

SOUTH AFRICA

Integrated primary care services and a partnership for mental health primary care

Ehlanzeni District, Mpumalanga Province, and Moorreesburg District, Western Cape Province

Case summaries

Two distinct best practice examples from South Africa are featured within this section of the report.

Integrated primary care services for mental health in the Ehlanzeni District, Mpumalanga Province

The first example, from the Ehlanzeni District of Mpumalanga Province, demonstrates how primary care for mental health can be provided using two distinct service models. In the first model, a skilled professional nurse sees all patients with mental disorders, within the primary care clinic. In the second model, mental disorders are managed as any other health problem, and all primary care workers treat patients with mental disorders. Importantly, clinics have tended to adopt the model that best accommodates their available resources and local needs. By the end of 2002, 50% of clinics in the Ehlanzeni District were delivering mental health services, and by early 2007, 83% of clinics were delivering these services. Primary care nurses and patients are generally satisfied with the integrated approach. These achievements are noteworthy because in 1994, at the end of Apartheid rule, Mpumalanga Province had no mental health services whatsoever. Yet within 10 years, it had developed and implemented primary care for mental health throughout the region.

A partnership for primary mental health care in the Moorreesburg District, Western Cape Province

The second example comes from the Moorreesburg District of the Western Cape. General primary care nurses provide basic mental health services in the primary care clinic, and specialist mental health nurses visit the clinic once per month to manage complex cases and provide supervision to primary care nurses. A regional psychiatrist visits the clinic once every three months, and a psychologist sees patients for eight hours per week. A medical officer is available daily at the clinic. Because patients are seen within the same clinic, access to mental health care is improved and potential stigma is reduced. Primary care practitioners are generally satisfied with the model. They appreciate the regular visits by the mental health nurse and the psychiatrist, who provide ongoing in-service training as well as support for complex cases.

The diversity of these two best practice examples, within the same national policy framework, demonstrates that when designing and implementing mental health services it is always essential to carefully examine local resources, opinions and needs, and to define solutions that are tailored to the specific situation.

1. National context

Key indicators for South Africa are summarized in Table 2.29. The country is a complex mix of highly developed cities with strong infrastructure, combined with large rural areas. South Africa is viewed as the “economic powerhouse” of Africa, with a gross domestic product that is four times larger than those of its southern African neighbours; and comprising 25% of the gross domestic product of the entire continent. Despite its overall economic success, large wealth disparities exist. Unemployment is high (around 25%) and poverty is common in both urban and rural parts of the country.

Table 2.29 South Africa: national context at a glance

Population: 47 million (59% urban) ^a
Annual population growth rate: 1.2% ^a
Fertility rate: 2.7 per woman ^a
Adult literacy rate: 82% ^a
Gross national income per capita: Purchasing Power Parity International \$: 12 120 ^a
Population living on less than US\$ 1 per day: 11% ^a
World Bank income group: upper-middle-income economy ^b
Human Development Index: 0.674; rank 121/177 countries ^c

Sources:

- ^a World Health Statistics 2007, World Health Organization (<http://www.who.int/whosis/whostat2007/en/index.html>, accessed 9 April 2008).
- ^b Country groups (<http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20421402~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html>, accessed 9 April 2008).
- ^c The Human Development Index (HDI) is an indicator, developed by the United Nations Development Programme, combining three dimensions of development: a long and healthy life, knowledge, and a decent standard of living. See Statistics of the Human Development report. United Nations Development Programme (<http://hdr.undp.org/en/statistics/>, accessed 9 April 2008).

South Africa is a multi-party democracy with an independent judiciary and a free press. It has one of the world's most progressive constitutions.¹ Its population comprises a mix of different ethnicities, religions, and languages.

2. Health context

Key health indicators for South Africa are displayed in Table 2.30. Both communicable and noncommunicable diseases are growing in the country and placing severe strain on public health services. Tuberculosis, malaria, heart disease, obesity, hypertension, and mental disorders are common.² However, HIV/AIDS is of greatest concern: around 17% of adult South Africans are infected, yet only one third of those with advanced infections are receiving anti-retroviral therapy.³ Preventing the further spread of HIV and providing treatment and care to those in need are the greatest challenges to the South African health system.

Table 2.30 South Africa: health context at a glance

Life expectancy at birth: 50 years for males/52 years for females
Total expenditure on health per capita (International \$, 2004): 748
Total expenditure on health as a percentage of GDP (2004): 8.6%

Source: World Health Statistics 2007, World Health Organization (<http://www.who.int/whosis/whostat2007/en/index.html>, accessed 9 April 2008).

