



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

**MENTAL HEALTH POLICY FRAMEWORK FOR SOUTH AFRICA AND
STRATEGIC PLAN 2014-2020**

October 2012

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Foreword by the Minister

Worldwide, the prevalence and burden of mental illness remains high. WHO estimates that 1 in 4 people experience a significant episode of mental illness during their lifetime, but the treatment gap between the need for, and receipt of, appropriate services remains wide. Most South Africans will be directly or indirectly touched by the impact of mental illness at some point in their lives. Mental illness is common, with 33% of the population predicted to experience

mental illness at some time in our lives. The impact on those affected their families and carers and the community at large can be profound.

We have to scale up our efforts to address and combat human rights violations, stigma, discrimination and social exclusion of our mental health care users and their families with vigour.

In South Africa, we have located mental health up the health policy agenda, where we believe it belongs, given its importance in public health. Having this national mental health policy framework is a fundamental achievement towards the delivery of effective, equitable and affordable treatment and coordinated actions across all agencies and sectors in response to the mental health needs of our people.

This National Mental Health Policy Framework represents an ongoing commitment by all responsible for mental health to the continual improvement of the Country mental health system and access. This commitment is in line with the principles of universal coverage, equity and the highest attainable standard of health as envisaged by the World Health Organization for all nations in the world.

The framework is aimed towards ensuring that we have a mental health system that detects and intervenes early in illness, prevent mental ill health, promotes recovery, lessens the stigma so often attached to mental illness. It will ensure that all South Africans with a mental illness have access to effective and appropriate treatment and community support toward full participation in the community.

The policy framework embeds the whole government approach to mental health. It builds upon the policies contained in the Constitution and the Mental Health Care Act No. 17 of 2002.

Recently, all key stakeholders in mental health met at the 2012 Mental Health Summit to tackle major issues that threatens the mental well-being of our

people. The first South African Ekurhuleni Declaration on mental health was adopted, which also set the course of this mental health policy framework. It is the actions and outcomes to flow from this policy framework that will ultimately make the difference.

In recommending this Mental Health Policy Framework to you, I acknowledge the evident commitment, expertise and experience of all those involved in the development of this important document. I envisage that this framework will significantly contribute to a “Long and Healthy life for all South Africans”.

I therefore call on all levels of Government, the private, community and non-government sectors to embrace the Mental Health Policy Framework and to forge an improved service system to improve the lives of all South Africans affected by mental illness.

Statement by the Deputy Minister

Mental health is an essential element of health, and is crucial to the overall well-being of individuals and society. However, 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. Furthermore, the burden of mental illness in this country is felt not only through the primary presentations of mental disorders, but through its high co-morbidity with other illnesses. Mental ill-health features prominently in the quadruple disease burden faced by South Africa, which is characterised by infectious diseases, the growing burden of non-communicable diseases, high levels of violence and injury; and maternal and child illness.

It is an important time for the development of a Mental Health Policy Framework in South Africa. There has never been so much visibility and recognition of the need to tackle mental health problems and promote good mental health than now. Now is the time to act.

This Mental Health Policy Framework is an important step toward bringing the issue of mental health to the forefront of the public policy debate. Within the historical context, social factors, legal and human rights perspective, community-based service provision and the role of people with mental health problems as advocates, the framework serves as a reference for those working to transform mental health services and lays a blueprint for moving forward. The policy draws from the principles laid in the Constitution of the Country, the Mental Health Care Act No. 17 of 2002 and the International human rights standards.

There is a great need for advocacy in mental health from a variety of angles, including the crucial work to address issues of social exclusion, promoting quality health care and social support. This policy framework promotes and protects the human rights of people with mental health problems in terms of access to education, housing, employment, leisure and cultural activities. Taking cognisance of the underdeveloped nature of community-based mental

health services in our country, it is urgent that we develop community-based alternatives to institutional care in order to ensure the full and equal participation of people with mental health problems in society. Also, alternative financing mechanisms that will make the shift of resources from institutions to community realistic and possible needs to be developed.

Most importantly, this framework advocates for people who use mental health services and their families to have a voice in planning, implementation and review of services.

I trust that this Mental Health Policy Framework will provide valuable insights into many of the pressing policy challenges which confront the South African mental health systems today. And that it will help to bolster efforts to turn our intentions and actions into concrete policy practices and programmes.

Indeed more still needs to be done to build on the progress we have made and to address the shortcomings on the Country mental health systems as we move towards the National Health Insurance system in South Africa.

Let us work together including our mental health care users and their families in implementing this important document towards improved mental health services for all.

Statement by the Director-General

I have great pleasure in presenting this important document, which reflects our predetermined efforts to put mental health right at the core of our health system and development agenda. There is a growing acknowledgement in South Africa that we must put mental health higher on the agenda.

We are all in the process of building a significant blueprint for mental health in this country, which will allow for a lasting difference for millions of people who expect better mental health services. This policy framework is one of many initiatives in the public health sector undertaken to improve mental health services in the Country, as well as the Mental Health Care Act No. 17 of 2002.

