Research **Newsletter**

'MENTAL ILLNESS: CHALLENGES IN HEALTH SERVICES'

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Contents

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Editorial

This 14th issue of the Western Cape Provincial Health Research Newsletter addresses mental health, a historically neglected but common health issue.

The recently compiled provincial Burden of Disease report (2019) highlights challenges with quantifying the magnitude of mental illness. The last South African Stress and Health Survey (SASH), conducted in 2004, found that the 12-month and lifetime prevalence of mental illness in the Western Cape was 39.4%, the highest of all provinces in South Africa. Despite poor information, since 2018, a Provincial Mental Health Strategy and several interventions were put in place to address mental illness. Interventions include improved management of specialist service waiting lists, strategies to improve patient counselling and retention. In addition, several service-model project at different facilities/sub-districts/districts are underway with promising results.

This Newsletter details the various presentations delivered by local mental health experts at the 2019 Provincial Health Research day. The articles present information regarding the national burden of mental health conditions, the extent and management of co-morbidities such as HIV or diabetes with mental health; the magnitude of common mental disorders during pregnancy; the epidemiology and management of severe mental health disorders; and the roles of non-specialised cadres of health workers in the management of mental illness.

The first article is a succinct summary of **Lund's** keynote presentation and discusses the epidemiology of mental ill-health in South Africa. We are reminded that the health system's mandate and responsibility includes the whole population and not only those with diagnosed mental illnesses and those at risk of mental ill-health. **Sorsdahl** and colleagues presented one of four round tables, and they focussed on the complex issue of chronic co-morbidities such as HIV and diabetes. These conditions are exacerbated by the high prevalence of mental health disorders, such as excessive alcohol consumption. The third article, from **Honikman's** roundtable, focuses on common mental health disorders in pregnancy and the year post delivery. Their research found that despite the perinatal period being a time of frequent contact with health services, these conditions remain undetected and poorly managed in health service delivery. They are top contributors to the global burden of disease and result in impaired social functioning.

The prevalence of severe mental disorders in the Western Cape adult population is significant and contributes substantially to the high rates of in-patient mental health populations. Despite this, these difficult conditions have not been the subject of mental health policy and service planning, which was discussed in **Parker's** roundtable. The final article reporting on **Sibeko**'s roundtable, addresses the challenge of the shortage of specialized mental health care providers. In light of this challenge, he argues that non-specialist health workers such as community health workers (CHWs) could be trained to address many common disorders such as HIV, TB, the sequalae of violence and mental health problems.

We hope that these articles will stimulate service providers and managers to explore and implement innovations that addresses the huge burden of mental health disorders affecting our communities.

Sabela Petros, Deputy Director: Health Research

'Mental Illness:
Challenges in Health Services'

The burden of Mental Health illness in South Africa

This article is based on the key-note presentation by **Prof Crick Lund** at the Provincial Health Research Day in October 2019.

Prof Lund reminded us that the responsibility of the health system for mental health includes that of the whole population and not only those with mental illness and those at risk of mental illness. This is depicted in Figure 1. There are a variety of measures to describe disease burdens and interventions that address them. These are drawn from epidemiology and health economics. Interventions to mitigate mental disease burdens require a comprehensive approach to mental health: mental health promotion, prevention, treatment and rehabilitation. Importantly, research can evaluate the impact of interventions. Research can inform health policy, both in its content and implementation. Research can promote health system design, innovate and improve delivery thus contributing to effective health services.

