

“Give them a reason to live”: exploring the prioritisation of adolescent and youth mental health policy in South Africa

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Aim

This study explores the factors underlying the prioritisation of adolescent and youth mental health policy in South Africa, or lack thereof, from the perspective of health policy actors and youth advocates.

Methodology

In-depth interviews were conducted with 34 key informants including researchers, civil society and government policy actors and a focus group with seven youth advocates, aged 18–24 years. Data were analysed thematically drawing on an adapted version of a policy prioritisation framework.

Results

The analysis revealed several barriers to prioritisation, including: a lack of policy community cohesion, inadequate leadership, insufficient collaboration with adolescents and young people and those with lived experience, evidence gaps, a fragmented policy landscape, and a lack of simple, scalable solutions. However, a number of opportunities were also identified: dedicated and passionate actors, new evidence, and contextual factors which have raised public awareness and provided opportunities for change, such as COVID-19 and the introduction of National Health Insurance.

Conclusion

Adolescent and youth mental health has not received the political attention necessary to ensure that action is taken to enhance and protect the mental health of young South Africans. More purposeful efforts to unite the adolescent mental health community and coordinate research, advocacy, policy and implementation efforts are needed to address these challenges. This research provides insight into the current state of adolescent and youth mental health policy in South Africa and potential actions to strengthen adolescent mental health policy development and implementation.

Introduction

The importance of prioritising mental health at a global level was demonstrated by its inclusion in the Sustainable Development Goals, and the work of the Lancet Commission on Global Mental Health and Sustainable Development.¹ However, in South Africa, despite considerable need, mental health remains largely unaddressed. Mental health disorders were ranked as the third-highest cause of Disability Adjusted Life Years (DALYs) for those

aged 10–24 in the country.² The COVID-19 pandemic made this worse, with South African adolescents reporting feelings of anxiety, stress, frustration and depression.³ Adolescents and young people make up a third of South Africa's population, and their life stage is a key developmental phase during which addressing mental health issues is vital in the context of the many social and economic deprivations and disparities they face.⁴

Despite these needs, there is significant lack of access to both prevention and treatment of mental health. Prevention, through combined interventions and addressing

the social determinants of health, remains critical for addressing mental health with co-ordination across development sectors.⁵⁻⁷ In terms of treatment, there is an average of only 0.31 public sector psychiatrists per 100 000 uninsured people, and only the Western Cape (0.08 per 100 000 uninsured), Free State (0.04 per 100 000 uninsured) and Gauteng (0.02 per 100 000 uninsured) reported any child psychiatrists working in the public sector. Furthermore, only 6.8% of admissions for mental health inpatients were younger than 18 years, while for those receiving out-patient services, only 5.8% were under 18, highlighting concerns about both under-diagnosis and under-treatment.⁸

At policy level, in 2020, the National Mental Health Policy Framework and Strategic Plan (2013–2020) lapsed and an updated policy was launched only in 2023 after limited consultation. The original plan was praised for its alignment with the World Health Organization (WHO) recommendations and for its emphasis on both evidence-based practice and a human rights perspective.^{9,10} However, the framework has not been well implemented and South Africans still do not have access to mental health prevention and care options.^{10,11} Concerning mental health policies specifically focusing on children and adolescents, there is one national-level Child and Adolescent Mental Health (CAMH) policy which is still in place; however, none of the nine provinces have corresponding policies or plans, nor have they integrated the national-level policy into their general provincial health policies.¹² There are also no implementation plans to support the policy at national and other levels. Supporting further development and implementation of child and adolescent mental health policies is urgent,¹² and should be informed by research that identifies and explores the barriers that are hindering child, adolescent and youth mental health policy.

