Planning for district mental health services in South Africa: a situational analysis of a rural district site

Inge Petersen,[1]* Arvin Bhana,[1,2] Victoria Campbell-Hall,[1] Sithembile Mjadu,[1] Crick Lund,[3] Sharon Kleintjies,[3] Victoria Hosegood,[4] Alan J Flisher[3,5] and the Mental Health and Poverty Research Programme Consortium

The shift in emphasis to universal primary health care in post-apartheid South Africa has been accompanied by a process of decentralization of mental health services to district level, as set out in the new Mental Health Care Act, no. 17, of 2002 and the 1997 White Paper on the Transformation of the Health System. This study sought to assess progress in South Africa with respect to deinstitutionalization and the integration of mental health into primary health care, with a view to understanding the resource implications of these processes at district level. A situational analysis in one district site, typical of rural areas in South Africa, was conducted, based on qualitative interviews with key stakeholders and the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). The findings suggest that the decentralization process remains largely limited to emergency management of psychiatric patients and ongoing psychopharmacological care of patients with stabilized chronic conditions. We suggest that, in a similar vein to other low- to middle-income countries, deinstitutionalization and comprehensive integrated mental health care in South Africa is hampered by a lack of resources for mental health care within the primary health care resource package, as well as the inefficient use of existing mental health resources.

Keywords   Primary mental health care, de-institutionalization, district, South Africa

---

KEY MESSAGES

- Decentralization efforts of mental health care in South Africa remain primarily focused on the emergency management of psychiatric patients and ongoing psychopharmacological care of patients with chronic stabilized mental disorders.
- Achieving deinstitutionalization and comprehensive integrated primary mental health care in South Africa requires an injection of mental health resources into the primary health care package and more efficient use of existing resources.

---

[1] School of Psychology, University of KwaZulu-Natal, Durban, South Africa.
[2] Child, Family, Youth and Social Development Unit, Human Sciences Research Council, Durban, South Africa.
[3] Department of Psychiatry and Mental Health, University of Cape Town, South Africa.
[4] Africa Centre for Health and Population Studies/University of KwaZulu-Natal, South Africa, and London School of Hygiene and Tropical Medicine, UK.
[5] Research Centre for Health Promotion, University of Bergen, Norway.
* Corresponding author. School of Psychology, Howard College, University of KwaZulu-Natal, Durban, 4001, South Africa. Tel: +27-31–260 7423. Fax: +27-31–260 2618. E-mail: peterseni@ukzn.ac.za

Introduction

Under the apartheid government, the focus of mental health services was on institutional care and psychopharmacological treatment of patients with psychiatric disorders, as was true for most low-income countries under colonialist rule (WHO 2000). The protection of society prevailed over the human rights of the individual (Burns 2008). In this regard psychiatric patients

were largely removed from society and treated in psychiatric institutions which were generally urban based. With the shift to a democratic political dispensation in 1994, the concept of universal primary health care (PHC) became central to the restructuring of health care, as contained in the White Paper for the transformation of the health system in South Africa (Department of Health 1997a) and National Health Act 61 of 2003 (Department of Health 2004a). In concert with this concept and a prevailing human rights agenda, South Africa embarked on a programme of decentralization and integration of mental health care into PHC, as framed within the first post-apartheid policy guidelines for mental health (Department of Health 1997b) and more recently stipulated in the new Mental Health Care Act, no. 17, of 2002 (MHCA) (Department of Health 2004). The focus of the initial decentralization and integration process in South Africa was purportedly largely limited to de-hospitalization, with care being focused primarily on the psychopharmacological management of patients with chronic mental disorders at PHC level, as well as screening and emergency management of patients presenting with mental disorders (Flisher *et al*. 1998).

De-institutionalization is, however, a much broader process and should include community-based rehabilitation programmes (WHO 2001). Further, comprehensive integrated mental health care should include mental health promotion and prevention programmes and access to care for more common mental disorders, such as anxiety and depression. The latter is crucial in the face of the historical paucity of mental health services for disadvantaged communities, and in a context where the legacy of apartheid, poverty and more recently HIV/AIDS have serious consequences for people's emotional lives. While the need for interventions for traumatized communities remains an imperative, mental health promotion and prevention programmes, which enhance resilience in the face of adversity and strive towards transforming the structural and material bases of mental ill-health, are crucial for the development of South African society. The WHO (2001) suggests that the challenge for middle-income countries such as South Africa is to increase access to mental health care for the entire population through integration into the PHC system, as well as schools and workplaces.

A recent nationally representative epidemiological survey of common mental disorders such as anxiety and depression in South Africa, found that of the 16.5% of adults who had suffered from a common mental disorder in the previous 12 months, only one in four had reported receiving treatment (Williams *et al*. 2008). The study also found that those adults with severe to moderate common mental disorders were more likely to have received treatment. In addition, this treatment was most often from the general health sector, with the mental health sector only providing care to a small percentage of cases (Williams *et al*. 2008). There is thus a large 'treatment gap' for common mental disorders in South Africa.

While there has been extensive work on the development of norms and standards for integrated primary mental health care such as bed/population, staff/population ratios, admission rates and community/hospital ratios (Lund and Flisher 2001; Lund and Flisher 2002a; Lund and Flisher 2002b; Lund *et al*. 2002; Flisher *et al*. 2003; Lund and Flisher 2003; Dawes *et al*. 2004; Lund and Flisher 2006), the mechanisms for monitoring service delivery remain weak, particularly at district level. There is thus limited data on how well policy, legislation and related norms and standards have been implemented, and on the access to or quality of mental health care at district level.

The aim of this study was to conduct a situational analysis of mental health services in one rural district in South Africa, as a case study, with a view to assessing progress in the processes of deinstitutionalization and integration of mental health into PHC. This situational analysis forms part of a broader four-country study aimed at examining how mental health policy development and implementation can assist in breaking the cycle of poverty and mental health in low- and middle-income countries (LMICs) in Africa (Flisher *et al*. 2007). This larger study is in response to: (i) the increasing body of literature highlighting the inter-relationship between poverty and mental, behavioural and physical ill-health which reduces the human capabilities available amongst the poor to reach their potential (Prince *et al*. 2007); and (ii) global imperatives to develop evidence-based policies for mental health services that promote a human rights agenda and which are appropriate for the resource deficient contexts of LMICs in Africa.

