

The State of Mental Health in South Africa Cross Examination of the Vicious Cycle of the Demographic and Socio-Economic Factors that Affect Mental Health

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Introduction

While numerous studies relate to mental illness, few provide prevalence estimates of diagnosable mental illness (e.g., major depressive disorder as opposed to feeling depressed, or generalized anxiety disorder as opposed to feeling anxious), and fewer still provide national prevalence estimates of diagnosable mental illness. It been proven that most people with alcohol or substance use and anxiety disorders experience them independently, but having both can be a vicious cycle. The symptoms of one disorder can make the symptoms another worse; an anxiety disorder may lead to using alcohol or other substances to self-medicate or alleviate anxiety symptoms. The co-occurrence of substance abuse, particularly alcohol abuse, is common among people who have social anxiety disorder. People with this disorder report that alcohol helps lessen their social anxiety, although it often makes it worse. Alcohol abuse usually develops after the onset of this disorder. PTSD and substance abuse commonly occur together. People suffering from this disorder often use alcohol or drugs to try to ease their anxiety, but substance abuse can exacerbate PTSD symptoms. Mental ill-health is strongly associated with poverty and social deprivation and living in poverty, exposure to stressful life events like crime and violence; inadequate housing, unemployment and social conflict, are all linked to mental ill-health. An overwhelming majority of people with mental and psychosocial disabilities are living in poverty, poor physical health, and are subject to human rights violations.

Mental health issues cannot be considered in isolation from other areas of development, such as education, employment, emergency responses and human rights capacity building. Despite overall global socio-economic development and improved social capital large part of this planet continues to be deprived. Poverty is one of the determinants of mental illnesses and social exclusion perpetuates deprivation. Since poverty is associated with exclusion, isolation, feelings of disempowerment, helplessness and hopelessness, it can lead to chronic insecurity and social mistrust, affecting people's mental well-being. Because of its close link to demographic and socio-economic factors, it is imperative that mental health is given as much weight or even more as a development issue and that appropriate programs are designed to address socioeconomic challenges resulting from mental disorders. In South Africa, as in many low- or middle-income countries (LMICs), the burden of mental disorders has grown over the past 20 years. Evidence suggests that nearly one in three South Africans will suffer from a mental disorder in his or her lifetime, a higher prevalence than many low- and middle-income countries. ().

Based on assessment with the Kessler Psychological Distress Scale, a measure of psychological distress, 17.1% of the patients (15.5% of men and 19.4% of women) had severe psychological distress. Having no income, poor health status, migraine headache and tuberculosis as significant factors associated with severe psychological stress for men. For women the factors identified were lower education, no income, having been diagnosed with a sexually transmitted disease, stomach ulcer and migraine headache. Findings from World Health Organization World Mental Health surveys on the global burden of mental disorders have shown that at least one-third of all patients seen in primary care in LMICs present with common mental disorders (CMDs). Majority of these is not recognized or are ineffectively treated. Although depressive and anxiety disorders are classified as separate diagnostic categories in the ICD-10, 1 the concept of CMDs is valid for public health

interventions owing to the high degree of co-morbidity between these disorders in primary care and the similarity in epidemiological profiles and treatment responsiveness.

In South Africa mental health is a vicious cycle whereby people with mental disorders will experience some of the worst forms of stigma and discrimination, linked to lack of awareness, misinformation and stereotyping about their condition. Consequently, they are denied the chance to participate fully in community activities or enjoy basic social services which pushes them further into poverty. Also the youths will start engaging in alcohol and substance abuse at very early ages which will reduce their chances of having a good education leading them to poverty and increasing their chances of developing mental disorders. Mental disorders negatively affect social capital of the affected and their families; yet this is a key asset for the poor and is an important element of sustainable poverty reduction. Some people with mental disorders become destructive, which often leads to strained relationships with neighbors and the need to spend money on dispute resolution at local courts; which further encroaches on their meager resources. Thus those who see their social capital eroded may face long-term, persistent and recurrent poverty. The mentally disturbed people will in most instances then be excluded from development programmes, membership of self help groups and government welfare schemes, and they find it difficult to find work. Even when they are willing to work, the rest of the community may be unwilling to offer them even casual work. There is the belief that mental illness is contagious exacerbates and intensifies stigma and exclusion.

