Proceedings of an Academy of Science of South Africa Workshop on

IMPLEMENTATION OF CORE COMPETENCIES FOR MENTAL, NEUROLOGICAL AND SUBSTANCE USE DISORDERS

27 – 28 MAY 2014
HOLIDAY INN SANDTON
JOHANNESBURG, SOUTH AFRICA

Applying scientific thinking in the service of society

ASSAf
ACADEMY OF SCIENCE OF SOUTH AFRICA

IBSN 978-0-9922286-7-5

September 2014

Published by:

Academy of Science of South Africa (ASSAf)

PO Box 72135, Lynnwood Ridge, Pretoria, South Africa, 0040

Tel: +27 12 349 6600 • Fax: +27 86 576 9520

E-mail: admin@assaf.org.za

 The Academy of Science of South Africa (ASSAf) was inaugurated in May 1996. It was formed in response to the need for an Academy of Science consonant with the dawn of democracy in South Africa: activist in its mission of using science and scholarship for the benefit of society, with a mandate encompassing all scholarly disciplines that use an open-minded and evidence-based approach to build knowledge. ASSAf thus adopted in its name the term 'science' in the singular as reflecting a common way of enquiring rather than an aggregation of different disciplines. Its Members are elected on the basis of a combination of two principal criteria, academic excellence and significant contributions to society.

The Parliament of South Africa passed the Academy of Science of South Africa Act *(Act 67 of 2001)*, and the Act came into force on 15 May 2002. This made ASSAf the only academy of science in South Africa recognised by government and representing the country in the international community of science academies and elsewhere.

This report reflects the proceedings of the symposium on Implementation of Core Competencies for Mental, Neurological and Substance Use Disorders hosted by the Academy of Science of South Africa on 27 - 28 May 2014 at the Holiday Inn Sandton, Johannesburg, South Africa.

Views expressed are those of the individuals and not necessarily those of the Academy nor a consensus view of the Academy based on an in-depth evidence-based study.

ACADEMY OF SCIENCE OF SOUTH AFRICA

PROCEEDINGS OF A WORKSHOP ON THE IMPLEMENTATION OF CORE COMPETENCIES FOR MENTAL, NEUROLOGICAL AND SUBSTANCE USE DISORDERS

27 – 28 MAY 2014
HOLIDAY INN SANDTON
JOHANNESBURG
SOUTH AFRICA

Applying scientific thinking in the service of society

ASSAf
ACADEMY OF SCIENCE OF SOUTH AFRICA

TABLE OF CONTENTS

ACRONYMS

ADHD	Attention deficit hyperactivity disorder
AIDS	Acquired immunodeficiency syndrome
APA	American Psychiatric Association
ART	Anti-retroviral therapy
ASSAf	Academy of Science of South Africa
CBO	Community-based organisation
CDA	Central Drug Authority
CPD	Continuing professional development
CSO	Civil society organisation
DENOSA	Democratic Nursing Organisation of South Africa
DHET	Department of Higher Education and Training
DoH	Department of Health
DSD	Department of Social Development
DST	Department of Science and Technology
EDL	Essential drugs list
EMERALD	European Commission's Emerging Mental Health Systems in Low and Middle-income Countries
FAS	Foetal alcohol syndrome
FET	Further education and training
FTE	Full-time equivalent
GP	General practitioner
HET	Higher education and training
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
ICDM	Integrated Chronic Disease Management
IOM	Institute of Medicine
LAMIC	Low and middle-income countries
MDG	Millennium Development Goal
MDMP	Mini Drug Master Plan
MEC	Member of the executive council
mHealth	Mobile health
MMed	Master of Medicine
MNS	Mental, neurological and substance use (disorders)
MRC	Medical Research Council

NASA	Neurological Association of South Africa
NCD	Non-communicable disease
NGO	Non-governmental organisation
NHC	National Health Council
NHI	National Health Insurance
NQF	National Qualification Framework
NWU	North-West University
OT	Occupational therapist
PC101	Primary Care 101
PHASA	Public Health Association of South Africa
PHC	Primary health care
PRIME	Programme for Improving Mental Health Care
PRIME-SA	PRIME South Africa
PSR	Psychosocial rehabilitation
PsySSA	Psychological Society of South Africa
SADAG	South African Depression and Anxiety Group
SAMA	South African Medical Association
SANC	South African Nursing Council
SANCA	South African National Council on Alcoholism & Drug Dependence
SAQA	South African Qualifications Authority
SCRC	South Coast Recovery Centre
SDG	Sustainable Development Goal
SSA	Sub-Saharan Africa
SU	Stellenbosch University
TB	Tuberculosis
TBI	Traumatic brain injury
UCT	University of Cape Town
UFS	University of the Free State
UKZN	University of KwaZulu-Natal
UP	University of Pretoria
US	United States
UWC	University of the Western Cape
WHO	World Health Organisation
Wits	University of the Witwatersrand
WRHI	Wits Reproductive Health and HIV Institute

ACKNOWLEDGEMENTS

This report is the summary of the workshop proceedings which took place from 27 – 28 May 2014 at the Holiday Inn Sandton, Johannesburg, South Africa. The workshop was entitled: Implementation of Core Competencies for Mental, Neurological and Substance Use (MNS) Disorders.

The initiative for this workshop came from the US Institute of Medicine (IOM). The main intention was to assess how South Africa can implement the candidate core competencies for MNS disorders as they are outlined in an IOM workshop summary report entitled: *Strengthening Human Resources through Development of Candidate Core Competencies for Mental, Neurological and Substance Use Disorders in sub-Saharan Africa.*

The key objectives of the workshop held in Johannesburg were: to identify and discuss the key challenges in the implementation of core competencies for MNS disorders; and to explore the best strategies and opportunities that can be adapted by the different stakeholders for effective implementation of these core competencies.

ASSAf would like to thank all the workshop participants (as listed in Annexure A) in their different roles, for enriching the discussions and sharing their experiences.

The task team that was part of the planning process for the workshop is sincerely thanked for their expert advice, guidance and assistance. Task team members were: Prof Solomon Rataemane (University of Limpopo), Dr Laila Asmal (Stellenbosch University), Prof Arvin Bhana (University of KwaZulu-Natal), Prof Inge Petersen (University of KwaZulu-Natal), Prof Bronwyn Myers (Medical Research Council) and Dr Mashadi Motlana (consultant).

ASSAf also extends its appreciation to Prof Melvyn Freeman and Mr Sifiso Phakathi (National Department of Health) for their valuable inputs and support received throughout the process.

Dr Bruce Altevogt (IOM) is thanked for all his inputs and assistance in the planning process, during the workshop and in the post-workshop phase. Other IOM staff who are acknowledged are: Dr Diana Pankevich and Ms Patricia Cuff.

The workshop and this publication were made possible through funding received from IOM. ASSAf extends its sincere appreciation to the IOM, particularly Dr Altevogt, for facilitating this funding process.

Mr Ashley Govender is thanked for undertaking the survey on The Current Status of MNS Disorders Curricula at South African Education and Training Institutions, the findings of which were presented at the workshop.

ASSAf staff, in their various roles, are also acknowledged for all their contributions to this project. They are: Ms Phakamile Mngadi, Mr Ian Shendelana, Ms Henriette Wagener, Ms Patricia Scholtz, Ms Lebo Makgae, Ms Constance Manyeli, Mr Phathu Nemushungwa and former intern, Ms Tumelo Matlala.

Scribes from Write Connection CC are thanked for compiling this workshop summary. BusinessPrint is also thanked for publishing the report.

Professor Roseanne Diab

Executive Officer: Academy of Science of South Africa

EXECUTIVE SUMMARY

According to the South African Depression and Anxiety Group (SADAG), one in six South Africans suffers from disorders such as anxiety, depression or substance use; this excludes disorders such as bipolar or schizophrenia. Due to inadequate resources in managing this burden, less than 16% of patients receive treatment (South African College of Applied Psychology, 2013).

The Academy of Science of South Africa (ASSAf) has a strong focus on health issues of the nation and through its convening influence, hosted a workshop on The Implementation of Core Competencies for Mental, Neurological and Substance Use Disorders on 27 – 28 May 2014 in Johannesburg. The workshop was attended by stakeholders from government (national and provincial), academia, non-government organisations (NGOs), civil society organisations (CSOs) and professional association/council representatives.

This ASSAf workshop follows a series of workshops initiated by the United States' Institute of Medicine (IOM) aimed at contributing towards addressing the burden of mental, neurological, substance use (MNS) disorders in sub-Saharan Africa (SSA). This included a workshop (August 2009) titled Reducing the Treatment Gap, Improving Quality of Care that was held in Uganda (in collaboration with the Ugandan National Academy of Sciences). In September 2012, a second workshop titled Strengthening Human Resources through Development of Core Competencies for MNS Disorders in SSA was also held in Uganda. It was at this 2012 workshop that the candidate core competencies for providers across all MNS disorders were developed, and the output from that workshop forms the basis for the ASSAf workshop. The core competencies enable screening, identification, formal diagnosis, referral, treatment and care of MNS disorders.

The **objectives** of the ASSAf workshop were to:

1. Identify and discuss the key challenges in the implementation of the MNS disorders core competencies within the South African health system context.
2. Explore the best strategies and opportunities that could be adopted by the different stakeholders for effective implementation of MNS disorders core competencies.

Workshop participants and speakers identified and discussed a number of overarching key challenges and gaps when it comes to addressing MNS disorders adequately in South Africa.

1. **Key challenges and gaps identified:**

- **Poor coordination:**
  - Coordination and integration of services to ensure provision of a holistic framework and services, beginning with prevention to treatment and the continuum of care are poor.
  - Peer-led or service user organisations are not as widely available as could be.
- **Limited resources** in dealing with the MNS disorders burden.
- **Stigmatisation** and **discrimination** prevent many people from accessing mental health-care services:
  - Lack of knowledge and acknowledgement of MNS disorders and the stigma attached to seeking and receiving treatment hamper effective care.
- **Prescription** of psychiatric medication:
  - There are issues of competencies related to risk management and lines of responsibility in respect to prescribing psychotropic drugs by non-specialists.
  - Some medical aid schemes do not allow non-specialists (such as general practitioners) to prescribe normal anti-depressants for a period longer than six months.
- **Baseline evidence:**
  - Reliable evidence on the situation in South Africa is required.
  - There is no nationally representative data on the prevalence of child and adolescent MNS disorders.
- **Curricula review** in order to meet the mental health-care needs:
  - Nurses will no longer be registered in psychiatric nursing (as of 2015) after they have completed the basic training and this poses a challenge for

MNS disorders.

- The role of **training** and **accreditation** bodies on a broader national scale needs to be ascertained.

2. Key strategies and opportunities for addressing the gaps and challenges

There was an extensive discussion on how the challenges and gaps identified could be addressed. The importance of leveraging available service delivery platforms, initiatives, resources and policies for the integration of MNS disorders was a main focus. There was also a focus on the National Mental Health Policy Framework and Strategic Plan 2013 to 2020, which has a task-sharing approach.

➢ Integration of mental health care

It was noted that it is important to decide whether particular priority MNS disorders should be identified for South Africa, then to identify available service delivery platforms that could be leveraged for the integration of these disorders. In this respect, mental health care should be integrated into the primary health-care (PHC) system and mental health care should become part of the job descriptions of health-care workers. In addition, collaborative stepped-care packages for each of the prioritised MNS disorders should be identified and the collaborative care approach embraced, particularly in respect of mental disorders and other chronic-care disorders, as well as a team-based approach to care that is required in task-shifting.

In response to the suggestion of prioritisation of MNS disorders, workshop participants highlighted these MNS disorders as key for South Africa: depression, non-communicable diseases (NCDs), alcohol use disorders/substance misuse, epilepsy, stroke, cognitive impairment, anxiety disorder, dementia, cognitive impairment, schizophrenia and bipolar mood disorder.

