THE MENTAL HEALTH GAP IN SOUTH AFRICA – A HUMAN RIGHTS ISSUE

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Introduction

On 30 March 2007, South Africa became a signatory to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol.[2] This was ratified several months later on 30 November 2007. The CRPD was negotiated during eight sessions of an Ad Hoc Committee of the General Assembly from 2002 to 2006 and adopted on 13 December 2006. To date, there have been 140 signatories to the CRPD (with 59 ratifications) and 83 signatories to the Optional Protocol (with 37 ratifications). The CRPD is intended as a human rights instrument with an explicit social development dimension and constitutes a significant global commitment to a human rights framework in which issues of achieving substantive equality and the full and unfettered rights of persons with disabilities are placed at centre-stage.

In aligning itself to this international human rights treaty, the South Africa Government committed itself to a radical new approach to persons with disabilities of all kinds, based on the fundamental premise that such persons are "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society. Importantly, mental health conditions are conceptualised as disabilities within the CRPD.[3] This political act by the South Africa Government has profound implications for both the health and social development agenda. Furthermore, the establishment of the international Committee on the Rights of Persons with Disabilities, which has oversight and monitoring functions, means that citizens of signatory states, including South Africa, have a means of reporting local violations and obtaining redress.

Despite the significance of this major step towards achieving human rights for disabled persons, it seems that there is widespread ignorance, both within and outside the public health sector, of the CRPD and its expectations. Similarly, members of the general public, whom the treaty is intended to protect, are likely to have little or no knowledge of its existence and its implications for their lives. By all accounts, the South Africa Government is not carrying out its obligations and responsibilities as a signatory to the CRPD. As is the case in many low- and middle-income countries (LAMICs), health and social services for the mentally disabled remain grossly inadequate, under-developed and under-funded.[4] The rights of such persons as outlined in the CRPD are routinely violated, and mentally disabled people generally remain isolated, stigmatised and in many cases disenfranchised 16 years after the end of apartheid.

South Africa's commitment to this international treaty followed an earlier domestic commitment to human rights for people with mental disabilities in the form of new

mental health legislation. The Mental Health Care Act 2002 (MHCA) was implemented in 2004 and was generally hailed as one of the most progressive pieces of mental health legislation in the world.[5] An entire chapter was dedicated to human rights for those with mental disabilities. Furthermore, the MHCA contained articles addressing compulsory admission, protection of patients' property, rights to appeal, the reporting of abuses and the formation of independent review boards with ombuds functions. It also highlighted several important principles including: the use of the minimum possible compulsion; the importance of not just treatment but also rehabilitation and reintegration; the decentralisation of mental health care from large psychiatric institutions into district and community-based health services; and the integration of mental health into primary health care.[6]

Unfortunately, the MHCA was an unfunded mandate. Very little preparation occurred – training was not provided, facilities were not developed at district and primary care levels, and no budget was allocated by the government for implementation of such a potentially transformative piece of legislation. The result is that now, six years later, a host of chronic problems are encountered throughout health services nationwide in relation to the care, treatment and rehabilitation of those with mental disabilities.[7]

This paper describes the "mental health gap" that exists between current resources for mental health care in South Africa and the huge "burden" of suffering and disability due to mental illness and disability.[8] It identifies the multiple inequities that exist between resources and opportunities for the physically ill and those for the mentally ill.[9] Finally, this paper considers the CRPD, its implications for the conceptualisation and understanding of mental disability, and the challenge it represents for transforming South Africa's health and social systems as well as its society from its current situation of gross inequity and discrimination against those with mental disabilities towards a situation where the mentally disabled enjoy full parity and human rights.

1. The Global "Mental Health Gap"

1.1 The Global Mental Health Burden

Globally, mental and neurological disorders are responsible for approximately 14% of the global burden of disease, while over 30% of disability-adjusted life-years (DALYs) are attributable to these disorders.[10] This is expected to increase over the next decades. Currently, neuropsychiatric disease surpasses both cardiovascular disease and cancer as the leading cause of disability due to non-communicable disorders. In addition, mental disorders are commonly co-morbid with physical disorders such as heart disease, cancer and metabolic diseases.[11] This is particularly relevant to LAMIC contexts within Sub-Saharan Africa where the HIV/AIDS pandemic has added considerably to the burden of neuropsychiatric disease and disability.[12] Mental disorders are responsible: for increased mortality due to suicide and reduced life expectancy; for considerable individual and collective suffering; for significant loss of social and occupational functioning and productivity; for extensive disability; and for a major burden on caregivers and families. The impact of mental disability is felt most keenly in LAMIC contexts.[13] For example, approximately 86% of the 800,000 annual suicides globally occur in LAMICs and this may be an underestimate as surveillance and reporting systems are often inadequate within these contexts.[14] There is evidence that maternal and perinatal mental