Around 80% of South Africans receive care in the public sector, while around 18% belong to private medical schemes and receive care in the private sector. Sixty per cent of all health expenditure is private.³ Although health services consume around 11% of the government's total budget, the public sector struggles to provide good quality health care to those in need.³

Mental health

A recent nationally-representative survey of South African adults indicated that 16.5% of the population had experienced a mental disorder in the prior 12-month period. The most common disorders were major depressive disorder (4.9%), agoraphobia (4.8%), and alcohol abuse or dependence (4.5%). Twenty-eight per cent of adults with a severe or moderately severe disorder received treatment, compared with 24% of mild cases. Treatment was provided mainly by the general medical sector.⁴

The National Department of Health is responsible for developing mental health policy and law, and the provincial health departments and local authorities are responsible for the delivery of services. Within this structure, a mental health policy based on primary care principles was adopted in 1997, and a mental health care act was passed in 2002 and enacted in 2005. Following establishment of the mental health policy and legislation, provincial and local health planners have been challenged to manage the transformation from hospital-based to community-based care, to integrate mental health into general health services, to secure an adequate number of trained health workers, and to expand mental health prevention and promotion initiatives.

3. Primary care and integration of mental health

The mission of the Department of Health is a caring and humane society in which all South Africans have access to affordable, good-quality health care. The primary care approach has

been adopted as the most feasible means to achieve this mission. Since 1994, the year of liberation from Apartheid rule, emphasis has been placed on building and developing primary care, and reorienting hospitals as referral facilities for complex or severe cases that require secondary and tertiary level care.

Given the diversity of different regions of South Africa, a variety of primary care facilities has been developed. Primary care facilities range from community health centres, which are open on a 24-hour basis and provide acute and chronic care, reproductive health services, immunization and other prevention and health promotion activities; through to mobile clinics in remote rural areas, where health personnel visit on a periodic basis and provide a less comprehensive service.^a Table 2.31 displays the clinics in the nine provinces during 2001.

Table 2.31 South Africa: primary care clinics across the nine provinces, 2001

Province	Community/district health centre	Clinic	Mobile facilities or clinic points	Total
Western Cape	6	340	191	537
Eastern Cape	12	724	44	780
Northern Cape	6	96	50	152
Free State	5	212	81	298
KwaZulu-Natal	10	365	638	638
Gauteng	26	333	79	438
North West	20	380	74	474
Mpumalanga	28	221	137	386
Limpopo	5	506	158	669
Total	98	3177	1077	4352

Since 1994, over 700 fixed clinics have been built, 2300 clinics have been upgraded and given new equipment, and 125 mobile clinics have been introduced. Access to primary care facilities increased from around 67 million visits in 1998, to over 100 million in 2006. The current national utilization rate is around 2.2 visits per annum.

Norms and standards have also been developed concerning the range of services to be provided through primary care. The integrated package includes reproductive health, integrated management of childhood disorders, immunization, adolescent and youth health, management of communicable illnesses, cholera and diarrhoeal diseases, management and prevention of sexually transmitted diseases, trauma and emergency, oral health, mental health, and management of chronic diseases such as diabetes and hypertension. Some clinics provide all services contained in these norms, while others are still working towards the implementation of the full package.

Other important primary care norms include the standard that primary care should be available to everyone within five kilometres of their homes. Moreover, at least one health worker at each clinic should have completed a course in comprehensive primary care. Each clinic should have a physician or other specialist accessible for consultation, support and referral. A

^a For simplicity, in the South African examples all these facilities are referred to as “clinics”.

physician also should make periodic visits to each clinic and see patients with more complicated problems. These norms have not yet been met in all areas of the country.

South Africa formalized a community health worker programme in 2004. Where possible, community health workers address the emotional and physical health needs of people in their geographical area and refer to higher levels patients who need additional care. Certain outlying rural areas have relied on community health workers for some time; it is estimated that as many as 40 000 informal community health workers exist across the country. With the growth of the HIV/AIDS epidemic and an emphasis on home-based care, additional workers (usually volunteers receiving small stipends) have been deployed in communities and are providing support and health care.

Mental health

Since 1997, primary care for mental health has been the official policy of the national government. Following adoption of the national policy, all provinces engaged in improving mental health services at community level and integrating mental health into primary care. A national programme for training in primary care was developed to facilitate this process.

