

# Primary level psychological services in South Africa: can a new psychological professional fill the gap?

INGE PETERSEN

*School of Psychology, University of Durban-Westville, Durban, South Africa*

Care for common mental health problems in medium-resourced countries has been conceptualized by the World Health Organization as needing to be provided by primary health care personnel, in particular primary health care nurses. This study, which comprised a file audit of a psychological referral service at primary level in South Africa, suggests that in contexts where specialized psychological services are lacking, the demand for mental health services includes that of psychometric assessment services for mental retardation and/or scholastic problems. It is argued that in these contexts, third generation health systems reforms should be applied to the provision of care for more common mental health problems as well as mental retardation and/or scholastic problems in medium-resourced countries. This would require the insertion of a 'package' comprised of both psychological assessment and intervention services. It is suggested that in South Africa, such a 'package' could be provided by the new professional category of 'counsellor', which the Professional Board of Psychology of the South African Health Professions Council has recently accredited.

**Key words:** primary health care, mental health, mental retardation, psychological care, human resources, South Africa

## Introduction

The history of health care services in South Africa mirrors the pattern of health care system reforms in other low-income countries. In this regard, under the apartheid regime, the bulk of the health budget was devoted to hospital-based tertiary care (African National Congress 1994). This reflects what the World Health Organization (WHO) refers to as first generation health care systems, which characterized most health care systems in low-income countries under colonialist rule in the 1940s and 1950s (WHO 2000). Second generation health systems reforms were characterized by the introduction of universal primary health care, which, in addition to emphasizing the need for accessible, affordable, equitable and comprehensive curative care, promoted preventative care, which included a development agenda (Rifkin and Walt 1986).

The concept of universal primary health care underpinned the vision for the restructuring of health care in South Africa under the new democratic political dispensation (Department of National Health 1997). However, it is argued elsewhere (Petersen and Swartz 2002) that implementation has been characterized largely by third generation reforms. According to the WHO (2000), third generation reforms involve the delivery of high quality essential care, driven by the criterion of cost-effectiveness whereby efforts are concentrated on those diseases that account for large, avoidable burdens of ill-health and are the basis of packages of interventions. It is argued that this approach is reflected in the manner in which the integration of vertical programmes is occurring through the insertion of 'packages' of interventions for specific illnesses into the existing primary health care services.

The history of mental health care in South Africa mirrors these stages. Under the apartheid government there was an emphasis on providing institutional psycho-pharmacological care for patients suffering from serious mental disorders. With the political transition and accompanying emphasis on primary health care, there was a concurrent shift in mental health policy. Community-based models of care were emphasized. Furthermore, as in many other low- and medium-income countries, the route chosen to achieve this end was through decentralizing and integrating mental health services into primary health care.

While the identification and care of common mental health problems forms part of the integration agenda, the emphasis in implementation has been on inserting psychiatric care for the seriously mentally ill into primary level care. According to Flisher et al. (1998), there appears to be general agreement among provincial coordinators that the restructuring process essentially involves the 'the provision of ongoing management of psychiatric patients with stabilized or chronic conditions in the community, as well as basic screening and emergency management by primary health care staff' (p.17). This is being achieved largely through training of primary health care personnel in technical skills, as well as the placement of psychiatric nurses at this level of care (Flisher et al. 1998). Other more specialist mental health professionals, notably psychiatrists and psychologists, are envisaged as providing a back-up referral service as well as playing a consultancy-liaison role to nurses at the primary level of care (Robertson et al. 1997; Petersen et al. 2000).

Ensuring care for psychiatric patients at the primary level thus remains the focus of integration efforts and is in keeping with third generation reforms, as it allows psychiatric care for

serious mental health problems to be packaged and implemented in ways which facilitate measurable outcomes at this level of care. While the need to prioritize the development of community-based services for serious mental illness is understandable, it is argued, using the WHO (2001) classification system, that South Africa has medium level resources, meaning that some resources are available for mental health care but are insufficient to provide access for the total population to essential mental health services. While the WHO recommends action to enlarge mental health services to cover the entire population, it is suggested that in doing so attention should not *only* be given to the development of services for more serious mental illness. Resource redistribution also needs to take account of the need for care of more common mental health problems as well as mental retardation and/or scholastic problems. The latter are not included within the group of disorders referred to as common mental disorders, a term developed by Goldberg and Huxley (1992) which refers to those non-psychotic disorders which are commonly encountered in community settings.