➢ Implementation of the National Mental Health Policy Framework and Strategic Plan 2013 to 2020

The National Mental Health Policy Framework and Strategic Plan 2013 to 2020 outlines South Africa's plans to address mental health-care issues. The objectives of this policy framework relate to: the implementation of a district-based mental health service aligned with primary health care; the development and

establishment of institutional capacity building; strengthening of surveillance, research and innovation; infrastructure and capacity of facilities; mental health technology, equipment and medicines; inter-sectoral collaboration between health and other sectors; human resources for mental health; and mental health advocacy and promotion, and prevention of mental illness.

Participants noted that with regard to the policy framework, the problem is that provincial representatives at the national level do not interface with the people who are responsible for implementation, which means that the work being done is not filtering down to the areas where implementation is meant to take place. It was highlighted that provincial road shows on the policy framework will be held to popularise the plan and to support provinces to develop provincial plans, secure funding and implement the plan.

The policy framework also outlines plans for addressing the issues/challenges of human resources in mental health care, and include:

- Basic mental training for all health staff working in general health settings, with ongoing routine supervision and mentoring.
- Expansion of the mental health workforce by all provincial Departments of Health (DoH).
- Task-shifting approach will be used in the development of the mental health workforce to allow trained non-specialist workers to deliver evidence-based psychosocial interventions with supervision and support from specialists.
- Capacity development for staff in the national directorate for mental health and substance abuse, and for provincial mental health coordinators in policy development, planning, service monitoring and the translation of research findings into policy and practice.
- Access to basic in-service training in mental health for non-health-related public sector workers and civil society partners at district level (including user-led service providers who can contribute to mental health care in the district).

The setting up of district mental health-care teams was also emphasised as a crucial part of the plan in addressing mental health care.

➢ **Human resource mix for integrated mental health care using the task-sharing approach: A case study**

A case study on the human resource mix for integrated mental health care using task-sharing approach was presented. This case study, based on the work of the Programme for Improving Mental Health Care (PRIME), a multi-country collaborative project aimed at generating evidence on how best to integrate mental health into PHC settings. This project is in collaboration with the DoH in one specific district, Dr Kenneth Kaunda District in the North-West province. PRIME South Africa is considering how to integrate mental health into the Integrated Chronic Disease Management (ICDM) service delivery platform, focusing on three disorders: depression and alcohol misuse co-morbid with chronic conditions, and psychosocial rehabilitation for chronic psychotic disorders, embracing the task-sharing approach.

➢ **Addressing training gaps**

Training was raised as one of the challenges during the discussions. These training gaps and challenges and how they can be addressed were the focus of two group discussion sessions (i.e. provider groups and sector groups). The provider groups included community/lay workers; non-specialist, non-prescribing providers; non-specialist prescribing providers (including nurses); and specialist providers. The sector groups were categorised as NGOs, CSOs and advocacy groups; health professional and education bodies/councils/associations; academia; and government.

A number of suggestions were made, by the different groups, on how to bridge some of the training gaps and these are summarised as follows:

- Training should be standardised and accreditation of training courses is crucial.
- Resources should be made available for referral purposes.
- The existing resources (both profession and lay) should be used adequately.
- There is a need to review prescribing protocols for the task-shifting and task-sharing approach. Telemedicine should be used as a means to facilitate prescribing in rural communities.

- Training programmes need to be reviewed and shorter training courses for non-specialists groups to screen, diagnose and manage MNS disorders should be encouraged.
- Production of specialists who will become trainers and quality controllers is needed. There is a need for the utilisation of already existing distance learning and web-based training programmes.
- Increasing awareness of available training materials in the NGOs sector.
- In-service training should incorporate interactions with people with lived experiences.
- Advocacy role to play within the health system and with policy to address stigma and the lack of policy and guideline implementation is important.
- Scope of practice for each profession needs to be clarified and ring-fenced.
- An audit is required to look at South African Qualifications Authority (SAQA) accreditation in order to map the landscape in terms of all of the cadres of social and health-care providers.
- Translation of the National Mental Health Policy Framework to every district and province of the country through customising a generic model.
- Provision of funding for training needs to be clarified.

Proposed way forward

Workshop participants agreed that more work and dialogue need to take place in trying to address the MNS disorders and that it is important not to work in silos but to get all sectors involved and actively participating. The way forward was proposed and it was noted that some issues can be resolved immediately while others may require more time. Some of the proposed suggestions for the way forward were as follows:

1. Inter-professional and multi-sectorial dialogue and sharing

- Full representation, to include provincial representatives, other government departments and the business sector.

2. Establishing a MNS disorders forum

- Forum should include all levels of professionals and stakeholders in MNS disorders.
- ASSAf to utilise its neutral standing to convene this type of forum.

3. An audit of the training curricula for MNS disorders

- Audit to include the number of professionals that are being trained across the field, what are they being trained for, to do what, and at what level.
- ASSAf to undertake this survey.

4. Optimal utilisation of existing resources

- Put more emphasis on resourcing the existing facilities.
- Consider the current training curricula in relation to the human resource needs that have been identified.

5. Harness technology, such as mobile health, in order to achieve and support integration.

6. Implementation of the National Mental Health Policy Framework 2013 – 2020.

7. Focus on building strong collaborative teams.

ASSAf agreed to be the convening body for continued dialogue between the different stakeholders and also to undertake an audit of MNS disorders curricula at tertiary institutions, both of which are envisaged to contribute towards addressing MNS disorders. The representation of stakeholders will also be taken into consideration for future dialogue in order to ensure a multi-sectoral approach.

Reference

South African College of Applied Psychology (2013). Retrieved on 22 September 2014 from http://www.sacap.edu.za/mental-health-south-africa-whose-problem-counselling/

DAY ONE

SESSION ONE: OPENING AND BACKGROUND

Facilitator: Prof Helen Rees, Wits Reproductive Health and HIV Institute (WRHI), South Africa

Opening and Welcome Remarks, Workshop Objectives, Focus Areas and Outputs

Prof Roseanne Diab, Academy of Science of South Africa (ASSAf)

Prof Diab welcomed everyone and she presented a brief overview of the Academy.

ASSAf is a statutory body that reports to and is funded by the Department of Science and Technology (DST), but is independent in that it draws on the expertise of its Members and others to give evidence-based science advice to government. ASSAf was established in 1996 and is officially recognised as the national science academy representing South Africa in the international arena of science academies through its Act of Parliament, which came into operation in 2002. ASSAf is a membership-based organisation and Members are elected to Membership based on their excellence and their standing in the scientific community. The current 423 Members are drawn from a very broad spectrum of disciplines. Membership of the Academy is both an honour and an obligation to serve society. Members volunteer their services and contribute their expertise to the studies undertaken by the Academy, and are not paid for these services.

ASSAf has a very strong reputation in the health sciences having previously undertaken a number of landmark studies such as one on HIV/AIDS, Tuberculosis and Nutrition and another on Revitalising Clinical Research in South Africa. One of the traditional strengths of science academies is their convening power: the ability to draw together a wide variety of experts from different disciplines, backgrounds and sectors. Policymakers, researchers and practitioners are brought together in a single forum to deliberate on a topic.

The key objective of the workshop is to explore how best South Africa could domesticate and implement the core competencies outlined in the IOM Workshop summary report entitled, *Strengthening Human Resources through Development of Candidate Core Competencies for Mental, Neurological and Substance Use Disorders in sub-Saharan Africa.* The anticipation being that the workshop would provide a platform to discuss the challenges and opportunities in the implementation of the MNS core competencies.

Millions of South Africans suffer from MNS disorders. Many are undiagnosed and untreated, and millions more are impacted and in need of support. It is estimated that 80% of those with MNS disorders in sub-Saharan Africa (SSA) do not reach health services. This huge treatment gap is one of the focus areas of the workshop.

Background to the Project and an Overview of Potential Core Competencies for MNS

Dr Bruce Altevogt, Institute of Medicine (IOM) of the US National Academies

Dr Altevogt directs the IOM's Forum on Neuroscience and Nervous System Disorders, which has an ongoing initiative focused on improving the quality of care for individuals in Africa with mental, neurological, and substance use (MNS) disorders. The Neuroscience Forum brings together stakeholders from government (including the United States (US) National Institutes of Health), foundations, academics, patient groups, industry and clinicians. Much of its focus is on improving the translation of neuroscience research findings and on improving quality of care in SSA. The MNS disorders project, a collaborative activity, started in 2008 as a result of concern expressed by forum members about the low levels of awareness of MNS disorders in SSA and a subsequent decision to address the burden of MNS disorders in SSA. The goals of the initiative are to:

- raise awareness and define the need for improved quality of care;
- develop overarching guidance;
- address two critical barriers to strengthening services for MNS disorders, namely human resources and access to essential medicines.

- Human resources:
  - Strengthen human resources through the development of core competencies.
  - Discuss potential task-shifting and task-sharing among human resources and across treatment locations.
  - Explore potential methods for acquiring and maintaining core competencies.
- Access to essential medicines:
  - Examine successful essential medicines procurement models.
  - Identify approaches for improving current pricing models.
  - Discuss methods to address quality assurance issues.
  - Explore national policies that directly impact access.
  - Develop a basic procurement model for SSA countries.

There is a significant absence of human resources for MNS disorders in SSA. There are 100-fold fewer providers than necessary, only 2.5 full-time equivalents (FTEs) providers per 100 000 individuals compared to the necessary; 250 per 100 000. In many countries nurses provide the greatest amount of care, but there are often only 5 – 10 specialists (psychiatrists or neurologists) for an entire country. Therefore, care is provided by many levels of providers from social workers and community health workers through clinical and psychiatric nurses. The project aimed to identify the core competencies for every level of provider within the health system.

The activity had begun with an international workshop, Reducing the Treatment Gap, Improving Quality of Care, held in Kampala, Uganda in August 2009 and organised in collaboration with the Ugandan National Academy of Sciences. The workshop objectives were to:

- examine the burden of disease for MNS disorders;
- explore opportunities to improve national, evidence-based policies addressing quality of care and health-care systems for MNS disorders, and discuss how to facilitate collaborations among a variety of stakeholders, including policymakers and health-care professionals.

The workshop summary emphasised the importance of developing and providing unified and coordinated care for mental, neurological, and substance use disorders, since they are each disorders of the nervous system. Based on this, the IOM initiative has focused its efforts on improving quality of care for all 'MNS disorders' and not just mental health or neurological disorders[1]. Two key themes emanating from the workshop focused on expanding the use of high quality, community-based care, training of community health workers and improving the available medication formulary for MNS disorders.

A second workshop, Strengthening Human Resources through Development of Core Competencies for MNS Disorders in SSA, organised by a multi-disciplinary planning committee comprising collaborative international expertise including expertise from SSA was held in Kampala, Uganda in September 2012. The workshop deliberated on the provider types, the core competencies that could be established for providers across all MNS disorders and competencies that had previously been identified and could serve as a starting point. Providers were divided into four categories: community/lay workers, non-specialised/non-prescribing, non-specialised/prescribing and specialised, and working group discussions focused on the core competencies required by providers for four MNS disorders (depression, schizophrenia (psychosis), epilepsy and alcohol use disorder) and the core competencies to enable screening, identification, diagnosis, treatment and care in each of the four MNS disorders.

An exercise that involved leveraging the expertise of the providers who participated in the working groups through filling in a series of questionnaires had resulted in the identification of over 111 different core competencies for consideration by stakeholders. The core competencies were organised across disorders and providers, and incorporated as Annexure A of the workshop summary report[2]. The summary of candidate core competencies are as indicated in Table 1 and Table 2.

Reference

[1]IOM. 2010. *Mental, Neurological, and Substance Use Disorders in sub-Saharan Africa: Reducing the Treatment Gap, Improving Quality of Care*. Summary of a Joint Workshop. Washington, DC: The National Academies Press.

[2]IOM. 2013. *Strengthening Human Resources through Development of Candidate Core Competencies for Mental, Neurological, and Substance Use Disorders in sub-Saharan Africa:* Workshop summary. Washington, DC: The National Academies Press.

