

Are we training our psychiatrists adequately as public mental health practitioners?

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There are enormous challenges in developing a mental healthcare service that meets the needs of South Africans. Many of these challenges have been described in the lay press^[1] and in both local^[2] and international^[3] journals. In recognition of these challenges, the South African Society of Psychiatrists (SASOP) has expressed its support for formalising a national mental health policy, in a position statement^[4] released following a strategic workshop in 2012. The workshop was co-ordinated by members of its State Employed Special Interest Group (SESIG).

SASOP argued then that psychiatrists should play a central role in the strategic and operational planning of mental health services, at local, provincial and national levels,^[4] in collaboration with the other mental health disciplines. It is easy to make such an argument at the present time, as the majority of state-employed psychiatrists occupy positions of relative power within mental health services which remain centralised, hospital-based^[5] and, it could be argued, psychiatrist-based. Indeed, from a global perspective, some authors have identified the power concentrated in psychiatrists, and in the large psychiatric institutions in which they tend to serve, as a particular barrier to the development of more comprehensive and equitable services.^[6]

If psychiatrists in South Africa do want to be part of the solution rather than part of the problem, there are two critical questions that need to be addressed:

- Are we developing relevant expertise within academic psychiatry?
- Are we equipping the new psychiatrists we are training in South Africa with this expertise?

Central to this expertise is the emerging discipline of public mental health. In a public mental health approach, the unit of analysis is a population or a community, rather than an individual or a patient. The psychiatrist is led logically to analyse the way in which services are organised for a given population; the policies, plans and budgets that inform that service organisation; the ethical dimensions underlying the allocation of resources; and the role of the psychiatrist in the health system. Public mental health requires the use of the best available research evidence to inform decision-making, and is driven by the objective of achieving equity in mental healthcare, including a primary healthcare approach to health systems.

A brief sampling of the literature would suggest that South Africa has produced – and continues to produce – a number of strong academics in the field of public mental health, but few of these are psychiatrists. What needs further interrogation is the extent to which this expertise (in public mental health) is being developed in a sustainable way within university psychiatry departments (as well as among the general body of South African psychiatrists), such that this knowledge is continuously updated, disseminated and put into practice.

In an examination of barriers to the improvement of mental health services in low- and middle-income countries (LAMICs) for the *Lancet's* 2007 Series on Global Mental Health, Saraceno *et al.*^[7] identified a variety of reasons for the inadequacy of funding for mental health in such countries, which speak directly to this issue. These include: a lack of consensus among mental health advocates generally and psychiatrists in particular, regarding priorities for spending in mental health; difficulties in communicating the sometimes complex concepts in mental health to those outside of the field; perceptions among decision-makers that mental health indicators are not sufficiently strong and that mental healthcare is not cost-effective; a lack of public interest in the subject; and weak advocacy due to the lack of visibility of people living with mental illness and their families.

Establishing public mental health as a priority discipline in university psychiatry departments would be a key step in addressing these inter-related problems. A lack of consensus and sporadic messages result when voices emerge intermittently in response to particular issues, on the basis of eminence (often due to achievements unrelated to the field of public mental health) rather than as a result of the rigorous accumulation, examination and dissemination of best evidence, as is the case for any other sub-discipline within psychiatry. The development of strong, relevant and comprehensible indicators of mental health, and of economic arguments for mental healthcare, are core features of public mental health philosophy, which also includes the areas of user empowerment and mental health advocacy. For this reason, recommendations regarding mental health policy and service organisation are not a matter that can be left to the attention of a few individuals scattered across academic departments, nor can it be visited intermittently when key decision-makers are thought to be listening.

If psychiatrists in South Africa want to play an important role in developing our mental health services, this crucial discipline must be nurtured and developed as a central feature of each academic psychiatry department and the broader field of psychiatry in this country. If this discipline is developed and sustained with sufficient academic rigour, then it increases the capacity of psychiatrists to advocate for improved and more evidence-based service models. Policy formulation and change is a process rather than a series of discrete events, requiring consistent and sustained pressure over an extended period of time,^[8] and the development of public mental health as a discipline and a core set of skills for psychiatrists will greatly increase the likelihood that mental health services will be given more sustained and appropriate priority in future.

Of course, when it comes to the training of new psychiatrists, whom we would hope will take forward the development of services, the above arguments also apply. Even more crucially, however, we need

to be interrogating what skills we should be imparting to those we train, if we aim to equip them to work in, and improve, what are clearly extremely challenging environments and not, as has been suggested, to work overseas.^[9] In LAMICs, psychiatrists are both low in number and inequitably distributed.^[10] Patel^[11] has argued powerfully that if the treatment gap in these countries is to be addressed, the primary role of the psychiatrist has to be one of public mental health leadership and task-shifting. South Africa had 632 registered psychiatrists in 2008. They were distributed inequitably between provinces, and over a third of them were exploring the possibility of emigration.^[12] Yet, any review of what is currently being taught in the majority of our universities and examined by the College of Psychiatrists reveals a paucity of content related to public mental health. While we may be making progress in the development of psychiatry as an academic discipline in South Africa,^[13] we seem to be doing precious little to ensure improved mental healthcare for the people of this country.

We would therefore argue that the development of public mental health as a core discipline is an immediate priority in the training of South African psychiatrists and should be one of the key academic foci within universities. We call on university departments of psychiatry and the College of Psychiatrists to consider this as a matter of urgency. Failure to do so will only serve to undermine efforts at reducing the mental health treatment gap and may ultimately threaten the potentially important role that South African psychiatrists could play in developing and leading better services.

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