The need for services to cater for common mental health problems at the primary level is highlighted by a multi-site study conducted by the WHO. This study revealed that around one-third of patients presenting at primary level have psychological/psychosocial problems, with the most common of all chronic conditions being depression (WHO 1998). Furthermore, two South African community-based studies show a weighted prevalence for anxiety and depressive disorders of 23.9% and 24%, respectively (Rumble et al. 1996; Bhagwanjee et al. 1998).

Following the WHO's recommendation (WHO 2001), training of primary health care nurses to provide care for more common mental health problems such as anxiety and depression has been identified as the strategy for addressing these problems in South Africa (National Department of Health 1997). Evidence suggests, however, that even if nurses are trained to identify and manage more common mental health problems, within the context of third generation reforms, and in the absence of a restructuring of the health care system to be supportive of a comprehensive approach to care, primary health care nurses have neither the time nor the will to provide such care (cf. Freeman and Pillay 1997; Petersen 1999, 2000). These findings are corroborated by international experience both in Guinea-Bissau and in Botswana (Ben-Tovim 1987; De Jong 1996), where evaluation of the impact of training nurses in the identification and management of common mental health problems remains unclear.

There is thus an increasing body of evidence which questions the viability of deploying primary health care nurses to provide mental health care for common mental health problems. This study, which involved a file audit of cases seen by a psychological referral service at primary level care in South Africa, suggests that in the context of a paucity of specialist psychological services to cater for mental retardation and/or scholastic problems, consumers of mental health services at the primary level also require psychometric

assessment services to cater for these problems, which falls beyond the scope of nursing practice.

The psychological referral service was run by a community outreach programme attached to an academic training institution in South Africa from 1997 to 2001. This programme offered an accredited community/counselling psychology internship programme as part of the professional training for counselling psychologists. It provided intern psychologists with the opportunity of providing, inter alia, a psychological referral service at the primary level in the Kwadedangendlale area of KwaZulu-Natal, a province on the eastern seaboard of South Africa. Over the period studied by the file audit, the area comprised five tribal areas and had an estimated overall population of 55 000 to 75 000 people (Pitt 1994). The area is semi-rural, experiencing many of the difficulties that characteristically face rural populations in South Africa. In this regard, the majority of the population live below the poverty datum line with few opportunities for formal employment in the area. Dwelling units are scattered and access to resources is limited. The formal health service comprises a Community Health Centre and mobile and/or satellite clinics in the five tribal areas. The psychological referral service was provided 1 day a week during university terms at the Community Health Centre, and common referral problems have formed the basis of a number of community-based intervention projects initiated by the programme.

### The file audit of the psychological referral service

A total of 303 files of cases seen by the referral service between 1997 and 2001 were audited. These files represent cases, and not number of visits, as many clients returned for follow-up sessions. Of this total, 67 were excluded from the analysis due to inadequate information, giving a total of 236 files. Analysis involved the application of descriptive statistical procedures to the data.

### Demographics

Of the files which indicated area of residence, the audit revealed that the largest percentage of clients were drawn from the immediate surrounding tribal area, which was within walking distance from the Community Health Centre (38.6%). While the Community Health Centre serviced four other tribal areas, access to the Centre from these other areas required public transport, which is costly to the majority of the population who live below the poverty datum line. As shown in Table 1, the majority of clients seen were female. While this trend is consistent across all age groups, the percentage of females appears to increase with age to the extent that 86.1% of clients over 30 years of age were female (see Table 2). Excluding missing data for age, approximately half the clients were 18 years or younger.

### Presenting problems

Mental retardation, scholastic problems and physical/sexual abuse were the most common presenting problems, followed

**Table 1.** Demographics of referral service clients studied

	Frequency (n)	Percentage (%)
Gender		
Female	145	61.4
Male	88	37.3
Missing data	3	1.3
Total	236	100
Age		
0–5 years	6	2.5
6–12 years	48	20.3
13–18 years	59	25.0
19–29 years	61	25.9
30–49 years	26	11.0
50+ years	11	4.7
Missing data	25	10.6
Total	236	100

by somatic complaints and depressive/anxiety symptoms (see Table 3). Almost half the presenting complaints related to mental retardation and/or scholastic problems (47.4%).

The relatively high percentage of physical/sexual abuse complaints concurs with the high rate of abuse in South Africa. This is reflected in 1996 Interpol statistics which indicated that South Africa had the highest number of reported rape cases per 100 000 in the world (Adar and Stevens 2000).