The South African Stress and Health (SASH) 2009 described as the first large-scale population-based study of common mental disorders in the country. This study was conducted between 2002 and 2004 and provides the only nationally representative data on the prevalence of common mental disorders. This was based on two international systems for the classification of mental disorders and other health problems, the ICD-10 and DSM-IV. These included anxiety disorders, such as panic disorder and post-traumatic stress disorder, mood disorders (a major depressive episode, for example), disorders to do with impulse control, as well as alcohol and drug disorders. The findings from the study showed that alcohol and substance abuse disorders were highly prevalent exacting a high emotional toll on individuals, families, and society further intensify the situation. Health24 gives a sobering overview of psychiatry in South Africa, they indicate that in South Africa it is estimated that between four-and-a-half to five million people are suffering from a psychiatric disorder. When alcohol and drug abuse are included in this figure, it rockets to a frightening 15 million people. Jonathan K Burns in 2010 summarizes the situation arguing by that “a significant 'mental health gap' between the major burden of mental and substance use disorders and the provision of psychiatric and mental health services”.

General information about the lifetime prevalence in south africa

In a study conducted in 2009 it was found that of 16% of the people suffering from mental disorders, only 25% had received treatment. (Inge, P., Sharon, K. et.al. 2009). Statistics from the South African Stress and Health further show that lifetime prevalence of common mental disorders was 30.3%, and prevalence in the 12 months prior to the survey was 16.5% of the respondents identified as meeting criteria for a common mental disorder during the 12-months preceding assessment. One in every 4–5 people meets criteria for a mental disorder with severe impairment across their lifetime in all. The median age of onset was earlier for substance use disorders (21) than for anxiety disorders (32) or mood disorders (37). According to a study by Lund et al (2011) 75% of people who live with a mental disorder in South Africa do not receive the care they need. SADAG put the figure at less than 16% of sufferers receive treatment for mental illnesses. Generally nearly three-quarters of these sufferers are not accessing any form of mental health care at all.

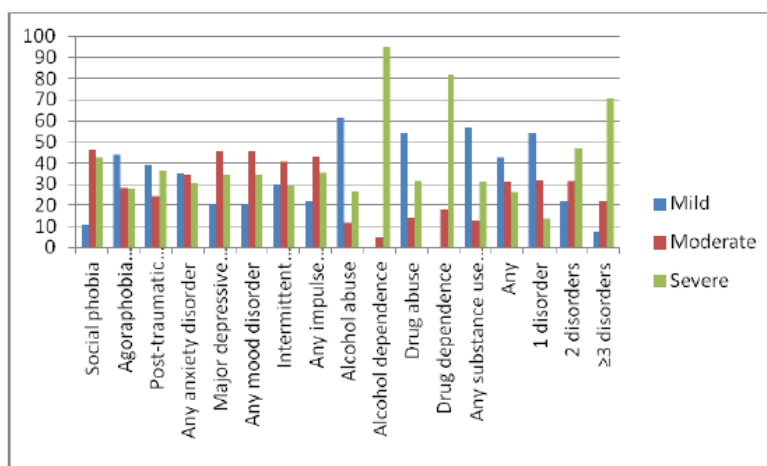


Fig 1

The research did find that 30.3% or around a third of the adult population would suffer from some form of mental disorder over the course of a lifetime with alcohol abuse (11.4%) being the most common disorder. In fig 1 alcohol abuse dependence had the highest contribution to mental disorder prevalence followed by drug dependence and the chances of person suffering from a mental disorder suffering from more than three other disorders were highest compared to having one or two disorders. The mental health problems that most commonly co-occur with substance abuse were depression, anxiety disorders and bipolar disorder. In comparison to data from other countries, South Africa has a particularly high lifetime prevalence of substance use disorders. It has been shown that dealing with substance abuse, alcoholism or drug addiction problem is never easy and this may be even more difficult when one is dealing with mental health problems. When you have both a substance abuse problem and a mental health issue such as depression, bipolar disorder, or anxiety, it is called a co-occurring disorder or dual diagnosis.