According to national norms for general health care at primary level, mental health should be included in all primary care services. General nurses should be able to identify and manage patients with depression, anxiety, stress-related problems, and severe mental disorders such as schizophrenia and bipolar disorder. They should also be able to provide maintenance medication and care for people with chronic mental disorders, as well as to offer basic counselling. In addition, all clinics should receive regular visits from dedicated mental health or psychiatric nurses; have 24-hour access to a mental health specialist for consultation; and be able to make referrals when necessary.

In reality, progress has been mixed. In some areas and provinces, the majority of clinics, community health centres, and mobile units now provide mental health services. In other areas, patients must travel to hospital outpatient departments or to other designated clinics to receive mental health care. In yet other instances, mental health services are provided by a psychiatric nurse, who might be on-site only part of the time.

Barriers to full mental health integration include:

- a lack of support by general health service managers at all levels, from facility managers to district health managers;
- a shortage of mental health professionals to provide ongoing supervision and support to primary care practitioners;
- restrictions that prohibit primary care nurses from prescribing common psychotropic medications;
- a lack of funding to support and sustain mental health services in primary care.

4a. Best practice example one: integrated primary mental health services in the Ehlanzeni District, Mpumalanga Province

Local context

The province of Mpumalanga (translated as “the place where the sun rises”) is in eastern South Africa and borders Mozambique and Swaziland. It has a total land area of 76 500 square kilometres and a population of 3.5 million people. The province is 60% rural and one third of its population is unemployed. Most households use pit latrines. The average household income in Mpumalanga is around US\$ 4000 per annum.⁵

The province is divided into three local authority districts, of which one is Ehlanzeni, the site of this best practice example. Slightly fewer than 1.5 million people reside in Ehlanzeni. Although it is the most urban of the three districts, much of Ehlanzeni remains rural and many must travel long distances for health care – especially hospital-based services. Mpumalanga has 28 public hospitals (9 in Ehlanzeni), 221 fixed clinics (68 in Ehlanzeni, including 6 that provide 24-hour services), and 91 mobile clinics (22 in Ehlanzeni). The province has 306 medical practitioners (83 in Ehlanzeni), and 2220 professional nurses (850 in Ehlanzeni, including 315 who work in clinics and community health care centres). There is one psychiatrist in the province.

The vast majority of people who receive mental health care through the public service are poor and dependent on government disability and/or family assistance for their survival.

Description of services offered

The model for integrating mental health into primary care in Ehlanzeni varies somewhat from clinic to clinic. Differences depend on multiple factors such as the clinic’s size and location, the training and qualifications of its nurses, and the willingness of health workers to participate in the integrated model. Two models predominate (see below).

Model 1. The first model is characterized by the presence of a skilled professional nurse, who sees all patients with mental health issues. The nurse’s primary functions are to conduct routine assessments of people with mental disorders, dispense psychotropic medication or recommend medication changes to the medical officer, provide basic counselling, and identify social issues for amelioration. Patients are referred to complementary services if available, although in many cases community-based social services are sparse.

The nurse schedules a specific time each week for mental health consultations and patients know to attend the clinic at this time. These patients do not queue with patients who are attending the clinic for other reasons. General health workers are trained to detect mental disorders, but refer patients either to the designated psychiatric nurse, or to the mental health district coordinator (see below).

Model 2. In the second model, mental disorders are managed as any other health problems. People with mental disorders wait in the same queues and are seen by the primary care practitioner who happens to be available when they reach the front of the queue. Nurses are trained to assess and treat both mental and physical health problems, and patients with comorbid

problems are treated holistically. Referrals to secondary care or community-based services are made as needed.

In both models, nurses are responsible for detecting mental health problems, managing chronic mental disorders including dispensing psychotropic medication or recommending medication changes, counselling, making referrals, and intervening in crisis situations.

A district mental health coordinator (trained as a psychiatric nurse) and a medical officer offer support when needed. Functions of the district coordinator include:

- supervising and supporting general health staff with the management of people with mental disorders;
- assessing patients referred from primary care;
- stabilizing patients where required;
- recommending initiation or change of medications to the medical officer;
- assisting in psychosocial rehabilitation;
- counselling;
- making home visits;
- checking the availability of medication in clinics;
- keeping mental health statistics;
- writing subdistrict reports.

