

‘Mental health is everybody’s business’: Roles for an intersectoral approach in South Africa

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Abstract

Intersectoral action is increasingly recognized as necessary to address the social determinants of mental health. This study aims to assess South Africa’s progress in intersectoral collaboration for mental health, and provide recommendations for intersectoral collaboration, to generate lessons for other low- and middle-income countries. We conducted a survey of the existing mental health system in South Africa using the World Health Organization Assessment Instrument for Mental Health Systems. We also conducted 96 semi-structured interviews and 12 focus group discussions with a range of stakeholders at national, provincial and district level. Data were analysed thematically to understand the roles and responsibilities of different sectors in realizing the right to mental health. A range of key sectors were identified as having roles in mental health promotion, illness prevention and service delivery. In discussing South Africa’s progress, respondents gave several suggestions about how to formulate an intersectoral response in this context, including increasing high level political commitment, and using leadership from the health sector. We outline roles and responsibilities for various sectors and lessons that can be learnt from this context. These include the importance of developing programmes alongside legislation, employing targeted awareness-raising to engage sectors, and developing a structured approach to intersectoral action.

Introduction

It is increasingly recognized that producing positive changes in population health status, including mental health, requires initiatives that go well beyond the confines of the health sector alone (Braveman & Gruskin, 2003). More specifically, there is increased consensus on the need for mutually beneficial intersectoral actions that address the social determinants of health (Williamson & Carr, 2009). This concept of intersectoral action to improve health is not new: in 1978 the Alma-Ata Declaration (WHO, 1978) recognized the benefit of economic and social development for health. In defining primary health care, the Alma-Ata Declaration clearly outlined the role of different sectors on both a national and local level; whilst calling for coordinated intersectoral action (Walley et al., 2008).

The rationale behind this expanded public health approach relates to emerging evidence revealing the key role that socio-economic factors play in

determining health status. Mental health is no exception. For example, poverty and social deprivation in low- and middle-income country (LMIC) settings is increasingly being shown to be associated with common mental disorders (Lund et al., 2010a). Physical and mental health also interact in a complex relationship, with those experiencing poor physical health at increased risk of mental health problems (Patel & Kleinman, 2003). Poor mental health can also lead to increased risk of poor physical health through negative health-related behaviour as well as a compromised immune system (Herrman et al., 2005).

Similarly, the link between mental health and key development priorities (defined in the Millennium Development Goals), such as maternal health (Prince et al., 2007), child health (Adewuya, Ola, Aloba, Mapayi, & Okeniyi, 2008; Rahman, Iqbal, Bunn, Lovel, & Harrington, 2004), and HIV-AIDS (Freeman, Nkomo, Kafaar, & Kelly, 2007) have

recently been shown. Furthermore, there is much evidence to suggest that social factors such as stigma and discrimination against people living with mental disorders can have deleterious effects on the lives of those affected, diminishing their willingness to make use of appropriate care and adhere to treatment regimes, limiting their ability to fully participate in society, and reducing their chances of accessing necessities such as housing and employment (Kakuma et al., 2010).

Despite the growing evidence of the social and economic determinants of mental health, and thus the need for intersectoral approaches to improving mental health, attention to mental health remains low on the public health (Saraceno et al., 2007) and development agenda. Indeed, there are very few large-scale programmes that address the social and economic determinants of mental health in LMICs. The few examples that do exist suggest that the involvement of communities and local level government (Assai, Siddiqi, & Watts, 2006; WHO, 2008), and the active targeting of vulnerable groups (Vega & Irwin, 2004; WHO, 2008) is crucial. It has also been shown that interventions that target the social determinants of mental ill-health could have positive impacts on population mental health (Patel et al., 2010).

Given the role of socio-economic factors in shaping mental health, and thus the importance of intersectoral collaboration, this paper sought to provide an assessment of South Africa's progress with intersectoral collaboration for mental health. It also sought to assess intersectoral roles and responsibilities for mental health in order to generate lessons that are potentially applicable to other LMIC settings. The paper draws on the findings of a situational analysis conducted by the Mental Health and Poverty Project, which aims to provide new knowledge on multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health in Ghana, South Africa, Uganda and Zambia (Flisher et al., 2007).

Methods

We made use of quantitative and qualitative methodologies. Quantitative data were collected using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 (WHO, 2005). The WHO-AIMS tool has been developed to assess key components of a mental health system and includes a section on inter-sectoral collaboration (Domain 5). Details of the administration of this instrument in South Africa have been reported elsewhere (Lund et al., 2010b).