disorders are more common in LAMICs[15] and further evidence supports an association between perinatal and maternal mental illness and a number of negative infant outcomes (including low birth weight, under-nutrition, poor growth, diarrheal disease and impaired motor and cognitive development).[16] Mental illness and disability is both a cause and outcome of traumatic injuries and accidents.[17] Finally, substance use disorders commonly co-occur with mental illnesses and are associated with multiple negative health and social effects.[18]

1.2 Global Mental Health Resources

Despite these alarming facts, services for mental illness and disability are almost universally inadequate. Furthermore, while advances have been made in general health promotion and prevention, the same cannot be said for mental disability. Ignorance, prejudice and stigma are widespread. This situation is undoubtedly worse in LAMIC contexts. Analysis of data from the World Health Organisation's Atlas Project on mental health shows "widespread, systematic and long-term neglect of resources for mental health care in low-income and middle-income countries".[19] Essential community-based mental health care services exist in only half of LAMICs, while only 60% of countries worldwide have facilities to train primary health workers in mental health care. Within Africa and Asia there is a gross inadequacy of beds for those requiring hospitalisation for mental illness. The median number of beds in African countries is 0.34 per 10,000 population and 73% of these are in psychiatric hospitals. In Asia the situation is worse with only 0.33 beds per 10,000 population and 83% of these located in psychiatric hospitals.[20] By contrast, Europe has a median of 8 beds per 10,000 population and, with the exception of some LAMIC countries in Central and Eastern Europe, most of these beds are in community-based hospitals.[21] Many psychiatric hospitals remain unsuitable for rehabilitation and reintegration of individuals admitted with severe mental disorders. Similarly, there is major inequity between high-income countries (HICs) and LAMICS in terms of trained mental health professionals. The average number of psychiatrists in HICs, for example, is 10.5 per 100,000 population, as opposed to low-income countries (LICs), where the average number is 0.05 per 100,000 population.[22] Globally, mental health receives a disproportionately small proportion of health budgets and mental health services are therefore funded from general health budgets where they receive low priority. This is especially the case in countries dealing with other major health problems such as HIV/AIDS, tuberculosis and malnutrition. In terms of mental health legislation and policy, LAMIC regions fare especially poorly. Globally, approximately a third of countries have no such regulations, while in Africa only half do. Of those countries that do have mental health legislation, a large proportion have not revised their legislation for decades, leaving persons with mental illness without legal protection.[23]

2. The "Mental Health Gap" in South Africa

2.1 The Mental Health Burden in South Africa

South Africa is a middle-income country with a population of 47 million characterised by multiple societal-level socioeconomic risk factors for mental illness and disability (see Table 1). It ranks 13th highest in the world in terms of the proportion of the population living under the poverty line (50%); is second highest in terms of income inequality (GINI coefficient is 65); has the 19th highest unem-

ployment rate (24%); and has a high rate of urbanisation, lying 41st with a rate of 1.4%.[24] In addition, South Africa has extraordinarily high rates of crime and violence, one of the highest road accident death rates in the world, and lies 99th out of 121 countries in a 2007 *Economist* rating using a "Global Peace Index".[25] It has the 4th highest rate of drug offences and, according to the United Nations Office on Drugs and Crime (UNODC), South Africa now ranks within the top 30% of countries in terms of rates of opiate addiction.[26] South Africa is also located at the epicentre of the HIV/AIDS pandemic in Sub-Saharan Africa with the 4th highest prevalence rate (18%) and the greatest number of people living with HIV/AIDS worldwide.[27] HIV/AIDS is associated with a significantly increased burden of neuropsychiatric disease and disability including depression, anxiety, psychosis and dementia.[28] Furthermore, the mortality due to AIDS impacts on children, hundreds of thousands of whom have been orphaned. Child-headed households are now a common phenomenon in South Africa. There is now substantial evidence that poverty, inequality, urbanisation, unemployment, trauma and violence and substance abuse are major environmental risk factors for mental illness and therefore increase the burden of mental illness and disability within a society.[29]