Candidate Core Competencies: Across Providers and Disorders

Table 1. Candidate core competencies discussed for all provider types across MNS disorders.[1]

Screening/Identification	
SI.1	Demonstrates awareness of common signs and symptoms
SI.2	Recognises the potential for risk to self and others
SI.3	Demonstrates basic knowledge of causes
SI.4	Provides the patient and community with awareness and/or education
SI.5	Demonstrates cultural competence
SI.6	Demonstrates knowledge of other mental, neurological, and substance use disorders
Formal diagnosis/Referral	
DR.1	Demonstrates knowledge of when to refer to next level of care/other provider/specialist
DR.2	Demonstrates knowledge of providers for specialised care within the community
Treatment/Care	
TC.1	Provides support for patients and families while in treatment and care
TC.2	Identifies and assists patients and families in overcoming barriers to successful treatment and recovery (e.g. adherence, stigma, finances, accessibility, access to social support)
TC.3	Demonstrates ability to monitor mental status
TC.4	Demonstrates knowledge of how to offer emergency first aid
TC.5	Initiates and/or participates in community-based treatment, care and/or prevention programmes

[1]This table presents candidate core competencies discussed by one or more workshop participants. During the workshop, all participants engaged in active discussions of candidate competencies. In some cases, participants expressed differing opinions about whether a particular competency could be useful and included in the list. However, since this is a summary of workshop comments and not meant to provide consensus recommendations, workshop rapporteurs endeavoured to include all candidate core competencies discussed by workshop participants across providers and disorders. This table and its content should be attributed to the rapporteurs of this summary as informed by the workshop.

Treatment/Care continued	
TC.6	Demonstrates knowledge of treatment and care resources in the community
TC.7	Promotes mental health literacy (e.g. to minimise impact of stigma and discrimination)
TC.8	Communicates to the public about MNS disorders
TC.9	Monitors for adherence to and/or side effects of medication
TC.10	Practices good therapeutic patient interactions (e.g. communication, relationship, attitude)
TC.11	Provides links between patients and community resources
TC.12	Identifies available resources to support patients (e.g. rehabilitation, medication supplies)
TC.13	Promotes activities that aim to raise awareness and improve the uptake of interventions and the use of services
TC.14	Protects patients and identifies vulnerabilities (e.g. human rights)
TC.15	Demonstrates respect, compassion, and responsiveness to patient needs
TC.16	Demonstrates knowledge and skills to use information technology to improve treatment and care

Table 2. Candidate core competencies discussed for non-specialised prescribers and specialised providers across MNS disorders.[2]

Screening/Identification	
SI.1	Demonstrates awareness of common signs and symptoms
SI.2	Recognises the potential for risk to self and others
SI.3	Demonstrates basic knowledge of causes
SI.4	Provides the patient and community with awareness and/or education
SI.5	Demonstrates cultural competence
SI.6	Demonstrates knowledge of other mental, neurological, and substance use disorders
SI.7	Demonstrates the ability to screen for and use screening tools

Screening/Identification continued	
SI.8	**Demonstrates knowledge and skills in taking patient history**
SI.9	**Demonstrates the ability to conduct a mental status exam**
SI.10	**Recognises patients who are relapsing and require inpatient care**
Formal diagnosis/Referral	
DR.1	**Demonstrates knowledge of when to refer to next level of care/other provider/specialist**
DR.2	**Demonstrates knowledge of providers for specialised care within the community**
DR.3	**Demonstrates skills in assessment of relative levels of social, cognitive, and physical functioning**
DR.4	**Demonstrates knowledge of required information for effective referral**
DR.5	**Demonstrates skills in using various functional assessment tools**
DR.7	**Demonstrates an understanding of and ability to apply contextually appropriate diagnostic systems (e.g. DSM, ICD)[3]**
DR.8	**Demonstrates knowledge and skills to make a formal diagnosis and formulation of differential diagnosis**
DR.9	**Demonstrates ability to determine severity level**
DR.10	**Demonstrates ability to make a diagnosis according to an algorithm (not considered a clinical diagnosis)**
Treatment/Care	
TC.1	**Provides support for patients and families while in treatment and care**

[2] This table presents candidate core competencies discussed by one or more workshop participants. During the workshop, all participants engaged in active discussions of candidate competencies. In some cases, participants expressed differing opinions about whether a particular competency could be useful and included in the list. However, since this is a summary of workshop comments and not meant to provide consensus recommendations, workshop rapporteurs endeavoured to include all candidate core competencies discussed by workshop participants across providers and disorders. This table and its content should be attributed to the rapporteurs of this summary as informed by the workshop.

[3] DSM: Diagnostic and Statistical Manual of Mental Disorders; ICD: International Statistical Classification of Diseases and Related Health Problems

Treatment/Care continued	
TC.2	Identifies and assists patients and families in overcoming barriers to successful treatment and recovery (e.g. adherence, stigma, finances, accessibility, access to social support)
TC.3	Demonstrates ability to monitor mental status
TC.4	Demonstrates knowledge of how to offer emergency first aid
TC.5	Initiates and/or participates in community-based treatment, care, and/or prevention programmes
TC.6	Demonstrates knowledge of treatment and care resources in the community
TC.7	Promotes mental health literacy (e.g. to minimise impact of stigma and discrimination)
TC.8	Communicates to the public about MNS disorders
TC.9	Monitors for adherence to and/or side effects of medication
TC.10	Practices good therapeutic patient interactions (e.g. communication, relationship, attitude)
TC.11	Provides links between patients and community resources
TC.12	Identifies available resources to support patients (e.g. rehabilitation, medication supplies)
TC.13	Promotes activities that aim to raise awareness and improve the uptake of interventions and the use of services
TC.14	Protects patients and identifies vulnerabilities (e.g. human rights)
TC.15	Demonstrates respect, compassion, and responsiveness to patient needs
TC.16	Demonstrates knowledge and skills to use information technology to improve treatment and care
TC.17	Demonstrates ability in general counselling skills
TC.19	Demonstrates ability to select appropriate treatment based on an understanding of diagnosis
TC.21	Provides brief advice on symptom management

Treatment/Care continued	
TC.28	**Demonstrates knowledge of and ability to apply relevant legislation and policies and access to appropriate services**
TC.34	**Reports information to relevant health management systems**
TC.36	**Assists patients with access to other providers and helps coordinate efforts**
TC.38	**Documents medical records**
TC.39	**Demonstrates knowledge and skills to consult with other providers in the treatment/care team**
TC.40	**Demonstrates knowledge and skills to provide proactive follow-up and monitors outcomes of care**
TC.41	**Demonstrates knowledge of standard drug regimens**
TC.42	**Provides mentoring and support to other health-care providers**

Reprinted with permission from *Strengthening Human Resources through Development of Candidate Core Competencies for Mental, Neurological, and Substance Use Disorders in sub-Saharan Africa:* Workshop Summary, 2013 by the National Academy of Sciences. Courtesy of the National Academies Press, Washington, D.C.

While not specifically addressed in the workshop summary, it is important to consider core competencies within the context of traditional healers and improve the integration of these providers, recognising that in many countries they are often the first port of call for patients. A further matter that requires consideration when applying the competencies into country-specific health systems is how to leverage existing resources in other components of the health system, (such as HIV and TB), and integrate MNS care within these well-supported programmes, mechanisms and models.

In January 2014, the Institute of Medicine's Forum on Neuroscience and Nervous System Disorders convened a workshop with the goal of bringing together key stakeholders to discuss opportunities for achieving long-term affordable access of medicines for MNS disorders in sub-Saharan Africa.

Workshop speakers and individual participants were invited to explore challenges and opportunities for improving access to essential medicines in four critical areas: insufficient demand, inappropriate selection, ineffective supply chains, and high pricing and poor financing. In addition, participants

examined successful activities that increased access to essential medicines both within SSA, and in other developing countries. Throughout the workshop, participants discussed a number of potential opportunities to improve access to essential medicines for MNS disorders, which can be found in a report that was published later in 2014[3].

The IOM has collaborated with many providers from SSA along with the World Health Organisation (WHO) and the European Commission's Emerging Mental Health Systems in Low and Middle-income Countries (EMERALD) Project to help enable countries such as South Africa to use the work as a starting point, to consider how to adapt it to meet the needs of South Africa in order to develop the core competencies and ensure that everybody had access to the right care at the right time and the at right place.

The objectives of the current workshop, in bringing together key stakeholders and experts within South Africa, are to:

- Identify and discuss the key challenges in the implementation of MNS disorders core competencies, asking how the core competencies could best be adapted to meet the needs of South Africans and fit into the South African health system.
- Explore the best strategies and opportunities that could be adopted by the different stakeholders for effective implementation of MNS disorders core competencies, asking:
    - what needs to be done to ensure that patients have access to the right care, at the right time and at the right place?
    - what are the actionable next steps to move this forward?

[3]IOM 2014. *Improving access to essential medicines for mental, neurological, and substance use disorders in sub-Saharan Africa*. Workshop summary. Washington, DC: The National Academies Press.

Discussion, Q&A

Dr Robin Allen:

1) I was intrigued to read that the grand challenges of global mental health identified that children were a particularly important group and yet there is nothing that addresses core competencies in relation to children, from the perspective of preventative action and smart investment.

2) I am curious about the composition of this group of participants and the expectations of the group that have been assembled to participate in today's workshop. I do not see any academic heads of departments from universities. They would be important to have if we are to discuss curriculum changes for training psychiatrists. The way in which psychiatrists are currently being trained is inappropriate to meet the mental health-care needs of low and middle-income countries.

Response, Dr Bruce Altevogt:

1) We did not go into any of the vulnerable populations in specific detail. This was deliberate as initially we wanted to make sure that we were able to at least identify the core competencies and access issues for anyone with MNS disorders. The economic perspective and preventative action was very important and should be highlighted throughout these deliberations.

2) I was not involved in the organisation of this workshop, which was organised by an *ad hoc* planning committee under the auspices of ASSAf. What I am hoping to learn from this workshops is how the general core competencies that our previous work identified could be adapted into the South African context. The expertise of the planning committee members was relied on for the identification of individuals to attend the previous IOM workshops. We wanted to hear about how the core competencies could be adapted. Actionable steps and responsible parties should be identified. Participants should not represent their organisations but their own individual views. We hope to have an open dialogue on how to implement these ideas and ensure that something tangible comes from this so that we can provide care for individuals.

Response, Prof Roseanne Diab: 2) We are aware that the coverage of academia, as well as some of the other sectors was not comprehensive. We tried to ensure that there was some representation from each of the sectors, and used the snowballing technique to contact others.

Response, Prof Helen Rees: This is a South African specific output and it would not be appropriate if buy-in was not obtained from all the sectors. A recommendation could be made from the floor that there needs to be a secondary set of recommendations emanating from this workshop.

Prof Melvyn Freeman: I assume that the slide giving the numbers of providers per category, making up the MNS health-care workforce in various countries is based on the numbers of people already working in mental health. However, the model seems to assume a much broadened version of who should be doing mental health (integrated, inter-general primary health care, community health workers, and so on). There seems to be a gap between developing core competencies for those who are potential mental health workers and those who are already working in the field. Many of the core competencies are those that need to be developed in people who could potentially do the work rather than in those who are already doing the work.

Response, Dr Bruce Altevogt: The material referred to is from the WHO's Mental Health Gap programme. The numbers included occupational therapists and social workers that would only be focusing on MNS disorders. I do not know what the gap would be for general practitioners (GPs) and others and how this would play into the numbers. The most important question was how to integrate and ensure that they have the knowledge base to provide the care needed. This is part of what I would like to hear coming out of this workshop.

Prof Crick Lund: The framework takes the debate to the next level in terms of identifying core competencies for a range of different health-care providers. One of the potential gaps, a task-sharing or task-shifting model, is shifting the role of specialists from those who provide clinical care to also being trainers and supervisors. To what extent has this been taken into account? The model seems to focus on identification, screening, diagnosis and treatment. Did you identify, per providers, the specific competencies required in supervision and training of specifically primary care generalist providers?

Response, Dr Bruce Altevogt: We did not go through the specific competencies for the training but recognised that it had a trickle-down effect and needed to move more towards supervision, oversight capacity recognising that in some countries where there are only five psychiatrists, they should not be the ones to provide day-to-day care, but needed to be in the supervisory role. This was taken into account. The questionnaire that participants filled out addressed the relationships and collaborations between the two.

