

# WHO-AIMS

**WHO-AIMS REPORT ON  
MENTAL HEALTH SYSTEM  
IN SOUTH AFRICA**



**World Health  
Organization**



**MINISTRY OF HEALTH  
SOUTH AFRICA**

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**MENTAL HEALTH SYSTEM**  
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*A report of the assessment of the mental health system in South Africa using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS).*

*Cape Town, South Africa*

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SOUTH AFRICA**

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The World Health Organization Assessment Instrument for Mental health Systems (WHO-AIMS) has been conceptualized and developed by the Mental Health Evidence and Research team (MER) of the Department of Mental Health and Substance Abuse (MSD), World Health Organization (WHO), Geneva, in collaboration with colleagues inside and outside of WHO.

Please refer to *WHO-AIMS* (WHO, 2005) for full information on the development of WHO-AIMS at the following website:  
[http://www.who.int/mental\\_health/evidence/WHO-AIMS/en/index.html](http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html)

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## **Executive Summary**

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in South Africa. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring change. This will enable South Africa to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

### **Policy and Legislative Framework**

There is officially no mental health policy present in the country. Although South Africa's first mental health policy was developed in 1997, the document did not follow more recently adopted policy development protocols and was not published for dissemination. Currently the national Directorate: Mental Health and Substance Abuse is drafting a new mental health policy, which it plans to circulate for comment. A major reform in legislation has led to the adoption of the Mental Health Care Act (2002), which is currently being implemented. There is a lack of data on current budget allocations to mental health.

### **Mental Health Services**

A national mental health authority exists which provides advice to the government on mental health policies and legislation, namely the national Directorate: Mental Health and Substance Abuse. All health services and budgets are decentralised to the 9 provinces. There is wide variation between provinces in the budget and resources available for mental health care. Mental health services are organized in terms of catchment areas in all provinces. There are 3,460 outpatient mental health facilities; 80 day treatment facilities (approximately half of which are provided by the SA Federation for Mental Health); 41 psychiatric inpatient units located in general hospitals with a total of 2.8 beds per 100,000 population; 63 community residential facilities (of which 47% are provided by the SA Federation for Mental Health) with a total of 3.6 beds per 100,000 population; and 23 mental hospitals providing a total of 18 beds per 100,000 population (provincial range: 8-39).

### **Mental Health in Primary Health Care**

Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses. A small percentage of the training for medical doctors is devoted to mental health, while 21% of undergraduate nursing is devoted to mental health. There is wide variability between provinces in the availability of assessment and treatment protocols for key mental health conditions. Primary health care nurses are allowed to prescribe but with restrictions (e.g., they are not allowed to initiate prescription but are allowed to continue prescription). Primary Health Care doctors are allowed to prescribe all medications on the essential medicines list. There is wide variation in the availability of psychotropic medicine at PHC level.

### **Human Resources**

The total number of human resources working in Department of Health mental health facilities or NGOs is 9.3 per 100,000 population. There are 0.28 psychiatrists, 0.45 other medical doctors (not specialized in psychiatry), 7.45 nurses, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists, 0.28 other health or mental health workers per 100,000 population. Information systems for monitoring staff are weak, with very few provinces able to identify the service locations of mental health staff. There was a general lack of data regarding either professional training or continuing professional development after qualification in all provincial Departments of Health. The government provides some economic support for consumer associations.

### **Public education and links with other sectors**

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders in South Africa, namely the Department of Health. Government agencies and NGOs have promoted public education and awareness campaigns in the last five years in all provinces, targeting a range of vulnerable groups. There are legislative provisions concerning a legal obligation for employers to employ a certain percentage of people with disabilities (including mental disabilities) and legislative provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder. However these provisions are not systematically enforced. In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and other departments/agencies from a range of sectors in most provinces.

### **Monitoring and Research**

Of the 9 provinces, 4 indicated that there is no formally defined minimum data set of items to be collected by mental health facilities. The extent of data collection is variable among mental health facilities and across provinces. Only 1 province uses service data to produce an annual report on mental health. In terms of research, 2% (78/3374) of all health publications in the country were on mental health during the last 5 years.

## **Introduction**

South Africa is a country with an approximate geographical area of 1,221,000 square kilometres and a population of 47.9 million people of which 24.3 million (51%) are female (Statistics South Africa, 2007). The proportion of the population under the age of 15 years is 31.9%. Life expectancy at birth is estimated at approximately 49 years for males and 52 years for females. The infant mortality rate is estimated at 45.2 per 1000. Fertility has declined from an average of 2.89 children per woman in 2001 to 2.69 children by 2007 (Statistics South Africa, 2007).

There are 11 official languages in the country with English being the predominant language of commerce. The largest religious groups are Christian and other religious groups are traditional African, Muslim, Hindu and a small Jewish population.

The country is a lower middle income group country based on World Bank 2004 criteria. The unemployment rate was estimated at 25.5% in September 2006 (<http://www.statssa.gov.za/keyindicators/keyindicators.asp>).

The proportion of the health budget to GDP is 8.6%. The total per capita expenditure on health is 652 international \$, and the government per capita expenditure on health is 270 international \$ (WHO, 2004). HIV/AIDS remains one of the major health challenges facing South Africa. The estimated overall HIV-prevalence rate is approximately 11%. The HIV positive population is estimated at approximately 5,3 million.

## **Domain 1: Policy and Legislative Framework**

### **Policy, plans, and legislation**

South Africa's mental health policy was last revised in 1997. This policy took the form of a document titled “National health policy guidelines for improved mental health in South Africa”, which was approved by a meeting of the national Minister of Health and provincial Ministers of Health (Department of Health, 1997a). In that year, a chapter on mental health was also included in the Department of Health’s “White Paper for the transformation of the health system in South Africa” (Department of Health, 1997b). These policy documents were associated with a range of major political reforms that followed the first democratic elections in South Africa in 1994, and marked the end of the apartheid era.

The 1997 policy guidelines document includes the following components: developing community mental health services; downsizing large mental hospitals; developing a mental health component in primary health care; human resources, involvement of users and families; advocacy and promotion; human rights protection of users; equity of access to mental health services across different groups; financing; quality improvement; and a monitoring system.

However, interviews with Department of Health officials reveal that the 1997 document did not follow more recently adopted policy development protocols and was not published for dissemination. It therefore cannot be regarded as official policy. There is therefore officially no mental health policy present in the country. Currently the national Directorate: Mental Health and Substance Abuse is drafting a new mental health policy, which it plans to circulate for comment.

