

Integrating mental health into South Africa's health system: current status and way forward

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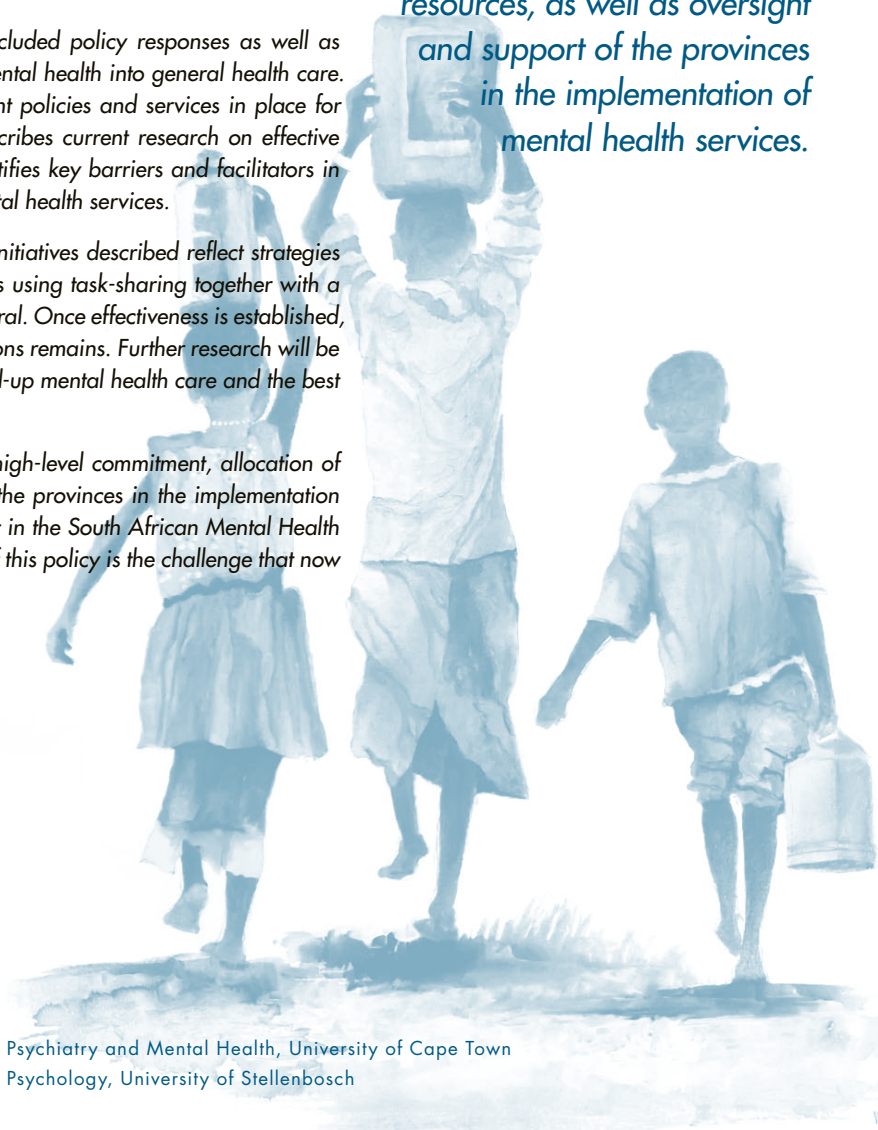
As implied by the World Health Organization's statement, "There is no health without mental health", it is essential to think of mental health as an integral part of health. As such, it should be integrated into health policy and practice in order to improve global health and address the significant treatment gap for mental, neurological and substance use (MNS) disorders.

Efforts to address this in South Africa have included policy responses as well as research and service innovations integrating mental health into general health care. This chapter provides an overview of the current policies and services in place for mental health care in South Africa; it also describes current research on effective strategies for providing such services, and identifies key barriers and facilitators in implementing these policies and scaling up mental health services.

The examples of research projects and service initiatives described reflect strategies of integration into Primary Health Care, such as using task-sharing together with a strong support structure for supervision and referral. Once effectiveness is established, the challenge of how to scale up these interventions remains. Further research will be required to evaluate both the outcomes of scaled-up mental health care and the best practices to achieve this.

Integration of mental health requires a vision, high-level commitment, allocation of resources, as well as oversight and support of the provinces in the implementation of mental health services. The vision is apparent in the South African Mental Health Policy and Strategy Plan – the implementation of this policy is the challenge that now lies ahead.

