

Mental Health Services in South Africa: Scaling up and future directions

K Sorsdahl, DJ Stein, C Lund

Department of Psychiatry & Mental Health, University of Cape Town, Cape Town, South Africa

Abstract

"No health without mental health" has become a rallying call for the World Health Organization and numerous service providers, training institutions, health researchers, and advocacy groups around the world. It is timely to consider the implications of this call for South Africa. We review key evidence regarding the burden and risk factors for mental disorders in South Africa and crucial challenges for local mental health services and research. We emphasize that mental disorders are more impairing but less treated than physical disorders, and that existing services need to be scaled up and adapted to the local context. New research is needed to determine what interventions work best in the South African context.

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Introduction

"No health without mental health" has become a rallying call for the WHO and numerous service providers, training institutions, health researchers, and advocacy groups around the world.¹ This pithy statement captures several issues: the growing contribution of mental disorders to the global burden of disease², the availability of efficacious and cost-effective treatments³, the high level of comorbidity between "physical" and "mental" illness⁴, and the need to achieve parity for mental health services as a basic human right for people living with mental illness.⁵

With the current movement for global mental health, it is timely to review these issues from a South African perspective. Are mental disorders important in our particular context and do they deserve additional resourcing? If we agree that services need scaling up, what adaptations are needed within our context? Finally, what is the most important mental health services research to conduct going forward?

Priority Conditions

Global surveys of mental disorders and a range of studies in South Africa have increasingly demonstrated the high prevalence, chronicity, and morbidity of these conditions.⁶ Nevertheless it is only recently that representative data in the form of the South African Stress & Health Study (SASH) become available. SASH was undertaken as part of the World Mental

Health Surveys⁷ and consisted of comprehensive structured interviews with 4351 South African adults administered in several languages.⁸

One of the primary goals of SASH was to determine the burden of mental disorders by assessing the prevalence and severity of specific psychiatric disorders and patterns of service use.⁹ For example, 12-month prevalence data indicated that 16.5% of adults have suffered a common mental disorder in the past year¹⁰, but that only 25% of these individuals had received treatment during this time.¹¹ Furthermore, although mental disorders are significantly more disabling than physical disorders, they are 10 times less likely to be treated.¹²

The SASH data also emphasize the importance of a number of key risk factors for mental disorders. In particular, a number of papers have emphasized the link between trauma and common mental disorders.¹³ Although SASH did not inquire about HIV status, it did provide some data indicating the importance of the link between HIV and mental disorder.¹⁴ In the South African context, food insufficiency was found to be a key risk factor for mental disorder¹⁵, and low socio-economic status was shown to be an independent risk factor for psychological distress.¹⁶

SASH data are consistent with a range of data from other local studies. First, South African morbidity data indicate that mental disorders are the 3rd highest contributor to the local burden of disease, after HIV and other infections disorders.¹⁷ Second, interpersonal violence is highly prevalent in South Africa, and is associated with major psychiatric morbidity.¹⁸⁻²⁰ Third, both HIV and substance use have extremely important associations with mental disorder in our context.^{21,22} Fourth, there are major links between poverty and mental illness, mediated by a range of factors other than food insufficiency.²³

Correspondence

Dr K Sorsdahl

Department of Psychiatry and Mental Health, J-Block Groote Schuur

Hospital, Observatory, Cape Town, South Africa

email: katherine.sorsdahl@uct.ac.za

The Scaling up of Services

Given these findings, an obvious conclusion is that there is a need to establish parity for mental health services in South Africa, to use existing human and infrastructure resources as efficiently as possible, and to develop additional resources over time. The growing evidence for the efficacy and cost-effectiveness of both pharmacotherapeutic and psychotherapeutic interventions for mental disorders^{24,25}, and emerging evidence that treating mental disorders can carry economic benefits at the individual and household level²⁶, provides persuasive arguments for such shifts. In addition, there is growing recognition of parity for mental health services as a human rights issue.²⁷ In considering how best to achieve parity for mental health, and how optimally to scale up services, an immediate issue is the current status of mental health policy, legislation and systems in South Africa. The Mental Health and Poverty Project (MHaPP) has emphasized that there are major gaps in current services and policies.^{28,29}

The mental health Gap Action Programme (mhGAP) is the WHO's action plan to scale up services for mental, neurological, and substance use disorders, and provides a set of practical clinical guidelines and algorithms for the delivery of mental health care by general health providers (doctors and nurses).³⁰ For example, the most appropriate package of treatment for attention-deficit/hyperactivity disorder (ADHD) in low- and middle-income countries (LMICs) should comprise screening high-risk groups, psycho-educational interventions, pharmacotherapy, and behavioural interventions.³¹ A key construct advocated by the WHO in scaling up services in resource constrained contexts is that of task shifting. The concept of task shifting has, for example, been advocated by the WHO to increase access to ARVs and HIV services.³² Task shifting is defined as "delegating tasks to existing or new cadres with either less training or narrowly tailored training".³³ Task-shifting may be a viable option to deliver mental health interventions in primary care and community based programs particularly in resource-constrained environments³⁴, and should ideally also be accompanied by development of more highly trained personnel to provide support and supervision.³⁵

Adaptation of Services to the South African Context

In scaling up services, it is vital that interventions are socially and culturally appropriate. The mhGAP provides guidelines for care, but at the same time indicates that countries must adapt interventions to their own contexts. A major issue is therefore whether interventions developed elsewhere are in fact effective and cost-effective in contexts such as South Africa. The available South African literature highlights a number of factors that should be considered when designing and implementing these interventions. Here we consider the importance of how best to integrate packages of mental health care into routine primary health care; how best to employ traditional healers; how to improve low mental health literacy; and how to address the negative impact of stigma.