In the absence of national policy, two provinces (Free State and North West) have developed their own provincial mental health policies, using the new Mental Health Care Act (2002) as a guide.

A list of essential medicines (EDL) is in place. These medicines include antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs.

There is no national mental health plan at present. The national Directorate: Mental Health and Substance Abuse has an operational plan for its own activities, and 5 of the 9 provinces have provincial mental health plans, some of which are integrated within the general health plan for that province.

There is no emergency/disaster preparedness plan for mental health at either the national or provincial level.

The most recent mental health legislation (the Mental Health Care Act) was enacted in 2002 and promulgated in December 2004. It includes the following areas:

1. access to mental health care including access to the least restrictive care;
2. rights of mental health service consumers, family members, and other care givers;
3. competency, capacity, and guardianship issues for people with mental illness;
4. voluntary and involuntary treatment;
5. accreditation of professionals and facilities;
6. law enforcement and other judicial system issues for people with mental illness;
7. mechanisms to oversee involuntary admission and treatment practices; and
8. mechanisms to implement the provisions of mental health legislation.

Standardised documentation exists for the implementation of all components of the mental health legislation.

### **Financing of mental health services**

The percentage of government health department expenditure devoted to mental health is not known at a national level. Only 3 of the 9 provinces were able to report on health expenditure on mental health: Northern Cape spends 1%, Mpumalanga 8% and North West 5% of its health budget on mental health. Many provinces are not able to report on this indicator because budgets for mental health are integrated into general health budgets, particularly at primary care level.



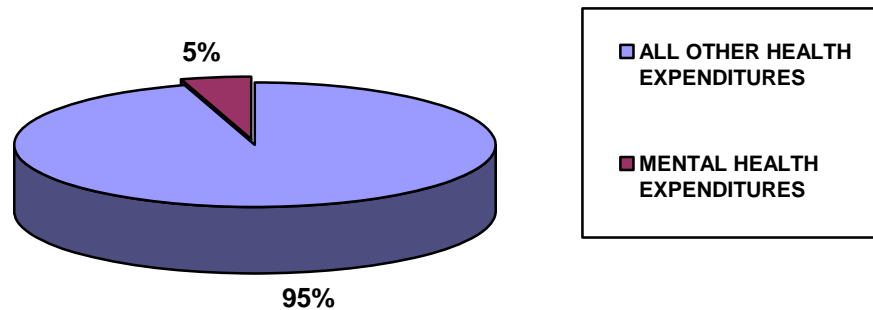
Only 4 of the 9 provinces were able to report on the proportion of mental health expenditure devoted to mental hospitals. These are set out in Table 1. It should be noted that these data do not include expenditure on mental health that is integrated into general health care, particularly at primary care level. It is therefore likely that this is an over-estimate of the proportion of the mental health budget devoted to mental hospitals.

**Table 1. Proportion of mental health budget devoted to mental hospitals**

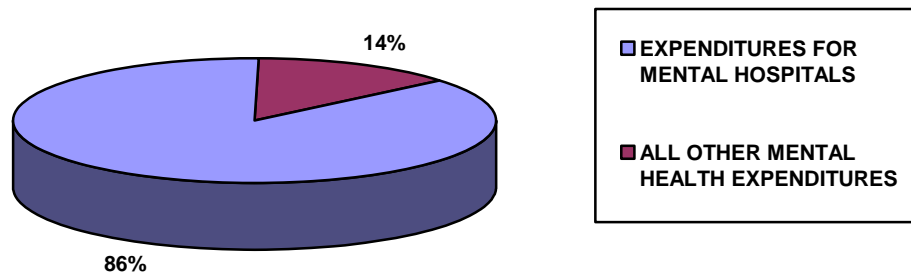
Province	Proportion (%)
Gauteng	67
Mpumalanga	85
North West	99
Northern Cape	94

80% of the population has free access to essential psychotropic medicines (provincial range: 75-83%). For those that pay out of pocket, the cost of generic antipsychotic medication is 24 cents per day (0.7% of the daily minimum wage) and generic antidepressant medication is 15 cents per day (0.5% of the daily minimum wage). There are no social health insurance schemes as government health services are tax based.

**GRAPH 1.1 HEALTH EXPENDITURE TOWARDS MENTAL HEALTH  
(from 3 provinces)**



**GRAPH 1.2 MENTAL HEALTH EXPENDITURE TOWARDS MENTAL HOSPITALS (from 4 provinces)**



### **Human rights policies**

In keeping with the Mental Health Care Act 2002, Review Boards are established in each province, with the authority to oversee regular inspections in mental health facilities, review involuntary admission and discharge procedures and review complaints investigation processes. The Review Boards have the authority to impose sanctions (e.g., withdraw accreditation, impose penalties, or close facilities that persistently violate human rights). In addition, the parliamentary Human Rights Commission has occasionally reviewed and produced reports on conditions in mental health facilities, and serves an external watchdog function.

52% of mental hospitals had at least one review/inspection of human rights protection of service users in 2005, while 29% of community-based inpatient psychiatric units and community residential facilities had such a review. 78% of mental hospitals and 40% of inpatient psychiatric units and community residential facilities have had at least one day of training on human rights protection of patients in the last two years.

## **Domain 2: Mental Health Services**

### **Organization of mental health services**

A national mental health authority exists which provides advice to the government on mental health policies and legislation, namely the national Directorate: Mental Health and Substance Abuse. The Directorate comprises a Director, 3 Deputy Directors, Assistant Directors and administrative staff. The national mental health authority provides policy direction to the provincial mental health authorities, who are involved in service planning, service management and coordination; and monitoring and quality assessment of mental health care. The seniority of the provincial mental health authority posts vary between provinces.

All health services and budgets are devolved to the 9 provinces. There is wide variation between provinces in the budget and resources available for mental health care. Therefore this report includes provincial indicators where these are available. Mental health services are organized in terms of catchment areas in all provinces.

### **Mental health outpatient facilities**

There are 3,460 outpatient mental health facilities available in the country, of which 1.4% are for children and adolescents only. These facilities treat 1660 users per 100,000 general population annually. Data on this service utilisation was only available from 4 provinces.

Of all users treated in mental health outpatient facilities, the percentage of female and children or adolescents is unknown. These data are not routinely collected in any provinces. Records are also not kept of the diagnoses of users treated in outpatient facilities in South Africa. If these are kept, they are held only in individual case files, but are not used for service planning.

