

## A new mental health policy for South Africa



Worldwide there has been a growing awareness of the disability, suffering and economic costs associated with mental disorders, and of the availability of cost-efficient treatments. A range of authors,<sup>[1]</sup> as well as key institutions such as the World Health Organization (WHO),<sup>[2]</sup> have played an important role in producing data and reports which emphasise these points. After an extensive consultative process, in May 2013, a further step forwards was taken when the World Health Assembly adopted the Comprehensive Mental Health Action Plan 2013 - 2020, committing all United Nations member states to take specified actions to help reach agreed targets. Four key objectives are: 'to strengthen effective leadership and governance for mental health; provide comprehensive, integrated and responsive mental health and social care services in community-based settings; implement strategies for promotion and prevention in mental health; and strengthen information systems, evidence and research for mental health.'<sup>[3]</sup>

In post-apartheid South Africa (SA), there has similarly been clear awareness that mental health has been neglected and that the transition to democracy requires paying much more attention to it. Local writers have emphasised these points,<sup>[4]</sup> and at a national level the Mental Health Act of 2002 made an important advance insofar as it emphasised the human rights of those with mental illness, including access to care.<sup>[5]</sup> After a major consultative process including provincial and national mental health summits between February and April 2012, a further important step forwards was taken in July 2013 when the National Health Council adopted the Mental Health Policy Framework (MHPF) for SA and the Strategic Plan 2013 - 2020. There are eight key objectives: 'district-based mental health services and primary healthcare re-engineering; building institutional capacity; surveillance, research and innovation; building infrastructure and capacity of facilities; mental health technology,

equipment and medicines; intersectoral collaboration; human resources for mental health; advocacy, mental health promotion and prevention of mental illness.'<sup>[6]</sup>

First and foremost, these initiatives call for celebration and congratulation. They are the culmination of a great deal of work by many dozens of individuals, they address a significant gap in public health, and they offer hope for millions of people suffering from mental illness. The integration in the MHPF of a focus on scientific evidence and best practice, together with an emphasis on human rights and vulnerable populations (including pregnant women), is laudable. The careful alignment of the MHPF with the WHO framework speaks to the rigorous and sustained planning that took place locally, and also deserves commendation. At the same time, it is also important to reflect critically on what has been achieved, and on what remains to be done, particularly in the SA context.

A first important question relates to the past: how were these successes achieved? Shiffman and Smith have argued that for political priority to be given to a health issue, various conditions must be met, including political support.<sup>[7]</sup> Tomlinson and Lund<sup>[2]</sup> have applied this framework to mental health, emphasising that although there has been a lack of political support in the area of mental health and insufficient mobilisation of civil society, cohesive leadership (by a network of individuals) and guiding institutions (such as the WHO) have contributed to bringing attention to mental health. This is an area that seems to beg further analysis, to better understand what has been achieved and how, but also to ensure a better understanding of what has not been achieved and why. Many challenges undoubtedly remain, but it is worth noting the remarkable number of contributions to psychiatry and clinical psychology that have emerged from SA.<sup>[8]</sup> While there is a growing interest in evidence-based policy making,<sup>[9]</sup> there is perhaps less attention paid to the question of the individual and social factors that promote the development and implementation of such policy making.

A second important question is the precise components of these international and national frameworks. The eight objectives of the MHPF are associated with catalytic key activities, chosen to achieve results most effectively. In preparation for the MHPF, the Society of Psychiatrists of South Africa (SASOP) put forward a series of position statements and also deliberated on each of its eight objectives.<sup>[6,10]</sup> Although these focus a good deal on the status of the profession of psychiatry with respect to the MHPF, they also instructively address a number of its potential strengths and weaknesses. Thus, for example, with regards to district-based mental health services, SASOP commends community-based services, but also warns that the integration of mental health services should not mean the dismantling of expert mental health teams, and that there is a need for flexible co-operation and effective communication with secondary and tertiary levels of services. Indeed, much of the devil will be in the detail; while the rationale for the objectives and activities seems sound, as the process moves from broad brushstrokes to detailed plans, precise pros and cons will become evident.

A third important question concerns the future: how should mental health clinicians best respond to the MHPF? Several points can be made. Importantly, while the MHPF indicates that there will be parity in the financing of mental health, provincial mental health plans still have to be developed and implemented. Thus, there is an ongoing need to bring attention to the importance of mental health at a provincial level.<sup>[7]</sup> There is also an urgent need for models of the delivery of mental health services at primary healthcare; there is growing research in developing countries on this issue, but relatively little work in low- and middle-income countries.<sup>[11]</sup> The development of such models arguably requires expertise not only in public mental health, but also in liaison psychiatry.<sup>[12]</sup> Another important need is for research on the various activities proposed by the MHPF. Thus, for example, while the policy understandably promotes a national education programme addressing mental health, the evidence base on whether and how such efforts impact mental illness deserves expansion.<sup>[13]</sup>

Public health is complex enough when disorders are caused by a single mechanism, and respond to simple interventions (e.g. vaccination, mosquito nets). Public mental health is particularly complex, because mental disorders are produced by multiple mechanisms and require a broad range of interventions.<sup>[14,15]</sup> Current debates about the optimal classification of mental disorders,<sup>[16]</sup> and how best to foster psychiatric research,<sup>[17]</sup> reflect this complexity; it would be surprising, for example, if there was unanimous agreement that alcoholism was primarily a brain disease (rather than also reflecting a range of other factors) and that the key solution

was for hospital-based clinicians to provide pharmacological and psychological interventions. Given this complexity, and the controversies that understandably surround it, it is remarkable that the world, including SA, has agreed to an action plan. That said, given these inherent complexities and resultant controversies, we can expect much further discussion as such planning moves forwards. It is timely for clinicians and researchers to get involved.

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