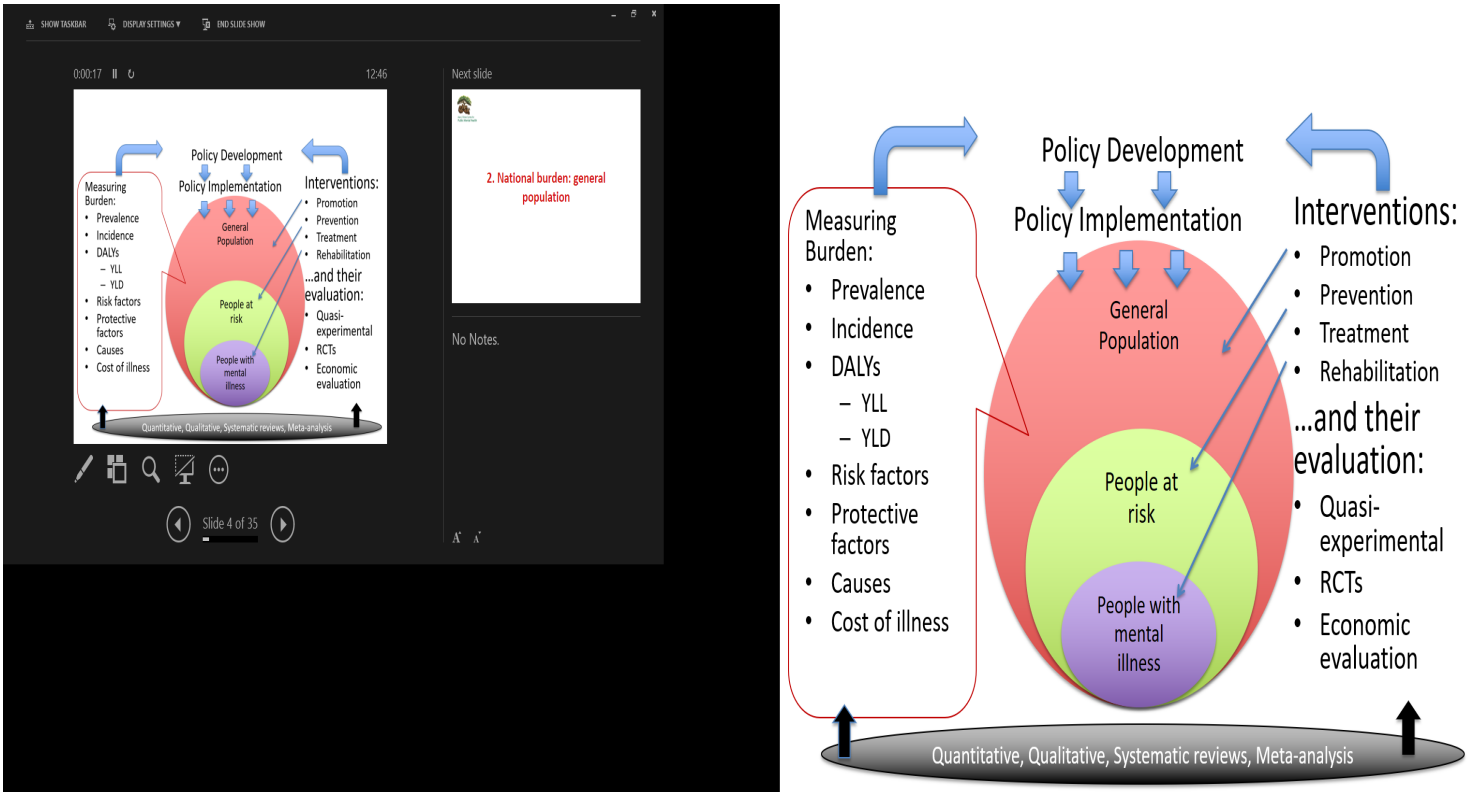


Figure 1 Public mental health approach

Mental health burden in South Africa

Globally the proportion of the total disease burden attributable to mental health disorders is growing. Mental illness is common in South Africa and the proportion of people who develop a common mental health disorder each year – the 12-month prevalence – is 16.5%.[1] This increases to 30% for any mental disorder over a person's life-time.[2] For common disorders such as anxiety, mood and substance abuse disorders, the life-time prevalence are 15.8%, 9.8% and 13.4%. Of concern, there is a growing burden of suicide, which represents the tip of the iceberg for mental health. In 2016, South Africa had an estimated 12.8 suicides per 100 000 of the population, affecting more men than women. South Africa is ranked 46th for suicides globally.

Mental health issues are common among people with other health problems. For example, people living with HIV (PLHA) are twice as likely to suffer from depression than people generally. A study among PLHA starting ART in Cape Town, there were high proportions with mild cognitive disorders (42%) or dementia (25%).[1] Studies conducted in the Eden district found that 80% of people with depression had other disorders.[2]

High risk populations

The age-group most at risk for common mental health problems are adolescents and young adults. They bear the highest risk of anxiety, depression, eating and substance use disorders and schizophrenia.

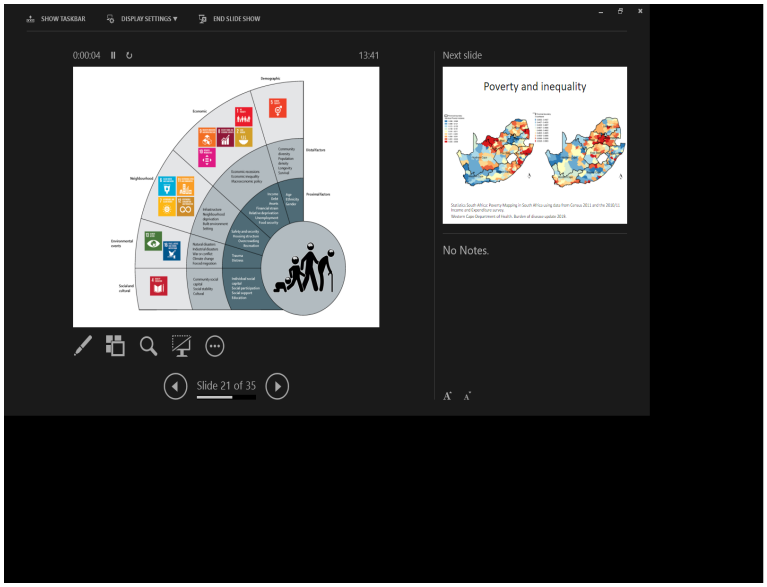
Mental health issues affect people throughout their life course. For example, peri-natal women are at high risk of depression, with 40% of antenatal women being depressed in KwaZulu-Natal and between 35-45% found to be depressed post-natally in Cape Town.[3] There are critical implications for child health as low-birthweight, inadequate childcare and bonding can affect a child's emotional wellbeing; their physical and cognitive development. This was found in the Drakenstein cohort study,[3] where there are high rates of maternal depression as well as other risks such as alcohol use, smoking, intimate partner violence and mothers' own history of childhood trauma. Researchers found that there were significant developmental delays among children at 2-years. These delays ranged from motor and language delays as well as cognitive delays affecting over 55% of children.[4]

A study in Western Cape schools published in 2016,[5] found that adolescents had high rates of depression (41%), anxiety (16%), and post-traumatic stress disorder (21%). These occurred along a social gradient with poor black adolescents being most affected.

There is poor data about dementia in South Africa. Nonetheless, in 2015 we estimate that 186 000 suffer from dementia, placing a huge burden on their families and social services.

Social determinants

Mental health problems are the result of both exposures to life events that precipitate mental disorders and the ability of people to cope with such events: both people's exposure and their vulnerability. These events do not occur uniformly in society, and are determined by structural, social and economic conditions that confer disadvantage or advantage. These factors are depicted in Figure 2 below.



