



health

---

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## **National Mental Health Policy Framework and Strategic Plan 2023 – 2030**

# Table of Contents

<b>FOREWORD BY MINISTER</b> .....	<b>4</b>
<b>MESSAGE BY DEPUTY MINISTER</b> .....	<b>5</b>
<b>ACKNOWLEDGEMENTS BY DIRECTOR-GENERAL</b> .....	<b>6</b>
<b>ABBREVIATIONS</b> .....	<b>7</b>
<b>GLOSSARY</b> .....	<b>8</b>
<b>1. INTRODUCTION</b> .....	<b>14</b>
1.1 SCOPE .....	15
<b>2. CONTEXT</b> .....	<b>17</b>
2.1 EPIDEMIOLOGY .....	17
2.2 DETERMINANTS OF MENTAL HEALTH AND ILLNESS .....	18
2.3 COSTS OF MENTAL ILLNESS .....	20
2.4 EVIDENCE FOR PROMOTION, PREVENTION, TREATMENT, AND REHABILITATION .....	22
2.4.1 <i>Mental health promotion and prevention of mental disorders</i> .....	22
2.4.2 <i>Care, treatment and rehabilitation</i> .....	22
2.5 CURRENT SERVICE PROVISION.....	24
2.6 RECOMMENDED NORMS AND STANDARDS .....	26
2.7 POLICY AND LEGISLATION MANDATES .....	26
<b>3. VISION</b> .....	<b>28</b>
<b>4. MISSION</b> .....	<b>28</b>
<b>5. VALUES AND PRINCIPLES</b> .....	<b>29</b>
<b>6. AREAS FOR ACTION</b> .....	<b>34</b>
6.1 ORGANISATION OF SERVICES.....	34
6.2 FINANCING .....	38
6.3 PROMOTION AND PREVENTION.....	39
6.4 INTERSECTORAL COLLABORATION.....	40
6.5 ADVOCACY .....	41
6.6 HUMAN RIGHTS.....	42
6.7 SPECIAL POPULATIONS .....	42
6.8 QUALITY IMPROVEMENT .....	42
6.9 MONITORING AND EVALUATION.....	43
6.10 HUMAN RESOURCES AND TRAINING .....	43
6.11 PSYCHOTROPIC MEDICATION.....	44
6.12 RESEARCH AND EVALUATION OF POLICY AND SERVICES .....	45
<b>7. ROLES AND RESPONSIBILITIES</b> .....	<b>45</b>
7.1 MINISTER OF HEALTH.....	45
7.2 DIRECTOR-GENERAL .....	46
7.3 PROVINCIAL DEPARTMENTS OF HEALTH .....	46
7.4 DISTRICT HEALTH SERVICES .....	47
7.5 DESIGNATED PSYCHIATRIC HOSPITALS, CARE AND REHABILITATION CENTRES ...	48

7.6 OTHER SECTORS .....	49
7.7 NON-GOVERNMENTAL ORGANISATIONS .....	50
<b>NATIONAL MENTAL HEALTH STRATEGIC PLAN: 2023-2030.....</b>	<b>51</b>
<b>MECHANISM TO MONITOR IMPLEMENTATION.....</b>	<b>59</b>
APPENDIX 1: TERMS OF REFERENCE FOR KEY STRUCTURES .....	61
APPENDIX 2: INTER-SECTORAL ROLES AND RESPONSIBILITIES.....	65
<b>REFERENCES.....</b>	<b>70</b>

## **Foreword by Minister**

## **Foreword by Deputy Minister**

## **Acknowledgements by Director-General**

## Abbreviations

<b>ACT: Assertive Community Treatment</b>	<b>ADHD: Attention deficit/hyperactivity disorder</b>
<b>AIDS: Acquired Immunodeficiency Syndrome</b>	<b>CTR: Care Treatment, and rehabilitation</b>
<b>DHIS: District health information system</b>	<b>EDL: Essential Drug List</b>
<b>FAS: Fetal alcohol syndrome</b>	<b>GDP: Gross Domestic Product</b>
<b>HIV: Human Immunodeficiency Virus</b>	<b>ID: Intellectual Disability</b>
<b>IDP: Integrated Development Plans</b>	<b>LE: Life Healthcare Esidimeni</b>
<b>MEC: Members of Executive Councils</b>	<b>MHCA: Mental Health Care Act</b>
<b>MHCU: Mental Health Care User</b>	<b>MHRB: Mental Health Review Board</b>
<b>MNS: Mental, Neurological, and Substance Use Disorders</b>	<b>NDoH: National Department of Health</b>
<b>NGO: Non-Governmental Organization</b>	<b>NHI: National Health Insurance</b>
<b>NPO: Non-Profit Organization</b>	<b>PHC: Primary Health Care</b>
<b>SAHRC: South African Human Rights Commission</b>	<b>SUD: Substance Induced Disorders</b>
<b>TB: Tuberculosis</b>	<b>TRC: Truth and Reconciliation Commission</b>
<b>UN: United Nations</b>	<b>WHO: World Health Organization</b>

## Glossary

**Accessibility:** the practice of making information, activities, and/or environments sensible, meaningful, and usable for as many people with mental health needs as possible, including access to healthcare and psychosocial support.

**Administrator:** A person appointed in terms of section 59 to care for and administer the property of a person living with mental health condition and where applicable includes an interim administrator.

**Applicant:** A person or organization that is applying to provide a mental health service or operate a residential or day care facility.

**Assisted care, treatment, and rehabilitation:** The provision of health interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions.

**Assisted Mental Health Care User:** A person receiving assisted care, treatment and rehabilitation.

**Associate:** A person with a substantial or material interest in the well-being of a mental care user or a person who is in substantial contract with the user.

**Care and Rehabilitation Centres:** Health establishments for the care, treatment and rehabilitation of people with intellectual disabilities.

**Care and Supervision:** Any one or more of the following activities provided by a care giver or facility: (a) Assistance in dressing, grooming, bathing and other personal hygiene; (b) Assistance with taking medication; (c) Central storing and/or distribution of medication as stipulated by the South African Pharmacy Council; (d) Support users in accessing necessary health care service; (e) The implementation of measures to ensure the safety and security of users; (f) Supervision of programmes and activities for users; (g) Maintenance and/or supervision of users' assets or property; and (h) Monitoring weight, blood pressure and glucose level, body temperature, intake and or special diets.

**Care Worker:** Voluntary staff member, usually a lay person, at an NGO who provides basic health care, including mental health care, to the residents of that NGO.

**Care:** The holistic provision of mental health care users' physical, psychological, and material needs where they are unable to provide these for themselves in order to live quality life.

**Caregiver:** Any person who provides care to a person with a disability.

**Community health worker:** Any lay worker whose primary function is to promote basic health or the delivery of basic health services within the home or primary health care facility.



**Community-based care:** Care that is provided outside of institutional and hospital settings, as near as possible to the places where people live, work and study.

**Constitution:** The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996).

**Correctional Centre:** A centre as defined in section 1 of the Correctional Services Act.

**Correctional Services Act:** The Correctional Services Act, 1998 (Act No. 111 of 1998).

**Court:** A court of law.

**Criminal Procedure Act:** Criminal Procedure Act, 1977 (Act No.51 of 1997).

**Day care:** Provision of daytime training, supervision, recreation, and often medical services for children of preschool age, for the disabled, or for the elderly.

**Disability:** A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). This comes about as a combination of impairments, activity limitations and restrictions or barriers imposed by society.

**Facility:** A building or structure which is ordinarily used in the course of providing services.

**Forensic psychiatric evaluations:** Mental observations as defined in the Criminal Procedure Act.

**Head of Establishment:** A person who manages the establishment concerned.

**Health Care Professionals:** Individuals registered with the various health related Statutory Bodies who render health and any related care to improve and maintain the health status of all health care users within the Department of Health (as stipulated in the National Health Act no 61 of 2003).

**Health Care:** Outpatient and inpatient, medical care, dental care, mental health care, acute and chronic care provided by registered health care professionals.

**Health Establishments:** The whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services. This includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals.

**Health:** A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity

**Involuntary Care, Treatment and Rehabilitation:** The provision of health interventions for the period during which people are deemed incapable of making

informed decisions due to their mental health status and who refuse health interventions but require such services for their own protection or for the protection of others.

**Involuntary Mental Health Care User:** A person receiving involuntary care, treatment and rehabilitation.

**Medical Practitioner:** A person registered as such in terms of the Health Professions Act, 1974 (Act No. 56 of 1974) as amended.

**Mental Health Care Practitioner:** A psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide mental health care, treatment and rehabilitation services.

**Mental Health Care Provider:** A person providing mental health care services to mental health care users and includes mental health care practitioners.

**Mental health condition:** A condition that meets the criteria for a mental disorder as defined by WHO International Classification of Disease (ICD) or the Diagnostic and Statistical Manual of mental disorders (DSM) and is marked by significant distress and severe impairment in functioning.

**Mental Health Care User:** A person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of this person. This includes a user, state patient and mentally ill offender and where the person concerned is below the age of 18 years or is incapable of taking decisions, in certain circumstances may include:

1. A prospective user;
2. The person's next of kin;
3. A person authorized by any other law or court order to act on that person's behalf;
4. An administrator appointed in terms of the Mental Health Care Act, 2002 (Act No.17 of 2002); and
5. An executor of that deceased person's estate.

**Mental Health Status:** The level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis.

**Mental health:** A state of mental well-being that enables people to cope with the stresses of life, to realize their abilities, to learn well and work well, and to contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder.

**Mental Illness:** A positive diagnosis of a mental health related illness in terms of diagnostic criteria made by a mental health care practitioner authorized to make such diagnosis.

**Mentally Ill Offender:** An offender as defined in section 1 of the Correctional Services Act in respect of whom an order has been issued in terms of section 52(3) (a) of the Mental Health Care Act to enable the provision of care, treatment and rehabilitation

services at a health establishment designated in terms of section 49 of the Mental Health Care Act.

**Minister:** Minister responsible for health.

**National Department:** National department of health services within the national sphere of government.

**Occupational Therapist:** A person registered as such in terms of the Health Professions Act.

**Perinatal period:** The period during pregnancy (antenatal/prenatal), labour and up to one year after birth (postnatal).

**People with Disabilities/Persons with Disabilities:** Those who have long term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

**Prevention:** Interventions that not only prevent the occurrence of disease, such as risk factor reduction (primary prevention), but also arrest its progress (secondary prevention) and reduce its consequences once established (tertiary prevention). This includes addressing determinants of mental health problems before a specific mental health problem has been identified in the individual, group, or population of focus with the ultimate goal of reducing the number of future mental health conditions.

**Primary Health Care:** Essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound, and socially acceptable (Alma Ata Declaration, 1978). This approach is organised to reduce exclusion and social disparities in health, is people-centred, intersectoral, collaborative, and promotes the participation of all stakeholders.

**Primary Level Services:** The first level of contact for individuals seeking health care.

**Promotion:** Actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain mentally healthy lives and actions that create living conditions and environments that support mental health.

**Provincial department:** The department responsible for rendering health services within the provincial sphere of government.

**Psychiatric Hospital:** A health establishment that provides care, treatment, and rehabilitation services only for users with mental illness.

**Psychiatrist:** Means a person registered as such in terms of the Health Professions Act.

**Psychiatric nurse/ Mental health nurse:** Mental health practitioner who is a professional nurse that has been trained as a mental health care nurse specialist and is able to provide prescribed mental health care, treatment and rehabilitation services.

**Psychologist:** Means a person registered as such in terms of the Health Professions Act. This includes clinical, counselling, educational, industrial, neuropsychology and research psychologists.

**Psychosocial disability:** Disability that arises when someone with an impairment in mental, intellectual or psychosocial functioning interacts with various barriers that may hinder their full and effective participation in society on an equal basis with others.

**Psychosocial rehabilitation:** Mental health services that bring together approaches from the rehabilitation and the mental health fields, combining pharmacological treatment, skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities.

**Recovery model:** An approach to mental health care and rehabilitation which holds that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.

**Registered Counselor:** A person registered as such in terms of the Health Professions Act.

**Rehabilitation:** A goal directed process to reduce the impact of disability and facilitate full participation in society by enabling people with disability to reach optimal mental, physical, sensory and/or social functioning at during their lifespan.

**Remand detainee:** (a) means a person detained in a remand detention facility awaiting the finalisation of his or her trial, whether by acquittal or sentence, if such person has not commenced serving a sentence or is not already serving a prior sentence; and (b) includes a person contemplated in section 9 of the Extradition Act, 1962, (Act No. 67 of 1962), detained for the purposes of extradition; [Definition of “remand detainee” inserted by s. 1 (c) of Act No. 5 of 2011.

**Respite Care:** Temporary institutional care of the sick, elderly, or disabled person, providing relief for their usual carer.

**Review Board:** Mental Health Review Board established in terms of section 18.

**Secondary Care:** Specialist Care that may be rendered in a hospital or community-based setting following a referral from a primary care facility.

**Severe or profound intellectual disability:** A range of intellectual functioning extending from partial self-maintenance under close supervision together with limited self-protection skills in a controlled environment through limited self-care and requiring constant aid and supervision, to severely functioning and requiring nursing care.

**Social Integration:** The full integration into society of people with disabilities including action to reduce the environmental barriers that they experience. Social integration is the key measure by which one can assess whether people with psychosocial and intellectual disabilities enjoy their full rights and are treated equally to all other citizens.