Cross-tabulations of age range and the most common presenting complaints, as depicted in Table 4, reveal that the most common presenting complaints for clients 18 years or younger were mental retardation and/or scholastic problems, totalling 63.3% of the complaints in this age category. The large number of children referred for these problems mirrors previous findings by Pillay and Lochat (1997) who found that the highest number of referrals to a visiting child mental health service in rural/peri-urban areas of KwaZulu-Natal were for mental retardation. While Pillay et al. (1999) found that mental retardation was also the most common referral problem in children attending an urban mental health clinic, comparative diagnostic distributions indicated that there was a significantly higher rate of mental retardation in the rural/peri-urban clinic attenders. They suggest that these findings need to be understood within the context of a lack of educational psychological services in more rural and peri-urban areas of South Africa compared with urban contexts. In 2002, a total of only 10 registered psychologists were employed within the educational sector in the province of

KwaZulu-Natal, which has a population of approximately 8 million people (personal communication: J Naidoo, Department of Education, KwaZulu-Natal).

Physical/sexual abuse also constituted a large percentage of the presenting complaints amongst clients aged 18 or younger when compared with older age groups. This reflects perhaps the increase in sexual offences against children, especially rape, in South Africa as reported in the Report on Sexual Offences against Children (South African Human Rights Commission 2002). Further analysis revealed that 70.9% (n = 22) of those aged 18 or younger presenting with physical/sexual abuse were girls. This also concurs with findings of the Report on Sexual Offences against Children (South African Human Rights Commission 2002), which found that girls are more likely than boys to have suffered some form of sexual violence before 18 years of age.

While the presenting complaints amongst young adults (19–29 years) suggest a more even distribution of intellectual/scholastic and emotionally based complaints, complaints amongst clients aged over 30 suggest a trend towards more emotional problems. The most common presenting problem in this age group was somatic complaints, which previous research suggests are strongly associated with depression in African culture (e.g. Swartz 1999).

### Diagnosis

As reflected in Table 5, the most common diagnosis recorded was mental retardation, followed by neurotic/mood disorders including post-traumatic stress disorder (PTSD).

Cross-tabulations of the most frequent diagnoses with gender (Table 6) suggest that roughly half of the male clients were given a diagnosis of mental retardation. By contrast, a larger percentage of female clients were given diagnoses related to neurotic/mood disorders including PTSD (44.8%) than mental retardation (36.6%). These findings suggest that more females used the service for emotional problems and concur with the greater percentage of females presenting with physical/sexual abuse as well as depressive/anxiety symptoms than males. Furthermore, it also reflects South African and international research, which suggests a greater prevalence of depressive disorders in women compared with men (e.g. Hirschfield and Cross 1982; Eaton and Ritter 1988; Bhagwanjee et al. 1998).

Cross tabulations of age range and diagnosis (Table 7)

**Table 2.** Cross-tabulations of age and gender

Age	Female (n = 129)		Male (n = 79)	
	Frequency (n)	% of total no. per age group	Frequency (n)	% of total no. per age group
0–18 years	61	54.9	50	45.1
19–29 years	37	60.7	24	39.3
30+ years	31	86.1	5	13.9

**Table 3.** Presenting problem as a percentage of the total

Presenting problem	Frequency (n)	Percentage (%)
Mental retardation	56	23.7
Scholastic problem	56	23.7
Physical/sexual abuse	56	23.7
Depression/anxiety	31	13.1
Somatic symptoms	33	14.0
Epilepsy	24	10.2
Behavioural problems	21	8.9
Substance abuse	12	5.1
Psychotic symptoms	7	3.0
Other	6	2.5

indicate that over half (56.6%) of the clients aged 18 or younger were given a diagnosis of mental retardation. This is not unexpected given that over half of this age group's presenting complaints were related to mental retardation and/or scholastic problems. Furthermore, these findings concur with epidemiological data of psychiatric problems of children presenting at tertiary level in South Africa (Robertson 1991; Pillay and Lochart 1997; Pillay et al. 1999).

Within the 19–29 years age range as well as in those over 30, neurotic/mood disorders (including PTSD) were the most common diagnoses given, being greatest in those clients aged over 30. These findings support previous research in South Africa, which shows a higher overall prevalence of these disorders in the 30+ age group compared with those aged 19–29 (Bhagwanjee et al. 1998).