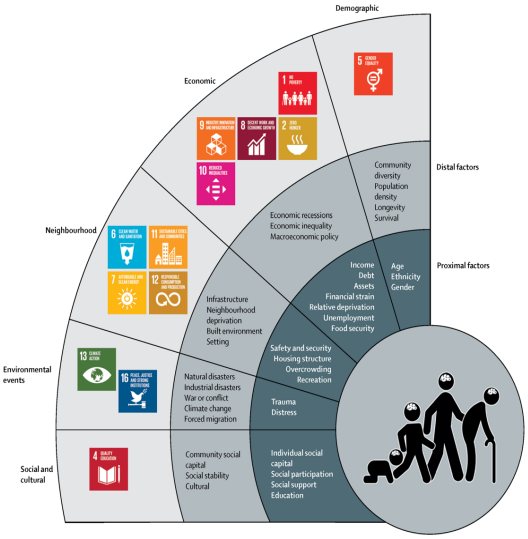


Figure 2: Social Determinants of Mental health[6]

Cost of mental illness

Recent research has found that only 5% of the South African 2016-7 health budget was spent on mental health services, and most was spent on in-patient care.[5] The Western Cape spent USD22M on mental health care, which is 7.7% of its health budget. The expenditure by province is given in Figure 3. As Gauteng and KwaZulu-Natal have larger populations, their budgets and expenditure are larger. Of concern are the high re-admission rates across the country with over 24% of people being readmitted within 3 months. This is important because investments in continuous community-based care after discharge could reduce re-admissions and yield significant cost-savings to the Department of Health.