Data on the average number of contacts per user was only available from two provinces. In the Western Cape, the average number of contacts per user is 1.7 and in North West it is 12. Data on the percentage of outpatient facilities that provide follow-up care in the community varied between provinces, with some provinces reporting that all outpatient facilities provided this service and some provinces reporting that none did (mean score for 7 provinces: 44%). Only 7% of outpatient facilities have mental health mobile teams.

In terms of available interventions, 2 provinces reported that 1-20% of users have received one or more psychosocial interventions in the past year, while another 2 provinces reported that 21-50% of users had received such interventions. The remaining provinces had no record of this item. 88% of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility or a nearby pharmacy all year round.

### **Day treatment facilities**

There are 80 day treatment facilities available in the country (approximately half of which are provided by the SA Federation for Mental Health). Of these none are for children and adolescents only. These facilities treat 3.4 users per 100,000 general population.

Of all users treated in day treatment facilities, the SA Federation for Mental Health reports that 41% are female and none are children or adolescents. The Department of Health does not keep statistics regarding gender and age in day treatment facilities. On average, users spend 268 days in day treatment facilities (data available from only 1 DoH Day treatment facility and 5 SA Federation for Mental Health facilities).

### **Community-based psychiatric inpatient units (psychiatric inpatient units in general hospitals)**

There are 41 community-based psychiatric inpatient units available in the country with a total of 2.8 beds per 100,000 population. 3.8% of these beds in community-based inpatient units are reserved for children and adolescents only.

The percentage of admissions to these facilities that are female or children/adolescents is unknown. Records are not kept of the diagnoses of users treated in community-based psychiatric inpatient units in South Africa. If these are kept, they are held only in individual case files, but are not used for service planning. The average length of admission is not routinely recorded and data were therefore not available.

Provinces reported a wide variety of practices regarding the availability of psychosocial interventions in community-based psychiatric inpatient units. One province reported that none were available, 2 provinces reported that a few (1-20%) users received such interventions, and 1 province reported that 80-100% of users received such interventions. 96% of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

### **Community residential facilities**

There are 63 community residential facilities available in the country (of which 47% are provided by the SA Federation for Mental Health). These facilities provide a total of 3.6 beds per 100,000 population. The number of these beds that are reserved for children and adolescents is not known.

The number of users in community residential facilities is 2.34 per 100,000 population and the average number of days spent in community residential facilities is unknown, except for 3 mental health societies that reported an average annual length of stay of 364 days. In community residential facilities provided by the SA Federation for Mental Health, 41% of users are female. The Department of Health does not keep a record of gender distribution in these facilities. Neither the SA Federation for Mental Health nor the Department of Health could provide information on the number of children and adolescents in these facilities.

### **Mental hospitals**

There are 23 mental hospitals in the country, providing a total of 18 beds per 100,000 population (provincial range: 8-39). 79% of these facilities are organizationally integrated with mental health outpatient facilities. Only 1% of the beds in mental hospitals are reserved for children and adolescents only.

The number of beds has decreased by 7.7% in the last five years. There is wide variability between provinces in this regard, with some provinces slightly increasing bed numbers

(e.g., Free State: 4%) and some dramatically decreasing bed numbers (Eastern Cape: -27%, Limpopo: -26%, Western Cape: -21%).

Records are not kept of the diagnoses of users treated in mental hospitals in South Africa. If these are kept, they are held only in individual case files, but are not used for service planning. None of the provinces could provide this data.

The number of users treated in mental hospitals in two provinces (Western Cape and North West) is 318 per 100,000 population. No other provinces could provide these data. The average number of days spent in mental hospitals in the Western Cape is 32 days. No other provinces could provide these data.

Based on data from 4 provinces (Free State, Mpumalanga, North West and Northern Cape), 40% of users spend less than one year, 4% of users spend 1-4 years, 15% of users spend 5-10 years, and 41% of users spend more than 10 years in mental hospitals. There was wide variability between the provinces in these distributions.

There was also wide variability in the percentage of users in mental hospitals who received one or more psychosocial interventions in the last year. Two provinces (North West and KwaZulu-Natal) reported that 21-50% of users received such interventions, while Mpumalanga reported 1-20% and Gauteng reported 51-80%.

All mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility.

### **Forensic and other residential facilities**

In addition to beds in mental health facilities, there are also 1676 beds for persons with mental disorders in forensic inpatient units and 1930 in other residential facilities such as homes for persons with learning disability, detoxification inpatient facilities, homes for the destitute, etc.

In forensic inpatient units, based on data from 3 provinces (Free State, KwaZulu-Natal and North West), 9% of users spend less than one year, 25% of users spend 1-4 years, 62% of users spend 5-10 years, and 3% of users spend more than 10 years.

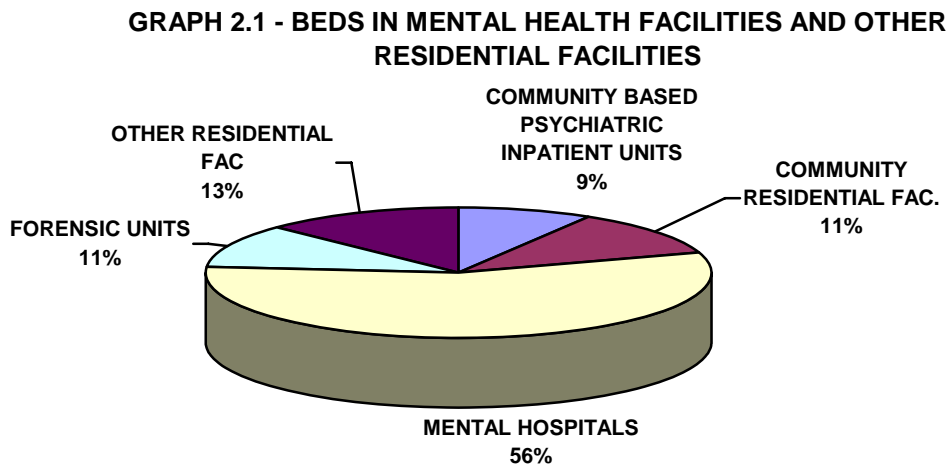
### **Human rights and equity**

There were limited data available on human rights and equity indicators. The following are reported from individual provinces, where data were available. Based on data from 3 provinces (Western Cape, Northern Cape and North West) 43% of all admissions to mental hospitals are involuntary. No data were available on the percentage of involuntary admissions to community-based inpatient psychiatric units.