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Introduction

The prevalence of mental disorders is relatively high in South Africa, as reported in the 2003 South African Stress and Health (SASH) study.^{1,2} The SASH study reported a 12-month prevalence of 16.5% and a lifetime prevalence of 30.3% for depression and anxiety disorder in the adult South African population. Although anxiety disorders were most common, high rates of substance abuse were also reported.

Yet, in South Africa, it is estimated that 75% of people with a mental disorder do not receive mental health services.³ This is commonly referred to as 'the mental health treatment gap'. Addressing this treatment gap is key to ensuring equitable access to health care for people with mental disorder. This was clearly set out in Daar et al.'s Declaration on Mental Health in Africa: Moving to Implementation,⁴ which noted that people with mental disorders have psychosocial disabilities arising from their mental disorder, as well as from the stigma, discrimination and social exclusion that they, their families and their caregivers experience on a recurring basis. These psychosocial disabilities lead to difficulty with accessing health services, finding and keeping employment, obtaining adequate schooling, and engaging in social activities and development programmes.⁵

Mental disorders result in lower life expectancy and increased risk of co-morbid physical illnesses, and often result in limited access to appropriate general healthcare services.⁶⁻⁸ Furthermore, people with physical health conditions have increased risk of common mental disorders.^{9,10} In South Africa, mental disorder often co-occurs with and exacerbates what is known as the quadruple burden of disease,^{11,12} namely: maternal and child illnesses; infectious diseases such as HIV and TB; non-communicable diseases (NCDs) such as cardiovascular disease and diabetes; and injury. The following sections review existing data on the prevalence of mental and substance use disorders and their association with this quadruple burden of disease.

Maternal depression is common in South Africa, with prevalence ranging from 18% to 47% for antenatal depression¹³⁻¹⁶ and from 32% to 35% for postnatal depression.¹⁷ The consequences of maternal depression on maternal and child outcomes are well documented and include premature delivery and other birth complications, and delayed milestones for the children,¹⁷⁻¹⁹ as well as increased risk of suicide, substance and alcohol abuse and non-adherence to medical treatment regimens in mothers.^{13,20,21}

Research suggests a high prevalence of mental disorders among people living with HIV,^{22,23} as well as those diagnosed with TB.²³⁻²⁵ This is particularly important given the high prevalence of both TB and HIV in South Africa.²⁶ There is growing evidence of increased risk of HIV infection for people with mental disorders as well as an increased prevalence of mental illness in people living with HIV. There is also substantial evidence showing that mental and substance use disorders are associated with poor adherence to HIV and TB treatment.^{20,27-29}

In recent years there has been increasing acknowledgement of the growing prevalence of NCDs, such as cardiovascular disease, cancer, diabetes and chronic respiratory disorders, in low- and middle-income countries (LMICs).^{11,30} While there may be genetic antecedents of these conditions, there is growing evidence that behavioural factors such as diet, physical inactivity, smoking and

alcohol use play an important role in determining their onset and severity.^{10,31} Also, the comorbidity of mental health, neurological, and substance use (MNS) disorders and NCDs has adverse implications for the prognosis of both conditions, and affects mood-related quality of life, family relationships, adherence to medical treatment and the potential for suicidal ideation.³²

Finally, non-fatal injuries as a victim, perpetrator/protagonist or witness have serious mental health implications.³³ This is especially relevant in South Africa, where the South African Medical Research Council's Burden of Disease Unit found that interpersonal violence was the second leading risk factor for healthy years of life lost in South Africa, associated with an increased burden of mental disorders such as major depression and anxiety disorders, and also increasing harmful alcohol use.³⁴ The SASH study noted that having suffered an accident (20%) or physical violence (21%), having witnessed atrocities (4%) and having witnessed a death or someone else being injured (20%) accounted for the majority of the traumatic events experienced in the sample.³⁵ In addition, over half of the relative post-traumatic distress burden was accounted for by witnessing an injury event or death.³⁵

These issues are exacerbated in the context of elevated levels of poverty. Over one fifth of South Africa's population lives below the 'food poverty line', and with a Gini co-efficient of 0.65, South Africa has one of the highest rates of inequality globally.³⁶ Population mental health is shaped by the social and economic environment of a country,³⁷ and common mental disorders have been linked with a number of indicators of poverty in low- and middle-income countries, including low education level, food insecurity, inadequate housing, social class, socio-economic status and financial stress.³⁸