Qualitative data were collected using semi-structured interviews with 64 national and provincial

stakeholders, including politicians, public sector policy makers and planners (from the Departments of Health, Education, Social Development, Housing, Labour, Justice and Constitutional Development, South African Police Services and Correctional Services), non-governmental (NGO) programme managers, mental health care users, religious leaders, and members of development agencies, professional associations, unions, universities and research institutions. A total of 33 semi-structured interviews and 12 focus groups in English or isiZulu were also held within one case-study district to gain information from stakeholders in a context of rural poverty, and limited access to mental health services. The district is broadly representative of rural South Africa, as it has elevated unemployment rates and limited access to basic services. Sampling was guided by the principle of maximum variation to ensure that multiple views were obtained from a range of sectors; and respondents were purposely selected as experts in the field of mental health policy, or as representatives of key organizations providing or receiving mental health services.

Interview schedules were then developed based on the objectives of the study and reviewed by research consortium partners. This process involved a scoping of the literature to identify priority areas of interrogation for policy development, which were added to a matrix for developing stakeholder-specific questionnaires. Priority issues identified included investigation of the major development challenges facing South Africa; key challenges facing the health system; mental health needs and priorities; the role of government in addressing mental health needs and the research agenda for mental health. Questions were also posed about the roles, policies and legislation of sectors other than health, as well as the potential for collaboration between sectors.

Interviews were transcribed verbatim. Those conducted in isiZulu were translated and transcribed into English, with back-translation checks being applied by an independent English-isiZulu speaker. Framework analysis, developed for understanding qualitative data in policy development research, was used, allowing for the both *a priori* and emerging themes to be used during data analysis (Lacey & Luff, 2001; Ritchie & Spencer, 1994). Themes and sub-themes based on the study objectives were generated, and these were reviewed by partners, through a process of iteration, until a single framework was developed for use in all four study countries. In the South African context, additional themes that emerged from the interviews were added to this coding frame. Nodes corresponding to the coding frame themes were used in NVivo 7 software to analyse the transcripts. All interviews were multi-coded within these nodes. For the purpose of this

paper, nodes relating to context-specific issues affecting the mental health situation in South Africa were analysed, along with 'other sector programmes' relating to mental health policy and legislation implementation at a national and provincial level. At a district level, analysis focused on nodes dedicated to the different sectors as well as on data gathered around 'management frameworks and intersectoral links'.

Informed consent was received from all participants and confidentiality was assured. Permission to conduct the study was obtained from the Research Ethics Committee of the Faculty of Health Sciences, University of Cape Town; the Research Ethics Committee of the Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal; and the Research Ethics Committee of the national Department of Health.

Results

Current levels of intersectoral collaboration in South Africa

There are formal collaborations between the government department responsible for mental health (national and provincial Departments of Health) and other departments/agencies at provincial levels (Table I). Some important steps have been taken towards inter-sectoral collaboration, particularly at the national level. For example, there is a national forum on forensic psychiatry, convened by the Department of Health, with the South African Police Service (SAPS), the Department of Justice and the Department of Correctional Services. Some provinces have attempted to establish inter-sectoral forums for mental health although the extent to which these groups meet regularly and function is variable. At the district level, such inter-sectoral collaborations are the exception rather than the rule.

Apart from the Department of Health, other government departments have included mental

health issues within their departmental policies and plans. These include the Department of Education and Department of Correctional Services. In addition the South African Police Services (SAPS) have developed a 'standing order' which sets out roles and responsibilities for police in relation to mental health. This document was developed together with the Directorate for Mental Health and Substance Abuse in the national Department of Health. It is currently in draft form but not yet approved.

Despite these developments, stakeholders who were interviewed strongly felt that South Africa's current level of intersectoral action for mental health is limited. While all sectors are required to integrate physical and mental disability into policy and operational strategies, sectors appear to have achieved different levels of engagement with mental health issues in practice.

Some stakeholders reported having specific interface with mental health issues, such as the justice, education and social development sectors. For example, a representative of the justice sector reported an initiative to develop guidelines for supported decision-making:

They [the South African Law Reform Commission] currently have a project that looks at 'adults with impaired decision-making'...If you have a mental issue or problem that makes you not able to make certain decisions, the courts would get involved there for their own protection. (Policy maker, Justice)

In a similar vein, a Department of Education respondent reported that this sector integrates mental health issues within a wider disability framework:

We are moving away from the notion of categorizing learners according to their disabilities... We rather want to look at what is the level of intensity of support that they need and the nature of support that they need,

Table I. Formal collaborations between the Department of Health and other sectors in South Africa.

