid substance use and mental disorders in designated psychiatric hospitals, rather than referring them to the substance abuse treatment centres run by the Department of Social Development. This decision is reflected explicitly in this Mental Health Policy.

2. Intellectual Disability

The Mental Health Care Act (2002) provides for care and rehabilitation services for mental health care users. The responsibility of the Department of Health is to provide developmentally appropriate healthcare for those with severe and profound intellectual disabilities, many of whom will also have physical disabilities. The vocationally related service needs of people with mild and moderate intellectual disability range are the responsibility of the Department of Education and later the Department of Labour, while housing and community service needs are currently provided in some provinces by the department of Social Development. Where co-morbidity exists between intellectual disability and mental disorders, the treatment and care of the person suffering from these disorders is the responsibility of the Department of Health.

2. Context

2.1 Epidemiology

Health is defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being".[12] Mental health is therefore an essential element of health, and is crucial to the overall well-being of individuals and society. Mental health is defined as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until later life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self esteem".[13]

Mental illnesses present themselves through clusters of symptoms, or illness experiences. When these symptoms, or experiences, are associated with significant distress and impairment in one or more domains of human functioning (such as learning, working or family relationships), they are defined as clinically significant mental disorders. These disabling disorders include a number of distinct conditions, which affect people across the life course, with diverse epidemiological characteristics, clinical features, prognoses and possible intervention strategies.[14]

Neuropsychiatric disorders are ranked 3rd in their contribution to the overall burden of disease in South Africa, after HIV and AIDS and other infectious diseases.[6] The first nationally representative psychiatric epidemiological study, the South African Stress and Health (SASH) survey found that 16.5% of adults have experienced a mood, anxiety or substance use disorder) in the previous 12 months (Table 1).[15] The 12-month prevalence of child and adolescent mental disorders in the Western Cape was reported to be 17%, based on a review of local and international epidemiological literature (Table 2).[16] There is no evidence that there are any differences between socially defined racial groups or cultural groups in the prevalence of mental disorders. However, there are important gender differences: women are at increased risk of developing depression and anxiety disorders, whereas men are at increased risk of developing substance use disorders.

Table 1: 12-month prevalence of adult mental disorders in South Africa[15;16]

Disorder	%
Anxiety	8.1
Mood	4.9
Impulse	1.8
Substance Use	5.8
Schizophrenia	1.0
Bipolar	1.0
Any anxiety, mood, impulse or substance use disorder	16.5

Table 2: 12-month prevalence of child and adolescent mental disorders in the Western Cape[16]

Disorder	(%)
Attention Deficit Hyperactivity Disorder	5.0
Conduct Disorder	4.0
Oppositional Defiant	6.0
Enuresis	5.0
Separation Anxiety	4.0
Schizophrenia	0.5
Depression & Dysthymia	8.0
Bipolar	1.0
Obsessive Compulsive	0.5
Agoraphobia	3.0
Simple Phobia	3.0
Social Phobia	5.0
Generalised Anxiety	11.0
Posttraumatic stress	8.0
Any child and adolescent disorder	17.0

The burden of mental illness is felt not only through the primary presentations of mental disorders, but through its high co-morbidity with other illnesses.[17] As South Africa is a country with a "quadruple disease burden,"[18] mental ill-health features prominently in its high level of co-morbidity with infectious diseases, such as HIV/AIDS and tuberculosis;[17] its association with the growing burden of non-communicable diseases, such as cardiovascular disease and diabetes mellitus;[17;19] high levels of violence and injury;[20] and maternal and child illness.[21]

In the South African context, the relationship between HIV/AIDS and mental illness is particularly pertinent. Research in South Africa shows that, with high prevalence in both, mental illness and HIV coexist in a complex relationship.[22] Mental health impacts on and is exacerbated by the HIV/AIDS epidemic, both being mutually reinforcing risk factors. Mental health problems are common in HIV disease, cause considerable morbidity, and are often not detected by physicians.

2.2 Determinants of mental health and illness

Mental health has multiple biological, psychological and social determinants. These determinants interact in a complex manner, to provide protection of mental health or increase the risk for the development of mental illness. For example, a combination of genetic vulnerability, childhood trauma and adverse living circumstances brought about by poverty may predispose a particular woman to a major depressive episode. Conversely, a combination of genetic resilience, supportive and stimulating childhood environment, and opportunities for learning, work and fulfilment of social roles are protective of a particular person's mental health. A person with mental illness may experience episodes of mental ill-health, which interrupt that person's capacity to fulfil their work, family, social, academic and community roles. The mental disorder might follow a chronic, episodic course, or may resolve after one or more episodes.

Most mental disorders have their origins in childhood and adolescence. Approximately 50% of mental disorders begin before the age of 14 years.[23] In South Africa, childhood adversity has been significantly associated with mood disorders,[24] and posttraumatic stress disorder, major depression and substance-related disorders each significantly increased the chances that students did not complete secondary school.[25]

The relationship between poverty and mental ill-health has been described as a "vicious cycle":[26] people living in poverty are at increased risk of developing mental disorders through the stress of living in poverty, increased obstetric risks, lack of social support, increased exposure to violence and worse physical health. On the other hand, those who live with mental illness are at increased risk of sliding into (or remaining in) poverty, as a result of increased health expenditure, lost income, reduced productivity, lost employment and social exclusion due to stigma.[27] (See Figure 1).[28]

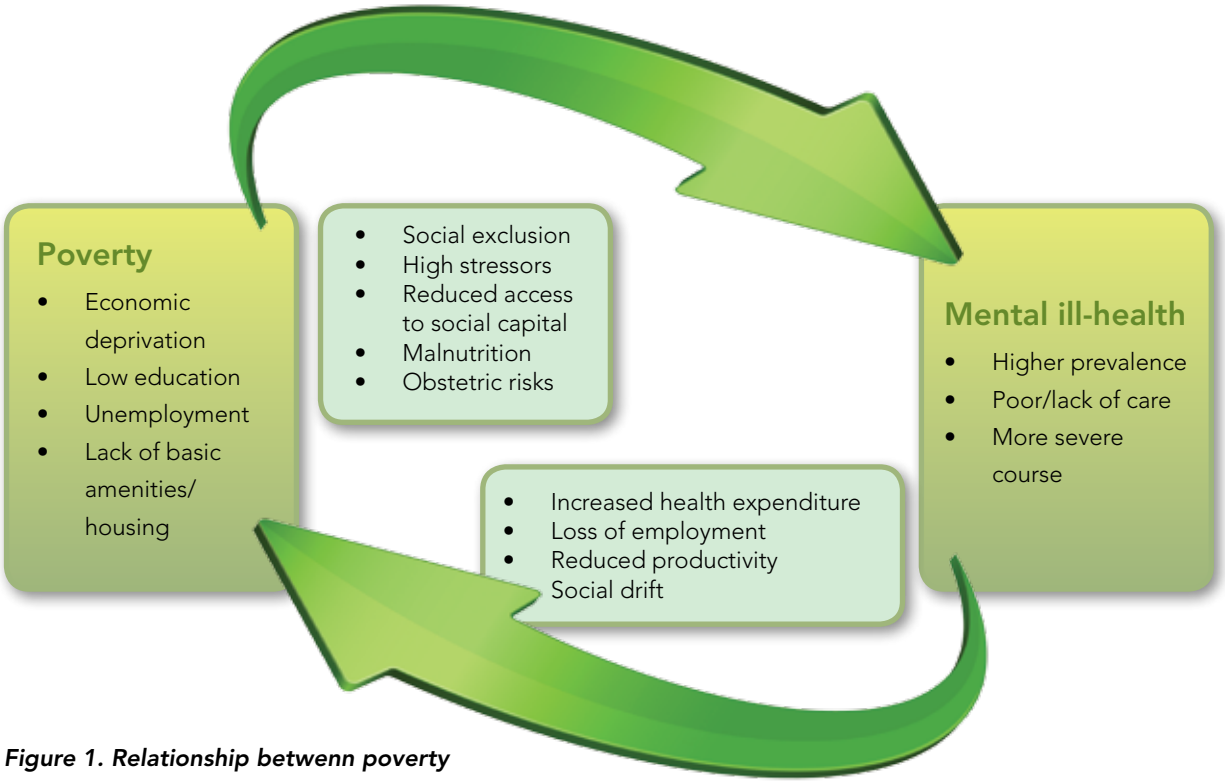


Figure 1. Relationship betwenn poverty and mental ill-health

In South Africa these patterns are exacerbated by the history of violence, exclusion and racial discrimination under apartheid and colonialism. The trauma and abuses meted out during the apartheid era have been well documented in the findings of the Truth and Reconciliation Commission (TRC) (Truth and Reconciliation Commission, 2000), as have the effects of these acts on the mental health of victims. Ongoing realities of violence and crime also exact their toll on the mental health of South Africans, chiefly through the trauma experienced by victims.

South Africa also has major challenges regarding substance abuse (including alcohol, tobacco and illicit drugs). South Africa has the highest incidence of alcohol abuse in the world, after the Ukraine. Until recently areas of the Western Cape had some of the highest rates of foetal alcohol syndrome (FAS) in the world, but have now been surpassed by the Northern Cape. In the Western Cape there is a growing methamphetamine (tik) epidemic. Cannabis is the most common illicit drug in the country, with particularly high use among the youth. The consequences of these patterns of substance abuse include increased risk for mental disorders, crime and violence and motor vehicle injuries.

2.3 Costs of mental illness

Mental health problems have serious economic and social costs. These include direct costs related to the provision of health care, and indirect costs, such as reduced productivity at home and work, loss of income and loss of employment. These costs have a direct effect on the mental health care user and their families' financial situation. The indirect cost of mental disorders outweighs direct treatment cost by two to six times in developed countries and may be even higher in developing countries. In the first nationally representative survey of mental disorders in South Africa, lost earnings among adults with severe mental illness during the previous 12 months amounted to R28.8 billion.[29] This represented 2.2% of GDP in 2002, and far outweighs the direct spending on mental health care for adults (of approximately R472 million). In short, it costs South Africa more to not treat mental illness than to treat it.