Indicator		**Ranked in the world (total no of countries)**
Proportion of the population living under the poverty line	50%	13th highest (100)
Index of income inequality (GINI coefficient)	65	2nd highest (134)
Unemployment rate	24%	19th highest (131)
Urbanisation rate	1.4%	41st highest (63)
Murder rate (per 100,000 population)	47.5	3rd highest (121)
Rapes (per 100,000 population)	1.2	1st highest (65)
Assaults (per 100,000 population)	12.1	1st highest (57)
Burglaries (per 100,000 population)	8.9	10th highest (54)
Total crimes (per 100,000 population)	77.2	10th highest (60)
Drug related offences (per 100,000 population)	53.8	4th highest (60)
Incarceration rate (per 100,000 population)	335	18th highest (155)
Road traffic deaths (per 100,000 population)	33.2	24th highest (178)
Opiate drug abuse (per 100,000 population)	0.38	47th highest (133)
Global Peace Index	2.4	22nd lowest (121)
HIV prevalence	18%	4th highest in world

Indicator		Ranked in the world (total no of countries)
Number of people living with HIV/AIDS	5.7 million	1st highest in world
HIV/AIDS deaths per year	350,000	1st highest in world
Tuberculosis incidence (per 100,000 population)	600	9th highest (200)
Life expectancy at birth (years)	48.9	16th lowest (221)
Death rate (per 1,000 population)	17	12th highest (220)
Infant mortality rate (per 1,000 live births)	44.4	59th highest (221)
Suicide rate – total (per 100,000 population)	15.4	22nd highest (106)
Suicide rate – male (per 100,000 population)	25.3	17th highest (103)
Suicide rate – female (per 100,000 population)	5.6	26th highest (103)
Physicians (per 1,000 population)	0.77	119th highest (201)
Psychiatrists (per 100,000 population)	0.28	
Psychologists (per 100,000 population)	0.32	
Social workers in mental health (per 100,000 population)	0.4	
Occupational therapists in mental health (per 100,000 population)	0.13	
Nurses in mental health (per 100,000 population)	10	
Psychiatric beds in mental health facilities (per 100,000 population)	24	

Table 1: Socioeconomic and health indicators for South Africa

Until quite recently, there was little in the way of epidemiological data on mental illness in South Africa. However, the South Stress and Health Study (SASH), which was part of the WHO World Mental Health (WMH) Survey Initiative conducted between 2002 and 2004, reported results of a population-based survey of 4351 adults.[30] The 12-month prevalence of any DSM-IV/CIDI disorder[31] was 16.5%, with the most common disorders being agoraphobia (4.8 %), major depressive disorder (4.9%) and alcohol abuse or dependence (4.5 %). The authors of the SASH study note that prevalence rates of common mental disorders are significantly higher in South Africa than in another WMH African country, Nigeria, and are in fact more similar to the rates reported from Colombia

and Lebanon. Interestingly, both of these countries have a number of socioeconomic features in common with South Africa and likewise have experienced chronic conflict.[32] The SASH study authors also observe that the estimated prevalence of substance abuse in South Africa (5.8%) was at least about twice as high as that in other WMH countries, with the exception of Ukraine. With a national suicide rate of 15.4 per 100,000 population, South Africa is ranked 22nd in the world.[33]

2.2 Mental Health Resources in South Africa

Despite South Africa's progressive mental health legislation (i.e. MCHA), multiple barriers to the financing and development of mental health services exist, which result in: (i) psychiatric hospitals remaining outdated, falling into disrepair, and often unfit for human use; (ii) serious shortages of mental health professionals; (iii) an inability to develop vitally important tertiary level psychiatric services (such as child and adolescent services, psychogeriatric services, neuropsychiatric services, etc.); and (iv) community mental health and psychosocial rehabilitation services remaining undeveloped, so that patients end up institutionalised, without hope of rehabilitation back into their communities. This state of affairs remains unchanged despite the legislated commitments to reform mental health care in the MHCA.