According to statistics released by the South African Depression and Anxiety Group (SADAG) as many as one in six South Africans suffer from anxiety, depression or substance-use problems and this does not include more serious conditions such as bipolar disorder or schizophrenia). Dealing with substance abuse, alcoholism, or drug addiction is never easy, and it's even more difficult when one is also struggling with mental health problems. The ability of certain mental illnesses to exacerbate morbidity from several chronic diseases is well-established. Recent studies have explored the causal pathways from mental illness to certain chronic diseases, highlighting the need for more accurate and timely information on the epidemiology of mental illness. Co-morbidity is a two-way; every time someone is in a hospital bed being treated for one of the major health diseases such as heart disease or cancer that person may also have a mental health condition. Most of the time, those mental health concerns even it's just anxiety related to the actual treatment or chances of recovery from the disease are often overlooked altogether, or treated as minor, almost unrelated issues but there are treatments that can help. With proper treatment, support, and self-help strategies, one can overcome a dual diagnosis and reclaim their life.

Understanding the link between substance abuse and mental health

When it comes to substance abuse and mental health problems, the whole is greater than the sum of its parts. In the case of dual diagnosis or co-occurrence, both the mental health issue and the drug or alcohol addiction have their own unique symptoms that may get in the way of your ability to function, handle life's difficulties, and relate to others. To make the situation more complicated, the co-occurring disorders also affect each other and interact. When a mental health problem goes untreated, the substance abuse problem usually gets worse as well. And when alcohol or drug abuse increases, mental health problems usually increase too. Addiction is common in people with mental health

problems. But although substance abuse and mental health disorders like depression and anxiety are closely linked, one does not directly cause the other.

Early experiences of adversity and stress have been associated with substance abuse, mental health problems and concurrent disorders which may put the youth at an even greater risk for concurrent disorders. These may include adverse childhood experiences such as experiences of abuse, neglect, and exposure to domestic violence are associated with substance abuse during the teen years (Dube, S.R., Anda, R.F. et.al. 2006). These early experiences are further carried on into adulthood resulting in adult mental health problems (Edwards, V. J., Anda, R. F. et.al. 2003). A growing body of research indicates that common protective factors can buffer the risks for both mental health problems and substance abuse. The protective factors include strong ties to family and school, supportive adults to talk to and feeling able to excel at something.

The British Columbia research argues that the presence of these protective factors is linked to fewer mental health and substance use problems and risky behaviour in those with both of these problems (McCreary Centre Society 2012). The most effective and efficient way to address a problem is to stop it before it starts, preventing concurrent disorders and their underlying problems means, at least in part, reducing the risk that accompanies early adversity and enhancing the benefits that result from common protective factors. Currently, most prevention efforts are developed for a specific health or behaviour problem. Therefore prevention efforts that address risk and protective factors can be effective at reducing substance abuse and produce a significant cost savings (Miller, T. & Hendrie, D. 2008). The same is true for preventing mental health problems (Knapp, M., Parsonage, M. et.al. 2011).