#### Assessment tests administered

As reflected in Table 8, the most common assessment tests administered were the Vinelands Social Maturity Scale followed by the Raven's Progressive Matrices. These findings reflect the large number of cases presenting with mental retardation and/or scholastic problems, which would necessitate assessment of intellectual and social functioning. The Vinelands Social Maturity Scale provides a useful index of individuals' abilities to look after their own needs and to take on responsibilities expected for their particular chronological age group. It is administered to the caregiver and is particularly useful for estimating mental retardation at the

younger age levels, although it covers an age range from birth to over 25 years (Anastasi 1982). The Raven's Progressive Matrices provide a measure of general intelligence, which, while developed originally in the United Kingdom, has been found to be suitable for cross-cultural use (Foxcroft and Roodt 2001).

#### Psychological interventions

As shown in Table 9, the most common interventions were assessments for school placements in specialized schools and/or for disability/child care grants. These findings reflect the large number of cases presenting with mental retardation and/or scholastic problems. Pillay and Lochat (1997) suggest that a large number of children with mental retardation are to be found in mainstream education in South Africa, despite being unable to cope with the curriculum. This is due to the lack of special services within the educational system to provide the necessary assessments, as well as the paucity of special facilities to cater for children with scholastic difficulties.

Furthermore, a large number of people living in rural areas of South Africa who are eligible for disability grants are not in receipt of them due to the lack of relevant services. In the absence of other specialist services, the psychological referral service audited in this study thus provided a mechanism to assist children and adults with mental retardation and/or scholastic problems to be placed in special schools/sheltered workshops, as well as to assist in their application for child care/disability grants to help finance these placements.

The second most common intervention was supportive therapy. Supportive therapy is integral to the work of the helping professions and is the non-systematic part of therapy. It involves empathic listening and communication of caring and concern. It is often used as a precursor to other therapies/interventions and is useful in helping to address relatively minor and transient problems, such as adjustment problems or bereavement, which do not require systematic counselling or therapy (Robertson 1996). The preponderance of supportive therapy over other forms of therapy needs to be understood within a context of poverty and unfamiliarity with the concept of counselling and psychotherapy by service users, which a previous study found to act as a barrier to clients returning for follow-up sessions (Govender and

**Table 4.** Cross-tabulations of age and selected presenting complaints

Presenting problem	0–18 years		19–29 years		30+ years	
	Frequency (n)	% of total no. of 0–18 year olds (n = 113)	Frequency (n)	% of total no. of 19–29 year olds (n = 61)	Frequency (n)	% of total no. of people 30+ yrs (n = 37)
Mental retardation	31	27.4	11	18.0	10	27.0
Scholastic problems	41	36.2	10	16.4	0	0
Physical/sexual abuse	31	27.4	10	16.4	10	27.0
Depression/anxiety	10	8.4	11	18.0	10	27.0
Somatic complaints	6	5.3	10	16.4	12	32.4

**Table 5.** Diagnoses as a percentage of the total

Diagnosis	Frequency (n)	Percentage (%)
Mental retardation	100	42.4
Neurotic/mood disorders (excluding PTSD)	58	24.6
Post-traumatic Stress Disorder	35	14.8
Disruptive disorders	19	8.0
Learning/other developmental disorders	17	7.2
Psychotic disorders	5	2.1
Other	5	2.1

PTSD = post-traumatic stress disorder.

Petersen 1999). Clients living beyond walking distance to the Community Health Centre could often not afford the transport money to attend follow-up sessions (Govender and Petersen 1999). To quote one service user from this previous study: "... this would lead me to not having money to come back as I spent R20.00 to come here".

Furthermore, some clients were unfamiliar with the concept of counselling and psychotherapy and had expectations for medical treatment (Govender and Petersen 1999). To quote from this previous study: "I thought I was going to a doctor who will check me as I am sick and find a cause for my illness and give me injections or tablets. I did not expect to just talk."

In this context, even though ongoing systematic therapy may

**Table 6.** Cross-tabulations of gender and most common diagnoses

Diagnosis	Female		Male	
	Frequency (n)	% of total no. of females (n = 145)	Frequency (n)	% of total no. of males (n = 88)
Mental retardation	53	36.6	45	51.1
Neurotic/mood disorders (excluding PTSD)	40	27.6	18	20.5
PTSD	25	17.2	9	10.2

PTSD = post-traumatic stress disorder.