The relationship between poverty and mental health has often been conceptualised as a vicious cycle, with people living in poverty at increased risk of developing mental health problems due to factors such as increased levels of stress, exclusion, and reduced access to social capital, as well as physical factors such as malnutrition, obstetric risks, and exposure to violence.³⁹ Simultaneously, those with mental disorders are more likely to slide into poverty due to stigma and exclusion from social and economic opportunities,³⁹ the high cost of accessing treatment, or the loss of employment due to diminished productivity.⁴⁰ Up until recently, mental health was often omitted from national health and development policies.⁴¹

However, the National Development Plan, intended to guide development in South Africa until 2030, identified the need to bolster the network of professionals to treat and support people experiencing psychosocial problems.⁴² The recent national Mental Health Policy Framework and Strategic Plan adopted in 2013 also showed that the government was ready to integrate mental health in the South African health system, and reduce the mental health treatment gap and health burden.⁴³ Concerns remain, however, as to whether this plan is feasible and sustainable, and whether other activities and policies should be put in place for full integration of mental health into the health system. The aims of this chapter are therefore to provide an overview of the current policies and examples of health services research and implementation for mental health care in South Africa; to identify gaps; and to propose a way forward for policy, research and practice to facilitate the integration of mental health in South Africa's health system.

National policy development

In the post-apartheid era, significant strides have been made in national policy with respect to mental health. In 1997, the White Paper on the Transformation of the Health System included a chapter on Mental Health (Chapter 12), which stated:

A comprehensive and community-based mental health service should be planned and coordinated at the national, provincial, district and community levels, and integrated with other health services.⁴⁴

This signified a major departure from apartheid-era mental health policy and practice, which was focused largely on institutional and custodial care, with racial segregation of facilities. In the same year, the Department of Health issued Mental Health Policy Guidelines,⁴⁵ which provided a framework for provinces to develop their own mental health policies and plans. In 1997/1998, the Department of Health commissioned a study on mental health service norms and standards for South Africa.⁴⁶ This initially focused on severe psychiatric conditions, and was followed by further studies on norms for community mental health services,⁴⁷ and child and adolescent mental health services.⁴⁸ The Mental Health Care Act of 2002⁴⁹ was promulgated in 2004, and was a major piece of legislation reform in line with international human rights instruments and World Health Organization (WHO) guidelines. The 1997 Mental Health Policy Guidelines were reviewed a decade later⁵⁰ and showed limited implementation in provincial health services. This was attributed to the low priority given to mental health, scarcity of human resource factors, and reluctance on the part of provinces to be active in the implementation of guidelines.

In 2012, the Minister of Health convened a series of provincial Mental Health Summits (February–March 2012), attended by over 4 000 mental health stakeholders around the country. The purpose of these summits was to generate national consensus around policy priorities for mental health in South Africa. This culminated in a national mental health summit, held in Pretoria in April 2012 and attended by over 400 stakeholders. It was convened by the Minister of Health, and marked a substantial new policy commitment to the neglected area of mental health. Subsequently, a task team was convened by the Deputy Minister to draw up a national Mental Health Policy Framework and Strategic Plan, based on previous mental health research in the country, and the recommendations from the summits. This new policy was adopted by the National Health Council in July 2013.⁴³

Policy Framework and Strategic Plan

The South African Mental Health Policy Framework and Strategic Plan (referred to hereafter as the SA MH Policy) aimed to realise the integration of mental health care into a comprehensive primary health care (PHC) approach enshrined in the Mental Health Care Act of 2002.⁴⁹ The SA MH Policy sets out the key aims of integrating mental health care into PHC as follows:

- To scale up decentralised 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 disorder

- 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 disorder
- 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.⁴¹

Prior to this policy, the mental health services context was characterised by the treatment gap for mental disorders previously described. A situational analysis of public mental health services and policies in South Africa and its nine provinces undertaken in 2005⁵¹ showed weak policy implementation at provincial level, marked inequality between provinces in terms of available resources for mental health care, lack of routine data collection for monitoring, and reliance on mental hospitals rather than more decentralised services. At the time of drafting the SA MH Policy, mental health care services primarily involved dispensing medication for severe mental disorders, with little effort to detect and treat other mental disorders such as depression and anxiety. However, there were some changes noted, such as endorsement of the integration of mental health into primary health care with training of some PHC nurses, and integration within emergency management and ongoing psychopharmacological care for those patients with stabilised chronic mental disorders.⁴³