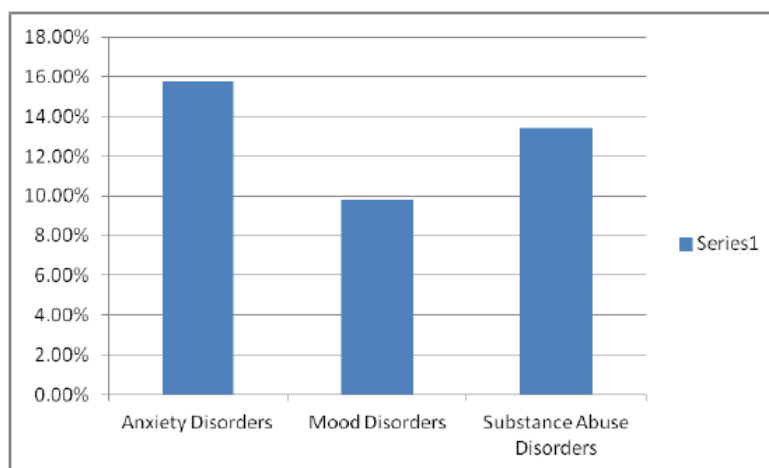


Fig 2

According to the lifetime prevalence of DSM-IV/CIDI disorders anxiety disorders had the highest prevalence (15.8%), followed by substance use disorders (13.4%), then mood disorders (9.8%), and any disorder (30.3%). Sunday Times indicated that more than 17 million people in South Africa are dealing with depression, substance abuse, anxiety, bipolar disorder and schizophrenia which accounts for around a third of South Africa's population of 51.8 million. Lifetime prevalence of substance abuse, but not other disorders, differed significantly across racial groups. Median age of onset was earlier for substance use disorders (21) than for anxiety disorders (32) or mood disorders (37). In comparison to data from other countries, South Africa has a particularly high lifetime prevalence of substance use disorders. These disorders have an early age of onset, providing an important target for the planning of local mental health services.

Some of the main reasons contributing to rampant substance abuse in South Africa is that many provinces are used as drug trafficking routes and as the South African government lacks the necessary resources to control this problem, many of these illicit drugs find their way into local populations as a

drug. In addition, the availability of the weed plant allows for its rampant abuse among all age categories. It was found that 52% of street children smoke the Cannabis plant and 22% on a daily basis. Educational campaigns are limited, and as a result, many do not realize the impinging health effects that will result from substance abuse. There is evidence that alcohol or drugs are often used to self-medicate the symptoms of depression or anxiety. Unfortunately, substance abuse causes side effects and in the long run worsens the very symptoms they initially numbed or relieved as these can increase underlying risk for mental disorders.

Mental disorders are caused by a complex interplay of genetics, the environment, and other outside factors. If you are at risk for a mental disorder, drug or alcohol abuse may push you over the edge. Alcohol and drug abuse can make symptoms of a mental health problem worse. Substance abuse may sharply increase symptoms of mental illness or trigger new symptoms. Alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective. It is important to note that addiction is common in people with mental health problems.

To obtain a better understanding of the direct relationship between mental disorders and suicidal behaviour, studies accounting for the effects of co-occurring mental disorders are essential. Risk factors for suicide among the young include the presence of mental illness- especially depression, conduct disorder, alcohol and drug abuse; previous suicide attempts and the availability of firearms in the home. In South Africa 60% of people who commit suicide are depressed while the suicide rate for children aged 10-14 years old has more than doubled over the last fifteen years. In South Africa the average suicide is 17.2 per 100 000 (8% of all deaths) which relates only to deaths reported by academic hospitals. Every day, an estimated 21 South Africans commit suicide and, according to experts, stress could be a significant contributing factor. Around 26% of cases were classified as severe, 31% as moderate and 43% as mild. Seedat explains that a case was rated as serious when the person was dependent on alcohol or drugs, had attempted suicide in the past 12 months, or when their functioning at work, or in their family or social life was severely impaired.

Studies done by University of KwaZulu-Natal researcher Lourens Schlebush estimate that 7 582 South Africans of suicide every year and 20 times that number attempt but fail to take their own lives. While reliable statistics and research as to why the rate is so high are scarce, Marthé Viljoen from the federation says new data suggests South Africans have unusually high stress levels. The few studies that have investigated these issues suggest that mental disorders predict the onset of suicide ideation, but may have weaker effects in predicting suicide plans or attempts among people with suicide ideation. (Kessler RC, Borges G, Walters EE. 1999, Nock MK, Beautrais A, et al. 2008 and Borges G, Kessler RC. 2008) recent study conducted by international research company Bloomberg, ranked South Africa as the second "most stressed out" nation in the world, following Nigeria. El Salvador was ranked third. Another study, conducted last year by IPSOS Global and Reuters, showed that up to 53% of South Africa's workforce does not take their allotted annual leave.