Province	PHC	HIV	Rep	Elder	Subst	Chil Pro	Educ	Emp	Hous	Welf	Crim	Child	Other
Western Cape	Y	Y	N	Y	Y	Y	Y	N	N	Y	Y	Y	
KwaZulu-Natal	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Northern Cape	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN
Mpumalanga	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Eastern Cape	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Free State	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Limpopo	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN
Gauteng	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
North West	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	NA

Column titles: Primary health care/community health; HIV-AIDS; Reproductive health; The elderly; Substance abuse; Child protection; Education; Employment; Housing; Welfare; Criminal justice; Child and adolescent health. Y, yes; N, no; NA, not applicable; UN, unknown.

and we are looking at the barriers that they face in terms of accessing support services and education in general. (Policy maker, Education)

Furthermore, it was revealed that the Department of Social Development is directly responsible for some aspects of service delivery, such as early childhood intervention, the provision of social grants, the development of poverty alleviation programmes, and substance use rehabilitation. Much of this service delivery is facilitated through the funding of NGOs, as indicated by a policy maker from this sector:

Our strength is in working with the communities, the NGO's and CBO's, the Department, because they are the ones who actually render services at ground level. (Policy maker, Social Development)

In practice, however, others stated that there tends to be a lack of clarity about how this and other departments' functions interact with complementary health department responsibilities. It seems that although engagement with mental health issues might be evident, formalized policy directives with which to inform the process are lacking, as revealed by this stakeholder:

We just apparently have a gentleman's agreement that the Department is also doing an outreach to Correctional services on a monthly basis... We need a formal agreement to say, 'This is how we will...'. (Provincial programme manager for mental health)

Other sectors, such as labour, housing and transport, seem not to engage at all with mental health concerns, due partially to a historic reliance on the health and so-called welfare sectors for disability-related services. Significantly, some stakeholder responses suggested that the lack of engagement with mental health issues in some sectors meant that consumers are even at risk of abuse at the hands of service providers in the current South Africa context. The most salient example of this was evident in the manner in which mental health care users are treated by the police force in transportation to treatment facilities.

Our job is to take them in, whether they are mentally ill or not, and there is no training necessary for that. We do not treat them in any special way, we handcuff them just like anyone who has done something wrong and if we have to take them to hospital, we take them there and take our handcuffs back once they have injected him. (District police officer)

It was also acknowledged that engagement with mental health issues is restricted by contextual challenges, as illustrated by this quote describing

human resource concerns in implementing supportive education systems in South Africa:

We can't go to all the schools. For that reason we will only get to see that problem when you visit the school and by then it may be late... There is only one team, with three people. (District school nurse)

Suggested areas of action for sectors

Despite the apparently limited existence of inter-sectoral action for mental health, this notion was well supported by respondents. Most respondents identified the cross-cutting nature of mental health issues, and the subsequent need for involvement of stakeholders beyond the health sector.

Mental health promotion

Several respondents recognized that while there is limited awareness of the links between positive mental health and human development, there are a number of development processes that have a direct impact on the mental well-being of people. For example, employment was seen as positively contributing to the quality of one's life through providing increased financial security, greater independence, increased self-esteem, and promoting involvement in the wider community. In another example a respondent spoke of the impact of adequate delivery of basic services in promoting mental health:

Access to adequate housing, access to education, access to employment, access to water, sanitation... They're critical, you know. And that would also engage access to health services as well. And all of these would ensure that our communities are empowered and participate, and mental illness... it's a form of addressing that. (Policy maker, Housing)

Furthermore, the lack of adequate transport was also referred to in these terms:

In this country some people lose jobs... because they come in late. People have to leave homes as early as five o'clock to catch transport... and what happens to families? What happens to their children? (Mental health researcher)

Beyond this recognition of the impact of service delivery on mental health, stakeholders' suggestions of concrete tasks for non-health sectors were variable. In particular, stakeholders were able to identify a range of strategies for the education sector. Firstly, a mental health promoting school environment could assist children and adolescents to cope

with the range of challenges that young people experience in modern-day South Africa.

[Children] are confronted and subjected to so many influences that if we, from education, can establish some, you know, support for these children; it will eliminate a lot of problems. (Policy maker, Education)

Secondly, it was suggested that schools could act as a vehicle for mental health literacy programmes, with the aim of reducing stigma and encouraging healthy behaviour. Finally, mental health promotion for educators was suggested by some, who felt that the mental health of teachers is a wholly under-recognized issue, which can affect the ability of educators to engage with mental health programmes. This sentiment was also echoed by some respondents in reference to health workers and other public servants.