To meet the objectives of the SA MH Policy, the National Department of Health proposed the establishment of multidisciplinary mental health teams in health districts, starting with the National Health Insurance (NHI) pilot sites, with the inclusion of non-specialised mental health counsellors as part of the team. Challenges to the implementation of this policy remain the lack of financial and human resources, the limited number of evidence-based treatment protocols (other than medication) for disorders such as depression and anxiety, beyond medication, limited awareness of and negative attitudes towards mental disorders (which may limit health-seeking behaviours by people with mental disorders), and a low level of health-system readiness to integrate mental health care.^{52,53} The financing challenges to integration are discussed further under the heading 'Financing barriers', as any health system improvement will be premised on the availability of adequate financing.

International trends

The new South African policy reflects the response seen globally, especially since the 2007 landmark Lancet series on Global Mental Health, culminating in the final "Call to Action" paper, which urged governments to scale up mental health care and provided the targets, indicators and costs required to do so.⁵⁴ In 2013, the World Health Assembly adopted the WHO Global Mental Health Action

Plan,⁵⁵ which set clear targets and indicators for increasing policy commitment to mental health and scaling up mental health services globally between 2013 and 2020. Every two years, the WHO Atlas survey collects data for these indicators to assess the extent to which countries are making progress towards these targets.⁵⁵ The four major objectives of the action plan 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.

In 2015, mental health was also included in the United Nations (UN) Sustainable Development Goals. In the Health Goal of the declaration, the UN points out the importance of mental health for overall health and global development. It states that by 2030, the aim of all countries is to “reduce by one third premature mortality from non-communicable diseases through prevention and treatment to promote mental health and well-being” (target 3.4); “strengthen the prevention and treatment of substance abuse” (target 3.5), and implement “universal health coverage” (target 3.8). This is a major departure from the WHO Millennium Developmental Goals^{56,57} which largely ignored mental health, and represents a significant move forward in linking mental health with social and economic development.^{56,57}

Financing barriers

While the policy initiatives by the South African National Department of Health are promising, the general fiscal constraints in the country may affect the roll-out of mental health services. From an economic point of view, it costs South African society more not to treat mental disorder than to treat it.⁵⁸ Bearing this in mind, together with the recognised lack of financial resources in South Africa and other LMICs, this section introduces the need and potential options for sustainable financing.

Some of the most significant barriers to the delivery of mental health services in South Africa and other LMICs emerge in part as a result of insufficient resourcing.⁵⁹ The resulting treatment gap also has an economic and social impact that is far-reaching and critical to countries, both at the micro-economic and macro-economic levels.

While there is a lack of data available for mental health financing in South Africa – particularly for care delivered at the community, primary care and district hospital level(s) – available budget reports have indicated that Government is the main source of funding for care of severe mental disorders in the country, where an estimated US\$ 59 million of annual government spending flows to tertiary and specialised care facilities providing mental health services.^{59,60} In contrast to this, the total annual cost in lost income for people living with mental disorder amounts to US\$ 3.6 billion – dwarfing the annual government spending on mental health services.⁵⁸ Where treatments are accessed by patients, they are often inappropriate and involve indirect costs that are economically catastrophic for affected individuals and their families – even in contexts where

out-of-pocket payments are not part of the public service financing mix.^{44,61–63} For example, South African households with illness (including mental disorders) often spend over 10% of their household income on public health-related needs, much of this being for costs such as transport, care arrangements and management of complex healthcare needs.⁶⁴

With the recent release of the NHI White Paper, the South African NHI scheme has recognised the quadruple burden of disease in the country, with NCDs including mental illness playing a contributory role.⁶⁵ The proposals set out in the NHI White Paper already face major financing and implementation constraints because of low growth rates, prevailing drought and power shortages. The consequences of this are that health insurance for neglected health problems like mental health are likely to be relegated to the ‘back-burner’, making the National Mental Health Policy Framework difficult to implement. Aside from the financing structure of the proposed NHI, the content of the comprehensive package for insurance-holders should also be redefined to incorporate mental health, as well as substance abuse. Indeed, although the White Paper includes mental health services and health counselling services as part of the comprehensive package, it does not acknowledge the wide-ranging nature of mental disorders, from depression and anxiety through to psychosis and mood disorders. Therefore, while the NHI implementation is likely to improve mental health systems through enhanced infrastructure and augmented investment in primary and community care, it is still unclear whether access to mental health services will improve substantially. Without clarity on and explicit objectives for mental health service provision, it is unlikely that the mental health needs of South Africa will be adequately addressed.