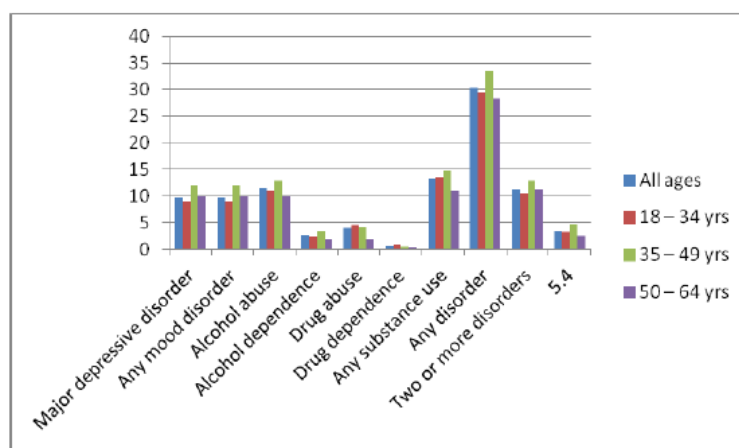
The findings from this study reveal that the presence of multiple disorders is associated with an increase in subsequent suicide attempt. This finding is consistent with a previous literature revealing that adults who had attempted suicide reported more than one mental disorder. (Ndosi NK & Lyamuya EL. 2004 and Slap GB, & Centor RM. 1989). "High stress levels have been linked to mental illnesses such as depression and anxiety, and can also lead to substance abuse. In severe cases, these problems can lead to a person becoming suicidal," says Viljoen. South Africa already has high rates of substance abuse with, for example, alcohol alone being the third-highest contributor to death and disability among citizens, according to a 2014 study published in the South African Medical Journal. Psychiatric illnesses in South Africa are on the rise with rates of major mental illnesses such as schizophrenia seeming to be stable but cases of depression and anxiety certainly escalating.

The most recent nationwide prevalence study for mental health was conducted from 2002 to 2004 and it found that South Africans have a 30% chance of suffering from a mental disorder in their lifetime, with depression being the most common. To begin with, 61% of South Africans who

seriously considered killing themselves and 70% who actually made a suicide attempt were found to have a prior mental disorder. Bivariate analyses revealed that individuals suffering from depression resulting from depression resulting from the stressful situations. Stott says she is "not surprised" that the country has such a high suicide rate. "We can see from the data that South Africans work too hard and don't take enough time off." A recent survey conducted by mental health awareness organization the South African Depression and Anxiety Group (SADAG) showed that, while a quarter of the more than 1 000 respondents have been diagnosed with depression, they were likely to remain at work while experiencing symptoms. Stott says the "mounting claims" for depressive and stress-related conditions show that many South Africans "can't cope". "A lot of people don't even recognize they have a problem as stress becomes so normalized."

She further says people suffering from stress-related depression and anxiety should seek professional help before "stress turns into despair". "People should see a counselor or a psychologist to discuss their problems. Antidepressants can also help if a professional thinks it is necessary," says Stott. For people with access to medical aid, she says most schemes pay for 21 days of in-hospital psychiatric treatment regardless of the condition. It can be difficult to diagnose a substance abuse problem and a co-occurring mental health disorder such as depression, anxiety, or bipolar disorder. It takes time to tease out what might be a mental disorder and what might be a drug or alcohol problem. Complicating the issue is denial. Denial is common in substance abuse. It's hard to admit how dependent you are on alcohol or drugs or how much they affect your life. Denial frequently occurs in mental disorders as well. The symptoms of depression or anxiety can be frightening, so you may ignore them and hope they go away. Or you may be ashamed or afraid of being viewed as weak if you admit the problem.