**Social worker:** A person registered as such in terms of the Social Services Professions Act, 1978 (Act 110 of 1978).

**Standard:** A minimum measures or levels at which a service provider must operate and has a time, cost, quality, equity or quantity dimension and refers to quantitative and qualitative statements that describe and constitute acceptable or adequate performance or resources.

**State patients:** A person so classified by a court directive in terms of section 77(6) (a) (i) or (78) (6) (i) (aa) of the Criminal Procedure Act.

**Task shifting (also referred to as task-sharing):** The delivery of mental health care by non-specialist healthcare providers who are trained and supervised by specialist mental healthcare providers to do so.

**Tertiary Care:** Specialist care that is rendered at central hospitals.

**Voluntary care, treatment, and rehabilitation:** The provision of health interventions to a person who gives consent to such interventions.

**Volunteer:** Any person who works for an organization without being paid.

# 1. Introduction

The Republic of South Africa has reached the end of its most recent mental health policy (2013-2020). Revisions and adaptations are required to keep up with recent developments in mental health service delivery and the challenges the country has encountered in recent years.

During the period of the previous Mental Health Policy Framework (2013-2020), the Life Esidimeni disaster occurred. This tragedy serves as a reminder of how, despite the provisions of the Mental Health Policy and Mental Health Care Act in South Africa, basic human rights of people living with mental illness can be violated.

In addition to the Life Esidimeni disaster, in recent years the mental health of South Africans has been challenged by major developments, including the COVID-19 pandemic (and its related socio-economic consequences) and natural disasters, such as the KwaZulu-Natal floods disaster and droughts in the Eastern Cape and Western Cape. There also remain several ongoing challenges that face mental health in South Africa. In particular, mental health experts have consistently stated that the lack of implementation plans, staff shortages, and poor mental health financing pose the most significant challenges.<sup>1</sup> There is broad consensus that actions are required in a number of areas:

1. Better financing and planning of mental health care at all levels.
2. Greater integration of mental health into general healthcare. This is important because of high levels of comorbidity between mental health conditions and other communicable and non-communicable diseases, and to address stigma that is associated with mental illness.
3. Strengthening of mental healthcare across all provinces of the Republic to ensure equal distribution of resources as well as equal access to high quality mental healthcare – in particular by removing barriers to care.
4. Improving pathways to care – including the integration of traditional and spiritual healing as part of holistic service delivery.
5. Task-sharing strategies that seek to utilise available community resources to improve service delivery in the community.
6. Recognise that tertiary psychiatric services need to be developed urgently, and these should be incorporated into tertiary health care centres.
7. The need for community based mental health services with effective social reintegration programmes.

8. Improved and efficient forensic mental health services in the country.
9. Coordinated strategies to prevent suicide, including through reducing access to means of self-harm and providing early interventions for those at risk.
10. Strengthen care, treatment and rehabilitation for people who have made suicide attempts.
11. Strengthening prevention of and treatment for substance use disorders including the associated public health consequences.
12. Strengthening child and adolescent mental health services.
13. Developing mental health promotion and mental illness prevention programmes, particularly for key developmental life stages such as pregnancy, early childhood, adolescence and old age.
14. Strengthening public awareness of mental health and reducing widespread stigma against those who have a mental illness.

Therefore, a new national mental health policy and strategic plan based on sound evidence, shaped by a wide range of stakeholders, and providing a framework for action is urgently needed in South Africa. This policy sets out the provisions of a mental health system based on a public health approach and human rights principles.

The purpose of this policy is to guide national and provincial governments in mental health promotion, prevention of mental illness, care, treatment and rehabilitation. The interventions are intended to be comprehensive, addressing the full age range and covering all mental disorders and dual diagnoses such as co-morbid substance use disorders.

## **1.1 Scope**

The primary objective of the policy is to address all mental health conditions across the lifespan, highlighting the social determinants of mental health which cut across the roles and responsibilities of other government departments and other related stakeholders. These mental health conditions and behaviours include:

1. Common mental health conditions such as depression, anxiety, and substance use disorders.
2. Severe mental health conditions such as schizophrenia and bipolar disorders.
3. Neurodevelopmental disorders such as autism spectrum disorders, and behavioural disorders such as conduct disorder and attention deficit and hyperactivity disorders.

4. Neurodegenerative disorders like dementia, including Alzheimers Disease, vascular dementia and HIV related dementia.
5. Suicidality and self-harm.
6. Severe and profound intellectual disability accompanied by comorbid mental disorders.

Issues of substance abuse are not covered by this policy as these are catered for by the Health Sector Drug Master Plan in line with the roles of the health sector emanating from the National Drug Master Plan. This policy address substance use disorders insofar as there is co-morbidity with mental health conditions (dual diagnosis).

There is a notable overlap in the scope of the health department when it comes to providing prevention, care, treatment and rehabilitation for substance abuse. For example, the Department of Social Development provides rehabilitation services for people with substance use disorders (SUD) as provided for by the Prevention of and Treatment for Substance Abuse Act (2008), while the Department of Health provides related health services including providing treatment for withdrawal and dual diagnosis. The policy and legislative frameworks for SUD are set out in the Prevention of and Treatment for Substance Abuse Act (2008) and the National Drug Master Plan . There are essential co-morbidity issues between substance use and mental disorders, hence a need to coordinate services. The Department of Health committed itself during the Parliamentary debate of the Prevention of and Treatment for Substance Abuse Act (2008) to manage those individuals that present with co-morbid substance use and mental disorders in designated health facilities rather than referring them to the substance abuse treatment centres run by the Department of Social development.

Additionally, coordinated services are required to provide prevention measures; treatment of SUD, aftercare services and reintegration services; coordination of SUD intervention services to individuals, families, and communities, and SUD treatment and recovery. This is essential, especially because dual diagnoses are common among those with mental illnesses. Therefore, developing dual diagnosis units within healthcare facilities may be more cost-effective and prevent the disintegration of services.

Intersectoral commitment is a cornerstone of this policy and is essential to address the needs of people living with mental health conditions, and to prevent mental health conditions. For example, for neurodevelopmental disorders such as autism spectrum



disorders, the roles of various departments such as the Departments of Basic Education, Social Development and Health are essential to ensure that optimum and efficient care is provided to improve the quality of life and outcomes. Other examples include the need for collaboration with the Criminal Justice System on forensic mental health services across various platforms.

## 2. Context

### 2.1 Epidemiology

The burden of mental health conditions has increased globally in recent years.<sup>2,3</sup> The Global Burden of Disease study attributes nearly 15% of years of life lost to mental disorders, making mental illnesses one of the most significant causes of disability worldwide. Globally, mental disorders are responsible for more than 400 million Disability Adjusted Life Years (DALYs) per year, or 16% of all DALYs.<sup>4</sup> In South Africa, mental health disorders are the leading cause of DALYs, accounting for 13.8% of disease burden, higher than HIV (11.8%), and musculoskeletal disorders (10.4%)<sup>5</sup>

Findings from the Global Burden of disease estimates in South Africa found that 15.9% of South Africans have experienced a mental or substance use disorder in the previous 12 months (**Table 1**). A recent systematic review of the prevalence of mental health problems in adolescents living in sub-Saharan Africa reported that the median point prevalence was 26.9% for depression, 29.8% for anxiety, 40.8% for emotional and behavioural problems and 21.5% for post-traumatic stress disorder.<sup>6</sup>

**Table 1. 12-month prevalence of mental, neurological and substance use conditions, and intellectual disability in South Africa<sup>1</sup>**

Condition	%
Idiopathic developmental intellectual disability	1.7
Schizophrenia	0.2
Alcohol use disorders	1.6
Drug use disorders	0.7
Depressive disorders	3.9
Bipolar disorder	0.6
Anxiety disorders	3.8
Eating disorders	0.2
Autism spectrum disorders	0.8
Attention deficit/hyperactivity disorder	1.2
Conduct disorder	0.8
Total: Mental and substance use disorders	15.9

There is no evidence of differences between socially defined racial groups or cultural groups in the prevalence of mental disorders.<sup>7</sup> However, there are significant gender differences: women are at increased risk of developing depression and anxiety disorders, whereas men are at increased risk of developing substance use disorders.<sup>8</sup>

The burden of mental illness is felt not only through the primary presentations of mental disorders, but through its high co-morbidity with other illnesses.<sup>9</sup> As South Africa is a country with many complex and interacting healthcare needs,<sup>10</sup> mental ill-health features prominently in its high level of co-morbidity with infectious diseases, such as HIV/AIDS and tuberculosis;<sup>9</sup> its association with the growing burden of non-communicable diseases, such as cardiovascular disease and diabetes mellitus;<sup>11</sup> high levels of violence and injury;<sup>12</sup> and maternal and child illness.<sup>13</sup>

In the South African context, the relationship between HIV/AIDS and mental illness is particularly pertinent. Research in South Africa shows that, with high prevalence in both, mental illness and HIV coexist in a complex relationship.<sup>14</sup> Approximately 28 to 62% of people living with HIV suffer from mental illnesses. This population has a prevalence of depression ranging from 14 to 78%.<sup>15</sup> There is also evidence that emerging global communicable disease pose a great threat to mental health. COVID-19 is a classic example of how rapidly spreading infections can affect mental health. In addition to causing anxiety, depression, isolation, and other severe mental illnesses, COVID-19 pandemic also disrupted the delivery of services.<sup>2</sup> The prevalence of mental illnesses increased significantly during the pandemic compared to pre-pandemic times, with the global prevalence of depression and anxiety increasing by 25%.<sup>16,17</sup> In this light, planning for future pandemics and mental health service adaptation is essential, given our lessons from 2020/2021.

## **2.2. Determinants of mental health and illness**

Mental health has multiple biological, psychological, and social determinants. These determinants interact in a complex manner, to provide protection of mental health or increase the risk for the development of mental illness. For example, a combination of genetic vulnerability, childhood trauma and adverse living circumstances brought about by poverty may predispose a particular woman to a major depressive episode. Conversely, a combination of genetic resilience, supportive and stimulating childhood environment, and opportunities for learning, work and fulfilment of social roles are

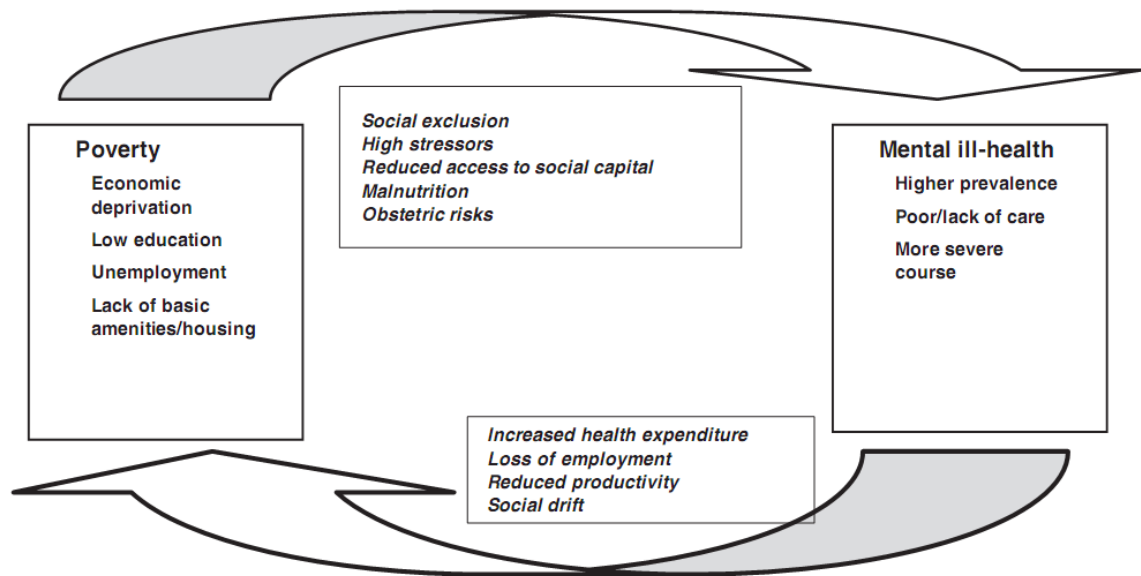
protective of a particular person's mental health. A person with mental illness may experience episodes of mental ill-health, which interrupts that person's capacity to fulfil their work, family, social, academic and community roles. The mental disorder might follow a chronic, episodic course, or may resolve after one or more episodes.

Most mental disorders have their origins in childhood and adolescence. Approximately 50% of mental disorders begin before the age of 14 years.<sup>18</sup> In South Africa, childhood adversity (which includes all forms of abuse, ranging from neglect to physical and sexual abuse) has been significantly associated with mood disorders,<sup>19</sup> and posttraumatic stress disorder, major depression and substance-related disorders each significantly increased the chances that learners did not complete secondary school.<sup>20</sup> Childhood and adolescent mental health is also influenced by contemporary issues such as sexuality, gender identity and social media issues all of which need to be considered in relation to their mental health.

