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MENTAL HEALTH POLICY AND PLANNING: CONTINUING THE DEBATES

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INTRODUCTION.

This paper will outline progress in developing a new mental health policy for South Africa. Up to this point there has been no coherent mental health policy, rather mental health interventions have been largely determined by the provisions of the Mental Health Act, 1973, as amended. This Act deals with various aspects of the treatment of mentally ill persons, inter alia, conditions under which people may be detained in psychiatric institutions, State patients, the licensing of institutions for the mentally ill and the establishment of hospital boards. It does not, for example, mandate the State to provide adequate and appropriate mental health care for the country's citizens. Without a holistic policy the provisions of the Act functioned as the *de facto* mental health policy for the country! This legacy is compounded by racially discriminatory practices and fragmentation that resulted from the influence of apartheid ideology on the provision of mental health care.

MENTAL HEALTH POLICY PROCESSES OVER THE PAST FIVE YEARS.

In 1991 the Department of National Health and Population Development produced a document entitled "The Organisation of Mental Health Services in the Republic of South Africa". In its introduction the document identified the following problems with the mental health system: it was curative and hospi-centric; all services were rendered at secondary and tertiary level with "almost total exclusion of primary health care teams" (p1); the service was expensive; it promoted the stigmatisation of the mentally ill; it neglected primary prevention; and the system was perceived to be "unrealistic". The model proposed by the Department of National Health and Population Development was based on the principle of "differentiation on the service-rendering level" (p2). This implied that different types of mental health care services would be offered at the different

levels of care, that is, preventive, promotive and rehabilitative care would be provided at the primary health care level, more specialised care at the secondary level and that tertiary care would be delivered by academic hospitals. In this scheme it was suggested that between 70 and 80% of all mental health problems would be treated at the primary health care level with between 10 and 20% being delivered at secondary care level. It was further suggested that there would be a gradual shift in emphasis from institutional care to community care.

In June 1993 the Mental Health Directorate of the Department of National Health and Population Development (DNHPD) convened a workshop of people from the various mental health professions to " ... consider various models for the delivery of mental health services and to develop draft guidelines for the rendering of mental health services" (Parry, 1993:2). It is significant that none of the policy guidelines proposed two years earlier had been implemented and that in the workshop proceedings there is no mention made of the 1991 document.

The participants concurred that there were several problems with the mental health care services which included: fragmentation; lack of intersectoral cooperation; lack of coordination of funding; inaccessibility of services in both urban and rural areas; lack of emphasis on psycho-social problems; lack of emphasis on prevention, promotion and early detection of mental health problems; too much emphasis on institutional care; shortage of mental health care workers; inadequately trained health care workers; and too much emphasis on one-to-one care and not enough on groups and community care. It is not surprising that deficiencies listed by the workshop participants were similar to those noted in the 1991 policy document of the DNHPD!

The workshop discussed various models for integrating mental health care into primary health care including: the Free State model; the WHO model of decentralised care (Fourie and Gagiano, 1988; Gagiano, 1990) and an idea for the development of Help and Guidance Centres. Although these models were discussed at some length, no consensus was reached on any specific model, rather it was agreed that a combination of approaches would be needed depending on resources and local needs. Certain participants were uncomfortable to take the issues raised further given the lack of representativeness at the workshop and that they were invited for a specific purpose, to "provide input to the DNHPD" (ibid:20) - at a time when the legitimacy of the Department of National Health and Population Development was in question. Some delegates also felt that the time was inappropriate for the DNHPD to be developing new policies when a change of government was imminent. The only decision taken was that the proceedings of the workshop would be written up and circulated to all participants and to the DNHPD. It would appear that this was where the discussions were laid to rest!

When it became evident that the first democratic elections were to be held, the African National Congress (ANC) created a series of policy development commissions. This was done in an effort to establish policies that could be used in its election platform. The fruits of many hours of labour of ANC members and sympathizers, from various provinces, can be found in the Reconstruction and Development Programme (1994) and the ANC's National Health Plan (1994).

Given the importance of the ANC's National Health Plan (1994:46-47), the section on mental health is reproduced here in its entirety:

'The aim of the mental health policy will be to ensure the psychological well-being of all South Africans and to enhance their ability to conduct themselves effectively in social, interpersonal and work relationships. As psychological well-being is determined by social and material conditions as well as by physical, spiritual and emotional health, the policy will aim to eliminate fragmentation of services and ensure comprehensive and integrated mental health care.