Previous mental health policy analyses^{13,14} have noted the fragmented mental health policy community as an important barrier to global prioritisation. Stigma and a lack of common understanding of the issue also impede prioritisation, as have missed opportunities for action and a lack of credible indicators and simple solutions.^{13,14} A study assessing political prioritisation of mental health in Ghana, South Africa, Uganda and Zambia in 2010 found that the mental health of the population as a whole was not prioritised in any of those countries.¹⁵ Reasons included: a lack of understanding of the prevalence of mental illness, variable understanding of the severity and impact of mental illness, limited coverage in the media, socio-cultural understandings of mental illness, competing health and development priorities, lack of funding and advocacy, and stigma.¹⁵

No studies have extended mental health policy analysis to adolescents and youth. This research responds to this gap by exploring the national prioritisation of adolescent and youth mental health in policy-making in South Africa. Using a political economy approach,¹⁶ this paper provides insight into the challenges impeding policy ac-

tion to improve mental health as well as opportunities for protecting adolescent and youth mental health.

Method

The aim of this study was to form a deeper understanding of the prioritisation of adolescent and youth mental health policy in South Africa, from the perspective of policy actors and youth advocates. An exploratory design and qualitative research methods were used. Ethical approval was provided by the Community and Health Science Research Committee and the Biomedical Ethics Committee at the University of the Western Cape.

Participants were purposively selected based on their role in adolescent and youth mental health research, practice and policy in South Africa. Participants were identified through the researchers' professional networks, as well as through consultation of relevant reports, a review of government, donor and non-governmental organisations' (NGO) documents, and of published scholarship. Snowball sampling was used to recruit additional research participants from national government departments and agencies, research institutions, and civil society organisations. Of 36 potential key informants contacted, 33 were interviewed through online calls. The study also entailed conducting a focus group discussion with seven young people, aged 18–24, who are involved in advocating for youth health as part of the National Youth Resilience Initiative. The interview guide was developed in an iterative manner and covered themes related to participants' understandings, definitions and prioritisation of adolescent and youth mental health, experiences of governance and coalition-building, as well as resourcing.

The data were analysed collaboratively drawing on Shiffman and Smith's policy analysis framework¹⁶ which outlines four key areas that influence the likelihood of an issue being prioritised: the power of the actors involved; how ideas are communicated or framed; the political context in which actors operate, and whether the problem lends itself to be understood and focused on easily (Table 1). This framework has been used extensively in global health to understand the prioritisation of a range of health issues,^{17,18} including mental health.^{4,13,19}

The framework was refined in relation to the interview content, as well as the local aims and objectives of the research. Certain categories were adapted or removed; for example, 'global governance structures' was removed and replaced with 'government policy landscape'. The framework was used to prepare an initial code book. The researchers independently applied the codes to the same transcript using Atlas.ti, and then met to reflect on and refine the codes to ensure a shared understanding of their meanings. Coding of the remaining transcripts was conducted through frequent team discussions, and a second researcher reviewed the coding of each transcript to ensure consistency. Reports assigned to team

Table 1. Policy analysis framework

Theme	Sub-theme	
Issue characteristics <i>Features of the problem</i>	Nature of the problem	Elements of the particular health problem that act as facilitators or barriers to prioritisation.
	Credible indicators	Clear measures that show the severity of the problem and that can be used to monitor progress.
	Severity	The size of the burden relative to other problems, as indicated by objective measures such as mortality levels.
	Effective interventions	The extent to which proposed means of addressing the problem are clearly explained, cost-effective, backed by scientific evidence, simple to implement and inexpensive.
Political contexts <i>The environments in which actors operate</i>	Government policy landscape	The existence, implementation and awareness of national policies.
	Policy windows	Political moments when conditions align favourably for an issue, presenting opportunities for advocates to influence a decision.
Ideas <i>The ways in which those involved with the issue understand and portray it</i>	Internal frame	The degree to which the policy community agrees on the definition of, causes of, and solutions to the problem.
	External frame	Public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources.
Actor power <i>The strength of the individuals and organisations concerned with the issue</i>	Policy community cohesion	The degree of coalescence among the network of individuals and organisations that are centrally involved with the issue at the national level.
	Leadership	The presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause.
	Guiding institutions	The effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative.
	Civil society mobilisation	The extent to which grassroots organisations have mobilised to press national political authorities to address the issue.