Social costs of mental illness can include disrupted families and social networks, stigma, discrimination, loss of future opportunities, marginalization and decreased quality of life. Stigmatizing beliefs reported in South Africa include beliefs that a people with mental illness are bewitched, weak, lazy, mad, insane, not capable of doing anything or unable to think.[9] The consequences of such inaccurate beliefs are that individuals who have been labelled as having mental illnesses are feared, ridiculed or exploited. Many individuals have also been neglected, isolated, rejected by family and peers, abused or excluded from social engagement and basic rights.[9] Stigma can thus act as a barrier to accessing education, employment, adequate housing and other basic needs.

2.4 Evidence for promotion, prevention, treatment and rehabilitation

2.4.1 Mental health promotion and prevention of mental disorders

In resource constrained and high risk contexts, mental health promotion and prevention initiatives which target key developmental stages can assist to break the cycle of poverty and mental ill-health through improving resilience in the context of widespread risk. These interventions are particularly important during childhood and adolescence given that most mental disorders have their origin in childhood and adolescence. There is an increasing body of evidence on the efficacy of mental health promotion and prevention interventions that target these key developmental stages.[30]

2.4.2 Care, treatment and rehabilitation

There is now good evidence for a range of cost-effective interventions for mental health. Depression can be treated effectively in low and middle-income countries with low-cost antidepressants and/or psychological interventions (such as cognitive behaviour therapy or interpersonal therapies).[31-33] Collaborative models and stepped care provide a proven framework for integration of psychological and drug treatments.[33] Cost-effectiveness of interventions for depression in primary care settings are comparable to the cost-effectiveness of anti-retroviral treatment for HIV/AIDS.[31] For the treatment of schizophrenia, first-generation anti-psychotic medications are effective and cost-effective, and their benefits can be enhanced through community-based models of care.[31] In the Western Cape, the newly established Assertive Community Treatment (ACT) teams have shown a reduction in inpatient admissions and length of stay among people with severe mental illness, as well as improved user, family, and staff satisfaction.[34] In less well resourced provinces, a group community-based rehabilitation model, such as that

developed by Chatterjee et al in India for people with psychotic disorders, may be more appropriate.[35] Brief interventions by primary care professionals can be effective for management of hazardous alcohol use, with some benefits evident from psychosocial and pharmacological interventions for alcohol dependence.[31] There is strong evidence for the effectiveness of both pharmacological and psychosocial interventions for attention-deficit/ hyperactivity disorder (ADHD).[36] For developmental disabilities, evidence for the efficacy of interventions in low and middle-income countries is inadequate, but community-based rehabilitation models provide a low-cost integrative framework for the care of children and adults with chronic mental disabilities.[31] There is emerging evidence of the effectiveness of treatment programmes for maternal mental illness[37;38] and to increase maternal sensitivity and infant–mother attachment.[39] Several of these programmes are proven low-resource interventions, adopting a task-shifting approach.

2.5 Current Service Provision

Current mental health service provision in South Africa, is marked by a number of features, as outlined in a recent situation analysis of the mental health system in South Africa:[9]

1. There is wide variation between provinces in the availability of service resources for mental health;
2. Mental health services continue to labour under the legacy of colonial and apartheid era mental health systems, with heavy reliance on psychiatric hospitals;
3. Some progress has been made with the integration of mental health into general health care;
4. Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses. At the District level, the integration of mental health care into primary health care is focused on the emergency management and ongoing psychopharmacological care of patients with chronic stabilized mental disorders, with little coverage of children and adolescents, or adults with depression and anxiety disorders;
5. The total number of human resources working in mental health in the Department of Health and NGOs is 9.3 per 100,000 populations;
6. There is an urgent need for mental health training of general health staff;
7. There is currently only one indicator for mental health on the District Health Information System, namely the number of mental health visits;
8. There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders in South Africa, namely the National Directorate: Mental Health and Substance Abuse, Department of Health;
9. A few consumer and family associations have been established in some provinces, often with the support of NGOs, such as the SA Federation for Mental Health. There are a few locally based, user run self-help associations;

10. Some important steps have been taken towards inter-sectoral collaboration, particularly at the national level. However, at the district level, and in many provinces, such inter-sectoral collaborations are the exception rather than the rule. This situation is improving with the legal requirement that districts should produce Integrated Development Plans (IDPs);

11. The emphasis on current spending for mental health falls on treatment and rehabilitation. There are few scaled up, evidence-based mental health promotion and prevention programmes; and

12. Deinstitutionalisation has progressed at a rapid rate in South Africa, without the necessary development of community–based services. This has led to a high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns of care.

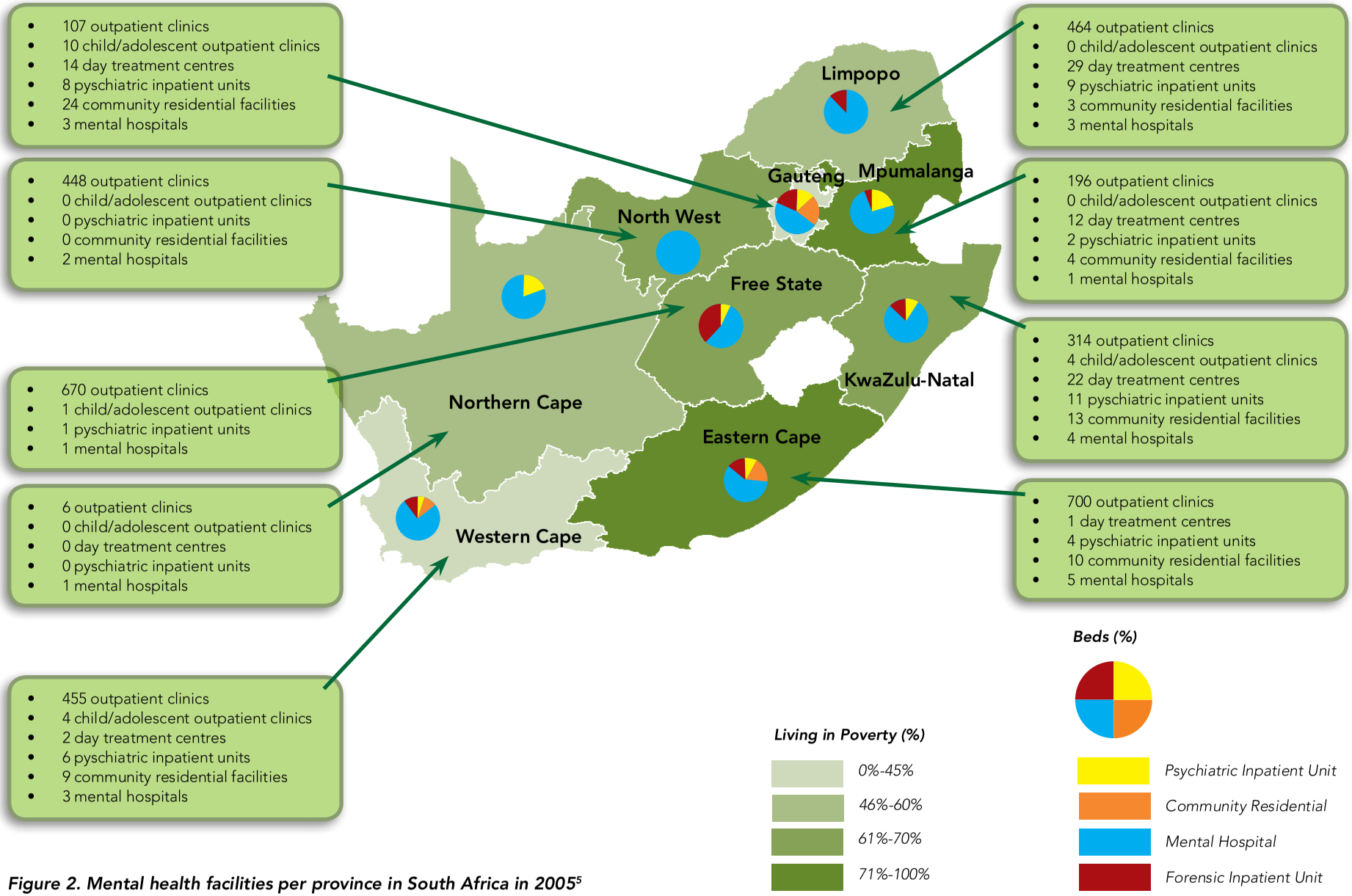


Figure 2. Mental health facilities per province in South Africa in 2005[5]

2.6 Recommended Norms and Standards

Since the publication of the White Paper for the Transformation of the Health System in 1997, a series of Norms and Standards have been developed for mental health care in South Africa, by the Department of Health. These include:

- Norms for people with severe psychiatric conditions (1998)[40-42]
- Standards for mental health care in South Africa (1998)[43;44]
- Norms for community-based mental health care (2003)[45;46]
- Norms for child and adolescent mental health services (2004)[4;47]

2.7 Policy and legislation mandates

This mental health policy is based on, and consistent with a number of existing policy and legislation mandates in South Africa. These include:

- The Constitution of the Republic of South Africa, 1996;
- The White Paper for the Transformation of the Health System in South Africa, 1997;
- Comprehensive Primary Health Care Package for South Africa;
- The National Health Policy Guidelines for Improved Mental Health in South Africa, 1997;
- National Health Act, Act 63 of 2003;
- Mental Health Care Act, Act 17 of 2002;
- Correctional Services Act, Act 111 of 1998;
- Medicine and Related Substances Control Act, Act 101 of 1965 as amended;
- Occupational Health and Safety Act, Act 85 of 1993;
- Pharmacy Act, Act 53 of 1974 as amended;
- Nursing Act, Act 50 of 1978;
- Health Professions Act, Act 56 of 1974 as amended;
- Choice on Termination of Pregnancy Act, Act 92 of 1996;
- Public Finance Management Act, Act 29 of 1999;
- The Children's Act, Act 38 of 2005;
- Prevention of and treatment for Substance Abuse Act, No. 70 of 2008;
- National Drug Master Plan 2013-2017;
- Promotion of Access to Information Act, Act 2 of 2002;
- Adolescent and Youth Health Policy Guidelines, 2001;
- School Health Policy and Implementation Guidelines, 2003;
- Child and Adolescent Mental Health Policy Guidelines, 2003;
- Child Justice Act, Act 75 of 2008;
- Sexual Offences Act, Act 37 of 2007;
- Older Persons Act, Act 13 of 2006; and
- Criminal Procedure Amendment Act, Act 65 of 2008.