The research consortium EMERALD (Emerging mental health systems in low- and middle-income countries) is currently attempting to address this gap.^a The project, which started in November 2012, seeks to improve mental health outcomes by enhancing health system performance. Specifically, the Project aims to identify key health system barriers to, and solutions for, the scaled-up delivery of mental health services in LMICs, and by doing so to improve mental health outcomes in a fair and efficient way. With respect to sustainable financing options for South Africa, the Project has three primary objectives in the South African context:

- to estimate the resource needs associated with an adequate and appropriate health systems response to the current burden of mental disorders;
- to quantify the resource distribution and household impacts of addressed and unaddressed mental disorders; and
- to provide sustainable options for how best to finance the estimated ‘price tag’ in a way that is feasible but also fair.

Efforts to integrate mental health into primary health care

Many factors have plagued the provision of mental health services in South Africa. The lack of human and financial resources to address the treatment gap remains evident.^{46,66,67} Despite the formulation of national policy and provision of guidelines, the limited resources that exist remain concentrated in large psychiatric hospitals with a predominantly vertical model of care. Given the global focus on the

a <http://www.EMERALD-project.eu>

integration of mental health into existing health platforms to address the lack of human resources, task-shifting or task-sharing has been proposed as a strategy to manage this shortfall.⁶⁸

The chapter by Spedding, Stein and Sorsdahl in the 2014/15 *South African Health Review*⁶⁹ provides an overview of task-shifting interventions for the management of mental disorders such as depression, anxiety and substance abuse. The emerging evidence suggests that this strategy has been successful in some instances. Box 1 contains examples of research initiatives and services which have focused on integrating mental health care into PHC and health programmes in South Africa.

Box 1: Research on integration of mental health into primary health care

Programme for Improving Mental Health Care (PRIME)

PRIME is a research consortium working in five LMICs (Ethiopia, India, Nepal, South Africa and Uganda) funded by the United Kingdom's Department for International Development (DFID).⁷⁰ In each country, a district demonstration site has been established to consult with local stakeholders and develop and implement a district mental healthcare plan. The South African site is a NHI pilot site recommended by the national Department of Health: Dr Kenneth Kaunda District in the North West Province. PRIME team members have been working with the Department of Health and local stakeholders to develop and implement the district mental health care plan. The South African plan is integrated with the Department of Health's chronic disease management approach, and includes core intervention packages at the healthcare organisation, facility and community levels, providing care for individuals with psychosis, depression and alcohol use disorder.⁵² PRIME-SA has worked to strengthen the mental health components of the Primary Care 101 (PC101) clinical guidelines, based on the WHO mhGAP Intervention Guide, as well as to provide counselling services for people with depression, and psychosocial rehabilitation groups for people living with severe mental disorder. The implementation of the plan is being evaluated through repeat facility detection surveys (to discern changes in the capacity of primary care staff to detect people with depression, and alcohol use disorders), cohort studies (to assess changes in clinical, functioning and economic outcomes), and a case study methodology (to assess the process of implementation). In addition, the PRIME team is working with the Department of Health to scale up the PRIME packages for depression in a large cluster-randomised controlled trial for people living with HIV and hypertension.⁵ This initiative addresses the need to integrate mental health care services within PHC through training and support of PHC nurses, primarily, and by identifying key steps in scaling up these services.

The Substance use and TRauma InterVention (STRIVE) model in the Western Cape

The treatment of substance use disorders is a public health priority, particularly in South Africa where the prevalence of these disorders is high. Efforts have been made to find ways to integrate the identification and treatment of individuals with these disorders into the emergency department services. In a recent randomised controlled trial, the effectiveness of a blended motivational interviewing–problem-solving therapy (MI-PST) was tested among patients presenting to emergency departments in the Western Cape.⁷¹ Results indicated that a blended MI-PST intervention was feasible to implement among patients presenting for emergency department services in South Africa. The preliminary findings also suggested promising outcomes for substance use and depression, although study design limitations reduced the interpretability and generalisability of the results. Should the intervention prove to be effective in subsequent research, the Western Cape Department of Health may consider rolling out this intervention to other emergency departments in the province. This initiative focuses on development of evidence-based treatment approaches that can be scaled up within emergency departments at all hospitals to address substance use disorders.

