South African Society of Psychiatrists

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SASOP POSITION STATEMENT
A human resource proposal for public sector psychiatric services

South Africa has pursued a policy of deinstitutionalisation of people with mental illness since the mid-1990s.[1] However, the transfer of people from institutions to the community has not been accompanied by the development of adequate psychiatric services in general hospitals or district clinics.[2] Even though this violates Chapter III, 8(2) and 8(3) of the Mental Health Care Act No.17 of 2002,[3] the NHI White Paper of December 2015 persists in restricting psychiatric services to "mostly specialised facilities designed for care of mentally ill patients" (clause 6.3, point 199). In keeping with this recommendation, no WISN assessment was performed for community based psychiatric care. This gravely limits the care of community dwelling people living with severe mental illness whose conditions, although markedly impairing, are not disruptive enough to access the limited number of hospital beds available.

We believe the lack of community based psychiatric services contributes to poor care outcomes such as lengthy hospitalisation, repeated admissions and high mortality and morbidity rates. It prevents community based education and training of medical, psychology and occupational therapy students and interns. It also limits specialist support of integrated primary mental health care for people with less severe illness.

In this statement, we put forward a proposal for human resource requirements for psychiatric services in the public health sector. We recognise that the norms and standards referenced in the National Mental Health Policy [4] may not be presently affordable for the Department of Health. We therefore present a modified version – *a bare minimum requirement* – with a request for implementation in all provinces.

Note that:

- The proposal is not based on the degree of unmet need but on consensus agreement of public sector psychiatrists, and brief consultation with psychologists, of what may be a minimal starting point.
- The needs of each province and each district differ. We present a model for a hypothetical district of 1 million people. However, regional priorities mean that this would have to be adapted to each situation.
- University and teaching duties are *not* included – academic institutions would require additional human resources to those proposed here. The placement of interns would also be additional.
- Infrastructure requirements are not included in this statement.
- Specialised psychiatric hospitals and long-stay facilities are not discussed. However, this statement does not preclude their need. In many provinces, this service level is grossly inadequate despite the heritage of colonial custodial mental health care in South Africa.
- Ongoing monitoring and evaluation of the services are vital so that future adjustments may be made according to specific needs of the population served.

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I. Service Levels

Three service levels are considered: primary health care (PHC), community mental health services and psychiatric units in general hospitals (Figure 1). An additional proposal is made for the staffing requirement of an 'NGO monitoring team' (Section V below).

a. Primary health care

Non-specialist integrated primary mental health care of people with uncomplicated or mild mental illness is required. The 2015 – 2019 WISN implementation guideline for PHC facilities does include a visiting/outreach psychologist of one individual to serve 10 clinics, each with a headcount of approximately 70 000. To us, this appears inadequate.

b. Psychiatric services in general hospitals

All Regional, T1, T2 or T3 general hospitals should have a psychiatric ward and infrastructure for multidisciplinary care, treatment and rehabilitation.

c. Community mental health services / Community psychiatric services

To our knowledge, no WISN assessment was done for this level of mental health care at all. However, the National Mental Health Policy places these services at the same level as general hospital *specialist* psychiatric services, i.e. equivalent to Regional, T1 or T2 service levels. To distinguish them from primary mental health care, they are designated as **Community Psychiatric Services** in this document.