The main priorities for primary mental health care in the district are the management of schizophrenia and related disorders, bipolar disorder, and major depression. Epilepsy is managed under the rubric of general chronic diseases. Some basic counselling is offered, however because of time constraints, this service is limited. In most cases, counselling referrals are not possible due to the lack of skilled counsellors and psychologists in the area.

The process of integration

Planning for mental health in the province

Mpumalanga was created as a province in 1994. A health department was established with the task of planning and providing comprehensive health care for the province. Consistent with national prioritization, mental health was identified as one of the key areas for service development. A provincial mental health coordinator was appointed to draft a plan for the implementation of mental health care and to oversee services in the province.

Prior to the development of community-based mental health services, most patients from the area were sent to the urban areas of Pretoria or Johannesburg for treatment (averaging around 400 kilometres). Many patients resided in psychiatric hospitals or custodial facilities. Transport was expensive and as a result of the distance and associated costs, many patients lost contact with their families and friends.

Two psychiatric wards in general hospitals also existed, but were in a state of terrible disrepair. When patients were discharged from the psychiatric hospitals, they were usually down-referred to outpatient departments at general hospitals, where they received ongoing psychotropic medication.

During the Apartheid era, the region that would come to be designated as Mpumalanga Province was part of the Transvaal Province. Transvaal had a number of psychiatric hospitals, but none was situated in the geographical area that became Mpumalanga. Soon after political transition, Mpumalanga was requested to assume care of its inhabitants who, at that time, were being kept in psychiatric hospitals outside the newly-designated province. Mpumalanga, however, did not have a psychiatric hospital to which these patients could be transferred.

The decision to move towards an integrated primary care approach for mental health was motivated by a number of factors. For example:

- there was a new national policy that called for a community-oriented and integrated mental health approach;
- mental health providers and consumers in the province wanted community-oriented rather than institutional care;
- resources to build and staff a psychiatric hospital would have been difficult or impossible to obtain;
- institutional care contradicts the Constitution of the Republic of South Africa in terms of people's right to respect and dignity and non-discrimination on the basis of disability;
- international opinion, led by WHO, favoured community-based integrated mental health care and this was carefully noted.

In accordance with the new national policy, a provincial plan was developed to provide mental health services at a community level. Psychiatric units would be created, in a phased approach, in many of the general hospitals. Until then, involuntary patients, those requiring medium- to long-term inpatient care, and criminal offenders would be sent to a psychiatric hospital outside the province. When patients were ready for hospital discharge, their treatment and care would be provided by the Mpumalanga primary care services.

To facilitate this new approach, the province agreed to appoint mental health coordinators in districts or municipal areas. Their main functions and duties have been outlined above.

Financing integrated mental health care

Financial resources for mental health services are far easier to measure and distribute when care is provided as a vertical rather than an integrated service. Within an integrated financing approach, mental health care risks being sidelined from the general health care provided at the clinic. Hence in allocating resources to clinics in Mpumalanga, it was made very clear that the amounts given incorporated funding for mental health care, including staff time and psychotropic medication.

Before any allocation could be made, a decision had to be made concerning the scope of mental health problems to be managed within the primary care service. After serious consideration, it was decided that functions would prioritize the identification of mental disorders, and the provision of care for schizophrenia and related disorders, bipolar disorder, and major depression. This decision was based on careful consideration of the number of people who would require mental health care; the resulting burden if care were not provided to them; the availability of known and effective treatments for different disorders; and the staff time that would be required per patient.

It was further decided that the programme funding would be phased in over time. This decision was based not only on the availability of funds, but also on the availability of nurses. Even if there were sufficient finances to employ all additional staff who would be required to provide mental health care, the staff would not have been available to employ.

Funds were also required for training of primary care workers. Anticipated expenses included trainer fees, venue rentals and accommodation, as well as participants' time away from their clinical duties. It was agreed that training would occur in a phased approach, with around 60 nurses trained each year.

Human resources and training

The province decided to employ one psychiatrist in each district (serving around one million people). These specialists would train medical officers and supervise primary care workers and coordinators, diagnose and prescribe treatment for referred patients, attend to patients with treatment-resistant conditions, and generally oversee the clinical care of mental health in the province. They would also develop treatment guidelines and protocols, and participate in mental health planning and budgeting.

Recruitment proved difficult and in the end, only one psychiatrist could be employed in the province, and none in the Ehlanzeni District.