Two provinces (Northern Cape and Eastern Cape) reported that 0-1% of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, and one province (KwaZulu-Natal) reported that 11-20% of patients were restrained or secluded. In mental hospitals, 7 provinces reported that 0-5% of patients were restrained or secluded at least once within the last year.

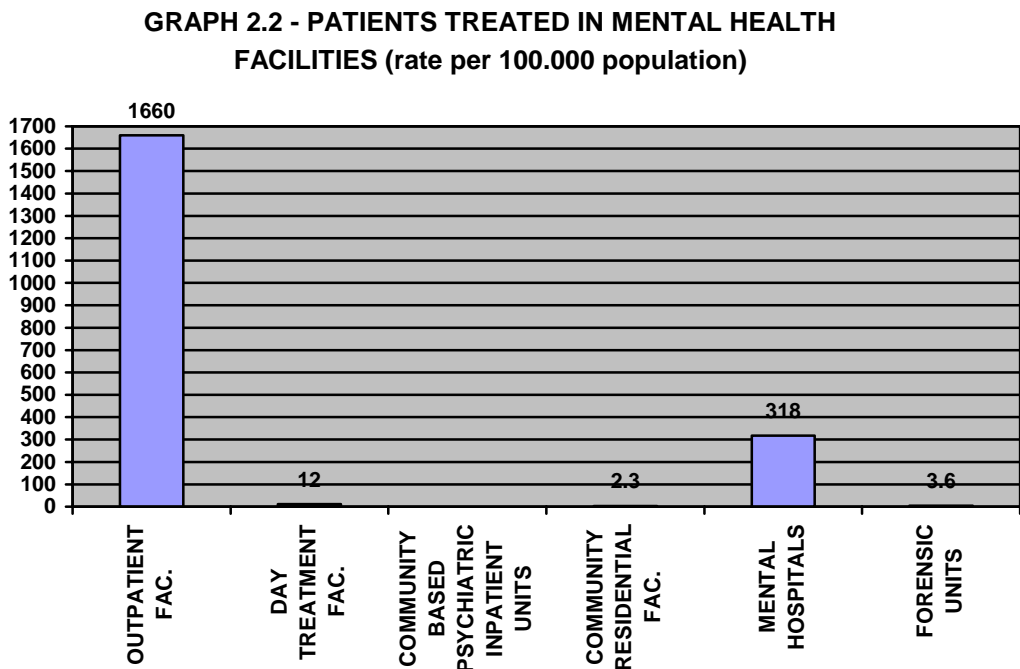
The density of psychiatric beds in or around the largest city is 1.2 times greater than the density of beds in the entire country. There was wide variability between provinces in this regard (provincial range: 0.28-4.78).

**Summary Charts: Mental health services**



Summary for Graph 2.1

The majority of beds in the country are provided in mental hospitals, followed by a

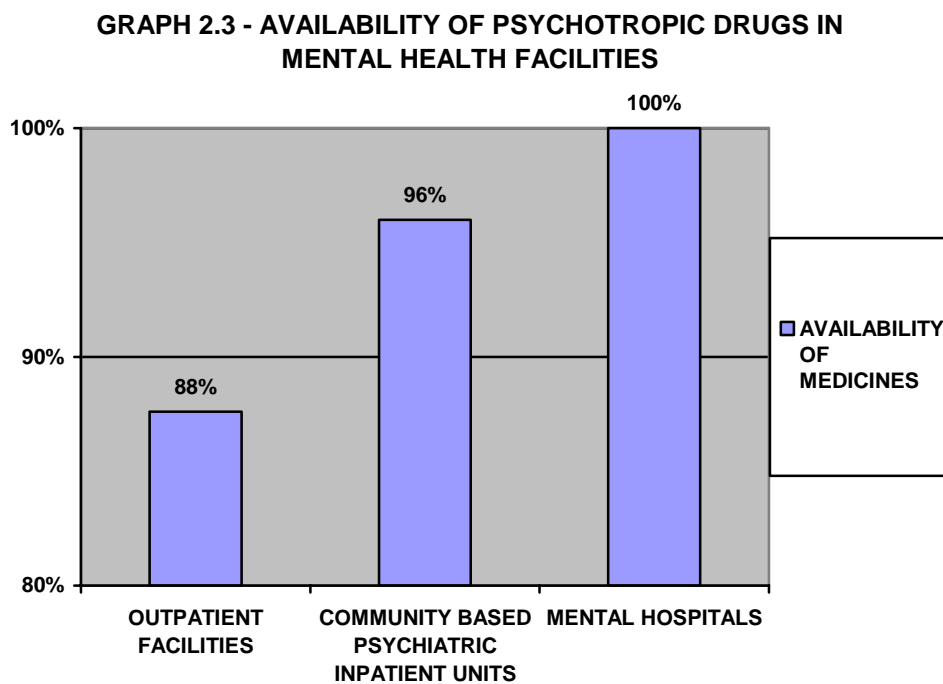


relatively even distribution of all other facilities.

**Note:** In this graph the rate of admissions in inpatient units is used as a proxy of the rate of users treated in the units. The number of patients in forensic beds on December 31 is used as a proxy for patients treated in forensic units.

### Summary of Graph 2.2

The majority of the users are treated in outpatient facilities and in mental hospitals, while the rate of users treated in inpatient units, day treatment facilities and residential facilities is lower. The number of users treated in community-based psychiatric inpatient units is not known.



### Summary for Graph 2.7

Psychotropic drugs are most widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities.

## Domain 3: Mental Health in Primary Health Care

Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses.

### Training in mental health care for primary care staff

In two provinces (Gauteng and KwaZulu-Natal) 5.5% of the training for medical doctors is devoted to mental health. According to the South African Nursing Council, 21% of undergraduate nursing is devoted to mental health. No data were available on the percentage of training time devoted to mental health for non-doctor/non-nurse primary health care workers.

In terms of refresher training, no data were available on the percentage of primary health care doctors, nurses or non-doctor/non-nurse primary health care workers who have received at least two days of refresher training in mental health. Only in one province (Northern Cape) was it estimated that 80% of nurses had received such training. In another province (KwaZulu-Natal) nurses had received training, but no records were kept of the numbers of nurses who were trained.