Source: Adapted from Shiffman and Smith, 2007.¹⁶

members were reviewed, and the researchers met again to present and discuss key findings within each theme.

Findings

Overview of participants

The majority of participants came from research, civil society, and youth activism. Participants from the national government departments, multi-lateral agencies, media outlets, donor organisations, and global health organisations were also included (Table 2).

The following sections describe the participants' views on adolescent and youth mental health prioritisation in South Africa, organised according to the adapted Shiffman and Smith framework.¹⁶

Issue characteristics

Nature of the problem

Participants mentioned several age ranges, when referring to adolescence, across policies and agencies. The various age ranges encompass many different stages of

development, each with its specific needs. The term 'mental health' is also used to refer to a range of diverse conditions which may share little in common in terms of symptoms, severity or treatment. Stigma and a lack of recognisable physical symptoms means that convincing others to take mental health seriously can be a challenge.

Table 2. Number of participants per sector

Research	14
Civil society	10
Government	5
Global health organisation	2
Media	1
Donor	1
Youth advocates	7
Total	40

Credible indicators and evidence

Participants felt that while there was a wealth of research available, there were notable gaps in evidence which were hindering progress towards prioritising adolescent and youth mental health. Some of these gaps relate to an absence of national prevalence studies, limited data recorded at health facilities, and lack of demonstrated impact on other sectors:

What are you measuring? [if] the person themselves feels better, that would be nice to know, but I still couldn't fund that. I would want to see some change in terms of service uptake. I want to see something tangible: staying in school, reducing substance use, whatever it might be. That's what I needed. I do think it is very tricky just to fund mental health in and of itself. (Participant 29)

The benefits of addressing adolescent and youth mental health may be most appreciated only after many years, and equally, the implications of inaction to address mental illness are less immediately visible in comparison to other health problems which may progress more quickly or may respond more rapidly to intervention. The significant economic toll of mental ill-health for the country is demonstrated in the recent mental health investment case²⁰; however, at the time of the study, this had not been published despite being commissioned by the government. These evidence gaps and a lack of co-ordinated and strategic knowledge translation efforts make attracting political attention less likely.

Severity

Some participants described particularly severe consequences of mental illness such as an increase in suicides observed among adolescents and children. Others pointed out the relationship between adolescent mental ill-health and other serious health, economic and social problems including: maternal and child health, reduced access to health services, school drop-out, unemployment, cycles of violence and neglect, and substance abuse:

Oh, my word, the trauma, the PTSD [post-traumatic stress disorder] in this country... the cultural issues, community level issues, the rape, ...this is a big thing. it's going to explode, you know! (Participant 24).

However, measuring and quantifying these relationships are challenging. Moreover, participants noted that South Africa faces many severe problems. These complexities in demonstrating the severity of adolescent mental ill-health pose a challenge to advocacy efforts.

Effective interventions

Multiple smaller-scale interventions were described by participants as being effective. The scalability of these interventions was, however, unclear. Because adolescent and youth mental health is linked to multiple social and structural determinants, participants argued that social,

economic, and longer-term interventions are necessary. However, some participants described these kinds of interventions as expensive, difficult to monitor and evaluate, and less appealing to donors:

Intersectoral collaboration would be nice but yes, so would flying to work. But what is possible is the question. (Participant 8)

There was also not complete consensus on the nature of policy responses needed. Overall, participants flagged the multi-faceted nature of mental health and the need for a multi-pronged prevention/promotion/treatment approach, including upstream policy change.