3.Vision

Improved mental health for all in South Africa by 2020.

4. Mission

From infancy to old age, the mental health and well-being of all South Africans will be enabled, through the provision of evidence-based, affordable and effective promotion, prevention, treatment and rehabilitation interventions. In partnerships between providers, users, carers and communities, the human rights of people with mental illness will be upheld; they will be provided with care and support; and they will be integrated into normal community life.

5. Objectives

- To scale up decentralized integrated primary mental health services, which include community-based care, PHC clinic care, and district hospital level care.
- To increase public awareness regarding mental health and reduce stigma and discrimination associated with mental illness.
- To promote the mental health of the South African population, through collaboration between the Department of Health and other sectors.
- To empower local communities, especially mental health service users and carers, to participate in promoting mental wellbeing and recovery within their community.
- To promote and protect the human rights of people living with mental illness.
- To adopt a multi-sectoral approach to tackling the vicious cycle of poverty and mental ill-health.
- To establish a monitoring and evaluation system for mental health care.
- To ensure that the planning and provision of mental health services is evidence-based.

6. Values and Principles

Values	• Principles
Mental health is part of general health	• Mental health care should be integrated into general health care • People with mental disorders should be treated in primary health care clinics and in general hospitals in most cases • Mental health services should be planned at all levels of the health service

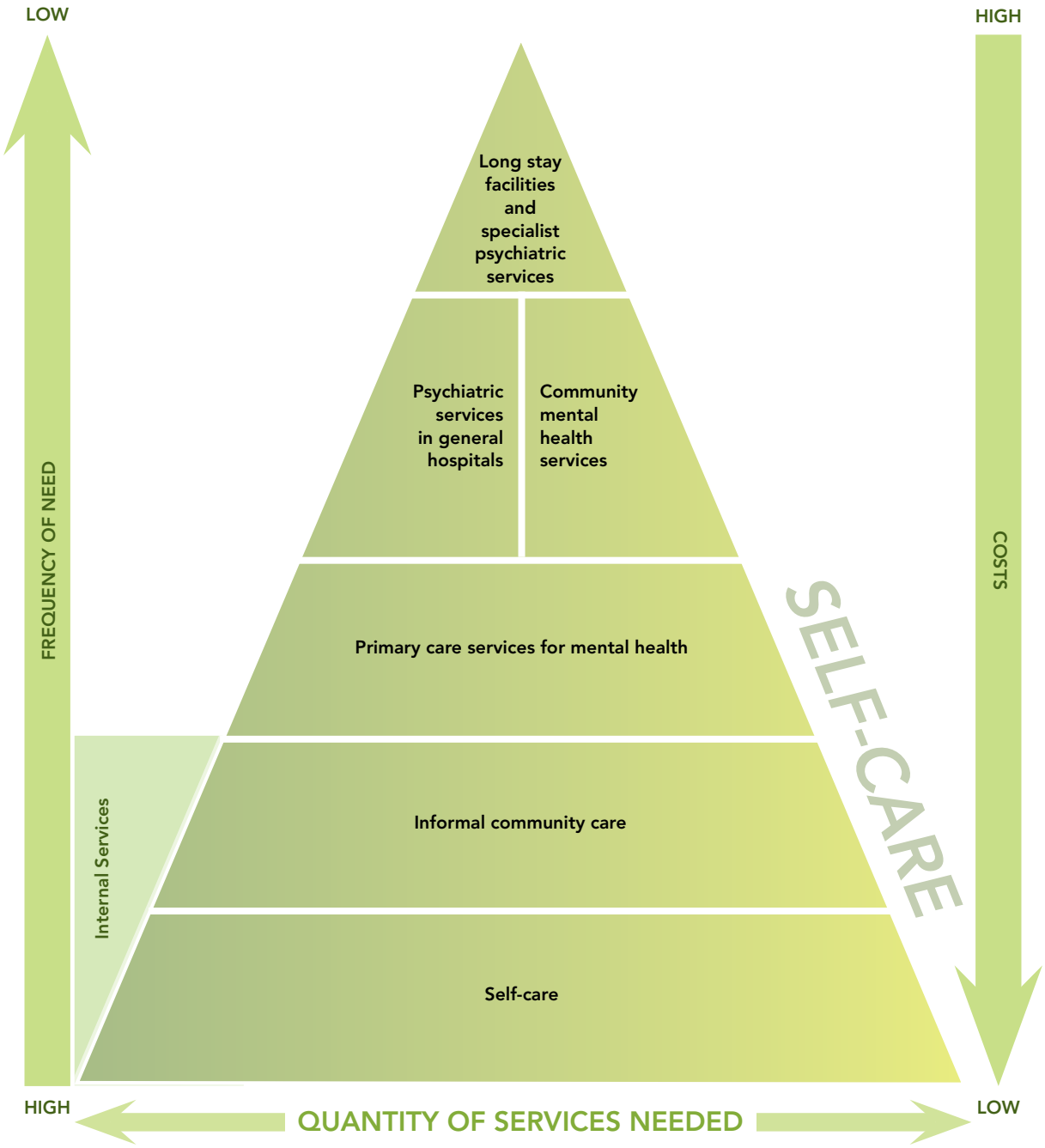
Human rights	• The human rights of people with mental illness should be promoted and protected • The rights to equality, non-discrimination, dignity, respect, privacy, autonomy, information and participation should be upheld in the provision of mental health care. • The rights to education, access to land, adequate housing, health care services, sufficient food, water and social security, including social assistance for the poor, and environmental rights for adult mental health care users should be pursued on a basis of progressive realisation. The non-conditional rights of mental health care users under the age of 18 years, including basic nutrition, shelter, basic health care services and social services, should be promoted and protected.
Community care	• Mental health care users should have access to care near to the places where they live and work. • Mental health care users should be provided with the least restrictive forms of care. • Local community-based resources should be mobilised where ever possible. • All avenues for outpatient and community-based residential care should be explored before inpatient care is undertaken. • A recovery model, with an emphasis on psychosocial rehabilitation, should underpin all community-based services.
Accessibility and equity	• Equitable services should be accessible to all people, regardless of geographical location, economic status, race, gender or social condition. • Mental health services should have parity with general health services.
Inter-sectoral collaboration	• Addressing the social determinants of mental health requires collaboration between the Health sector and several other sectors, including Education, Social Development, Labour, Criminal Justice, Human Settlements and NGOs.
Mainstreaming	• Mental health should be considered in all legislative, policy, planning, programming, budgeting, and monitoring and evaluation activities of the public sector.
Recovery	• Service development and delivery should aim to build user capacity to return to, sustain and participate in satisfying roles of their choice in their community.

Respect for culture	• There are varying cultural expressions and interpretations of mental illness, which should be respected, insofar as they protect the human rights of the mentally ill.
Gender	• Services should be sensitive to gender-related issues experienced by men and women, and boys and girls.
Social support and integration	• Maximum support should be provided to families and carers of those with mental illness, in order to broaden the network of support and care.
Participation	• Mental health care users should be involved in the planning, delivery and evaluation of mental health services. • Self-help and advocacy groups should be encouraged.
Self-representation	• Mental health care users and their associates should have support to enable them to represent themselves. • The development of self-help, peer support and advocacy groups should be supported.
Citizenship and non-discrimination	• Mental health care users should be given equal opportunities and reasonable accommodation to ensure full participation in society. • Attitudinal and structural barriers to full participation should be overcome. Access to education, employment, housing, and social supports should receive particular attention.
Efficiency and effectiveness	• The limited resources available for mental health should be used efficiently, for maximum effect. • Interventions should be informed by evidence of effectiveness.
Comprehensiveness	• Mental health interventions should be directed at mental health promotion, the prevention of mental illness, treatment and rehabilitation.
Protection against vulnerability	• Developmental vulnerabilities to mental health problems associated with life stages of infancy, middle childhood, adolescence, adulthood and old age), as well as vulnerabilities associated with gender (including pregnancy), socio-economic position, ill-health and disability should be protected against through the provision of targeted prevention interventions.

7. Areas for action

7.1 Organisation of services

In line with the World Health Organisation recommendations regarding organisation of mental health services, the mental health systems will include an array of settings and levels that include primary care, community based settings, general hospitals and specialised psychiatric hospitals.



By 2020:

1. Community mental health services will be scaled up, to match recommended national norms,[45;46] and will include three core components:

a. Community residential care (including assisted living and group homes);

b. Day care services; and

c. Outpatient services (including general health outpatient services in PHC and specialist mental health support).

These community mental health services will be developed before further downscaling of psychiatric hospitals can proceed. In accordance with the Mental Health Care Act (2002) NGOs, voluntary and consumer organisations will be eligible to provide and be funded for community programmes/facilities. This includes capacity development for users (service users, their families) to provide appropriate self-help and peer led services, for example as community health workers.

2. The district mental health system will be strengthened in the following areas:

a. Specified mental health interventions will be included in the core package of district health services, embracing a task shifting approach whereby trained non-specialist workers deliver evidence-based psychosocial interventions. This should include:

- Medication monitoring and psychosocial rehabilitation within a recovery framework for severe mental illness;
- Detection and a stepped approach to management and referral of depression and anxiety disorders in PHC clinics;
- Detection and management of child and adolescent mental disorders in PHC clinics and community level (e.g., schools), and referral where appropriate; and
- Routine screening for mental illness during pregnancy, and a stepped approach to management and referral.

b. Mental health training programmes for general health staff will be conducted at PHC level and district and regional hospitals.

c. Supervision systems will be put in place for mental health staff at PHC level.

d. Specialist mental health teams will be established to support non-specialist PHC staff and community-based workers.

e. Clinical protocols will be available for assessment and interventions at PHC level, through Integrated Management Guidelines, which will include mental health.

f. Community-based rehabilitation programmes will be established in all Districts, using a task shifting approach.

g. Mechanisms will be developed for inter-sectoral collaboration for mental health, led by the Health sector and engaging a range of other sectors.

h. Inpatient units will be built in district and regional hospitals.

i. Voluntary mental health care users that require admission will be admitted in terms of general health legislation.

j. Assisted and involuntary mental health care users will be admitted in terms of the provisions and procedures described in the Mental Health Care Act as emergency admissions, or for 72-hour assessment in facilities that are listed for this purpose. Further care, treatment and rehabilitation of such users will be provided at health establishments designated for this purpose in terms of the Mental Health Care Act.