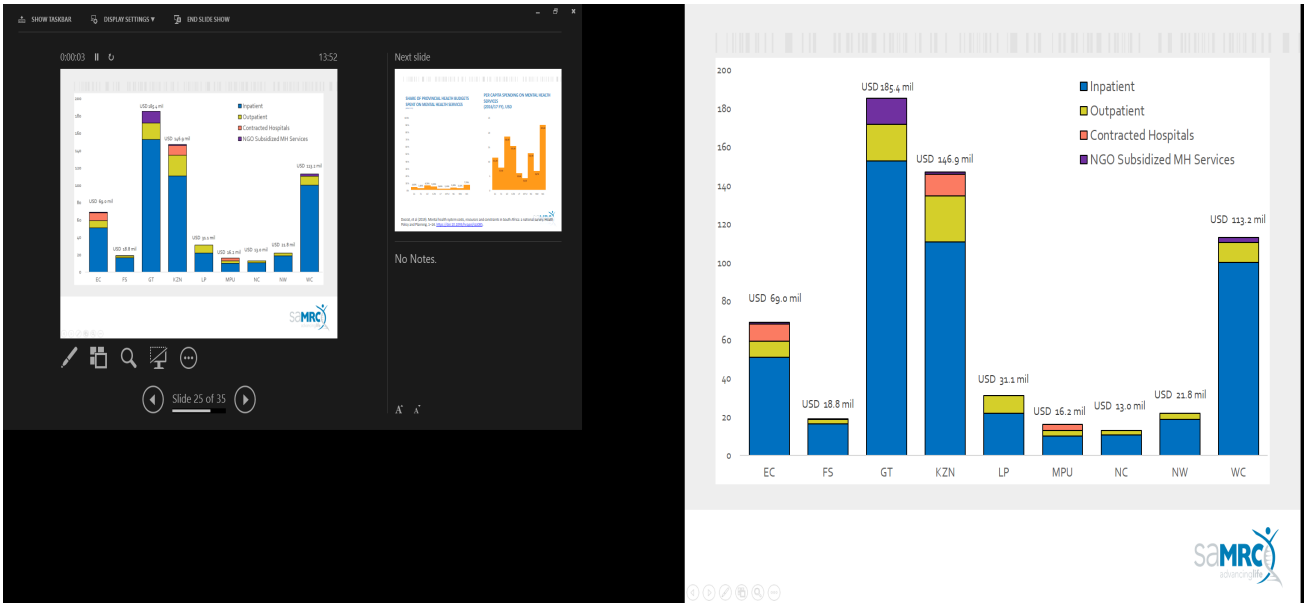


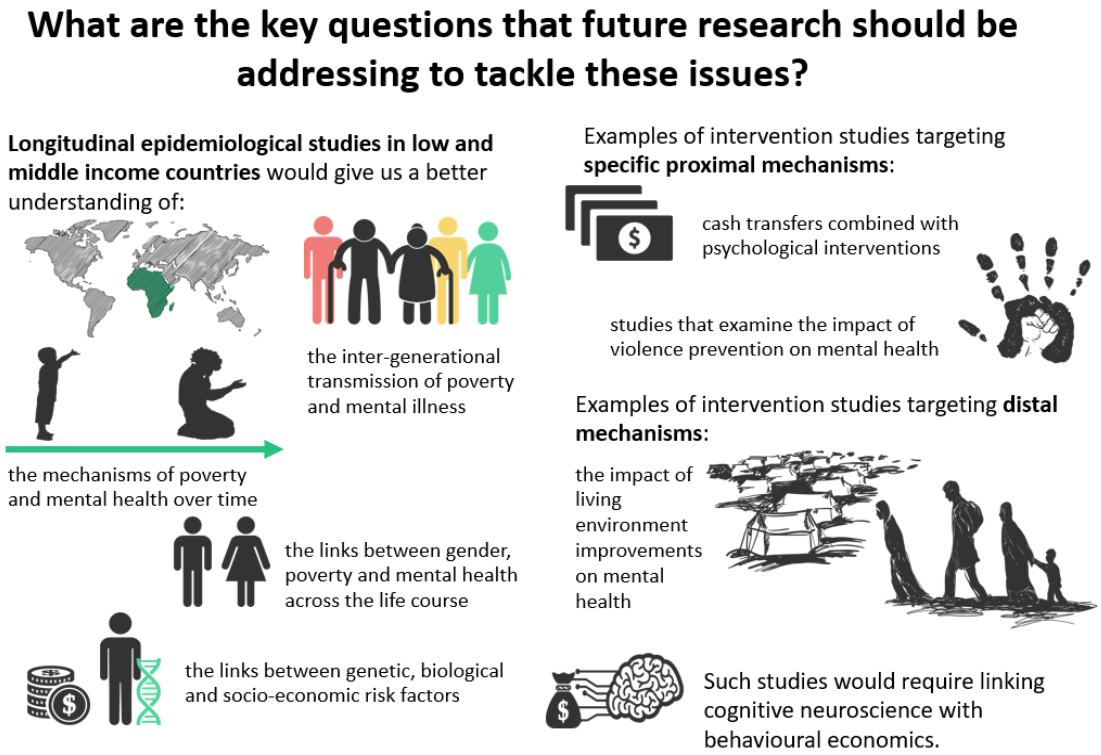
Figure 3. Expenditure by province on mental health

Mental health disorders have huge impact on people's lives. It is estimated that mental health disorders account for 18% of healthy lives lost to disability. Anxiety and depression prevent people from assuming their usual roles. Anxiety reduces a sufferer's productive life, on average, by 28 days per annum and for depression, this is 27 days. This is also an economic loss for countries. For South Africa, this costs around USD3,6 billion or 2.2% of our Gross National Product annually. These figures dwarf the money spent on mental health services. Consequently, it costs more NOT to treat mental illness than to treat it.

The way forward

We have some knowledge gaps about important disorders that require research. In the area of child health, there is scant information about childhood developmental and behavioural dosorders. There is insufficient data on the burden of severe adult mental health disorders such as schizophrenia and bipolar disroders, and also dementia. There is little information about trends over time of the magnitude mental health disorders in South Africa. Consequently, there is an urgent need for up to date nationally representative data that includes information regarding disease burdens by socio-economic disadvantage and location. Such information will facilitate service planning, enabling the provision of appropriate services, to address mental health needs.

There are important policy options that need discussion.These are: Do we invest in mental health care services? Or should we focus on interventions that address the underlying social determinants of mental health and ill-health? Prof Lund recommended that *both* are required. We need multi-sectoral interventions that address *both* the causes and consequences of mental illness. We need interventions that address upstream determinants of mental health as well as downstream service requirements. Research is required that examines how poverty contributes to mental illness; the impact of exposure to violence on mental disorders; and the role of genetics and biological factors on mental ill health. Collaboration between policy-makers, researchers and service providers is critical.



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Integrating mental health into chronic disease care

This article covers the presentation at a 'Roundtable' discussion forum at the October 2019 Provincial Research Day by **Prof Katherine Sorsdahl, Dr. Petal Petersen, Dr. Carrie Brookes-Sumner and Mr. Yuche Jacobs** and summarises the discussion that followed. These researchers are based at the Alan J. Flisher Centre for Public Mental Health and the Alcohol, Tobacco and Other Drug Research Unit at the South African Medical Research Council.

Increasingly, the challenge of chronic co-morbidities occupies the global public health agenda. In South Africa, high rates of chronic diseases such as HIV and diabetes are compounded by a high prevalence of mental disorders. Many people who live with a chronic illness also suffer from mental health problems, such as alcohol abuse, anxiety and depression. This can affect their adherence to treatment for their chronic illness(es). Project MIND, is a collaboration between the South African Medical Research Council (SAMRC), the University of Cape Town (UCT), Oxford University and the Western Cape DoH. The purpose of Project MIND is to develop two collaborative care models for mental health and chronic disease care and to test which of these models is the most effective for improving mental health and chronic disease outcomes.

The Project MIND intervention

Project MIND compared *two* collaborative care models with treatment as usual: a "dedicated" model, where a counsellor was added to the team, and a "designated" model, where facility-based counsellor was assigned to do counselling on top of their usual workload. Each counsellor received five days of training, with pre - and post - training proficiency testing. Counsellors also had weekly supervisor and debriefing with opportunities for booster training. In both models patients that screened at risk for alcohol or depression were offered three sessions with one booster session that could be completed over the phone. Sessions were between 25 and 60 minutes long. The counselling program was based on previous interventions such as 'Project STRIVE' and 'Teachable Moments'. The programme aimed to help patients solve problems, deal with intrusive thoughts and worries, as well as accept problems that cannot be changed such as a chronic disease diagnosis and death of a loved one.

Results

A total of 1348 patients were recruited into the project: 76% were female; 40% had diabetes, 54% lived with HIV and 6% had both chronic conditions. About 48% had hazardous drinking habits and 78% had probable depression. The study had a good retention rate, with 75% completing all three sessions. We will be seeing the outcome results of this study in April 2020.

Experiences of counsellors

The facility based ("designated") counsellors experienced a change in scope of work. The benefits they observed were that patients were more compliant to treatment, and they were able to probe more into what non-adherent patients needed. They particularly valued the training that included role plays and the structured support provided by the registered counsellors.

Experiences of patients who participated in Project MIND

During the first session, patients admitted to having difficulty accepting their diagnosis, and anger at having HIV. They had relationship difficulties with partners, children and parents, who were battling with their own health problems, such as drugs and gambling. Many of them experienced violence and had complex trauma histories.