But currently we are upside-down, whereby the understanding is that for us to have the services, we need psychiatrists. Yes, we need them, but very few would require such intense and specialised interventions. Most would have been prevented if we employ and address the intervention of those at high-risk and addressing the determinants upstream. (Participant 34)

In contrast, a young activist expressed a desire for more psychologists as opposed to counsellors:

There will always be a need for affordability, for more psychologists at public hospitals, even at clinics, because at the clinic level you just get some counsellor, that's not really a psychologist, so you sit there with a counsellor. (Participant, youth activist focus group)

Political contexts

Government policy landscape

While a few participants were actively trying to catalyse the lack of national policy development and implementation (as noted in the introduction), many study participants were not familiar with the current mental health policy landscape. This lack of awareness about existing or lapsed policies indicated a general lack of faith in the ability of policies to effectively create change, as well as limited efforts by the government to actively and broadly engage those working on adolescent and youth mental health in various ways.

Policy windows

Participants described policy windows which had not been effectively leveraged, as well as future opportunities. The Life Esidimeni tragedy exposed the serious faults in mental health services and human resources for mental health. Life Esidimeni is the private provider from which some 1500 state patients were relocated by the Gauteng Department of Health in 2016 to cheaper care centres, many of which were later found to be unlicensed and grossly under-resourced. The resulting deaths of 144 people, including from starvation and neglect, has been called "the greatest cause of human rights violation" in democratic South Africa,^{21(p1)} stimulating discussion about the care of psychiatric and other state patients.²¹⁻²⁴ This very public failure of the health system

presented an opportunity for substantial advocacy efforts to demand change. While significant gains were made in terms of the legal action taken on behalf of the affected families, this did not lead to the necessary reforms required to ensure adequate mental health treatment options.

Participants also noted that the COVID-19 pandemic led to more public and political attention being paid to mental health in the media, particularly for adolescent and youth mental health:

Coming out of COVID, I think the whole world has recognised that keeping young people out of school, the uncertainty of the pandemic for their futures, I think there is a recognition that young people are suffering, particularly bad. I am hoping that there is more of a recognition of the need to do more in this space. (Participant 29)

Participants discussed the need to leverage the work done to produce the 2022/23 Child Gauge publication²⁵ which made a strong case for prioritising mental health and presented a clear conceptualisation of the problem, evidence for the scope of the problem, key interventions, and the economic argument for investing in adolescent and youth mental health. The country is also working towards implementing National Health Insurance which, participants argued, presents a key opportunity to ensure that mental health is adequately included in the basic health packages.

Ideas

Internal frame

Definitions and causes of mental health

For adolescents, mental health was understood to be intertwined with a period of transition. In addition, participants generally described a mental health spectrum or continuum ranging from optimal wellness to severe psychological disorders. While this was the dominant way of framing mental health, one participant did describe a more categorical understanding, distinguishing those with a clinical disorder from those responding to a harsh environment. All of the participants also acknowledged the situatedness of mental health, explaining the importance of social, political, economic, cultural, and physical environments, and rejected the notion of mental health as a purely clinical or biological issue. They particularly emphasised the role of violence and trauma in shaping adolescent mental health.

One area of divergence in defining mental health was in relation to the specific terms used by different participants. 'Mental health', 'mental wellbeing/wellness' and 'psychosocial wellbeing' were all used to describe the same set of issues. Despite the issue of language, participants generally seemed to have a shared definition of mental health which should facilitate community cohesion to promote prioritisation.

External frame

Insights on public perceptions

Participants commented that some of the challenges to prioritisation were related to how adolescent mental health was publicly perceived. They described stigmatising ideas linking mental illness to being incompetent, dangerous, insufficiently motivated, or involved in witchcraft. They also described a trivialisation of mental illness in comparison to physical health, including by funders. Perceptions around the period of adolescence as being associated with mood and hormonal changes was sometimes thought to lead to society not taking adolescent mental health seriously enough.