The relationship between poverty and mental ill-health has been described as a "vicious cycle":<sup>21</sup> people living in poverty are at increased risk of developing mental disorders through the stress of living in poverty, increased obstetric risks, lack of social support, increased exposure to violence and worse physical health. On the other hand, those who live with mental illness are at increased risk of sliding into (or remaining in) poverty, as a result of increased health expenditure, lost income, reduced productivity, lost employment and social exclusion due to stigma (**See Figure 1**).<sup>22</sup>

In addition, environmental factors such as displacement, natural disasters, climate change, political turmoil, and social unrest are closely associated with increased risk for the development of mental disorders. The number of migrants in South Africa has increased continuously, whilst cross-sectional studies have shown a higher rate of mental illness associated with trauma and food insecurity in this population.<sup>23</sup>

**Figure 1: Relationship between Poverty and Mental ill-Health**



In South Africa, these patterns are worsened by the history of violence, exclusion and racial discrimination under apartheid and colonialism. The trauma and abuses meted out during the apartheid era have been well documented in the findings of the Truth and Reconciliation Commission (TRC) (Truth and Reconciliation Commission, 2000), as have the effects of these acts on the mental health of victims.<sup>24,25</sup> Ongoing realities of violence and crime also exert their toll on the mental health of South Africans, mostly through the trauma experienced by victims.

South Africa also has major challenges related to substance abuse (including alcohol, tobacco, cannabis, and illicit drugs). South Africa is ranked among the top 20 countries in the world for alcohol consumption, with a particular problem of heavy alcohol use among those who drink.<sup>26</sup> The prevalence of foetal alcohol syndrome ranges from 29 to 290 per 1000 live births, the highest prevalence in the world.<sup>27</sup> In the Western Cape there is a growing methamphetamine (tik) epidemic.<sup>28</sup> The consequences of these patterns of substance abuse include increased risk for mental disorders, crime and violence and motor vehicle injuries.

### **2.3 Costs of mental illness**

The cost of mental health conditions for the economy of South Africa is enormous, and includes costs to individuals and households. The impact of mental illnesses such as depression and anxiety have been estimated to cost the economy more than US\$3.6 billion (R61.2 billion) in lost earnings.<sup>29</sup> Certain conditions such as perinatal depression

and anxiety have lifelong cost consequences, for example it is estimated that the lifetime costs of perinatal depression and anxiety in South Africa amount to US\$2.8 billion (R47.6 billion) per annual cohort of births.<sup>30</sup> At a societal level, lost income associated with mental illness far exceeds public sector expenditure on mental health care.<sup>29</sup> In other words, it costs South Africa more to not treat mental illness than to treat it. There is growing evidence, from the national Investment Case for Mental Health in South Africa, commissioned by the Department of Health and the National Treasury, that there is a potential significant return on investment for scaling up mental health care. It is estimated that the economic value of restored productivity over a 15-year scale-up period (2020-2035) amounts to ZAR 60.2, and ZAR 117.7 billion when quantifying the social value of the investment.<sup>31</sup>

There is consensus that mental health remains underfunded in South Africa. The most recent data indicates that 5% of the total public health budget was allocated to public mental health expenditure in 2016/2017.<sup>1</sup> While the provincial public health budget allocation towards mental health showed marked inequality, ranging from 2.1 – 7.7% across provinces.<sup>1</sup> There is a need to improve efficiencies in the use of allocated budget and for provinces that are spending less than 5% minimum to gradually increase their mental health budget allocation towards strengthening of mental health services in those provinces.

The study also found that 86% of the mental health budget was allocated to inpatient care with almost half of all the total expenditure on mental health allocated to psychiatric hospitals. The cost is further exacerbated by the high re-admission rates of patients within three months which cost the public sector 18% of the total mental health expenditure.<sup>1</sup>

Social costs of mental illness can include disrupted families and social networks, stigma, discrimination, loss of future opportunities, marginalization, and decreased quality of life. Stigmatizing beliefs reported in South Africa include beliefs that people with mental illness are weak, lazy, mad, insane, not capable of doing anything or unable to think. Stigma is widespread among service providers, including healthcare workers and police.<sup>32</sup> The consequences of such inaccurate beliefs are that individuals who have been labelled as having mental illnesses are feared, ridiculed, or exploited.<sup>32</sup> There are also reports of individuals that have been neglected, isolated, rejected by family and peers, abused, or excluded from social engagement and basic rights

because of their mental illness. Stigma can thus act as a barrier to accessing health, education, employment, adequate housing, and other basic needs.

## ***2.4 Evidence for promotion, prevention, treatment, and rehabilitation***

### **2.4.1 Mental health promotion and prevention of mental disorders**

Mental health promotion and prevention initiatives remain crucial to reducing the burden of mental health conditions. They are also vital to promote and protect mental wellbeing of all people, including people not living with mental health conditions, children, adolescents and all those at risk. Prevention of mental illness and promotion of mental health also has an economic value through improvements in educational and labour market outcomes, and reducing the high cost of treatment when people become sick; thus demonstrating the instrumental argument for investing in prevention and promotion interventions.<sup>2</sup>

In resource constrained and high-risk contexts, mental health promotion and prevention initiatives which target key developmental stages can assist to break the cycle of poverty and mental ill-health through improving resilience and self-regulation in the context of widespread risk. These interventions are particularly important during childhood and adolescence given that most mental disorders have their origin in childhood and adolescence. There is an increasing body of evidence on the efficacy of mental health promotion and prevention interventions that target these key developmental stages.<sup>33</sup>

In relation to prevention, it is important to distinguish primary, secondary and tertiary prevention interventions. Interventions should not only prevent the occurrence of disease, such as risk factor reduction (primary prevention), but also arrest its progress (secondary prevention) and reduce its consequences once established (tertiary prevention).

### **2.4.2 Care, treatment and rehabilitation**

There are numerous cost-effective interventions for mental health that can be implemented at all levels of care. Depression can be treated effectively in low and middle-income countries with low-cost antidepressants and/or psychological interventions (such as cognitive behaviour therapy or interpersonal therapies).<sup>3</sup>

Collaborative models and stepped care provide a proven framework for integration of psychological and drug treatments.<sup>3</sup> Cost-effectiveness of interventions for depression in primary care settings are comparable to the cost-effectiveness of anti-retroviral treatment for HIV/AIDS.<sup>34</sup> For the treatment of schizophrenia, first-generation anti-psychotic medications are effective and cost-effective, and their benefits can be enhanced through community-based models of care.<sup>34</sup> In the Western Cape, Assertive Community Treatment (ACT) teams have shown a reduction in inpatient admissions and length of stay among people with severe mental illness, as well as improved user, family, and staff satisfaction.<sup>35</sup> In less resourced provinces, a group community-based rehabilitation model, such as that developed by Chatterjee et al in India for people with psychotic disorders, may be more appropriate.<sup>36</sup> This has been developed in some provinces, for example the Gauteng Province has established Clinical Teams and NGO Compliance Teams to improve clinical care and governance in the mental health system.

Brief interventions by primary care professionals can be effective for management of hazardous alcohol use, with some benefits evident from psychosocial and pharmacological interventions for alcohol dependence.<sup>34</sup> Evidence suggests that treatment of substance use and dual diagnosis is more effective when it is approached in an integrated way from a multi-disciplinary team perspective – for instance psychotherapy can commence with a person who is using substances, rather than waiting for the person to be clean before starting with treatment. There is strong evidence for the effectiveness of both pharmacological and psychosocial interventions for attention-deficit/hyperactivity disorder (ADHD).<sup>3</sup> Community-based rehabilitation models provide a low-cost integrative framework for the care of children with developmental disabilities.<sup>3</sup> There is strong evidence of the effectiveness of psychological treatment programmes for maternal mental illness,<sup>37</sup> and a local intervention has shown improvements in the quality of the mother-infant relationship and on security of infant attachment in the Western Cape.<sup>38</sup>

Several of these programmes are proven low-resource interventions, adopting a task-shifting approach. For example, a large cluster randomised controlled trial comparing ‘dedicated’ and ‘designated’ models of delivering mental health care in primary care clinics for people living with HIV and diabetes in the Western Cape found both to be effective in treating depression.<sup>39</sup>

## **2.5 Current Service Provision**

Current mental health service provision in South Africa, is marked by a number of features, as outlined in a situation analysis of the mental health system in South Africa;<sup>1</sup> and a number of other reports including the Report of the National Investigative Hearing into the Status of Mental Health Care in South Africa released by the South African Human Rights Commission in 2018.<sup>40</sup>

1. There is considerable under-investment in mental health in South Africa.
2. There is wide variation between provinces in the availability of services and resources for mental health.
3. Mental health services continue to labour under the legacy of colonial and apartheid era mental health systems, with heavy reliance on psychiatric hospitals.
4. Some progress has been made with the integration of mental health into general health care in some provinces.
5. There remain major shortfalls in human resources for mental health care (see Table 2). Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses. At the District level, while the integration of mental health care into primary health care used to focus on the emergency management and ongoing psychopharmacological care of patients with chronic stabilized mental disorders with little coverage of children and adolescents, or adults with depression and anxiety disorders, data from the District Health Information System have shown that primary health care facilities are now screening and initiating treatment for mental disorders. The recent allocation of a direct grant by the National Treasury for provinces to contract psychiatrists, psychologists, registered counsellors, social workers, and occupational therapists to complement the already available staff and render mental health services at primary health care should further strengthen the access and quality of mental health services rendered in primary health care.
6. There is an urgent need to further strengthen mental health training of general health staff and specialized mental health personnel including in child and adolescent and forensic psychiatry sub-specialities.
7. There are currently only five indicators for mental health on the District Health Information System, namely: mental health caseload, PHC mental disorders treatment rate-new, mental health separation rate, mental health involuntary admission rate and the recently added child and adolescent attempted suicide rate.



8. There is a coordinating body to oversee national public education and awareness campaigns on mental health and mental disorders in South Africa, namely the National Directorate: Mental Health and Substance Abuse, Department of Health. Provincial Departments of Health have at least one focal persons responsible for mental health services in the province.
9. A few consumer and family associations have been established in some provinces, often with the support of NGOs, such as the SA Federation for Mental Health and others. There are a few locally based, user run self-help associations.
10. Some important steps have been taken towards inter-sectoral collaboration, particularly at the national level. However, at the district level, and in many provinces, such inter-sectoral collaborations are the exception rather than the rule. There is a slow pace in instituting forums for people with lived experience of mental illness.
11. The situation is improving with the legal requirement that districts should produce Integrated Development Plans (IDPs) however few of these plans include mental health.
12. The emphasis on current spending for mental health falls on treatment and rehabilitation. There are few scaled up, evidence-based mental health promotion and prevention programmes, particularly in schools, where they are urgently needed.
13. Deinstitutionalisation has made some progress in South Africa, but without the necessary development of community-based services. Among other things, this has led to a high number of people living with mental illness facing housing insecurity, people living with mental illness in prisons and revolving door patterns of care.
14. Services for children and adolescents' mental health are severely lacking.
15. Substance use disorders treatment services are lacking and there is weak coordination between sectors.
16. The state of forensic mental health services in the criminal justice, health and correctional services systems is poor, due in part to weak inter-sectoral coordination.

**Table 2. Mental health human resources in South Africa<sup>1</sup>**

Profession	Number per 100,000 uninsured population
Psychiatrists	0.31
Sessional psychiatrists	0.02
Psychiatry registrars	0.01
Child psychiatrists	0.02
Child psychiatry registrars	0.01
Psychologists	0.97
Psychologists (Community Service)	0.26
Psychologist Interns	0.16
Medical Officers	18.3
Medical Officers (Community Service)	2.98
Medical Officer Interns	6.71
Occupational Therapists (Grades 1-3)	1.53
Occupational Therapists (Community Service)	0.61
Speech therapists and audiologists (Grades 1-3)	1.07
Social Workers	1.83
Professional Nurses	80.0
Professional Nurse Specialists	27.23
Professional Nurses (Community Service)	7.47

## **2.6. Recommended Norms and Standards**

Since the publication of the White Paper for the Transformation of the Health System in 1997, a series of Norms and Standards have been commissioned for mental health care in South Africa, by the Department of Health. These include:

- Norms for people with severe psychiatric conditions (2003)<sup>41,42</sup>
- Norms for community-based mental health care (2003)<sup>45</sup>
- Norms for child and adolescent mental health services (2004)<sup>46</sup>

## **2.7. Policy and legislation mandates**

This mental health policy is based on, and consistent with several existing policy and legislation mandates in South Africa. These include:

- The Constitution of the Republic of South Africa, 1996.

- The White Paper for the Transformation of the Health System in South Africa, 1997.
- Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000
- Guidelines for the licensing of residential and day care facilities for people with mental and/ or intellectual disability
- National core Standards for health establishments, 2011
- Disability Rights Charter of South Africa
- National patients' rights charter
- Employment Equity Act 55 of 1998
- National Health Act Guide, 2019
- Comprehensive Primary Health Care Package for South Africa.
- The National Health Policy Guidelines for Improved Mental Health in South Africa, 1997.
- National Health Act, Act 63 of 2003.
- Mental Health Care Act, Act 17 of 2002.
- Correctional Services Amendment Act 7 of 2021.
- Medicine and Related Substances Amendment Act 59 of 2002.
- Occupational Health and Safety Act, Act 85 of 1993.
- Pharmacy Act, Act 53 of 1974 as amended.
- Nursing Act, Act 33 2005.
- Health professions amendment act 29 of 2007.
- Choice on Termination of Pregnancy Act, Act 92 of 1996.
- Public Finance Management Act, Act 29 of 1999.
- The Children's Act, Act 38 of 2005.
- Prevention of and treatment for Substance Abuse Act, No. 70 of 2008.