Mental illness prevention

The importance of the prevention of mental illness was most strongly supported in the education setting. Stakeholders often referred to children and adolescents with poor mental health being at particular risk of dropping out of school as is shown in the quote below:

I felt better later that year and then I went back to school. But I never finished school. I still wish I could finish school but I am not sure how I could do it. (District mental health care user)

In order to prevent the devastating consequences of school drop-out, which were identified as affecting career choices, earning potential and mental health outcomes, a specific role identified for the education sector was increasing the capacity of educators in the early identification of learners at risk for mental health problems.

Your educators need to be sufficiently knowledgeable, they're not necessarily the experts, but have knowledge around identification. [later]...there needs to be, in their training, something which says that when a child starts to display 'blah', you need to be sufficiently alert to know that this child, it's a call for help. (Director, provincial mental health NGO)

A focus on prevention of mental illness through early identification was also deemed relevant to other sectors, as illustrated by this comment from a representative from the Department of Correctional Services:

Interviewer: And do you have any idea why the juveniles might be so vulnerable?

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Respondent: For me...it's the issue of being in prison because most of them commit suicide within the first six months of admission, not after a year, because I think after six months they have adjusted to the prison system. But I think it's the shock of being in prison, the issues of being not free anymore, pressure to belong to gangs.

Beyond primary prevention, respondents frequently discussed the role of service provision in lessening the impact of an existing mental illness in the life of an individual. For example, anti-poverty initiatives supported by the social development sector were discussed principally in terms of how they could impact on the mental health of those affected:

They would be going through depression and they would be going to the clinic from time to time but the moment they get into the projects then they're eking a living for themselves; that status begins to change...in terms of them having something to do and going to do it mainly changed their ability and just their outlook to life. (Representative, South African Council of Churches)

In the same vein, several consumers spoke of the necessity of transport to access different types of mental health care and the potential impact on mental health:

As soon as a person with mental illness does not have transport...first thing is they gonna miss their appointments with their doctors they gonna miss their medication. (User and advocate)

In the quote below, this respondent explains that not only does the ability to access basic services lessen the impact of the illness, but that makes a positive contribution to the process of recovery:

I really believe in it [supported accommodation]...you genuinely see first of all an improvement in the quality of life for people with psychiatric disorders. Suddenly, if they are provided with the necessary support they are have an opportunity to engage in life and have some meaning and some quality...the residents and the people who use those services have far less re-admissions. (Manager, NGO)

Removing barriers to service delivery for people with mental disabilities

Respondents recognized that there are significant barriers to a range of services for people with mental disability in South Africa. For example, in accessing

social security:

The social security system looks at disability as physical, and without any physical manifestations for people with mental disabilities; it's often difficult for them to access social security. (Director, mental health NGO)

This stakeholder went on to identify similar difficulties in the justice sector:

Justice, we're still struggling with getting them on board and I think that they are critical especially in the issue of the court system and how it accommodates people with mental disabilities.

Participants made several references to the removal of barriers to service delivery as a means of promoting the integration and participation of people with mental disabilities in community life, as seen in the quote below:

A person with a mental illness must be accepted by the community... They must not be isolated because they have got a mental illness. They must stay around the community with people they know, with people who used to like them and the people they love. (User and advocate)

Within the education setting, it was suggested that this process can occur through the development of an inclusive and supportive education system:

We need to create community schools which will be there to cater for all the educational needs of all the people in the community. And that is what I mean if I do give you a definition of 'inclusive education'. (User and advocate)

Respondents provided a range of strategies to remove barriers to participation within the labour sector, including developing guidelines for the reasonable accommodation of mental health care users. For those already unemployed, it was recommended that those with psychosocial conditions are actively included in skills building and employment initiatives provided by the labour sector. Related to this, several service users reported that they were in need of specific skills in order to increase their ability to gain access to employment, outlining a further role for the education sector.

Participants were less clear about the roles of the housing sector. There was concern about the lack of community-based accommodation for people with chronic mental illnesses, but at least one respondent felt that the housing sector should not be responsible for the provision of supported housing. Others indicated that in line with the South African housing sector's social housing policy, barriers to the provision of housing should be removed for vulnerable

groups through targeted allocations, in order to protect their right to access housing on an equitable basis:

The National Housing Policy talks about special needs housing... People with mental illness, who need group homes and assisted living residential facilities... those are referred to as special needs housing. (Director, mental health NGO)

Intersectoral collaboration: How to formulate the approach

Respondents gave a range of suggestions of how to formulate an intersectoral response in the South African context. Firstly, the need for high-level political commitment for such an initiative to succeed was made clear.