Dr Angelique Coetzee: In South Africa, the GP is the first entry point at primary care level. We see a lot of psychiatry, predominantly depression and anxiety, in our daily consultations. I am not sure that GPs are always equipped to deal with this. Unfortunately, it is not possible to do courses as these are full time and impractical for a GP in private practice to attend. There is a need for part-time courses. In addition, GPs find that patients want them to take time to listen to their problems. It would help if health-care workers were trained to do this.

Response, Dr Bruce Altevogt: The idea of a short course for GPs is what we would like to hear more about so that ways can be found to move this forward.

Dr Lawrence Tucker:

1) Epilepsy is one of the conditions we have been tackling in the SSA context. Training people who are not neurologists or even nurses to treat, diagnose and manage epilepsy in particular, can be done simply. On the other hand it is very important to maintain the quality of our specialist education. We need to produce excellent specialists who will become trainers and quality controllers and then devolve responsibility for particular conditions to people who are specifically trained in that area. We have already started with distance learning and a web-based programme for training competencies in neurophysiology. The courses are practical-based with an assessment component and are a wonderful way to reach people who are in geographically remote areas of SSA. Access to information is possible but the problem is how to use the information appropriately. This also applies to diagnostic machines.
2) The 2nd Africa Epilepsy Congress held recently in Cape Town was organised by a collaborative partnership between advocacy and academic groups.

Dr Bruce Altevogt: How can we use cell phones to communicate health strategies to get the knowledge to people who might not be able to attend a full-time course, but who will be able to communicate using a cell phone or an application? This applicability is not being utilised and should be considered.

Dr Angelique Coetzee: An excellent document explaining the levels of health-care provision was compiled a few years ago. These guidelines should be used to train GPs and health-care workers in the basics of care for those with MNS disorders.

Dr Robin Allen: I am the national convenor for the public sector group of the South African Society of Psychiatrists and we have many guidelines. The problem is that we are a non-statutory body that represents psychiatrists and we do not have any official standing. This means that the adoption of the guidelines cannot be enforced. We are working towards establishing a relationship with government and various provincial services so that we can offer the guidelines as a resources base to inform practice. This is work in progress.

Prof Carolus Reinecke: I manage the metabolomics platform located at the North-West University. I used to have the view that mental conditions would not be reflected in the metabolite profile but I was wrong. It is clear that a metabolite profile can reflect some of the conditions (such as mother-to-child transmission of HIV, alcoholism, fibromyalgia). South Africa has the ability to have a small sector that looks at metabolite profiles in cases of MNS disorders. The necessary expertise is available and should be used.

Ms Nomvula Sibanyoni: My question concerns the candidate core competencies. The model seems to suggest that promotion and prevention would be part of treatment and core competencies. Was a decision taken not to elevate promotion and prevention as primary care, separate from treatment care? The competencies listed suggest that patients are not seen before developing an MNS disorder, but present themselves at health centres already with an MNS disorder.

Response, Dr Bruce Altevogt: We did not deliberately say that prevention would not be taken into account. Prevention is a critical piece of this. Some of the competencies identified contribute towards the idea of promotion and recognition at every level but there are gaps. This is where we need you to

adapt the list of core competencies within the context of the South African health system. If there needs to be a strong emphasis on prevention then we should have a conversation about how it should be implemented.

Response, Prof Inge Petersen: The workshop was structured around the four specific disorders and focused on people presenting with MNS disorders. We need to look at the evidence for prevention of these disorders in low and middle-income countries (LAMIC). We have general evidence on mental health promotion but very little on the prevention in LAMIC. This was one of the factors that could have hindered the inclusion of prevention and promotion in the process. This does not mean that we should not be looking at these areas. It is difficult to do everything at once. Perhaps we need to take things one step at a time in developing these services. The next major challenge will be prevention and mental health promotion.

Dr Thirusha Naidu: I can understand why we should not immediately address mental health prevention and promotion issues but I wonder if there is enough emphasis on maintenance treatment after symptom alleviation and so on. As a psychologist my work involves a lot of maintenance and requires a high level of care. I do not think there is enough task-shifting to communities. Many of the terms used in the list of core competencies are vague (such as 'awareness', 'demonstrating knowledge'). Will these be defined in practice? In psychology we spend a lot of time supporting the health practitioner. This should be considered at primary health-care level, at the beginning of implementation or it could fall by the wayside.

Unknown person:

1) Literature indicates that peer-led organisations or service user organisations are very important. I do not see peer-led or service user organisations coming to the fore in South Africa. What can be done to encourage this development in the country?

2) I noticed that although the role of advanced nurse practitioners is changing dramatically, they are not included under the provider categories presented by Dr Altevogt. Was there any input from advanced nursing organisations such as the South African Nursing Council (SANC)?

Response, Dr Bruce Altevogt: Clinical and other levels of nurses did participate

in the workshop. The diversity across Africa and how nurses are able to provide care is being reflected and needs to be applied to the specific context of what can be done by clinical nurses within the South African context.

Ms Charlene Sunkel: I represent a service user-led organisation that operates in Gauteng. There is potential to expand advocacy movements to other provinces. The advocacy movement uses representatives who are volunteers and have MNS disorders. They receive relevant training on mental health disorders treatment, compliance, human rights and so forth, and they go into the communities and build partnerships with local clinics, train service users, and offer them emotional support. The national movement is not as widely spread as it could be. Funding is also a challenge.

Response, Dr Bruce Altevogt: It is encouraging to hear the strength of advocacy within South Africa. It should be leveraged within the South African context as it would help apply pressure to the implementers and would encourage the conversation about how to do this is a coordinated and collaborative manner. One of the reasons why there have been advances in mental health care in the US is because of the strength of the patient advocates

Mrs Carol du Toit: I represent the South African National Council on Alcoholism and Drug Dependence (SANCA) in Durban and the South African Council for Social Service Professions. My concern is that we are not addressing one of the biggest problems we face that has to do with the coordination and integration of services to ensure provision of a holistic framework and service, beginning with prevention to treatment and the continuum of care. These are not unique and distinct processes but we should be looking at one long process in a holistic way as this is the problem we face currently. There are many good initiatives but very little effort has gone into the proper coordination and proper strategic planning around the broader framework.

Prof Yusuf Moosa: I represent clinical services in the Johannesburg health district. My view is that the core competencies are excellent and cover almost every area.

1) My concern is that when the core competencies were matched against the various categories of providers there was no agreement on the South African understanding of a community health worker, for example. It would be necessary to match the core competencies with the South African resources available, with our legislation, the prior learning skills and basic level of education of the various categories of providers.

2) Before deciding that the core competencies should be implemented it is necessary to look at the resources available and whether implementation would be realistically possible.

Dr Bruce Altevogt: These two comments are relevant to the purpose of this workshop and I would encourage continued dialogue in this regard.

Prof Helen Rees: Looking at the levels of providers that we have and who we currently rely on in the system, one of the challenges, as in the case of HIV, is that although many counsellors are trained it is extremely difficult to counsel. This quite sophisticated job is given to people after three days of training. What can be expected of people who might not have a matric? We will be forced to think about the challenges of our own health-care professionals. What does the Department of Health (DoH) think about this and about task-shifting and task-sharing?

Prof Melvyn Freeman:

1) I made the assumption that all participants of this workshop would have read the National Mental Health Policy Framework and Strategic Plan 2013 to 2020. It sets out the framework in which we believe mental health care needs to develop over the next few years, and certainly involves a task-shifting approach. We will not be able to do it with the mental health professional resources that we have currently. Task-shifting will bring resource constraints on the existing staff members if new ones are not added. We have to look at what the extra FTEs are.

2) There is also the issue of the National Health Insurance (NHI). We will have to start thinking more positively about its potential. If we assume that less than 10% or 20% of our mental health resources are serving 80% of the population, and we bring in the other 80% or 90% then the picture looks different in terms of user to professional ratios and the current situation, what we could do and how we can start a process to contract GPs into the public health service. There is no reason why we should not contract other professionals who could play a particular role, both in their traditional professional competency as well as in training and so on. There is a lot of potential that we should use in moving to NHI.

3) With regard to re-engineering primary health care we have looked at screening within school health services as a means to intervene as early as possible. We are concerned that we will not be able to take the next step once cases are identified. Could it be linked to NHI potential by bringing more people in and referring more people out? We need the NHI fund in order to do this.

4) The DoH has been struggling with the issue of prescribing of psychiatric medication. We thought we had made a breakthrough when nurses were allowed to prescribe anti-retroviral therapy (ART), but it has not been quite so simple.

5) There is much work still to be done but we have a fair idea of where we are going. We have looked at who should be involved and general competencies that they might need, but not the specific competencies. This is where this group could be useful to the DoH.

Dr Bruce Altevogt: I encourage everybody to read the DoH plan. When the IOM identified countries where we would do more direct implementation, South Africa came to the fore because of the plan. There is an opportunity to leverage what the DoH is leading and it is important to move forward within the context of the DoH plan.

Unknown person: We have seen the DoH plan. The framework is excellent and covers all the areas. The problem is that those at national level who represent other provinces do not interface at all with the people who are responsible for implementation. There is a mismatch. The excellent work done is not filtering down to the areas where implementation takes place. This issue needs to be addressed.

Prof Helen Rees: This is a very practical suggestion and is noted.

Roundtable Discussion: Reflections on the IOM Report's MNS Disorders Core Competencies and how these can be Domesticated for the South African Context

Panel: Prof Arvin Bhana, University of KwaZulu-Natal (UKZN), Prof Inge Petersen (UKZN), Ms Sebolelo Tseeke (SANCA)

The panel comprised South African experts who had participated in the 2012 workshop on MNS disorders in SSA in Uganda.

Prof Arvin Bhana

The IOM had the insight to understand how to improve access to mental health services and how to do this in SSA. Initially, there was a sense that because of the diversity of views and opinions, and the fact that different countries had very different contexts, it would be difficult to develop a coherent and comprehensive list of core competencies. The initial process involved gathering of information as groups of people got together in teleconferences to fill out the questionnaires (presented by Dr Altevogt) and to debate the different elements that would constitute core competencies across the different levels of health-care providers. This formed the basis of the discussion at the workshop in Uganda.

The Ugandan meeting was interesting from the point of view that it brought together people in groups around depression, psychosis, epilepsy and alcohol use, and people often moved between groups. The breakout group discussions were very interesting. People were not reserved and expressed the issues they thought were important, including whether it was good practice to allow people who did not have core competencies to go near patients. Everybody was willing to give serious thought about how task-sharing could occur. There was an incredible amount of consensus about the core competencies. The workshop summary presented a distillation of the wide-ranging views, including how to bring in those who practised what could be described as elements of witchcraft considered as therapy.

This workshop should concentrate on making headway in terms of the plan that has been put forward by the DoH in order to advance access to mental health care.

Prof Inge Petersen

It is a very useful idea to apply the work done at the Uganda workshop, to look at how the core competencies could be implemented in a particular country. The difficulty is to look at how the list of core competencies can be integrated into service delivery platforms within the context and the framework of the National Mental Health Policy Framework and Strategic Plan 2013 to 2020, which embraces task-sharing.

In order to move forward, it is necessary to begin by deciding whether particular priority MNS disorders should be identified for South Africa, and then to identify available service delivery platforms that could be leveraged for the integration of MNS disorders. The third task is to identify collaborative stepped-care packages for each of the prioritised MNS disorders.

The work done in Uganda was largely related to the compilation of lists of core competencies and did not consider the relation between different mental health-care workers. It is necessary to embrace the collaborative care approach particularly in respect of mental disorders and other chronic-care disorders, and a team-based approach to care that is required in task-shifting. Roles and functions need to be identified for available providers that can be utilised within the service delivery platform and those that can provide care for a particular disorder within the collaborative stepped-care package. This will avoid task-dumping on the level below and will give a broad picture of the core competencies within the collaborative care framework and clarify roles and functions.

Once teams have been identified and there is clarity about the services they should provide, it will be possible to identify tasks that will inform the core competencies. Last, it will be necessary to identify how core competencies can be obtained, as well as sustained. This presents a further challenge and will require integration of core tasks into job descriptions and stipulated performance targets.