### **Mental health in primary health care**

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. In terms of physician-based and non-physician-based primary health care clinics, there was wide variability between provinces in the availability of assessment and treatment protocols for key mental health conditions (see table). The general trend is that there appears to be wider availability of protocols among non-physician-based clinics.

**Table 2. Availability of assessment and treatment protocols for key mental health conditions in primary health care clinics**

<b>Province</b>	<b>Physician-based PHC clinics (% with protocols)</b>	<b>Non-physician-based PHC clinics (% with protocols)</b>
Eastern Cape	21-50	51-80
Free State	51-80	51-80
Gauteng	0	1-20
KwaZulu-Natal	51-80	21-50
Limpopo	0	81-100
Mpumalanga	0	0
North West	Unknown	51-80
Northern Cape	0	81-100
Western Cape	1-20	81-100

There is also wide variation between provinces in the percentage of of physician-based primary health care doctors who make on average at least one referral per month to a mental health professional. In the Eastern Cape, 1-20% of doctors make such referrals, in KwaZulu-Natal, Northern Cape and Free State, 21-50%, and in the Western Cape and Gauteng 81-100%. The remaining provinces did not provide data.

Only four provinces were able to report on the number of non-physician based primary health care clinics that make a referral to a higher level of care. Again there was wide



variation, with Gauteng reporting 0%, Western Cape 1-20% and Free State and North West 51-80%.

In terms of professional interaction between primary health care staff and other care providers, only Free State and KwaZulu-Natal were able to report that 21-50% and 1-20% of primary care doctors have interacted with a mental health professional at least once in the last year respectively.

In North West, 1-20% of PHC clinics were reported to have had interactions with traditional practitioners and in Gauteng no clinics were reported to have had such interactions. No other provinces reported on interactions with traditional practitioners at PHC level.

### **Prescription in primary health care**

According to the South African Nursing Council, primary health care nurses are allowed to prescribe but with restrictions (e.g., they are not allowed to initiate prescription but are allowed to continue prescription, or they are allowed to prescribe in emergencies only; they are allowed to hand-out medicines but are formally not allowed to prescribe). Primary Health Care doctors are allowed to prescribe all medications on the essential medicines list.

As for availability of psychotropic medicines, 3 provinces reported that 81-100% of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) and one province reported that 51-80% of these clinics have such medicines. In non-physician-based clinics, 4 provinces reported 81-100% availability, 3 provinces 51-80%, 1 province 21-50% and 1 province 0%.

## **Domain 4: Human Resources**

### **Number of human resources in mental health care**

The total number of human resources working in Department of Health mental health facilities or NGOs per 100,000 population is 9.3. The breakdown according to profession is as follows: 0.28 psychiatrists, 0.45 other medical doctors (not specialized in psychiatry), 7.45 nurses, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists, 0.28 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors). (See Graph 4.1). Data were not available on the numbers of mental health professionals working in private practice.

Important limitations should be noted with regard to these data:

1. KwaZulu-Natal was not able to report on the number of nurses working in mental health in that province. The national figure for nurses is therefore an underestimate.
2. There was wide variability between provinces in the number of nurses per 100,000 population (provincial range: 1.06 to 20.6), which may be partially attributed to differing definitions of nurses between provinces, in spite of the clear definition provided in the instrument. This may reflect a broader trend of inconsistent record keeping and/or information systems across the provinces.
3. Gauteng was not able to provide data on the number of psychologists, social workers or occupational therapists. As a highly urbanised province, with a large population, it is likely that there is a higher concentration of these professionals in this province, and therefore that these gaps in data lead to an underestimation of these staff nationally.

Only KwaZulu-Natal and North West were able to report on the distribution of psychiatrists between government services and private practice. In KZN, 52% of psychiatrists work in government services and 48% in private practice. In North West, 10% of psychiatrists work in government services. The trend in North West appears to be more consistent with previous studies, which have shown a higher concentration of psychiatrists in private practice than government services (Flisher et al., 1997).

No provinces were able to report on the distribution of psychologists, social workers, nurses and occupational therapists between government-administered mental health facilities and private practice.

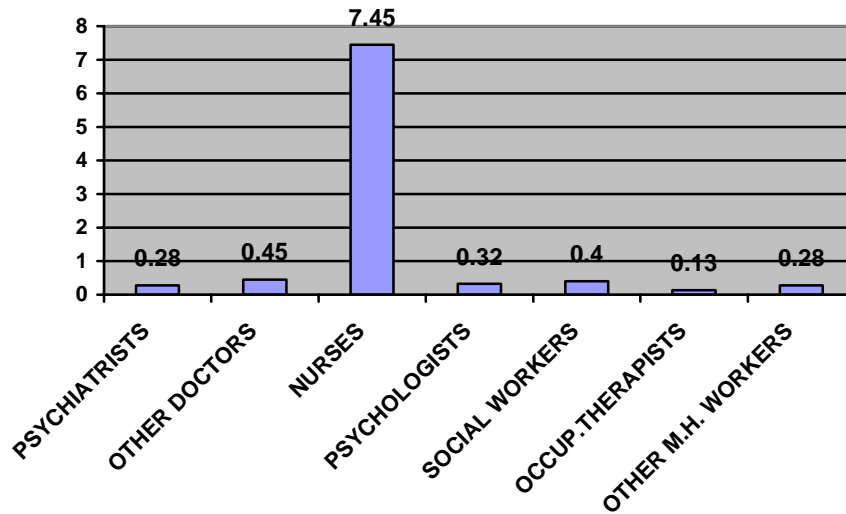
Very few provinces were able to identify the service locations of mental health staff. Those that were able to provide this information could only report on the locations of some staff categories in some locations. It is therefore not possible to report on national trends regarding the service locations of the various mental health staff categories.

In terms of staffing per bed in inpatient facilities, in KwaZulu-Natal, Mpumalanga and Free State there are an average of 0.04 psychiatrists per bed in community-based psychiatric inpatient units, in comparison to an average of 0.02 psychiatrists per bed in mental hospitals in KwaZulu-Natal, Free State and Gauteng. As for nurses, in Mpumalanga and Free State there are an average of 0.6 nurses per bed in community-based psychiatric inpatient units, in comparison to an average of 0.95 per bed in mental hospitals in Mpumalanga, Free State, Limpopo, Gauteng and North West. Finally, for other psychosocial staff (psychologists, social workers and occupational therapists), there are an average of 0.03 per bed for community-based psychiatric inpatient units in Mpumalanga, Free State and Limpopo, and 0.05 per bed in mental hospitals in KwaZulu-Natal, Mpumalanga, Free State, Limpopo and North West. (See Graph 4.2).