Based on this situational analysis, resource implications for deinstitutionalization and comprehensive integrated primary mental health care in South Africa are discussed.

Method

Study site

The district and sub-district in which our study was conducted lies in the north of the KwaZulu-Natal province. The study site was selected for two main reasons. First, the district and sub-district are rural areas in which public mental health services are provided in line with provincial and national guidelines, and have not been additionally supported by other public or non-government organization mental health initiatives. Second, the area and its population are well characterized given that the sub-district site comprising around one-fifth of the district population has been a Demographic and Health Surveillance Site (DSS) since 2000. DSS sites provide demographic and health information in selected sites on a regular basis across a number of LMICs with the view to, *inter alia*, monitoring and tracking health threats and providing sites for action-oriented research aimed at testing and evaluating health interventions (INDEPTH Network 2002). Longitudinal socio-demographic data have been collected by the Africa Centre for Health and Population Studes, details of which have been published elsewhere (e.g. Hosegood and Timæus 2005; Tanser *et al*. 2007).

The district covers $12\,819\,km^2$ with a population estimate in 2002 of 503 760, while the sub-district is approximately $1417\,km^2$, having a population estimate of 168 508 in 2002 (Curtis *et al*. 2002). The district is similar to many other rural parts of South Africa, including areas administered by a municipal authority (township and some peri-urban sections) and more rural areas administered by a tribal authority. Characteristic of other rural populations in South Africa, there are high levels of circular labour migration and unemployment (Case and Ardington 2004). The unemployment rate, as a percentage of the economically active, is high (39% of people aged 15–65 years were estimated to be unemployed in 2001) (Case *et al*. 2004).

Data collection methods

Data were collected using both quantitative and qualitative methods during the period February to November 2007. Quantitative data on mental health facilities, resources and services provided in the district and sub-district as well as service usage were collected for the year 2005, using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 (WHO 2005a). The WHO-AIMS tool was specifically developed to provide essential information to strengthen mental health systems following the recommendations of the *World Health Report 2001* (WHO 2001). The instrument includes six domains: policy and legislative framework; mental health services; mental health in primary care; human resources; public education and links with other sectors; and monitoring and research. Only those aspects relevant to district-level analysis are presented, for example items regarding national policy and legislation for mental health were excluded.

Qualitative methods included semi-structured interviews and focus group interviews. Interview schedules were developed for each stakeholder group covering a range of topics that explored, inter alia, understandings of mental illness, type and quality of services provided, adequacy of training and capacity building, and resource constraints and needs.

Sample

Items from the computer-based WHO-AIMS Excel Data Entry Programme that requested data regarding mental health services, mental health in primary care, human resources, public education and links with other sectors for all public sector services in the district were adapted into a questionnaire for use by district respondents. This was distributed to the district and sub-district health management team for completion. Information on some items was obtained from the qualitative interviews and cross checked with the completed questionnaire. The sampling of respondents for the qualitative interviews was purposive, with a view to ensuring that the perspectives of all stakeholders in mental health service use and provision were obtained. In total 34 semi-structured interviews and 14 focus group interviews in either English or isiZulu were held with various stakeholders within the targeted district and sub-district. A schematic depiction of the stakeholders interviewed at this level is provided in Figure 1.

The type and number of interviews with each stakeholder group varied and was dependant on the number of participants available within a stakeholder group, for example there is only one District Health Manager, thus requiring an individual interview. In addition, focus group interviews and individual follow-up interviews were conducted with some participants, e.g. PHC nurses, when it was found that many of the participants did not participate fully in the focus groups. While there were a number of service users, individual interview was the preferred method due to the sensitivity of the discussion and the difficulty of conducting interviews with less than optimally functioning individuals. Further, the paucity of information emerging from some of these interviews meant that a greater number had to be conducted to obtain saturation of data.

Procedure

The quantitative data were checked telephonically with the Senior Technical Advisor for Mental Health in the district and
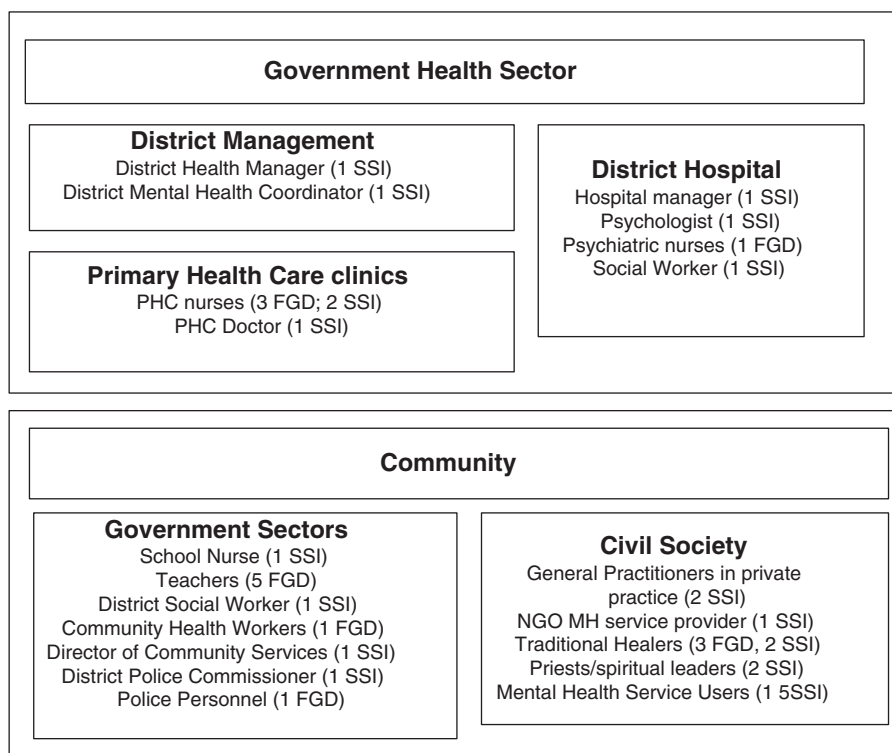

Figure 1 Stakeholders interviewed at the District level. SSI = semi-structured interview; FGD = focus group discussion

entered into the WHO-AIMS Version 2.2 (WHO 2005a) Excel Data Entry Programme, which automatically calculates the percentages and ratios of the various items such as beds per 100 000 population. Following informed consent procedures, qualitative interviews were recorded with the permission of respondents and the English interviews were transcribed verbatim. The isiZulu interviews were translated and transcribed into English, with back-translation checks being applied by an independent bilingual English-isiZulu speaker.