Tenets. The principal tenets of the policy on mental health include the following:

* Promoting the development of an adequate, flexible range of mental health services at a community level wherever possible.
* Ensuring a multisectoral and integrated approach to mental health services.
* Promoting the empowerment of people and communities, thus enhancing psychological well-being.
* Emphasis on the promotion of healthy life styles and the prevention of mental disorder where possible with priority given to high risk groups.
* Fostering respect for the rights of people with mental illness and mental handicaps.
* Promoting awareness of mental health and mental illness issues.
* Promoting mental health in children with priority given to addressing the needs of vulnerable children.

Mechanisms. These policy principles will be translated into action through the following mechanisms:

* Improved integration of mental health care, including mental disorders, especially at primary level into the sectors where direct mental health care is necessary, namely, the health care system, the welfare system, educational system, correctional services, defence force and the workplace.
* Development of intersectoral structures at community, district, provincial and national levels to ensure coordination of mental health care provision between different departments and levels of mental health care services.
* Improving the provision of community care, including for the homeless mentally ill, hospital/institutional care, rehabilitation services and education of mentally handicapped, mentally disabled and mentally ill people. Support services for care-givers and families of these groups will also be developed.
* Supporting the development of non-governmental community-based mental health care services and fostering cooperation between the various mental health service providers.
* Fostering liaison and cooperation with traditional healers.
* Ensuring that mental health care personnel more adequately reflect the language and cultural diversity of South African society.
* Supporting and developing programmes aimed at preventing violence and injury.
* Supporting and developing services for all those affected by violence and civil conflict.
* Developing prevention and promotion programmes aimed at promoting youth development and effective parenting.

* Supporting and extending services aimed at preventing STDs and HIV infection, and at counselling people with AIDS.
* Improving and supporting services concerned with the survivors of rape, child abuse and family violence.
* Improving institutional care for the acutely psychiatrically disturbed.
* Ensuring the participation of consumers of mental health care services in decision making and policy forums at all levels".

POLICY DEVELOPMENTS WITHIN THE PSYCHOLOGY PROFESSION.

Various mental health fora, including the Organisation for Appropriate Social Services in South Africa (OASSSA) and the Psychological Association of South Africa (PASA) had in the late 1980s made various recommendations for alternative mental health services. OASSSA for example hosted conferences that focused on issues such as "Mental Health: Struggle and Transformation" (Eagle, Hayes & Bhana, 1988) and "Social Services in a changing South Africa" (Hazelton & Schaay, 1989) while the PASA made recommendations for changing the mental health system in a report entitled "Mental Health in South Africa" (PASA, 1989). In addition cultural, language and training issues and the question of financing mechanisms for mental health care services have received some attention (Swartz, 1986, 1987; Gobodo, 1990; Nicholas & Cooper, 1990; Freeman, 1991; Seedat & Nell, 1992).

The Professional Board for Psychology recognised the need to re-evaluate the training and accreditation of psychologists. It hosted a workshop entitled "The forum on the role and function of psychology in the new South Africa" in September 1993. At this forum a group was selected to develop the issues and ideas that were discussed. This group was later co-opted as an ad hoc committee of the Professional Board. It was at the suggestion of this ad hoc group that the Board commissioned Rock and Hamber to provide a report on these issues (Rock and Hamber, 1994). While the Report documents some of the deficits in the profession and the services provided by psychologists, the major focus of their work was the production of a strategic plan for the profession which they labelled "A National Psychology Development Programme". The Programme emphasised the need for a " ... new vision for South African psychology" (p33) which was to be based on the following: (i) psychology will be undisputedly relevant in South Africa; (ii) psychology will no longer reflect the disparities of apartheid; (iii) psychology will find ways to address the shortfall of psychological services and address the mental health needs of the South African population; (iv) psychology will address the issues of psychological training and how best the profession can meet the present needs of the population; (v) psychology will develop into a richly diverse discipline guided by stable and strong organisations with significant social power (pp34-35).

The Report suggests that various strategies could be used to achieve the above: (i) a national awareness campaign ("the profession must project a public image and take responsibility for the communication of mental health as a priority"); ongoing lobbying and public relations (the need for advocacy and to educate the general public, government, community organisations, non- governmental organisations, medical aid schemes; and the need for an internal newsletter so that the various sub-groups within the profession can keep each other informed of their activities.

The deadline for submissions of comments was 28 February 1995. As yet nothing further has been heard from the Professional Board on how it anticipated taking up the issues raised in the Report.

THE RESTRUCTURING OF GOVERNMENT AFTER THE APRIL 1994 ELECTIONS.