3. Psychiatric services in general hospitals

a. Inpatient units will be provided in general hospitals to improve access for voluntary admission, assisted care, emergency mental health services, 72-hour assessment of involuntary mental health care users, further care, treatment and rehabilitation.

b. Voluntary mental health care users that require admission will be admitted in terms of general health legislation.

c. The psychiatric wards that are attached to general hospitals must be designated in terms of the Mental Health Care Act where they meet the criteria.

d. The general hospitals that provide 72-hour assessment for involuntary mental health care must be listed as prescribed in the general regulations of the Mental Health Act No.17 of 2002.

e. Information regarding health establishments that provide 72-hour assessment for involuntary mental health care must be compiled and provided to relevant stakeholders to facilitate referral and access to services.

4. Specialised psychiatric hospitals

a. Further care, treatment and rehabilitation of mental health care users will be provided in specialised psychiatric hospitals.

b. Provision of inpatient and limited outpatient mental health services.

c. Functioning as centres of excellence that provide ongoing routine training, supervision and support to secondary and primary health care services.

d. Provision of sub-specialist services, such as forensic psychiatry and child and adolescent services.

e. Forensic facilities will fulfil their role as set out in the Criminal Procedure Act No. 51 of 1977 as amended, with regards to forensic psychiatric observations. Section 41 and 49 of the Mental Health Care Act provides for designation of health establishments and procedures with regards to State patients and mentally ill prisoners.

7.2 Financing

By 2014:

1. Mental health will be financed according to the principles adopted for all health financing in South Africa, and people will be protected from the catastrophic financial consequences of mental ill-health.[48]
2. In the financing of the National Health Insurance system, mental health services will be given parity with other health conditions, in proportion to the burden of disease and evidence for cost-effective interventions.
3. Private medical aids should also be required to offer parity in their cover between mental health and other health conditions.
4. The limited financial resources available for mental health care will be used efficiently, and informed by evidence of cost-effectiveness where possible.
5. At national level, budget will be allocated to meet targets set for the implementation of areas of action within the policy and regular discussions will be held with provinces to discuss strategies and monitor progress with implementation. At provincial level, mental health budgets will be reviewed annually to align mental health with national priorities, for each of the areas for action in 2011 and annually thereafter.
6. All provinces will develop provincial strategic plans for mental health, in keeping with national policy, which outline specific strategies, targets, timelines, budgets and indicators in 2011 and annually thereafter.[49]

7.3 Promotion and prevention

By 2015:

1. Mental health will be integrated into all aspects of general health care, particularly those identified as priorities within the 10 point plan e.g., TB and HIV and AIDS.
2. Mental health promotion and prevention initiatives will be integrated into the policies and plans of a range of sectors including, but not restricted to, health, social development and education.
3. Distal protective influences will be promoted through sustaining and improving existing macro-level policies which are mental health promoting such as the Child Support Grant, National Integrated Plan for Early Childhood Development and the Integrated Nutrition Programme; as well as promoting the improvement in policies to ensure adequate education (including for learners with learning disorders), skills development, employment opportunities, housing and services.
4. Specified micro and community level mental health promotion and prevention intervention packages will be included in the core services provided across a range of sectors to address the particular psychosocial challenges and vulnerabilities associated with the different lifespan developmental stages. These will include:
    a. Motherhood
    - Treatment programmes for maternal mental health as part of the routine antenatal and postnatal care package
    - Programmes to reduce alcohol and substance use during and after pregnancy

b. Infancy and Early childhood:

- Programmes to increase maternal sensitivity and infant–mother attachment

c. Middle childhood:

- Family strengthening programmes for at-risk children
- Programmes to strengthen school connectedness

d. Adolescence:

- Lifeskills programmes in schools
- Prevention of school dropout
- 'Out-of-school' programmes

e. Adulthood and older people

- Social support programmes

7.4 Intersectoral collaboration

By 2013:

1. The Department of Health will engage non-health sectors (such as Education, Social Development, Labour, Criminal Justice, South African Police Service, Housing, Agriculture and NPOs), as well as for-profit organisations, to ensure that an inter-sectoral approach to mental health is followed in planning and service development.
2. The Department of Health will liaise with local government with a view to strengthening inter-sectoral collaboration and the implementation of this policy at local level.
3. The Department of Health will liaise with the Department of Social Development and other relevant departments to include the poverty-mental health link on the policy agenda. This focus area will be integrated into policies and programmes of all sectors involved in poverty alleviation and community upliftment. This includes addressing the social determinants of mental illness, by improving daily living conditions and reducing inequalities, and evidence-based support to promote recovery[50] and inclusion of people with mental disability in general community life, such as access to:

- education and skills development;
- income generation opportunities for users, and reasonable accommodation provisions in the workplace;
- social insurance where income generating work is not possible for the user;
- housing support; and
- transport.

7.5 Advocacy

By 2015:

1. The Department of Health will engage with a range of stakeholders who lobby for political support for mental health on the public agenda. This will include discussion regarding the importance and place of mental health within the broader disability agenda, and within other development priorities and public concerns will be better articulated.
2. The Department of Health will engage with other non-health sectors, such as the Department of Disability within the Ministry of Children, Women and the Disabled, with a view to strengthening the place of mental health within the broader disability agenda, and improving the rights of disabled citizens.
3. In its role as the leading Department in Public Education regarding mental health, the Department of Health will give exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health in order to change discriminatory attitudes toward mental disability. This work will 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, as well as advocacy guidelines from the WHO.[51] The development and distribution of advocacy strategies and media guidelines will support this work.
4. The Department of Health will also engage with consumer and family associations in policy development and implementation, as well as the planning and monitoring of services. Emphasis will be placed on ensuring representation of people with mental disability on the broader disability agenda, and developing capacity to place mental health user concerns on the political, development and public health agenda.
5. The Mental Health Review Boards in each province will, as stipulated in the Mental Health Care Act, play a key role in advocating for the needs of mental health service users, and upholding and protecting their human rights.

7.6 Human rights

By 2014:

1. The human rights of people living with mental illness will be promoted and protected, through the active implementation of the Mental Health Care Act (2002).
2. The Department of Health will work closely with the Ministry for Women, Children and Persons with Disability to ensure that provisions of the UN Convention on the Rights of Persons with Disabilities (2007) are actively implemented for persons with mental disability in South Africa.

7.7 Special populations

By 2013:

Certain vulnerable groups will be targeted for specific mental health needs. These include women, children, adolescents, the elderly, and those living with HIV and AIDS.

7.8 Quality improvement

By 2014:

1. Quality improvement initiatives for mental health will be aligned with other general Department of Health's quality initiatives.
2. Guidelines will be developed for safe and effective mental health services within regional and district hospitals.
3. Existing Standards for the Delivery of Mental Health Care[43;44] will be used to routinely assess and accredit public and private mental health facilities.
4. The functions of licensing and designation of facilities will be yoked to quality improvement mechanisms.
5. A monitoring and evaluation system will be established at all levels to help shape changes in policy and programmes.

7.9 Monitoring and evaluation

From 2013:

1. National mental health indicators will be integrated with the district health information system (DHIS), based on a set of nationally agreed indicators and a minimum data set.
2. Information gathered from the information system will be used for routine planning and management of mental health services at all levels.
3. Policy implementation will be evaluated using the data from the mental health information systems.
4. Data generated from the information systems will be used to assess the performance of the mental health system against agreed norms and standards.
5. Future reforms of mental health policy will draw on information systems' data.
6. A culture of information use for mental health service development will be promoted, through capacity development activities addressing the various stages of collection, processing, dissemination and use of mental health information.

7.10 Human resources and training

By 2015:

1. All health staff working in general health settings will receive basic mental health training, and ongoing routine supervision and mentoring.
2. The expansion of the mental health workforce will be actively pursued by all provincial Departments of Health.
3. A task-shifting approach will be used in the development of the mental health workforce, whereby trained non-specialist workers deliver evidence-based psychosocial interventions, with supervision and support from specialists.

4. Capacity will be developed for staff in the national Directorate: Mental Health and Substance Abuse, and the provincial mental health coordinators in policy development, planning, service monitoring and the translation of research findings into policy and practice.
5. At the district level, non-health related public sector workers and civil society partners, including user-led service providers who can contribute to mental health care in the district will have access to basic in-service training in mental health.

7.11 Psychotropic medication

By 2015:

1. All psychotropic medicines, as provided on the standard treatment guidelines and essential drugs list (EDL) will be available at all levels of care, including PHC clinics.
2. Drug interactions with other medications will be carefully monitored in all treatment of mental disorders.
3. Routine screening and treatment of physical illness in all consultations for people with mental illness will be implemented.
4. The use of psychotropic medication should be carefully monitored and evaluated, in line with broader quality improvement mechanisms in the Department of Health.

7.12 Research and evaluation of policy and services

By 2013:

1. A national mental health research agenda will be developed based on identified priority areas.
2. A framework will be developed for the routine periodic evaluation of mental health services, which will be used for ongoing planning and service delivery by all provinces.

8. Roles and responsibilities

The roles and responsibilities are consistent with the roles as set out in the Constitution and the National Health Act. The roles of the Minister of Health, MECs, Heads of Health at National and Provincial level, the National Health Council, Provincial Health Councils and District Health Councils are set out in the National Health Act. The roles and responsibilities as articulated in this document pertain only to mental health functions within this overall structure.

