Reflections on the South African Human Rights Commission Report of the National Investigative Hearings into the Status of Mental Health Care in South Africa – 14 and 15 November 2017

Good morning!

As an academic and clinical psychiatrist representing the Division of Public Mental Health in the University of Cape Town's Department of Psychiatry and Mental Health, I would like to thank the Human Rights Commission for the invitation to reflect on this report, in the place of our Department's Professor Katherine Sorsdahl, who took part in the investigation but was unable to be present today.

In opening I would also like to make two acknowledgements: the first is to pay respect to the Human Rights Commission for the very thorough manner in which this report was prepared, particularly in giving voice to the many who too often remain unheard. The second acknowledgement is of a need to pause for a moment and to register, as a South African, my deep sense of shame at how we have **all** failed in our duty of care towards so many of our fellow human beings. (pause)

Thank you. This is, I believe, a critical point of departure because a key finding of the Commission relates to how the widespread and systemic stigmatisation of people with psychosocial and intellectual disabilities has led to, not only the deprivation of basic rights to healthcare but also to exposure to a range of discriminatory attitudes that have resulted in exclusion, neglect and at times even active persecution.

Thus the Commission makes a decisive step in placing on record what it refers to as the "prolonged and systemic neglect of mental health at the level of policy implementation", noting particularly the considerable under-investment in mental health care by the South African government, as well as the substantial progress that needs to be made on numerous fronts to meet our obligations in terms of the Convention on the Rights of Persons with Disabilities.

There is of course an intersectionality here with many other forms of oppression - but the particularity of psychosocial and intellectual disability relates to how prevalent it is, and yet how invisible. In terms of prevalence, the evidence suggest that at least one in three South Africans will suffer from a clinically treatable level of mental disorder in their lifetimes. It should also come as no surprise to learn that studies in disadvantaged groups in our country have revealed far higher rates of depression in particular, as well as of other mental disorders. Global research has shown a strong correlation between levels of inequality in countries and the prevalence of mental disorder and globally a picture is also emerging of growing levels of depression as well as of suicide in some age groups, and additionally a major epidemic of substance misuse. Yet, in South Africa research suggests that **less than ten percent** of those requiring mental health care in the public sector, actually receive it.

A key reason for this relates to how issues such as shame and isolation interact with disorders to render those who are suffering disempowered and invisible. This not only deprioritizes funding when compared to other medical problems but also leaves those who are disabled excluded, in terms of basic rights, from the political to the personal. The Commission has thus highlighted the importance of work to develop a right's based approach, to consider the constitutionality of various laws that

restrict the rights of people with psychosocial and intellectual disability and to ensure the participation of mental health care users in decisions regarding their care.

Most critically in terms of development, the Commission notes that the (reasonably well planned) National Mental Health Policy Framework was established in 2013 with a goal of implementation by 2020. Reports on progress made in provinces however revealed that most had not even achieved key first steps of establishing mental health directorates and of putting in place the basic building blocks of district community mental health teams, with not only inadequate community services but a general decline in spending on specialised services as well. Additionally there are massive disparities between the various provinces and between urban and rural areas.

This general malaise is hardly surprising as funding for mental health services must compete with other service s for general health funding provided by National Government. Shrinking budgets have allowed for the neglect of mental health care, in favour of more visible priorities in other disciplines. Further key problems include insufficient expenditure on community-based services, little in the way of preventative services and even more appallingly, a lack of services for children and adolescents that not only results in exposure to human rights abuses but also allows for progression to more severe and intractable adult disorders.

Additional challenges to prioritization pertain to arguments related to a nihilistic view of mental health care, and to concerns around the effectiveness of treatment interventions. Yet there is a solid evidence base for the cost effectiveness of treatments in a range of modalities, with intervention studies demonstrating how these can be implemented on multiple levels of the health system. Similarly with regard to the more chronic and severe disorders, the Recovery Movement Internationally has demonstrated greatly improved levels of function when people are treated in empowering and hopeful ways that emphasise access to meaning and purpose in their lives and reconnection to communities.

The commission's recommendations demand substantial progress in implementing the National Mental Health Policy Framework but for this to happen effectively will require significantly more funding. Ideally, as the Commission argues, this should be made available in the form of a conditional grant that is dedicated to the development of mental health services in each of the provinces, according to a specifically costed plan. This, would of course require considerable expertise in terms of the development of a properly motivated bid to National Treasury as well as in the ability to implement it - but in this respect a great deal of work has already been done. Our country is blessed with considerable resources in the form of internationally recognised research teams and experts, and strong collaborations with the WHO and other groups internationally. Extensive research on how to introduce and scale up services has been undertaken, particularly in the PRIME and EMERALD projects with ongoing work on development as a primary focus.

With regard to the large Institutions, the Commission has made it clear that although a policy of deinstitutionalisation is seen as desirable, this cannot happen without interventions to ensure that there is real care in the community. We have hopefully by now, all realised that economies of scale will inevitably mean that claims of cost savings through the closure of large hospitals, are more likely to be a disguise for the externalisation of these costs on to other players, including the patients themselves. It is also likely that institutions will be placed under increased pressure as the expansion of primary services will initially uncover a range untreated illnesses. It may be wise to consider whether the institutions are not capable of being reformed into centres of care that connect with multiple sectors of society to create networks of protection and support throughout communities. There is of course a critical lesson in this, that mental wellbeing is not simply a medical issue but is

related to all aspects of how our society functions, further emphasising the multi-sectoral approach recommended by the Commission.

Beyond the rights based arguments, the economic case for investment in mental health care is a strong one, emphasised by the WHO Development Report as a key development issue with research evidence from lower and middle income countries, showing a clear trend of improved economic status in individuals, families and carers as a result of mental health interventions. Research from more developed nations also shows greater economic benefit from investment in mental health care than in general health care, and a clear link to macroeconomic benefits.

The message is thus abundantly clear. Mental illness and intellectual disability issues are not about the isolated problems of some minority that can be addressed by a few tweaks to the health system. When we stop and listen to the countless tales of distress and despair that surround us, we have to recognise that, directly or indirectly, this affects everyone…it is about ALL OF US! Thus the challenge we face is to at once not only grasp the nettle of this growing epidemic but also to step forward more fully, in the embracing of diversity that we so cherish, as a founding principle of our nation.

Thank you for your attention!

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