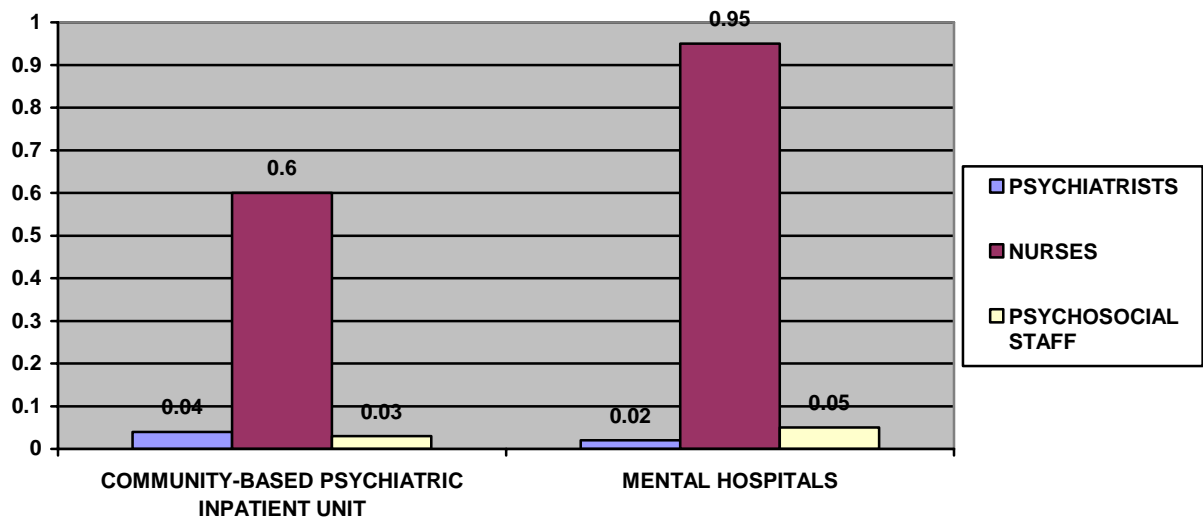
The distribution of human resources between urban and rural areas is disproportionate. Based on data from only 2 provinces (Free State and North West), the density of psychiatrists in or around the largest city is 3.6 times greater than the density of

psychiatrists in the entire country. The distribution of nurses between urban and rural areas is not known.

**GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH**  
(rate per 100.000 population)



**GRAPH 4.2 - AVERAGE NUMBER OF STAFF PER BED**

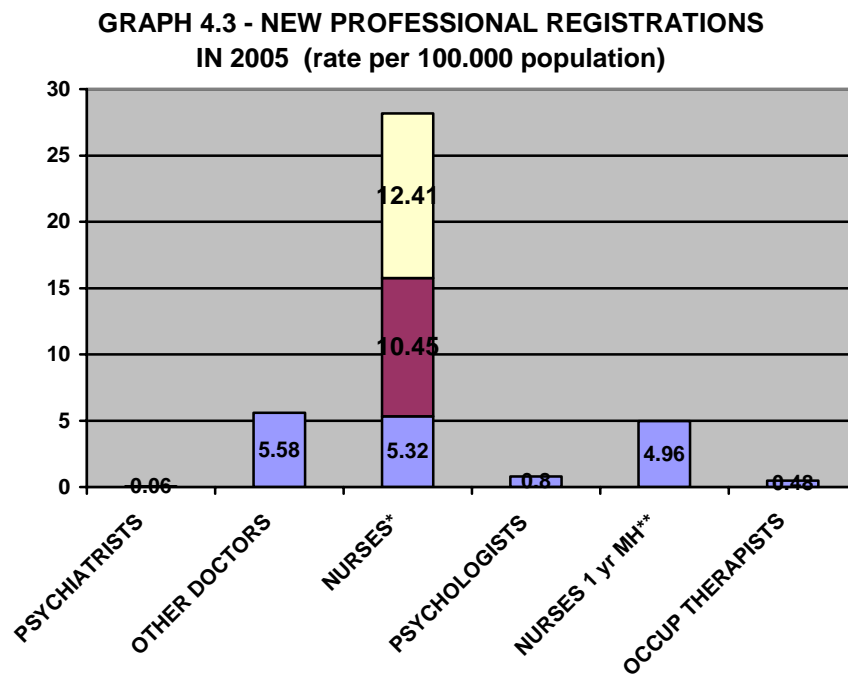


**Training professionals in mental health**

In KwaZulu-Natal the number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: medical doctors (not specialized in psychiatry) 1.81 and psychiatrists 0.04. No other provinces were able to report on the number of mental health professionals who graduated.

In KwaZulu-Natal and Free State it was reported that 1-20% of psychiatrists emigrate to other countries within five years of the completion of their training.

There was a general lack of data regarding either professional training or continuing professional development after qualification in all provincial Departments of Health. However, the Health Professions Council of South Africa (HPCSA) and the South African Nursing Council were able to provide data on the number of new professional registrations in 2005, according to the following categories (see Graph 4.3).



\* Nurses include Registered Nurses (5.32), Enrolled Nurses (10.45) and Enrolled Nursing Auxiliary (12.41).

\*\* Nurses 1 yr MH refers to nurses with at least 1 year training in mental health care.

The Health Professions Council have implemented a Continuing Professional Development scheme for medical doctors and psychologists, which covers both private and public sectors. Professionals are required to undertake certain activities each year in order to remain registered with the HPCSA. However, no data are kept regarding the amount of CPD training undertaken each year for all registered professionals, as audits are conducted each year on a group of randomly selected professionals.

## **Consumer and family associations**

There are 120 users/consumers that are members of consumer associations, and an unknown number of family members that are members of family associations. The government provides some economic support for consumer associations in the Western Cape, Gauteng, Free State and Mpumalanga, and for family associations only in the Western Cape, Free State and Mpumalanga. Consumer associations have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years in the Western Cape, Mpumalanga, Limpopo and Gauteng. Family associations have only been involved in this role in Limpopo and North West.

