Community Access to Mental Health Services: Lessons and Recommendations

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Abstract

According to the Alma Ata Declaration, health is a fundamental human right. Post-1994, South Africa passed legislation that moved the country in the direction of Primary Health Care at the district level. This chapter reviews the challenges to community-wide access to mental health services in South Africa. The background to mental health care in South Africa is first presented. The introduction of Primary Health Care in South Africa is discussed in relation to the Alma Ata Declaration and other international developments, such as selective Primary Health Care. The challenges regarding the integration of mental health care into the Primary Health Care system, namely poverty, the biomedical orientation of health care, staff workload and inadequate support, poor infrastructure, and limited funding and resources, are discussed, followed by an overview of the de-institutionalisation process. It is argued that integration within the framework of a biomedical model is insufficient. A holistic approach to integration, incorporating the social, economic, psychological and cultural aspects of illness, is necessary. The chapter concludes with recommendations for policy implementation, training and research.

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Introduction

Prior to the advent of a new democratic dispensation in 1994, South Africa was characterised by gross violations of human rights. This was sanctioned by law in terms of the policy of apartheid. The majority of the population were not represented in Parliament, and hence had no voice in decision making structures affecting them. The health care system was highly fragmented. Not only were health care services segregated by race or ethnic group, they were also centralised, with the best resourced facilities located in the urban areas while the rural and homeland ‘states’, home to the vast majority of the Black population, were under-resourced. There were 14 health departments in the country, providing services that were not only separate but also unequal. Tertiary care received more funding than primary care, while mental care for the chronically ill was centralised in large institutions. The move towards Primary Health Care (PHC) and de-institutionalisation, described below, should be understood against this background.

This chapter reviews factors affecting community-wide access to mental health services in South Africa. It starts with an overview of the initiatives undertaken in the post-apartheid era towards achieving a comprehensive PHC system, particularly the influence of the Alma Ata Declaration and South Africa’s ‘White Paper on the Transformation of the Health System’. Then the challenges of the integration of mental health services into the PHC system in South Africa are discussed. In the main, it is argued that integration is unlikely to be successful if it is characterised by an approach where services for serious mental disorders get inserted into the PHC system. Other factors that have a bearing on the provision of integrated mental health care services such as poverty, inadequate resources and poor support for PHC workers, poor infrastructure and the management of the de-institutionalisation process are discussed. The paper concludes with recommendations highlighting issues for further research, training and implementation.

Methodology: Selective literature review

The methodology comprised a selective review of the literature on South African mental health policy, the Alma Ata Declaration, PHC incorporating the integration of mental health care services into the PHC system, and de-institutionalisation. Guiding the review were questions such as: What is the state of mental health care services in South Africa in the post-apartheid era? What are the gains that have been made as far as the integration of mental health services into the PHC system is concerned? What are the challenges and obstacles towards integration of mental health care into the PHC system? A literature review search was conducted using databases such as PsycINFO, MEDLINE and others. Included in the review were journal articles, research reports, books and book chapters published locally and internationally from 1978 up to 2008.

The post-apartheid era: Comprehensive Primary Health Care

Post-1994, South Africa embarked on a major initiative to integrate health and other services, not only to counter the destructive divisions of the past but also to align the country’s health services with international trends, such as the Alma Ata Declaration and World Health Organization (WHO) reports. An overview of international and national developments around PHC is dealt with in Chapter 1 and Chapter 2 respectively.

The definition of health contained in the Alma Ata Declaration envisaged a comprehensive approach to health care that incorporates physical, social and economic well-being. It is important to bear this definition in mind in looking at the relationship between poverty and mental health discussed below.

Primary Health Care and district-based care

In a PHC system, it is envisaged that care will take place at the district level; users should be able to access all their health care needs in an integrated health care system at the level closest to them. In line with this understanding, South Africa’s White Paper on the Transformation of the Health System endorsed PHC within an integrated health care system at the district level. While the previous health care system was curative and hospital-based, the new system emphasised prevention and health promotion. In keeping with these developments, mental health services were to be integrated into PHC. This was also motivated by the fact that mental health services were skewed in favour of the