We can actually have all these enabling policies and documentation and how we would like to actually integrate, but without the willpower and the resources and the commitment from key stakeholders, it's very important, we won't be able to do it. (Policy maker, Social Development)

Secondly, respondents identified the use of current networks between departments as a springboard for intersectoral collaboration in policy and decision-making processes, such as in this example, the 'social cluster', which includes the health, education and social welfare departments.

I think we should take the matters through the social cluster because there's a lack of collaboration from Health, who approach us for the implementation of that section, and it's actually also basically their Act. So they should actually take the initiative to keep this whole matter on the table. (Policy maker, Education)

The health sector was identified as a key partner in the development of an intersectoral approach due to their position in relation to treatment issues, technical expertise, and experience.

We work with the Department of Health, they're the responsible department for mental health; they are the custodian of the Mental Health Act and everything else. (Policy maker, disability sector)

Thirdly, the importance of creating a culture of communication between departments was emphasized:

Government has learned that [the way] for our strategies to work more effectively... is to talk to one another. For instance if Health is developing a policy for mental health... that

would also impact on housing... So that is important: to ensure that whatever programme that we implement, we do it jointly, and when we reach out to the community, we are talking the same language. (Policy maker, Housing)

Fourthly, working through special parliamentary mechanisms was also suggested. This could draw attention to the high levels of discrimination experienced by people with mental disabilities and ensure that mental health concerns are represented at the highest level of government.

We have a portfolio committee that looks at issues of people with disabilities, so they have that oversight role. They use it because they are able to call in a Director-General of a particular department and say: tell us what you are doing in terms of implementing the government disability strategy... And then in the Presidency we have a whole Directorate... the OSDP [the Office for the Status of Persons with Disability¹] that is there to also give that broad framework, hence the strategy that we have, and the machinery goes even further to government departments. (Policy maker, Justice)

Fifthly, the use of local government structures was stressed. Respondents indicated that local government needs to develop responses to mental health issues by taking up the provision of support services within their own communities, in line with the national policy of deinstitutionalization.

Local government needs to prioritize the issues of mental disabilities and recognize mental disability as a feature in their communities, and then from then onwards we need to dedicate particular support care, social services, health services. (Director, mental health NGO)

Several strategies were identified as a means of doing this. Firstly, involvement of community-level stakeholders to provide insight on local issues was recognized as a key step in developing a mental health response. For example, a teacher commented on the importance of stakeholder involvement to overcome the secrecy surrounding sexual crimes such as rape:

They keep quiet about a lot of things... [you] can have programmes here in school just for the sake of it but stakeholder involvement matters; you can't work with a secretive community. What are you going to get because when you work you have to get something from the people... you get nothing. (Teacher, district level)

The development of governance structures to deal with mental health issues such as the development of

an intersectoral mental health forum, and the involvement of service users in political activities at a local level was advocated:

There's one individual who goes to Council meetings, representing the association, representing people with mental disabilities... They've got a forum for disabilities and this chap represents mental health and at this meeting they also discuss issues around disability. (User and advocate)

By developing the role of consumers, they would be empowered to participate more fully in their own communities, according to several respondents.

You've got to have people with disabilities participating in community life; which means that you create conditions that would allow them to participate in community life, from the family perspective to the community and the society. (Policy maker, disability sector)

Discussion

Intersectoral collaboration is embedded within the South African approach to public health (RSA, 2003). The results of this study, however, reveal limited intersectoral collaboration for mental health in South Africa, despite widespread awareness of the cross-cutting nature of mental health issues and the resultant links with a range of sectors. There was also general positive support for greater intersectoral initiatives among those interviewed.

Suggested roles and responsibilities for intersectoral partners

Based on the suggestions from the stakeholders who were interviewed, a number of potential roles for various sectors can be identified (Table II). The roles outlined in Table II draw from stakeholder suggestions which have been reframed and further elaborated in order to provide a comprehensive picture of potential roles for various non-health sectors. In addition to this, where respondents identified gaps in knowledge and indicated that health department support would be required, we have articulated specific areas for health sector involvement.

Although not exhaustive, Table II shows expanded roles for a range of sectors that were identified by respondents, including transport, local government, housing, justice, correctional services, police services, social development and education.

Several sectors were identified as having roles in promoting mental health or preventing mental illness, as well as increasing accessibility to their services for those with mental disability. For the purposes of

Table II. Intersectoral roles and responsibilities recommended by South African stakeholders.