Media portrayal

The media were described as an important actor involved in shaping the public framing of adolescent and youth mental health. Some stigmatising representations of mental health in the media were noted, and a few participants commented on the use of a 'crisis narrative' when reporting on mental health, especially in relation to the Life Esidimeni tragedy. Health system failures and an emphasis on the pervasiveness of the problem of mental illness in South Africa were at times critiqued for leading to paralysis and pessimism, while at other times, were felt to be the startling reality that was needed to ignite action:

The problem of the crisis narrative is that these days, everything is a crisis, so it doesn't help ... we call everything a crisis and it is not because we are exaggerating, I think it is because we have so many things that have reached crisis point, but it is an overused word, and it can demobilise and demotivate rather than motivate sometimes. (Participant 31)

The media were also credited with portraying the lived experiences of mental illness, and there were examples given of the media being used for knowledge translation purposes — introducing some of the findings from academic work to a wider audience.

Actor power

Policy community cohesion

In this study, policy communities were understood to include all those involved in adolescent and youth mental health, both professionally and personally. Participants generally described a fragmented policy community and identified a range of barriers to cohesion, including: working in silos linked to organisational structures and funding environments; competitiveness; no organisation with the mandate and funding to foster collaboration; communication and knowledge translation challenges; exclusion of certain groups such as traditional healers, psychiatrists and the private sector, and limited knowledge of who other stakeholders are, especially decision-makers, and of the policy-making process.

However, there were some positive examples given, along with opportunities for increased cohesion. Primarily, among the participants interviewed, there was a shared passion and commitment to adolescent and youth mental health and an eagerness and interest in sharing and collaborating more; there was also a specific demand for a platform which could facilitate this. Some positive examples were shared regarding provincial-level inter-sectoral engagement and existing partnerships between NGOs, governments and researchers, which could be built upon and learnt from.

Leadership

Participants spoke of historic positive examples of leaders in mental health generally, not specifically in adolescent mental health. Charismatic and dynamic individuals who had a passion for mental health were involved in convening various mental health think-tanks, which included groups such as the Alan J. Flisher Centre for Public Mental Health at the University of Cape Town, the Southern African Research Consortium for Mental Health Integration, and the Group for the Advancement of Psychiatry. However, more recently, there were reports of high government leadership turnover, a lack of decision-maker presence in inter-sectoral engagements, insufficient leadership consultation with other invested stakeholders, and leaders not having advantageous relationships and not being able to secure funding for mental health.

The need for other stakeholders outside of government to take on a leadership role was also discussed as necessary for driving change. In relation to adolescent mental health specifically, a lack of investment in positive and inspiring youth leadership was lamented. The lack of effective leadership in adolescent mental health policy-making was seen as impeding substantive investment and progress in this issue.

Guiding institutions

While the National Department of Health (NDoH) is officially responsible for the national mental health policy, the multi-dimensional nature of adolescent mental health leads departments such as the Department of Basic Education, the Department of Social Development, and many other departments to also have mandates relevant to adolescent and youth mental health. For example, the Integrated School Health Policy includes provisions for addressing mental health needs by offering screening, psychosocial support, and referrals for learners struggling with mental health issues.

While there are several other groups who play roles of varying prominence in the national mental health policy landscape, there is no specific department or group that is clearly responsible for guiding the engagement of the multiple invested actors in elevating mental health prioritisation. This lack of a clear guiding institution, and the challenges related to multi-sectoral collaboration, have

hampered the prioritisation of adolescent mental health and led to a lack of co-ordination.

Civil society mobilisation

Youth advocacy

The historic importance of youth advocacy and mobilisation to bring about change in South Africa was highlighted by participants. However, there was a sense that the current generation of adolescent and young people were not politically active in the same way, and that consumer culture, systems of power, and technologies had all played a role in 'depoliticising' adolescents and young people:

I think it is about giving voice to people and that's what happened so effectively to overthrow Apartheid... People were mobilised and now it's like 'shut up, sit down, sit in the queue, don't complain.'... that movement-building that South Africa is really good at has somehow missed ... the children or the grandchildren or the people who were in the struggle are not mobilised in a way that is productive, it is more destructive. (Participant 29)

