

# "No Health without Mental Health": Challenges and Opportunities in Global Mental Health

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## Abstract

Mental health is an essential component of health, yet it is often not given the attention that it deserves as a global health and development issue. In this paper, we examine the global health context, including the substantial burden of disease, resources available for mental health, treatment gap, human rights issues, links between mental health and development, and economic impact of mental disorders. Then we consider recent actions taken at the global level to advance mental health as a global health issue. Finally, we look at South Africa as an example of a country that is ripe for change in its approach to mental health. This is a country with a high prevalence of mental disorders and a large treatment gap, yet it has a number of strengths on which to build a response to improving population mental health. We make suggestions as to how South Africa can move ahead on its mental health agenda, whilst also being a model for other countries in the region and across the globe.

**Key words:** Mental health; Mental disorders; Psychiatry; South Africa

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## Introduction

Mental health is an integral and essential component of health. The World Health Organisation Constitution states that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", and the UN General Assembly Resolution on the Right to Health declares that everyone should enjoy the "highest attainable standard of physical and mental health". Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In reality, however, mental health is often not given the attention it deserves as a global health issue. In this paper, we explore the global context of mental health,

with regard to the burden of disease, treatment gap, human rights considerations and economic impact. Finally, we will examine the mental health context of South Africa, a middle income country with growing political commitment to mental health, and consider how it can build upon its strengths to improve its response to mental health issues.

## The global mental health context

Mental disorders are prevalent across all countries and cultures. Globally, neuropsychiatric disorders make up 13% of the global disease burden.<sup>1</sup>

Depression is the third leading contributor to Disability-Adjusted Life Years. It is also the leading cause of burden of disease for women between the ages of 15 and 44 years in both high and low and middle income countries, while neuropsychiatric disorders account for 7 of the top 15 causes. By 2030 it is predicted that unipolar depression will be the second highest cause of disability in the world, ranking second in middle income countries after HIV/AIDS, and third overall in low income countries after HIV/AIDS and perinatal causes, as can be seen in Table I.<sup>1</sup> Worldwide, suicide is one of the three leading causes of death among people between the ages of 15 and 44 years, and the second leading cause of death in the 15-19 years age group.<sup>2</sup>

In spite of the heavy burden of disease, countries tend to

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**Table I: The leading causes of DALYs lost: predicted 2030 rankings**

	Ranking	Cause
World	1	HIV/AIDS
	2	Depression
	3	Ischaemic heart disease
High-income	1	Depression
	2	Ischaemic heart disease
	3	Alzheimers
Middle Income	1	HIV/AIDS
	2	Depression
	3	Cerebrovascular conditions
Low Income	1	HIV/AIDS
	2	Perinatal conditions
	3	Depression

allocate minimal resources to mental health. In 2011, the World Health Organisation published the Mental Health Atlas, a survey of the resources available to prevent and treat mental disorders, and help protect the human rights of people living with these conditions. The overall picture is one of grossly inadequate resources for mental health, with the distribution of resources across regions and income groups being substantially uneven. For example, it was found that, on average, mental health budgets of countries constitute only 3% of their total health expenditures. This trend towards allocating minimal resources to mental health care is particularly marked in low and middle income countries. Countries with fewer resources have smaller health budgets, from which they spend a lower percentage on mental health, thus resulting in a very few resources available in these settings.<sup>3</sup>

The Mental Health Atlas documents that in terms of human resources, the situation is much the same. Almost half of the world's population lives in a country where there is one psychiatrist (or less) to serve 200,000 people. Globally, nurses account for most health professionals working in the mental health sector. In fact, there are more nurses per 100 000 population working in mental health than all other human resources groups combined. For all human resource categories, there is a clear pattern whereby greater rates of human resources are observed in higher income countries. For example, there is a median rate of 0.05 psychiatrists (per 100,000 population) in low income countries, 0.54 in lower-middle income countries, 2.03 in upper-middle income countries, and 8.59 in high income countries.<sup>3</sup>

In addition to inaccessibility of treatment, people with mental disorders often face stigma and discrimination due to their health status and human rights abuses. In 2010 WHO published the Mental Health and Development Report, which outlined the extent to which they are often isolated from their communities, and as a result encounter restrictions in accessing health and social services as well as educational and employment opportunities. As a result, they are more likely to die prematurely compared with the general population.<sup>4</sup>