Analysis

Simple descriptive statistical analysis was conducted on the quantitative data, such as means and proportions. A framework analysis approach (Ritchie and Spencer 1994) was used to analyse the qualitative data. Framework analysis was specifically developed for qualitative data analysis in applied policy analysis research (Ritchie and Spencer 1994; Lacey and Luff 2001). It provides a systematic structure for the analysis process, with visible stages allowing funders and others to clearly follow how the results were obtained from the data (Lacey and Luff 2001). Further, it also allows for the use of *a priori* and emergent codes to be used in the analysis process (Lacey and Luff 2001), which is particularly useful when coding data across multiple sites. An *a priori* coding framework was developed for the four countries of the broader Mental Health and Poverty Project based on the objectives of the study and questions in the interview schedules. Representatives from all four countries participated in this process during a training workshop. NVivo7 software (QSR) was used to store the data as well as to code the data using the developed coding framework and to code new emergent country-specific themes.

To ensure reliability of the findings, the same interview schedules and *a priori* coding framework developed for all four countries was used in this study, and the process of data collection and analysis documented to ensure replicability. To ensure validity, information from different sources about the same issue was compared through the process of triangulation. Findings were also validated through dissemination at two district stakeholder workshops, the MHAPP Mental Health Advisory Committee, and one meeting of Provincial mental health coordinators.

Ethical approval for the study was obtained from the Reseach Ethics Committee, Faculty of Health Sciences, University of Cape Town, the Research Ethics Committee of the Faculty of Humanities, University of KwaZulu-Natal, and Research Ethics Committees of the national and provincial Departments of Health.

Results

Mental health service resources available to the sub-district

The mental health service resources available to the district and sub-district are contained in Table 1.

As reflected in the table, the sub-district is serviced by one hospital. The district as a whole lacked specialist mental health staff, particularly with respect to psychiatrists and psychologists. There was no psychiatrist and only one psychologist for the entire district. There were, however, many more psychiatric nurses, with 10 based at the sub-district hospital and six in the sub-district PHC clinics.

The number of dedicated psychiatric beds at the district hospital is reflective of the national average, estimated by the WHO to be 3.8 per 100 000 population (WHO 2005b). The district as a whole has 4.4 and the sub-district 3.3 dedicated psychiatric beds per 100 000 population.

A technical advisor for mental health had been recently appointed to co-ordinate mental health services in the district. Due to staff shortages, she was, however, required to manage other programmes as well. Thus in reality, she was not solely dedicated to mental health. At the time of the situational analysis, a mental health plan for the district had not yet been developed, nor had a multisectoral forum been put in place. According to a district manager:

> ''. . . there is a lot that is not even happening right now. You find that (the technical advisor for mental health) has to run there and there . . . and yet mental health is having a lot that is not yet being done, especially for the district. I think if (the technical advisor) will get enough time to look to mental health services, the district will be proper . . .''

Moreover, while there were 10 psychiatric nurses at the sub-district hospital and six in the sub-district clinics, these nurses were not used exclusively for mental health, having to perform general health care duties because of staff shortages, as indicated in the following excerpt from an interview with a district manager:

> ''Except . . . I was having a problem again with (this hospital), because now each time they employ a person (psychiatric nurse) . . . she's not . . . at the mental health services, she's doing other things, she's in OPD.''

Table 1 Mental health service resources in the case study district site

	District	Sub-district
Facilities		
Hospitals	5	1
Fixed clinics	50	15
Mobile clinics PHC	12	–
Dedicated MH beds	22	5
Community residential	0	0
Dedicated MH child/adolescent	0	0
Crisis centre	–	1
Outpatient departments	–	1
Staff		
Technical Advisor for mental health	1	0
Psychiatrist	0	0
Psychologist	1	0.3
Nurses	51	–
Psychiatric nurses	–	16
Social workers	8	4
Occupational therapists	10	0

Note: – = unknown.

A mental health budget of R200 000 (approximately £1330) per annum allocated to the district was regarded as insufficient to cover the costs of training PHC personnel in mental health care, mental health promotion and prevention programmes, as well as psycho-social rehabilitation, for which it was earmarked. This budget was not ring-fenced and thus poorly accounted for and open to being used for purposes other than mental health. To quote a PHC nurse:

"Like now we haven't received anything but the year is coming to an end, even last year . . . Even though the money is there. You find that we do not get the things we need. There is a poor process that side."

Symptom management of mental health problems

District management staff indicated that they generally have all the necessary psychopharmacological medication required to meet patient needs in the district:

"I've not experienced a situation where we've ordered a drug for the patient and they've said that the hospital pharmacy doesn't have. It might be a situation in the clinics sometimes that they run out and then I've just got to do an order from the pharmacy that they deliver those meds, you know, to the clinics."

At the PHC clinic level, PHC nurses provide follow-up medication for people with chronic stabilized psychiatric conditions as part of their routine service package. Although they felt quite comfortable managing stable conditions, they reported several issues which adversely impacted on their work. Firstly, a need for improvement in the referral process: while they provided onward referral information when referring patients to the hospital, they did not generally get any back-referral information to assist in the management of psychiatric patients, as reflected in the following interview with a PHC nurse:

". . . when you refer a person to (the district hospital), whether you have written a follow-up card or a letter, there is no feedback, you don't get it. That system is not right . . . They are supposed to come here and continue here. They just come with pills. You ask them what they (at the hospital) said . . . maybe you gave a certain diagnosis and it has changed . . . what is it . . . you don't know . . ."