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a PsycINFO is an abstract database of psychological literature from the 1800s to the present, and is available at http://www.apa.org/psycinfo

b MEDLINE is the world’s most comprehensive source of life sciences and biomedical bibliographic information, with nearly eleven million records, and is available at http://medline.cos.com
wealthier urban areas, and therefore not readily available to the rest of the population. It was also envisaged that integration of mental health and substance abuse into the PHC system would enable patients to receive physical and mental care simultaneously in one visit. Further, it was considered that this move would help reduce the stigma of mental illness, especially because community and family involvement were integral parts of the plan. Thus, the White Paper made the following recommendation for implementation at community level:

“At the community level, non-governmental and other grassroots organisations should be involved in mental health services. Communities should be actively involved in the planning and implementation of community-based mental health care services, as well as substance abuse prevention, management and rehabilitation”.6

The White Paper envisaged that community involvement would be promoted by engaging in activities such as community mental health forums, developing special programmes addressing violence against women and children in particular, provision of information on substance abuse, and through development of programmes aimed at educating and supporting mental health users and psychogeriatrics in order to improve their quality of life. Community participation is an integral part of the Alma Ata Declaration. Further, the WHO report supports the care of people in the community.7

In 2002, new mental health legislation was passed, aligning the provision of mental health services in South Africa with the country’s constitution, which prioritises protection of human rights. The legislation seeks to affirm the rights of mental health users (i.e. patients) and also de-medicalises the management of mental illness. In terms of the legislation, mental health services are to be integrated into the PHC system.

The integration of mental health care into the PHC system has to be seen against the backdrop of global and national changes in economic policies.

**Selective Primary Health Care**

Before the challenges to the implementation of comprehensive PHC in South Africa are discussed, it is important to distinguish between three generations of health care systems. The dominant feature of first generation health care systems was the emphasis on hospital-based care. Health care was not immediately available, especially to the rural poor, given that hospitals were centralised in the urban areas. Second generation reforms not only emphasised comprehensive PHC, they also envisaged provision of basic health services at the level closest to the people, and gave importance to community participation, health promotion and empowerment.10 The empowerment agenda of comprehensive PHC finds support, for example, in the fact that it was aimed at providing universal access to basic health care, even to the poorest of the poor. Social and material conditions impacting on health and well-being were also emphasised, thus provision of safe water, proper nutrition, and food supply were prioritised.

Within a year of the publication of the Alma Ata Declaration, Walsh and Warren published an article on selective PHC, which marked a radical shift away from the principles of the Alma Ata Declaration.12 The article argued for the postponement of comprehensive PHC on the grounds that it was costly to implement. Instead, a selective approach to PHC, characterised by a focus on limited interventions, was advanced, thus marking the beginning of third generation health reforms. In line with this selective approach, international donor agencies preferred to prioritise demand-driven as opposed to needs-driven interventions. This demand-driven approach emphasised cost-effectiveness for everyone and measurable, short-term outcomes.11

Selective PHC focuses on providing packaged interventions to cater for avoidable health problems that account for large burdens of suffering, and not the provision of basic care for the whole nation. This shift towards selective PHC, while perhaps partly motivated by the challenges of implementing comprehensive PHC, is somewhat accounted for by the global shift towards market-oriented economies that have dominated the world since the 1980s. As a result of these market-oriented policies, it could be argued that there has been a discernible trend towards individual responsibility for health care.10,11

The Italian Global Health Watch argues that selective PHC is contrary to the Alma Ata Declaration, in that it inevitably led to a vertical approach to health interventions, by which international donor agencies selected interventions on the basis of measurable outcomes and cost-effectiveness. It has been argued, however, that this selective approach may drain human and other resources required for combating common diseases. Further, the different priorities and supervisory structures of various donors may lead to confusion.14 Due to the lack of community involvement, the ownership and sustainability of the programmes is also threatened. Green wrote as follows on this approach:

“The vertical programme approach is contrary to the idea of integrated PHC services. The use of centrally defined criteria to select the problems to be addressed reduced the possibility of involving populations in the choice of priorities. All this
implicates a return to the medical health model that ignores the importance of development in the wider sense and at a practical level this strategy does not take into account the need to reinforce or construct an adequate infrastructure without which no programs succeed”. 

Likewise, Newell opined as follows on selective PHC:

“Selective PHC is a threat and must be considered as a counter-revolution. It is a form of health feudalism that is destructive rather than an alternative. Attractive to professionals, financing agencies and governments that are seeking results in the short term, but is a pure illusion”. 