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"> Development of school-based mental health promotion programmes for learners Provision of counselling to children and adolescents with mental and related learning disorders Development of employee assistance programmes for educators Introduction of mental health literacy education into curriculum to increase awareness and healthy behaviours, and decrease stigma 	<ul style="list-style-type: none"> Integration of people with intellectual disabilities into the inclusive education system Collaboration with health sector to promote ongoing learning following periods of illness, development of joint approach to management of affected children and adolescents Collaboration with the labour sector to coordinate basic education outcomes with skills and vocational training opportunities and career path development for people with mental and intellectual disability 	<ul style="list-style-type: none"> Identification and management guidelines for educators working with children and adolescents with intellectual disability and mental and substance use disorders Development of protocols for the management of employee assistance programmes for educators 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) Assessment and review of the need for specialized mental health expertise within the school sector
Labour	<ul style="list-style-type: none"> Increased awareness of mental health benefit of provision of employment, with an emphasis on youth Including mental health promotion in employee wellness guidelines 	<ul style="list-style-type: none"> Clarity on the roles and responsibilities of Department of Labour for skills development, vocational training opportunities and career planning for people with mental and intellectual disability Inclusion of people with mental disability in monitoring employers' compliance with equity targets 	<ul style="list-style-type: none"> Development of technical guidelines for the implementation of the reasonable accommodation provisions of the Employment Equity Act, with respect to people with mental disabilities
Social development	<ul style="list-style-type: none"> Increased targeting of people with mental disabilities in poverty alleviation programmes Increased awareness of the mental health benefits of being a recipient of poverty alleviation strategies, including social grants Increased awareness of early childhood intervention as a mental health promotion programme 	<ul style="list-style-type: none"> 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 comorbid substance abuse and mental disorders and in the provision of community based mental health services Development of guidelines to facilitate access to social grants for people with mental or intellectual disabilities 	<ul style="list-style-type: none"> Identification and management guidelines for social sector workers working with intellectual disability and mental and substance disorders in Child and Youth Care Centres Guidelines to identify people with mental and intellectual disabilities for social grants 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
Police services	<ul style="list-style-type: none"> Early identification and referral of youth offenders 	<ul style="list-style-type: none"> 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 s/he is judged to be a danger to him/herself or others due to mental illness or intellectual disability 	<ul style="list-style-type: none"> 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 hospitalization

(continued)

Table II. Continued.

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
Correctional services	<ul style="list-style-type: none"> • Early identification and referral for treatment of prisoners 	<ul style="list-style-type: none"> • Develop guidelines for the management of prisoners with mental health conditions, substance abuse and suicidality 	<ul style="list-style-type: none"> • Assistance with identification and treatment guidelines development
Justice	<ul style="list-style-type: none"> • Early identification and referral for treatment of those awaiting trial 	<ul style="list-style-type: none"> • Development of special courts for those with intellectual disability or impaired decision-making skills • 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 	<ul style="list-style-type: none"> • Assistance with developing appropriate court procedures for people with intellectual disability • Training of magistrates in the identification and management of offenders with mental health conditions
Housing	<ul style="list-style-type: none"> • Increased awareness of mental health benefit of provision of adequate housing 	<ul style="list-style-type: none"> • Agreement on the responsibilities of Department of Human Settlement (policies to support inclusion, municipalities (provision of transitional and permanent housing), NGOs (support programmes for residents) and Social Development (programmatically funded to NGOs) in housing provision • Review of special housing needs policy to accommodate subsidy of the housing needs of people with mental and intellectual disability, and to support their access to housing provision through the national housing programme (family and community residential care) 	<ul style="list-style-type: none"> • Eligibility and procedures to accommodate subsidy and equitable access to housing provision (family and community residential care)
Local government	<ul style="list-style-type: none"> • Building awareness of the mental well-being benefits of the provision of basic services such as water, electricity and sanitation • Inclusion of programmes for the promotion of mental well-being and prevention of mental illness in municipal health services 	<ul style="list-style-type: none"> • Clarity on the role of local government in including people with mental and intellectual disability in the provision of community and municipal services to disabled people under their jurisdiction • Including the needs of people with mental disability in accessibility plans, for example transport, housing, recreational needs of people with mental disabilities 	<ul style="list-style-type: none"> • Input at local level to assist with the development of accessibility plans and local programmes
Transport	<ul style="list-style-type: none"> • A safe and effective public transport system will promote mental well-being by increasing all citizens' access to work, social and recreational opportunities, and to public services 	<ul style="list-style-type: none"> • Investigate travel pass or benefit for disabled citizens to increase access to work, hospital services and social supports 	<ul style="list-style-type: none"> • Assistance with guidelines for eligibility and procedures for travel pass

this paper, we will expand further on two examples from Table I, namely the education and labour sector. Firstly, the education sector is ideally positioned to incorporate mental health promotion and prevention of mental illness into their practice through the

development of school-based programmes. Early identification of children and adolescents at risk for developing poor mental health, such as those with specific learning difficulties, could impact upon school drop-out rates (Myer et al., 2009). In addition,

the provision of targeted specialized support, to promote the inclusion of children and adolescents with mental disorders, will mean that all learners will be able to participate in school life on an equal basis. In developing education's role, technical expertise will be required from the health sector. This could include assistance with developing identification, management and referral guidelines for schools, employee assistance programmes for educators with work-related and other mental health conditions, and the development of a district-based model for child and adolescent mental health services.