- National drug master plan 2019-2024.
- Health Sector Drug Master Plan, 2019-2025
- Promotion of Access to Information Act, Act 2 of 2002.
- National Adolescent and Youth Health Policy, 2017.
- Integrated School Health Policy, 2012.
- Child and Adolescent Mental Health Policy Guidelines, 2003.
- Child Justice Act, Act 75 of 2008.
- Sexual Offences Act, Act 32 of 2007.
- Older Persons Act, Act 13 of 2006; and
- Criminal Procedure Amendment Act, Act 65 of 2008.
- White paper on the rights of persons with disability
- UN Convention on the Rights of Persons with Disability
- Non-communicable diseases strategic plan
- Special Needs Housing Policy
- Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

### **3. Vision**

Comprehensive, high quality, integrated mental health promotion, prevention, care, treatment and rehabilitation for all in South Africa by 2030.

### **4. Mission**

From infancy to old age, the mental health and well-being of all South Africans will be enabled, through the provision of evidence-based, affordable, and effective promotion, prevention, treatment, and rehabilitation interventions. In partnerships between providers, people with lived experience, carers and communities, the human rights of

people with mental health conditions will be upheld; they will be provided with care and support; and they will be integrated into normal community life.

## 5. Values and Principles

Values	Principles
Mental health is part of general health	<ul style="list-style-type: none"> <li>• Mental health care should be integrated into general health care.</li> <li>• People with mental health conditions should be treated in primary health care clinics and in general hospitals in most cases.</li> <li>• Mental health services should be planned at all levels of the health service.</li> </ul>
Human rights	<ul style="list-style-type: none"> <li>• The human rights of people with mental illness should be promoted and protected</li> <li>• The rights to equality, non-discrimination, dignity, respect, privacy, autonomy, information, and participation should be upheld in the provision of mental health care.</li> <li>• The rights to education, access to land, adequate housing, health care services, work, sufficient food, water, and social security, including social assistance for the poor, and environmental rights for adult mental health care users should be pursued on a basis of progressive realisation at the same level with other citizens. The non-conditional rights of mental health care users under the age of 18 years, including basic nutrition, shelter, basic health care services and social services, should be promoted and protected.</li> </ul>

Community care	<ul style="list-style-type: none"> <li>• Mental health care users should have access to care near to the places where they live and work.</li> <li>• Mental health care users should be provided with the least restrictive forms of care in line with their care, treatment and rehabilitation needs and within the prescripts of the law.</li> <li>• Local community-based resources should be mobilised wherever possible.</li> <li>• All avenues for outpatient and community-based residential care should be explored before inpatient care is undertaken.</li> <li>• A recovery model, with an emphasis on psychosocial rehabilitation within a biopsychosocial and spiritual approach, should underpin all community-based services.</li> </ul>
Accessibility and equity	<ul style="list-style-type: none"> <li>• Equitable services should be accessible to all people, regardless of geographical location, economic status, race, gender, or social condition.</li> <li>• Mental health services should have parity with general health services.</li> <li>• People with psychosocial, mental and intellectual disabilities should be given support to access care and services.</li> </ul>
Universal health coverage	<ul style="list-style-type: none"> <li>• The right to access quality mental and physical healthcare according to need and free of financial barriers, in keeping with Section 27 of the Constitution, the United Nations Convention on the Rights of Persons with Disability and the Sustainable Development Goals.</li> <li>• The right to access high quality care close to home (in keeping with the Mental Health Care Act). This should include care that improves</li> </ul>

	outcomes (personal functioning, wellbeing, and service related outcomes such as reduced readmissions).
Person-centred mental health care	<ul style="list-style-type: none"> <li>• Mental healthcare service should be tailored to the person's needs, severity of illness and level of disability</li> </ul>
Inter-sectoral collaboration	<ul style="list-style-type: none"> <li>• Addressing the social determinants of mental health requires collaboration between the health sector and several other sectors, including Education, Social Development, Labour, Criminal Justice, Human Settlements and NGOs.</li> </ul>
Mainstreaming	<ul style="list-style-type: none"> <li>• Mental health should be considered in all legislative, policy, planning, programming, budgeting, and monitoring and evaluation activities of the public sector.</li> </ul>
Preservation of life	<ul style="list-style-type: none"> <li>• Suicide prevention should be a core strategy, requiring partnerships between a range of government and civil society organisations.</li> <li>• The value of the lives of people living with mental, intellectual and psychosocial disabilities should be treated equally with all other citizens.</li> </ul>
Recovery	<ul style="list-style-type: none"> <li>• Service development and delivery should aim to build user capacity to return to, sustain and participate in satisfying roles of their choice in their community, within a person-centred approach.</li> </ul>
Respect for culture	<ul style="list-style-type: none"> <li>• There are varying cultural expressions and interpretations of mental illness, which should be respected, insofar as they protect the human rights of people living with mental health conditions and cause no harm.</li> <li>• People living with mental health conditions have a right to practice religious rituals and adhere to spiritual beliefs, in line with their culture.</li> </ul>

Gender	<ul style="list-style-type: none"> <li>• Services should be sensitive to gender-related issues experienced by all genders, inclusive of non-binary and transgender individuals</li> <li>• Services should be sensitive to gender-related issues experienced by men and women, and boys and girls.</li> </ul>
Social support and integration	<ul style="list-style-type: none"> <li>• Maximum support should be provided to families, carers, and communities of those with mental illness to broaden the network of support and care, including promoting wellness in the workplace</li> </ul>
Participation	<ul style="list-style-type: none"> <li>• People with lived experience of mental health conditions should be involved in the planning, delivery, and evaluation of person-centred mental health services.</li> </ul>
Self-representation	<ul style="list-style-type: none"> <li>• Mental health care users and their associates should have support to enable them to represent themselves.</li> <li>• The development of self-help, peer support and advocacy groups should be supported.</li> </ul>
Citizenship and non-discrimination	<ul style="list-style-type: none"> <li>• Mental health care users should be given equal opportunities and reasonable accommodation to ensure full participation in society.</li> <li>• Attitudinal, discriminatory structural barriers to full participation should be overcome. Their access to education, employment, housing, and social supports should receive particular attention.</li> </ul>
Efficiency and effectiveness	<ul style="list-style-type: none"> <li>• The limited resources available for mental health should be used efficiently, for maximum effect.</li> <li>• Interventions should be informed by evidence of effectiveness.</li> </ul>
Comprehensiveness	<ul style="list-style-type: none"> <li>• Mental health interventions should be directed at mental health promotion, the prevention of mental illness, care, treatment, and rehabilitation.</li> </ul>
Protection against vulnerability	<ul style="list-style-type: none"> <li>• Developmental vulnerabilities to mental health problems associated with life stages of infancy,</li> </ul>



	<p>middle childhood, adolescence, adulthood, and old age), as well as vulnerabilities associated with gender (including pregnancy), socio-economic position, ill-health and disability should be protected against through the provision of targeted prevention interventions.</p>
<p>Mental health exists on a continuum</p>	<ul style="list-style-type: none"> <li>• Understanding that mental health exists on a continuum implies the need to provide care according to a staging model, including promotion, and primary, secondary, and tertiary prevention. This means a shift in approach from hospital based care of acute episodes to preventative, community-based, multidisciplinary psychiatric care (early intervention, prevention of functional impairment, prevention of relapse, prevention of hospital admissions, prevention of abuse, exploitation, homelessness and incarceration). This implies that assisted, involuntary, and forensic admissions should be rare and a last resort (not the mainstay of care).</li> </ul>

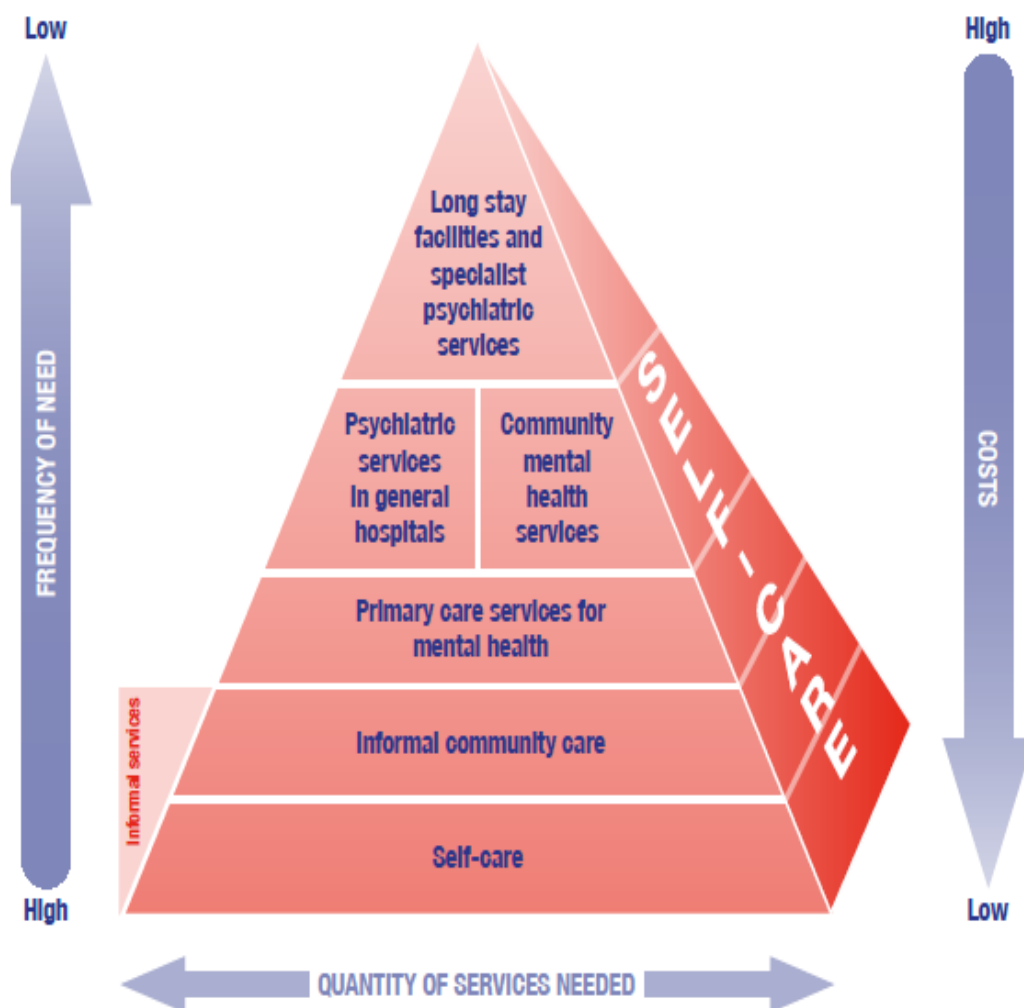
## 6. Areas for Action

All areas for action in this policy framework require a designated budget and clear monitoring mechanism. Implementation of these areas for action should be conducted with the relevant costing of these actions.

### 6.1 Organisation of services

In line with the World Health Organisation recommendations regarding organisation of mental health services, the mental health systems will include an array of settings and levels that include primary care, community-based settings, general hospitals, and specialised psychiatric hospitals.

**Figure 2: Services Organisation Pyramid for Optimal Mix of Services for Mental Health**



Source: World Health Organisation

1. **Community mental health services** will be scaled up, to match recommended national norms,<sup>45,47</sup> and will include three core components:
  - a. Community residential care (including mental health care users assisted living and group homes including halfway houses).
  - b. Day care services; and
  - c. Outpatient services (including general health outpatient services, mental health services in PHC and specialist mental health support).

These community mental health services will be developed before further downscaling of psychiatric hospitals can proceed. In accordance with the Mental Health Care Act (2002) NGOs, voluntary and consumer organisations will be eligible to provide and be funded for community programmes/facilities. This includes capacity development for users (service users, their families) to provide appropriate self-help and peer led services.

The regulatory environment for community mental health services will be strengthened in order to remove unnecessary barriers to the licensing of facilities, particularly community residential care facilities. It will do so whilst ensuring that care and rehabilitation services rendered in these facilities comply with safety and human rights standards and principles, are evidence-based, comply with legislation and promote optimal development and wellbeing of the mental health care users.

Over time, there will be a shift in specialised service resources to reduce stand-alone hospitals utilisation and increase community-based mental health care (thus increasing access to specialist assessment and care early in the course of illness), in keeping with the 2022 WHO World Mental Health Report.<sup>2</sup>

2. **The district mental health system** will be strengthened in the following areas:
  - a. Specified mental health interventions will be included in the core package of district health services, embracing a task sharing approach whereby trained non-specialist workers deliver evidence-based psychosocial interventions. This should include:
    - Medication monitoring and psychosocial rehabilitation within a recovery framework for severe mental illness.