The move towards selective PHC was to be followed by the structural adjustment policies of the World Bank and International Monetary Fund (IMF), which recommended drastic cuts in public spending and consumption, privatisation and a reduced role for central government. In 1987, the World Bank introduced a document on public health, in which it recommended, amongst others, fee payment for health services, privatisation of health care, promotion of private insurance, and that the management of health care be decentralised.

It is with these global market forces in mind, and the South African government’s response to them, that we will now turn to the challenges of the integration of mental health services into the PHC system in South Africa. It is argued that national and global economic policies have had a bearing on the implementation of the integration process.

Implementation: The challenges

While South Africa has made significant strides at the level of policy and legislation, thus bringing the country in line with other countries around the world that have made similar efforts at integration, there have been a number of challenges at the level of implementation. These challenges, which mirror the experiences of many low and middle income countries, ultimately highlight the fact that integration of mental health into the PHC system, without adequate community participation and involvement, limited resources, lack of infrastructure and political will, amongst other factors, poses a serious threat to the realisation of the principles enshrined in the Alma Ata Declaration. This section highlights these challenges in relation to the South African context.

Poverty, service delivery and mental well-being

Swartz et al. provide some tentative evidence on the links between poverty and mental well-being. In particular, they were interested in how access to basic services, such as electricity and water affect the mental well-being of low income households with a family member diagnosed with a serious mental disorder (e.g. schizophrenia) in the Cape Town area. A strong relationship between poverty and mental health has indeed been noted, while a greater prevalence of common mental disorders has been reported among the poor. Unemployment and poor social welfare provision could lead to anger, despair and loss of hope.

Swartz et al.’s study on the mental well-being of a small group of low income households living with a member diagnosed with schizophrenia, was motivated by the government’s introduction of neo-liberal economic reforms, which, inter alia, introduced cost recovery measures and commercialisation of municipal services such as electricity and water.

The study found that these policies possibly contributed to relapse. Families’ social activities were also curtailed. For example, some families would not watch television in order to save on electricity. As a result, some family members would get bored and turn to drugs. Generally, inadequate service provision was associated with stress for the caregivers, while social tension within the family was also noted. This compounded the stigma associated with the mentally ill in the neighbourhood. These findings find support in the work of Petersen, who has argued that the recognition of the material basis of poverty requires that initiatives falling outside the traditional boundaries of health care, such as (un)employment and (lack of) housing, be investigated. She also cautions that the market-oriented economic policy of the country, namely GEAR (Growth, Employment and Redistribution), which emphasises deficit reduction and foreign debt repayment, could possibly undermine equity in service delivery. South Africa continues to be plagued by social ills such as high levels of unemployment, with some households relying on the social grant as their only source of income. As far as mental health is concerned, it has been shown that patients’ concerns go beyond traditional psychological concerns, they also incorporate concerns about housing, disability benefits and finding jobs. This calls for social service delivery, health promotion and an emphasis on developmental activities outside the health sector, and this requires collaboration between various sectors of society.
The biomedical orientation of mental health services

While South Africa has adopted the PHC system and its underpinning principles, implementation has been generally biomedical in orientation. Implementation has been characterised by the insertion of psychiatric care for serious mental disorders at the primary level of care, to the exclusion of common mental disorders such as anxiety, depression and behavioural problems.\textsuperscript{10,17,20} For example, in a situational analysis of integrated mental health services in the Lower Orange district and Mount Frere, it was noted that mental health care in these districts was basically psychiatric in nature.\textsuperscript{17,18} While the hospitals provided psychiatric care, no counselling services were available.

Petersen and Swartz note that some nurses at the primary care level focus on the clinical examination of the body; they do not take into consideration the illness narrative, which is the patient’s subjective experience of the distress.\textsuperscript{11} Further, nurses failed to account for somatic complaints where there were no physiological causes. This follows the pattern in many developing countries, where the provision of mental health services has remained deeply ensconced within the biomedical model. Similarly, in South Africa, the restructuring of the health care system to provide for mental disorders tends to rely on psychiatric nurses and trained PHC personnel managing chronic or stabilised psychiatric patients at the basic level of care.\textsuperscript{10,17,20}