Whether the mental health condition or substance abuse problem came first, recovery depends on treating both disorders since untreated co-occurring disorders can lead to major problems at home, work and in the day to day life. Individuals with mental disorders and their families may delay seeking professional help because they do not realize their condition can be treated; may not afford treatment; or fear being labeled and stigmatized. So it's important for people to be encouraged to seek help. Recovery depends on treating both the addiction and the mental health problem. Recovering from co-occurring disorders takes time, commitment, and courage. It may take months or even years but people with substance abuse and mental health problems can and do get better. Combined treatment is best. Your best chance of recovery is through integrated treatment for both the substance abuse problem and the mental health problem. This means getting combined mental health and addiction treatment from the same health provider or team.



35-49 years had the highest prevalence in all the categories of disorders apart from drug abuse. Age groups 35-49 and 50-64 years had the highest prevalence of having two more disorders. Alcohol dependence and drug dependence had the lowest prevalence in all the age groups. As noted, some

people might abuse substances to cope with mental health problems. This connection means that by providing effective and timely mental health treatment, we might be able to impact problems with substance abuse. Alternately, given that substance abuse can trigger mental health problems, addressing substance abuse may help reduce distress and the risk of the other concurrent disorders. When opportunities for prevention and early intervention are missed, people who have both mental health and substance use problems may need treatment that can address both the problems.

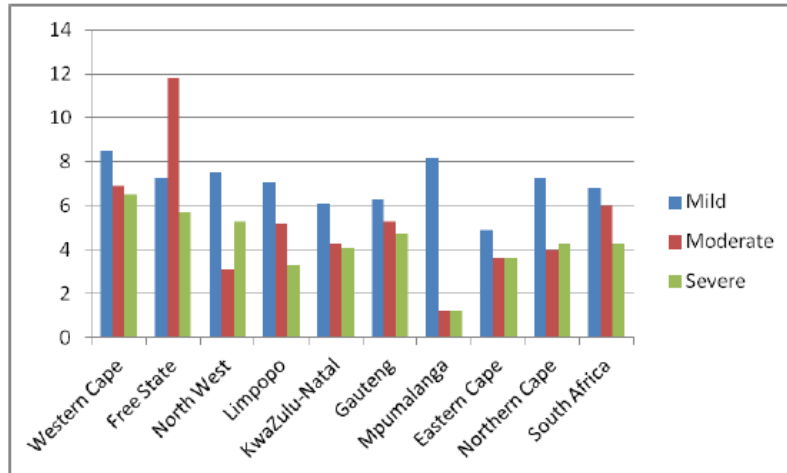


Fig 3

Significant differences in lifetime prevalence of mental disorders occurred across the nine provinces, with the Western Cape having higher prevalence rates as compared to the overall national prevalence rates, this province has the highest prevalence of severe cases of common mental disorders, followed by Free State with the Eastern Cape and Mpumalanga having the lowest prevalence. These provincial differences held for all mental disorders except impulse disorders, where the lowest provincial rates were found in Mpumalanga (0.2%) and the Eastern Cape (0.1%). Significant differences in prevalence with age occurred with panic disorder and generalised anxiety disorder (showing a general monotonic increase in rates with age) and drug abuse and drug dependence (showing a tendency to peak at 35 – 49 years). There was a marginally significant increase in the rate of mood disorders with increasing age. The situation is further evident based on the fact that 17% of children and adolescents in the Western Cape have a mental disorder and very few school-based mental health prevention programmes in place. (SASH 2009).