After the elections of April 1994 the provincial and national Departments of Health embarked on restructuring programmes. A number of provinces had special mental health task groups that were established by the Strategic Management Teams to develop mental health policies (the Strategic Management Teams were created to manage the transformation in integration processes). This process has resulted in much variation among the provinces via a vis the structure for the delivery of mental health care through a basic primary health care approach is common. At national level and in Gauteng, directorates for mental health and substance abuse have been formed. In the Western Cape and the North West Province sub-directorates which are envisaged to provide vertical support for horizontal programmes has been established. The KwaZulu-Natal Department of Health decided that they would not have vertical support structures with the exception of sub- directorates for HIV/AIDS and nutrition. This decision was premised on the belief that all services should become integrated into horizontal programmes or levels of care - primary health care, secondary and tertiary health care. How this was to be achieved has not been articulated. Other provinces have also not created managerial structures for mental health.

In October 1994 the Centre for Health policy, together with the Mental Health Directorate of the Department of National Health convened a two-day workshop entitled "Developing Primary Psychiatric Care at Provincial and local levels". All nine provinces were represented. The primary aim of the workshop was to help provinces in their practical planning processes through the sharing of information, knowledge and experiences. The workshop highlighted the major disparities which exist across provinces. For example, Gauteng public health services employs 57 psychiatrists and 48 psychologists (for about 7 million people) and the Western Cape 62 psychiatrists and 55 psychologists (for 3.5 million people) while Mpumulanga and the Northern Cape had only 1 and 2 psychiatrists and 1 and 1 psychologist respectively.

In February 1995, the Minister of Health, Dr Zuma, appointed a committee to develop a policy for mental health and substance abuse. The plan includes recommendations regarding the following: the restructuring of services; mental health indicators; intersectoral co-ordination; legislative changes; services for substance abuse; and privatisation of institutions. A selected number of mental health workers were invited to a workshop to discuss the draft document. The second draft produced by the committee included a number of suggestion made by the mental health workers who attended the workshop.

According to the newly appointed national Director for Mental Health and Substance Abuse, Ms Hlengiwe Mkize, the intention of the Directorate is to call for public comment after the Plan was presented to the Minister of Health. This has not occurred as yet.

In its overview the Report (1995) notes the following inadequacies in the current mental health system: that mental health data was scarce; that interventions were largely medical and institutional; that mental health services was provided as a vertical programme and not integrated into the primary health care system; that inter-sectoral collaboration and co-ordination was inadequate; that relative to other types of health care services mental health care enjoyed low priority; that services for children and adolescents were inadequate; that users of the services did not participate in the development of policy, its implementation and monitoring; that whites, urban dwellers and the wealthy enjoyed greater access to services than blacks, the poor and those in rural areas; that there was substantial emphasis on curative care with little emphasis on preventive, promotive and rehabilitative care; that training provided by tertiary institutions were inappropriate to the needs of the majority of the populace; and that substance abuse was a significant problem in South Africa.

The Report recommended that the following principles should guide mental health policy development in South Africa:
"(1) Mental health services should be available, accessible, affordable, appropriate, and acceptable to all.
(2) Mental health services should be integrated into a comprehensive health service based on primary health care approach (promotive, preventive, curative, rehabilitative).
(3) Mental health should be provided by a multi-disciplinary and multi sectorial team at all levels (Primary, Secondary, Tertiary).
(4) The services should address psychiatric as well as psychological well-being of individuals and communities.
(5) A community based Mental health delivery system should be well co-ordinated and well defined country wide.
(6) Mental health should not be isolated from physical health as the mind and body function together and cannot be separated.
(7) Mental health should be interpreted broadly, as encompassing structural and social problems as well as areas such as drug and alcohol abuse, family breakdown, recreation, job satisfaction, child and spouse abuse, violence, AIDS and other areas requiring non-medical and medical interventions" (1995:5-6).

Besides the Report of the Committee on Mental Health and Substance Abuse, the recently released Report of the Committee of Inquiry into a National Health Insurance System entitled "Restructuring the National Health System for Universal Primary Health Care" also makes various recommendations vis a vis mental health services. It recommends that the following basic principles should shape any restructuring of the primary health care service:

(a) that all permanent residents of the country will be *guaranteed access to primary health care which includes mental health care* that is delivered at the primary health care level; that such barriers to access to care as finances, and geography be eliminated; that there should be *equivalent quality of care* for all who use the public health care system (the Report recognises that the fulfillment of the principle of universal access with good quality care will have be phased in over time but suggests that the *attainment of guaranteed access should be accorded the highest priority by the national and provincial Departments of Health).*