Insertion of psychiatric care for serious mental disorders at the primary level of care is consistent with third generation reforms, mentioned above, which emphasise cost-effectiveness and measurable outcomes. The focus on serious mental disorders is perhaps partly explained by the fact that common mental disorders do not present with strong, tangible indicators to allow for consensus in measurement.\textsuperscript{22} However, given the understanding that mental well-being is not just the absence of a measurable psychiatric condition (i.e. disease), but also incorporates cultural, physical, social and spiritual dimensions of life, it is important to train and support PHC personnel to identify and handle common mental disorders such as anxiety, post-traumatic stress disorder, depression, mental retardation and other school-related problems, which have been shown to be quite common at the community level.\textsuperscript{20,27}

Workload and inadequate support for Primary Health Care workers

Many authors have noted that PHC workers are overloaded and hence do not have adequate time to cater for people with mental disorders.\textsuperscript{11,22,28} Neither do they receive the necessary support and supervision to enable them to confidently undertake their tasks. For example, Petersen has shown that, even in instances where PHC nurses understand the holistic conception of illness, incorporating physical, spiritual and psychosocial well-being, this understanding was not translated into practice because nurses did not feel empowered enough to deal with problems of a psychological nature.\textsuperscript{10}

Petersen goes on to suggest that the task-oriented biomedical model adopted by PHC workers, as described above, is a defence mechanism to deal with their own anxieties in the face of the patients’ subjective experiences of their illness. It is generally recognised that emotional labour is psychologically draining and as such requires intensive quality training and support.\textsuperscript{28} This is particularly so if volunteer health workers are employed, as envisaged in the White Paper on the Transformation of the Health System.\textsuperscript{6} Volunteer community health workers do not have a clearly defined career trajectory within the health care system and as such, they are likely to be disrespected by professional staff.\textsuperscript{28} Saraceno et al. decry the tendency in developing societies to introduce mental health care as a free-standing activity in PHC settings, without the necessary training, support, supervision and follow-up.\textsuperscript{22} They note that this goes against the Alma Ata Declaration, which called for a PHC system complete with referral systems, supervision and support, amongst others. They note that anything short of this could in fact lead to inappropriate mental treatment.

Professional identity, job insecurity and relationships between staff

Integration entails that both the specialist mental health care nurse and the generalist PHC nurse will be expected to undertake roles for which they have not been adequately trained, and hence they feel insecure.\textsuperscript{6,17} This may lead to a loss of professional identity and job insecurity. Further, despite the fact that one of the goals of integrating mental health care into the PHC system was to reduce the stigma associated with mental illness, this laudable goal has not been achieved.\textsuperscript{18,22} It has been reported that, despite the integration, non-psychiatric nurses may opt to leave the onerous task of attending to mentally ill patients entirely to the psychiatric nurses, who in turn feel stigmatised by other staff due to the nature of their work.\textsuperscript{18}

Poor infrastructure, limited funding and insufficient supplies and equipment

Poor infrastructure hinders the provision of mental health services at the primary level of care and this is particularly
so in the rural areas. This is perhaps due to the fact that, compared to other areas of health, mental health services remain low on the priorities of most governments in low and middle income countries, South Africa included.\textsuperscript{28,29} Shortages of vehicles means that mental health workers are unable to visit patients at home and they also encounter difficulties in transferring patients between the clinics and the hospital.\textsuperscript{18} Telephones and communication equipment are inadequate, nor is continuous supply of psychotropic medication guaranteed.\textsuperscript{18} Privacy and confidentiality are not guaranteed for victims of trauma, rape, alcoholism, abuse; and as a result, hardly any counselling or psychotherapy takes place.\textsuperscript{18}

**Leadership style and organisation of the health care system**

Primary mental health care presupposes an egalitarian relationship between those responsible for running the health care system, the health workers themselves, and the service users. A study of integration of mental health care into the PHC system in KwaZulu-Natal has, however, shown that bureaucratic and technocratic approaches to management persist.\textsuperscript{10} Strict divisions between various categories / ranks of staff were noted. Junior staff mostly performed routine duties, while the senior nurses diagnosed disorders and prescribed medication.