- Detection and a stepped approach to management and referral of depression and anxiety and other disorders as outlined in the APC manual in PHC clinics.
  - Detection and management of child and adolescent mental disorders in PHC clinics and community level (e.g., schools), and referral where appropriate.
  - Routine screening for mental illness during pregnancy and other identified high risk group services, and a stepped approach to management and referral.
- b. District specialist mental health teams (see Appendix for Terms of Reference) will develop and implement District mental health plans, drawing on all available resources within the district, and using tools and lessons from South African innovations in district mental health care plans.<sup>48,49</sup>
  - c. Mental health training programmes for general health staff will be conducted at PHC level and district and regional hospitals, including training on the provisions of the Mental Health Care Act.
  - d. Mental health competencies will be included in the core competencies of all primary care staff.
  - e. Supervision systems will be put in place for mental health staff at PHC level.
  - f. Specialist mental health teams will be established to support non-specialist PHC staff and community-based workers.
  - g. Clinical protocols will be available for assessment and interventions at PHC level, through Integrated Management Guidelines, which will include mental health.
  - h. Community-based psychosocial rehabilitation programmes will be established in all Districts, using a task shifting approach, with clearly articulated roles for the relevant stakeholders in each district.
  - i. Mechanisms will be developed for inter-sectoral collaboration for mental health, led by the health sector and engaging a range of other sectors, for example through district level inter-sectoral mental health forums.
  - j. Inpatient units will be built in general hospitals.
  - k. Voluntary mental health care users that require admission will be admitted in terms of general health legislation.
  - l. Assisted and involuntary mental health care users will be admitted in terms of the provisions and procedures prescribed in the Mental Health Care Act as emergency admissions, or for 72-hour assessment of involuntary mental

health care users in facilities that are listed for this purpose. Further care, treatment and rehabilitation of such users will be provided at health establishments designated for this purpose in terms of the Mental Health Care Act.

- m. South African Police Services (SAPS) play a critical role in supporting involuntary admissions, and will receive regular training, including on the reduction of stigma against people living with mental health conditions.

### **3. Psychiatric services in general hospitals**

- a. Inpatient units will be provided in general hospitals to improve access for voluntary admission, assisted care, emergency mental health services, 72-hour assessment of involuntary mental health care users, further care, treatment, and rehabilitation.
- b. Voluntary mental health care users that require admission will be admitted in terms of general health legislation and general hospitals must provide mental health beds for this purpose, as well as mental health training for all general health staff.
- c. The psychiatric units that are attached to general hospitals must meet the criteria and be designated in terms of the Mental Health Care Act.
- d. The general hospitals that provide 72-hour assessment for involuntary mental health care must be listed as prescribed in the general regulations of the Mental Health Act, (Act No.17 Of 2002).
- e. Information regarding health establishments that provide 72-hour assessment for involuntary mental health care must be compiled, published and provided to relevant stakeholders to facilitate referral and access to services.
- f. Regular audits of inpatient mental health units in general hospitals will be conducted, to monitor and improve quality of care .

### **4. Specialised psychiatric hospitals**

- a. Further care, treatment and rehabilitation of mental health care users will be provided in specialised psychiatric hospitals.
- b. Provision of inpatient and limited outpatient mental health services.
- c. Functioning as centres of excellence that provide ongoing routine training, supervision, and support to secondary and primary health care services.
- d. Provision of some Tertiary psychiatric services.

- e. Provision of sub-specialist services, such as forensic psychiatry, child and adolescent, neuropsychiatry, geriatric psychiatry, and consultation-liaison psychiatric services.
- f. Specialised hospitals will provide forensic mental observation services as set out in the Criminal Procedure Act No. 51 of 1977 as amended. Section 41 and 49 of the Mental Health Care Act provides for designation of health establishments and procedures with regards to State patients and mentally ill offenders .
- g. Forensic mental health services also include the Child Justice Act and the Sexual Offence and Related Matters Amendment. Cases related to these can also be managed at the general hospital level (as is currently the situation), and has several advantages, including reducing the stigma for children and rape complainants.

## **6.2 Financing**

1. Mental health will be financed according to the principles adopted for all health financing in South Africa, and people will be protected from the catastrophic financial consequences of mental ill-health.<sup>50</sup>
2. In the financing of the National Health Insurance (NHI) system, mental health services will be given parity with other health conditions, in proportion to the burden of disease and evidence for cost-effective interventions. NHI will specifically include packages of care for mental health, in line with the evidence for the most cost-effective interventions.
3. Private medical aids should also be required to offer parity in their cover between mental health and other health conditions.
4. The limited financial resources available for mental health care will be used efficiently and informed by evidence of cost-effectiveness where possible.
5. Budget will be allocated to meet targets set for the implementation of the policy and regular discussions will be held with provinces to discuss strategies and monitor progress with implementation. At provincial level, mental health budgets will be reviewed annually to align mental health with national priorities, for each of the areas for action in 2023 and annually thereafter.
6. All provinces will develop provincial strategic plans for mental health, in keeping with national policy, which outline specific strategies, targets, timelines, budgets and indicators in 2023 and annually thereafter, informed by specific unique local challenges.<sup>51</sup>

### **6.3 Promotion and prevention**

1. Mental health will be integrated into all aspects of general health care, particularly those identified as priorities within the 10-point plan e.g., TB, HIV and AIDS and maternal and child health.
2. Mental health promotion and prevention initiatives will be integrated into the policies and plans of a range of sectors including, but not restricted to, health, social development, and education.
3. Distal protective influences will be promoted through advocating for and supporting existing macro-level policies which are mental health promoting such as the Child Support Grant, National Integrated Plan for Early Childhood Development, Integrated School Health Policy and the Integrated Nutrition Programme; as well as promoting the improvement in policies to ensure adequate education (including for learners with learning disorders), skills development, employment opportunities, housing, and services.
4. Comprehensive suicide prevention programmes will be implemented at national and provincial level in collaboration with relevant stakeholders, and include reducing access to means of suicide, providing general public information about mental health and suicide prevention, and providing early interventions for those at risk of suicide and self-harm.
5. Specified micro and community level mental health promotion and prevention intervention packages will be included in the core services provided across a range of sectors to address the psychosocial challenges and vulnerabilities associated with the different lifespan developmental stages. These will include:
  - a. Motherhood
    - Treatment programmes for maternal mental health as part of the routine antenatal and postnatal care package
    - Programmes to reduce alcohol and substance use during and after pregnancy
  - b. Infancy and Early childhood:
    - Programmes to increase maternal sensitivity and infant–mother attachment
  - c. Middle childhood:
    - Parenting programmes for caregivers of at-risk children
    - Programmes to strengthen school connectedness

- Programmes to prevent adverse childhood experiences, including through improved law enforcement and child protection.
- d. Adolescence:
- Life skills programmes in schools
  - Prevention of school dropout
  - Suicide prevention programmes in secondary schools
  - Substance abuse prevention programmes in secondary schools
  - Support regarding gender and sexual identity
  - 'Out-of-school' programmes
- e. Adulthood and older people
- Social support programmes

### ***6.4 Intersectoral collaboration***

1. The Department of Health will engage non-health sectors (such as Education, Social Development, Labour, Criminal Justice, South African Police Service, Housing, Agriculture and NPOs), as well as for-profit organisations, to ensure that an inter-sectoral approach to mental health is followed in planning and service development.
2. The Department of Health will liaise with the Department of Social Development and other relevant departments to include the poverty-mental health link on the policy agenda. This focus area will be integrated into policies and programmes of all sectors involved in poverty alleviation and community upliftment. This includes addressing the social determinants of mental illness, by improving daily living conditions and reducing inequalities, and evidence-based support to promote recovery<sup>50</sup> and inclusion of people with mental disability in general community life, such as access to: education and skills development; income generation opportunities for users, and reasonable accommodation provisions in the workplace; social insurance where income generating work is not possible for the user; housing support; and transport.
3. The Department of Health will collaborate with stakeholder departments such as Correctional Services, Justice and Constitutional Development, Social Development, National Prosecuting Authority, Legal Aid South Africa and the South African Police Service in planning, coordinating and rendering forensic mental health services including forensic mental observations, the management of State patients and mentally ill prisoners, as well as criminal capacity assessments of minor offenders in terms of the Child Justice Act.



## **6.5 Advocacy**

1. The Department of Health will engage with a range of stakeholders who lobby for political support for mental health on the public agenda. This will include discussion regarding the importance and place of mental health within the broader disability agenda, and within other development priorities and public concerns will be better articulated.
2. The Department of Health will engage with other non-health sectors, such as the Ministry of Women, Youth and Persons with Disabilities and people with lived experiences of mental illness, with a view to strengthening the place of mental health within the broader disability agenda and improving the rights of persons living with psychosocial disabilities.
3. In its role as the leading Department in Public Education regarding mental health, the Department of Health will give exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health to change discriminatory attitudes toward mental illness. This work will be framed within the provisions of the UN Convention of the Rights of Disabled Persons and the human rights based framework of South African law, as well as advocacy guidelines from the WHO.<sup>2</sup> The development and distribution of advocacy strategies and media guidelines will support this work.
4. The Department of Health will also engage with mental health care users and family associations in policy development and implementation, as well as the planning and monitoring of services. Emphasis will be placed on ensuring representation of people with psychosocial disabilities on the broader disability agenda and developing capacity to place mental health user concerns on the political, development and public health agenda.
5. The Mental Health Review Boards in each province will, as stipulated in the Mental Health Care Act, play a key role in upholding and protecting the human rights of mental health care users and contribute in advocating for the needs of mental health care users in line with their functions as prescribed in the Mental Health Care Act, 2002.
6. Work with the Department of Monitoring and Evaluation for monitoring and accountability on the implementation of the policy imperatives for each stakeholder department highlighted in this policy framework.

## **6.6 Human rights**

1. The human rights of people living with mental illness will be promoted and protected, through the active implementation of the Mental Health Care Act (2002).
2. The Department of Health will work closely with the Ministry for Women, Youth and Persons with Disability to ensure that provisions of the UN Convention on the Rights of Persons with Disabilities (2007) are actively implemented for persons with mental disability in South Africa.
3. The Department of Health will also closely collaborate with the South African Human Rights Commission (SAHRC), to ensure protection of human rights of people living with mental health conditions, as per the recommendations of the SAHRC in the Report on the Investigative Hearing of the Status of Mental Health Care in South Africa, 2019. This is essential to ensure adequate governance and accountability for the protection of the human rights of people living with mental health conditions.

## **6.7 Special Populations**

Certain vulnerable groups will be targeted for specific mental health needs. These include women, children, adolescents, the elderly, LGBTI++ groups, those that have come into contact with the Law and those living with HIV/AIDS, TB, Cardiovascular diseases, Diabetes and other chronic diseases.

## **6.8 Quality Improvement**

1. Quality improvement initiatives for mental health will be aligned with other general Department of Health's quality initiatives.
2. Guidelines will be developed for safe and effective mental health services within regional and district hospitals as part of the health facility quality norms and standards.
3. Existing Infrastructure norms will be used to routinely assess and accredit public and private mental health facilities and for infrastructure quality improvement mechanisms.
4. The functions of licensing and designation of facilities will be yoked to quality improvement mechanisms.
5. A monitoring and evaluation system will be established at all levels to help shape changes in policy and programmes.

## **6.9 Monitoring and Evaluation**

1. National and provincial mental health indicators will be integrated with the district health information system (DHIS) and at all levels, based on a set of nationally and provincially agreed indicators and a minimum data set.
2. Information gathered from the information system will be used for routine planning and management of mental health services at all levels.
3. Data generated from the information systems will be used to assess the performance of the mental health system against agreed norms and standards to ensure high quality care.
4. Future reforms of mental health policy will draw on information systems' data.
5. A culture of information use for mental health service development will be promoted, through capacity development activities addressing the various stages of collection, processing, dissemination, and use of mental health information.

## **6.10 Human Resources and Training**

1. All health staff working in health settings will receive basic mental health training, inclusive of anti-stigma training, and ongoing routine supervision and mentoring.
2. The expansion of the mental health workforce will be actively pursued by all provincial Departments of Health.
3. A task-shifting approach will be used in the development of the mental health workforce, whereby trained non-specialist workers deliver evidence-based psychosocial interventions, with supervision and support from specialists.
4. Capacity will be developed for staff in the National Directorate: Mental Health and Substance Abuse, and the provincial mental health coordinators in policy development, planning, service monitoring and the translation of research findings into policy and practice.
5. Psychologist, Occupational Therapist posts will be prioritised in line with available resources
6. In provinces where Registered Counsellors are not in permanent posts on the DOH staff establishment, permanent posts will be made available in primary care settings as per their competencies.
7. The District Specialist Mental Health Teams will be capacitated on the fulfilment of their mandates espoused in this policy document.

8. At the district level, non-health related public sector workers and civil society partners, including user-led service providers who can contribute to mental health care in the district will have access to basic training in mental health.
9. In relation to other sectors, such as Departments of Labour, Transport, Education and Social Development, key policy and management staff will be sensitised on mental health and their respective Departments' role, including raising awareness and education on reducing stigma against people living with mental illness.

### ***6.11 Psychotropic Medication***

1. All psychotropic medicines, as provided on the standard treatment guidelines and essential medicines list (EML) will be available at all levels of care, including PHC clinics.
2. Medication stockouts will be carefully monitored and minimised.
3. Psychotropic medication will be closely monitored to facilitate down referral from hospital care.
4. Drug interactions with other medications will be carefully monitored in all treatment of mental health conditions.
5. The use of psychotropic medication should be carefully monitored and evaluated, in line with broader quality improvement mechanisms in the Department of Health.
6. Nurse initiated prescription of anti-depressants such as fluoxetine will be explored by the relevant regulatory bodies.
7. Service users should be informed about the medication they are prescribed, understand any side effects, understand choices that they have in relation to medication and be included in their treatment planning.
8. The EML will be updated periodically, in keeping with new evidence from research.

## **6.12 Research and Evaluation of Policy and Services**

1. A national mental health research agenda will be developed based on identified priority areas.
2. A framework will be developed for the routine periodic evaluation of mental health services, which will be used for ongoing planning and service delivery by all provinces.