The policy framework is a reflection of a promise in South Africa for a brighter future for people suffering from mental disorders and the attendant discrimination.

It calls for transformation of mental health systems through major investment, expansion and reorganization of mental health services and also emphasises holistic multi-sectoral, multi-dimensional and evidence-based approaches. Services should be developed in an appropriate way to meet the needs of all stakeholders including mental health care users and their families.

This Mental Health Policy Framework is particularly important as it seeks to improve public awareness on mental health issues, strengthen community-based prevention and early interventions, expand specialized mental health services for adults, children and adolescents, improve mental health workforce, improve accessibility of services and stimulate education and research.

The framework rightly puts emphasis not just on good treatment and rehabilitation but also on promotion of good mental well-being. It also provides an opportunity to reduce suffering, disability, poverty and premature death. This fits in very well with the Health Sector four outputs, which

provides key strategies for accelerating progress towards the vision of a “Long and Healthy Life for all South Africans”.

We look forward to working more intensely with all role players, forging sustainable partnerships that will do justice to mental health care users to improve provision of mental health services and treatment for all those who need them.

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.

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; 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 academic health institutions.

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
- ❑ 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).
- ❑ 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 health care 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 Cape¹⁶

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

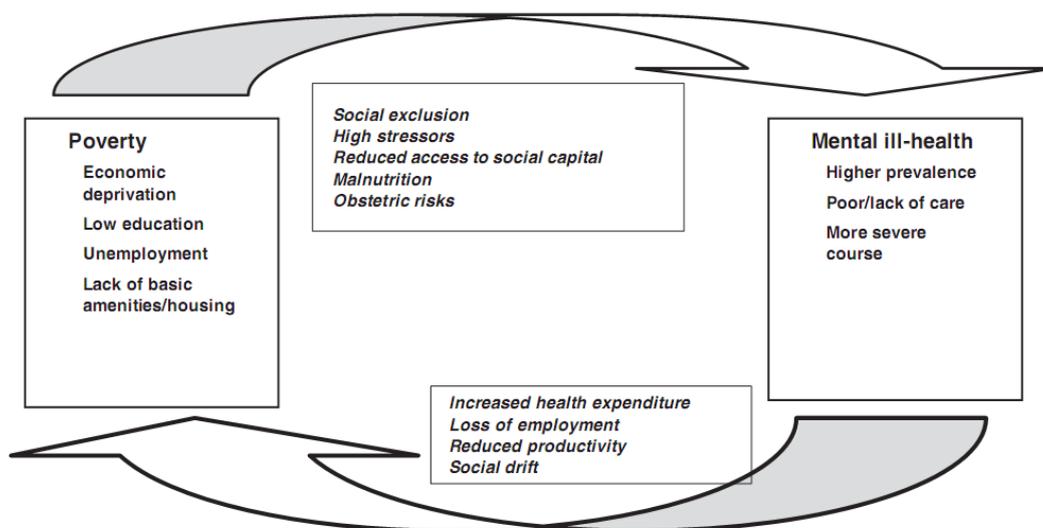


Figure 1. Relationship between poverty and mental ill-health.

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 has 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. Stigmatising 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 population.
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.
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.