Through the intervention, patients felt empowered by having better information on health literacy and alcohol. They felt internal motivation to be healthier, and reported that they had learned new skills, which helped them to accept their HIV diagnosis and control their anger. Importantly, patients experienced an alleviation of their symptoms of depression and reduced their drinking. They also reported improved adherence to ART. They experienced reported positive life changes in their employment status, as well as in their relationships with partners, children and community members. Patients wanted to share their new knowledge and help other community members, such as peers, friends and family members with similar issues. They valued the intervention and wanted it to continue.

Conclusions and recommendations

In South Africa, task-shared interventions that capacitate non-specialist health workers at primary care level to address life problems and risky behaviours that impact on adherence and disease management are critical to manage the large burden of chronic illnesses and mental disorders.

However, to ensure health care workers buy-in requires their input on training, that their concerns are heard and their work is recognised. For example, in this project the counsellors made several suggestions on what could be done differently for the intervention to work better. They would have preferred less intensive training over a longer time period. And they would like the training to involve more skills rehearsal and role-play. They added that they needed more training content on dealing with substance abuse in patients. They recommended more supervision and debriefing and suggested that group debriefing sessions would be beneficial.

The Western Cape Government: Health (WCG:H) is championing the idea of 'Whole of society approach' (WOSA) to address health challenges. This approach accords with the South African Mental Health Policy and Strategic Framework (2013-2020), which promotes non-specialist delivery of psychosocial support services on the chronic disease care platform. This points to the importance of more lay people being involved in the management of chronic health conditions and mental health problems. As this intervention has shown, such counsellors could be a key human resource for future implementation of this type of intervention.

Acknowledgements

Thanks to Carla Pienaar for her notes on which this article is based. Project MIND is funded jointly by the British Medical Research Council, Wellcome Trust, Department for International Development, the Economic and Social Research Council, the Global Challenges Research Fund (MR/M014290/1)

Integrating mental health into maternity care: lessons from the Perinatal Mental Health Project

This article covers the presentation at the 'Roundtable' discussion forum at the October 2019 Provincial Research Day by **Assoc Prof Simone Honikman** and summarises the discussion that followed. Simone Honikman is director of the Perinatal Mental Health Project based in the Alan J Flisher Centre for Public Mental Health in the Department of Psychiatry and Mental Health, University of Cape Town.

Background

Common mental disorders (depression and anxiety) in pregnancy and the year post birth are neglected in health service delivery, despite the perinatal period being a time of high contact with health services. These mental health conditions are top contributors to the Global Burden of Disease and are associated with a significant degree of impaired functioning.[1] However, there is strong evidence that these conditions may be managed cost-effectively in resource constrained settings. [2-4]

The prevalence of perinatal depression in high-income countries (HIC) is between 11-12%,[5] and higher – 16-20% - in low- and middle-income countries (LMICs).[6] In South Africa, the prevalence of perinatal depression is very high: between 22-47%.[7, 8]

Antenatal and postnatal anxiety and depression are associated with a range of adverse child outcomes; physical, cognitive as well as emotional.[9,10,11] Antenatal depression is associated with low birth weight and pre-term delivery, and mothers suffering with depression are less likely to take up immunisation and other health services.[12] They are at increased risk of domestic violence, increased substance use, and are less likely to adhere to treatment protocols including PMTCT.[13,14] Poor child outcomes associated with maternal mental health problems may be mitigated by the presence of another mentally well caregiver for the child.[10]

In 2002, to address mental health problems amongst pregnant women, the Perinatal Mental Health Project (PMHP) began working first at Mowbray Maternity Hospital, at the Liesbeeck MOU (Midwife Obstetric Unit). Over the years, the project integrated mental health services into four MOUs in the Western Cape. The PMHP then changed its focus towards system strengthening and supports others to integrate mental health (MH) into maternal health services and other public health platforms. Hanover Park MOU remains a demonstration and learning site where the PMHP operates an integrated service. Its service design model is: screening, referral, counselling, postnatal follow up with case management and, liaison with stakeholders, via counsellors.

The services offered begin at the first booking visit, until one-year post-partum. After this, if needed, clients are referred to relevant services such as community mental health services and relevant non-governmental organizations (NGOs). The stepped-care model has been described in several publications.[15, 16]

Work at Hanover Park MOU

Research conducted at Hanover Park MOU has focused on the prevalence of common mental disorders and associated risk factors among pregnant women attending antenatal care. PMHP recruited and interviewed 376 pregnant women at their booking visit using the Mini-International Neuropsychiatric Interview (MINI) tool to assess for depression, anxiety and suicidal ideation. Mental health screening data and socio-demographic data were also gathered. A fifth of the participants had depression,[8] a fifth suffered from anxiety,[17] a fifth had substance use disorders (SUDs)[18] and, comorbidities were high. Surprisingly, over half of the participants who were actively suicidal, had neither depression nor anxiety.[19]

The researchers argue that, in this research site, people faced chronic trauma and deprivation, and that women who considered suicide may not be depressed or anxious. Further research is needed to identify what lies behind suicidal tendencies. They maintain that asking about suicidality should take place in addition to asking about symptoms of depression and anxiety. Hence, screening for suicidality requires a separate screening item that this is not embedded in questions and tools for depression and anxiety.

The research conducted at Hanover Park lead to the development of a validated screening tool for depression, anxiety and suicidality[20, 21] which is now incorporated into the Maternity Case Records (MCR).