Psychologists were equally difficult to recruit. However in 2003, the government introduced a compulsory year of community service for a range of health professionals, including psychologists, and as a result at least two psychologists have been deployed in each district.

The province did not allow the dearth of psychiatrists to prevent the provision of mental health care. To the contrary, the lack of psychiatrists was an important driver of integrated mental health care. Ironically, many of the advantages of integrated mental health care might not have occurred if there had been an abundance of mental health specialists in the province.

Although a number of primary care nurses were qualified already as psychiatric nurses, or had taken psychiatry as part of their comprehensive nursing training course, most were out of practice and ill-equipped to provide mental health care. Training was hence regarded as an essential prerequisite.

The provincial coordinator and three subdistrict coordinators attended a train the trainer course, and then conducted the training in Mpumalanga. The course lasted 5 days and was drawn from a mental health training manual approved by the South African Nursing Council for use in primary care. Topics included the detection of mental health problems, history taking, interview skills, assessment, basic intervention skills, management of chronic mental disorders, counselling, medication maintenance, referral and crisis intervention.

During the first five years, more than 256 primary care nurses were trained in the province. By the end of 2005, 315 primary health care nurses were trained.

Psychotropic medication supply

Procurement and distribution of essential medicines, including psychotropics, was a key challenge for the primary care system as a whole. Consequently, teams of experts were established

to design and implement effective purchasing and distribution strategies. However it was the role of the provincial coordinator to ensure that appropriate psychotropic medications were included on the essential drugs list, and that the specific needs of people with acute and chronic mental disorders were addressed. Calculations were made for each clinic that was to provide mental health care, to determine the number of patients who required medication and their dosages, the estimated number of new cases that would require care, and the medication changes that might be needed for patients already receiving medication.

At the national level, an essential drug list and treatment guidelines for primary care were developed. The provincial coordinator, with a team of consultants, adapted this list to meet the requirements of the province.

Until very recently, legal restrictions have prohibited primary care nurses from prescribing common psychotropic medications. As such, these restrictions created a major access barrier for the use of psychotropics in community-based clinics. To overcome this barrier, nurses make recommendations for medication changes to the physician, who visits the clinic on a weekly basis. The superior mental health training of the nurses compared with the doctors is well-recognized and respected in the province. New legislation has just been passed and permits nurses who complete training to prescribe and dispense psychotropic medications that are on the primary care level essential drugs list. Because the legislation is new, no nurses in the district have yet received this training.

Transfer of patients to clinics and implementation

Patients and their caregivers were informed of the transition to community-based care. The range of reactions was mixed, and at times necessitated careful management by the old and new health professionals. The district coordinator and where possible, a clinic nurse, met patients together with a hospital nurse to make the transition as smooth as possible.

Certain patients were transferred from the psychiatric hospitals to the clinics. For many, leaving the hospital was traumatic and required liaison between the district coordinator and the patients and their families regarding their new treatment procedures.

Detailed medical files were also transferred to the clinic. In some cases, meetings were held between the new and old health providers to discuss particular patients and share relevant information not contained in the files.

Once the clinics started seeing patients, the district coordinator visited each clinic at least once per month, and busier clinics at least twice per month. These visits still continue. The coordinator provides support and supervision, sees patients with complex presentations, and performs other functions described earlier.

General hospital-based care is available if needed. In these cases, primary care practitioners make referrals and depending on the urgency of the situation, patients are transported for further assessment by ambulance or in police custody.

Liaison with nongovernmental organizations

Nongovernmental organizations were contracted to manage community-based residential facilities for patients who were unable to live independently and without family support. Clinics and nongovernmental organizations liaise on individual patients, to ensure that care is coordinated and that relapses are identified and addressed at an early stage.

Mental health information

Mental health data are collected and collated by the district coordinators. Information is collected on indicators such as the numbers of people seen at each clinic (ongoing and new); diagnoses made; medication provided; relapses and referrals, and attendance at clinics of patients receiving ongoing treatment. This information is useful for the clinic to monitor and improve services. For the district and provincial coordinator, the information is used to help plan future services and allocate human resources, as well as to identify potentially problematic clinics.

5a. Evaluation/outcomes for best practice example one

Services available

By the end of 2002, 50% of clinics in the district were delivering mental health services, and by early 2007, 83% of clinics were delivering these services.

For the most part, psychotropic medication is available and dispensed by trained nurses.