The Africa Focus on Intervention Research for Mental health (AFFIRM)

The AFFIRM project funded by the National Institute of Mental Health (USA) comprises a randomised controlled trial (RCT) which tests the effectiveness of a manual-based counselling intervention by trained lay counsellors for depressed pregnant women attending one of two Midwife Obstetric Units (MOUs) in Khayelitsha.⁷² Pregnant women were screened for depression and recruited into the trial if they scored 13 or higher on the Edinburgh Postnatal Depression Scale (EPDS). The intervention arm received six sessions of basic counselling by trained counsellors supervised and supported by a Master's-level mental health counsellor. The women allocated to the control arm received brief phone calls once a month for three months to assess basic health. The final results will be available towards the end of 2016, but anecdotal evidence suggests that women appreciated the contact and felt better able to cope with their pregnancy. Of note is the changing awareness of the midwives and the clinic psychiatric nurse on the extent of prenatal depression and the need for counselling services. If the RCT shows an effect from the counselling, then the RCT implementation provides a model for scaling up the implementation of this type of service. This piece of research addresses the need to develop task-sharing interventions for maternal depression that are feasible to scale up at all antenatal care services.

Integration of mental health services into chronic disease care

In South Africa, the integration of chronic disease and mental health services delivery has been slow due to limited knowledge of feasible, acceptable and effective collaborative care models.

The project entitled 'Strengthening South Africa's health system through integrating treatment for mental disorder into chronic disease care' (Project MIND) is presently investigating the feasibility, acceptability, effectiveness and cost-effectiveness of two collaborative care models for patients receiving chronic disease care (specifically HIV and diabetes) in the Western Cape: a vertical and horizontal model of care. In the horizontal model, within the chronic disease team, one or more healthcare providers are designated to provide mental health care. The mental health services are provided by designated personnel who are responsible for their usual chronic disease duties as well as mental health care. In the vertical model, services are provided by separate cadres of health providers, where mental health services are provided by dedicated personnel whose only responsibility is to deliver mental health care. This is a project currently under way and no results are published yet. However, Project MIND constitutes research that addresses not only the integration of mental health services within chronic care, but also the services and systems requirements for this to be achieved effectively.

^b The protocol for this COBAL T RCT is registered at <https://clinicaltrials.gov/ct2/show/NCT02407691>

Integration of mental health into primary care

Two current services where mental health care is fully integrated in the health system are described in Box 2.

Box 2: Examples of integration of mental health into primary care

The Perinatal Mental Health Project

The Perinatal Mental Health Project^c (PMHP) provides a stepped-care, collaborative model for delivering a mental health service at three MOUs in Cape Town.⁷⁵ Given that 99% of pregnant women attend antenatal care facilities for an average of 3.7 visits,⁷⁶ this provides an important opportunity to screen for common perinatal mental health problems, and provide integrated care. All women are offered psychosocial risk and depression screening at their first antenatal visit, and those who meet the criteria for being at risk are offered on-site, free-of-charge counselling with one of the trained PMHP counsellors. Two counsellors are nurses who were trained in counselling and the third counsellor has a BPsych degree; all three are supervised by a clinical psychologist. The counsellors conduct a detailed assessment and tailor their intervention according to the needs of the patient. This may include couple or family therapy, motivational interviewing, problem-solving therapy, psycho-education, and interpersonal and cognitive behavioural therapy. The counsellor is also responsible for co-ordinating referrals, as required, to a wide range of social support services. A small minority of women with severe symptoms are eligible for and accept referral to psychiatric services.

Several years of service delivery, with embedded monitoring and evaluation procedures, have resulted in the development of several design features that address access to care, stigma and mental health awareness. For example, the PMHP has conducted participatory capacity-building and training activities with all maternity care staff at the three MOUs to improve mental health literacy, empathic skills and self-care practices. This training has created an enabling environment for the sustained integration of the mental health services. The number of women screened has increased, as has the rate of uptake with a reduction in the loss to follow-up. While the programme is currently self-funded, the model of care developed by PMHP provides an example of the feasibility of integrating the content into existing maternal health care services. Challenges remain as to the funding model and the support structures required to ensure that the counsellors are effective and avoid burnout.