## **7. Roles and Responsibilities**

The roles and responsibilities are consistent with the roles as set out in the Constitution and the National Health Act. The roles of the Minister of Health, MECs, Heads of Health at National and Provincial level, the National Health Council, Provincial Health Councils and District Health Councils are set out in the National Health Act. The roles and responsibilities as articulated in this document pertain only to mental health functions within this overall structure.

### **7.1 Minister of Health**

1. Developing national mental health policy and legislation, in consultation with a range of stakeholders.
2. Advocate for increased funding for health services including mental health services.
3. Liaise with the Ministry of Women, Children and Persons with Disabilities to support inclusion of persons with mental disability in disability related policies and programmes.
4. Monitoring and evaluating the implementation of policy and legislation, in relation to specified targets and indicators.
5. Evaluating the prevalence and incidence of mental illness.
6. Identifying and driving the implementation of key priority areas, namely:
  - Child and adolescent mental health.
  - Community-based services within a psychosocial rehabilitation and recovery framework.
  - Detection and management of common mental disorders (e.g., depression and anxiety disorders) at PHC level.
  - Mental health promotion and prevention.
  - Forensic Mental Health Services

- Mental Health Infrastructural issues
7. Promoting research in priority areas, and utilising research evidence to inform policy, legislation, and planning.
  8. Facilitating an intersectoral approach to mental health, through engagement of other sectors, and providing leadership on health matters to other sectors.
  9. Facilitating equity among provinces in mental health service provision.

## **7.2 Director-General**

1. Developing national strategic plans for mental health, in collaboration with provincial health services, and in consultation with a range of stakeholders.
2. Develop guidelines for human resources for mental health.
3. Issue guidelines for planning and delivery of evidence-based mental health services within the prescripts of legislation.
4. Developing and implementing norms and standards for mental health care.
5. Developing and monitoring the implementation of clinical guidelines for mental health at all service levels.
6. Periodic review of the implementation of this national Mental Health Policy Framework and Strategic Plan.

## **7.3 Provincial Departments of Health**

1. Translation of national policy into provincial strategic and operational plans, which include clear targets, indicators, budgets, and timelines.
2. Allocation of consistent and sustainable budget for the implementation of this Mental Health Policy Framework and Strategic Plan.
3. Monitoring and evaluation of the implementation of national mental health policy and legislation at provincial level.
4. Provision of a sustainable budget for mental health services, keeping parity with other health conditions, in proportion to the burden of disease, and evidence for cost-effectiveness.
5. Working closely with district health managers to promote the equitable provision of resources and services for mental health at district level.
6. Consulting with a range of stakeholders in the planning and delivery of services.
7. Integrating mental health indicators into the Provincial Indicator Data Set (PIDS), for the routine monitoring and evaluation of mental health care.

8. Facilitating inter-sectoral collaboration, to bring together all sectors involved in mental health, including Education, Social Development, Labour, Criminal Justice, Housing, Agriculture and NGOs, among others through establishment of provincial mental health stakeholders' forums.
9. Ensuring the integration of mental health care into all health services, particularly within the district health system.
10. Expanding the mental health workforce in all provinces.
11. Building capacity for provincial health management in mental health planning, service monitoring and the translation of research findings into policy and practice.
12. Establishment of a Mental Health Directorate in each province, with responsibility for both community and hospital based mental health services as well as mental health promotion and prevention and intersectoral collaboration.
13. Reporting to the national Department of Health on a quarterly basis, regarding the implementation of this Mental Health Policy Framework.

#### **7.4 District Health Services**

1. Providing mental health promotion and prevention interventions, in keeping with national and provincial priorities.
2. Integration of mental health care within PHC at all facilities.
3. Inclusion of mental health in the core package of district health treatment and rehabilitation services:
  - Routine screening for mental illness during pregnancy, and provision of counselling and referral where appropriate.
  - Medication monitoring and psychosocial rehabilitation within a recovery framework for severe mental illness.
  - Detection of mental illness and management of common mental disorders (e.g., depression and anxiety disorders) in PHC clinics, and referral where appropriate; and
  - Detection and management of child and adolescent mental disorders in PHC clinics and schools, and referral where appropriate.

4. Providing emergency care (24 hour) and 72-hour assessment services in designated District and Regional Hospital Inpatient settings, as set out in the Mental Health Care Act (2002).
5. Conducting mental health training programmes for all general health staff for basic screening, detection, and treatment, as well as referral of complex cases.
6. Establishing and maintaining mental health supervision systems for health staff at PHC level.
7. Establishing and maintaining specialist mental health teams to support PHC staff.
8. Establishing and maintaining referral and back-referral pathways for mental health.
9. Implementing clinical protocols for mental health assessment and interventions at PHC level.
10. Establishing, strengthening, supporting and maintaining community-based mental health services programmes, through trained community health workers.
11. Developing intersectoral collaboration between a range of sectors involved in mental health, through the establishment of District Multi-Sectoral Forum for mental health.
12. Undertaking mental health education programmes in communities.
13. Improving the capacity of District Health Management teams for planning, implementing, supervising, monitoring and evaluation of mental health programmes at district and community levels.
14. Provision of psychotropic medication to all appropriate levels of the district health system, as determined by the essential medicines list.
15. Focus on substance abuse care, treatment, and rehabilitation:
  - Establishing a dual diagnosis treatment program within PHC in line with the available resources including referral where appropriate.
  - Link with DSD to establish services for patients referred from DSD for medical assessments before admission to substance abuse rehabilitation facilities.

### ***7.5 Designated Psychiatric Hospitals, Care and Rehabilitation Centres***

These are mental health units that are attached to general hospitals as well as specialised psychiatric hospitals designated in terms of section 5 of the Mental Health Care Act. Key functions include:



1. Provision of inpatient and limited outpatient mental health services.
2. Functioning as centres of excellence that provide ongoing routine training, supervision, and support to secondary and primary health care services.
3. Provision of sub-specialist services, such as forensic psychiatry and child and adolescent services.
4. Psychiatric hospitals will provide forensic psychiatric observations as set out in the Criminal Procedure Act No 51 of 1977 as amended. Section 41 and 49 of the Mental Health Care Act provides for designation of health establishments and procedures with regards to State patients and mentally ill prisoners.
5. In keeping with the recommendations of the World Health Organization,<sup>2</sup> all long stay custodial specialist mental health facilities will be incrementally downscaled and replaced with a network of community-based residential and day care facilities. Deinstitutionalisation should not proceed until the necessary community-based facilities are in place.

## **7.6 Other sectors**

1. National, provincial, and local partnerships between government departments, traditional, faith-based, non-governmental and other private sector organisations will be actively pursued by the Department of Health.
2. Public/private partnerships will be pursued to provide facilities, where these can be adequately financed and regulated in keeping with the principles and values of this policy and related legislations.
3. Human resources provided in private and NGO services will be regulated under a common regulatory authority e.g the Health Professions Council of South Africa, the South African Nursing Council and other statutory professional bodies, according to the package of services funded under NHI.
4. People living with mental health conditions in correctional facilities will be reviewed periodically to assess their needs for care in line with the Correctional Services Act of 1998 and other relevant legislation including the Mental Health Care Act, 2002.
5. At the district level a task shifting approach to resource coordination, utilisation and capacity development will be adopted to support all public sector workers and civil society partners who can contribute to mental health care in the district.

## **7.7 Non-governmental organisations**

1. The Provincial Departments of Health will licence and regulate the provision of community-based mental health services by NGOs and for-profit organisations, such as community residential care, day care services, and halfway houses. This is in keeping with Regulation 43 of the Mental Health Care Act, 2002 General Regulations as amended.
2. The National Department of Health will keep a register of provincially licensed facilities, with data on costing, staffing and services provided as part of oversight role.
3. NGOs will also play an active role in the provision of health education and information on mental health and substance abuse, and targeting vulnerable groups such as women, children, the elderly, and those with disabilities.
4. Licenced NGOs will play a key role in the provision of community-based mental health services, including residential and day care services.
5. In keeping with the UN Convention on the Rights of Persons with Disability, people living with a mental illness have a right to live independently within communities, with access to care, treatment and rehabilitation services as required.

## NATIONAL MENTAL HEALTH STRATEGIC PLAN: 2023-2030

Objective*	Key activities	Outputs	Baseline (2023)	Target dates		Responsible organisation
				Commence	Complete	
<b>1. To strengthen District and Primary Health Care based mental health services</b>	Establish at least one specialist mental health team in each District. <i>(See Appendix 1. For Terms of Reference for all key structures).</i>	Specialist mental health teams are established in each district	14 of the 52 districts have an established district specialist mental health team	2023	2030	Provincial DoH
	All district hospitals, community health centres and selected clinics will provide mental health services with appropriate human and other resources.	District hospitals, Community health centres and selected clinics rendering mental health services in provinces	District hospitals, Community health centers and selected clinics are rendering mental health services at a limited scale with limited resources	2023	2030	Provincial DoH
<b>2. Build Institutional Capacity (National, Provincial, District)</b>	Support the activities of the national mental health Technical Advisory (Ministerial Advisory) Committee established in terms of Section 71 of the Mental Health Care Act No. 17 of 2002.	A national mental health Technical Advisory (Ministerial Advisory) Committee in place and functioning in	The committee currently exists	2023	On-going	National DoH

		terms of its mandate				
	Establish Mental Health Directorates in each of the 9 provinces.	Mental Health Directorates are established in each province	Only 5 provinces currently have Mental Health Directorates	2023	2030	Provincial DoH
	Ensure availability and functionality of Review Boards in all provinces, in keeping with the Mental Health Care Act, 2002	All health establishments providing mental health care, treatment and Rehabilitation supported by a Mental Health Review Board	28 Mental Health Review Boards have been established. Resources and statistics for the Boards limited	2023	On-going	Provincial DoH and NDoH
<b>3. To conduct mental health Surveillance and research and strengthen innovation</b>	Ensure the accurate collection and use of the minimum dataset for mental health that is integrated into the general health information system at all levels.	Indicators are established; data is accurately collected and integrated into DHIS.	Currently 5 mental health indicators are collected, but accuracy and use of the data is limited.	2023	On-going	Provincial DoH and NDoH
	Establish a national mental health research agenda in partnership with all research stakeholders to meet national mental health	National mental health research agenda is established	No formal mental health research agenda currently exists	2024	ongoing	NDoH (Mental Health Technical Advisory Committee);

	priorities and submitted to the National Health Research Committee.					Academic research institutions
	Develop and implement a monitoring and evaluation framework to track and report progress with implementation of the health sector drug master plan	M&E framework in place and used to track progress with the health sector drug master plan	No M&E system is in place	2024	2025	NDoH
<b>4. To develop and improve Infrastructure and capacity of facilities</b>	Build/attach mental health inpatient units to designated district and regional hospitals (for emergency admissions, 72-hour assessment and care, treatment, and rehabilitation of voluntary, assisted, and involuntary mental health users).  Design specifications should comply with the Mental Health Care Act. Units attached to regional hospitals to have facilities for child and adolescent mental health inpatient care for	Units are built and fit for purpose in all tertiary, regional and district hospitals, to ensure adequate infrastructure and security to protect the human rights of mental health users, and to protect the rights and safety of clinical staff working in these units.	40 Mental Health Inpatient Units have been established. There are wide provincial variations in relation to distribution and access to mental health facilities.	Ongoing	2030	NDoH and Provincial DoH

	voluntart, assisted and involuntary care.					
	Establish a specialized psychiatric hospital in Mpumalanga Province with the capacity to conduct forensic psychiatric evaluations, admit State patients and mentally ill prisoners, as well as provide services to, voluntary, assisted, and involuntary mental health care users.	A specialized psychiatric hospital established in Mpumalanga Province.	No specialized psychiatric hospital in Mpumalanga Province	2024	2027	NDoH and Mpumalanga provincial DoH
	Conduct an audit on the infrastructural status of the mental health facilities in the country and develop a plan to address identified challenges	A report on the status of mental health facilities in the country and plan to address the identified challenges	No status report exists	2024	2026	NDoH and Provincial DoH
	Implement a plan to revitalize dilapidated mental health facilities in all provinces.	Fit for purpose mental health facilities exist in all provinces.	No status report exists	2027	Ongoing	NDoH and Provincial DoH
	Develop community residential care facilities (including halfway houses, assisted living and group homes) to	Community residential care facilities for people with severe mental	297 Community residential care facilities have been established and are run by NGOs	2024	On-going	DoH and NGOs

	strengthen community-based mental health services in line with national community-based care norms	illness and/or severe and profound intellectual disability are established in line with national community-based care norms				
	Equip community health centers and selected clinics with psychology infrastructure and equipment (private consultation rooms and group facilitation rooms, lock up filing cabinets for secure storage of psychology specific files, psychological assesment instruments) where psychologists deliver services.	Clinics and community health centres are equipped appropriately according to local needs	Facilities are frequently inadequately equipped for psychological services.	2024	On-going	NDoH and Provincial DoH