The Socio-demographic trends of mental health situation

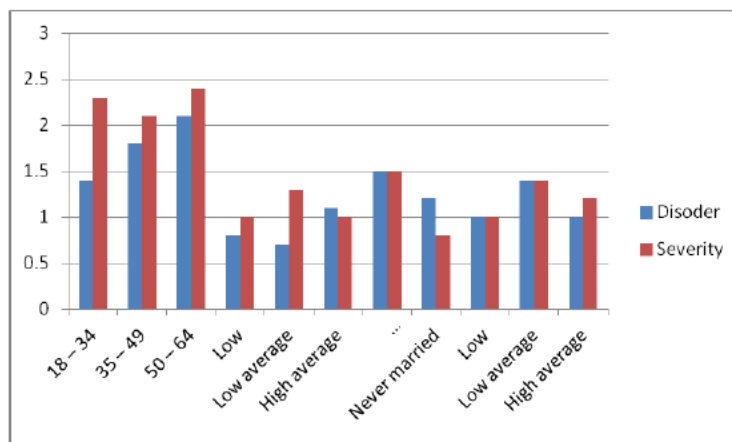


Fig 4

Socio-demographic variables significantly related to onset of psychiatric disorders, women had a significantly higher risk than men of anxiety and mood disorders onset while men had a significantly higher risk of substance use disorders onset, and there were no significant associations with race. Furthermore, in an analysis that examined inter-cohort differences in demographic effects, no interactions with cohort were found for gender, race, and education, indicating that these effects have been stable over the generations included in the SASH survey. A significant positive relation between socioeconomic status (SES) indicators (e.g. income, education, wealth) and mental health was evident. Because SES and demographic variables are often confounded, disentangling their unique contribution to mental health and general psychological functioning is an important area of exploration.

Studies over the last 20 years indicate a close relationship between factors associated with poverty and mental health. The findings in fig 4 further support this notion and help to emphasize on the need for mental health efforts to target the low average earners are the most affected in terms of severity of the prevalence with high average earners having more disorder prevalence. Many studies indicate that individuals of lower SES report a greater number of stressors related to finances, relationships, transportation and employment than those of higher SES. (Gallo LC & Matthews KA. 2003, McLeod JD & Kessler RC. 1990, Matthews KA, Raikkonen K, Everson SA, et al. 2000 and Lantz PM, House JS, Mero RP, et al.2005). Residence in lower SES neighborhoods has also been linked to greater levels of stress. (Everson-Rose SA, Barnes LL, et al. 2011). The associations of psychiatric disorder with gender, the female gender was significantly associated with mood and anxiety disorders, male gender associated with substance use disorders which are consistent with those found in many other countries, whether low- or high-income.

In terms of the socio-demographic correlates the mental disorders the more the older population groups from 35 to 64 with plans for severe treatment targeting mostly the 35-49 age groups. It was further noted the mental disorders were highest among the age 50-64 group with 18-34 experiencing higher levels of severe disorders as compared to 35-49. Since most individuals with alcohol problems initiate drinking during adolescence, a period when not only the body is changing dramatically, but behavioural, cognitive, emotional, and attitudinal changes also take place (Dawson, 2000; Grant *et al.*, 2006; Maggs and Schulenberg, 2005; Semlitz & Gold, 1986). Repeatedly using alcohol (frequency or quantity) at such a critical stage in life may result in detrimental effects on brain development. It is important to lay more emphasis on the young people by targeting most of the preventive interventions towards this group. This is because youth with better mental health are physically healthier, demonstrate more socially positive behaviours and engage in less risky behaviour (Resnick, 2000). Conversely, youth with mental health problems, such as depression, are more likely to engage in health risk behaviours (Brooks *et al*2002).

Other findings may, in terms of income severity was highest amongst the low average earners with high average earners experiencing the highest disorder prevalence and the low income earners experiencing lowest prevalence both in terms of disorders and severity. This points to the importance of local factors; the lack of an association between very low income and substance use disorders suggests the possibility that at least some disposable income is required for the purchase of alcohol which is the most commonly misused substance in South Africa and other substances.

In terms of levels of education the category with the low average education had the highest prevalence of both disorders and the severity of the disorder prevalence. This is consistent with several studies which have shown that socioeconomically disadvantaged individuals tend to experience more distress following a stressor than their more advantaged counterparts. (Collins JW Jr, David RJ, Symons R, et al. 1998, Chen E & Matthews K. 2001 and Cohen S, Doyle WJ, Baum A.2006). The overall findings of the study indicated that although socioeconomically disadvantaged individuals reported fewer stressors, the stressors that they experienced were of greater severity. (Grzywacz JG, Neupert SD, et al., 2005). Therefore necessary efforts need to be made to target this group as opposed to the current held norm that the poor are the ones that suffer most in relation to

mental disorders. This is consistent with levels of education where the people with low average were the most affected in terms of severity and disorder prevalence.