Further, staff evaluations were not based on the principles underpinning PHC, such as a holistic approach to care that incorporates the patients’ subjective experience of their distress. Rather, staff initiatives to address patients’ psychological illness experiences were not rewarded. In general, the evaluation tends to focus on the provision of biomedical care, which is an easily quantifiable task from a biomedical perspective. Such bureaucratic organisational patterns, argues Petersen, not only stifle staff creativity; they also run counter to the principles enshrined in the Alma Ata Declaration, which envisages holistic care that incorporates not only the biological component but the social, economic and psychological dimensions of being.\textsuperscript{10}

Pillay and Lockhart report on a similar trend internationally, whereby it was shown that there was a low detection rate of common psychological problems at the PHC level.\textsuperscript{27} Patients presenting with mental health problems such as depression and anxiety were most likely to be given medication for conditions such as peptic ulcers or hypertension.\textsuperscript{27} Both Petersen, as well as Pillay and Lockhart argue that PHC workers not only need training in basic counselling skills, crisis intervention, interview skills and detection of common mental health problems, but that they also need to be rewarded and supported for their own emotional labour.\textsuperscript{10,27} This requires a paradigm shift away from a predominantly authoritarian biomedical model towards a comprehensive, integrated PHC system, with a holistic approach to care, as envisaged in the Alma Ata Declaration.

**De-institutionalisation and Primary Health Care**

In line with developed countries, where de-institutionalisation has been in place for over 50 years, changes to the South African health care system included de-institutionalisation and integration of previously institutionalised patients with severe and chronic mental disorders into the community, thus reducing the historical reliance on long-term institutionalisation for this category of patients.\textsuperscript{19,30} Not only was mental health care incorporated into the PHC system, revisions were also made to the Mental Health Act (Act 17 of 2002) to ensure that the human rights of mental care users were protected, in line with the South African constitution.\textsuperscript{31} The changes to the Act were also meant to ensure that mental care users received the best possible care, treatment and rehabilitation services.\textsuperscript{19,28,32} Thus, following international trends, current South African legislation advocates for a rehabilitative, community-based model of health care, an approach that is meant also to reduce the stigma attached to mental illness.\textsuperscript{23} It is envisaged that de-institutionalisation will free resources which will in turn be channelled to residential care and ambulatory services at the community level.\textsuperscript{2,19}

While the idea behind de-institutionalisation is a laudable one, a number of authors have suggested that de-institutionalisation is a complex process that needs to be implemented cautiously and gradually, in order to ensure continuity of care for patients with severe and chronic mental disorders.\textsuperscript{2,19,30} Indeed, following patterns in other low and middle income countries, de-institutionalisation in South Africa has proven difficult to translate from the level of policy to practice.\textsuperscript{23,30} Not only do hospitals that historically catered for the mentally ill continue to serve a large residual of chronic, long-term patients, increases in the number of acutely ill patients have also been noted.\textsuperscript{30}

The following are some of the difficulties and concerns that have been raised in South Africa in relation to de-institutionalisation:

- **Limited resources:** To successfully close large institutions, resources need to be released from the hospitals to the community to ensure continuity of care. However, mental health services remain underdeveloped and poorly resourced.\textsuperscript{30} Reflecting on the Gauteng de-institutionalisation process, Lazarus
notes that funds were not available to transform the health care system, forcing the financing of mental health to rely on budget shifts. This mirrors the experiences in other low and middle income countries, where competition between different government departments has hindered transfer of human and financial resources to support community care.

Availability of care at community level:
De-institutionalisation must be preceded by the development of community residential care facilities and ambulatory services in order to reduce the possibility of relapse, homelessness and high re-admission rates amongst de-institutionalised patients. In South Africa, community facilities are under-developed, with poor rural provinces such as Mpumalanga having hardly any medium to long stay community residential facilities. In the provinces where downsizing of patient beds has occurred, the motivation has been financial constraints rather than the development of ambulatory or residential community care. It is partly for this reason that Lund and Flisher, and Lund et al. argue that a delicate balance needs to be maintained between hospital and community-based care, with a sufficient number of psychiatric beds retained for those who cannot be cared for at community level.

The potential for family neglect:
Whilst the international literature shows that patients prefer community over hospital care, patients and families in South Africa preferred hospital over community care. This may be associated with the burden of caring for the mentally ill on the family. Swartz et al. note that family members are sometimes forced to leave employment in order to care for a family member, which poses financial implications for the family as a whole. Gureje and Alem also note that, while some African communities are fortunate enough to have extended family to look after their mentally ill, urbanisation is impacting negatively on the extended family system and not every family has the resources to look after their mentally ill. It has been noted that, due to economic hardships, families may resort to using the individual’s disability grant for other purposes and not to support the individual.