Findings from Hanover Park study

Between July 2015 to December 2017 the service was offered to 8272 pregnant women. Only 20% declined mental health screening and of those screened, 33% qualified for referrals. While 83% accepted the offer of counselling services, 77% attended the session and 2.7% were referred to other organizations and/or professionals within the health system. Problems identified at counselling were a lack of primary support (80%); poor social environments (55%); health/medical problems (36%); life cycle transition issues (55%); psychiatric problems (48%); and, problems in more than one category (84%). It became clear that the counsellors needed mental health as well as social work skills because they had to liaise with stakeholders such as shelters, mental health teams, NGOs and families.

Post intervention

At postnatal follow-up consultations, the project assessed 961 mothers, who had received counselling, for depression and anxiety symptoms and for the degree their presenting problem had resolved. The prevalence of symptoms of depression and anxiety had significantly diminished after the intervention, suggesting that the service made a difference. However, there is the possibility that symptoms could have resolved naturally over time.

The intervention was acceptable for staff and clients. Staff voiced relief that they had a counsellor on site who is part of the team, who assisted them with the social and emotional issues that impacted on service users. But, for mothers themselves, fear of gossip, judgement and trust in the community meant that mothers needed reassurance that the service is a place of safety and confidentiality.

They concluded that the way screening is done is critical and must communicate care, safety and confidentiality. This will lead to women providing valid screening responses and taking up referrals.

Regarding adolescent mothers in the project, a small qualitative study was conducted (in press). Adolescents face a 'double stigma' about mental health and teen pregnancy and would prefer individual sessions over group work, due to a fear of gossip.

Health systems lessons learnt

The PMHP has identified several service design components which may inform the development of other health service and system interventions:

- **Prepare and maintain the service environment** – relationship building and active collaboration with all staff, including administration personnel; building buy-in, understanding the micro-culture and context.
- **Build capacity of maternity staff** – increasing their mental health knowledge, empathic engagement skills, and provide compassionate care in labour. This requires a collaborative, participatory training approach which includes strategies for provider self-care. The PMHP training approach incorporates self-reflection, theatre training methods, film and multimedia.
- **Address the stigma** surrounding mental health, which is a barrier to uptake of care. This can be achieved through the distribution of engaging Information Education and Communication materials, incorporating mental health screening into routine history-taking procedures, basic psychoeducation of clients and avoiding stigmatising language such as 'mental'.
- **Train staff in the art of referral** – training of staff to maximise uptake of referrals, as mothers with mental health conditions face challenges in taking up care. Mapping of resources is crucial and initiating and maintaining relationships with other service providers greatly assists in the efficiency and effectiveness of referral process.
- **Offer brief mental health counselling services** (PMHP averages 2.8 contacts per mother) and activate social support as a critical intervention component. Institute postnatal follow-up assessments at 6-10 weeks, mostly telephonically using a standard assessment tool. Offer ongoing counselling based on the assessment.
- **Care for the counsellor** is an important investment, through peer and individual supervision. Supervision should be regular and scheduled and, ongoing professional development and support builds loyalty. Additionally, regular mental health days for counselling staff add value.
- **Embed monitoring and evaluation** into routine work and involving the full range of stakeholders in the service.

Conclusion

Healthy relationships are the central element and tool for recovery for the common mental health conditions. South Africa has a very high prevalence of these disorders in pregnancy and in the year postpartum. These conditions impact social functioning and perpetuate social adversity, but they can be managed through an integrated and stepped-care approach.

These studies demonstrate that it is feasible, acceptable and effective to integrate a multi-component mental health service into routine maternity care.

Acknowledgement

Thanks to Fadia Gamieldien for her notes on which this article is based.

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Managing severe mental illness appropriately

This article is based on the roundtable presentation by **Dr John Parker** and the discussions that followed. Dr Parker is a psychiatrist at Lentegeur Psychiatric hospital, in Mitchells Plain. He is the founder of the Spring Foundation and is affiliated with the University of Cape Town.

Introduction

Despite mental health being a leading contributor to the global burden of disease, mental health policy has been neglected. Severe mental health disorders, such as non-affective psychosis, bipolar disorder and substance-induced psychotic disorder, are difficult to manage and contribute substantially to the high rates of in-patient mental health populations.

In the Western Cape, the prevalence of severe mental disorders in the adult population is significant. For example, in the setting of the availability of 1091 'acute beds' in psychiatric and regional hospitals, a modeling exercise predicts 45 287 admissions amongst the population annually. This means an average length of stay of 8.8 days per patient per bed at all levels of the system. This underestimates the need for acute mental health beds. A recent Lentegeur Hospital study demonstrated high admission thresholds because of violence and psychosis; the significant contribution of substance use requiring acute admission; depression, HIV and other medical causes also requiring admission; with the private sector contributing minimally. Consequently, the treatment gap for severe mental disorders is high: between 51-75%.

Unless this treatment gap is addressed, developing primary care mental health services will further uncover the untreated burden of severe mental disorders which will result in more admissions. With time, we will need to implement higher thresholds for admission. Evidence suggests that community interventions such as a 'crisis Intervention' will have little effect as severe cases will require admission in any case.

Addressing the burden of severe mental health

Managing severe mental disorders and increasing admissions requires a *situational analysis* that quantifies the size of the problem and challenges experienced by the public sector health service in managing severe mental disorders. Overcrowded emergency and mental health units, long waiting lists, the high prevalence of substance-related disorders, together with violence and behaviour disturbances are key drivers. In addition, assessment of the infrastructure, staffing and skills capacity together with the mandate of mental health care at the different levels in the public health services are required to fully understand the situation.