While legislation exists and a mental health policy was approved in 1997, to date this policy has not been widely published or implemented together with guidelines.[34] This is due to both administrative and capacity issues and to the low priority given to mental health by provincial health departments.[35] In addition, there is no national mental health plan and, at a provincial level, only one of nine provinces has a specific mental health plan.[36] There is no specific budget for mental health either at national or provincial level and therefore mental health services are funded out of general health budgets where they inevitably end up at the bottom of a pile of pressing needs when money is allocated. In a recent survey of all nine provinces, Lund and colleagues found that only 3 provinces could report data on mental health expenditure – these reported 1%, 5% and 8% respectively.[37] While this range is about average for most middle-income countries, it reflects the disproportionately low allocation made to mental health (given the high prevalence of mental disorders and the fact that over 30% of disability-adjusted life-years (DALYs) are attributable to these disorders).[38]

Research conducted in KwaZulu-Natal Province reveals gross inequity in the allocation of provincial health budgets to psychiatric facilities.[39] Budget increases to six psychiatric hospitals over the 5-year period (2006-2010) ranged from 8% to 25% with a mean 5-year increase of 19% and a mean annual increase of 3.8%. This contrasted with budget increases to seven general hospitals over the same 5-year period, which ranged from 29% to 64% with a mean 5-year increase of 51% and a mean annual increase of 10.2%. The median cumulative budget increase for psychiatric hospitals was significantly lower than that of general hospitals, clearly illustrating a pattern of inequitable treatment of psychiatric hospitals in relation to general hospitals. Furthermore, this analysis showed that four of the six psychiatric hospitals surveyed experienced an actual year-to-year drop in budget allocations at some point during the 5-year period. None of the general hospitals experienced a drop in budget during the period. This highlights the impression that the government does not value psychiatric services and is prepared to sacrifice the

expansion of psychiatric services in order to maintain general hospital services.

The MHCA made law the introduction of Mental Health Review Boards (MHRBs) in every region of the country. The establishment of such boards is the responsibility of provincial departments of health. These boards have "ombuds" functions, representing the interests of patients, reviewing compulsory treatment, hearing appeals and investigating allegations of abuse. While MHRBs have been set up in most regions, their efficiency and effectiveness varies considerably. A recent review conducted in KwaZulu-Natal Province, for example, reported that the MHRB had visited only 7 of the 36 hospitals in the region in the preceding 6 months, while 10 hospitals had either never been visited or had not been visited for more than 2 years.[40] The authors observe that operational inefficiencies limit substantially "the capacity of the Review Board or judiciary to intervene timeously in the event of a violation of the Act".

In terms of hospital resources for psychiatry, South Africa is not too badly off compared with other African countries with 2.1 beds per 10,000 population, but fares badly in comparison with the European median of 8 beds per 10,000 population. Of these 2.1 beds, 1.8 are in psychiatric hospitals and 0.3 in general hospitals.[41] This figure represents just over 60% of the beds required to comply with norms established by the South African National Department of Health.[42] Availability of beds for psychiatric care varies substantially from province to province – for example, KwaZulu-Natal has only 25% of the number of acute beds required to comply with norms.[43]

Community-based services are worse off: there are only 80 day treatment facilities available in the country (for a population of 47 million) and half of these are provided and run by a non-governmental organisation (the South African Federation of Mental Health (SAFMH)). In addition, there are 0.36 beds per 10,000 population located within 63 community residential facilities nationwide and, again, half of these are provided by the SAFMH.

Resources specifically structured for the treatment of children and adolescents are grossly inadequate. Only 1.4% of outpatient facilities, 3.8% of acute beds in general hospitals and 1% of beds in psychiatric hospitals are for children and adolescents.[44] Information is not available for the total number of child and adolescent psychiatrists in South Africa (and the number varies considerably from region to region) but in general there are very few. For example, in KwaZulu-Natal Province (which has a population of 10 million) there are only two such specialists within the public health system.

Human resources for mental health care in South Africa are desperately inadequate. A recent national survey revealed that, per 100,000 population, the country has only 0.28 psychiatrists, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists and 10 nurses.[45] Thus, as far as psychiatrists are concerned, South Africa has less than 30% of the number required to comply with national norms of 1 per 100,000 population. Furthermore, this figure (0.28 per 100,000 population) falls far below the average for other middle-income countries (which is approximately 5 per 100,000 population) and even further below the average for high-income countries (which is approximately 15 per 100,000 population).[46] Furthermore, most mental health professionals tend to be located within urban centres, leaving large

rural regions of the country without such services. For example, of the 32 psychiatrists working in the public health sector in KwaZulu-Natal Province, only 6 are located outside of the major cities.