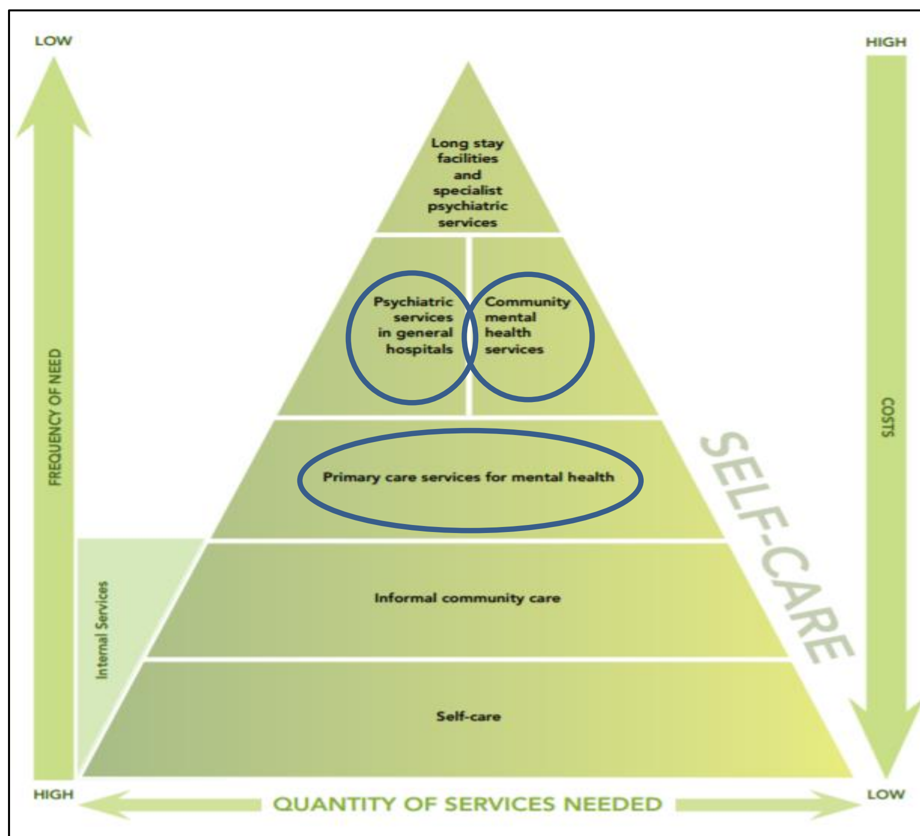

Fig 1. Intervention Pyramid (MH Policy page 22)

II. Integrated primary mental health care

Psychological services to be available in selected PHC sites (Objective 1 of the National Mental Health Policy).[4] To work with the PHCNs and other nursing staff, Family Medicine and PHC Medical Officers, Social Workers & Occupational Therapists. Receive referrals from informal community care, PHC and Community Mental Health Services. Work together with Community Psychiatry to support residential and day care facilities.

Range of services to include the provision of individual therapy, group therapy and family therapy. To support preventative and educational community based programmes.

We propose, per district hospital catchment area:

- 1 Counselling or Clinical Psychologist – supervisory role
- 1 Educational Psychologist – supervisory role
- 1 Registered Counsellor per 4 clinics – one day per clinic and one day for supervision / admin / case discussions

District hospitals are to provide 72-hour observation and detoxification from substances. They are to be staffed by family physicians according to needs of the population and supported by specialists at the next level hospital, as per NHI Annexure A.

III. Psychiatric services in general hospitals

No district can provide psychiatric care without provision for hospital admission for severe illness.

Each Regional or Tertiary general hospital should have a specialist psychiatric ward. Proposed staffing per 30 bed unit is based on WHO estimates and the Helen Joseph Hospital Psychiatric unit.[5]

Table 1. Recommended Staffing for a 30-bed unit

HR	Number of personnel
Psychiatrist (Head of Unit)	1
Psychiatrist (Specialist)	2
Registrars / Medical Officer	5
Nursing (R/Ns and E/Ns)	18
Nursing Assistants	8
Clinical Psychologist – senior	1
Clinical Psychologist – junior	2
Occupational Therapy	2
OT Technician	2
Social Worker	1
Ward Clerk (Admin support)	1

IV. Community Psychiatry (community based specialist services = R or T1 or T2)

Accessible specialist psychiatric services to provide care, treatment and rehabilitation to community dwelling people with severe mental illness and to support integrated primary mental health care.
Receive referrals from a) primary mental health care, b) general hospital psychiatric units (R, T1, T2 or T3) and c) specialised psychiatric hospitals (T3)

Range of services described on page 23 of the Policy:

- Support day care and residential homes
- Provide training, supervision and support to PHC practitioners
- Assess and manage people with mental illness which is too severe for PHC
- Provide care to MHCUs after discharge from hospital: optimise treatment, prevent relapse and readmission, and promote recovery
- Engage with other health sectors, the non-health sectors and other community stakeholders re the integration of severely mentally ill in the community, plus early detection and management.

The referenced norms and standards for minimal coverage of mental illness in the Mental Health Policy differ from each other.[6, 7] The rationale for this is not clear, however, as the norms are hypothetical estimates, it is reasonable to take the lowest estimate with ongoing monitoring and evaluation. In addition, some HR may be covered by PHC personnel.

Table 2. Human resource norms for minimal coverage of adults with mental illness

Type of Professional	Policy reference No. 45[6] 'Minimal coverage' Norms / 100 000 population	Reference No. 46[7] 'Minimal coverage' Norms / 100 000 population	**Numbers of personnel for a district of 1 million population**
General Nurses	21	9.4	**94**
Psychiatric Nurses	9	3.9	**39**
Occupational Therapists	6	3.5	**35**
Occupational Therapy Assistants	11	7.4	**74**
Social Workers	11	6.0	**60**
Psychologists	7	2.5	**25**
Psychiatrists	1	0.4	**4**
Registrars / Medical Officers	3	1.8	**18**
Managers	1	0.5	**5**

We propose that Community Psychiatric services should be run from **Day Care Mental Health Centres** which are close to district hospitals. **Satellite psychiatric clinics**, operating from primary health care clinics or community health centres would ensure greater accessibility for chronic mental health care users. For a hypothetical district of 1 million population with 1 Regional or Tertiary general hospital, 2 district hospitals, 4 Community Health Centres and 36 Primary Health clinics, we propose that there should be:

- **2 Day Care 'Community Psychiatric Centres'** – usually close to the two District Hospitals
- **8 Satellite psychiatric clinics** – located in or close to Community Health Centres or Primary Health Clinics.

