Mental illness: South Africa's blind spot

To the Editor: The articles by Odendaal *et al.*[1] and Pillay-van Wyk *et al.*[2] indicate poor recognition of mental illness and its complex interplay with physical health in South African (SA) research. While Odendaal *et al.*[1] screened for depression in pregnant women, the relationship between mental illness and persistent smoking was not explored and the possible need to tailor interventions to perceptual, cognitive or personality functioning was not discussed. Pillay-van Wyk *et al.*[2] include mental illness among 'other' comorbidities in COVID-19 deaths, but do not mention substance use. Furthermore, they do not discuss the low prevalence of these comorbidities among COVID-19 deaths, although it is an unexpected finding given the excess mortality associated with mental disorders.[3]

In pregnancy, mental disorders are associated with preterm delivery, low birth weight, hypertension, gestational diabetes and neonatal morbidity.[4-6] The extent to which these outcomes are mediated by smoking and/or social deprivation is unknown. Smoking is more prevalent among people with mental illness (PWMI) than in the general population, with more intense addiction and reduced response to population-level interventions.[7,8] Mental illness is also associated with social deprivation. The association between persistent smoking and social deprivation found by Odendaal *et al.*[1] is similar to that found in Canada among PWMI,[9] and is consistent with the well-documented mental health/poverty cycle[10] (related to social exclusion as well as social and/or occupational impairment).

While mental healthcare may improve socioeconomic outcomes among PWMI,[10] it alone does not reduce smoking. Neither does education. However, behavioural and pharmacological interventions may. Prochaska *et al.*[8] discuss the application of the Host-Agent-Vector-Environment (HAVE) public health model to smoking cessation among PWMI. The four domains of this application are:

- 'Host – tobacco user characteristics (e.g. biobehavioural, social/cognitive, mental health).
- Agent – tobacco product characteristics (e.g. nicotine content, delivery, flavourings).
- Vector – tobacco industry efforts (e.g. research, development, advertising, distribution).
- Environment – broader community and policy structures (e.g. taxation, smoking bans, insurance coverage, retailers).'[8]

In SA, collaborative biopsychosocial Host interventions are lacking.

Regarding mortality, compared with the general population, all-cause mortality is doubled among PWMI, with a 10 - 20-year reduced life expectancy.[3] Recent US database studies found, in their population, higher COVID-19 mortality rates among people with psychiatric[11,12] or substance use disorders[13] compared with those without such disorders. As with the study by Pillay-van Wyk *et al.*,[2] their findings are dependent on accurate death records. While such accuracy is lacking for most conditions in SA, it is particularly so for mental disorders. During the investigation by the Ombudsman for Health in the Life Esidimeni tragedy, even unmissable, profoundly severe mental, neurological or intellectual disability was not considered an underlying cause of death by those completing certificates.[14] In a country where it is estimated that <10% of PWMI needing mental healthcare access it,[15] what is the possibility that comorbid mental illness was recorded in COVID-19 deaths?

In discussing costs of COVID-19 on our quadruple burden of disease, Hofman and Madhi[16] mention psychological ramifications, but not mental illness. This omission might be related to difficulty in quantifying mental illness, paucity of data or scant interrogation in physical health research. Perhaps mental illness is assumed to fall under non-communicable diseases, or maybe it is not perceived as integral to our disease burden. Nevertheless, omitting discussion on COVID-19 costs regarding incident mental illness; compromised access to maintenance treatment, increased relapse and hospitalisation; and the vulnerability of PWMI to substance use, assault, homelessness and mortality, keeps mental illness in our blind spot. How then will it feature in co-ordinated, collaborative research and healthcare planning?

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