Then, a *needs assessment* could determine what is required to achieve adequate capacity to effectively manage severe mental disorders. At a district hospital level, improving emergency management, particularly for violent and aggressive patients, would contribute to efficiencies. Better coordination with district social services could help prevent relapses and readmissions. At specialist levels of care and post-discharge, interventions should focus on improving the throughput of mental health care users; and again, prevent relapse and readmission. Interventions for the prevention of relapse and readmission may include community-based interventions, deinstitutionalisation and recovery.

Evidence from other countries

Evidence shows that community-based interventions have the potential to achieve these efficiencies. European studies show that generalist services for managing mental health care add value. However, the evidence supports such approaches for managing depression but not for other severe mental disorders.

The preferred route for severe mental disorders is generalist services coupled with 'case management'. This approach promotes a multidisciplinary team in the care of the mental health care user, regular contact and broad, shared responsibility for health and social care. It is essential to have the capacity to stay in touch with individual cases of severe mental illness and to provide tailored information to support and coordinate their care throughout the system. This should result in fewer relapses and readmissions. There is good evidence for the effectiveness of 'collaborative care' models from the United States that follow similar principles.

It has been shown that 'integrated mental health services' do not work well for severe mental health disorders as these require specialised care. For example, evidence for 'assertive community treatment' (ACT) is weakening in developed countries. This is mainly because of diminished caseloads in general mental health services which are generally used as controls in studies. The United Kingdom has less than 15 clients per mental health care worker, which contrasts to the Western Cape where caseloads can exceed 200 per mental health care worker.

ACT showed positive results in a local study, where the caseloads for a three to four member team were a maximum of 25-35 clients per mental health care worker. This means that in the early stages of mental health disorders, use of 'intensive case management' would achieve better outcomes for severe mental disorders. 'Crisis intervention' (CI) is another community-based intervention which involves focussed interventions at the client's home and prevents admission and facilitates early discharge. However, research suggests that CI's impact may be primarily on voluntary admissions and for less severe cases and is less useful when thresholds for admission are high, such as in the Western Cape.

Recommendations

Community oriented interventions can assist in addressing the burden of severe mental illness. From a human rights perspective, deinstitutionalisation of clients is essential. However, the motive for such a step must be carefully considered and not done for economic reasons. Unfortunately, learning from the Life Esidimeni tragedy, deinstitutionalisation can have disastrous consequences. Significant service and community development are required before mass discharges can take place. This has not worked well in the South African context, where clients were discharged to free up space.

A community oriented model that shows positive results is the 'recovery' model. 'Recovery' has become the key underlying philosophy of mental health services in most middle- and high-income countries. Its key focus is on the restoration of meaning and purpose in the life of a person with a mental illness, whether they remain symptomatic or not.

Key to this is a focus on the restoration of a sense of connection to community, hope, identity, meaning and empowerment. This holistic model promotes the rights of a client and their empowerment, and is used in many developed countries. Evidence from many high-income countries shows that it fosters community connection and involvement. However, there is little evidence for its use and success in low or middle-income countries (LMICs).

The development of recovery models in South Africa and in the Western Cape can facilitate properly managed deinstitutionalisation. This speaks to the Community Orientated Primary care (COPC)

approach, which emphasises an integrated approach. A concern is that mental health can get lost with competing demand for health care in an integrated model.

A multi-disciplinary approach is advocated for primary care settings in the national mental health policy Framework and Strategic Plan. While mental health community teams can do 'case management', the presence of only one psychiatrist is insufficient. This can be remedied by additional training and assumption of new roles – task shifting – by other members of the team. Such inter-sectoral strategies rely on different stakeholders, such as the Department of Social Services, with responsibilities not being shouldered by the health sector alone. However, both departments are inadequately resourced and over-burdened. Together with inadequate health infrastructure and skilled health providers, this contributes to the burden of relapse and readmissions seen in the health sector. Obtaining adequate resources for mental health services may require a conditional grant to develop primary care mental health services, but needs to be balanced with the need for service integration.

Acknowledgement

Thanks to Thato Mosidi on whose round table notes this article is based.

Mental health training programme for Community Health Workers in South Africa

This article covers the presentation at a 'Roundtable' discussion forum at the October 2019 Provincial Research Day by **Dr Goodman Sibeko** and summarises the discussion that followed. Dr Sibeko is Head of Addiction Psychiatry in the Department of Psychiatry and Mental Health at the University of Cape Town.

Our context

In South Africa (SA) there is a shortage of specialized mental health care providers, despite the significant contribution of psychiatric disorders to the national disease burden. Dr Sibeko believes that community health workers (CHWs) and other non-specialist health care providers could be trained to address many common disorders such as HIV, TB, the sequalae of violence and mental health problems.

According to UNAIDS, in 2018, SA has the largest HIV epidemic globally, with 20% of all HIV-infected people reside in the country. In addition, we have 14% of all new global HIV infections and 9% of all AIDS related deaths.[1] Despite the huge treatment programme – there are 4.8 million people on ART – in SA we have 12 times more AIDS related deaths than in the USA. Coupled with this HIV problem, illicit substance use and mental disorders are responsible for considerable disability. For example, the South Africa's Stress and Health (SASH) study, the country's first national population-based survey of common mental health disorders found that among adults, lifetime alcohol use was 38.7%, tobacco use 30.0%, cannabis use 8.4%, other drug use was 2.0%, and psychoactive drug use was 19.3%. Alcohol use disorders ranked among the top three most prevalent lifetime mental disorders in the country, at 11.4%.[2]

Substance abuse disorders, TB, and psychiatric disorders are more common in people living with HIV than in the general population. Patients reporting hazardous or harmful use of alcohol and/or drug use are significantly more likely to miss taking ART which can, in turn, lead to them stopping treatment completely. They also report greater psychological distress (anxiety and depression) and low levels of family support.