Many adult and youth participants also commented on the lack of active engagement of adolescents and young people by policy-makers and researchers, the devaluing of their voices, and tokenistic inclusion of young people which have exacerbated the problem:

Have we asked the youth what they want and what they are saying?... With some small exceptions, ... it was grey-haired people like me sitting in rooms making these decisions on behalf of the youth..., we then say to the youth, we would like to do this mostly to you, not even with you. (Participant 4)

Lived experience

Those with lived experiences of poor mental health were described as largely uninvolved in national mental health policy and that this reflected a lack of consultation and involvement of these stakeholders. One participant described how even when there was engagement with these groups, their input was not necessarily reflected in the policy:

They had months long consultations with persons with lived experience... it was just absolutely devastating, because not one of those things were eventually reflected in the strategic plan. (Participant 13)

Participants discussed the importance of building an adolescent mental health 'movement', with those with lived experiences of mental illness at the centre. They commented on how important this had been for advocacy around other health issues such as HIV, and acknowledged the power of elevating the stories of those with lived experiences to challenge stigma and silence around mental illness:

One is that the TAC [Treatment Action Campaign], one of its first challenges was to make HIV visible and that meant making people with HIV visible so that that broke the stigma, but it also created a small army of activists, eventually you could push for a response on the issue. It is very difficult to have effective advocacy around a disease which is hidden. You have to bring it out into the open, one way or another... but there has never really been a coalescing of people determined to build a movement. You almost need people who live with mental illness to be at the core. (Participant 31)

Engagement with NGOs

The relationship between government and NGOs was sometimes viewed as collaborative and examples of NGOs effectively complementing government functions were discussed. However, at other times, the relationship was portrayed as oppositional and hostile. A participant explained how the loss of faith in NGOs in reaction to the Life Esidimeni tragedy has harmed the image of NGOs, which may further hamper their ability to effectively champion mental health at a national level.

Discussion

While participants reported an increased interest in and public discussion of mental health in South Africa, a number of barriers to political prioritisation were identified. The findings suggest that actor power is being undermined by a fragmented policy community, lack of effective leadership including youth leadership, no clear guiding institution, and variable civil society participation. Tomlinson and Lund¹³ as well as Lemmi,¹⁴ using the same Shiffman and Smith framework,¹⁶ noted similar trends when studying mental health prioritisation at a global level. Bird, et al.¹⁵ also found that a fragmented mental health lobby and a lack of advocacy were impeding prioritisation of mental health generally in South Africa, Ghana, Uganda and Zambia. Their study noted that of the four countries, South Africa had the most developed mental health user network, notably the South Africa Federation for Mental Health, as well as independent user groups in some provinces. However, even when there were advocacy efforts, these groups still played a limited role in policy processes and affecting change.¹⁵

Internally, among the participants interviewed, there was a shared understanding of adolescent and youth mental health as being socially determined and multi-dimensional, which appears to be an improvement in comparison to the national situation in 2010,¹⁵ as well as the global situation^{13,14} where a lack of shared understanding was noted as a challenge to prioritisation. Externally, stigma and trivialisation of mental health and understandings of adolescence as a naturally emotional time impede prioritisation.^{13–15} The role of the media in shaping public framing of adolescent and youth mental health, and having the power to either reproduce or challenge stigmatising ideas, was highlighted by participants.

A key opportunity for future action would involve harnessing this power to strategically frame adolescent and youth mental health in a sufficiently nuanced way that challenges stigma and draws political attention.