8.1 Minister of Health

1. Developing national mental health policy and legislation, in consultation with a range of stakeholders.
2. Liaise with the Ministry of Women, Children and Disabilities to support inclusion of persons with mental disability in disability related policies and programmes.
3. Monitoring and evaluating the implementation of policy and legislation, in relation to specified targets and indicators.

4. Evaluating the prevalence and incidence of mental illness.
5. Identifying and driving the implementation of key priority areas, namely:

- Child and adolescent mental health;
- Community-based services within a psychosocial rehabilitation and recovery framework;
- Detection and management of common mental disorders (e.g., depression and anxiety disorders) at PHC level; and
- Mental health promotion and prevention.

6. Promoting research in priority areas, and utilising research evidence to inform policy, legislation and planning.
7. Coordinating an intersectoral approach to mental health, through engagement of other sectors, and providing technical support to other sectors.
8. Ensuring equity between provinces in mental health service provision.

8.2 Director-General

1. Developing national strategic plans for mental health, in collaboration with provincial health services, and in consultation with a range of stakeholders.
2. Develop guidelines for human resources for mental health.
3. Issue guidelines to promote a multi-disciplinary team approach to the planning and delivery of services.
4. Developing and implementing norms and standards for mental health care.
5. Developing and monitoring the implementation of clinical protocols for mental health at all service levels.

8.3 Provincial Departments of Health

1. Translation of national policy into provincial strategic and operational plans, which include clear targets, indicators, budgets and timelines.
2. Monitoring and evaluation of the implementation of national mental health policy and legislation.
3. Provision of a sustainable budget for mental health services, keeping parity with other health conditions, in proportion to the burden of disease, and evidence for cost-effectiveness.
4. Working closely with district health managers to promote the equitable provision of resources and services for mental health at district level.
5. Consulting with a range of stakeholders in the planning and delivery of services.
6. Integrating mental health indicators into the routine information system, for the routine monitoring and evaluation of mental health care.
7. Facilitating inter-sectoral collaboration, to bring together all sectors involved in mental health, including Education, Social Development, Labour, Criminal Justice, Housing, Agriculture and NGOs.

8. Ensuring the integration of mental health care into all health services, particularly within the District health system.
9. Expanding the mental health workforce in all provinces.
10. Building capacity for provincial health management in mental health planning, service monitoring and the translation of research findings into policy and practice.
11. Establishment of a Mental Health Directorate in each province, with responsibility for both community and hospital based mental health services.

8.4 District health services

1. Providing mental health promotion and prevention interventions, in keeping with national and provincial priorities.
2. Inclusion of mental health in the core package of district health treatment and rehabilitation services:

- Routine screening for mental illness during pregnancy, and provision of counselling and referral where appropriate;
- Medication monitoring and psychosocial rehabilitation within a recovery framework for severe mental illness;
- Detection of mental illness and management of common mental disorders (e.g., depression and anxiety disorders) in PHC clinics, and referral where appropriate; and
- Detection and management of child and adolescent mental disorders in PHC clinics, and referral where appropriate.

3. Providing emergency care (24 hour) and 72 hour observation services in designated District and Regional Hospital Inpatient settings, as set out in the Mental Health Care Act (2002).
4. Conducting mental health training programmes for all general health staff for basic screening, detection and treatment, as well as referral of complex cases.
5. Establishing and maintaining mental health supervision systems for health staff at PHC level.
6. Establishing and maintaining specialist mental health teams to support PHC staff.
7. Establishing and maintaining referral and back-referral pathways for mental health.
8. Implementing clinical protocols for assessment and interventions at PHC level.
9. Establishing and maintaining community-based rehabilitation programmes, through trained community health workers.
10. Developing intersectoral collaboration between a range of sectors involved in mental health, through the establishment of District Multi-Sectoral Forum for mental health.
11. Undertaking mental health education programmes in communities.
12. Improving the capacity of District Health Management teams for planning, implementing, supervising, monitoring and evaluation of mental health programmes at district and community levels.
13. Provision of psychotropic medication to all appropriate levels of the district health system, as determined by the essential drugs list.

8.5 Designated Psychiatric Hospitals, Care and Rehabilitation Centres

These are mental health units that are attached to general hospitals as well as specialised psychiatric hospitals designated in terms of section 5 of the Mental Health Care Act.

1. Provision of inpatient and limited outpatient mental health services.
2. Functioning as centres of excellence that provide ongoing routine training, supervision and support to secondary and primary health care services.
3. Provision of sub-specialist services, such as forensic psychiatry and child and adolescent services.
4. Forensic facilities will fulfil their role as set out in the Criminal Procedure Act No 51 of 1977 as amended, with regards to forensic psychiatric observations. Section 41 and 49 of the Mental Health Care Act provides for designation of health establishments and procedures with regards to State patients and mentally ill prisoners, which need to be included in the mental health policy.

8.6 Other sectors

1. National, provincial and local partnerships between government departments, traditional, faith-based, non-governmental and other private sector organisations will be actively pursued by the Department of Health.
2. At the district level a task shifting approach to resource coordination, utilisation and capacity development will be adopted to support all public sector workers and civil society partners who can contribute to mental health care in the district.

8.7 Non-governmental organisations

1. The Provincial Departments of Health will licence and regulate the provision of community-based mental health services by NGOs and for-profit organisations, such as community residential care, day care services, and halfway houses. This is in keeping with section 43 of the regulations of the Mental Health Care Act.
2. NGOs will also play an active role in the provision of health education and information on mental health and substance abuse, and targeting vulnerable groups such as women, children, the elderly and those with disabilities.

NATIONAL MENTAL HEALTH STRATEGIC PLAN: 2013-2020

Objective*	Key activities	Outputs	Baseline (current)	Target dates		Responsible organisation
				Commence	Complete	
1. District based mental health services and Primary Health Care Re-engineering (initial focus on NHI pilot sites)	At least one specialist mental health team will be established in each District. ***(See Appendix 1. For Terms of Reference for all key structures).***	Specialist mental health teams are established in each district	Some limited costing models have already been developed	2013/14	2014/15	DoH
	Selected community health centres and clinics will be designated to provide psychological services with appropriate accreditation and staffing.	Selected community health centres and clinics are accredited in all provinces	Few clinics currently accredited	2013/14	2015/16	DoH

2. Institutional Capacity building (National, Provincial, District).	Establish a national mental health Technical Advisory Committee in terms of Section 71 of the Mental Health Care Act No. 17 of 2002.	A national mental health Technical Advisory Committee is established	No such committee currently exists	2013/14	Ongoing	DoH
	Establish Mental Health Directorates in each of the 9 provinces.	Mental Health Directorates are established in each province	Only 2 provinces currently have Mental Health Directorates	2013/14	Ongoing	DoH
	Establish functioning Review Boards in all provinces, in keeping with the Mental Health Care Act (2002)	Mental Health Review Boards established and resourced for all health establishments providing mental health care, treatment and rehabilitation services in all nine provinces.	Varies from province to province	2013/14	January 2013	Reporting to National Council

3. Surveillance, research and innovation.	Ensure the accurate collection and use of the minimum dataset for mental health that is integrated into the general health information system at all levels.	Indicators are established; data is accurately collected and integrated into DHIS.	Currently 5 mental health indicators are collected, but accuracy and use of the data is limited.	2013/14	2015/16	DoH
	A national mental health research agenda will be established to meet national priorities, and submitted to the National Health Research Committee.	National mental health research agenda for 2015-2020 is established	No formal agenda currently exists	2013/14	Ongoing	DoH (Mental Health Technical Advisory Committee); Academic research institutions
	Develop and implement a monitoring and evaluation system to track and report progress with the implementation of the health sector drug master plan	M&E system in place and used to track progress with the health sector mini drug master plan	No M&E system currently exists	2013/14	2014/15	DoH

4. Infrastructure and capacity of facilities	Build/attach mental health inpatient units to designated district and regional hospitals (for emergency admissions, 72-hour assessment, care, treatment, and rehabilitation of voluntary, assisted and involuntary mental health users). Design specifications should comply with the Mental Health Care Act.	Units are built and fit for purpose in all designated district and regional hospitals, to ensure adequate infrastructure and security to protect the human rights of mental health users, and to protect the rights and safety of clinical staff working in these units.	There are wide provincial variations in relation to distribution and access to mental health facilities.	Ongoing	2020	DoH
	Establish a specialised psychiatric hospital in Mpumalanga Province with the capacity to conduct forensic psychiatric evaluations, admit State patients and Mentally ill prisoners, voluntary, assisted and involuntary mental health users.	A specialized psychiatric hospital established in Mpumalanga Province.	No specialized psychiatric hospital in Mpumalanga Province to conduct forensic psychiatric evaluations, admit State patients, mentally ill prisoners, voluntary, assisted and involuntary mental health users.	2013/14	Ongoing	DoH
	Revitalise dilapidated mental health facilities in all provinces.	Fit for purpose mental health facilities exist in all provinces.	The majority of Mental health facilities are dilapidated and not fit for purpose.	2013/14	Ongoing	DoH

	Develop community residential care facilities (including halfway houses, assisted living and group homes) to provide accommodation for deinstitutionalised service users, in line with national community-based care norms	Community residential care facilities for people with severe mental illness are established in line with national community based care norms	Residential care facilities are minimal (current levels unknown)	2013/14	Ongoing	DoH; SAFMH and other NGOs
	Equip designated clinics and community health centres with psychology infrastructure (private consultation rooms and group facilitation rooms) where psychologists deliver services.	Clinics and community health centres are equipped appropriately according to local needs	Facilities are frequently inadequately equipped.	2013/14	2016/17	DoH

5. Mental health technology, equipment and medicines.	Make all psychotropic medicines, as provided on the essential drugs list (EDL) available at all levels of care, including PHC clinics.	All EDL psychotropic medications are available as necessary.	Unknown	2013/14	Ongoing	DoH
	Equip clinics and health centres with psychology equipment (psychological assessment instruments) where psychologists deliver services.	Clinics and health centres are equipped according to local needs, and specifications are developed for appropriate levels of care	Facilities are frequently inadequately equipped.	2013/14	Ongoing	DoH; HPCSA Board for Psychology
6. Inter-sectoral collaboration	Mental health will be included on the agenda and mental health representation will be assured on the newly established National Health Commission.**	A national multi-sectoral health commission will be established which includes mental health.	No such commission exists	2013/14	2014/15	Departments of Health, Education, Social Development, Labour, Criminal Justice, South African Police Service, Housing, Agriculture and NPOs

7. Human resources for mental health	Training health professionals (including medical interns, nurses, pharmacists) will rotate through psychiatric units in district and regional general hospitals.	Placements are available for medical intern rotations. Interns are placed in these rotations.	Few such rotations currently available in some provinces	2014/15	2016/17	DoH, HPCSA, College of Medicine
	Selected key staff in every primary health facility will receive basic mental health training using PC101, and ongoing routine supervision and mentoring.	Selected nurses, doctors and social workers in each health facility receive basic mental health training and ongoing routine supervision and mentoring as required.	Training and supervision is currently piecemeal and inconsistent	2013/14	Ongoing to 2020	DoH
	The language competency of all mental health professionals will be improved, particularly in indigenous African languages.	All psychiatrists, psychologists, social workers and OTs receive training in an indigenous African language as part of their mental health training, integrated into the degree.	Very few mental health professionals are able to speak indigenous African languages.	2013/14	Ongoing	Academic training institutions for mental health professionals.