Secondly, the labour sector is the key stakeholder in this process, especially in the current conditions of high unemployment in South Africa. Not only is unemployment linked with mental disorders (Araya, Rojas, Fritsch, Acuna, & Lewis, 2001) but it has been shown that young people with limited job opportunities experiencing educational pressures have higher rates of suicide (Patel, Flisher, Hetrick, & McGorry, 2007). On the other hand, to ensure that people with, or at risk for, poor mental health are able to access labour sector initiatives there is a need for increased clarity on the roles and responsibilities of this sector in skills training and career development for people with mental and other disabilities. This is particularly pertinent for youth, as most mental disorders have their onset before 24 years, meaning that they might miss out on mainstream training opportunities (Patel et al., 2007). Additionally, the findings from this study revealed that it appears that people with mental disability are often forgotten in the implementation of the equitable employment legislation, and further work is required to ensure that this group also benefits from its provisions.

Formulating the approach: What lessons from South Africa?

Based on the findings from this study, a number of lessons can be generated for other low- and middle-income countries.

Lesson 1: Develop supportive legislation and policy alongside the other formalized structures for intersectoral action

Intersectoral action is most likely to succeed in settings where government structures are supportive of this process, and awareness of the importance of this approach appears to be growing. The importance of intersectoral collaboration appears to be commonly recognized in African health policies (Barry, Diarra-Nama, Sambo, Kirigia, & Bakeera, 2009). There are even documented examples of LMIC non-health sector regulations having an impact on mental

health outcomes, as is evident in the Sri Lankan government's systematic approach to banning dangerous pesticides in their country which led to a drop in suicide-related deaths (although not in rates of attempted suicide) (Gunnell et al., 2007; Patel, 2007). Responses from this study, however, show that while legislation and policy are important mechanisms to support the process, in the South African context this has not been sufficient in addressing mental health issues. LMICs need to invest in the development of protective legislation alongside other methods of achieving change, such as the constitution of an intersectoral forum for mental health, following guidelines set out in South Africa's 1997 White Paper for Health (DoH, 1997). In this setting, examples of this type of initiative already exist, such as the South African National AIDS Council, which brings together stakeholders from a range of sectors to advise government on issues pertaining to HIV-AIDS. Initiatives from other countries also show the effectiveness of this approach: in assessing the success of implementing intersectoral action for health in Brazil, researchers point to the importance of public participation in local level forums as a means of successfully drawing attention to invisible health issues (Dall'Agnol Modesto et al., 2007).

Lesson 2: Develop leadership in the health sector and beyond

Participants were much more likely to articulate clear strategies for the government departments that fall within the traditionally 'social' services, such as health, education and social development. This tendency was evident in participant responses about leadership in mental health, and many indicated that the health sector should head the development of an intersectoral response, due to the historic involvement of this sector in mental health issues and their resultant technical expertise. This echoes findings in the literature which suggest that the health sector should take responsibility for facilitating intersectoral action to address the social determinants of health (Gilson, Doherty, Loewenson, & Francis, 2007).

There is, however, evidence that a range of potential mechanisms remain underutilized, and that involvement of other cross-cutting agencies would greatly enhance the development of an intersectoral approach to mental health. For example, while there were a number of references to child and adolescent mental health, no stakeholders identified intersectoral structures dedicated to young people as potential vehicles for driving an intersectoral response. This is also true of the disability sector. The findings that mental disability is often absent from the disability discourse are worrying in

the light of evidence that the invisibility of HIV-AIDS was identified as a barrier in early efforts to formulate intersectoral approaches to combat this disease (Hemrich & Topouzis, 2000). There is even some evidence of the exclusion of people with mental disabilities in the work of some sectors, for example in the recent South African Adult Basic Education and Training policy which refers only to physical disability (DoE, 2003). The disability, youth and children's sectors should be actively involved as leaders in the formulation of an intersectoral response for mental health issues. Ministries responsible for these issues should engage lobby groups to inform policy direction and service development for these groups.