(b) that there was a need to strengthen the public health system (this does not exclude participation of private providers within the new primary health care system) - this should mean an *increase in the quantity and quality of mental health care within the public health sector* (it certainly would mean the reallocation of resources - for example from psychiatric hospitals to facilities that offer community based care);

(c) that the re-organisation of the primary health care system has to occur within the framework of the evolving district health system - this means that primary health care services would be delivered within the district health system with its defined geographic catchment and at the following sites:mobiles, clinics, community health centres, and community hospitals. These then become the sites at which primary mental health care could/should be delivered;

(d) the comprehensive primary health care approach is stressed - this implies: a broad definition of health (not merely the absence of disease) including: prevention, promotion, rehabilitation; and the recognition of the influence of environmental factors on health, eg, clean water, proper housing and education. This means that mental health services should also be comprehensive (ie, focussing on prevention, promotion, curative services, and rehabilitation) and should occur with appropriate intersectoral collaboration (eg, this could mean that collaboration, at minimum, includes the Departments of: welfare, education, safety and security, prisons, and the justice system);

(e) a coherent link between the primary health care system and other levels of health care should be established: for mental health this implies the establishment of an appropriate referral/support/supervision system between the district health system (at which PHC services will be delivered) and regional and tertiary hospitals (including psychiatric hospitals); and

(f) at the primary health care level there should be an optimal mix of private and public providers: for mental health this could mean that mental health providers in the private sector should provide some services to/in the public health system (given the skewed distribution of mental health providers - where the bulk of the psychiatrists and psychologists are in private practice where they, at best, provide care for 23% of the population).

The Report lists mental health care services as one of the components of a universal PHC package. This is clearly an illustration of the importance that the Committee attached to the provision of mental health care services at primary health care level.

The personnel considered necessary at the PHC level include:psychiatric nurses and social workers (with appropriate referral to medical practitioners and psychologists). The Report does *not* suggest that PHC nurses would also be responsible for mental health care delivery (for example for basic screening, counselling and appropriate referral).

Community mental health and substance abuse services are listed as one of the components of the "non-personal" (sometimes called environmental health) PHC

services. Here PHC nurses, social workers, psychologists and medical practitioners are listed as the providers of care.

Projecting the human resource requirements at the PHC level the Report uses the norm of 1 psychologist:100,000 people and suggests that at the PHC level the country required 363 psychologists; 2.5 social workers per 100,000 resulted in the need for 921 social workers - who would not provide mental health care exclusively. The Report does not comment on the number of psychiatric nurses that would be required at the PHC level.

The Report also does not make provision for community health workers/village health worker, or mental/health auxillaries of any type. This suggests that the PHC service envisaged will be purely professionally based. The Report also makes no mention of any role for traditional healers at the primary health care level.

The Report suggests that all personal and non-personal health services at the PHC level will be free at the point of delivery. A small (actual amount is un-determined) user fee will however be levied for medicines. The rational for this is that if patients pay for medicines they would value it higher thus increasing compliance rates. This presents a problem for mentally ill patients, especially the chronically ill who are often un- or under-employed. It is possible that the introduction of a fee for the mentally ill will *decrease access*.

In addition, the Report recommends the introduction of the UK model of purchasers (the District Health Authority for example) and providers (eg, Health Maintenance Organisations, group practices, Independent Practitioners Associations). The District Health Authority will be the purchaser of comprehensive PHC services from providers (who can be either in the public or private health sector). This implies that the DHA may purchase services from mental health providers in the private sector. It may also mean that - at a point when, according to the Report, the public sector is adequately resourced and can compete on even terms with the private sector - the DHA may prefer to purchase services from the private sector rather than the public sector.

The *costing* of finances required to implement the PHC system envisaged is based on *2 clinic visits per person per year*. This does not appear to take into consideration the cost of out-reach programmes (largely preventive and promotive); the treatment of certain forms of illness like mental disorders which usually require between 5-10 hour long interventions per illness episode; an escalation of the HIV/AIDS pandemic; and the treatment/rehabilitation of chronic illness (again including mental health) which may require monthly treatments. The figure of 2 visits per capita is higher than current utilisation in the public sector (between 1,6 and 1,8 visits) and significantly lower than that in the private sector (5,0 visits).

Current (1995/6) public mental health expenditure is reported to be of the order of R28 664 000 - of total PHC expenditure of R3 638 483 000 (or 0,79%). Regardless of the accuracy of the figures used this level of spending on primary mental health care is insufficient. However it should be noted that one would need to include the expenditure on hospital care (the bulk of mental health expenditure) to get picture of the total public mental health budget. Clearly, there is a need to

increase mental health care funding at the PHC level. Some of this may come from the large psychiatric hospitals as patients are relocated to community based facilities.