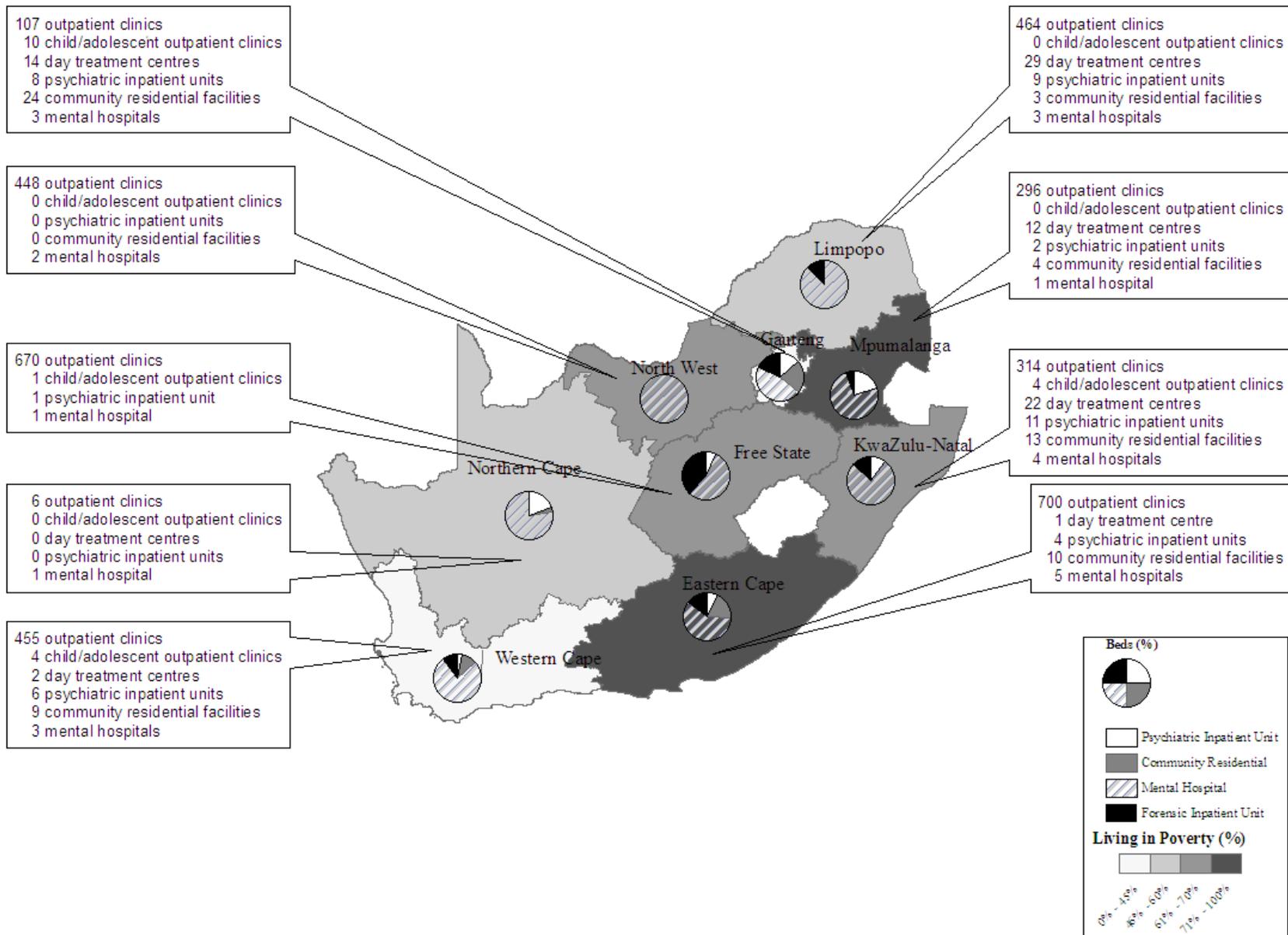


Figure 2. Mental health facilities per province in South Africa in 2005⁵

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 2006-2011.
- ❑ 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.
- ❑ 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	<ul style="list-style-type: none">❑ 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, 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

Respect for culture	<p>their community.</p> <ul style="list-style-type: none"> ❑ 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	<ul style="list-style-type: none"> ❑ Services should be sensitive to gender-related issues experienced by men and women, and boys and girls.
Social support and integration	<ul style="list-style-type: none"> ❑ 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	<ul style="list-style-type: none"> ❑ 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	<ul style="list-style-type: none"> ❑ 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	<ul style="list-style-type: none"> ❑ 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	<ul style="list-style-type: none"> ❑ The limited resources available for mental health should be used efficiently, for maximum effect ❑ Interventions should be informed by evidence of effectiveness.
Comprehensiveness	<ul style="list-style-type: none"> ❑ Mental health interventions should be directed at mental health promotion, the prevention of mental illness, treatment and rehabilitation.
Protection against vulnerability	<ul style="list-style-type: none"> ❑ 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

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
 - 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.
 - 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. No new psychiatric hospitals will be built. Where inpatient units are needed, these will be developed in district and regional hospitals.
- i. Voluntary mental health 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.

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
 - Programmes to reduce alcohol and substance use during pregnancy
 - 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 recovery⁵⁰ 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 their function stipulates 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 effectively implemented for persons with mental disability in South Africa.

7.7 Special populations

By 2013:

1. 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 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

By 2012:

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 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 2012:

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
 - 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 Designated Psychiatric Hospitals, Care and Rehabilitation Centres

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 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.

8.5 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
 - Detection and management of child and adolescent mental disorders in PHC clinics, and referral where appropriate
3. Providing 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.

8.6 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.

9. Appendix 1. 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	<ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - 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 children 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 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Early identification and referral of youth offenders. 	<ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - Early identification and referral 	<ul style="list-style-type: none"> - Develop guidelines for the management of 	<ul style="list-style-type: none"> - Assistance with identification

Services	for treatment of prisoners.	prisoners with mental health conditions with mental health conditions, substance abuse and suicidality.	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	– Clarity on the role of local government in including people with mental and intellectual	– Input at local level to assist with the development of

	<p>provision of basic services such as water, electricity and sanitation</p> <ul style="list-style-type: none"> - Inclusion of programmes for the promotion of mental well being and prevention of mental illness in municipal health services 	<p>disability in the provision of community and municipal services to disabled people under their jurisdiction</p> <ul style="list-style-type: none"> - Including the needs of people with mental disability in Accessibility Plans, for example transport, housing, recreational needs of people with mental disabilities. 	<p>Accessibility Plans and local programmes.</p>
Transport	<ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - Investigate travel pass or benefit for disabled citizens was suggested to increase access to work, hospital services and social supports. 	<ul style="list-style-type: none"> - Assistance with guidelines for eligibility and procedures for travel pass.

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