The role of training and accreditation bodies in training on a broader national scale will have to be ascertained. Although there are several small-scale projects to support task-sharing approaches, country-wide implementation of task-sharing and uniformity of training and accreditation is necessary.

Ms Sebolelo Tseeke

It will be useful to take the work from the Uganda workshop and try to implement it in South Africa. Regional differences, especially in relation to the treatment of substance abuse, were highlighted at the workshop. In South Africa, social workers are very involved in the treatment of substance abuse, whereas in other SSA countries, nurses are the main role players in this area. In South Africa, non-governmental organisations (NGOs) provide services in the area of substance abuse, particularly in urban areas. There are too few social workers who are directly involved with substance abuse treatment and care in rural areas.

This workshop should focus on the way forward and address the lack of coordination of mental health services in the country.

Discussion, Q&A

Prof Helen Rees: This was a useful starting point to open our thinking about how we use the recommendations from the Uganda consultation. The panellists gave some important thoughts and comments for further consideration. Important points raised were about:

- The categories of health-care workers (including traditional healers and the traditional framework).
- Taking the recommendations of the Uganda workshop and looking at the framework for health-care providers, the tasks and the competencies.
- Regional differences, social workers as the main caregivers of substance abuse patients in South Africa and the disparity between rural and urban communities in respect of treatment and care of MNS disorders.

Prof Crick Lund: I agree with the suggestions from the panel in terms of the way forward, especially in respect of the need to prioritise the main disorders and which key professional groups we want to include. The Health Professions Council of South Africa (HPCSA) is a key stakeholder. Was the HPCSA willing in principle to engage in this process to the extent that the professional guidelines of various professional categories can be modified within the remit of the HPCSA?

Prof Tholene Sodi: I am the Vice-President of the HPCSA, as well as the Head of Department of Psychology at the University of Limpopo. The HPCSA is entrusted with the responsibility to guide the health professions and protect the public, and would welcome these issues being brought to its attention. It is only on this basis that the council will be in a position to act.

Prof Crick Lund: One of the things that needs to change within the task-sharing approach is the core competencies for psychiatrists and psychologists who are also involved in supervision and training of primary care providers to be team leaders within an integrated health service delivery platform. To what extent can we change the accreditation of psychiatrists and psychologists and would there be support for this in the HPCSA? The other is that generalists would need to expand their competencies to include detection and management of common mental health problems, referral and so on. Quite a lot of the framework for their core competencies would need to be changed

in a regulated way and it needs to filter down into the training programmes that are offered by universities across the country in a fairly consistent way in order to be scalable. These are large institutional changes that need to happen.

Prof Melvyn Freeman: Another related issue is that although the HPCSA can agree to certain things, problems will occur if the agreement is not part of the provincial commitments. The HPCSA agreed to the training of middle-level psychologists and the universities started doing the training, but once they were trained there were no jobs within the public service. There must be a coordinated effort where all the role players agree that there will be jobs. I raised the issue of time in respect of community health-care workers to do mental health care. It will be necessary to allocate a specific proportion of their time to mental health care or it will not work. This is a real issue that has to be looked at in conjunction with the prescribing issue.

Prof Helen Rees: Is there a platform in which these kinds of issues have been widely discussed or has it tended to happen in silos?

Prof Crick Lund: It does tend to happen in silos. This is an opportunity to look across the different professions.

Prof Helen Rees: Prof Freeman made the point about the DoH struggling with the issue of prescribing psychiatric medication, who is allowed to prescribe what? This is important in the context of task-sharing. What is the barrier to changes in this regard?

Ms Nomvula Sibanyoni: The DoH engaged SANC on the issues relating to nurses prescribing medication. The major issue is that there are legal limitations placed on nurses in terms of prescribing specific drugs. There are issues of competencies related to risk management and lines of responsibility in respect of psychotropic drugs, most of which are Schedule 5 drugs. SANC agreed to allow nurses to be authorised to prescribe psychotropic drugs on condition that they have the requisite training and their competencies are being monitored by an outside body to ensure that the risk issues are addressed.

Dr Angelique Coetzee: I would like to point out that the South African Medical Association (SAMA) raised the problem of discrimination against GPs. Some of the medical schemes informed the GPs that they could not prescribe normal

anti-depressants for a period longer than six months. The patient would need to visit a psychiatrist and this leads to patients discontinuing the medication. SAMA has also noticed that although GPs cannot prescribe normal anti-depressants that are on the market, they are allowed to prescribe generic medicines. Medical schemes place barriers in the way of GPs prescribing psychiatric medication. Some patients do not need to visit a psychiatrist.

Prof Helen Rees: An interesting point has been raised. The influence of the medical schemes in the private sector could be controlling behaviour. We need to engage this sector in this discussion.

Prof Inge Petersen: When looking at the different providers it is crucial that we leverage mental health care to be integrated into the primary health-care (PHC) system. Mental health care should become part of the job descriptions and the way PHC providers are measured otherwise they will not do mental health care. Task-sharing is not necessarily cheaper and integrating mental health will require more investment on the part of the DoH. Mental health is not yet a priority and much more advocacy work and evidence are required before people see the impact that integrating mental health can have on overall health care, and the cost saving to health care. This is very important. The advocacy work in relation to the service user bodies in South Africa also needs to be leveraged in order to raise the public health priority of mental health.

Prof Helen Rees: What are the barriers to this not being a priority? Is it reluctance for the different categories of health-care providers to have an expanded job description or is it that it is not recognised on a national level for the impact that it has?

Prof Inge Petersen: The PHC providers see too many patients and do not have time to do a proper consultation. One nurse can see 90 patients in a day at a chronic-care clinic. How would the nurse identify someone with depression? This is a systemic reality. There is a lot of quality improvement work going on and we are in an encouraging position in relation to what the DoH is doing with regard to re-engineering. Leveraging the NHI system will also help. We need to look at the whole process of integration from a very broad perspective in terms of what is required to strengthen the systems. This will be a slow process and we should take it step by step. It will be important for us to prioritise.

Ms Sebolelo Tseeke: I would like to comment on accreditation. Social workers receive generic education and training. I feel that social workers who work in any of the four priority fields should get accreditation after working for some time and attending workshops. We also need an accreditation body.

Prof Helen Rees: Do you think that the priority areas identified at the Uganda workshop would be appropriate in the South African setting, or should we consider other/additional/alternative priority areas?

Prof Inge Petersen: We know that depression compromises ART adherence, thereby compromising the huge investment made in ART. We also have a rising burden of non-communicable diseases (NCDs) in this country and depression also compromises adherence, as well as changes in lifestyle of NCD patients. Depression has the highest prevalence in South Africa. I would therefore say that it would be very important to target depression, particularly in chronic-care patients.

Prof Arvin Bhana: I would like to see alcohol use disorders as a priority. The latest WHO report indicates that 50% of mortality of NCD patients is associated with alcohol. The issues of substance misuse in South Africa are particularly significant, as are the impacts on treatment compliance for HIV, as well as chronic illnesses. Alcohol use is a very critical element of priority setting.

Ms Sebolelo Tseeke: I agree with Prof Bhana. The scourge of substance abuse and alcohol abuse is on the increase and the country is ill prepared for the effects. Children start experimenting at an early age and patients present with co-morbid conditions. I put forward substance abuse and alcohol abuse as priorities.

Dr Lawrence Tucker: Epilepsy quite clearly must be on the list of priorities. There are ten million people in SSA who suffer from the condition. HIV is also a priority but to train someone in core competencies in this area is a mammoth task as it manifests in so many ways. Stroke should also be looked at as a priority. This condition is top of the list of causes of physical disability. Secondary prevention and lifestyle changes can make a huge difference, and can dramatically reduce the incidence of strokes. I would add epilepsy and stroke to the list of priorities.

Dr Angelique Coetzee: Anxiety disorder should be a priority as it is on the

increase, especially in the youth. Statistics about anxiety disorder diagnoses are skewed as funders only pay for depression at a GP level.

Dr Laila Asmal: I would like to suggest that dementia and cognitive impairment be regarded as a priority. This covers stroke and some of the neurocognitive disorders associated with HIV. The 1066 project has recognised that only 10% of research is in developing countries, yet they account for 66% of dementia worldwide. South Africa has a huge prevalence of dementia and cognitive impairment in people under 60, which is related to HIV, strokes and substance abuse. Language, education and cultural differences in this country cause problems with the recording of conditions, as well as screening, which is often not done appropriately.

Unknown person: I support what Dr Asmal said about dementia. If we think about dementia as associated with traumatic brain injury (TBI) and a history of violence, HIV and stroke, and not only age-related dementia, then it should be prioritised. We are seeing a changing epidemiology.

Prof Helen Rees: How good are our overall statistics on many of these conditions, particularly in the context of the rapid emergence of HIV, HIV on ART and people getting older? It would be worth exploring how well we are recording the conditions, especially something like dementia, as older people can often be written off without a diagnosis.

Prof Crick Lund: Children and adolescents are an overlooked group. Around 40% to 43% of our South African population is under the age of 18 and around 50% of MNS disorders have their origin before the age of 18. We need to take a life course approach to intervene, especially in relation to childhood behavioural disorders and childhood neurodevelopmental disorders in those who are often overlooked. There are no nationally representative data on the prevalence of child and adolescent MNS disorders.

Prof Helen Rees: Do you see the introduction of the new school health programme as an opportunity and have any nurses been trained?

Prof Crick Lund: The programme is definitely an opportunity and core competencies of teachers and school nurses within this framework should be considered.

Dr Annatjie van der Wath: I want to paint the picture from the nursing perspective. All the nursing schools are in the process of re-curriculating according to

the new regulations of the SANC. Nurses will no longer be registered in psychiatric nursing after they have completed their basic training. It will become more difficult to instil the core competencies. They will be registered in general nursing and midwifery. There will be some outcomes prescribed by SANC related to mental health and mental illness, but it will become more difficult because nurses will no longer have that qualification. The good news is that the post-basic qualification in psychiatric nursing will be brought back. Nurses will also be able to do a Masters degree in advanced psychiatric nursing. These nurses will work more in the tertiary services and the specialised services. The core competencies could be compared with the outcomes prescribed by SANC in order to implement this in the new curriculum. The major changes are being implemented currently.

Prof Helen Rees: The impact of this decision has not been clearly thought through nor has there been consultation. This information highlights a gap at the level of nursing.

Dr Taskeen Khan:

1) My comment is about doctors who do a diploma in mental health. Perhaps this is another resource for us to look at when drawing in people for competencies. In this way there may be more interest in the field of psychiatry. At present it is unclear what those with this qualification are capable of doing.

2) The statistics and epidemiology of mental disorders in South Africa are a problem. For NCDs in general, the problem is that what gets measured gets done and at present we are not measuring mental health adequately or appropriately. Until we start developing baseline research and baseline statistics we will not be able to contextualise the setting. Given the quadruple burden of disease in this country, it will also be extremely difficult to make a case for why it is needed. A starting point will also be to gather some evidence on the situation in South Africa or at least concur on what evidence we can use reliably as a baseline.

Unknown person: I am an occupational health practitioner. I would like to support those who put forward substance abuse, depression and anxiety as priorities. These are prevalent. When we consider implementation of the

management of MNS disorders, it is also necessary to address stigmatisation, which is very common and affects productivity in the workplace.

Ms Tania Rauch-van der Merwe: I represent occupational therapy, which is one of the allied health professions that straddles both social and natural sciences. As we are currently re-curriculating, one of the natural avenues for the implementation of these core competencies would be by service learning taking into account that all health professionals deliver community service after their training. Most occupational therapists (OTs) are placed in rural communities where we deliver service learning and find a prevalence of substance abuse and alcohol. Foetal alcohol syndrome (FAS) is evident in communities. In some of the classrooms in schools that are serviced by OTs, the majority of children are diagnosed with FAS. This is a huge problem. A very common observation is that under-diagnosed depression and anxiety disorders occur more commonly among community leaders. The definition of occupational therapy in the IOM workshop summary report neglects the important occupational science basis of social justice and the advocacy of human rights. In addition, no mention is made of the political and social dimensions. The WHO has pointed out that social determinants are the major determinants of health. This needs to be recognised.