Indeed, mental health is also intricately linked to first six Millennium Development Goals, seen in Table II, which guide global development efforts. For example, in terms of Goal 1, it has been shown that people living in poverty are at increased risk of

developing mental health problems due to factors such as increased exposure to stress, and physical factors such as malnutrition, obstetric risks, and violence.<sup>5</sup> Those with mental illnesses are more likely to slide into poverty due to exclusion from social and economic opportunities, the high cost of accessing treatment, or the loss of employment due to diminished productivity.<sup>6</sup> In terms of Goal 2, research suggests that increasing levels of education may have a positive impact on mental health through improving one's social status, increasing earning capacity, or by providing protection from mental disorders through optimal brain development during childhood.<sup>7</sup> In terms of Goals 4, 5, and 6, the variety of physical health disorders associated with poor mental health was extensively explored by Prince and colleagues, under the often used phrase 'no health without mental health'.<sup>8</sup> In particular, poor maternal mental health is associated with a range of negative child health indicators such as poor nutrition, stunting, early cessation of breastfeeding, and diarrhoeal disease.<sup>9,10</sup>

**Table II: The Millennium Development Goals**

GOAL 1	Eradicate extreme poverty and hunger
GOAL 2	Achieve universal primary education
GOAL 3	Promote gender equality and empower women
GOAL 4	Reduce child mortality
GOAL 5	Improve maternal health
GOAL 6	Combat HIV/AIDS, malaria and other diseases
GOAL 7	Ensure environmental sustainability
GOAL 8	Develop a global partnership for development

Given these links with a range of developmental outcomes, it is clear that impact of the burden of disease of mental disorders is likely to have a devastating effect on the economic wellbeing of countries. At present mental disorders are, along with cardiovascular disease, the dominant contributor to the global economic burden of non communicable diseases (NCDs). Recent data suggests that the current global cost of mental disorders is US\$2.5 trillion, with this expected to rise to US\$6 trillion by 2030.<sup>11</sup>

**The global response**

The question remains, why are we investing so little in mental health care, given clear evidence of a large burden of disease, a massive treatment gap, the links between mental health and development, and the economic burden of disorders. Recent years have seen increased attention on this topic, with two landmark special series on Global Mental Health published in the Lancet in 2007 and 2011. In 2008 World Health Organisation launched the Mental Health Gap Action programme (mhGAP) to increase the commitment of governments, international organizations and other stakeholders to improving mental health, and to significantly increase coverage of mental health care.<sup>12</sup> Based on the real world context of limited resources, the mhGAP Intervention Guide was developed for use as a tool by non-specialist health workers to provide mental health care, and includes guidelines on integrated management of priority conditions which have been organised

into user-friendly protocols for clinical decision-making.<sup>13</sup>

More recently, further developments at WHO reflect a growing interest in and concern about mental health on a global level. In January 2012, the WHO Executive Board passed a resolution on mental health for the first time in more than a decade, urging member states to allocate appropriate priority and resources to mental health, and to develop policies and strategies within their countries that address mental health promotion, prevention of disorders, and early identification, treatment and support for people with mental disorders. In addition, WHO was requested to develop a mental health action plan to guide efforts to improving the global response for mental health, which was duly approved by the World Health Assembly at their annual gathering in May 2012.<sup>14</sup>

At country level, there have also been signs of a fresh appreciation of the importance of mental health to overall health and well-being. The recent National Mental Health Summit held in South Africa in April 2012 was a groundbreaking event for the country and set the Department of Health on a new course towards improving the mental health of all South Africans. With this high-level support, South Africa is in a good position to make real progress in improving mental health outcomes for its population, and moving forward, could set an important example for other low and middle income countries.

### **Mental health context in South Africa**

The mental health context in South Africa is complex. The South African Stress and Health Survey, conducted between 2002 and 2004 as a part of the World Mental Health Surveys, revealed that the lifetime prevalence of mental disorders is as much as 30.3%.<sup>15</sup> Recent estimates of maternal depression in the country have ranged from 39 to 47%, a great deal higher than expected rates in high income countries.<sup>16,17</sup> Limited data is available on the prevalence of child and adolescent disorders, although experts estimate a prevalence of 17% in the Western Cape province.<sup>18</sup> This high prevalence of mental disorders in South Africa is characterised by a range of contextual issues in the country. For example, South Africa has one of the highest HIV rates in the world, and research indicates that 43.7% of people with HIV in the country may have a mental disorder.<sup>19</sup> Non-communicable diseases, such as cardiovascular diseases and diabetes, are prevalent and have been linked with certain mental disorders.<sup>20</sup> Pockets of high levels of maternal substance abuse exist, meaning that up to 1 in 10 children presenting with features of foetal alcohol syndrome in some areas.<sup>21</sup> Violence and injury are the second leading cause of mortality and intimate partner violence in particular has reached epidemic proportions.<sup>22</sup>