8. Advocacy, Mental health promotion and prevention of mental illness	A national public education programme for mental health will be established, including knowledge about mental health and illness; stigma and discrimination against people with mental illness; and services that are available, including suicide helplines. This will include exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health in order to change discriminatory attitudes toward mental disability.	National public education programme is in place. Members of the South African public across the socioeconomic spectrum are exposed to messages regarding the nature and causes of mental health and mental illness.	No concerted national programme exists.	2014/15	2016/17	DoH

**Objectives are based on the National Mental Health Summit Ekurhuleni Declaration (April 2012) and the Mental Health Policy Framework and approved by the National Health Council.*

APPENDIX 1: TERMS OF REFERENCE FOR KEY STRUCTURES

Key Structure	Terms of Reference

1. District specialist mental health team	• Adopt a public health approach to the mental health of the district, conducting a situation analysis of mental health needs and service resources in the district population, and developing an action plan for promotion, prevention, treatment and recovery.
	• Establish routine ongoing training and supervision for PHC staff through the district specialist mental health team.
	• Establish routine referral pathways from primary care to specialist services in each district.
	• Introduce routine indicated assessment and management of common mental disorders (depression, anxiety and alcohol use disorders) in priority programmes at PHC level:
	  • TB;
	  • HIV&AIDS;
	  • Antenatal mothers;
	  • Postnatal care;
	  • Family planning; and
	  • Chronic diseases.
	• Embed suicide prevention in treatment at primary care level, through identification of risk factors for suicide in all health service provision.
	• Strengthen school systems for mental health promotion, prevention of mental illness, detection and management of child and adolescent mental disorders in schools, and referral where appropriate, in line with the School Health Policy.
	• Establish posts for psychologists in community settings, and look for opportunities for psychologists in psychiatric hospital settings to move to community settings.
	• Provide clinical and consultation liaison services within the district.
	• Encourage implementation of the Traditional Health Practitioners Act by facilitating links between mental health services and traditional healers and faith healers at local district levels, including appropriate referral pathways in both directions.
	• Deploy Intern Psychologists and Registered Counselors to provide training, supervision and support for counseling roles of community health workers.
	• Build capacity for users (service users, their families) to provide appropriate self-help and peer led services, such as support groups, facilitated by NGOs.

2. Ministerial Technical Advisory Committee on Mental Health	• Provide advice to the Department of Health on evidence-based and cost effective minimum mental health care packages for each level of the health system. • Engage with consumers and family associations in policy development and implementation, as well as planning and monitoring of services, to give substance to the slogan: "nothing about us without us". • Provide technical support to the Department of Health to ensure that in the financing of the National Health Insurance system, mental health services will be given parity with other health conditions, in proportion to the burden of disease and evidence for cost-effective interventions. • Update national norms and standards in line with the Mental Health Care Act 2002 and the service delivery platform. • Provide technical support to the national Department of Health for the routine periodic population survey of the prevalence and burden of mental illness in South Africa (every 10 years) and a national evaluation of mental health services (every 5 years). Data from these surveys will be used for ongoing planning and service delivery by all provinces. • Facilitate the development of a national mental health research agenda, in consultation with the National Health Research Council and academic research institutions.

3. Provincial Mental Health Directorates	• All provinces and districts will develop provincial and district strategic plans for mental health, with specific strategies, targets, timelines, indicators and budgets to give effect to the national policy framework and action plan. • Ensure representation of mental health specialists (psychiatrists and/or psychologists) on appropriate budget allocation committees at provincial and district levels. • Support all Provincial Health MECs and HODs to ensure the establishment and ongoing existence of functional review boards in all provinces as per the provisions of the Mental Health Care Act. • Monitor functioning of the provincial Review Boards • Review Boards will educate the public about recourse to legal aid resources that are available to all mental health service users. • Promote a culture of DHIS information use for mental health service development, through capacity development activities addressing the various stages of collection, processing, dissemination and use of mental health information. This will include training of provincial and district health information officers and mental health programme staff in all provinces, in the collection, processing, dissemination and use of mental health indicators. • Consult with all mental health professions and with representative service user organizations in the design specification of buildings to ensure compliance with the basic requirements of professional practice and human rights. • Involve psychiatrists, psychologists, psychiatric nurses, social workers and occupational therapists in the design of the HR plan for mental health services. • Ensure that care is provided for the needs of mentally ill prisoners, and establish appropriate assessment and referral mechanisms.
4. National Health Commission	Ensure that the social determinants and risk factors for mental health are addressed in an evidence-based manner across all relevant sectors, to promote the mental health of all South Africans, and prevent mental illness

APPENDIX 2: INTER-SECTORAL ROLES AND RESPONSIBILITIES

Sector	Roles and responsibilities in mental health promotion and prevention	Roles and responsibilities in removal of barriers to service delivery	Technical Expertise required from the health sector
Education	• Provision of supports such as counselling to children and adolescents with mental and related learning disorders within the inclusive education system • Development of school-based mental health promotion programmes for learners. • Development of employee assistance programmes for educators with work-related and other mental health conditions • Introduction of mental health literacy education into curriculum to increase awareness, healthy behaviours and decrease stigma.	• Integration of people with intellectual disabilities into the inclusive education system • Collaboration with the department of Health to promote ongoing and re-entry to learning following periods of illness, and to develop a joint approach to management of chidren and adolescent with severe mental and developmental disorders. • Collaboration with the department of Labour to coordinate basic education outcomes with skills development and vocational training opportunities and career pathing for people with mental and intellectual disability	• Identification and management guidelines for educators working with children and adolescents with intellectual disability and mental and substance use disorders • Development of protocols for the management of, and employee assistance programmes for educators with work-related and other mental health conditions. • Development of a district based model for the management of mental health disorders presenting in school-going children (schools as a node of identification and intervention for mental health-related problems) • Assessment and review of the need for specialised mental health expertise within the school sector

Social Development	• Increased targeting of people with mental disabilities in poverty alleviation programmes. • Increased awareness of the mental health benefits of being a recipient of poverty alleviation strategies, including social grants. • Increased awareness of early childhood intervention as mental health promotion programme.	• Clarity on the roles, responsibilities and service interface of Health and Social Services for children, adolescents and adults with mental disorders and intellectual disability, and for the treatment of co-morbid substance abuse and mental disorders and in the provision of community based mental health services • Development of guidelines to facilitate access to social grants for people with mental or intellectual disabilities	• Identification and management guidelines for social sector workers working with intellectual disability and mental and substance disorders in Child and Youth Care Centres • Guidelines to identify people with mental and intellectual disabilities for social grants. • Supportive arrangements for continuation of social grant support during periods of review, and for transitional benefits during job placement programmes linked to reintegration into the workplace.
Police Services	• Early identification and referral of mental health care users in terms of section 40 of the Mental Health Care Act, 2002.	• Development of guidelines for the implementation of Section 40 of the Mental Health Care Act, which obliges the police services to transport a person to a health facility when he is judged to be a danger to himself or others due to mental illness or intellectual disability.	• Collaboration in developing guidelines for early identification and the management of forensic and behaviourally disturbed clients in police custody while in transit to or awaiting hospitalisation

Correctional Services	• Early identification and referral for treatment of prisoners.	• Develop guidelines for the management of prisoners with mental health conditions with mental health conditions, substance abuse and suicidality.	• Assistance with identification and treatment guidelines development.
Justice	• Early identification and referral for treatment of those awaiting trial.	• Development of special courts for those with intellectual disability or impaired decision-making skills • Supporting equality under the law for people with mental and intellectual disability, for example in the areas of inclusive education, workplace discrimination on the grounds of mental disability, and protection of the integrity of body and mind in the provision of mental health care services.	• Assistance with developing appropriate court procedures for people with intellectual disability • Training of magistrates in the identification and management of offenders with mental health conditions.
Housing	• Increased awareness of mental health benefit of provision of adequate housing	• Agreement on the responsibilities of Human Settlement (policies to support inclusion, municipalities (provision of transitional and permanent housing), NGOs (support programmes for residents) and Social Development (programmatic funding to NGOs) in housing provision • Review of special housing needs policy to accommodate subsidisation of the housing needs of people with mental and intellectual disability, and support to their access to housing provision through the national housing programme (family and community residential care)	• Eligibility and procedures to accommodate subsidisation and equitable access to housing provision (family and community residential care)

Local Government	• Building awareness of the mental wellbeing benefits of the provision of basic services such as water, electricity and sanitation • Inclusion of programmes for the promotion of mental well being and prevention of mental illness in municipal health services	• Clarity on the role of local government in including people with mental and intellectual disability in the provision of community and municipal services to disabled people under their jurisdiction • Including the needs of people with mental disability in Accessibility Plans, for example transport, housing, recreational needs of people with menttal disabilities.	• Input at local level to assist with the development of Accessibility Plans and local programmes.
Transport	• A safe and effective public transport system will promote mental wellbeing by increasing all citizens' access to work, social and recreational opportunities, and to public services.	• Investigate travel pass or benefit for disabled citizens was suggested to increase access to work, hospital services and social supports.	• Assistance with guidelines for eligibility and procedures for travel pass.