Staff and patient satisfaction

Views of clinic staff

Professional nurses working at primary care level (135 out of 315) completed self-report questionnaires. A subset provided additional qualitative information on their experiences.⁶ Among those surveyed, 34% had received specific training in psychiatry, and an additional 23% had received a short course in primary care for mental health.

Most nurses felt comfortable with dealing with people with mental disorders. The vast majority who did not feel comfortable had not received mental health training, and as such it is unlikely that they were attending to people with mental disorders. Of concern was that 27% of respondents thought that people with mental disorders were dangerous. Again, the majority were nurses who had not received mental health training.

Nurses' views about integrated mental health care were also assessed. Ninety per cent felt that people with mental disorders should receive services in the same way as people with any other health problem. Just over 60% felt that the integrated process was working, while 80% felt that the integrated model can work. Twenty per cent felt that they were being forced or pressured to treat mental disorders, and 62% felt that the number of health workers was insufficient for the integration process to be successful. In follow-up discussions, staff shortages were again identified as the major shortcoming of the model. A typical quote was "... integration of the mental health programme is so good; the only problem that we are experiencing is shortage of staff."

Views of patients

Five patients participated in a focus group to elicit their views. Before the integrated model was introduced, they received psychotropic medications from the outpatient department of a general hospital in the region. Each patient was now being treated within Model 1, that is: seen by the same well-qualified nurse for all their mental health-related clinic visits.

All patients expressed relief to be finished with the overcrowded outpatient hospital clinic, and satisfaction with their new clinic services. In particular, they were happy that their wait times were reduced to 15 or 20 minutes, on average. They were also pleased because the clinic was within walking distance of their homes. Compared with the hospital, they were able to make considerable savings in terms of transport, meals, and time.

On the other hand, patients felt that their physical health problems were not addressed adequately within the new model of care. They felt that their physical health problems were better managed at the hospital, because medications were more readily available.

Patients expressed mixed views regarding the quality of their treatment when their usual nurse was unavailable. Some patients experienced no problems, while others felt uncomfortable discussing personal issues with replacement nurses, whom they also felt did not understand mental health issues. One patient commented, “We dislike nurses who do not respect us because we are mentally ill. Any different way of treating us in comparison with others will definitely make us unhappy.”

One patient felt uncomfortable with being segregated from other clinic patients. He stated, “By using a back door, it is clear that we are mentally ill and cannot mix with other people. By being separated, everybody can identify us as mentally ill. We need to mix with other patients because our illness is not different from others. We wish to be together with other patients and seen to be one family and not feared. We wish to sit next to other patients in a queue. We wish to play with other patients’ children while waiting for treatment without somebody sounding a warning that this person is mentally ill and as such, unpredictable.”

Other patients disagreed. One remarked, “What matters is that we are getting our treatment quickly and we do not have to wait in long queues together with other patients. If we are mixed with others, we would be delayed for hours before being seen.”

Model 1 versus Model 2: which is more effective and acceptable?

The two models of integrated care were both found to have advantages and disadvantages.

Advantages of Model 2 are that people with mental disorder are not stigmatized, because they are treated in the same manner as all other patients. They are also treated more holistically: they are not treated for their mental health problem by one practitioner and for their physical health problem by another, but rather as people with both physical and mental health needs.

Disadvantages of Model 2 are that the general health workers are usually less experienced in mental health care, compared with dedicated mental health workers (as in Model 1). Seeing different health workers at each visit disrupts continuity of care and prevents the development

of treatment alliances between patient and provider. Because mental health patients queue with all other patients, wait times are longer.

The advantages and disadvantages of Model 1 are the reverse of those described for Model 2.

6a. Conclusion for best practice example one

Integrated mental health care in the Ehlanzeni District of Mpumalanga Province is highly functional and has been sustained for more than 10 years. Although improvements in implementation are still needed, the model is generally acceptable to most staff. Patients prefer this model to the previous approach, in which they were forced to travel long distances for treatment.

Key lessons learnt (best practice example one)

- Integrated mental health care needs to be understood flexibly. Within the relatively small district of Ehlanzeni, clinics have used different models of integration, depending on staff availability and local need.
- A nurse-led model of primary care for mental health is feasible.
- Clinic nurses need to be given a limited number of tasks. It is unrealistic to expect that they will have the time or expertise to perform all mental health functions needed in the district. Priorities must be determined.
- Training of new staff must occur periodically.
- Psychotropic medications can be made available in clinics in the same way as other medicines.
- The absence of a psychiatric hospital in the newly-formed province was a driver of primary care for mental health. At the same time, general hospital-based services continue to be essential for patients who require intensive services.
- Support in the form of district and provincial mental health coordinators has been important for the success of the service.
- Collaboration with community-based nongovernmental organizations has resulted in better care for patients.
- Regular feedback from health workers and patients has been extremely helpful in ensuring a functional service.