The recent political context of adolescent and youth mental health in South Africa has been characterised by lapsed and insufficiently implemented policies and limited communication and consultation between government and external actors. A lack of familiarity with policy and policy-making processes by non-government participants is an additional barrier to prioritisation. Historically, policy windows such as that presented by the Life Esidimeni tragedy have not been effectively leveraged, resulting in missed opportunities. Missed policy windows were also acknowledged as an obstacle to global mental health prioritisation.¹⁴

Despite substantial research efforts, persistent data and evidence gaps have made advocating for adolescent and youth mental health prioritisation more challenging. In addition, the complexities around demonstrating the severity of mental illness, as well as a lack of simple, scalable interventions, pose barriers to political prioritisation. Similar findings have been observed for mental health globally,^{13,14} and were flagged as concerns over a decade ago in South Africa and other African countries.¹⁵

Notwithstanding these challenges, the study's interviews mapped a wide network of enthusiastic, dedicated people wanting to collaborate more. Building stronger relationships between researchers, policy actors, implementers, and adolescents and young people themselves, as well as with donors, would help to improve policy community cohesion and build a vibrant mental health movement which could enhance national prioritisation. There is also an opportunity to build on recent advocacy and awareness campaigns including the 2022/23 Child Gauge on Child and Adolescent Mental Health²⁵; the UNICEF U-Report Platform (a free, user-friendly and anonymous messaging platform that empowers and connects young people to speak out on issues that matter to them, engage in dialogue with decision-makers, and participate in shaping policies and programmes)²⁶; and the first South African Mental Health Conference convened in 2023 by the NDoH, the Foundation for Professional Development with the associated Masiviwe organisation to address mental health challenges in South Africa and promote a 'whole-of-society' approach to mental health care.²⁷ Recent crises such as COVID-19, as well as health system developments — specifically National Health Insurance — present new policy windows for future policy action.

The construction of adolescence as a time of transition, and its framings through economic arguments and life-course understandings, present opportunities to develop and advocate for a clearer strategy for adolescent mental health. The investment case has also provided the adolescent mental health community with strong evidence which could be used as a powerful advocacy tool to demand improved prioritisation.²⁰

While there are important opportunities for improving or addressing some of the obstacles to prioritisation,

some challenges are more complex, such as balancing the need for simple, cost-effective, scalable interventions with multi-dimensional long-term interventions that address the structural causes of mental ill-health. Overemphasising the severity of mental illness may be in conflict with efforts to reduce stigma. There is a need to demonstrate that this issue is salient despite potentially not leading directly to as many deaths as other conditions, and that there are feasible, evidence-based strategies which could improve adolescent mental health, although they may not always be simple.

This study has some limitations, including the representativeness of the sample as not all national government departments involved in mental health were represented, for example, the Department of Social Development. Also, the study did not focus on provinces which may have a greater impact on, or more control over, the implementation of policies. Future research could focus on how policy development and implementation is prioritised at provincial level. Research focusing on effective strategies for engaging adolescents and young people with lived experiences in policy processes would also be useful, as would evidence on the effectiveness of different frames at enhancing prioritisation among different audiences.

Recommendations

- Actively create opportunities to strengthen understanding of the factors that shape policy prioritisation for adolescent and youth mental health policy.
- Increase efforts to strengthen actor power by improving networking and co-ordination, in alliance with adolescent and youth movements, leadership, and those with lived experience, to support prevention and response.
- Strengthen the internal and external framing of adolescent and youth mental health to ensure consensus about its definition, measurement, and the

investments needed to respond to the issue strategically.

- Build coalitions and informed advocacy, coupled with the existing desire for change, among a broad range of stakeholders to ensure the optimisation of policy windows.

Conclusion

Adolescent and youth mental health has not received the political attention necessary to ensure that action is taken to enhance and protect the mental health of young South Africans, despite its considerable burden. This study demonstrates the range of challenges that have made prioritisation more difficult. However, a passionate and dynamic network of actors interested in collaboration, coupled with recent advocacy and awareness campaigns, and national health system changes, present important opportunities for increased prioritisation going forward.

Abbreviations

Abbreviation	Description
CAMH	Child and Adolescent Mental Health
DALYs	disability-adjusted life years
NDoH	National Department of Health
NGO	non-governmental organisation
NMHPFSP	National Mental Health Policy Framework and Strategic Plan
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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