APPENDIX 3: THE EKURHULENI DECLARATION ON MENTAL HEALTH - APRIL 2012

We, the participants in the National Mental Health Summit held on 12-13 April 2012, consisting of representatives of government departments, non-governmental organizations, the World Health Organization, academic institutions, research organizations, professional bodies, traditional health practitioners, clinicians and advocacy and user organizations, gathered around the strategic theme 'Scaling up investment in mental health for a long and healthy life for all South Africans':-

Informed by the Constitution of the Republic of South Africa, 1996; the Mental Health Care Act 2002 (No. 17 of 2002); Resolution WHA55.10 of the World Health Assembly; United Nations General Assembly resolution 65/95; the United Nations Convention on the Rights of Persons with Disabilities; the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and the eThekwini Declaration of the 2nd Biennial Substance Abuse Summit.

Recognising that health is a state of mental, physical and social wellbeing and not just the absence of infirmity and that there can be no health without mental health; human rights of people with mental disabilities are entrenched in South African and International law; poor mental health and substance abuse is often associated with poverty, violence and other adversities and vulnerability while good mental health is an important contributor to social and economic development; attaining good mental health requires the commitment and practical involvement of a number of government and non-government sectors and partners; users of mental health services are integral to planning and delivery of mental health services; mental health service delivery must be accessible, affordable and acceptable; the right of all South Africans to the enjoyment of the highest attainable standards of physical and mental health must be achieved through increased services for mental health at all levels of the health care system, and that culture plays a key role in mental health.

Noting that mental and neurological disorders account for 13% of the global burden of disease and for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively; in South Africa neuropsychiatric disorders rank 3rd in their contribution to the overall burden of disease - after HIV and AIDS and other infectious diseases; over 16% of adults in South Africa have a 12 month prevalence of mental disorder; around three quarters of people in South Africa that suffer from a mental disorder do not currently receive any mental health intervention; mental and substance use disorders are closely correlated with physical diseases including both communicable diseases such as HIV and AIDS and non-communicable diseases such as heart disease and cancer; mental and substance use disorders and intellectual disabilities impact on every strata of South African society, men and women, all races, economic groups, urban and rural populations and all age groups; there is considerable inequity in mental health service provision especially between the private and the public sectors and also between urban

and rural areas; mental health services within general health care and community based mental health services are underdeveloped; people with mental disorders and disabilities continue to be stigmatized and discriminated against in most aspects of their lives; improved primary mental health care would reduce the number of mental health visits to secondary and tertiary health care facilities.

This national mental health summit was a culmination of an intensive process of consultation in provinces involving over 4000 people.

Realizing that primary health care is the foundation of the health care system and that there is a need to fully integrate mental health care into primary health care in South Africa with the view to increasing prevention, screening, self management, care, treatment and rehabilitation; in order to achieve equitable, efficient and quality health services, South Africa is in the process of implementing a National Health Insurance System and mental health must form an integral part of this system.

Hereby commit to:-

1. Promoting mental health as an important development objective;
2. Eliminating stigma and discrimination based on mental disability and promoting the realisation of the United Nations Convention on the Rights of Persons with Disabilities (2006);
3. Full implementation of the Mental Health Care Act, 2002 (Act No. 17 of 2002) and changing the legislation where this is needed;
4. Ensure collaboration across sectors and between governmental and non-governmental organizations, academics and with other stakeholders to improve mental health services;
5. Providing equitable, cost-effective and evidence based interventions and thereby ensure that mental health is available to all who need it, including people in rural areas and from disadvantaged communities;
6. Integrating mental health and substance abuse services into the general health service environment;
7. Providing mental health and substance abuse care to people within communities while referring to higher health care levels where clinically required;
8. Ensuring that all users of mental health services participate in the planning, implementation, monitoring and evaluation of mental health services and programmes;
9. Fostering person-centred recovery paradigm that respects the autonomy and dignity of all persons;
10. Increasing human resources to address mental health needs throughout the country through additional training across sectors, integration into general health care and through the National Health Insurance System;
11. Developing and strengthening human capacity for prevention, detection, care treatment and rehabilitation of mental and substance use disorders and build links with traditional and complementary health practitioners;
12. Providing physical infrastructure that is conducive to the needs and human rights of people with mental disorders and disabilities;
13. Reducing costs and increase the efficiency of mental health interventions, including making medicines more affordable, in order to provide essential health services;
14. Establishing comprehensive mental health surveillance mechanisms, health information systems and dissemination processes to assist policy and planning;
15. Developing and supporting research and innovation in mental health; and
16. Using the outputs from the summit to finalise the Mental Health Policy Framework 2012-2016 and to assist with its implementation and monitoring.

And consequently to:

1. Develop and implement a mental health service delivery platform based on community and district based models to ensure that prevention, promotion, treatment and rehabilitation services meet the needs of all;
2. Implement with vigour the Health Sector Mini Drug Master Plan;
3. Establish at least one specialist mental health team in each district;
4. Adequately fund mental health services as per WHO recommendations;
5. Embed and increase mental health human resources within the National Human Resource Plan;
6. Develop a fit for purpose plan for mental health infrastructure at all levels;
7. Revise norms and standards in line with the service delivery platform;
8. Strengthen Mental Health Review Boards;
9. Establish a national surveillance system and appropriate monitoring and evaluation systems for mental health care integrated into the National Health Information System;
10. Establish a national suicide prevention programme; and
11. Strengthen links with traditional, complementary and faith based healers and non-governmental organizations.

References

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

(2) Department of Health. National health policy guidelines for improved mental health in South Africa. 1997. Pretoria, Department of Health.
Ref Type: Report

(3) Draper CE, Lund C, Kleintjes S, Funk M, Omar M, Flisher AJ et al. Mental health policy in South Africa: development process and content. Health Policy And Planning 2009;czp027.

(4) Lund C, Boyce G, Flisher AJ, Kafaar Z, Dawes A. Scaling up child and adolescent mental health services in South Africa: Human resource requirements and costs. Journal of Child Psychology and Psychiatry 2009; 50(9):1121-1130.

(5) Lund C, Kleintjes S, Kakuma R, Flisher A, the MHaPP Research Programme Consortium. Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications. Social Psychiatry and Psychiatric Epidemiology 2009; 10.1007/s00127-009-0078-5.

(6) 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; 97:438-440.

(7) Lund C, Flisher AJ. Community/hospital indicators in South African public sector mental health services. The Journal of Mental Health Policy and Economics 2003; 6:181-187.

(8) Petersen I, Bhana A, Campbell-Hall V, Mjadu S, Lund C, Kleintjies S et al. Planning for district mental health services in South Africa: a situational analysis of a rural district site. Health Policy And Planning 2009; 24(2):140-150.

(9) Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A et al. Mental health policy development and implementation in South Africa. Phase 1 Country Report. 2008. Cape Town, Mental Health and Poverty Project, University of Cape Town.
Ref Type: Report

(10) WHO. Mental health policy, plans and programmes. Mental health policy and service guidance package. 2005. Geneva, WHO.
Ref Type: Report

(11) WHO. Human resources and training for mental health. Mental health policy and service guidance package. Geneva: WHO; 2005.

(12) WHO. World Health Report 2001, Mental Health: new understanding, new hope. 2001. Geneva, WHO.
Ref Type: Report

(13) US Department of Health and Human Services. Mental health: a report of the surgeon general. 2000. Rockville, MD, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
Ref Type: Report

(14) Patel V, Lund C, Hatherill S, Plagerson S, Corrigall J, Funk M et al. Social determinants of mental disorders. In: Blas E, Sivasankara Kurup A, editors. Priority public health conditions: From learning to action on social determinants of health. Geneva: WHO; 2009.

(15) Williams DR, Herman A, Stein DJ, Heeringa SG, Jackson PB, Moomal H et al. Prevalence, Service Use and Demographic Correlates of 12-Month Psychiatric Disorders in South Africa: The South African Stress and Health Study. Psychological Medicine 2007; 38(2):211-220.

(16) Kleintjes S, Flisher A, Fick M, Railon A, Lund C, Molteno C et al. The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. South African Psychiatric Review 2006; 9:157-160.

(17) Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR et al. No health without mental health. Lancet 2007; 370:859-877.

(18) Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. Lancet 2009; 374(9692):817-834.

(19) Mayosi B, Flisher AJ, Lalloo UG, Sitas F, Tollman SM, Bradshaw D. The burden of non-communicable diseases in South Africa. Lancet 2009; 374:934-947.

(20) Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Violence and injuries in South Africa: prioritising an agenda for prevention. Lancet 2009; 374:1011-1022.

(21) Chopra M, Daviaud E, Pattinson R, Fonn S, Lawn JE. Saving the lives of South Africa's mothers, babies and children: can the health system deliver? Lancet 2009; 374:835-846.

(22) Ciesla JA, Roberts JE. Meta-analysis of the relationship between HIV infection and risk for depressive disorders. American Journal of Psychiatry 2001; 158:725-730.

(23) WHO. Mental health: the bare facts. http://www.who.int/mental_health/en/ . 1-28-2010.
Ref Type: Internet Communication

(24) Seedat S, Stein DJ, Jackson PB, Heeringa SG, Williams DR, Myer L. Life stress and mental disorders in the South African Stress and Health study. South African Medical Journal 2009; 99(5):375-382.

(25) Myer L, Stein DJ, Jackson PB, Herman AA, Seedat S, Williams DR. Impact of common mental disorders during childhood and adolescence on secondary school completion. South African Medical Journal 2009; 99(5):354-356.

(26) Patel V. Poverty, inequality, and mental health in developing countries. In: D.A.Leon, G.Walt, editors. Poverty, inequality and health: An international perspective. Oxford: Oxford University Press; 2001. 247-262.