Mental health facilities interact with consumer and family associations in Mpumalanga, Limpopo, Gauteng, North West, Eastern Cape, KwaZulu-Natal and the Western Cape. In addition to consumer and family associations, there are 33 other NGOs in the country involved in individual assistance activities such as counselling, housing, or support groups.

## **Domain 5: Public education and links with other sectors**

### **Public education and awareness campaigns on mental health**

There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders in South Africa, namely the Department of Health. The Department is assisted by various NGOs, including the South African Federation for Mental Health, the South African Depression and Anxiety Group (SADAG) and other professional, consumer and advocacy bodies.

Government agencies and NGOs have promoted public education and awareness campaigns in the last five years in all provinces. However, only the Western Cape, Free State and Gauteng reported the involvement of professional associations in these campaigns, and only the Western Cape reported the involvement of private trusts, foundations and international agencies.

These campaigns have targeted the following groups:

- The general population
- Children
- Adolescents
- Women
- Trauma survivors
- Ethnic groups
- Other vulnerable or minority groups

In addition, there have been public education and awareness campaigns targeting professional groups in Gauteng and the Western Cape, including:

- Health care providers
- Complimentary/alternative/traditional healers
- Teachers
- Social service staff
- Leaders and politicians
- Other professional groups linked to the health sector.

In the Free State all these groups have been targeted with the exception of social service staff and politicians. In Mpumalanga these campaigns have been limited to teachers, politicians and other professional groups linked to the health sector. In North West campaigns have targeted only health professionals. No other provinces have conducted public education and awareness campaigns for mental health.

**Legislative and financial provisions for persons with mental disorders**

The following legislative and financial provisions exist to protect and provide support for users:

- Legislative provisions concerning a legal obligation for employers to employ a certain percentage of people with disabilities (including mental disabilities);
- Legislative provisions concerning protection from discrimination (dismissal, lower wages) solely on account of mental disorder;

However these provisions are not systematically enforced.

At the present time, there is no legislative or financial support for the following:

- Legislative or financial provisions concerning priority in state housing and subsidized housing schemes for people with severe mental disorders.
- Legislative or financial provisions concerning protection from discrimination in allocation of housing for people with severe mental disorders.

**Links with other sectors**

In addition to legislative and financial support, there are formal collaborations between the government department responsible for mental health and other departments/agencies as indicated in the following table.

**Table. Formal collaborations between mental health and other sectors.**

Province	PHC	HIV	Rep	Elder	Subst	Chil Pro	Educ	Emp	Hous	Welf	Crim	Child	Other
WC	Y	Y	N	Y	Y	Y	Y	N	N	Y	Y	Y	
KZN	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
NCAPE	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN
MPUM	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

EC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
FS	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
LIMP	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN
GTNG	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NWP	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	NA

Column titles: Primary health care/ community health; HIV/AIDS; Reproductive health; The elderly; Substance abuse; Child protection; Education; Employment; Housing; Welfare; Criminal justice; Child and adolescent health.

Y = Yes, N = No, NA = Not Applicable, UN = Unknown.

In terms of support for child and adolescent health, the percentage of primary and secondary schools with either a part-time or full-time mental health professional is unknown. Free State, Gauteng and North West province indicated that 1-20% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders. In the Western Cape 51-80% of schools have such activities. No other provinces indicated any school-based promotion or prevention activities.

The percentage of prisoners with psychosis and mental retardation is unknown. Regarding mental health activities in the criminal justice system, only Gauteng reported that 1-20% of prisons have at least one prisoner per month in treatment contact with a mental health professional. No other provinces indicated any mental health interventions in prisons.

As for training, 1-20% of police officers have participated in educational activities on mental health in the last five years in Gauteng and Free State. 21-50% have participated in such activities in Mpumalanga. No other provinces reported training activities for police officers. In addition, there were no educational activities reported with judges and lawyers in any provinces.

In terms of financial support for users, in 4 provinces (Western Cape, KwaZulu-Natal, Eastern Cape and Gauteng), 1-20% of mental health facilities have access to programmes outside the mental health facility that provide outside employment for users with severe mental disorders. In the Free State 21-50% of mental health facilities have access to such programmes. No other provinces reported such programmes.

The percentage of people who receive social welfare benefits due to a mental disability is unknown. The Department of Social Development, which administers social welfare benefits, does not keep records of the distinction between physical and mental disabilities.

## Domain 6: Monitoring and Research

Of the 9 provinces, 4 indicated that there is no formally defined minimum data set of items to be collected by mental health facilities (Western Cape, KwaZulu-Natal, Northern Cape and Mpumalanga). The remaining 5 provinces reported that a formally defined list of individual data items that ought to be collected by all mental health facilities exists.

As shown in the table 6.1, the extent of data collection is variable among mental health facilities and across provinces.

The provincial health department receives data from all mental hospitals, all community based psychiatric inpatient units, and all mental health outpatient facilities, with the exception of the Western Cape, KwaZulu-Natal and Limpopo, which receive data from 67%, 23% and 89% of outpatient facilities, respectively. However, no report was produced on the data transmitted to the government health department in any province except North West.

In terms of research, 2% (78/3374) of all health publications in the country were on mental health during the last 5 years.

The research addressed a variety of areas, including epidemiological studies in community samples; epidemiological studies in clinical samples; non-epidemiological clinical/questionnaires assessments of mental disorders; services research; biology and genetics; policy, programmes, financing/economics; pharmacological interventions; and psychosocial interventions/psychotherapeutic interventions

**Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information**

TYPE OF INFORMATION COMPILED	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	100%*	100%‡	NA
N° inpatient admissions/users treated in outpatient facilities	100%*	100%‡	100% in 3 provinces§
N° of days spent/user contacts in outpatient facilities.	100%*#	100%‡	100% in 3 provinces§
N° of involuntary admissions	100%*#	100%‡	NA
N° of users restrained	100%	100%‡	NA
Diagnoses	Mixed†	100% in 2 provinces☼	100% in 1 provinceΩ

\* Except Northern Cape

# Except Limpopo

† Only KZN, Eastern Cape and North West provide all this information. Western Cape provides diagnoses in 1 of 3 mental hospitals. Other provinces provide none.



