

Providing psychiatric services in general medical settings in South Africa: Mental health-friendly services in mental health-friendly hospitals

Neuropsychiatric disorders rank high on the list of the most disabling medical disorders in both the developed and developing worlds.¹ Significant comorbidity also exists between neuropsychiatric disorders and general medical disorders;² this is key in the South African context where HIV/AIDS and substance use disorders are highly prevalent.^{3,4} It has therefore become essential to provide mental health services in a range of settings, including those that focus on the delivery of general medical services. Furthermore, the Mental Health Care Act 17 of 2002 underlines the importance of providing integrated, accessible mental health care in the local community.

Despite growing recognition of the burden of disability due to common mental disorders, mental health services remain under-resourced in relation to their burden, both in developed and in developing countries.⁵ In South Africa, the historical focus has been on providing mental health care in psychiatric hospitals rather than in general medical or community settings.⁶ De-institutionalisation has occurred in recent decades, but development of adequate community-based services has lagged in catering for the immense need of community outpatients.

In the Western Cape, considerable effort and energy has been devoted to preparing a strategic plan for providing more effective community- and district-based mental health services in line with the new Mental Health Care Act. This plan is part of the Provincial Government of the Western Cape Department of Health's Comprehensive Service Plan for the Implementation of Health Care 2010 (HC2010). In this plan, a series of models of mental health care services is outlined to determine the number of posts for mental health clinicians, including community-based psychiatric nurses, in coming years (the 2010 Comprehensive Service Plan (CSP)). Additional work, however, is needed to implement the CSP, adjusting it to the realities 'on the ground'.

Challenges

As part of the province's HC2010 strategy, a clinician was appointed in each of the major specialties as co-ordinating clinician to assist the Department in guiding the discipline towards HC2010. Co-ordinating clinicians have worked with university departments, management, clinicians and the provincial mental health programme in order to identify problems and find possible solutions. A number of challenges were identified across the following levels of care:

1. The first challenge was to assess the burden of psychiatric disease in the population. Estimates of the burden of disease using mortality have led to mental illness being under-represented elsewhere. Locally, a relative absence of data has made it difficult to estimate the burden of mental illness due to disability. Nevertheless, a growing emphasis by international organisations on the burden of mental disorder worldwide,⁵ and a range of additional local considerations (e.g. the comorbidity of mental illness with physical trauma, comorbidity with chronic medical diseases including HIV, and the unforeseen dramatic escalation in methamphetamine use in the province) seemed to indicate that the burden of psychiatric disease had been grossly underestimated in the planning of future services.

2. A second challenge has been the past lack of attention to community-based services for patients with mental illness. In recent years, there has been a decrease in funding for chronic hospital services which *inter alia* has accelerated the discharge of long-stay patients from large psychiatric institutions. At the same time, the development of community-based services has been very slow. More attention has been given to non-profit organisations (NPOs) rather than to developing new community-based services. The relatively low funding norm for existing NPOs, limitations in the ability and availability of NPOs to provide the envisioned services, and difficulties in finding adequately trained and dedicated staff, have contributed further to the slow development of appropriate mental health services in the community.

3. A third challenge has been the development of models that adequately integrate mental health and general medical services at the primary care level.⁷ A key aim of primary mental health services at community centres is to cater for outpatients with psychiatric disorders, and to prevent hospitalisation. When hospitalisation is required, patients should be treated in accessible district and regional hospitals. However, community centres and district hospitals are generally poorly equipped, understaffed, and unwilling to take on their mental health responsibilities. Obstacles to the provision of mental health services at district hospitals include:

- difficulties in managing acutely suicidal and disruptive psychotic patients in general wards, together with the frail medically ill
- the absence of safe observation facilities as well as clear seclusion guidelines
- limited availability of psychotropic medication
- a culture of not treating patients with psychiatric disorders, with stigmatisation of this population

- limited dedicated staff and lack of mental health competencies in existing staff
- difficulties in access to level 2 units (in regional and psychiatric hospitals).

Taken together, the shortage of dedicated psychiatric beds in regional hospitals (particularly in rural districts) is an obstacle to providing inpatient services that are close to home, in smaller units and cost-effective. The shortage of dedicated *full multidisciplinary specialist services* at this level means that patients are too frequently referred to urban psychiatric hospitals, situated far from where they live. This is a sub-optimal arrangement for many reasons, including difficulties in optimising discharge planning. This in turn contributes to high re-admission rates in the Cape Town metropole psychiatric facilities.