(27) Flisher AJ, Lund C, Funk M, Banda M, Bhana A, Doku V et al. Mental health policy development and implementation in four African countries. Journal of Health Psychology 2007; 12(3):505-516.

(28) Flisher AJ, Lund C, Funk M, Banda M, Bhana A, Doku V et al. Mental health policy development and implementation in four African countries. Journal of Health Psychology 2007; 12:505-516.

(29) Lund C, Myer L, Stein DJ, Williams DR, Flisher AJ. Mental ill-health and lost income among adult South Africans. Social Psychiatry and Psychiatric Epidemiology 2013; 48:845–851.

(30) Petersen I, Bhana A, Flisher AJ, Swartz L, Richter L. Promoting mental health in scarce-resource contexts: Emerging evidence and practice. Cape Town: HSRC Press; 2010.

(31) Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M et al. Treatment and prevention of mental disorders in low-income and middle-income countries. The Lancet 2007; 370:991-1005.

(32) Bolton P, Bass J, Neugebauer R, Verdeli H, Clougherty KF, Wickramaratne P et al. Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial. JAMA: The Journal Of The American Medical Association 2003; 289(23):3117-3124.

(33) Araya R, Flynn T, Rojas G, Fritsch R, Simon G. Cost-effectiveness of a primary care treatment program for depression in low-income women in Santiago, Chile. American Journal of Psychiatry 2006; 163(8):1379-1387.

(34) Botha U, Koen L, Oosthuizen P, Joska J, Hering L. Assertive community treatment in the South African context. African Journal of Psychiatry 2008; 11:272-275.

(35) Chatterjee S, Pillai A, Jain S, Cohen A, Patel V. Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India. British Journal of Psychiatry 2009; 195:433-439.

(36) Rappley MD. Attention deficit hyperactivity disorder. New England Journal of Medicine 2007; 352:165-173.

(37) Rahman A, Malik A, Sikander S, Roberts C, Creed F. Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised control trial. Lancet 2008; 372:902-909.

(38) Araya R, Rojas G, Fritsch R, Gaete J, Rojas M, Simon G et al. Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. Lancet 2003; 361(9362):995-1000.

(39) Cooper PJ, Tomlinson M, Swartz L, Landman M, Molteno C, Stein A et al. Improving the quality of the mother-infant relationship and infant attachment in a socio-economically deprived community in a South African context: a randomised controlled trial. British Medical Journal 2009; 338(doi:10.1136/bmj.b974).

(40) Flisher AJ, Lund C, Muller L, Dartnall E, Ensink K, Lee T et al. Norms and standards for psychiatric care in South Africa: A report submitted to the Department of Health, Republic of South Africa (Tender No. GES 105/96-97). 1998. Cape Town, Dept of Psychiatry, University of Cape Town.
Ref Type: Report

(41) Lund C, Ensink K, Flisher AJ, Muller L, Robertson BA, Dartnall E et al. Facing the absolute need: norms and standards for severe psychiatric conditions in South Africa. South African Medical Journal 1998; 88(11):1480-1481.

(42) Lund C, Flisher AJ. Norms for mental health services in South Africa. Social Psychiatry and Psychiatric Epidemiology 2006; 41:587-594.

(43) Muller L, Flisher AJ. Standards for the mental health care of people with severe psychiatric disorders in South Africa: Part 1. Conceptual issues. South African Psychiatry Review 2005; 8:140-145.

(44) Muller L, Flisher AJ. Standards for the mental health care of people with severe psychiatric disorders in South Africa: Part 2. Methodology and results. South African Psychiatry Review 2005; 8:146-152.

(45) Flisher AJ, Jansen S, Lund C, Martin P, Milligan P, Robertson BA et al. Norms for community mental health services in South Africa. 2003. Cape Town, Department of Psychiatry and Mental Health, University of Cape Town

Ref Type: Report

(46) Lund C, Flisher AJ. A model for community mental health services in South Africa. Tropical Medicine & International Health 2009; 14(9):1040-1047.

(47) Dawes A, Lund C, Kafaar Z, Brandt R, Flisher AJ. Norms for South African Child and Adolescent Mental Health Services: Report for the Directorate Mental Health and Substance Abuse – National Department of Health (Tender No. DOH 48/2003-2004). 2004. Cape Town, Human Sciences Research Council.
Ref Type: Report

(48) WHO. Mental Health Financing. Mental Health Policy and Service Guidance Package. Geneva: WHO; 2003.

(49) WHO. Planning and budgeting to deliver services for mental health. Mental health policy and services guidance package. 2003. Geneva, WHO.
Ref Type: Report

(50) Farkas M, Gagne C, Anthony W, Chamberlin J. Implementing recovery oriented evidence based programs: Identifying the critical dimensions. Community Mental Health Journal 2005; 41:141-158.

(51) WHO. Advocacy for Mental Health. Mental Health Policy and Service Guidance Package. Geneva: WHO; 2003.

(52) 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.

(53) UNAIDS. AIDS Epidemic Update, November 2009: UNAIDS & WHO. Available online at http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf [6 February 2010].; 2009.

(54) Freeman M, Nkomo N, Kafaar Z, Kelly K. Mental disorder in people living with HIV/AIDS in South Africa. South African Journal of Psychology 2008; 38(3):489-500.

(55) Williams DR, Herman A, Stein DJ, Heeringa SG, Jackson PB, Moomal H et al. Twelve-month mental disorders in South Africa: Prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. Psychol Med 2008; 38(2):211-220.

(56) Rochat TJ, Richter L, Doll HA, Buthelezi N, Tomkins A, Stein A. Depression among pregnant rural South African women undergoing HIV testing. Journal of the American Medical Association 2006; 295:1376-1378.

(57) Meade CS, Sikkema KJ. HIV risk behaviour among adults with severe mental illness: a systematic review. Clinical Psychology Review 2005; 25(4):433-457.

(58) Mellins CA, Kang E, Leu CS, Havens JF, Chesney MA. Longitudinal study of mental health and psychosocial predictors of medical treatment adherence in mothers living with HIV disease. AIDS Patient Care and STDs 2003; 17(8):407-418.

(59) Schneider M, Kaplan SH, Greenfield S, Li W, Wilson IB. Better physician-patient relationships are associated with higher reported adherence to antiretroviral therapy in patients with HIV infection. Journal of General Internal Medicine 2004; 19(11):1096-1103.

(60) Lusskin S, Pundiak T, Habib S. Perinatal Depression: Hiding in Plain Sight. Canadian Journal of Psychiatry 2007; 52(8):479-488.

(61) Cooper PJ, Tomlinson M, Swartz L, Woolgar M, Murray L, Molteno C. Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. British Journal of Psychiatry 1999; 175:554-558.

(62) Cooper PJ, Landman M, Tomlinson M, Molteno C, Swartz L, Murray L. Impact of a mother-infant intervention in an indigent peri-urban South African context: pilot study. British Journal of Psychiatry 2002; 180:76-81.

(63) Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bulletin Of The World Health Organization 2003; 81(8):609-615.

(64) Saraceno B, Barbui C. Poverty and mental illness. Can J Psychiatry 1997; 42(3):285-290.

(65) 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; 4:181-185.

(66) Abas M, Broadhead J. Depression and anxiety among women in an urban setting in Zimbabwe. Psychological Medicine 1997; 27:59-71.

(67) Almeida-Filho N, Lessa I, Maghalaes L, Araujo M, Aquino E, James S et al. Social inequality and depressive disorders in Bahia, Brazil: interactions of gender, ethnicity, and social class. Social Science & Medicine 2004; 59:1339-1353.

(68) Araya R, Rojas G, Fritsch R, Acuna J, Lewis G. Common mental disorders in Santiago, Chile: prevalence and socio- demographic correlates. British Journal of Psychiatry 2001; 178:228-233.

(69) Araya R, Lewis G, Rojas G, Fritsch R. Education and income: which is more important for mental health? Journal Of Epidemiology And Community Health 2003; 57:501-505.

(70) Bhagwanjee A, Parekh A, Paruk Z, Petersen I, Subedar H. Prevalence of minor psychiatric disorders in an adult African rural community in South Africa. Psychological Medicine 1998; 28:1137-1147.

(71) Robertson BA, Ensink K, Parry CD, Chalton D. Performance of the Diagnostic Interview Schedule for Children, Version 2.3 (DISC-2.3) in an informal settlement area in South Africa. Journal of the American Academy of Child and Adolescent Psychiatry 1999; 38:1156-1164.

(72) 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; 66(8):1828-1840.

(73) Stein DJ, Seedat S, Herman A, Moomal H, Heeringa SG, Kessler RC et al. Lifetime prevalence of psychiatric disorders in South Africa. British Journal of Psychiatry 2008; 192(2):112-117.

(74) WHO. Mental health aspects of women's reproductive health: A global review of the literature. Geneva: WHO; 2009.

(75) Stewart DE, Ashraf IJ, Munce SE. Women's mental health: A silent cause of mortality and morbidity. International Journal of Gynecology & Obstetrics 2006; 94(3):343-349.

(76) Engle PL, Black MM, Behrman JR, Cabral de Mello M, Gertler PJ, Kapiriri L et al. Strategies to avoid loss of developmental potential in more than 200 million children in the developing world. Lancet 2007; 369:229-242.

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

(78) Walker SP, Wachs TD, Gardner JM, Lozoff B, Wasserman GA, Pollitt E. Child development: risk factors for adverse outcomes in developing countries. Lancet 2007; 369(9556):145-157.

(79) 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 2008; 49:313-334.

(80) Bell C, Bhana A, Petersen I, McKay M, Gibbons R, Bannon W et al. Building protective factors to offset sexually risky behaviours among black South African youth: A randomized control trial. Journal of the National Medical Association 2008; 100(8):936-944.

(81) Richter LM. Studying adolescence. Science 2006; 312(5782):1902-1907.

(82) Flisher AJ, Gevers A. Adolescence. In: Petersen I, Bhana A, Swartz L, Flisher AJ, Richter LM, editors. Promoting mental health in scarce-resource contexts. Pretoria: HSRC Press; 2010. 143-166.

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