Yet, as is the situation in many low and middle income countries, there is a massive mental health treatment gap. SASH data revealed that while over a quarter of people with a mental disorder have sought treatment in the last 12 months, only 5.7% had actually received mental health care from a formal service.<sup>23</sup> This is surprising, considering that South Africa has relatively well developed health infrastructure. The WHO Atlas report for South Africa reported that mental health care in South Africa is available through a range of services, including outpatient clinics, day treatment facilities, psychiatric beds in general hospitals, community residential facilities, and specialist psychiatric hospitals.<sup>24</sup> Previous research has shown that while the policy and legislative environment is supportive of decentralised mental health services, in reality this has been hampered by a lack of

resources at provincial and district level<sup>25</sup> meaning that there is still an over-reliance on centralised mental hospitals for mental health care in the country.<sup>26</sup> It also appears that there is wide variation between provinces in the budget and human resources available for mental health care.<sup>26</sup>

In addition, there are only an estimated 0.27 psychiatrists per 100 000 population, with the bulk of the mental health workforce made up mental health nurses, of which there are 9.72 per 100 000.<sup>24</sup> Mental health resources and service use are difficult to track due to limited mental health information available in the country. At present, no data is collected and reported on a systematic basis.

South Africa does have some important strengths on which to build ongoing improvements to the mental health care system. In addition to a relatively well developed network of health facilities and an existing specialist workforce, recent years have seen a steady growth in global mental health research programmes in South Africa, some with a particular focus on improving mental health systems.<sup>27,28</sup>

### **Conclusion**

There is still much work to be done in order to fulfill the maxim "No Health without Mental Health". Some suggested actions are outlined below:

#### **1. Increased resources for mental health**

As a starting point, resources for mental health need to be increased. This includes increasing budgetary allocation to reflect the burden of disease in the country. In addition, there is a need for an increased focus on health workers in the general health system to support the process of decentralisation of mental health care. Implementation of the mhGAP programme and training of staff with the mhGAP Intervention Guide will build the capacity of non-specialised staff to manage mental health within the general health system.

#### **2. Improving processes to get research into policy and practice**

There need to be increased efforts by both researchers and public service officials to collaborate in the development of a research agenda for the country and then use the evidence that is produced to implement improvements in mental health care at a national level. There is already some promising progress towards this way of working. For example, PRIME (PRogramme for Improving Mental health care) is a collaboration between research institutions and Ministries of Health in five countries in Asia and Africa, one of which is South Africa. In this project, which started in 2011, researchers are working in the North West Province to implement an adapted version of the mhGAP programme. Lessons from this research will be invaluable for scaling up services to other areas across the country.<sup>29</sup>

#### **3. Integrating mental health into other priority health programmes**

There are clear relationships between mental health and other priority health conditions, which provide an important point for intervention. Integration of mental health concerns into South Africa's relatively well-developed HIV management systems is one potential opportunity. Similarly, given South Africa's elevated prevalence of maternal depression and high coverage of antenatal care in the country, the feasibility of integration into the maternal health programme should also be investigated.

#### 4. Considering mental health within a developmental framework

There is already evidence that mental health interventions can improve economic outcomes<sup>30</sup> and given the links between mental health and various development indicators, it will be important to consider interventions to improve mental health within a developmental framework. A lack of progress in developmental targets within the country will continue to have a significant impact on mental health outcomes, while improving mental health at the population level would build individual, family and community level capacity in the country. This type of framework already exists in the country with regards to the response to the HIV epidemic, which could provide an effective model for the intersectoral response required moving forward.<sup>31</sup>

#### 5. Providing assistance to other countries within and outside Africa

Finally, South Africa is well-placed to provide assistance to other countries in developing their mental health systems. South Africa is one of the countries in Africa with a critical mass of mental health expertise that can be utilized to assist other countries within the region as well as across the world in their mental health planning and research. Engaging in this type of assistance to other nations would be of great benefit to South Africa too.

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