

Mental healthcare in the community



During the last decade or so, there has been a growing international recognition of the high burden of disease associated with mental health problems,^[1] with local research that supports this view.^[2] The most comprehensive study of common mental disorders in South Africa, the South African Stress and Health Study,^[3] carried out in 1999, showed a lifetime prevalence for these disorders of 30.3%. Of those who had had a mental disorder in the past year, only 25.2% sought treatment and a tiny number, 5.7%, used any formal mental health service.^[4] In the years since that study, the HIV/AIDS and substance abuse epidemics have contributed further to this burden, while at the same time mental health services have seen a reduction in hospital beds with de-institutionalisation, yet little growth in community-based services.^[5]

Historically, mental health services have been poorly funded and left to a small minority of professionals in dedicated services.^[6] The reasons for this are complex and interwoven. However, important themes include the stigmatisation of mental illness, the historical (but relatively modern trend) of excluding those with mental illness in mental asylums (which the philosopher Foucault attributed to the need for social exclusion of the 'unreasonable' as a product of Enlightenment thinking),^[7] and the origins of psychiatry within these institutions. Additionally, the traditional way of measuring the impact of disease in terms of mortality statistics led to an underestimation of the impact of mental health disorders, which are characterised by long-term disability rather than extensive mortality, something that has been rectified in more recent studies that have used the measure of Disability Adjusted Life-Years (DALYs).

We are therefore left with the current situation, where it has become increasingly apparent that mental illness is no longer something that can be hidden from public view and left to a small group of specialists. With only 772 psychiatrists^[8] for a population of nearly 53 million^[9] in South Africa, it is clear that such an approach will lead to further compromise of an already marginalised yet substantial portion of our society. It is time that we made it clear that mental illness is everyone's concern, and that all healthcare practitioners recognise that we have a role to play in the care of people living with such illnesses.

The good news is that there has been increasing recognition that information on effective, evidence-based interventions for mental health problems needs to be made available for healthcare practitioners at every level of service. Extensive resources have been developed for this purpose, such as those produced by the World Health Organization's Mental Health Gap Action Program,^[10] which

are specifically designed for low- and middle-income settings and are freely available. The evidence shows that there is a great deal that can be done by an array of service providers at the primary level and that mental health services can be upgraded in a manner that is both practical and cost effective.

The key therefore is to present mental healthcare in a manner that is accessible to a wide range of non-specialist practitioners and, additionally, to ensure that such care is offered in a manner that acts to counter a legacy of exclusion and discrimination. The articles in this edition of *CME* have therefore been selected to focus on developing an understanding of the mental health assessment that facilitates its use in a primary setting, on the management of a few key disorders that present at this level, and on the integration of mental health with general principles of primary care. Lastly, in the 'More about' articles, an attempt is made to provide some understanding of the recent major changes to the context in which mental healthcare is delivered and to provide some indication of how our attitudes and priorities need to change as we move from an era of exclusion and removal to one of partnership and empowerment.



John Parker

Guest editor

john.parker@westerncape.gov.za

1. Murray CJL, Lopez AD. The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge: Harvard School of Public Health, 1996.
2. Bradshaw D, Groenewald P, Laubscher R, et al. Initial burden of disease estimates for South Africa, 2000. *S Afr Med J* 2003;93:682-688.
3. Stein DJ, Seedat S, Herman A, et al. Lifetime prevalence of psychiatric disorders in South Africa. *Br J Psychiatry* 2008;188:465-471.
4. Seedat S, Williams DR, Herman JJ, et al. Mental health service use among South Africans for mood, anxiety and substance use disorders. *S Afr Med J* 2009;99:346-352.
5. Van Heerden S, Hering L, Dean C, Stein DJ. Providing mental health services in general medical settings in South Africa. Mental health friendly services in mental health friendly hospitals. *S Afr Med J* 2008;98:4-6.
6. Jacob KS, Sharan P, Mizra I, et al. Mental health systems in countries: Where are we now? (No. 4 in Global Mental Health Series.) *Lancet* 2007;370(9592):1062-1077. [[http://dx.doi.org/10.1016/S0140-6736\(07\)61241-0](http://dx.doi.org/10.1016/S0140-6736(07)61241-0)]
7. Foucault M. *Madness and Civilisation: A History of Insanity in the Age of Reason*. London: Tavistock, 1971.
8. HPCSA Register: Psychiatrists. <http://register.hpcsa.ca.za/RegisterSearch.aspx> (accessed 23 October 2013).
9. Stats SA. SA Population Data. <http://www.statssa.gov.za/publications/statsdownload.asp?PPN=P0302&SCH=5500> (accessed 24 October 2013).
10. World Health Organization Mental Health Gap (MHGAP) Action Program. <http://www.statssa.gov.za/publications/statsdownload.asp?PPN=P0302&SCH=5500> (accessed 24 October 2013).

S Afr Med J 2014;104(1):68 DOI:10.7196/SAMJ.7734