In 2017, the World Health Organisation reported on the high prevalence of these physical and behavioural disorders, that health services are under-resourced, and that trained mental health providers are scarce. [3] The intersecting and reinforcing risks between harmful substance use, mental health and HIV suggest that interventions targeting HIV need to be multipronged, comprehensive and multidisciplinary. This suggests incorporating a screening programme using validated tools, followed by appropriate brief interventions and referral to treatment. In a study led by Dr Sibeko, an alternative non-specialist trainable cadre of CHWs providers[4] supervised by various health non-government organizations (NGOs) was identified jointly with the Western Cape Department of Health. These trained CHWs provide their service under supervision to increase the reach of specialized services for mental health and HIV care.[5]

The Mental health training programme for CHWs

Dr Sibeko, supported by mental health practitioners at Valkenberg Hospital together with the Western Cape Department of Health developed a mental health training programme[6] in line with UNESCO guidelines, the WHO Mental Health Gap Action Programme and the South African National framework for CHW training. CHWs from Khayelitsha and Mitchells Plain were recruited to receive an eight session (3-hours per session) introductory training in mental health, which was designed to sensitize them to mental health and substance abuse topics and management approaches. The intention was never to capacitate them to necessarily make clinical diagnoses, but to capacitate them to screen at the community level and refer appropriately as per existing supervision protocols.

The first round of training was conducted with 42 CHWs, supervised by two NGOs – one from Khayelitsha and one from Klipfontein sub-districts. The second round of training included 60 CHWs split between supervising NGOs in Strand and Mitchells Plain. There were no exclusion criteria in the selection of trainees.

Currently, on request of collaborators and organizations, an updated version of the curriculum has been rolled out across various high HIV burden regions throughout the country. Training has occurred in Kwa Zulu Natal, Eastern Cape, Mpumalanga and Gauteng provinces.

Outcomes

CHW's who were exposed to mental health training have demonstrated firstly, an overall improvement in mental health knowledge; secondly, improvement in confidence; thirdly, we found an overall positive change in attitudes, amongst trained CHWs; Finally, CHWs expressed satisfaction with the course content, the processes in the training and were grateful for the learning. In addition, CHWs felt empowered to make a meaningful contribution to their communities.

Discussion and recommendations

Roundtable group discussion centred on including additional areas into training. For example, participants voiced that it may be fruitful to incorporate other key neglected issues societal and health issues into training, such as gender-based violence and maternal perinatal mental health. Additionally, including interpersonal violence and substance abuse disorders into training are important as these are often linked. Negative social issues such as stigma should be directly covered with the aim to normalize experience of not being okay so that appropriate referrals can be made.

Some argued that developers of the intervention should ensure greater support and ongoing training for the CHWs as this is crucial to ensure project sustainability. Others commented that the training materials should be adapted and translated into all the 11 South African official languages to cover and benefit as many communities as possible. Finally, sound advice was given – that a clinical governance module should form an integral part of the training to ensure accountability, reasonable and quality standard of care by the CHWs.

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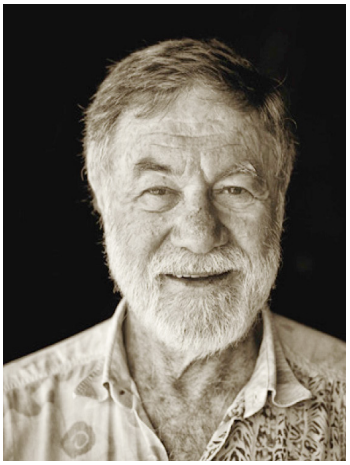
Dedication

To Professor David Sanders

This newsletter was prepared in January 2020 soon after the November 2019 Research Day, just before the start of the Covid-19 pandemic. The Public Health community had just lost a stalwart of public health, David Sanders, and this newsletter edition is dedicated to his memory.

Since David Sanders' passing, our country, society and health system have faced the Covid-19 pandemic. A long, neglected health need that has become obvious to all is mental health. This includes the mental health of health care workers, Covid-19 cases, their contacts, families and communities. As our society, communities and health systems have been indelibly changed, it is clear that mental health service must become central, and embedded in health service delivery. It is fitting that this newsletter is distributed after the devastating third Covid-19 wave in November 2021.

As a doyen of PHC we believe David would have been the first to argue for the strengthening of the PHC system as a key national response over this time. This would mitigate the devastating impact of COVID-19 on the health and wellbeing of thousands, while not forgetting long standing chronic health conditions such as TB, HIV, cardiovascular diseases, maternal and child health, malnutrition which all face South Africans, the region and the world



Prof David Sanders

Conferences and Training

10th Ethics Institute's Annual Conference, taking place on 17 May 2022 at the Indaba Hotel in Johannesburg, South Africa. For enquiries contact, Corisa Walter, Email: corisa.walter@tei.org.za

THE VALUES:

Innovation
To be open to new ideas and develop creative solutions to challenges in a resourceful way

Caring
To care for those we serve and work with.

Competence
The ability and capacity to do the job we were employed to do.

Accountability
We take responsibility.

Integrity
To be honest and do the right thing.

Responsiveness
To serve the needs of our citizens and employees.

Respect
To be respectful to those we serve and work with.

THE VISION:

Internal Vision
We are commited to the provision of
“Access to Person-Centred Quality Care”

External Vision
Open opportunity for all.

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