Secondly, they complained of a lack of support and supervision from mental health specialists, as indicated by a PHC nurse:

"But the problem at the moment is that there is no one overseeing things from the hospital. Before, there was a psych sister, who used to come . . . she would visit them and see them (sisters in the clinics) . . . (ask) like 'okay, how many cases do you have, how many have defaulted, what problems do you have?' Now there is no one . . . no psych sister coming here."

A third problem was that while there was training for PHC nurses in managing psychiatric patients, high turnover of staff meant staff who had received this training were not always available. To quote a PHC nurse:

"even though we do not have psych, we do have these short courses . . . on particular conditions . . . then you know that you have

someone to help you out . . ..then maybe she leaves . . . So now if she leaves, we will be all alone . . ."

Psychosocial support services

While the MHCA stipulates that follow-up services for patients with chronic mental illness at PHC and community level should include rehabilitation programmes within available resources, no community residential services were provided in the district and psychosocial support was extremely limited. Community care givers, who are general community health workers with no specific training in community-based rehabilitation, were tasked with ensuring patients take their medication properly.

". . . make sure that the patient is linked to the local . . . home-based care-givers . . . And uh the villagers I tell them to be very responsible for this person to make sure that the treatment is taken correctly; the patient is eating correctly; if there is a problem they should report back to us."

Service providers at the community level expressed a desperate need for special shelters or housing, supported employment, support groups, and other forms of psychosocial rehabilitation in the area.

". . . a lot of these people who are mentally disturbed, (are) on the streets and they are seen as harmless. They are harmless in fact but you begin to say how long will they be moving on the streets . . . because the community itself is not that much sensitized . . . that is fine . . . Because they do no harm to anybody but at the end you see that this person is not well. Maybe a home will do for them . . ."

Mental health service users who were interviewed also felt that it would be helpful to have psychosocial rehabilitation programmes, as illustrated by the following excerpt from interviews with mental health service users.

". . . But you know people. They sit at home and mind their business so you don't really get to meet and talk about your similar problems . . . it would be nice (to have a support group) because we can talk to other people and help each other with problems like feeling bad when people discriminate you. There are a lot of us in my community."

Emergency management of patients with psychiatric disorders

The MHCA provides standards of mental health care, such as the availability of mental health staff, medicines and beds, to ensure that admission, assessment and ongoing referral for more specialist treatment of a mental health patient in a district hospital occurs within a 72-hour period at PHC level.

The MHCA has promoted improvement in some aspects of emergency treatment of patients with psychiatric disorders, particularly with respect to the imperative for district hospitals to provide for 72-hour admission and observation as reported by a district manager.

"it (the Act) has identified the need for improved facilities to accommodate mental health . . . patients. It has also identified the

need for people to (improve) the protocols for mental health ... it is bringing more information ... people will start to be more serious with their assessments ...''

Still, in practice, both human resources and infrastructural improvements are needed to support uptake of this function at district hospital level. There is currently no specialist unit or designated area for psychiatric patients who are managed in the general wards, which is proving inadequate as a facility for psychiatric care, as noted by a member of the hospital management team.

''We have a little corner where we have got a few beds that we put in there. But it's not a maximum security; it's not user-friendly to be honest. We hope one day we'll be able to say, even if it's not a ward, but some psychiatric unit in the ward where you can have an area where you can put the patients because it's very difficult to manage them.''

With regard to human resources, while the hospital has a number of psychiatric nurses, they are rotated through the wards and the outpatient department due to staff shortages, and the psychiatric patients are cared for by nurses with varying degrees of experience in mental health.

At the PHC clinic level, PHC nurses expressed reticence to attend to patients with psychiatric conditions requiring emergency management. There was a preference for these cases to be seen by a mental health care practitioner. According to a variety of stakeholders, including a PHC doctor, a psychiatric nurse and a PHC nurse, this stems from a lack of confidence in their skills, the extra time that assessing a psychiatric patient requires, as well as stigma associated with mental illness, which appears to still be pervasive amongst general health care workers. As suggested by a PHC doctor:

''... I think they're often seen as getting in the way or people want to get rid of them rather than actually giving care to the patients. I think it's often because they're a bit unaware of what to do and it's also fear from staff (because) they (psychiatric patients) can get quite violent.''

According to a PHC nurse:

''I think it's the fear that a psych person is frightening ... a trained person has the skills; they have the approach to deal with them ... when the person is being aggressive ... maybe a skilled person will have the (right) approach.''

To quote from an interview with a psychiatric nurse:

''...a psych person is not just about treatment ... it's about assessment and their assessment is deep, it's not the same as a normal person, where you would listen to them saying 'I have a headache'. With them, while they are talking you need to be picking up something, you see, their assessment is long ... for psych ... it's a long procedure, just assessing one person ... so I think the workload is adding to people saying ... there should be a special somebody.''

The local South African Police Services (SAPS) are required by the MHCA to transport psychiatric patients where necessary.

The SAPS participate in the annual district planning meeting, and although their personnel in the district had been orientated to the MHCA requirements of the police, a fair amount of reluctance to deal with psychiatric patients was still reported. This seemed to stem from a belief that their core role was management of criminals, and that psychiatric patients with challenging behaviour should be managed by health personnel, as suggested by the following quote from a member of the SAPS.

''They (health) are shifting the responsibility. They should be taking these people from the community, not unless the person has done something incriminating. Somebody who has not really done anything criminal is not our case because for them it is all about illness.''

Care for more common mental health problems

More common mental health problems such as mood and anxiety disorders were generally not identified or treated, as reflected in the following response from a PHC nurse when asked specifically about common mental health problems.

''... you will not hear that much about (common) mental health (problems) in this clinic ... The one thing ... that is given attention is BP (blood pressure), ARVs (anti-retroviral medicines), (these) people ... are at the fore. Not mental health ... the way I see it, they are not recognised people.''

Key reasons for the lack of attention paid to common mental health problems were: insufficient time to make a thorough assessment that would allow for the identification of common mental health problems; insufficient time to manage these conditions; and insufficient mental health specialists for referral. To quote two different PHC nurses:

''I think ... it's overload ... you can just not assess a person fully, you see ... you just take it lightly while the person has depression and you don't pick up that they have depression ... I think we are lacking in our assessments ... we do not assess enough such that we are able to pick up that they have depression because once you pick up that they have depression, you won't just let them go that easily. Maybe we will just say that they have stress ...''