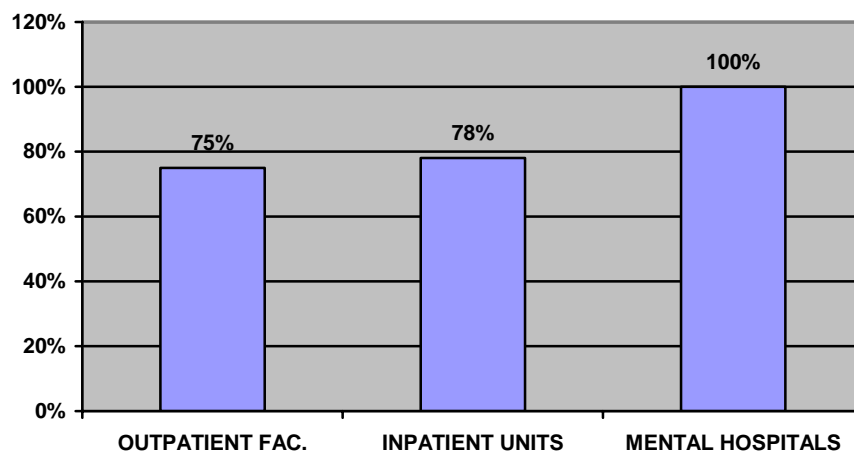
‡ Only KZN, Mpumalanga, Eastern Cape, Free State and Gauteng provide all this information. In the Western Cape 17% of facilities provide this information and in other provinces none do.

⊗ These provinces are Mpumalanga and the Eastern Cape. No other provinces provide diagnoses.

§ These provinces are Mpumalanga, Eastern Cape and North West. No other provinces provide this information.

Ω Only Mpumalanga reports diagnoses in outpatient facilities.

**GRAPH 6.1 - PERCENTAGES OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT**



## **Strengths and Weaknesses of the Mental Health System in South Africa**

There are several strengths in the South African mental health system. Compared to many other African countries, South Africa has relatively well resourced mental health services, including human resources, facilities and available psychotropic medications. There has recently been a reform in the mental health legislation, with the promulgation of the Mental Health Care Act (2002), which is in keeping with international human rights standards. Many of the reforms currently being implemented in the country, such as the introduction of Mental Health Review Boards, and the establishment of 72 hour assessment facilities in District general hospitals, appear to be driven by the new Mental Health Care Act.

In spite of these strengths, there remain several weaknesses in the current system:

1. There is currently no officially endorsed mental health policy, which provides the vision and overall national leadership for developing the mental health system.

- The result is that many of the inequalities between provinces (some of which have their origins in apartheid divisions) are not being addressed.
2. Related to this problem there is a lack of nationally agreed indicators for mental health information systems, with the result that information on current service resources (budgets, staff, facilities) and provision (admissions, outpatient visits) is extremely sparse. If data is collected it is seldom made available for planning, and if it is made available, it is seldom reported on systematically.
  3. In general mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on mental hospitals. There are 23 mental hospitals in the country, and 56% of mental health beds are located in these facilities. This is an outdated form of care, which is vulnerable to human rights abuses and stigmatisation of service users. There is an urgent need to develop community-based mental health services (which include community-based residential care, day services and outpatient services), in keeping with international best practice.
  4. There is also an urgent need for mental health training of general health staff and public sector staff in a range of other sectors (such as education, social development, criminal justice, housing, employment). Evidence from this report indicates that while some training does occur, it is frequently not monitored and evaluated, and where training of PHC staff takes place, it is not supported by ongoing supervision and the establishment of referral pathways to and from specialist mental health care. There is currently a lack of clinical protocols at PHC level and standardised mental health training for health care providers.
  5. There is some evidence of the establishment of consumer and family associations, often with the support of NGOs, such as the SA Federation for Mental Health, but the role of these associations in the formulation of policy and planning of services is limited.

Please also include a paragraph which helps to contextualize the information on the strengths and weaknesses of the mental health system by comparing it to regional and world information. This information is available from the Mental Health Atlas 2005 at <http://www.cvdfinfo.ca/mh-atlas/>. Finally, please include a statement regarding progress made/not made in your country in the areas of strengths/weaknesses you have identified. Include information on the critical barriers or facilitators to progress.

## **Next Steps in Strengthening the Mental Health System**

The next steps in strengthening the mental health system follow logically from the weaknesses identified above. These are:

1. Develop a national mental health policy, through a thorough process of consultation and consensus building with a range of stakeholders throughout the

- country. Guidelines for the development of such a policy are available from WHO.
2. Develop a national mental health information system, integrated with the district health management information system, based on a set of nationally agreed indicators and a minimum data set.
  3. Build community mental health services that include three core components:
    - a. Community residential care
    - b. Day services
    - c. Outpatient services (combining general health outpatient services in PHC and specialist

These community mental health services need to be developed before further downscaling of mental hospitals can proceed.

4. Conduct and evaluate training programmes for general health staff at PHC level.
5. Develop specialist mental health teams to support PHC staff.
6. Develop clinical protocols for assessment and interventions at PHC level.
7. Strengthen the role of consumer and family associations in policy development and implementation, as well as the planning and monitoring of services.

## **Reference List**

Department of Health (1997a). National health policy guidelines for improved mental health in South Africa Pretoria: Department of Health.

Department of Health (1997b). White paper for the transformation of the health system in South Africa. Pretoria: Government Gazette.

Flisher, A. J., Riccitelli, G., Jhetam, N., & Robertson, B. A. (1997). A survey of professional activities of psychiatrists in South Africa. *Psychiatric Services*, 48, 707-709.

Statistics South Africa (2007). Mid-year population estimates 2007 Pretoria: Statistics South Africa, Statistical Release P0302.

The WHO-AIMS was used to collect information on the mental health system in South Africa. There is officially no mental health policy present in the country. Currently the national Directorate: Mental Health and Substance Abuse is drafting a new mental health policy, which it plans to circulate for comment. A major reform in legislation has led to the adoption of the Mental Health Care Act (2002), which is currently being implemented. There is a lack of data on current budget allocations to mental health.

A national mental health authority exists which provides advice to the government on mental health policies and legislation, namely the national Directorate: Mental Health and Substance Abuse. All health services and budgets are decentralised to the 9 provinces. There is wide variation between provinces in the budget and resources available for mental health care.

Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses. A small percentage of the training for medical doctors is devoted to mental health, while 21% of undergraduate nursing is devoted to mental health. There is wide variability between provinces in the availability of assessment and treatment protocols for key mental health conditions.

The total number of human resources working in Department of Health mental health facilities or NGOs is 9.3 per 100,000 population. Of the 9 provinces, 4 indicated that there is no formally defined minimum data set of items to be collected by mental health facilities.