To fund PHC services the Report recommends that a national "Primary Health Care Fund" be established which will attract funds from two sources: (i) funds allocated to PHC from the national health budget; (ii) national PHC vote from the ficus. It is envisaged that the funds from the Primary Health Care fund will be allocated to the provinces who in turn will distribute it to the districts using a capitation based formula.

A gap exists between current levels of spending on PHC and required expenditure to meet the anticipated need. This gap will of the order of R1,36 billion in 1997/8 and R3,39 billion by 2000/1. The Committee is of the view that additional finances will be required even with reprioritisation of finance allocations to the different levels of health care and improved efficiency in the health care sector. While the Committee examined various options to financing this gap they did not make any recommendations in this regard - they suggest that it is more appropriately left to the Cabinet and its social partners. Some of the possible sources of additional funding include: general tax revenues; dedicated funding from excise duties and/or VAT; dedicated tax funding from reductions in tax expenditure through modification of the tax relief employers gain from sponsoring medical aid; a dedicated payroll tax; and a flat rated user charge on all forms of private health insurance contributions. Clearly the affordability of the scheme will constrain both the nature of the package of services that can be delivered and the time frame of its full implementation.

The Report has specific implications for mental health care delivery in South Africa. Firstly, it locates the delivery of PHC services (including mental health care) within the District Health System. It recommends that a team of mental health care specialists be available to deliver mental health care at this level. Given that the majority of mental health professionals, employed in the public health sector, work in psychiatric hospitals at present, it will probably be necessary for some mental health specialists at the primary health care level to be shifted from the psychiatric hospitals to community hospitals, health centres and clinics.

Secondly, it is implied that mental health care services will become integrated into primary health care, i.e., it will lose its status as a vertical programme. This may imply that separate funding for mental health care at primary health care level may cease which in turn may mean that mental health will have to struggle like all other disciplines for a slice of the financial pie. While this scenario is usually viewed as a problem by mental health professionals, it can also be seen as an opportunity to obtain more resources. Mental health professionals have to be become more creative about lobbying for more resources. If, as we suspect it is, the route to more funding is to show cost effectiveness, then some of the time of the PHC mental health team should be spend on undertaking such studies. In addition, we need to systematically educate our colleagues about mental health and the impact of mental illness on physically health.

The most recent policy document from the Department of Health, "Towards a National Health System", dated November 1995 - which called for public comment

by the end of December 1995 - contained a chapter on mental health policy which according to the preface of the document reflects the " ... reflects a synthesis of the reports of Committees appointed by the Minister of Health ... (and) also includes the preliminary thinking within the Department of Health, based on wide-ranging consultations with a variety of stakeholders". It notes three principles that should guide policy making and lists a series of implementation strategies.

The three principles listed are:
- "a comprehensive and community-based mental health and related service (including substance abuse prevention and management) should be planned and co-ordinated at the national, provincial, district and community levels, and be integrated with the other health services provided;

- essential national health research should include mental health and substance abuse to identify the magnitude of these problems in South Africa;

- human resources development for mental health services should ensure that personnel at various levels are adequately trained to provide comprehensive and integrated mental health care, based on primary health care principles".

The roles of the various levels of government in terms of the implementation strategy are then specified. In addition, the need for adequate and appropriate training of primary health care workers in mental health skills and the need for additional funding for mental health research were identified. It is expected that the principles and implementation strategies suggested in the document would, after redrafting to take into account comments made since its release, become the official policy framework of the Department of Health.

CONCLUSIONS.

There has been much activity in mental health policy development since 1991 both in the Department of National Health and in various sectors outside the state bureaucracy. However, there appears to be little evidence to suggest that these workshops and policy papers have been accepted as policy, still less implemented. The problems have been diagnosed ad nauseam since in the mid 1980s at least (see for example Vogelman, 1986; and Freeman, 1992). There is agreement, for example, that there needs to be a shift to primary mental health and community based care with greater emphasis on prevention and promotive activities.

What is required is strong leadership from the newly appointed Director for mental health in the Department of National Health *and* equally important, from her counterparts in provincial government to ensure that the policies that have been debated for the last four or five years are implemented. Where no specific management structures have been set up for mental health we foresee particular problems in policy development and in the implementation of changes to the delivery of mental health care services. Well organised and strong lobbying groups in civil society are also required to exert the types of pressure that appear to be essential for all levels of government to meet the needs of the populace. These groups should also play a role in monitoring the results of the implementation of new mental health policies in South Africa.

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