Other obstacles and concerns:
Other obstacles to, and concerns about, de-institutionalisation have been summarised as follows:
- the culture of custodial care in mental hospitals is firmly entrenched and this is difficult to change;
- while intersectoral collaboration and coordination is improving, it remains inconsistent and uneven;
- family and community members are not well-informed about mental illness and stigmatisation continues, which makes it difficult to arrange community placements;
- due to staff constraints and attrition, provision of effective continuity of care and support to families and non-governmental organisations (NGOs) has been limited;
- homelessness among the mentally ill due to eviction from home and inability to find alternative shelter; and
- reduction of hospital beds may lead to the discharge of patients without due consideration of their readiness and availability of family and community support.

Inadequate epidemiological data and information to inform planning and intervention

For the integration of mental health services into the PHC system to be successful, there needs to be a reliable and valid database on the prevalence of common mental disorders in the community. However, in many African countries including South Africa, reliable and valid epidemiological information on various mental disorders is insufficient, and hence planning for mental health interventions is difficult. In one of the earlier prevalence studies conducted in Mamre in the Western Cape, the weighted prevalence rate of psychiatric morbidity (mostly depressive and anxiety disorders) was estimated at 27.1%. In a similar study conducted in a rural KwaZulu-Natal community, Bhagwanjee and his colleagues reported a weighted prevalence rate of 23.9% for generalised anxiety and depressive disorders. Recently, Havenaar and colleagues reported a high prevalence rate of mental health and substance abuse problems at PHC settings and among patients visiting traditional healers, noting that these problems account for a considerable burden of disease among South Africa’s disadvantaged communities. In another study in the Western Cape, the overall prevalence rate of mental disorders was 25% for adults and 17% for children and adolescents. The preponderance of common mental disorders in the South African population finds...
further support in the comprehensive South African Stress and Health Study, which indicates lifetime prevalence rates of 15.8%, 9.8% and 13.4% for anxiety disorders, mood disorders and substance use disorders respectively.\textsuperscript{40-42}

While the recent prevalence studies mentioned above are welcome, there is consensus in the literature that there is a general lack of adequate data on service provision, including data on the diagnosis and other characteristics of mental health service users.\textsuperscript{35} Epidemiological data on special populations and special problems, such as youth violence and child abuse, are also limited.\textsuperscript{43-45} Thus, evidence-based intervention models geared towards these populations need to be developed and tested in order to ascertain their effectiveness and cost.\textsuperscript{28,29}

**Integration and language**

Swartz and McGregor caution that, in countries such as South Africa, which are characterised by resource constraints as well as race and class divisions, integration does not mean that psychiatric patients will receive the best available care.\textsuperscript{23} They suggest that integrated services operate in the language of those who are in power, and this may preclude the marginalised and previously disadvantaged groups from receiving the best available care. The question of language in mental health care provision within an integrated health care system finds support in the works of Grazin and Jones, who note that, in some instances, family members have had to be enlisted to act as interpreters because the health workers were not conversant in the patient’s primary language.\textsuperscript{17,18} Similar concerns have been raised by Pillay and Kramers, who decry the fact that proficiency in the indigenous languages of South Africa has not been prioritised in the training of psychologists, and one might add, other health care professionals.\textsuperscript{46}

**Recommendations**

Several recommendations have been highlighted in the literature, to ensure that mental health services are available at the primary level of care.\textsuperscript{4,8,10,11,20,28,47-50} The recommendations listed below include issues covered in the current review as well as those that have been highlighted in the literature, but were not dealt with at length in this paper, due to its limited scope.

**Research and information monitoring**

- Epidemiological research should be carried out to collect data in order to understand the prevalence of serious and common mental disorders, especially in disadvantaged areas. This will facilitate planning, intervention and resource allocation.
- Research into intervention models that take into account the patient’s culture, their explanatory models of illness (their subjective accounts of their distress) as well as their help-seeking pathways, need to be developed, tested and evaluated.
- Research into, and education of the community on, various aspects of mental illness might go a long way in reducing the stigma of mental illness. Such research should be community-based; the research agenda should be developed jointly with the community and the findings disseminated using media and mechanisms accessible to the community.
- Information and monitoring systems on the integration process need to be developed and strengthened. This includes tools for monitoring de-institutionalisation, with a view to developing best practice models.