**Table 7.** Cross-tabulations of age range and most common diagnoses

	0–18 years		19–29 years		30+ years	
	Frequency (n)	% of total no. of 0–18 year olds (n = 113)	Frequency (n)	% of total no. of 19–29 year olds (n = 61)	Frequency (n)	% of total no. of people 30+ years (n = 37)
Mental retardation	64	56.6	17	27.9	10	27.0
Neurotic/mood disorders (excl. PTSD)	13	11.5	23	37.7	15	40.5
PTSD	19	16.8	5	8.0	8	21.6

PTSD = post-traumatic stress disorder.

have been indicated, it was often precluded by clients failing to return for follow-up sessions.

## Discussion

The argument for services to cater for more common mental health problems at primary level has been based, in the main, on the need to service the large number of clients who present with depressive/anxiety disorders at this level (cf. Freeman and Pillay 1997; WHO 1998, 2001). The results of this study suggest, however, that in the context of a paucity of specialist psychological services to cater for mental retardation and/or scholastic problems, there is also a demand at the primary level for psychological assessment services for these problems.

While acknowledging that this study does not ascertain need for such a psychometric assessment service based on community prevalence of mental retardation/scholastic problems, or on views of service users, the relatively high number of consumers referred for intellectual and/or scholastic assessment suggests a demand for such a service. According to Robertson (1996), mental handicap is common, affecting 2–4% of the population in South Africa. It is more common in developing countries due to poor perinatal services as well as the strong link between poverty and mild mental retardation (Robertson 1996). A common problem in mental health service planning has been the neglect of service users' problems (Binner 1993). As Freeman (2000) indicates, the situation in South Africa has not been much different

**Table 8.** Assessment tests administered as a percentage of the total

Assessment test administered	Frequency (n)	Percentage (%)
Vineland's Social Maturity Scale	80	33.9
Raven's Progressive Matrices	58	24.6
Projective drawings	39	16.5
Bender Visual Motor Gestalt Test	34	14.4
Zulu South African Intelligence Scale (ZSAIS)	24	10.2
South African Individual Scales (excluding the ZSAIS)	4	1.7
Other	4	1.7

**Table 9.** Psychological interventions as a percentage of the total

Psychological intervention	Frequency (n)	Percentage (%)
Supportive psychotherapy	81	34.3
Assessment for school placement	67	28.4
Assessment for disability/childcare grant	50	21.2
Psycho-education	25	10.6
Trauma therapy	24	10.2

with local and national political priorities often informing resource provision.

While 39.4% of clients using the service audited in this study were given diagnoses of neurotic/mood disorders, 42.4% of clients were diagnosed with mental retardation. Furthermore, 49.6% of the interventions provided were related to assessments for school placements and/or disability grants/child care grants. While these services may be provided by psychological services within the educational system in highly resourced countries, in South Africa, these assessment services are limited. In this context it is understandable that where clinical/counselling-oriented services are provided, there would also be a demand for intellectual/scholastic assessments.

South Africa is clearly committed to providing a service for more common mental health problems in addition to serious mental illness, as contained in the White Paper for transformation of the health system in South Africa (National Department of Health 1997). However, the findings of this study suggest that in addition to care for neurotic/mood disorders, in the absence of specialist psychological services, particularly within the education sector, the range of services required by consumers at the primary level also includes psychometric assessments for mental retardation and/or scholastic problems. In South Africa, many of these psychometric tests are required to be administered by registered psychometricists/psychologists. While primary health care nurses may, under certain conditions, be able to provide care for common mental disorders, this study suggests that the services required by consumers in rural/semi-rural areas of South Africa extend beyond this to include psychometric assessments which fall outside the professional scope of practice of nursing care.

It has been argued that third generation reforms characterize the integration of mental health services for psychiatric patients into primary level care in South Africa. Given the range of mental health services required for common mental health problems and mental retardation and/or scholastic problems, it is suggested that third generation health systems reforms should also be applied to the provision of care for these problems, particularly in rural/peri-urban areas where specialist psychological services are lacking. Such an approach would require the insertion of a 'package' of psychological assessment and intervention services for these problems within the existing primary health care services.

Within the context of a limited number of psychologists in South Africa, the feasibility of this suggestion is dubious. According to the WHO (2002), South Africa has a ratio of 4 psychologists per 100 000 population. Better resourced countries such as the United States have a ratio of 26.4 psychologists to 100 000 population (WHO 2002). Furthermore, only a small percentage of these psychologists are employed in the public health system. In 2002, a total of 31 registered psychologists were employed within the public health system in KwaZulu-Natal (personal communication: F Clark, Department of Health, KwaZulu-Natal), which services around 80% of a population of approximately 8 million. In the context of these scarce resources, it is suggested that given the limited range of services required, this 'package' could be provided by a new psychological professional category, which the Professional Board of Psychology of the Health Professions Council of South Africa has defined as a 'counsellor' in a defined practice field. This would be a far more cost-effective strategy than employing more qualified psychologists at the primary level, who are currently envisaged as playing a back-up consultancy/referral role to primary care providers.