4b. Best practice example two: a partnership for primary mental health care in the Moorreesburg District, Western Cape Province

Local context

The second best practice example from South Africa focuses on the small town and surrounding farm areas of Moorreesburg (population: 9670 people), which is located in the West Coast Winelands region of the Western Cape Province. The region is mainly rural and under-resourced, and has a total population of 560 000 people. Health care planning for the region, including mental health care, is overseen by the Regional Director and her team. Budgets are devolved and decisions regarding resource allocation and employment are made at this level.

The main primary care clinic in Moorreesburg is the Comprehensive Health Centre. The clinic is staffed by three clinical nurse practitioners, three enrolled nurses, two nursing assistants, and

one HIV/AIDS counsellor. Additional services include occupational therapy, physiotherapy, 24-hour labour and delivery, and medical officer consultations.

Description of services offered

General primary care nurses provide basic mental health services in the primary care clinic, and specialist mental health nurses visit the clinic to manage complex cases and provide supervision. A psychologist and psychiatrist also visit the clinic.

General primary care nurses assess patients for mental health concerns, conduct longer interviews if indicated, decide whether to refer patients, and provide ongoing care to patients with stable mental disorders. After assessment by the primary care nurse, certain cases are referred to the mental health nurse. Referrals are accompanied by a form stating the reasons for referral, interventions already completed, and the kind of assistance needed.

The mental health nurses visit the clinic once per month to provide care to patients with complex presentations, and to supervise general primary care nurses. In this role they are responsible for assessing referred patients; initiating treatment in consultation with the regional psychiatrist or where appropriate, the medical officer; managing patients according to their specific needs; and referring to secondary and tertiary hospitals if needed. These nurses also supervise the provision of psychotropic medication.

In addition to nursing care, a regional psychiatrist visits the clinic once every three months, and a psychologist sees patients for eight hours per week. A medical officer is available daily at the clinic.

The mental health nurse and psychologist are based in an administrative regional office in Malmesbury, 40 kilometres from the clinic, while the psychiatrist is based in an administrative regional office in Paarl, 70 kilometres from the clinic.

In total, 161 patients attend the clinic for ongoing management of their chronic mental disorders.

To promote continuity and quality of care, a protocol was developed to guide all practitioners in appropriate use of the different service levels.

Patients would be treated by a primary care nurse if they suffered from epilepsy without a comorbid mental disorder; if they were stable and already seeing the nurse for general medical conditions; or if they had intellectual disabilities without a comorbid mental disorder or behavioural difficulties.

Patients would be treated by the mental health nurse or psychiatrist if they were high risk, taking antipsychotic psychotropic medications; had bipolar disorder; were at risk of harm to self or others; or with a history of repeated physical aggression.

Patients with stable mental disorders could be transferred back into the care of the primary care nurses if they had not been hospitalized for a mental disorder in the previous two years; had not changed medication in the previous one year; did not have a history of serious aggression; had adequate social support; and had a record of monthly clinic attendance and good

adherence to medication. In these cases, the mental health nurse would complete a referral form, introduce the patient to the primary care nurse, and ensure that the primary care nurse had access to the secondary-level medical file for further information, if necessary. Following back-referral, patients would be evaluated monthly by the primary care nurse and annually by the medical officer.

The process of integration

The rationale behind the change

Before 1997, when the new national mental health policy was adopted, mental health care in the region was provided through a psychiatric hospital some distance away, and by a mental health nurse who travelled to clinics on a monthly rotational basis. Psychotropic medications were supplied from the psychiatric hospital to the mental health nurse, who then transported them to the clinics. Most patients were stabilized and prescribed medications in the hospital before being transferred to the community-based service.

Following adoption of the new mental health policy, health workers had some concerns about how integration would be implemented, but also saw several potential advantages to this new model of care. They realized that primary care would result in improved identification and treatment of mental disorders, and would increase access while reducing potential stigma.

Managing the transformation

A community-based psychiatrist was appointed for the region in 1997. One of his first tasks was to collaborate with local health workers, community members, and the regional health planning team to develop a system of community-based mental health care.