First, while there is growing evidence on "what" interventions work in other countries²³, there is less evidence on both efficacy and effectiveness in South Africa. van't Hof and colleagues reviewed the literature on psychotherapy trials in low and middle income countries, and noted that there is some evidence for efficacy.³⁶ A number of preliminary effectiveness studies in South Africa show promise, including the treatment of depression by community workers using interpersonal therapy in primary care³⁷ and a multimedia-supported adherence tools administered by lay counsellors for ARV adherence.³⁸ Data on efficacy and effectiveness

of packages of care for priority mental disorders are important for the primary care revitalisation programme of the South African Department of Health.

Second, several studies have emphasized that traditional healers may play an important role in addressing mental health care needs in South Africa by offering culturally appropriate treatment.³⁹⁻⁴¹ In many traditional African belief systems, mental health problems are perceived as due to ancestors or bewitchment, and traditional healers and religious advisors are viewed as having expertise in these areas.⁴² A nationally representative sample of adults found that 9% of the respondents consulted traditional healers and 11% consulted a religious or spiritual advisor for their mental health care needs.⁴³ Use of traditional healers was predicted by having an anxiety or a substance use disorder. Although a few studies have shown the potential of traditional medicine⁴⁴, some traditional healers' practices have been found to be perilous.⁴⁵ Equipping traditional healers to understand and effectively manage mental disorders in their communities may contribute towards scaling up services.

Third, one of the most significant barriers to accessing care for people with a mental disorder in South Africa is low mental health literacy, defined as "knowledge and beliefs about mental illness that aid their recognition, management or prevention".⁴⁶ In a study investigating barriers to treatment in a nationally representative study in South Africa, the most common reason for not accessing mental health services was a low perceived need for treatment (93%).⁴⁷ Mental health literacy in South Africa has been investigated in community samples^{48,49}, and in an HIV population.⁵⁰ This work indicates that common mental disorders are viewed as the result of everyday life challenges, rather than as treatable conditions. However, there is some evidence (none from South Africa) to suggest that population-wide and individual level interventions designed to improve mental health literacy are effective.⁵¹ A mental health literacy component may be integral to developing local interventions.⁵²

Fourth, stigma is another barrier to scaling up services for people with mental disorders.⁵³ A few studies have, for example, investigated community attitudes towards the mentally ill in the South African context.^{54,55} Compared to an average person, those with a mental disorder are viewed as being more unpredictable, tense and dangerous, worthless, delicate, slow, weak, dirty, and foolish.⁵⁶ Furthermore, in a study investigating the attitudes South Africans have toward people with specific psychiatric disorders (schizophrenia, substance use, post-traumatic stress disorder and depression), results found more stigmatizing attitudes toward patients with substance abuse and schizophrenia than other disorders.⁵⁷ Thus, there is an urgent need to implement effective strategies to reduce stigma. While a number of anti-stigma campaigns and activities have been conducted locally^{58,59}, the effectiveness of these activities requires better assessment.⁶⁰

Future Research

Lund and Petersen²⁷ have recently reviewed mental health services research in South Africa and concluded that research should focus on intervention and economic evaluations of packages of care adapted for the South African context. However, as indicated above, South Africa's rich cultural diversity poses significant challenges when adapting Western diagnostic conventions, research tools and psychosocial interventions. Great care in programme design, training of non-specialists, implementation and research is required.

First, it is important to undertake intervention research on priority mental disorders that have been shown to be highly prevalent and disabling. Investigating how useful screening tools are for the

detection of priority disorders and which psychosocial interventions are the most acceptable to patients and produce the best outcomes, would prove useful for scaling up services.⁶¹

Second, it is important to assess whether adaptations of interventions for delivery by non-specialists in the local context proves feasible and effective. Investigating whether or not various types of non-specialists have the ability to deliver evidence based intervention, and retain fidelity to treatment guidelines would also be useful. There is also need for greater work locally on the most effective way to training non-specialist health workers to deliver mental health care.⁶²

Third, it is important to discover the best way to address the high levels of trauma and interpersonal violence in the country.^{63,64} One hypothesis is that if prevention and management services were integrated into the health system, they might be more effective, through screening, brief interventions and referral to treatment where necessary. Interventions developed to address substance use may also be important from a prevention and promotion perspective.

Finally, it is important to undertake additional research in the crucial areas of substance use⁶⁵ disorders and HIV/AIDS.⁶⁶ Each of these is a vitally important area in their own right in the South African context, and they also intersect in important ways.⁶⁷ Research on preventive interventions, as well as on effective treatments for individuals suffering from substance use disorders and from neuroHIV/AIDS is urgently needed in the South African context.

Conclusions

In this paper we have emphasized that local data on burden of disease confirms the crucial importance of mental disorders, that mental health services urgently need to be scaled up, that such services need to be carefully adapted with the local context in mind, and that further work is needed to determine what interventions work best in the South African context. Although further research is needed, our hope is that over the next decades much will be learned about how to provide evidence-based, cost-effective, feasible and acceptable interventions in the South African context, and the political will can be found to implement such interventions.

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