''Mmh ... for instance, there is one person I saw today, she says she is always tired and has headaches. There are problems at home but now who do I refer them to? You see ... if it is affecting them physically, there is a problem but who do I refer to? ... people like this need time ... If there were people that deal with them, we would be greatly helped because when they do counselling they take their time ... I am needed outside.''

Care for child and adolescent mental health problems

There were no specialist services for children and adolescents with mental health problems in the district. Within the Department of Health, services for children and adolescents were seen as a component of general mental health services. Children were generally only referred for disruptive behaviour disorders or the sequalae of abuse, as illustrated in the

following quotation from a focus group interview with PHC nurses.

> "There are those who decided, okay, the child has got a negative behaviour and they came in . . . Kids are usually neglected. They are only attended to once they become aggressive, destructive."

Within the Department of Education, interventions appear to be confined to using existing referral opportunities to manage problems identified within the school setting, as reflected in the following quotation from a focus group with teachers.

> "Uh . . . the Department of Education has hosted a workshop where they called us . . . they said that if there are cases like . . . for instance like with the guns, you should contact the police; with a child that's been raped, phone, they (gave) us the number so that a person . . . a social worker or whoever, can come. That is all I can say we have at the moment, it deals with things like that . . ."

The Department of Social Development also manages child and adolescent referrals, mainly from the Child Protection Unit of the SAPS, Childline, a crisis telephone service, and from teachers, school nurses and the clinics as outpatients. A need for more social workers was expressed.

Mental health promotion and prevention of mental disorders

Prevention and promotion activities in the district were largely limited to awareness days, particularly in schools, and normally organized by the school nurses, as illustrated by the quotation below from a focus group with psychiatric nurses.

> ". . . go out to the community to do some talks, like awareness days. They are in the HR's calendar. So we celebrate those days by having some talks to the community. And for two years I've been invited by the school health team and we are going around educating the kids on some issues. But . . . it's not a continuous thing, it should be a continuous thing."

School-based mental health promotion and prevention programmes, particularly for substance abuse and sexual violence, were identified as a major need by teachers, as were programmes to increase parental involvement with their children.

Multisectoral collaboration

While there was some collaboration between the SAPS and the Department of Health in relation to the transportation of psychiatric patients, between the health and educational sectors through the school nurses, and between health and social development regarding access to disability grants and other social services, there was very little evidence of any other collaboration. Of particular concern was the need for collaboration between traditional healers and western health care practitioners. Service users and community members largely adopt traditional explanatory models of illness in understanding mental health problems, but utilize both western and traditional systems of healing. Two-thirds of service users interviewed reported using both systems of healing.

While traditional healers expressed a willingness to incorporate western-based medication into their treatment plan, no formal collaboration arrangement exists between the two systems, as reflected in the following quotation from a traditional healer and mental health practitioner, respectively.

> "You can also find that a person becomes mentally ill because of their ancestors . . . To treat that, the person can go to a traditional healer who will give them medication . . . we still recommend that the person also include medication from the hospital."

> ". . . there's a gap in terms of liaising, there's a gap in terms of formalizing a relationship, there's a gap in terms of understanding treatment methods . . ."

Discussion

The results of the situational analysis suggest that a decade since the passing of the White Paper for the transformation of health service in South Africa (Department of Health 1997a), as well as the passing of the new Mental Health Care Act, no. 17 of 2002 (Department of Health 2004), and the National Health Act 61 of 2003 (Department of Health 2004), the focus of decentralization and integrated primary mental health care in the case study site still remains largely limited to de-hospitalization, screening and emergency management of patients presenting with mental disorders. In this regard, decentralization efforts at the case study site have included providing dedicated beds for the 72-hour admission and observation of mental health care users at the district hospital. Psychopharmacological medication was available in all the PHC clinics for follow-up care and a referral system was also in place, although problems with the back-referral process were reported.

In relation to human resources, data from the WHO-AIMS suggests that the case study district falls far below the target estimates for middle-income countries for psychiatrists and psychologists required to adequately treat a small basket of more severe mental disorders through outpatient and primary care. Chisholm et al. (2007) estimate the target human resource requirements to treat schizophrenia, bipolar affective disorder, depressive episode and hazardous alcohol use to be 0.5 psychiatrists and 1.0 psychologist per 100 000 population. However, the district as a whole had no psychiatrist and only 0.2 psychologist per 100 000 population. There were, however, many more psychiatric nurses than the suggested estimate. Chisholm et al. (2007) estimate that 2.0 psychiatric nurses per 100 000 population would be required. The sub-district had just under 10 psychiatric nurses per 100 000 population, including the hospital-based psychiatric nurses. However, both at district hospital and PHC clinic levels, available psychiatrc nurses were not dedicated to mental health care, being used for general health care services due to overall staff shortages in the system.

As suggested in the introduction, being an upper middle income country, South Africa should have sufficient resources to ensure widespread access to mental health services. The scarcity of psychiatrists and psychologists in the case study site is reflective of their scarcity within the public health sector generally. At the time of the study, only 0.28 psychiatrists per

100 000 population were employed by the Department of Health (Lund *et al.* 2007) which services 80% of the population. There were, however, estimates that South Africa as a whole had 1.2 psychiatrists per 100 000 population (WHO 2005b). Further, while the WHO Atlas estimated that there were four psychologists per 100 000 population in South Africa (WHO 2005b), there were only 0.32 psychologists per 100 000 employed by the Department of Health at the time of the study (Lund *et al.* 2007).

As reflected in the case study site, South Africa is, however, relatively well endowed with psychiatric nurses, with the majority of them also being employed in the public sector. In this regard, South Africa has more psychiatric nurses (7.5 psychiatric nurses per 100 000 population) compared with the median of 5.3 per 100 000 for upper middle-income countries (WHO 2005b).