Solutions

Fortunately for the effort to bring data on the burden of disease associated with mental illness to the attention of health planners, the province embarked on a burden-of-disease project a few years ago, and mental health was included. The final report placed considerable emphasis on mental health by identifying the causes of premature death in the Western Cape (suicide ranked number 10), addressing data on years lost due to disability (the indicator being the DALY, a summary measure of the time lived with disability and the time lost due to premature mortality), noting the comorbidity of mental illness with other major contributors to premature death, and emphasising that improvement of mental health services could play a major role in the cost-efficient prevention of mental illness.⁸ The development of local datasets on burden of disease⁹ and the epidemiology of mental illness¹⁰ has been useful in arguing that resources for the prevention and treatment of mental illness need to be increased in future planning.

Increased attention has been paid to improving mental health service delivery in community centres and by NPOs. The province has embarked on a process of communication with existing NPOs to identify current gaps and to attempt to resolve these collaboratively. In addition, clinicians and members of the mental health programme have devoted significant energy to the training of primary health care nurses. Ultimately, the availability of dedicated and trained mental health care staff in community settings is necessary to ensure that appropriate diagnosis and management of mental illness occurs. In particular, there is a need to increase the number of dedicated mental health nurses both in community health care centres and in district hospitals. As a first step, the Division of District Health Services, Department of Health, Western Cape, has committed itself to a ratio of 1 mental health nurse per 30 000 of the population in high-density areas.

Progress has also been made towards developing a model of the provision of mental health services in general medical facilities – one which emphasises the importance of mental health-friendly institutions. Aspects of this model include adequate personnel, appropriate protocols and guidelines, and outreach and training. The province has agreed to the appointment of mental health nurses in all district hospitals in the Cape Town metropole as well as in the larger rural district hospitals. Attention has been paid to seclusion protocols and to ensuring that the Mental Health Care Act is implemented. A ‘mental health-friendly hospital’ initiative has been implemented to emphasise equitable, non-discriminatory treatment of patients with psychiatric disorders in general hospital settings. For example, there needs to be an awareness of, and ability to manage, the ‘confused’ patient in an adequate environment until diagnosis can be confirmed, be it a psychiatric or general medical illness. Just as for maternity and paediatric cases, district hospitals should aim to provide admission for appropriate patients with psychiatric disorders.

The model emphasises the need for regional hospitals to have dedicated psychiatric beds and the ability to provide appropriate specialist inpatient, outreach and outpatient services. The development of L2 (regional) hospital-based services is internationally acknowledged as a specific priority in developing mental health services and should arguably *precede the development of district health services*. In the Western Cape, the process of providing specialist outpatient services is well on its way, and all the rural districts now have at least one specialist psychiatrist. Nevertheless, the provision of *dedicated* multidisciplinary teams (including psychologists) has not been optimal, with erratic appointments. Furthermore, a great deal of work is needed for rural regional services to overcome a range of barriers, and to build and put into operation dedicated psychiatric units.

Conclusion

A great deal of scientific work in community psychiatry has emphasised the principles of primary health care service delivery, parity of mental health and general medical services, and an integrated framework that allows referral from primary through to secondary and tertiary services, where indicated. Equally important, however, is an emphasis on human rights; the current focus on improving mental health services in the state sector is consistent with the emphasis in the new Mental Health Care Act on the rights of those with mental disorders to appropriate care.

A reconsideration of mental health services in general provides an opportunity to re-address the nature of specialist outreach and support in particular. Traditionally, specialists have travelled to primary health care sites to deliver direct face-to-face

consultations. Although this system had some benefits, it placed a great burden on specialists, taking them out of district and regional hospitals and limiting the time for training, supervision and service developments. Arguably, this system of mental health care service delivery also contributed to perpetuating the separation of mental health care and general medical care. The focus of a more integrated mental health service delivery would be to *empower and enable* primary health care providers to be able to manage all acute, mild and moderate mental illness, while still providing specialist consultation services.

In the Western Cape, a range of stakeholders is involved in the planning and implementation of mental health services. Clearly, an integrated approach is needed, with good collaboration between the different divisions in the Department of Health, the partner universities and mental health clinicians, in a range of different disciplines and institutions. Therefore, we have placed strong emphasis on communication and cohesion of the 'mental health family'. This process is often fraught with difficulties within the context of different institutional priorities, and real resource constraints. Nevertheless, a collaborative approach to decision-making provides an opportunity for workable solutions to be found.

Much more remains to be done. Firstly, additional data are needed on disease profiles, the extent of current mental health service provision, and the effects of changes in the system. Secondly, greater support for the concept that mental health services deserve parity is needed in all health care settings (primary, secondary, and tertiary). Thirdly, community psychiatry as a whole needs to be invigorated, with appropriate training and research, to ensure that current and future models are evidence-based. In the interim, the development of mental health-friendly hospitals to support the integration of psychiatric services within general medical services appears to be a worthwhile goal in the Western Province.

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