The category of 'counsellor' is part of the new professional practice framework for Psychology in South Africa. It is the product of years of debate as to the need for a lower level psychological professional to meet the demand for psychological services in South Africa given the paucity of psychologists, as well as the expense entailed in their training. The qualification leading to registration in this category is a 4 year Bachelor of Psychology degree, which has been introduced in other parts of the world such as Australia. The scope of practice of registered 'counsellors' is based on core competencies required of the defined practice field (Professional Board of Psychology 2001).

The results of this study provide information with respect to the scope of practice of this new category of 'counsellor' in the field of 'primary mental health care'. Core competencies required would include firstly, the administration, scoring and interpretation of a limited range of psychometric tests, including both intellectual and personality tests, as well as writing of structured reports. Secondly, with respect to more emotionally related problems, competencies in supportive therapy/counselling would also be required. Thirdly, competencies in the development and implementation of prevention programmes to address common referral complaints would be necessary in order to facilitate the provision of a

comprehensive service, which encompasses both curative and preventative care. Within the context of the district health system approach in South Africa, it is entirely feasible that the quality of care provided by counsellors could be overseen by registered psychologists deployed to provide a consultancy-referral back-up service to primary care providers.

## Conclusion

Within the restructuring of mental health care in South Africa towards integration into primary level care, the focus has largely been on the roles and functions of psychiatric and primary health care nurses in relation to the provision of psychiatric care for more serious mental disorders. This is in line with WHO (2001) recommendations for low-income countries to prioritize serious mental illness in the development of systems of mental health care. It is argued, however, that South Africa, being a medium-resourced country, needs to redistribute resources to ensure the provision of care for common mental health problems as well. While this aspect of care has been conceptualized as being provided by primary health care personnel, this study suggests that the service required at the primary level includes psychometric services for the assessment of mental retardation and/or scholastic problems as well, which falls beyond the scope of nursing care.

It is argued that third generation health systems reforms need to be applied equally to these problems, especially in more rural/peri-urban contexts where specialist services may be lacking. Within a society characterized by poverty and HIV/AIDS, the need for a 'package' of services for common mental health problems at the primary level of care is also timeous and necessary.

In addition to assisting families with members who may have mental retardation and/or scholastic problems through assessments which are required for placements and disability/child care grants, such a service would play an important role in assisting community members to cope with the psychological sequelae of HIV/AIDS (cf. UNAIDS 2000). Primary health care nurses cannot be expected to carry this burden in addition to having to care for the physical illnesses associated with HIV/AIDS. While mid-level health workers<sup>1</sup> may well be trained in providing pre- and post-test HIV counselling, such workers are, however, unlikely to have the necessary expertise or capacity to provide ongoing counselling and supportive psychotherapy for those people affected by HIV/AIDS. Richter et al. (1999), in a comprehensive evaluation of HIV/AIDS counselling in South Africa, found that most counselling services provided by nurses and other non-professional counsellors centred around pre- and post-test counselling, with little ongoing counselling being offered. Furthermore, they found that in practice, most counsellors used a directive and health advising approach as opposed to the avowed client-centred approach indicated upon being interviewed.

It is suggested that delivery of such a package could be facilitated by including the new professional psychological

category of 'counsellor' within the cadre of health workers identified as necessary for primary level care within the framework of the district health system in South Africa.

## Endnote

<sup>1</sup> Mid-level health workers are not professionals who receive a full university training but are assistants or auxiliaires such as rehabilitation assistants who receive a more technical education over 1 or 2 years (Buch 2000).

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## Biography

Inge Petersen is currently Director of the School of Psychology at the University of Durban-Westville, South Africa. Her academic interests include mental health policy development, community psychology and more recently health promotion with a specific focus on HIV/AIDS. In line with these interests, Dr Petersen completed a PhD at the University of Cape Town in the field of mental health policy development in South Africa and has published in both local and international journals on this topic.

*Correspondence:* Inge Petersen, School of Psychology, University of Durban-Westville, Private Bag X54001, Durban, 4000, South Africa. Tel: +27-31-2044423; fax: +27-31-2044611; e-mail: inge@pixie.udw.ac.za