With this background contextual information on the mental health resources available in the district site, and based on the findings of the qualitative interviews, we argue that the limited access to and scope of mental health services within the target study site is both a product of *insufficient resources with respect to certain categories of mental health workers within the primary health care resource package*, as well as *inefficient use of existing resources*. Similar barriers to decentralized integrated primary mental health care in LMICs have been identified by other studies. For example, Saraceno *et al.* (2007), using a qualitative survey of key informants from LMICs, found that the absence of adequate decentralization of resources for mental health care and inefficient use of existing mental health specialists in clinical care were among the barriers to the scaling up of mental health services.

Insufficient numbers of certain categories of mental health workers within the PHC resource package

First, at the PHC clinic level, PHC nurses in this study indicated that they did not have the time to identify and manage patients with common mental disorders. Further, they suggested that even if they identified a patient with a common mental disorder, they had difficulty in finding someone to refer them to. Just one example of the need for attention to be paid to the treatment of common mental disorders is that provided by Prince *et al.* (2007), who estimate that 20% of infant stunting could be averted by adequately treating maternal depression in LMICs.

With regard to expanding the PHC service to include the identification and management of common mental disorders, we suggest that the public health sector in South Africa has not taken advantage of a new cadre of mental health specialists, called psychological counsellors, who have a 4-year Bachelor in Psychology degree (BPsych). This category of mental health professional was officially introduced as part of the professional practice framework for Psychology in South Africa in 2003, in response to the unmet need for psychological services in South Africa, with the view to providing counselling and preventive services at the primary level of care (Petersen 2004; Elkonin and Sandison 2006). To date, posts for this cadre of workers within the PHC package have not been created. We argue that this cadre of workers could be appropriately deployed at PHC level to provide a referral counselling service for people with more common mental health problems. Further, they would be ideally placed to provide support and supervision to lay counsellors, such as Voluntary Counselling and Testing (VCT) counsellors as well as community-level workers for both curative and preventive services. As revealed by this situational analysis and other studies (e.g. Freeman and Pillay 1997; Petersen 2000), insufficient organizational support and time to adequately assess and manage patients with these problems renders it unlikely that PHC nurses in South Africa will ever be able to take on these roles.

Moreover, a recent review of efficacious psychotherapeutic treatments for depression at PHC level in LMICs revealed, inter alia, that group therapy and cognitive behavioural therapy for mild depression showed the most promise (Patel *et al.* 2007a). These interventions, which require specialist training, generally do not fall within the scope of practice of PHC nurses. Chisholm *et al.* (2007) set target estimates of 2.0 primary care counsellors per 100 000 population for middle-income countries to meet the needs of patients within the limited basket of disorders in their study.

Second, at the community level of care, this case study revealed that community-based rehabilitation programmes were limited to using community health workers to assist psychiatric patients to adhere to treatment. Further, mental health promotion and prevention was limited to the occasional awareness campaign.

The need for psychosocial rehabilitation programmes is given impetus by evidence showing that improved treatment adherence, strengthening social integration, and reducing stigma and discrimination can improve clinical and social outcomes for patients with chronic mental disorders in LMICs (Patel *et al.* 2007a). Further, trained community members have been shown to be able to effectively provide this service in a low to middle income country (Chatterjee *et al.* 2003).

With respect to mental health promotion and prevention interventions, the need for such programmes in LMICs is highlighted by evidence that shows that early childhood development programmes with children from low socio-economic backgrounds have positive outcomes. Efficacy trials have shown that early stimulation interventions have long-term positive impacts on cognitive and social emotional development outcomes for children from low socio-economic backgrounds, as do nutritional interventions to improve the diet of at-risk pregnant women and reducing iron and iodine deficiencies in infants (Engle *et al.* 2007). Further, there is mounting evidence from high-income countries as to the efficacy, effectiveness and even cost-effectiveness of prevention trials for conduct disorder and aggression, depression, pathological eating behaviour and alcohol misuse amongst adolescents (Patel *et al.* 2008). There is also emerging evidence that these programmes, when adapted for cultural contexts, have positive effects (Patel *et al.* 2007a).

In South Africa, given that existing community health workers are overburdened by the demands of other 'priority' illnesses such as HIV/AIDS and tuberculosis, the development and implementation of community-based services for psychosocial rehabilitation and mental health promotion and prevention requires an injection of trained community-based workers dedicated to mental health. Greater use of trained community workers to increase access to mental health services in LMICs has been argued as essential in the absence of sufficient specialist mental health resources and overburdened PHC

personnel (Saraceno *et al*. 2007). Chisholm *et al*. (2007) suggest that for the limited basket of more severe disorders they identified, a target estimate of 2.5 community health workers per 100 000 population for middle-income countries would be required.

In South Africa, the need for an expansion and acceleration of the number of 'mid-level' and community-based health workers, especially in peripheral areas, has been recognized as a mechanism to address the human resource deficits in the PHC system as a whole (Department of Health 2005). With respect to mental health care specifically, the Ministry of Health has proposed the introduction of mid-level 'mental health assistants' who would have a 2-year Diploma qualification. This cadre of worker would be ideally placed to deliver community-based rehabilitation programmes as well as community-based mental health promotion and prevention programmes. It would, however, be imperative that these workers are located within a district mental health care framework which provides the necessary training and support infrastructure from mental health specialists, given that insufficient training and supervision could lead to inappropriate services and poor outcomes (Swartz 1998; Saraceno *et al*. 2007).

Inefficient use of existing resources

The findings of this study suggest that lack of training and support from mental health specialists impeded PHC nurses' capacity to provide adequate care to psychiatric patients. While psychiatrists have provided an important ambulatory specialist liaison service for some time in South Africa, given the scarcity of psychologists within the health care system, particularly in rural areas, these mental health specialists could also be more efficiently utilized in training, supervisory and consultant liaison roles to health personnel at PHC level. Since 2003, clinical psychologists have been introduced into more rural areas in South Africa through the development of community service posts (Pillay and Harvey 2006). The concept of 1 year community service for health practitioners, after their training, was introduced in 1999 as a strategy to address the human resource shortages within the health care sector in South Africa. Given that the majority of psychologists in South Africa have been trained to employ individually oriented treatment modalities (Pillay and Petersen 1996), utilizing these specialist mental health practitioners in training, supervisory and consultant liaison roles would, however, require substantial revisions to existing training programmes to include community psychology theory and practice, as has been suggested by Pillay and Harvey (2006).