A number of consultative meetings exposed important barriers to be addressed: some mental health nurses felt their positions and authority would be undermined; primary care workers and community members felt that quality of care might be compromised; and regional health authorities did not view mental health issues as relative priorities. The psychiatrist, too, expressed concerns, including that the policy might lead to “overintegration” of mental health into primary care; that primary care workers were already overstretched and mental health services might be reduced to pharmacotherapy; and that some primary care workers would not be able to provide the human element needed for mental health consultations, even after training. Concern was further expressed by a number of people that primary care nurses lacked the skills and experience of mental health nurses.

From these discussions, it was decided that the existing community-based services would need to be consolidated while mental health services were integrated into general health care. Substantial training would also be required. To meet these aims, a new mental health team was established to provide specialized mental health services, while also training, supporting and supervising the primary care nurses in basic identification and management. The mental health team consisted of one psychiatrist, eight mental health nurses, one full-time psychologist, and several other psychologists who provided specialized services.

Training

Two types of courses were designed: the first was intended for primary care nurses who had some previous training in mental health; the second was for primary care nurses with no previous mental health training.

The specific aims of the training were to ensure basic competence in the management of patients with stable mental disorders, and in the assessment and referral of patients with common mental disorders.

Supervision

Mental health nurses are supervised by the regional psychiatrist, who is always accessible for urgent consultations. A care plan is developed for each patient with a mental disorder. The mental health nurses are responsible for initiating treatment and providing care until the patient meets criteria for being devolved to general primary care nurses.

Support is provided to the primary care nurses through regular visits by the mental health team to the clinic; in-service training; and efficient and accessible referral and back-referral to and from mental health specialists.

Close links with management in the district

The mental health team holds monthly meetings with the managers of the regional health service to discuss overall clinical priorities and to address the mental health budget, which covers the salaries of the team, as well as training, medication, and equipment. Additional meetings are held at district level to coordinate and monitor medication supply. Management supports this process by insisting that interruptions of medicine supply are unacceptable.

5b. Evaluation/outcomes for best practice example two

Staff satisfaction

Primary care practitioners are generally satisfied with the inclusion of mental health issues into their area of work. They appreciate the regular visits by the mental health nurse and the psychiatrist, who provide ongoing in-service training as well as support for complex cases.

The general primary care nurses found the mental health training extremely useful and reported that it increased their confidence and skill base to undertake their clearly delineated functions.

Some problems have been experienced. On a few occasions, medication delivery has been delayed. Time and transport problems have hindered nurses' ability to conduct home visits and provide psychosocial rehabilitation services. Social work services and resources have also been limited, complicating recovery of some patients.

6b. Conclusion for best practice example two

This primary care model for mental health is based on a partnership between a mental health team and general primary care practitioners. Importantly, primary care for mental health and secondary support services are provided mainly by nurses – although with different skills and qualifications. A psychiatrist is also available to see patients once every three months. Where

medical care is needed, nurses can refer patients to a medical officer, who visits the clinic daily.

Although this example is drawn from the small area of Moorreesburg, the same service is offered throughout the district. The model is being examined currently at a provincial and national level for possible implementation in parts of the country with similar characteristics.

This model of primary care for mental health is different from that of Ehlanzeni – the previous South African example. Although evolving within the same South African policy framework, Moorreesburg has made greater use of mental health specialists while using primary care nurses to identify mental health problems and provide treatment for patients with stable disorders.

The diversity of these two models, within the same national policy framework, demonstrates that when designing and implementing mental health services it is always essential to carefully examine local resources, opinions and needs, and to define solutions that are tailored to the specific situation.

Key lessons learnt (best practice example two)

- National and provincial policies for integration of mental health into primary care provided a context for discussions between mental health specialists, primary care workers, and district health management on how this could be best achieved, and what type of training and support would be required.
- It was helpful to hire a regional psychiatrist at an early stage of the process. The psychiatrist was accountable to the Regional Director (who manages primary care services and district hospitals), and the work description included training, service provision and service development. This effectively shifted psychiatric consultation from a hospital-based outreach activity to an integral part of the district health system.
- Support from a mental health team was central to the overall success of the programme.
- Agreements and regular ongoing discussions with district health managers were important to address problems and ensure an adequate budget.
- In situations where community-based mental health nurses already exist, integrated primary care for mental health should incorporate and leverage their expertise.

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