Thus it is clear that resources for mental health care are seriously inadequate in South Africa and, given the large burden of disease which is undoubtedly increased by socioeconomic conditions of poverty, inequality, violence and infectious diseases, there is a considerable gap between needs and services. This is borne out by recent research. In the SASH study, only 28% of adults with a severe or moderately severe disorder and only 24.4% of those with mild cases received treatment.[47] Other research in KwaZulu-Natal shows that a large proportion of the population relies on informal services in the community for mental health treatment.[48] In a sample of patients with first-episode psychosis (FEP), Burns and colleagues reported that 38.5% had consulted a traditional healer for the incipient psychotic illness prior to making contact with formal psychiatric services.[49] This compares with rates reported in FEP patients in other LAMIC contexts – a third in Zambia, 24% in Singapore and 23% in Iran.[50] Consultation with traditional healers may delay access to care for people with early mental illness and this in turn may impact negatively on the course and outcome of the illness.[51] Traditional healers are more geographically accessible and more culturally accessible to many citizens, particularly in the largely rural province of KwaZulu-Natal. There is good evidence that a significant proportion of individuals experiencing mental health problems in this region consult traditional healers as their first port of call despite the fact that the services of traditional healers are often more expensive than public health services.[52] In addition to geographical and financial barriers, another major factor leading individuals to traditional healers is societal stigma associated with the use of formal mental health services.[53] Thus South Africa, like most other LAMICs, is characterised not just by inadequacies in the availability of resources for mental health care but also by numerous barriers to access to mental health services.[54]

3. The Mental Health Gap Is a Human Rights Issue

The gap that exists between the burden of mental illness and disability and the relative lack of mental health resources in South Africa is a human rights issue. The state has an obligation to provide services for the health needs of its people; and it is clear that services for those with mental illness and disability are woefully inadequate and, for many people, inaccessible in that nation. South Africa is by no means the only country characterised by a mental health gap – indeed most countries fall short of meeting the mental health needs of their citizens.[55] However, South Africa is a nation that has publically declared its commitment to upholding the rights of the mentally ill and disabled – both in enacting one of the most progressive pieces of mental health legislation in the world[56] and through signing and ratifying the CRPD. In making these commitments, the government of South Africa has affirmed its belief that all members of the society have a fundamental constitutional right to care. Emerging from decades (if not centuries) of racism and discrimination based on ethnicity, the new regime has been both passionate and vocal in addressing the rights of minority and previously discriminated groups in society. The South African Constitution guarantees these rights and it is clear that discrimination on the basis of race, gender, sexual orientation

or physical disability is punished severely within the new dispensation.[57]

This is not the case however regarding those with mental illness or disability. As is still the case in many countries around the world, people with mental disabilities face multiple forms of inequity and discrimination in their daily lives.[58] Both outside and within the health system, patients encounter discrimination and prejudice – in the form of reduced work opportunities and social opportunities, disenfranchisement and restriction of civil liberties, inferior treatment of co-morbid physical illnesses, and in the form of social stigma. This is reflected, as we have seen, in the state's failure to close the mental health gap through the provision of resources. This means that people with mental disabilities experience a fundamental violation of their basic right to care by the state. This calls for a human rights approach to the mental health gap in South Africa as well as in other nations.

4. A Human Rights Approach to Inequity in Mental Health Care

The CRPD sets out a framework for a rights-based approach to disability and in doing so "calls for changes that go beyond quality of care to include both legal and services reforms" and "demands that we develop policies and take actions to end discrimination in the overall society that has a direct effect on the health and well-being of the [mentally] disabled".[59] The CRPD sets out a number of guiding principles:

a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;

b) Non-discrimination;

c) Full and effective participation and inclusion in society;

d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

e) Equality of opportunity;

f) Accessibility;

g) Equality between men and women; and

h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.[60]

In addition to these principles, the CRPD highlights the importance of a number of related rights. These include:

1) Equal recognition before the law, access to justice, and legislative reform to abolish discrimination in society;

2) Awareness-raising to educate society, combat prejudices and promote awareness of the capabilities of persons with disabilities;

3) The right to life, liberty and security of person including freedom from degrading treatment, abuse, exploitation and violence;

