Mental health is integral to public health: A call to scale up evidence-based services and develop mental health research

The Global Burden of Disease studies documented the challenges posed by mental illness.[1] Mental illness comprised an estimated 12% of the global burden of disease in 2000, and is predicted to rise to 15% by 2020. Mental disorders comprise 5 of the 10 leading causes of health disability; it is predicted that, by 2030, unipolar depression will be the world's second most disabling health condition.[2]

The burden of mental illness in South Africa has gone unrecognised because of scarce population-based data. However, there have been important recent developments in measuring mental illness in this country. The South African Stress and Health (SASH) survey provided the first nationally representative psychiatric epidemiological data for common mental disorders in adults. About 16.5% of South Africans report having suffered from a common mental disorder (such as depression, anxiety and somatoform disorders) in the past year.[3] This finding is consistent with international data which show that 1 in 4 people suffer from a diagnosable mental disorder in their lifetime.[4,5] A review of existing studies revealed that 17% of children and adolescents suffer from mental disorders.[6] Mental illness affects people of all ages, and there are no differences between socially defined racial or cultural groups in mental disorder prevalence.[3,6]

The South African Medical Research Council (MRC)'s National Burden of Disease Study used disability-adjusted life years (DALYs) as a measure of health impact.[7,8] Neuro-psychiatric conditions were ranked third in their contribution to the overall burden of disease in South Africa, after HIV/AIDS and other infectious diseases.[8,9] The DALY is a summary measure of life lived with disability (YLD), and life lost due to premature mortality (YLL). Relative to mortality, mental disorders have a large morbidity component. In the YLD ranking for revised burden estimates, neuro-psychiatric conditions rank second. Eight neuro-psychiatric conditions were ranked among the top 20 single causes of disability, namely unipolar depressive disorders (2nd), alcohol abuse (6th), bipolar affective disorder (9th), schizophrenia (11th), drug abuse (14th), obsessive compulsive disorder (18th), panic disorder (19th) and epilepsy (20th). In the South African Comparative Risk Assessment (SA CRA), which estimated the contribution of 17 selected risk factors, mental health outcomes were identified for three risk factors: interpersonal violence, alcohol abuse and lead exposure.[10]

Although these studies highlight the large scale of mental illness in South Africa, they fail to capture the full extent of the interaction of mental disorders and other health conditions. Mental illness is an 'upstream' determinant of multiple health outcomes,[11] which include cardiovascular disease, diabetes mellitus, reproductive illness, substance misuse, tobacco use, unsafe sex, HIV infection, accidental injury and violent behaviour. Conversely, many health conditions increase the risk for mental disorders. Co-morbidity also complicates help-seeking behaviour, diagnosis and treatment. This is confirmed in one of the few local studies of its kind, in which up to 21% of attendees at a primary health care clinic in Khayelitsha (Cape Town) were found to have psychologically induced physical symptoms (so-called 'somatisation disorder').[12] As Prince *et al*. aptly state, there is '… no health without mental health'.[11]

Despite the difficulty in determining the exact expenditure on mental health services in South Africa, the funds allocated are not commensurate with the proportion of mental illness to the overall disease burden. The Mental Health Care Act of 2002 emphasises the rights of those with mental illness to equitable and accessible care. However, SASH data show that only 28% of people with severe or moderate common mental disorders accessed mental health professionals in the last 12 months.[3]

There appear to be two major reasons for inadequate resource allocation to mental health care in South Africa. Firstly, partly as a result of the lack of population morbidity data for mental illness, mental health budgets have been (and continue to be) primarily based on historical precedent. These demand and utilisation data grossly underestimate service needs, particularly for common mental disorders. Secondly, there is a widespread misconception that common mental disorders are difficult to diagnose and treat. In fact, common mental disorders can now be diagnosed with good reliability and validity, and their treatment is cost-efficient even in low- and middle-income countries.[13] Patel *et al*. assessed the evidence of interventions to prevent and treat selected mental health conditions and, among other findings, they concluded that depression can be treated effectively with low-cost antidepressants or psychotherapy; antipsychotic drugs are cost-effective interventions for people with schizophrenia; hazardous alcohol abuse can be dealt with effectively by providing brief interventions by trained primary care workers; and, for adults and children with chronic mental disabilities, community-based rehabilitative models provide low-cost care.[14] Furthermore, models have been developed for calculating the cost of scaling up these mental health services in low- and middle-income countries, and these can be readily adapted for South Africa.[13,15]

The Western Cape Burden of Disease reduction project demonstrated the link between mental illness and numerous social and economic difficulties, including poverty, unemployment, alienation, teenage pregnancy, domestic

violence and impaired family functioning.[16] This connection indicates the need to co-ordinate the planning of mental health interventions with other poverty alleviation and development strategies.[16-18] It costs our economy more to ignore the burden of mental disorders than to provide appropriate resources. The need to strengthen health care systems to provide mental health services by integrating care with programmes that are operational has been emphasised.[11] More must be done to ensure that the Mental Health Care Act is implemented and parity achieved for a long-neglected group of patients in South Africa.[19]

While there is ample indication of the burden of mental illness in South Africa and evidence highlighting the need to scale up effective services, there are gaps in the data to determine resource allocation at a local level. We propose that the following areas of research are needed simultaneously with service developments: Firstly, the methodology for calculating DALYs and collecting more population-based data in South Africa must be strengthened. DALY methodology should use recent local data and local expert consensus groups to determine the weight and duration of disabilities associated with specific mental disorders. Secondly, the evidence base for interactions between mental health and other health conditions needs to be increased.[11] Thirdly, trials examining the cost-effectiveness of a range of psychosocial and psychopharmacological interventions for mental disorders need to be conducted. Fourthly, the mental health consequences of wider social and economic development interventions should be evaluated. Finally, tools need to be developed for routinely monitoring mental health in South Africa. Routine surveillance needs to be developed to highlight areas of greatest need. The recent Global Mental Health series of review articles published in *The Lancet* proposes indicators for monitoring mental health in low- and middle-income countries, which could be readily adapted and applied in this country.[14] Routinely monitoring levels of mental illness in South Africa can be a vital tool for targeted interventions aimed at preventing the rapid increase in mental illness predicted by the World Health Organization, as well as a range of other economic, health and social challenges with which mental illness is associated.

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