Lesson 3: Employ targeted awareness-raising to engage sectors

As indicated above, respondents were largely able to identify the impact that various types of service delivery could have on mental health, but found it more difficult to articulate specific roles and strategies, particularly for historically less involved sectors, such as housing and labour. In order to mount an effective intersectoral campaign in LMICs, where knowledge about mental health as a development issue tends to be low, there is a need for effective awareness-raising which targets these identified sectors.

Previous research suggests that framing health issues in a manner to which non-health sectors can relate can increase awareness about the need for intersectoral action (WHO, 2008). Engaging other sectors is best done by packaging information that speaks directly to the priorities of the targeted groups, formalizing relationships between sectors, setting explicit workable targets, and using existing government organizational structures which support this approach (Gilson et al., 2007). Drawing attention to the economic implications of poor population mental health is a potential approach. (Scott, Knapp, Henderson, & Maughan, 2001). The personal burden of mental ill-health is also an important consideration (Knapp, Mangalore, & Simon, 2004). Focusing on human rights issues associated with mental health is another potential means of drawing attention to the issue. The use of public hearings to draw attention to mental health issues, as suggested by one respondent, is a strategy which could be implemented through existing bodies such as the local Human Rights Commission, or other organizations that have an intersectoral reach. In a similar vein, in Brazil the introduction of a national commission looking at the social determinants of health has encouraged debate about these issues, initiated

new research, and focused press and public attention on these issues (Buss & Filho, 2006).

Lesson 4: Develop a formal, structured approach to intersectoral action for mental health

Results from this study indicate that there is currently a piecemeal approach to intersectoral action, which has resulted in unclear roles and a lack of budgeting, and essentially meant that the response in this setting has been weak, due largely to the invisibility of mental health as a priority. This demonstrates the need for countries to commit to a structured response which includes stakeholders entering into formal agreements, the development of tangible strategies, and measurable goals and targets (Gilson et al., 2007). Respondents spoke frequently of using opportunities within existing mechanisms for intersectoral collaboration and this needs to be more closely explored in different settings. For example, in the current South African context, a working group meets to look at issues of policy implementation, review and improvement across the social sectors, in order to ensure coordination across sectors (Onya, 2007), which could be targeted in the development of an intersectoral response.

Information is a cornerstone to this process: there is currently a dearth of information about mental health in South Africa and many other LMICs, which is crucial for both decision-making and monitoring of systems and programmes (Saxena, van Ommeren, Lora, Saraceno, 2006). While intersectoral programmes are notoriously difficult to monitor (Walley et al., 2008), there are certainly opportunities for information-sharing. For example, tracking the number of people with mental disabilities who are receiving social security benefits or government housing and comparing these figures with health service use indicators could provide some information about service delivery patterns at local level.

Lesson 5: Work at local level

The importance of working at all levels of government was strongly reflected in the responses of stakeholders involved in the study. While it is clear that high level support will be central to the initiation and development of intersectoral work at a micro-level, local municipalities need an increased cognisance of the mental well-being benefits of the provision of basic services such as water, electricity and sanitation (Breen et al., 2007); to develop programmes for the promotion of mental well-being and prevention of mental illness in municipal health services; and to include the needs of people with mental disability in accessibility plans for

transport, housing, and recreational facilities (Corrigall et al., 2007). Working at local community level will also allow for increased involvement of civil society groups, such as user groups, who might not have access to national level processes. Several examples in the literature describe the participation of marginalized groups and the involvement of non-governmental partners at this level as significantly contributing to the success of an intersectoral approach (Assai et al., 2006; WHO, 2008). In South Africa in particular, the emerging intersectoral HIV response has been largely attributed to the success of the sector in mobilizing civil society organizations (Schneider & Stein, 2001).

Limitations

There are limitations in this study that should be noted. Firstly, the respondents were selected through purposive sampling, based on their exposure to mental health and disability issues within their own fields of expertise. It is possible that there are respondents whose perspectives were not captured by those sampled. Further work to explore these recommendations and the feasibility of their implementation will be required.

Conclusion

Governments in low resource settings need increased awareness of mental health as a cross-cutting development issue and the range of sectors that have a role to play in promoting mental health, preventing mental illness, and removing barriers to the participation of those with mental disability in their communities. In addition to the development of supportive legislation and policy, governments should initiate the development of formalized processes to facilitate an intersectoral response to mental health, led by the health sector and with ongoing input and support from other existing intersectoral mechanisms.

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Note

- [1.] As of April 2009, the OSDP is known as the Department of Disability and is housed within the Ministry for Children, Women and People with Disabilities.

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