4) The right to movement, mobility, independent living and full inclusion within the community including full access to and participation in cultural life, recreation, leisure and sport;

5) Freedom of expression and opinion, access to information and full participation in political and public life;

6) Respect for privacy, for the home and the family, including the freedom to make decisions related to marriage and parenthood;

7) The right to equal education, work and employment including the full accommodation of individual requirements;

8) The right to health, habilitation and rehabilitation; and

9) The right to an adequate standard of living, suitable accommodation and social protection.[61]

With respect to mental illness, how does this framework inform our response to the inequities and discrimination present in society and mental health care? Specifically, if we take these principles and rights and apply them to the South African context, what actions are required to transform that society so that persons with mental disabilities experience full equality, an end to discrimination, and full recognition of their personhood? An action plan at national as well as local levels would include:

1. The development of a strong advocacy movement, led by persons with mental disabilities. Repeatedly it has been shown that "user-led" advocacy around issues of legal reform, services development, and societal transformation has been most effective in ending discrimination and stigmatisation and achieving human rights for specific minority communities.[62]

2. Legislative reform to abolish discrimination, outlaw abuse and exploitation, and protect personal freedom, dignity, and autonomy. Civil commitment laws that deprive individuals of their freedom "must provide for minimum substantive and procedural protections that protect mentally ill individuals' fundamental agency".[63] In addition, such laws should guarantee the rights to counsel, appeal, and review in relation to involuntary commitment as well as redress for violations. As mentally disabled persons may not be in a position to safeguard their personal rights while unwell, there should be a mechanism for active monitoring and enforcement of such rights. The MHRBs legislated in the MHCA are a good start and are intended to fulfil an ombuds function.[64] However, as discussed earlier, the functioning and actual power of these boards has so far been inadequate. If this is to be more than just a gesture then the state needs to act urgently to implement this important structure as an effective guardian of human rights for the mentally disabled.

3. Legislative reform to enforce equality of opportunity, access, and participation in all aspects of life. While health-related legislative reform is important, this must be accompanied by legal measures aimed at rectifying inequalities and discrimination that exist in respect of the mentally disabled in social, economic, and political facets of society. Substantive equality requires attention to the social context that contributes to the origin of mental disabilities as well as to the use of mental health services by individuals.

4. Inclusion of mental disability on the agenda of development programs and targets such as the Millennium Development Goals. At the international, national, and regional levels, mental disability rights and "needs" must be included in programs aimed at achieving development targets and alleviating poverty and inequality.

5. Mental health and social services reform with equitable funding for resources, infrastructure, and programmes development.

Along with other governments, the South African government should be pressured to heed growing calls for the up-scaling of health and social services relevant to mental disability as well as increased budget allocations for mental health.[65] Signatories to the CRPD and its Optional Protocol must be held to account in terms of their domestic planning. The establishment of the Committee on the Rights of Persons with Disabilities as a monitoring organ means that citizens of States Parties to the CRPD have a means of reporting local violations of the CRPD and obtaining redress.[66]

6. Removal of barriers to access to health services encountered by persons with mental disabilities. Legal reforms are required to remove financial barriers to access for those with mental disabilities. Legislation is also required to enforce equality and outlaw discrimination based on ethnicity, race, gender, and age within health services. Finally, education campaigns and programs on mental disability and the rights of mentally disabled persons should be conducted on an ongoing basis within the health service.

7. Removal of barriers to access to social, family-related, accommodation, educational, occupational and recreational opportunities, and full participation for persons with mental disabilities. Legislative reforms, as well as public and institutional education campaigns and programmes, should be implemented at national and local levels to remove these barriers to access, eradicate stigma, and ensure the full participation of persons with mental disabilities. Suitable accommodation is a fundamental right as enshrined in the CPRD, and domestic policies, planning, and legal reform need to be informed by an acknowledgement of this right.

8. Service systems reform to move away from institutional care toward providing treatment, care, rehabilitation, and reintegration within the community. As Alicia Yamin and Eric Rosenthal state:

> "From a human rights perspective, people are entitled to live in and receive care in the community not because it is more efficient, but because all human beings develop their identities within social contexts, and have rights to work and study, as well as be with family and friends."[67]

Furthermore, planning and decision-making power related to care in the community needs to be transferred to "the individuals and communities that the health system is supposed to serve".[68] This means the integration of "users" and family members into both national and local decision-making structures.