Prof Helen Rees: The discussion identified the following priorities:

- Depression and anxiety disorders, the link between the two and the relationship between depression and the NCDs, HIV and TB, and lifestyles.
- Alcohol abuse, substance abuse and their interplay with NCDs.
- Epilepsy, which was reaffirmed as an important issue.
- Stroke, particularly primary and secondary prevention, is a new issue that has been firmly put onto the agenda.
- Dementia and cognitive impairment in the context of our changing epidemiology, NCDs and HIV.
- Prevention, the issue of reaching children and adolescents particularly through school health programmes and the fact that South Africa has a youthful population.
- Schizophrenia and psychotic disorders (bipolar mood disorder) as both are

misunderstood and are often associated with demon possession or bewitchment. Stigmatisation and discrimination prevent many people accessing mental health-care services.

Prof Arvin Bhana: I believe that all the priorities mentioned are important, and that we should champion children and adolescents as an important area. In terms of this exercise, the evidence for treatment efficacy through task-sharing is a critical element. If the core competencies are to be taken up then one has to look at the evidence. There is a reasonable level of evidence for depression, as well as for alcohol misuse. The issue of dealing with prevention, health promotion and early intervention is a critical area. We may want to think about using the platform that already exists in terms of screening at schools and expand it to include a level of identification that includes task-sharing and so on. The pragmatics about what is achievable should be looked at and then building on that platform rather than trying to do everything and doing nothing well.

Prof Inge Petersen: Whatever we decide must be guided by the DoH priorities. We need to consider the best options in relation to integrating mental health into health-care service delivery platforms. We also need to look at where we have the best evidence for interventions. This needs to be done for both treatment, as well as prevention. The disease control priority exercise which is underway is looking at extended cost-benefit analyses of what will be the best buys for mental health, both treatment and prevention at a health-care facility level, as well as at a community and policy level. Some of the current work can be leveraged to inform our decisions.

Prof Helen Rees: The fact that there is no simple answer to the priority question and that this matter has generated so much discussion show that there is a need to stimulate the debate. The following issues have come out of the discussions in terms of consensus:

- We need to relook at the dedicated and potential capacity that is already in place in order to increase integration and the overall capacity of the health sector to respond to the needs that we are not able to do adequately at the moment, in the context of PHC re-engineering, the NHI and the private sector that is not integrated into the workplace sector.

- We need to identify not only the categories of health-care providers but also look at how to integrate the issues better into the outputs of health-care providers in the different categories.
- We need to look at the levels of health-care providers in this country and identify the tasks for each, and identify the minimum that they could do in order to intervene in mental health care, without overloading health-care workers with things that are beyond their capacity.
- We need to clarify the referral mechanism after screening and identification.
- We recognise that we do not have a good grasp of the epidemiology of many of the diseases that have been prioritised.
- We need to look at the evidence for best practice for intervention, both for prevention and treatment.
- We should be looking at what is the best practice for treatment efficacy, adherence and prevention efficacy.

Some additional thoughts that were raised in discussions are:

- The lack of civil society mobilisation and advocacy.
- The need for more attention to stigma, prevention, and social determinants of the emergence of some of the disorders.

The priorities (neglected areas) identified are:

- depression and anxiety disorders;
- alcohol abuse, substance abuse;
- epilepsy;
- stroke, particularly primary and secondary prevention;
- dementia and cognitive impairment;
- children and adolescents, with an opportunity through school health programmes and teachers;
- schizophrenia and bipolar mood disorder.

There is a need to improve coordination across the sectors, particularly as currently, thinking at all levels is taking place in silos. One national strategy is required and this will relate to recommendations concerning training and accreditation.

SESSION TWO: TOWARDS IMPLEMENTATION OF MNS DISORDERS CORE COMPETENCIES

Facilitator: Prof Bronwyn Myers, Medical Research Council (MRC), South Africa

South African Mental Health Policy Framework and Implementation

Prof Crick Lund, University of Cape Town (UCT)

Mental health services in South Africa were introduced with colonialism when the view was that mental health problems should be removed from society. The development of psychiatric hospitals was a hallmark of colonialism that saw the establishment of several asylums in South Africa, including one on Robben Island in 1846, which had 500 patients by 1912. Mental health care was profoundly racialised. Reforms were introduced under the Mental Disorders Act of 1916, which repealed previous legislation and replaced the use of the term 'asylums' with new terms such as 'mental institutions', but continued to enforce racial segregation in facilities, a practice that continued up to 1994. In 1979, South African psychiatric facilities were criticised by a visiting delegation from the American Psychiatric Association. Mental health services under apartheid were marked by racial discrimination, institutionalisation, custodial care and paternalism.

During the period 1950 to 1990, a large movement of de-institutionalisation took place in many western countries and psychiatric hospital beds were reduced by between 80% and 90%. The movement was driven by psychotropic medication, the growth of the human rights movement and attempts to save costs associated with psychiatric care. In many cases this was a failure and led to a burgeoning population of mentally ill prisoners and homeless mentally ill people. De-institutionalisation has worked relatively well in some countries, such as Italy, and today there are fewer psychiatric hospitals and a large array of community-based, residential facilities. Mental health services have been integrated into PHC. The de-institutionalisation movement

bypassed South Africa and mental health services in this country remained based in psychiatric hospitals. The DoH had made piecemeal efforts at community service development in South Africa but it was only in the post-apartheid era that a new National Mental Health Policy (1997) was adopted. It introduced a strong community-based approach and was pro-human rights. The DOH's White Paper of 1997 stated that, "a comprehensive and community-based mental health service should be planned and coordinated at the national, provincial, district and community levels, and integrated with other health services", in line with the model proposed by the IOM report and the framework presented to this workshop.

This was taken further through the reform of the South African national mental health legislation. The new Mental Health-care Act (2002) is based on international human rights principles, consistent with WHO recommendations and a powerful advocacy tool for the rights of mental health service users. Part of the difficulty and challenge with regard to the implementation of the Act is the lack of resources and budgets to implement some of the provisions. For example, the Act provides for the establishment of 72-hour observation facilities in district and regional hospitals, but the provincial departments have been unable to commit resources to these facilities in order to adequately house people who are admitted under the provisions of the Act. Inadequate resources have prevented review boards from functioning in some provinces.

Many of the post-apartheid challenges experienced in the area of mental health, but also common to the area of substance abuse and neurological disorders, relate to:

- formalising mental health policy;
- implementing new legislation;
- translating national policy into provincial strategic plans and budgets;
- integrating mental health into primary health care;
- strengthening community-based services;
- broadening the area of mental health to other sectors, such as education, housing, criminal justice and social development.

In 2011, the National Health Council (NHC) resolved that mental health services needed to be reviewed. A national consultative process ensued, led by the Minister of Health and provincial members of the executive councils (MECs) of Health. A number of provincial mental health summits, attended by about 4 000 participants, took place in early 2012, which culminated in a national summit held in April 2012 under the theme Scaling-up Investment in Mental Health for a Long and Healthy Life for all South Africans. Discussions at the summits focused on:

- reviewing both the quality and quantity of mental health services that were being provided;
- identifying the key challenges in the mental health-care system;
- providing information on best practices that have emerged since 1994.

Agreement was reached at the summits about the priorities that would have to be implemented as part of the reorganisation and further strengthening of the health system.

The national summit adopted the Ekurhuleni Declaration, put together at the summit, consisting of 11 action areas and a commitment to formalising a new National Mental Health Policy and an action plan that would enable the policy to be implemented.

Findings from the national summit were:

- Some progress has been made in enacting mental health legislation and policy, but there are still many challenges especially with implementation.
- Neuropsychiatric disorders ranked third in their contribution to the national burden of disease, after HIV/AIDS and other infectious diseases.
- The high prevalence of common mental disorders (depression, anxiety and substance use disorders).
- Mental health intersects with other health priorities and outcomes, particularly HIV and NCDs.
- High levels of poverty, unemployment, violence, substance abuse and other adversities increase vulnerability.

- The existence of a substantial treatment gap (only 25% of those with a common mental disorder have access to formal mental health services).
- Mental health systems' weaknesses and weak institutional capacity (at all levels).
- Dilapidated and old infrastructure.
- Inequity in distribution of resources (including human resources) between and within provinces.
- Over-reliance on specialised psychiatric hospitals.
- Limited investment in community-based mental health care and primary mental health care.
- Limited information on mental health.
- Challenges with the production, supply and retention of mental health practitioners.
- Challenges with access to and supply of appropriate mental health technology, equipment and medicines.
- Widespread stigma and discrimination against people living with mental illnesses.
- Public ignorance about mental health.
- Poor coordination of effort with other key sectors.
- Sufficient evidence is not available on the effectiveness of prevention and treatment of mental disorders to scale up mental health services.

Subsequent to the national summit, the DoH appointed a working group of stakeholders to help formulate an action plan from the many areas prioritised by the summit, and to draft a mental health policy. The new Mental Health Policy Framework and Strategic Plan was formally adopted for implementation by NHC on 29 July 2013. Eight catalytic objectives were selected by the working group in consultation with the Deputy Minister and senior policymakers in the DoH, forming the substance of the policy framework and strategic plan, aligned with the WHO Global Mental Health Action Plan 2013 – 2020. The objectives relate to:

1) Implementation of a district-based mental health service aligned with primary health care (focusing initially on the NHI pilot district sites at a projected cost of around R23 million), involving:

    - establishment of at least one specialist mental health team in each district;
    - designating selected health centres and clinics to provide psychological services (current services are primarily medical);
    - inclusion of mental health as part of chronic care within primary health services.

2) Development and establishment of institutional capacity building, by:

    - establishing a Ministerial Mental Health Technical Advisory Committee in terms of section 71 of the Mental Health-care Act, approved by the Minister. The regulations are currently out for comments;
    - establishing and appropriately staffing mental health directorates in each of the nine provinces;
    - establishing functional Mental Health Review Boards in keeping with the Mental Health-care Act.

3) Strengthening surveillance, research and innovation by:

    - ensuring the accurate collection and use of the minimum dataset for mental health that is integrated into the general health information system at all levels;
    - establishing a national mental health research agenda;
    - developing and implementing a monitoring and evaluation system to track and report progress with the implementation of the Health Sector Drug Master Plan.

4) Infrastructure and capacity of facilities, by:

    - building/attaching mental health inpatient units to designated district and regional hospitals (for emergency admissions, 72-hour assessment, care, treatment, and rehabilitation of voluntary, assisted and involuntary mental health users);

- designing specifications to comply with the Mental Health-care Act. (A unit within the CSIR is addressing this matter.);
- establishing a specialised psychiatric hospital in Mpumalanga Province (to conduct forensic psychiatric evaluations, admit state patients and mentally ill prisoners, etc.);
- revitalising dilapidated mental health facilities in all provinces;
- developing community residential care facilities (including halfway houses, assisted living and group homes) to provide accommodation for de-institutionalised service users.

5) Mental health technology, equipment and medicines, by:
   - making all psychotropic medicines, as provided on the essential drugs list (EDL) available at all levels of care, including PHC clinics;
   - equipping clinics and health centres with psychology infrastructure and equipment.
6) The ongoing challenge of inter-sectoral collaboration between health and other sectors, by:
   - including mental health on the agenda and assuring mental health representation on the newly established National Health Commission.
7) Human resources for mental health, by:
   - training health professionals (including medical interns, nurses, and pharmacists) who will rotate through psychiatric units in district and regional general hospitals;
   - selecting key staff in every primary health facility who will receive basic mental health training using the Primary Care 101 guideline, and ongoing routine supervision and mentoring;
   - ensuring that the language competency of all mental health professionals is improved, particularly in indigenous African languages.
8) Mental health advocacy and promotion, and prevention of mental illness, by:

- establishing a national public education programme for mental health, including knowledge about mental health and illness, stigma and discrimination against people with mental illness, and available services.

The way forward, as directed by the NHC, is that provincial road shows on the Mental Health Policy Framework and Strategic Plan be held to popularise the plan and to support provinces to develop provincial plans, secure funding and implement the plan. In addition, regular reports on progress will be submitted to the NHC.