Conclusion

The study concludes that mental health and substance abuse problems are common and come at an enormous cost to individuals, families, communities and systems. The links between mental health and substance abuse issues are complex, they might develop independently as a result of common risk factors or one might lead to the other as a result of self-medication or prolonged distress. The most effective and efficient way to address co-occurring mental health and substance abuse disorders is to stop them before they start. Prevention of and early intervention for mental health and substance use problems is best, but when concurrent disorders develop, they require specialized intensive services. For South Africa to alleviate its overall healthcare burden, mental health more especially cases of substance and alcohol abuse need to be made a priority. Despite limitations, this paper provides further insight into the relationship between alcohol and substance abuse, suicidal behaviour and mental disorders in South Africa.

People with mental and psychosocial disabilities are a vulnerable group as a result of the way they are treated by society. They are subjected to stigma and discrimination on a daily basis, and they experience extremely high rates of physical and sexual victimization. Frequently, people with mental disabilities encounter restrictions in the exercise of their political and civil rights, and in their ability to participate in public affairs. They also are restricted in their ability to access essential health and social care, including emergency relief services. Most people with mental disabilities face disproportionate barriers in attending school and finding employment. As a result of all these factors, people with mental disability are much more likely to experience disability and die prematurely, compared with the general population. It is hoped that the findings will aid in the development of appropriate preventive interventions for the target population in South Africans that is more at risk for alcohol and substance abuse and suicide. For these programmes to be more successful the importance of co-morbidity and analogous programs are necessary in South Africa.

The best treatment for co-occurring disorders is an integrated approach, where both the substance abuse problem and the mental disorder are treated simultaneously. The dual diagnosis and treatment for co-occurring substance abuse and mental health disorders can be further improved on by setting up a substance abuse and treatment database of private and public substance abuse treatment facilities that can help people be able to easily be able to access services. Setting up of support groups for substance abuse and co-occurring disorders. These groups are very helpful, not only in maintaining sobriety, but also as a safe place to get support and discuss challenges. Also helping drug and substance addicts to become involved with supported employment and other services that may help them in the recovery process and also providing them with a counselor trained in integrated dual diagnosis treatment to provide special counseling specifically designed for people with dual diagnosis. This can be done individually, with a group of peers, with your family, or with a combination which will in turn help these addicts to identify and develop their own recovery goals.

According to the World Health Organization 2002 report about 90.0% of mental disorders are non-psychotic disorders. Such disorders due to their high prevalence in the general population (20.0%-30.0%), are usually called common mental disorders (CMD). These are mainly characterized by the presence of symptoms of depression and anxiety, and various nonspecific and somatic complaints (Goldberg DP, Huxley PY. 1992). CMD affect individuals in different age groups and, when present, may be early and less specific manifestations of more serious mental disorders, also impairing the social relationships and school performance in the youth population. Mental disorders have emerged as major challenges health services must face, hence to be able to address the challenge it is important to identify and treat mental health or substance abuse problems early. Often, before the formal diagnosis of a psychiatric disorder, it is already possible to find evidence of psychic suffering during clinical practice. Therefore development of early identification of CMD and its main risk factors,

adequate screening, prevention and intervention tools would benefit from a more in depth understanding of mental disorders as a risk factor for suicide can contribute to specific interventions and a better prognosis.

Limitations of this study

This study has a number of limitations, this being a secondary analysis of an existing data base, there were limited data available to be able to make conclusive findings. These sentiments are shared by Lund who states that there is an urgent need of conducting a nationally representative prevalence study of mental disorders across the age range, including children, adolescents, adults and older adults. The other limitation was on time and resources to be able to do a comprehensive literature review. In future there is need to conduct more regular national survey on mental health.

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