Conclusion

South Africa has "nailed its colours to the mast" through enacting legislation and signing international treaties aimed at upholding and ensuring the human rights of people with mental disability. Despite this, that nation continues to fall far short of meeting the needs of its citizens affected by mental illness. The mental health gap is considerable in South Africa, despite a progressive regime that has championed the rights of other disadvantaged groups in society. While laudable, South Africa's efforts to achieve formal equality should not stand alone, without similar advocacy focused on the achievement of substantive equality for persons with mental disabilities. Real life factors such as poverty, illiteracy, income inequality, homelessness, war and displacement, discrimination based

on ethnicity, race, and gender, social exclusion, stigma, and abuse all impact the mentally ill individual's ability to access services and realise full personhood within their communities. A rights-based approach to mental disability means domesticating such treaties as the CRPD. Using the framework of this convention and others like it, it is possible to formulate an active plan of response to the multiple inequalities and discrimination that exist in relation to mental disability, both in South Africa and in other nations.

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[2] The Convention on the Rights of Persons with Disabilities and its Optional Protocol were adopted on 13 December 2006. The Convention was opened for signature on 30 March 2007 and entered into force on 3 May 2008. The UN Enable website was established to report all aspects of the treaty and contains information on the guiding principles, entry into force, signatories, and monitoring of the Convention, as well as full-text versions of the Convention and its Optional Protocol in a number of languages. The UN Enable website is available at: http://www.un.org/disabilities/default.asp?navid=12&pid=150.

[3] Convention on the Rights of Persons with Disabilities, Article 1.

[4] See, for example, Kohn, R., Saxena, S., Levav, I. and Saraceno, B., "The treatment gap in mental health care", *Bulletin of the World Health Organization,* Vol. 82, 2004, pp. 858–866.

[5] Mental Health Care Act, 2002, available at: www.acts.co.za/mental_health_care_act_2002.htm.

[6] The principle of integration of mental health into primary health care is central to global mental health efforts. For example, WHO and the World Organization of Family Doctors co-sponsored an investigation into the progress made in integrating mental health into primary health care. For the report in full, see World Health Organization and World Organization of Family Doctors, *Integrating mental health into primary care: A global perspective*, Geneva, 2008.

[7] See Burns, J. K., "Implementation of the Mental Health Care Act (2002) at District Hospitals in South Africa: Translating Principles into Practice", *South African Medical Journal,* Vol. 98, No. 1, 2008, pp. 46-51; and Ramlall, S., Chipps, J. and Mars, M., "Impact of the South African Mental Health Care Act No. 17 of 2002 on regional and district hospitals designated for mental health care in KwaZulu-Natal", *South African Medical Journal,* Vol. 100, No. 10, pp. 667-670.

[8] Regarding the "mental health gap", see The WHO World Mental Health Survey Consortium, "Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys", *Journal of the American Medical Association,* Vol. 291(21), 2004, pp. 2581–2590. Note also that the use of the term "burden" here requires clarification. The term is not used in the sense of individuals being "burdensome" or a cause of hardship for others. The term is used to describe the added social and economic responsibilities and costs associated with either living with a mental disability or being in a care-giving role in relation to a person with a mental disability.

[9] For a comprehensive overview of the inequities and inequalities that characterise mental health care, see Burns J. K., "Mental health and inequity: a human rights approach to inequality, discrimination and mental disability", *Health and Human Rights: An International Journal,* Vol. 11, No. 2, 2009, pp. 19-31.

[10] Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R. and Rahman, A., "No health without mental health", *The Lancet*, Vol. 370, Issue 9590, 2007, pp. 859-877.

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[32] Colombia is rated 13th highest in terms of income inequality (GINI coefficient 53.8), 14th highest in terms of population living under the poverty line (49.2%), has the highest murder rate in the world (63 per 100,000 population) and is rated 116th out of 121 countries in terms of the Global Peace Index. Lebanon has a GINI coefficient of 45 (ranked 38th), has 28% of its population below the poverty line (ranked 49th) and is ranked 114th out of 121 on the Global Peace Index. See Central Intelligence Agency, *The World Factbook 2010*, above note 24; United Nations Development Programme, above note 24; and Institute for Economics and Peace and Economist Intelligence Unit, above note 25.

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[67] See above, note 59.

[68] *Ibid.*