**Training**

- Indigenous conceptions of health and illness need to be incorporated into the training curricula for general and specialist mental health workers. This requires collaboration with traditional healers such as izangoma (diviners) and izinyanga (herbalists), who could be used as instructors and referral sources, as it has been shown that a large number of patients with mental health problems present to them.\textsuperscript{51} This is partly due to the fact that traditional healers are likely to use illness explanatory models that are consistent with the patient’s view of the origins of mental health problems.\textsuperscript{52,53} The training of mental health professionals is incomplete, if it does not include exposure to, and collaboration between, the two health care systems that continue to exist side-by-side in South Africa.
- Generalist nurses should be trained so that they are empowered to identify and refer serious, as well as common mental disorders, including behavioural and school-related problems, which have been shown to be common at PHC level. Incentives should be provided and initiative rewarded. Supervision by specialists (e.g. psychiatrists, psychologists) and support for emotional labour should also be provided in order to prevent burnout.\textsuperscript{51}
- Due cognisance should be taken, however, that generalist nurses cannot be expected to singularly carry the burden of providing psychological counselling to patients presenting at PHC settings, even if they have received appropriate training. The newly established professional psychological category of ‘counsellor’, can
play a meaningful counselling role at PHC settings. Resources need to be freed for the training of this professional category, and employment opportunities made available in the public sector.

- Training and support should also be provided to supervisory and other management staff in order to develop a leadership culture that is in tandem with the egalitarian principles of PHC.

- Language of service delivery. Despite the constitutional recognition of all eleven languages of South Africa, it is not always the case that mental health services are provided in the language of the patients’ choice. Even indigenous mental service providers sometimes struggle to translate the language of mental health into the vocabulary accessible to patients. It is recommended that the Health Professions Council should require competency in at least one indigenous South African language for all mental health professionals. Research needs to be undertaken to develop mental health vocabulary in the indigenous languages.

- Integration of mental health care into the PHC system should be conceptualised beyond the ‘insertion’ of mental health services into the PHC system; service providers should be trained holistically, incorporating training in psychosocial care and health promotion, over and above providing medical and nursing care.

### Implementation and empowerment

- Mechanisms to narrow the gap between policy and implementation need to be developed. Ongoing communication between researchers, policy makers and service providers / users is essential, in recognition of the fact that integration is not a single event but an ongoing process. There needs to be a shift in focus from preoccupation with immediate outcomes, to processing and acting on the feedback that is received as the policies are implemented.

- Resource transfer to the community. For the integration of mental health care into the PHC system to be successful, resources (e.g. community crisis centres, ambulatory services, personnel and financial resources) need to be transferred to the community. Given the low prioritisation of mental health issues, this might require that research on the relationship between poverty, HIV and AIDS and mental health be tabled to the government. The cost of mental ill-health and mental health provision in general also need to be established. Lobbying for resources will require collaboration with NGOs and other sectors of civil society, such as women’s and youth groups.

- Community empowerment; users of mental health services need to be empowered in line with the Alma Ata Declaration. Mental health users’ forums need to be established to liaise with researchers, government, policy-makers and service providers.

- South Africa experiences high levels of violence, especially against women and children. Mental health services geared to the needs of these special groups should be prioritised. There also need to be mental health services to cater for adolescents and the elderly.

### Conclusion

It was envisaged in the Alma Ata Declaration that health services will be available to all those in need at the primary level of care. However, shifts towards selective PHC, necessitated by economic and other factors, have made it difficult to implement the principles envisaged in the Declaration. This paper has reviewed a number of factors impacting on the integration of mental health services into the PHC system in South Africa. In particular, it has been argued that integration, whereby services for serious mental disorders are inserted into the PHC system, is insufficient. A holistic approach to integration, incorporating psychosocial and indigenous conceptions of health and ill-health, needs to be considered. While advances at the level of policy and legislation are recognised, further effort is needed to translate these into local provincial policy plans and actions. Ongoing training and support are needed for PHC workers, while multisectoral collaboration, epidemiological studies and data monitoring systems need to be strengthened.

### Acknowledgements

The authors would like to express their appreciation to the reviewers for their insightful comments.
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