The idea of using specialist mental health practitioners in training and supervisory roles is not new. It has been previously suggested for South Africa (e.g. Robertson *et al*. 1997; Petersen *et al*. 2000; Mkhize *et al*. 2004) as well as being mooted for LMICs generally (Saraceno *et al*. 2007). Further, the use of specialists in these roles is supported by evidence which suggests that mental health service work undertaken by general and lay workers equipped with basic skills can have good outcomes, but only in the context of adequate training and close supervision and support (Swartz 1998; Saraceno 2007).

With regard to psychiatric nurses, while they are in greater supply compared with other mental health specialists in South Africa, in the case study site they were not efficiently used in their specialist roles for clinical care, being used as a stop gap for general nursing shortages. This finding highlights a possible negative implication of the integration of mental health care with general health services where, in the context of general health care shortages, it becomes difficult to ensure that resources intended for mental health care are utilized for this purpose. While ringfencing resources for mental health services is a possibility, appropriate and accessible district mental health services are never going to be achieved in isolation from broader efforts to address the human resource crisis within the health care service generally.

This case study also revealed inefficient use of a wealth of existing resources at a community level which could be harnessed to assist in the treatment and care of mental health problems. Existing opportunities, such as the setting up of a multisectoral forum to coordinate and streamline mental health related work between departments and other structures, had not been utilized. The White Paper for the transformation of the health system in South Africa (Department of Health 1997a) provides that district health authorities plan district-level mental health care services, as well as substance abuse prevention, management and rehabilitation services, together with non-governmental and community-based organizations and structures as well as roleplayers from other sectors.

In particular, traditional healers could be more efficiently utilized for the identification and care of patients with mental health problems. As reflected in the findings of this case study, the majority of users indicated that they had used both systems of health care either simultaneously or sequentially. While there have been many calls for greater collaboration around patient care and treatment between the two healing systems, the findings of this case study suggest that there has been little progress in this regard. The imperative to develop effective models of collaboration between the two healing systems in South Africa has been given impetus by the recent promulgation of the Traditional Health Practitioners Bill in South Africa, No. 35 of 2004 (Department of Health 2003). This Bill hails a step towards the formalization, regulation and professionalization of this sector. However, the existence of traditional healers, especially in more remote or rural areas, should not be used as a rationale for the lack of development of the formal public sector mental health care infrastructure in these areas. Further, collaboration between the two sectors needs to promote mutual learning and trust. In this regard, training of traditional practitioners in western understandings and treatment for mental illness, as well as training of western practitioners in traditional explanatory models of illness, is important, as is the establishment of mutual referral systems.

Conclusion

Using a case study site of a typical rural area in South Africa, this situational analysis has provided grounded information on the status of decentralized and integrated primary mental health from the perpectives of district managers, service providers and service users. The findings suggest that mental health services remain primarily focused on the emergency

management of psychiatric patients and ongoing psychopharmacological care of patients with chronic stabilized mental disorders. For adequate de-institutionalized care to be achieved which upholds the human rights agenda on which the concept is based, greater equity and efficient use of existing specialist and community-based resources as well as additional community-based resources for community-based rehabilitation within the district health system are required. Further, access to care for common mental disorders at primary level as well as mental health promotion and prevention requires an injection of additional specialist and community-based workers into the PHC resource package. These recommendations are supportive of the mixed model of service delivery recommended for LMICs (Saraceno et al. 2007).

Given the historical and ongoing trauma experienced by the vast majority of South Africa's population who remain poor and marginalized, there is a dire need to increase access to appropriate mental health services. Appropriate and accessible mental health services have the potential to break the cycle of poverty and mental and physical ill-health. As suggested by Miranda and Patel (2005) and Patel et al. (2008), lack of attention to mental health services could seriously compromise achieving the Millennium Development Goals in LMICs. In South Africa, this is going to require the political will to increase the resource package allocated to mental health care at PHC level as well as to introduce innovative strategies for more efficient utilization of existing mental health resources.

Acknowledgements

References

Africa Centre for Health and Population Studies. 2006. *Quality of life in Umkhanyakude*. Hlabisa, South Africa: Africa Centre.

Burns J. 2008. Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice. *South African Medical Journal* **98**: 46–51.

Chatterjee S, Patel V, Chatterjee A, Weiss H. 2003. Evaluation of a community-based rehabilitation model for chronic schizophrenia in a rural region of India. *British Journal of Psychiatry* **182**: 57–62.

Chisholm D, Lund C, Saxena S. 2007. Cost of scaling up mental disorders in low- and middle-income countries. *British Journal of Psychiatry* **191**: 528–35.

Curtis B, Bradshaw D, Nojilana B. 2002. *Socio-demographic Profile of the Magisterial District of Hlabisa – 1996 Census*. Durban: Medical Research Council.

Dawes A, Lund C, Kafaar Z, Brandt R, Flisher AJ. 2004. *Norms for South African Child and Adolescent Mental Health Services: Report for the Directorate Mental Health and Substance Abuse – National Department of Health (Tender No. DOH 48/2003–2004)*. Cape Town: Human Sciences Research Council.

Department of Health. 1997a. *White paper for the transformation of the health system in South Africa*. Pretoria: National Department of Health.

Department of Health. 1997b. *National health policy guidelines for improved mental health in South Africa*. Pretoria: Directorate for Mental health and Substance Abuse, National Department of Health.

Department of Health. 2004a. *National Health Act (61 0f 2003)*. Pretoria: Department of Health.

Department of Health. 2004b. *Mental Health Care Act (17 of 2002)*. Pretoria: Department of Health.

Department of Health. 2005. *A strategic framework for the human resources for health plan*. Pretoria: National Department of Health.

Elkonin DS, Sandison A. 2006. Mind the gap: Have registered counselors fallen through? *South African Journal of Psychology* **36**: 598–612.

Engle P, Black MM, Behrman JR et al. 2007. Child development in developing countries 3: Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world. *The Lancet* **369**: 229–42.

Flisher AJ, Lund C, Muller L et al. 1998. *Norms and standards for services for South Africans with severe psychiatric morbidity. Report to the Directorate: Mental Health and Substance Abuse, Department of Health, Republic of South Africa*. Cape Town: Department of Psychiatry, University of Cape Town.