Staffed by the following Specialist Mental Health HR:

- **Managers: 2** – one to manage clinic based services and one to assist with management of NPOs
- **Psychiatric Nurses**: 20 – 3 of which are senior staff – one for each of the Mental Health Centres and one for NPOs
- **General Nurses**: 20 – half may be auxiliary nurses
- **Occupational Therapists:** 5 – one for the NPO team, one for each of the Mental Health Centres and two to supervise the OTTs at satellite clinics & NPOs
- **Occupational Therapist Technicians:** 10 – to serve the two Centres, the satellite mental health clinics, residential homes and day care centres
- **Social Workers:** 5 – one for the NPO team, one each for the two Centres, and two for the satellite mental health clinics
- **Clinical Psychologists:** 4 – one for each of the two Centres, three for the satellite mental health clinics
- **Psychiatrists:** 3 – one Head of Clinical Unit, the other two Grade 1 or 2, based at each of the two Centres – supervise Mental Health and PHC personnel.
- **Registrars:** 4
- **Medical Officers:** 4
- **Pharmacists:** 2, or 1 pharmacist and 1 pharmacy assistant, plus packers, at the District Pharmacy to ensure supply of pre-packed scripts for issuance to mental health care users by psychiatric nursing staff.
- **Data Capturer:** 2 – for accurate quality assurance and improvement of the overall service

V. Monitoring of NGO facilities

These include all residential and day care facilities for people with severe mental illness and intellectual disability, homes and shelters for abused people, substance rehabilitation NGOs, old age homes etc.

NGOs all receive their non-profit organisation license from the Department of Social Development. However, even those NGOs which are not registered with the Department of Health often care for people who have medical problems and mental health issues.

People with mental illness die most often from medical problems, and people with medical or age-related problems may have mental illness. Integrated primary mental health care should be offered and specialised psychiatric care reserved for those with more severe mental illness. We suggest that the monitoring of NGOs is done by a multidisciplinary and intersectoral district health team. Such a team would monitor all the NGOs in the district.

The NGO monitoring team could be comprised of:

- Joint Managers – one from Dept. of Health, the other from Dept. of Social Development
- A Family Physician / General Medial Officer / PHCN
- A psychiatrically trained Medical Officer/ Psychiatric Nurse
- A Dietitian
- An Occupational Therapist
- A Social Worker
- Environmental health personnel
- A representative from Dept. of Education for NPOs with children and adolescents
- A representative from Dept. of Labour for protected learnership and employment opportunities

VI. In summary

Table 3. Summary of Community-based HR personnel required for very basic service delivery

Service Level	HR	Number of personnel
PHC – for primary mental health care	Counselling or Clinical Psychologist	2
	Educational Psychologist	2
	Registered Counsellors	10
	Sufficient PHCNs, Occupational Therapists and OTTS, Social Workers, Dietitians in total PHC staff	X
Community Psychiatry	Managers	2
	Psychiatrists	3 (one HOCU)
	Medical Officers	4
	Registrars	4
	Clinical Psychologists	4 (one HOU)
	Social Workers	5
	Occupational Therapists (psychiatric)	5
	OTTs	10
	Psychiatric Nurses	20 (3 senior)
	General Nurses	20 (10 staff, 10 auxiliary)
	Pharmacists	1 pharmacist, 1 pharmacy assistant and 3 packers
	Data Capturers	2

References

1. Lazarus R. Managing de-institutionalisation in a context of change: The case of Gauteng, South Africa. South African Psychiatry Review. 2005;8(2):65-9.
2. Lund C, Petersen I, Kleintjes S, Bhana A. Mental health services in South Africa: taking stock. Afr J Psychiatry (Johannesbg). 2012;15(6):402-5.
3. Government of South Africa. Mental Health Care Act No.17 of 2002. Pretoria: Government Gazette; 2004.

4. National Department of Health. National Mental Health Policy Framework and Strategic Plan 2013 - 2020. Pretoria: Government of South Africa; 2012.
5. Janse van Rensburg AB. Acute mental health care and South African mental health legislation: part 1- morbidity, treatment and outcome. Afr J Psychiatry (Johannesbg). 2010;13(5):382-9.
6. Flisher A, Jansen S, Lund C, Martin P, Milligan P, Robertson B, et al. Norms for Community Mental Health Services in South Africa: Report for the Department of Health, Republic of South Africa. Tender No. GES 142/2001-2002. Government Printer; 2003.
7. Lund C, Flisher AJ. A model for community mental health services in South Africa. Trop Med Int Health. 2009;14(9):1040-7.