<b>5. Monitor availability of Mental health technology, equipment and medicines</b>	Make all psychotropic medicines, as provided on the essential medicines list (EML) available at all levels of care, including PHC clinics.	All EML psychotropic medications are available as necessary and stockouts are routinely monitored.	Psychotropic medications stock outs occur when there are supplier issues	2023	On-going	DoH
<b>6. To strengthen Inter-sectoral collaboration</b>	Establish and sustain intersectoral mental health forums at National, Provincial and local levels	Functional intersectoral mental health forums exist at National and provincial levels	Intersectoral mental health forums exist at national and some provinces but functionality is limited.	2023	Ongoing	NDoH and Provincial DoH
<b>7. To increase and strengthen Human resources for mental health</b>	Review training curriculum to ensure that training relevant health professionals (including medical interns, nurses, pharmacists) rotate through psychiatric units in district and regional general hospitals.	Placements are available for medical intern rotations. Interns are placed in these rotations.	Few such rotations currently available in some provinces	2023	On-going	DoH, HPCSA, College of Medicine
	Strengthen training of primary health staff care staff in basic mental health using APC, and provide ongoing routine	Selected nurses, doctors and social workers in each health facility receive	Training is currently integrated and driven by the Regional Training Centers. Supervision is	2023	On-going	DoH



	supervision and mentoring.	basic mental health training and ongoing routine supervision and mentoring as required.	currently piecemeal and inconsistent			
	The language competency of all mental health professionals will be improved, particularly in indigenous African languages.	All psychiatrists, psychologists, social workers, and OTs receive training in an indigenous African language as part of their mental health training, integrated into the degree.	Very few mental health professionals can speak indigenous African languages.	2023	On-going	NDoH and Academic training institutions for mental health professionals.
<b>8. To strengthen mental health promotion, prevention and advocacy for mental health</b>	A national public education programme for mental health will be established, including knowledge about mental health and illness; stigma and discrimination against people with mental illness; and services that	National public education programme is in place. Members of the South African public across the socioeconomic spectrum are	No concerted national programme exists.	2024	Ongoing	NDoH and Provincial DoH

	<p>are available, including suicide helplines. This will include exposure to positive images of mental health advocates, prominent user role models and well-known and influential champions for mental health to change discriminatory attitudes toward mental illness. This will be done in collaboration with national mental health advocacy bodies that have direct links with community based and user led organisations.</p>	<p>exposed to messages regarding the nature and causes of mental health and mental illness.</p>				
--	---	---	--	--	--	--

## MECHANISMS TO MONITOR IMPLEMENTATION

- Provincial and district plans for mental health will be developed in line with this policy and strategic plan also taking into consideration the provincial specific needs and annual performance plans.
- Provinces will compile and submit quarterly reports to the National Department of Health on the implementation of the National Mental Health Policy Framework and Strategic Plan 2023-2030. Quarterly meetings will be held between the national and provincial focal persons for mental health to track progress against the set strategic objectives.
- The National intersectoral mental health Committee, the Ministerial Advisory Committee on Mental Health and the provincial intersectoral mental health forums will be used to track progress by other sectors in implementing their roles in terms of the National Mental Health Policy Framework and Strategic Plan 2023-2030
- For the overall assessment of the results of the National Mental Health Policy Framework and Strategic Plan 2023-2030, a list of core indicators will be used.

Prioritised Indicator	Domain
Number of clients screened for mental disorders	Quality
Number of new clients identified and treated for mental disorders	Quality
Number of days in last one month that at least one psychotropic medicine was out of stock	Quality
Proportion of national health budget allocated to mental health services	Financial protection
Number of trained mental health workers at inpatient, outpatient and PHC services	Quality
Number of clients seen for mental disorders at ambulatory health services	Utilisation

Number of people that attempt suicide	Need
Number of people that commit suicide	Need
Default rate	Quality
Proportion of patients re-admitted to in-patient mental health care within three months of discharge	Quality
Number of persons on psychotropic medication	Need
Proportion of mental health care users and caregivers expressing satisfaction with received services	Quality
Number of known mental health care users that are declared State patients	Quality
Average waiting time for forensic mental observations	Need
Average waiting time for transfer of State patients from DCS to psychiatric hospitals	Need
Number of new State patients admitted into specialised psychiatric hospitals from Correctional Centers	Utilisation
Average waiting time for criminal capacity assessment in terms of the Child Justice Act	Need
Proportion of people receiving mental health interventions with their mental health condition controlled.	Quality

## **APPENDIX 1: TERMS OF REFERENCE FOR KEY STRUCTURES**

<b>Key Structure</b>	<b>Terms of Reference</b>
<p><b>1. District specialist mental health team</b></p>	<ul style="list-style-type: none"> <li>• Adopt a public health approach to the mental health of the district, conducting a situation analysis of mental health needs and service resources in the district population, and developing an action plan for promotion, prevention, treatment, and recovery.</li> <li>• Establish routine ongoing training and supervision for PHC staff through the district specialist mental health team.</li> <li>• Establish routine referral pathways from primary care to specialist services in each district.</li> <li>• Introduce routine indicated assessment and management of common mental disorders (depression, anxiety, and alcohol use disorders) in priority programmes at PHC level:             <ul style="list-style-type: none"> <li>○ TB.</li> <li>○ HIV&amp;AIDS.</li> <li>○ Antenatal mothers.</li> <li>○ Postnatal care.</li> <li>○ Family planning; and</li> <li>○ Chronic diseases.</li> </ul> </li> <li>• Embed suicide prevention in treatment at primary care level, through identification of risk factors for suicide in all health service provision.</li> <li>• Strengthen school systems for mental health promotion, prevention of mental illness, detection and management of child and adolescent mental disorders in schools, and referral where appropriate, in line with the School Health Policy.</li> <li>• Establish posts for psychologists and registered counsellors in community settings.</li> <li>• Provide clinical and consultation liaison services within the district.</li> </ul>

	<ul style="list-style-type: none"> <li>• Encourage implementation of the Traditional Health Practitioners Act by facilitating links between mental health services and traditional healers and faith healers at local district levels, including appropriate referral pathways in both directions.</li> <li>• Deploy Registered Counsellors to provide training, supervision, and support for counselling roles of community health workers.</li> <li>• Build capacity for users (service users, their families) to provide appropriate self-help and peer led services, such as support groups, facilitated by NGOs.</li> </ul>
<p><b>2. Ministerial Technical Advisory Committee on Mental Health</b></p>	<ul style="list-style-type: none"> <li>• Provide advice to the Department of Health on evidence-based and cost effective minimum mental health care packages for each level of the health system.</li> <li>• Engage with consumers and family associations in policy development and implementation, as well as planning and monitoring of services, to give substance to the slogan: “nothing about us without us”.</li> <li>• Provide technical support to the Department of Health to ensure that in the financing of the National Health Insurance system, mental health services will be given parity with other health conditions, in proportion to the burden of disease and evidence for cost-effective interventions.</li> <li>• Provide technical advise on required national norms and standards in line with the Mental Health Care Act 2002 and the service delivery platform.</li> <li>• Provide technical support to the national Department of Health for the routine periodic population survey of the prevalence and burden of mental illness in South Africa (every 10 years) and a national evaluation of mental health services (every 5 years). Data from these surveys will be used for ongoing planning and service delivery by all provinces.</li> </ul>

	<ul style="list-style-type: none"> <li>• Facilitate the development of a national mental health research agenda, in consultation with the National Health Research Council and academic research institutions.</li> </ul>
<p><b>3. Provincial Mental Health Directorates</b></p>	<ul style="list-style-type: none"> <li>• All provinces and districts will develop provincial and district strategic plans for mental health, with specific strategies, targets, timelines, indicators, and budgets to give effect to the national policy framework and action plan.</li> <li>• Ensure representation of mental health specialists (psychiatrists and/or psychologists) on appropriate budget allocation committees at provincial and district levels.</li> <li>• Support all Provincial Health MECs and HODs to ensure the establishment and ongoing existence of functional review boards in all provinces as per the provisions of the Mental Health Care Act.</li> <li>• Monitor functioning of the provincial Review Boards</li> <li>• Review Boards will educate the public about recourse to legal aid resources that are available to all mental health service users.</li> <li>• Promote a culture of DHIS information use for mental health service development, through capacity development activities addressing the various stages of collection, processing, dissemination, and use of mental health information. This will include training of provincial and district health information officers and mental health programme staff in all provinces, in the collection, processing, dissemination and use of mental health indicators.</li> <li>• Consult with all mental health professions and with representative service user organizations in the design specification of buildings to ensure compliance with the basic requirements of professional practice and human rights.</li> <li>• Involve psychiatrists, psychologists, psychiatric nurses, social workers, and occupational therapists in the design of the HR plan for mental health services.</li> </ul>

	<ul style="list-style-type: none"> <li>• Ensure that care is provided for the needs of mentally ill prisoners and remand detainees with mental illness and establish appropriate assessment and referral mechanisms.</li> </ul>
<b>4. Intersectoral mental health forms</b>	<ul style="list-style-type: none"> <li>• Ensure that the social determinants and risk factors for mental health are addressed in an evidence-based manner across all relevant sectors, to promote the mental health of all South Africans, and prevent mental illness</li> <li>• Address cross cutting issues including forensic mental health, child justice, mental health infrastructure and substance abuse services</li> </ul>



## APPENDIX 2: INTER-SECTORAL ROLES AND RESPONSIBILITIES

Sector	Roles and responsibilities in mental health promotion and prevention	Roles and responsibilities in removal of barriers to service delivery	Technical Expertise required from the health sector
Education	<ul style="list-style-type: none"> <li>- Provision of supports such as counselling to children and adolescents with mental and related learning disorders within the inclusive education system in collaboration with stakeholders.</li> <li>- Development of school-based mental health promotion programmes for learners.</li> <li>- Development of employee assistance programmes for educators with work-related and other mental health conditions</li> <li>- Introduction of mental health literacy education into curriculum to increase awareness, healthy behaviours and decrease stigma.</li> <li>- Infuse literacy education on mental health in the Life Skills (Intermediate Phase) and Life Orientation (Senior and FET Phases) subjects.</li> <li>- Strengthen the Screening, Identification, Assessment and Support (SIAS) Policy with Mental Health content.</li> <li>- Train School Based Support Teams on mental health education.</li> </ul>	<ul style="list-style-type: none"> <li>- Collaborate with the Department of Health to strengthen early identification and intervention mechanisms to ensure that learners experiencing mental health issues can learn and succeed.</li> <li>- Collaboration with the department of Health to promote ongoing and re-entry to learning following periods of illness, and to develop a joint approach to management of children and adolescent with severe mental and developmental disorders.</li> <li>- Collaboration with the Department of Labour to coordinate basic education outcomes with skills development and vocational training opportunities and career pathing for people with mental and intellectual disability.</li> <li>- Incorporate mental health literacy education in both the GET and FET curriculum.</li> </ul>	<ul style="list-style-type: none"> <li>- Early identification and support guidelines for educators to ensure that learners experiencing mental health issues can learn and succeed.</li> <li>- Development of protocols for the management of, and employee assistance programmes for educators with work-related and other mental health conditions.</li> <li>- Development of a district-based model for the management of mental health disorders presenting in school-going children (schools as a node of identification and intervention for mental health-related problems)</li> <li>- Assessment and review of the need for specialised mental health expertise within the school sector.</li> <li>- Provision of relevant content that will be incorporated into the Screening, Identification, Assessment and Support (SIAS) Policy</li> </ul>

Social Development	<ul style="list-style-type: none"> <li>- Increased targeting of people with mental disabilities in poverty alleviation programmes.</li> <li>- Increased awareness of the mental health benefits of being a recipient of poverty alleviation strategies, including social grants.</li> <li>- Increased awareness of early childhood intervention as mental health promotion programme.</li> </ul>	<ul style="list-style-type: none"> <li>- Clarity on the roles, responsibilities and service interface of Health and Social Services for children, adolescents and adults with mental disorders and intellectual disability, and for the treatment of co-morbid substance abuse and mental disorders and in the provision of community based mental health services</li> <li>- Development of guidelines to facilitate access to social grants for people with mental or intellectual disabilities</li> </ul>	<ul style="list-style-type: none"> <li>- Identification and management guidelines for social sector workers working with intellectual disability and mental and substance disorders in Child and Youth Care Centres</li> <li>- Guidelines to identify people with mental and intellectual disabilities for social grants.</li> <li>- Supportive arrangements for continuation of social grant support during periods of review, and for transitional benefits during job placement programmes linked to reintegration into the workplace.</li> </ul>
Police Services	<ul style="list-style-type: none"> <li>- Early identification and referral of mental health care users in terms of section 40 of the Mental Health Care Act, 2002.</li> </ul>	<ul style="list-style-type: none"> <li>- Development of guidelines for the implementation of Section 40 of the Mental Health Care Act, which obliges the police services to transport a person to a health facility when he is judged to be a danger to himself or others due to mental illness or intellectual disability.</li> </ul>	<ul style="list-style-type: none"> <li>- Collaboration in developing guidelines for early identification and the management of forensic and behaviourally disturbed clients in police custody while in transit to or awaiting hospitalisation including guarding services for the accused undergoing forensic psychiatric evaluations in designated psychiatric hospitals</li> </ul>