Flisher AJ, Jansen S, Lund C et al. 2003. *Norms for community mental health services in South Africa. Report to the Directorate: Mental Health and Substance Abuse, Department of Health, Republic of South Africa (Tender Number GES 142/2001–2002)*. Cape Town: Department of Psychiatry and Mental Health, University of Cape Town.

Flisher AJ, Lund C, Funk M et al. 2007. Mental health policy development and implementation in four African countries. *Journal of Health Psychology* **12**: 505–16.

Freeman M, Pillay Y. 1997. Mental health policy – plans and funding. In Foster D, Freeman M, Pillay Y (eds). *Mental health policy issues for South Africa*. Cape Town: Medical Association of South Africa, pp. 32–54.

Hosegood V, Timæus IM. 2005. Household composition and dynamics in KwaZulu Natal, South Africa: mirroring social reality in longitudinal data collection. In van der Walle E (ed.) *African Households. Census data*. New York: M.E. Sharpe Inc., pp. 58–77.

INDEPTH Network. 2002. *Population and Health in Developing Countries. Population, Health and Survival in INDEPTH Sites*. Ottawa: International Development Research Centre.

Janse van Rensburg B. 2005. Community placement and reintegration of service users from long-term mental health care facilities. *South African Psychiatry Review* **8**: 100–3.

Kilbourne AM, Reynolds CF, Good CB *et al*. 2005. How does depression influence diabetes medication adherence in older patients? *American Journal of Geriatric Psychiatry* **13**: 202–10.

Lacey N, Luff D. 2001. *Trent Focus for Research and Development in Primary Health Care: An introduction to qualitative data analysis.* Sheffield, UK: Trent Focus Group.

Lund C, Flisher AJ. 2001. South African mental health process indicators. *Journal of Mental Health Policy and Economics* **4**: 9–16.

Lund C, Flisher AJ. 2002a. Staff/bed and staff/patient ratios in South African public sector mental health services. *South African Medical Journal* **92**: 157–61.

Lund C, Flisher AJ. 2002b. Staff/population ratios in South African public sector mental health services. *South African Medical Journal* **92**: 161–4.

Lund C, Flisher AJ. 2003. Community/hospital indicators in South African public sector mental health services. *The Journal of Mental Health Policy and Economics* **6**: 181–7.

Lund C, Flisher AJ. 2006. Norms for mental health services in South Africa. *Social Psychiatry and Psychiatric Epidemiology* **41**: 587–94.

Lund C, Flisher AJ, Lee T, Porteus KA. 2002. Bed/population ratios in South African public sector mental health services. *Social Psychiatry and Psychiatric Epidemiology* **37**: 346–9.

Lund C, Kleintjes S, Campbell-Hall V *et al*. 2007. *A situation analysis of mental health policy development and implementation in South Africa.* Cape Town: University of Cape Town.

Miranda JJ, Patel V. 2005. Achieving the millienium development goals: does mental health play a role? *PLoS Medicine* **2**: 0962–5.

Mkhize D, Green-Thompson RW, Ramdass P *et al*. 2004. Mental health services in KwaZulu-Natal. *South African Journal of Psychiatry* **10**: 8–13.

Patel V, Araya R, Chatterjee S *et al*. 2007a. Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet* **370**: 991–1005.

Patel V, Chrisholm D, Kirkwood BR *et al*. 2007b. Prioritizing health problems in women in developing countries: comparing the financial burden of reproductive tract infections, anaemaia and depressive disorders in a community survey in India. *Tropical Medicine and International Health* **12**: 1–19.

Patel V, Flisher A, Nikapota A *et al*. 2008. Promoting child and adolescent mental health in low and middle income countries. *Child Psychology and Psychiatry* **49**: 313–34.

Petersen I. 2000. Comprehensive integrated primary mental health care for South Africa: pipedream or possibility. *Social Science and Medicine* **51**: 321–34.

Petersen I. 2004. Addressing the need for psychological services at the primary level of care in South Africa. Can a new psychological professional fill the gap? *Health Policy and Planning* **19**: 33–40.

Petersen I, Bhagwanjee A, Parekh A. 2000. From policy to praxis: a framework for the delivery of district mental health care for KwaZulu-Natal. *South African Medical Journal* **90**: 798–804.

Pillay AL, Harvey BM. 2006. The experiences of the first South African community service clinical psychologists. *South African Journal of Psychology* **36**: 259–80.

Pillay Y, Petersen I. 1996. Current practice patterns of clinical and counselling psychologists and their attitudes to transforming mental health policies in South Africa. *South African Journal of Psychology* **26**: 76–80.

Ritchie R, Spencer L. 1994. Qualitative data analysis for applied policy research. In Bryman A, Burgess RG (eds) *Analyzing qualitative data*. London: Routledge, pp. 173–94.

Robertson B, Zwi R, Ensink K *et al*. 1997. Psychiatric service provision. In Foster D, Freeman M, Pillay Y (eds) *Mental health policy issues for South Africa*. Cape Town: Medical Association of South Africa, pp. 69–93.

Saraceno S, Van Ommeren M, Batniji R *et al*. 2007. Barriers to improvement of mental health services in low and middle-income countries. *The Lancet* **370**: 1164–74.

Swartz L. 1998. *Culture and mental health: A southern African view*. Cape Town: Oxford University Press.

Tanser F, Hosegood V, Barnighausen T *et al*. 2007. Cohort Profile: Africa Centre Demographic Information System (ACDIS) and population-based HIV survey. *International Journal of Epidemiology* **37**: 956–62.

Williams DR, Herman A, Stein DJ *et al*. 2008. Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine* **38**: 211–20.

WHO. 2000. *World Health report 2000. Health systems: improving performance.* Geneva: World Health Organization.

WHO. 2001. *World Health Report 2001. Mental Health: New Understanding, New Hope*. Geneva: World Health Organization.

WHO. 2005a. *Assessment Instrument for Mental Health Systems*. Geneva: World Health Organization.

WHO. 2005b. *Atlas: Mental health resources in the world*. Geneva: World Health Organization.