Implementation of Core Competencies for MNS Disorders

Prof Melvyn Freeman, National DoH

It has often been stated that less than 25% of people in need of mental health treatment receive treatment. This raises questions about possible reasons for the undersupply and whether additional mental health services would adequately address the matter. A lack of knowledge and acknowledgement of MNS disorders, and the stigma attached to seeking and receiving treatment for MNS disorders are the major factors contributing to the gap between the disorders and treatment. More resources and even putting resources in the right places is only part of the answer to the problem.

Integrating mental health into general health care, decentralising and equipping health workers with the core competencies are the main thrust of the discussions at this workshop. Ironically, current debates around what needs to be done are no different from those of 30 years ago, or 20 years ago in 1994. The vision of what was required 20 years ago has not changed and remains focused on decentralised services, integration into general health care, more prevention and promotion taking into account the social determinants. The key principles that has prevented the vision being accomplished are decentralisation, integration into generalised health care, more prevention and promotion, advocacy and changing people's views and perceptions, and social determinants. Enabling legislation has not helped advance the cause for mental health. This stagnation can be attributed to a lack of or poor leadership, evidence or research, guidance literature, human and financial resources,

prioritisation of mental health, and understanding of MNS disorders and the needs of people with MNS disorders. It may also be due to an overloaded workforce and the fear of moving towards a decentralised mental health system or shifting resources allocated to mental health.

The National Mental Health Policy Framework and Strategic Plan 2013 – 2020 states, in respect of human resources, that by 2015:

- All health staff working in general health settings will receive basic mental health training, and ongoing routine supervision and mentoring. (In order to provide mental health services for all it would be essential to task-shift and to train people.)
- The expansion of the mental health workforce will be actively pursued by all provincial Departments of Health. (This will involve task-shifting and expansion of the workforce.)
- A task-shifting approach will be used in the development of the mental health workforce to allow trained non-specialist workers to deliver evidence-based psychosocial interventions with supervision and support from specialists.
- Capacity will be developed for staff in the national directorate for mental health and substance abuse, and for provincial mental health coordinators in policy development, planning, service monitoring and the translation of research findings into policy and practice.
- Non-health-related public sector workers and civil society partners at district level (including user-led service providers who can contribute to mental health care in the district) will have access to basic in-service training in mental health.

The DoH's current political leadership and commitment to the policy differs from that of 20 years ago. Even though the Minister of Health's priorities for the next term of office are uncertain, there is certainty about the United Nations' (UN) priorities in relation to the post-2015 Millennium Development Goals (MDGs) agenda or Sustainable Development Goals (SDGs) and it is critical for the DoH to set certain targets as part of the SDGs. The Minister has indicated that the three priorities in this context will be: addressing universal health coverage, completion of the current MDGs and addressing NCDs. The DoH has added mental health to its NCDs plan, but it is unclear whether or not mental

health is regarded as an NCD. If NCDs are included as part of the SDGs, presumably mental health will come together in the prioritisation process. The Minister is committed to ensuring the implementation of the new Mental Health Policy Framework for South Africa and setting up district mental health teams will be a crucial step in the process. The terms of reference for district mental health teams addresses the following:

- Adopting a public health approach to the mental health of the district, conducting a situation analysis of mental health needs and service resources in the district population, and developing an action plan for promotion, prevention, treatment and recovery.
- Establishing routine, ongoing training and supervision for PHC staff through the district specialist mental health team.
- Establishing routine referral pathways from primary health care to specialist services in each district.
- Introducing routine indicated assessment and management of common mental disorders (depression, anxiety and alcohol use disorders) in priority programmes at PHC level, looking at the integration of MNS disorders and other health problems, such as TB, HIV/AIDS, family planning, chronic diseases, antenatal and postnatal care within a certain district.
- Embedding suicide prevention and treatment at primary care level through identification of risk factors for suicide in all health service provision.
- Strengthening school systems for mental health promotion, prevention of mental illness, detection and management of child and adolescent mental disorders in schools, and referral where appropriate in line with the School Health Policy.
- Establishing posts for psychologists in community settings, and looking for opportunities for psychologists in psychiatric hospital settings to move to community settings.
- Providing clinical and consultation liaison services within districts.
- Encouraging implementation of the Traditional Health Practitioners Act by facilitating links between mental health services and traditional healers and

faith healers at local district levels, including appropriate referral pathways in both directions.

- Deploying intern psychologists and registered counsellors to provide training, supervision and support for counselling roles of community health workers.
- Building capacity for users (service users, their families) to provide appropriate self-help and peer-led services, such as support groups, facilitated by NGOs.

Time allocated to screening, follow up and counselling per percentage of 100 000 population will affect the level of FTEs required. Adding tasks to primary care workers will require additional time and resources. The core competencies required at each level of care could be easily determined, but work will have to be done to determine appropriate screening tools, as well as training curricula and courses. Congruency in respect of all aspects of the National Mental Health Policy Framework will be of the utmost importance.

Human Resource Mix for Integrated Mental Health Care using a Task-sharing Approach

Prof Inge Petersen, UKZN

Prof Petersen presented a case study, based on the work of the Programme for Improving Mental Health Care (PRIME), a multi-country collaborative project aimed at generating evidence on how best to integrate mental health into PHC settings. South Africa is one of five countries involved in the study. The programme's international partners include:

- Centre for Public Mental Health
- WHO
- Centre for Global Mental Health
- Basic Needs
- Perinatal Mental Health Project

PRIME in South Africa (PRIME-SA) works in collaboration with the DoH in one specific district, the Dr Kenneth Kaunda District in the North-West Province,

which has been selected as the PRIME site because of its status as a NHI pilot site, as well as a pilot site for Integrated Chronic Disease Management (ICDM). The ICDM model adopted in South Africa addresses servicing of all people with chronic diseases including people with mental disorders at a single service point. PRIME-SA is considering how to integrate mental health into the ICDM service delivery platform, focusing on three disorders: depression and alcohol misuse co-morbid with chronic conditions, and psychosocial rehabilitation for chronic psychotic disorders, embracing the task-sharing approach.

PRIME-SA plays a role similar to that envisaged for district management teams in terms of setting up a service. The project started with a formative phase including a situational analysis, theory of change, workshops with key stakeholders in the district and 87 in-depth qualitative interviews with service users, service providers, as well as focus groups, towards developing a district mental health-care plan.

Primary Care 101 (PC101) is an integrated set of guidelines for chronic diseases (including mental health) for PHC providers, piloted by the DoH in the nine NHI pilot sites, with a focus on strengthening the mental health-care component of the guidelines.

The role of the PHC nurse has been identified as being responsible for:

- identifying schizophrenia, alcohol misuse, depression and other mental disorders, and communicable diseases and NCDs using PC101;
- initiating initial management of these illnesses, including referral;
- providing follow-up repeat medication for chronic conditions (including schizophrenia).

The following three different collaborative care models have been developed for each of the disorders in collaboration with district health authorities, looking at the available human resources to implement the models within the district.

- Depression: PHC nurses would identify people with moderate to severe depression using PC101 and refer them to a PHC doctor and for counselling. People with suicide risk would be referred directly to the outpatient section for specialist care. Referred patients would be reassessed by the PHC nurse after nine to ten weeks and referred back to the local clinic for continued management.

- Alcohol misuse: PHC nurses would identify people with alcohol misuse disorders using PC101 and initiate screening brief intervention, included in PC101. Those identified as having alcohol dependency would be referred to the district hospital for detoxification and referred onwards to rehabilitation services.
- Schizophrenia: PHC nurses would identify people with schizophrenia and refer acute conditions to the district hospital, send them for observation management as contained in the Mental Health-care Act, and refer them onwards to a specialist in-patient care. After stabilisation, patients would be referred back to local clinics for continued management. A psychosocial rehabilitation intervention (which has been identified as a gap in the system) would be facilitated by auxiliary social workers or health promoters.

Community health workers in the system would be involved in case detection and tracing of non-adherent patients, as well as psycho-education to improve mental health literacy and self-referral.

Tasks performed by each human resource and tools provided to assist them to perform these tasks have been identified within the following tiers:

- PHC support team:

  The team is available at the district level and comprise a PHC manager, sub-district master trainer, a district or sub-district chronic care or mental health coordinator, a part-time psychiatrist, psychologists and intern psychologists at the district and sub-district hospitals, and the family physician. Services or tasks of each level of health provider on the team have been identified and specific tools have been placed at the disposal of the PHC management team responsible for PHC as a whole in the district as part of integrating mental health care into the PHC system. Change management workshops (for certain levels of health-care managers) have been introduced because historically, the health-care system geared towards acute episodic care and a shift to chronic care had not seen a change in staff attitudes to operate within a different paradigm of care. Chronic care requires a team-based approach and a shift from a biomedical approach to a more patient-centred approach. Each district or sub-district will have a master trainer who will train facility-based trainers in PC101 so that each facility has a PC101 trainer, ensuring provision of ongoing training, as well as supervision and support.

- PHC facility tier:

  This tier comprises the resources available at PHC clinics in the re-engineering PHC model (facility manager, PHC doctors, PC101 facility trainer, PHC nurse, lay counsellor, information officer, health promoter and community health worker), it looks at the services and tasks at each level, and provides tools to facilitate the integration of mental health care into the PHC management system.

- Community tier:

  This tier comprises social workers, auxiliary social workers, user groups, NGOs and private practitioners, as well as traditional healers. Engagement with traditional healers has not been addressed in the plan because more research is requried. The roles of each provider in terms of mental health have been identified and tools have been provided to facilitate the integration of mental health care. Social workers are responsible for assisting psychiatric patients in their applications for disability grants and for training and supervision of auxiliary social workers in the delivery of community-based psychosocial rehabilitation. Commitment has not yet been obtained from the Department of Social Development (DSD) to utilise auxiliary social workers for the delivery of community-based psychosocial rehabilitation. This highlights the need for much more multi-sectoral engagement in mental health care. User groups and NGOs will assist in psycho-educational campaigns to improve mental health literacy and reduce stigma and discrimination.

Identification of core competencies would be the next step in the process.

The implementation toolbox that includes all the material made available by PRIME-SA is as follows:

Material	Designed for use by	Purpose
PRIME Implementation Toolkit	All those involved in implementing PRIME in a facility	A how-to guide to implement An educational resource
PC101+ guideline 2014 edition	PC 101/PRIME trainers nurses, doctors, pharmacists, managers	Central training tool for PC101/PRIME trainers With accelerated mental health component
PC101+ training manual	PC 101/PRIME trainers	Used as interactive tool for on-site training
Lay counsellor step-by-step	Lay counsellors	Central tool for lay counsellors for delivering intervention groups
Psychosocial Rehabilitation (PSR) Facilitator Guideline 2014 edition	Health promoters, auxiliary social workers	Tool for delivering PSR group sessions
PSR training manual	PSR programme trainers	Facilitator training for PSR programme
Waiting room educational talks	Lay counsellors, health promoters, auxiliary social workers and nurses	Assist in making mental health issues accessible for all
Patient information leaflets and posters	Lay counsellors, health promoters, auxiliary social workers, nurses	Patient information leaflets and posters
Referral documentation	Nurses, lay counsellors, health promoters, auxiliary social workers, doctors	Standardise referral system
Supervision documentation	Supervisors, lay counsellors, health promoters, auxiliary social workers	Ensuring safe practice and care for those delivering

Human resource estimates, taking into account that task-sharing require additional resources, looked at existing coverage and used assumptions of current coverage and target coverage in 2025. Current coverage has been adjusted to accommodate findings from a recent facility detection survey that surveyed over 1 200 chronic-care patients from clinics. Findings showed that only 5% of people presenting with depression and less than 1% of people presenting with alcohol misuse disorder had been correctly identified. Conservative targets of 25% and 10% respectively have been set for 2025. According to figures from 2011 in terms of costs, the actual FTE per 100 000 population for care for these priority disorders is about two. Scale up according to the National Mental Health Policy Framework and Strategic Plan 2013 – 2020 and the inputs required in the plan, require just over nine FTEs per 100 000 population to reach these targets. The exercise showed that task-shifting would not be able to be implemented effectively without an input of resources.