Correctional Services	<ul style="list-style-type: none"> <li>- Early identification and referral for treatment of offenders.</li> <li>- Awaiting trial detainees shall be managed equivalent to those in Justice.</li> </ul>	<ul style="list-style-type: none"> <li>- Develop guidelines for the management of offenders with mental health conditions substance abuse and suicidality within their legal mandates.</li> <li>- Develop guidelines for the management of remand detainees with mental health conditions.</li> </ul>	<ul style="list-style-type: none"> <li>- Assistance with identification and treatment guidelines development.</li> </ul>
Justice	<ul style="list-style-type: none"> <li>- Early identification and referral for treatment of those awaiting trial.</li> </ul>	<ul style="list-style-type: none"> <li>- Development of special courts for those with intellectual disability or impaired decision-making skills</li> <li>- Supporting equality under the law for people with mental and intellectual disability, for example in the areas of inclusive education, workplace discrimination on the grounds of mental disability, and protection of the integrity of body and mind in the provision of mental health care services.</li> </ul>	<ul style="list-style-type: none"> <li>- Assistance with developing appropriate court procedures for people with intellectual disability</li> <li>- Training of magistrates in the identification and management of offenders with mental health conditions.</li> </ul>
National Prosecuting Authority	<ul style="list-style-type: none"> <li>- Improved coordination on mental health services among stakeholder departments</li> </ul>	<ul style="list-style-type: none"> <li>- Intersectoral protocols on mental observations, management of State patients and criminal capacity assessments</li> </ul>	<ul style="list-style-type: none"> <li>- Well coordinated forensic mental health system</li> </ul>
Human Settlements	<ul style="list-style-type: none"> <li>- Increased awareness of mental health benefit of provision of adequate housing</li> </ul>	<ul style="list-style-type: none"> <li>- Agreement on the responsibilities of Human Settlement (policies to support inclusion, municipalities (provision of transitional and permanent housing), NGOs (support programmes for residents) and Social Development (programmatic funding to NGOs) in housing provision</li> <li>- Review of special housing needs policy to accommodate subsidisation of the housing needs of people with mental and intellectual disability, and support to their access to housing provision through the national housing programme (family and community residential care)</li> </ul>	<ul style="list-style-type: none"> <li>- Eligibility and procedures to accommodate subsidisation and equitable access to housing provision (family and community residential care)</li> </ul>

Local Government	<ul style="list-style-type: none"> <li>- Building awareness of the mental wellbeing benefits of the provision of basic services such as water, electricity, and sanitation</li> <li>- Inclusion of programmes for the promotion of mental wellbeing and prevention of mental illness in municipal health services</li> </ul>	<ul style="list-style-type: none"> <li>- Inclusion of people with mental and intellectual disability in the provision of community and municipal services to disabled people under their jurisdiction</li> <li>- Including the needs of people with mental disability in Accessibility Plans, for example transport, housing, recreational needs of people with mental disabilities.</li> </ul>	<ul style="list-style-type: none"> <li>- Input at local level to assist with the development of Accessibility Plans and local programmes.</li> </ul>
DPM&E	<ul style="list-style-type: none"> <li>- Accountability of stakeholder departments on the implementation of policy prescripts</li> </ul>	<ul style="list-style-type: none"> <li>- Implementation reports by each department</li> </ul>	<ul style="list-style-type: none"> <li>- Monitoring of relevant government department's implementation of their role in terms of this policy and strategic plan</li> </ul>
Labour	<ul style="list-style-type: none"> <li>- Create opportunities for employment for people living with mental health conditions and ensure all employees, including those living with mental health conditions, receive the necessary mental health support within the workplace.</li> </ul>	<ul style="list-style-type: none"> <li>- Provide information about mental health in the workplace, drawing on WHO Guidelines for Workplace mental health programmes.</li> </ul>	<ul style="list-style-type: none"> <li>- Provide information to Department of Labour on the key requirements for mental health in the workplace.</li> </ul>
Licensed Non-governmental organisations (NGOs)	<ul style="list-style-type: none"> <li>- Provision of community care, including day care and residential care for people with severe mental health conditions and intellectual disabilities.</li> <li>- Supporting mental health care users in the community following discharge from inpatient healthcare facilities.</li> </ul>	<ul style="list-style-type: none"> <li>- Liaison with Departments of Health, Social Development, Education and other relevant departments to provide integrated community-based care.</li> <li>- Advocate for the human rights of people with mental health conditions.</li> </ul>	<ul style="list-style-type: none"> <li>- The Department of Health will liaise with the NGO sector to provide a whole-of-society approach to prevention, promotion and care for mental health</li> <li>- The Department of Health will provide an appropriate regulatory environment to support the involvement of NGOs in the provision of mental health care.</li> </ul>

## References

1. Docrat S, Besada D, Cleary S, Daviaud E, Lund C. Mental health system costs, resources and constraints in South Africa: a national survey. *Health Policy and Planning* 2019.
2. WHO. World Mental Health Report: Transforming mental health for all. Geneva: WHO; 2022.
3. Patel V, Saxena S, Lund C, et al. The Lancet Commission on global mental health and sustainable development. *Lancet* 2018.
4. Arias D, Saxena S, Verguet S. Quantifying the global burden of mental disorders and their economic value. *EClinicalMedicine* 2022; **54**: 101675.
5. Carpenter B, Nyirenda M, Hanass-Hancock J. Disability, a priority area for health research in South Africa: an analysis of the burden of disease study 2017. *Disabil Rehabil* 2022; **44**(25): 7839-47.
6. Jorns-Presentati A, Napp AK, Dessauvagie AS, et al. The prevalence of mental health problems in sub-Saharan adolescents: A systematic review. *PloS one* 2021; **16**(5): e0251689.
7. Williams D, Herman A, Stein D, et al. Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological medicine* 2008; **38**.
8. Williams DR, Herman A, Stein DJ, et al. Prevalence, Service Use and Demographic Correlates of 12-Month Psychiatric Disorders in South Africa: The South African Stress and Health Study. *Psychological Medicine* 2008; **38**(2): 211-20.
9. Prince M, Patel V, Saxena S, et al. No health without mental health. *Lancet* 2007; **370**: 859-77.
10. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. *Lancet* 2009; **374**(9692): 817-34.
11. Mayosi B, Flisher AJ, Lalloo UG, Sitas F, Tollman SM, Bradshaw D. The burden of non-communicable diseases in South Africa. *Lancet* 2009; **374**: 934-47.
12. Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Violence and injuries in South Africa: prioritising an agenda for prevention. *Lancet* 2009; **374**: 1011-22.
13. Chopra M, Daviaud E, Pattinson R, Fonn S, Lawn JE. Saving the lives of South Africa's mothers, babies and children: can the health system deliver? *Lancet* 2009; **374**: 835-46.
14. Necho M, Zenebe Y, Tiruneh C, Ayano G, Yimam B. The Global Landscape of the Burden of Depressive Symptoms/Major Depression in Individuals Living With HIV/AIDS and Its Effect on Antiretroviral Medication Adherence: An Umbrella Review. *Front Psychiatry* 2022; **13**: 814360.
15. Hoare J, Sevenoaks T, Mtukushe B, Williams T, Heany S, Phillips N. Global Systematic Review of Common Mental Health Disorders in Adults Living with HIV. *Curr HIV/AIDS Rep* 2021; **18**(6): 569-80.
16. Champion J, Javed A, Sartorius N, Marmot M. Addressing the public mental health challenge of COVID-19. *Lancet Psychiatry* 2020; **7**(8): 657-9.
17. COVID-19 Mental Disorders Collaborators. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *Lancet* 2021; **398**: 1700-12.
18. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. *Current opinion in psychiatry* 2007; **20**(4): 359-64.

19. Seedat S, Stein DJ, Jackson PB, Heeringa SG, Williams DR, Myer L. Life stress and mental disorders in the South African Stress and Health study. *South African Medical Journal* 2009; **99**(5): 375-82.
20. Myer L, Stein DJ, Jackson PB, Herman AA, Seedat S, Williams DR. Impact of common mental disorders during childhood and adolescence on secondary school completion. *South African Medical Journal* 2009; **99**(5): 354-6.
21. Ridley M, Rao G, Schilbach F, Patel V. Poverty, depression, and anxiety: Causal evidence and mechanisms. *Science* 2020; **370**(6522).
22. Flisher AJ, Lund C, Funk M, et al. Mental health policy development and implementation in four African countries. *Journal of Health Psychology* 2007; **12**: 505-16.
23. Maharaj V, Tomita A, Thela L, Mhlongo M, Burns JK. Food Insecurity and Risk of Depression Among Refugees and Immigrants in South Africa. *Journal of immigrant and minority health* 2017; **19**(3): 631-7.
24. Truth, Reconciliation C. Report of the Truth and Reconciliation Commission of South Africa. London: MacMillan, 2000.
25. Kaminer D, Stein DJ, Mbanga I, Zungu-Dirwayi N. The Truth and Reconciliation Commission in South Africa: relation to psychiatric status and forgiveness among survivors of human rights abuses. *British Journal of Psychiatry* 2001; **178**: 373-7.
26. WHO. Global status report on alcohol and health 2018. Geneva: WHO; 2018.
27. Adebisi BO, Mukumbang FC, Beytell AM. To what extent is Fetal Alcohol Spectrum Disorder considered in policy-related documents in South Africa? A document review. *Health Res Policy Syst* 2019; **17**(1): 46.
28. Pluddemann A, Myers BJ, Parry CD. Surge in treatment admissions related to methamphetamine use in Cape Town, South Africa: implications for public health. *Drug and Alcohol Review* 2008; **27**: 185-9.
29. Lund C, Myer L, Stein D, Williams D, Flisher A. Mental illness and lost income among adult South Africans. *Social psychiatry and psychiatric epidemiology* 2013; **48**.
30. Bauer A, Garman E, Besada D, Field S, Knapp M, Honikman S. Costs of common perinatal mental health problems in South Africa. *Global Mental Health* 2022; **9**: 429-38.
31. Docrat S, Besada D, Lund C. Mental health investment case for South Africa. Cape Town: Commissioned by national Department of Health, South Africa; 2021.
32. Thornicroft G, Sunkel C, Alikhon Aliev A, et al. The Lancet Commission on ending stigma and discrimination in mental health. *Lancet* 2022; **400**(10361): 1438-80.
33. Skeen S, Laurenzi CA, Gordon SL, et al. Adolescent Mental Health Program Components and Behavior Risk Reduction: A Meta-analysis. *Pediatrics* 2019; **144**(2).
34. Patel V, Araya R, Chatterjee S, et al. Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet* 2007; **370**: 991-1005.
35. Botha U, Koen L, Oosthuizen P, Joska J, Hering L. Assertive community treatment in the South African context. *African Journal of Psychiatry* 2008; **11**: 272-5.
36. Chatterjee S, Pillai A, Jain S, Cohen A, Patel V. Outcomes of people with psychotic disorders in a community-based rehabilitation programme in rural India. *British Journal of Psychiatry* 2009; **195**: 433-9.
37. Branquinho M, Rodriguez-Munoz MF, Maia BR, et al. Effectiveness of psychological interventions in the treatment of perinatal depression: A systematic review of systematic reviews and meta-analyses. *Journal of affective disorders* 2021; **291**: 294-306.
38. Cooper PJ, Tomlinson M, Swartz L, et al. Improving the quality of the mother-infant relationship and infant attachment in a socio-economically deprived community

- in a South African context: a randomised controlled trial. *British Medical Journal* 2009; **338**(doi:10.1136/bmj.b974).
39. Myers B, Lombard CJ, Lund C, et al. Comparing dedicated and designated approaches to integrating task-shared psychological interventions into chronic disease care in South Africa: a three-arm, cluster randomised, multicentre, open-label trial. *The Lancet* 2022; **400**(10360): 1321-33.
  40. Human Rights Commission. Report of the national investigative hearing into the status of mental health care in South Africa. Gauteng: South African Human Rights Commission; 2018.
  41. Flisher AJ, Lund C, Muller L, et al. Norms and standards for psychiatric care in South Africa: A report submitted to the Department of Health, Republic of South Africa (Tender No. GES 105/96-97). Cape Town: Dept of Psychiatry, University of Cape Town, 1998.
  42. Lund C, Flisher AJ. Norms for mental health services in South Africa. *Social Psychiatry and Psychiatric Epidemiology* 2006; **41**: 587-94.
  43. Muller L, Flisher AJ. Standards for the mental health care of people with severe psychiatric disorders in South Africa: Part 1. Conceptual issues. *South African Psychiatry Review* 2005; **8**: 140-5.
  44. Muller L, Flisher AJ. Standards for the mental health care of people with severe psychiatric disorders in South Africa: Part 2. Methodology and results. *South African Psychiatry Review* 2005; **8**: 146-52.
  45. Lund C, Flisher AJ. A model for community mental health services in South Africa. *Tropical Medicine & International Health* 2009; **14**(9): 1040-7.
  46. Lund C, Boyce G, Flisher AJ, Kafaar Z, Dawes A. Scaling up child and adolescent mental health services in South Africa: Human resource requirements and costs. *Journal of Child Psychology and Psychiatry* 2009; **50**(9): 1121-30.
  47. Flisher AJ, Jansen S, Lund C, et al. Norms for community mental health services in South Africa. Cape Town: Department of Psychiatry and Mental Health, University of Cape Town, 2003.
  48. Petersen I, Fairall L, Bhana A, et al. Integrating mental health into chronic care in South Africa: the development of a district mental healthcare plan. *The British journal of psychiatry : the journal of mental science* 2016; **208 Suppl 56**: s29-39.
  49. Petersen I, Bhana A, Fairall L, et al. Evaluation of a collaborative care model for integrated primary care of common mental disorders comorbid with chronic conditions in South Africa. *BMC psychiatry* 2019; **19**(107).
  50. Docrat S, Lund C, Chisholm D. Sustainable financing options for mental health care in South Africa: findings from a situation analysis and key informant interviews. *Int J Ment Health Syst* 2019; **13**: 4.
  51. WHO. Planning and budgeting to deliver services for mental health. Mental health policy and services guidance package. Geneva: WHO, 2003.