Thuthuzela Care Centres

The 24-hour Thuthuzela Care Centres^d offer services at primary- and secondary-level health facilities for the care of adults and children who have been sexually assaulted. These Centres were established under the mandate of the Sexual Offences and Community Affairs Unit of South Africa's National Prosecuting Authority, and a number of partners are involved in service provision. The Centres provide psychological support in the acute phase and beyond, while also providing access to physical care, forensic examinations and legal support.⁷⁷ To our knowledge, the psychosocial interventions provided have not been formally evaluated, and it is not clear whether these interventions are standardised or evidence-based. This is an example of a mental health care service provided within the healthcare system. However, the extent of its integration as a health services component remains to be seen. It does nevertheless show the possibilities of providing intersectoral services, in this instance between the justice and health systems.

HIV Counsellors

Additionally, a number of HIV counsellors have been trained and deployed in the South African health system as an integrated service within PHC. However, the current status of the counselling provided by these and other similar cadres does not appear to adhere to good counselling models.^{78,79} Their focus is on giving advice rather than addressing mental health disorders. Nevertheless, there is growing evidence that lay counsellors are able to provide good

and effective task-sharing interventions^{67,80,81} and the AFFIRM trial should provide further evidence on this nature.

Limitations

Although there are a number of effective evidence-based treatment interventions available in the South African and broader LMIC context, such as those described, these remain largely at the testing phase and need to be scaled up more broadly and their feasibility assessed. Many of the models are research-led, with access to resources that might otherwise not be available in primary care settings. Indeed, effective services, especially task-sharing models of services, require strong training, supervision and support structures to ensure high-quality services and retention of human resources. Stigmatisation of patients with mental or substance use disorders by healthcare workers may directly affect health-seeking behaviours of patients, and must also be addressed on an ongoing basis during training and supervision.⁷³

Furthermore, research shows that mental disorders can be detected through effective screening by trained non-professionals; however, we need more definitive evidence on optimal detection methods, including when and for whom screening might be appropriate.⁷⁴ This should be provided together with a well-functioning referral mechanism to ensure that those who require more specialised services are able to access these. Indeed, system strengthening is important to ensure continuity of care across primary, secondary and tertiary care, and access to medication and psychosocial care. Given the financial, systemic and human resources challenges that the South African health system faces, the scaling-up of research-related programmes is complex.

Conclusion

Progress has been made in South Africa with regard to integrating mental health into health systems. Recent South African policy developments show a high level of commitment by the National Department of Health, with the formation of the Ministerial Mental Health Advisory Committee in 2015. However, despite compelling evidence supporting the case for investment in mental health systems,⁵⁵ there exists a lack of understanding as to how investments in scaled-up mental health services can best be paid for in a way that is feasible, fair and appropriate within the fiscal constraints and structures of different countries.⁵⁹ Decision-makers should weigh up a number of additional, complementary financing mechanisms or strategies, in particular how to increase access at a cost that is affordable, not only for the South African economy as a whole, but also for the households or individuals who make use of services that are available.

The distal determinants of mental disorder such as unemployment, inequality and violence, the co-morbid nature of mental disorder, the high burden of disease, and the large treatment gap underscore the importance of an inter-sectoral response that goes beyond health care services. Neglecting mental health services not only affects people with mental disorders, but also people with mental disorders secondary to physical illness, affecting their treatment adherence and health-seeking behaviours. Therefore, an integrated approach to mental health care seems to be the most promising way forward. However, there remains limited evidence on the

c www.pmhp.za.org

d <http://www.thuthuzela.co.za/>

evaluation of models of integrated mental health care in South Africa and internationally. Although the integration of mental health into primary care is likely to present challenges, not doing so will result in mental health continuing to be underfunded and relegated to the margins. In particular, showing that integration can be both efficient and cost-effective is a fundamental step.

The examples of research projects and service initiatives described in this chapter show promise as effective interventions for mental disorders. They reflect strategies of integration into PHC such as using task-sharing together with a strong support structure for supervision and referral. Once effectiveness is established, the challenge of how to scale up of these interventions remains. Further research will be required to evaluate both the outcomes of scaled-up mental health care and the best practices to achieve this. These research studies utilise implementation science and health systems research methods and frameworks to ensure effective programmes. The PRIME project is starting to do this in the NHI pilot site in the North West Province.

Integration of mental health requires a vision, high-level commitment, allocation of resources, as well as oversight and support to the provinces for the implementation of mental health services. The vision is apparent in the South African Mental Health Policy and Strategy Plan – implementation of this policy is the task ahead.

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