In addition to the core competencies, the biomedical orientation of healthcare providers would have to shift as chronic care requires a patient-centred approach. Not everyone is suited to providing mental health care and employee assistance programmes are very important to support this initiative. System issues include:

- Lack of space for counselling
- High patient numbers
- Weak information systems for mental health
- Poor tracking of defaulters
- Exclusion of mental health care from job descriptions of lay counsellors and unclear roles of lay counsellors
- No targets for identification of mental disorders

Discussion, Q&A

Dr Angelique Coetzee:

1) Would the DoH clarify the role of the GP in the district mental health teams? The models do not show involvement of GPs. If GPs are not involved at district level, silos will be perpetuated within district mental health care.

2) There is a huge problem with regard to mentally ill prisoners being held in the same penitentiary facilities as normal prisoners. This should receive urgent attention.

3) How many psychiatrists are there in South Africa currently, in private practice, as well as the state system?

4) Does the use of 'psychologists' refer to clinical psychologists?

Response, Prof Melvyn Freeman:

1) There is a role for GPs in this system. I mentioned the issue of contracting GPs earlier. There is no reason why they should not play a mental health role as part of the contract. It would be necessary to look at the resource within a specific district because GPs might play varying roles depending on the resources available in the district. For example, the GP's role would be accentuated in a district where there is no psychiatrist.

3) I believe that there are about 800 psychiatrists on the registry currently but this does not mean that they are all in practice or are all in the country. About 60% of them are in private practice (serving 20% of the population) and 40% are in state mental health care.

4) At the moment the DoH employs clinical psychologists. We are looking at extending this to include community and counselling psychologists, and potentially others as well.

Dr Lawrence Tucker: There is quite a significant difference in the way we approach psychiatric and neurological conditions no matter what training there is or personnel we have doing this work. I understand why epilepsy is acceptable in this mix of primary conditions. Stroke is a very important illness and I can see why it sits uncomfortably in the conversations and should perhaps be looked at in terms of NCDs. Do we see a way of unifying the structures

for neurological conditions, such as epilepsy, which is not an illness but a condition?

Response, Prof Crick Lund: Dr Tucker's comment speaks to the fact that we have tended to drift into silos during this process. The value of this kind of forum is that it is an opportunity to come together and to realise that we have a lot in common in terms of our policy agenda. We are all speaking about conditions that have a high public health burden and are generally neglected in public health policy debates. Epilepsy is one of the conditions we are focusing on in three of the other PRIME countries (Nepal, Ethiopia and Uganda). A similar plan to the Mental Health-care Plan for South Africa is being implemented in the other three PRIME countries that have similar kinds of challenges. We should do more to lobby together as we have more power as a group but we do not have enough fora to do this. I agree that stroke is a slightly different area.

Prof Bronwyn Meyers: I agree with Prof Lund. We have a framework that we can use to apply to epilepsy and other common mental disorders and we should work together to push this agenda.

Dr Paulina van Zyl: There is a clear disjuncture. Substance abuse treatment and prevention is legislated by the DSD, but the medical treatment for substance abuse is the responsibility of the DoH. This is done in ordinary district hospitals or secondary or tertiary hospitals, which fall under the Provincial Hospital Act. Substance abuse as a directorate falls under mental health. Substance abuse is not mentioned in the Mental Health Act of 2002. Could this disjuncture be the main reason for the lack of prioritisation of mental health care in the DoH?

Response, Prof Melvyn Freeman: I would like to refer you to page 10 of the National Mental Health Policy Framework where this issue of substance abuse is addressed. Essentially it says that where there is co-morbidity we work more within the DoH. We do acknowledge that detoxification is a medical procedure and can be done within a health-care environment and we take responsibility for that. We work very closely with the DSD through their Central Drug Authority (CDA) and bilateral meetings.

Response, Prof Bronwyn Meyers: The Mini Drug Master Plan (MDMP) also allows for brief interventions in PHC settings for alcohol use disorders.

Dr Saiendhra Moodley: One of the objectives of the National Human Resources for Health Strategy is the establishment of public health units at each district, staffed by public health medicine specialists and other public health practitioners. These units have already started to be established in some of the districts. Has any thought been given to the role that these units will play in terms of implementation of the National Mental Health Strategic Plan given that the district mental health team seems to be responsible for what could be considered a public health role of conducting a situation and needs analysis?

Response, Prof Crick Lund: The Technical Advisory Committee did not think about this or know about these units being set up. Better coordination is necessary. One worries that if we were to integrate mental health into the function of public health units it would be dropped as in many instances in the past, and we would want to retain the function of the district mental health teams as fulfilling a public health function with a MNS disorder lens in the way they work. I would like to hear more about these units and how we can better coordinate between them and avoid duplication.

Dr Angelique Coetzee: People looking after stroke patients have the potential to suffer from depression or anxiety. Maybe we should look at stroke/epilepsy and the impact these have on health-care providers.

Dr Lawrence Tucker: All the reorganisation, task-shifting and so on must be based on training and education of those fulfilling the roles in order for them to do so competently. What are the ideas of the DoH in this context?

Response, Prof Melvyn Freeman: This links with the different legs of the strategy working together. We do not want a situation where training moves ahead of the rest. In each district there are district training authorities that are set up to do training, but they have not been doing much for mental health. It would be necessary to train the trainers so that they become master trainers. At the same time a lot of materials have been developed around telemedicine and other alternative training methods, and where feasible, these will be used.

Mrs Carol du Toit:

1) When we looked at the different functions of the various categories of workers or professionals in the PHC team (in Prof Petersen's presentation), the social workers are allocated functions to do with disability grants and training

auxiliary social workers. Is that what social workers are used for in that specific setting, or is this the view of a social worker's function?

2) Involvement of NGOs was in awareness and information, but were they used as referral sources as well? Some of them do provide specialised services.

Response, Prof Inge Petersen: I presented a case study of a particular district and I showed what was represented in the district at the time. Other services of social workers were not mentioned in that study. Getting the DSD to commit to providing resources has been a stumbling block, particularly getting the provincial directorates on board. This was a key challenge of the study.

Prof Solomon Rataemane:

1) The process in the DoH of establishing a Mental Health Technical Advisory Committee will be very important because they will perform a number of tasks. For example, we recognise that the data are not coordinated in the country and we need a common pool of data on different issues. The discussion on core competencies implies that we have a country that is not uniform, and some areas are better resourced than others.

2) We have about 500 psychiatrists in South Africa and 70% of them are in private practice, and the other 300 on the South African registry are outside South Africa. We find that there is a strong relationship between those working in private practice and those in public service because most patients are not on medical aid schemes and those who exhaust their medical funds by mid-year are sent to the public service. We give them different medication and this often leads to relapses. A team process is in place.

3) Those from psychiatry see the need to work closely with neurology. We teach neuropsychiatry and that involves working with neurologists and we handle many conditions together. Neurologists will have stronger participation in the teams that we want to build.

4) The CDA cannot function without the DoH. I think the new formation will ensure that we will work closer together. The WHO has given guidelines on how to manage substance abuse-related problems, including an essential drug list (EDL). Several good medications are not on the list. When the Tech-

nical Advisory Committee is fully appointed and able to advise the Ministry, these gaps will be identified and we will be in position to see what is already in place and what is cost-effective for the country. Evidence will be needed to support certain approaches. This is a key issue.

5) The process of core competencies has helped focus more on what we are doing and what we are not doing. This will lead to cohesion in terms of the way forward.

Unknown person:

1) Prof Lund mentioned something about rotation in training in the hospitals but nothing about training for community services. Will this also happen?

2) Prof Freeman spoke about some of the reasons for the change not happening but did not mention paternalism. Is this not perhaps one of the reasons why things have not changed in 20 or 30 years?

3) In Prof Petersen's presentation it seemed that there was a top-down effect. She spoke of task-shifting and task-sharing, but was it a mere use of terminology or it is actually happening? Is there any negotiation taking place in this regard?

Response, Prof Crick Lund: Community training is definitely part of the agenda using the PC101 tool. It is the core element.

Response, Prof Melvyn Freeman: The policy framework and plan was the result of a consultative process in which users took part. We did try to listen to that voice. Users are not well organised in South Africa. One of the terms of reference for the district teams is to help the building of user groups so that we can respond appropriately.

Response, Prof Inge Petersen: I mentioned in relation to developing the collaborative care models that we held theory of change workshops involving all stakeholders. Three workshops were held and all providers attended the workshops. The idea was to negotiate who does what. This underpins the collaborative care model.

Survey Findings: Current Status of MNS Disorders Curricula of South African Education and Training Institutions

Mr Ashley Govender, Contracted Researcher

Mr Govender was contracted in April 2014 to conduct an assessment of the current status of MNS disorders in curricula of South African education and training institutions. ASSAf designed a questionnaire (See Table 1) that was circulated to universities. Mr Govender was tasked with the following:

- Review, assess/evaluate and consolidate the inputs received from the questionnaires that were circulated to the different training and education institutions.
- Survey the training and education institutions' curricula handbooks on MNS disorders and to cross-check this information with that received from the completed questionnaires.
- Search and provide curricula information for institutions/departments that did not complete or return the questionnaires.
- Compile and consolidate a status report that would be reviewed by ASSAf before finalisation and approval.
- Present the study findings.

The IOM 2012 workshop summary document indicated that SSA has one of the largest treatment gaps for MNS disorders in the world and identified human resources as a critical contributing factor. The final discussion at that workshop highlighted the following points:

- The need to integrate MNS health care as a complement of general health.
- The need for community-driven public education to reduce stigma and misperceptions.
- The need to revise training and career paths of mid-level providers to offer degrees and career growth with continual education being of equal importance to the initial provider trainings.

- The lack of system level competencies in supervision, teaching, leadership, and advocacy at all curricula levels and the need to address these in order to ease the integration of MNS care into general health care.
- The use of information technology to enable remote consultations with experts by providers in remote or rural areas, and to enhance training and mentoring.
- The application of lessons learnt from examples of successful integration of MNS disorders into the established health systems to guide implementation in training and engagement.
- The importance of collaboration and engagement of stakeholders in improving care for MNS disorders in SSA.
- The need for evidence-based research to secure the support of stakeholders.

Table 3 Questionnaire to South African education and training institutions.

BACKGROUND INFORMATION	
Name of the University/Institution	
Name of the Faculty/School/Department	
Location of the Faculty/School (Province and City)	
Your Full Name (Optional)	
Your Position/Job Title	

CURRICULA INFORMATION						
Name of module/ course/ programme	**Level of study** *(1st year 2nd,… post-grad)*	**Part of which degree(s), diploma(s) or certificate(s)** *(list all of them)*	**Description of MNS disorders content in formal lectures** *(list main topics/ themes that are covered)*	***Estimated # of hours per module on MNS disorders in formal lectures**	**Description of MNS disorders content in clinical teaching**	**Estimated # of hours per module on MNS disorders in clinical setting**

ADDITIONAL INFORMATION	
Your institution offers other opportunities (formal and informal) for exposure to MNS disorders as part of the training and education	Yes ☐ No ☐ If 'yes' please mention them and indicate for which degree/diploma, if applicable:
Challenges related to the MNS disorders curricula within your institution	Yes ☐ No ☐ If 'yes' please mention the key five challenges:

•Note: While the number of hours spent on theory and practica could not be determined, respondents had indicated that a large amount of time was spent on theoretical content and practica/clinical setting content.

Survey Results

Several universities perceived the questionnaire as a formal study that required ethical approval and therefore did not complete the questionnaires. Relevant departments of the following five institutions completed the questionnaire:

- Monash University South Africa – Psychology
- University of the Free State (UFS) – Nursing
- UKZN – Nursing
- North-West University (NWU) – Biokinetics, Nursing, PHARMACEN, Pharmacology and Social Work
- Wits – Occupational Therapy

ASSAf had contacted other institutions in the further education and training (FET)/higher education and training (HET) band that offered programmes in MNS disorders, but was unsuccessful in obtaining the required information. The Department of Higher Education and Training (DHET) website was used to identify universities and FET colleges in South Africa, and the South African Qualifications Authority (SAQA) website was accessed to identify all programmes related to MNS disorders.

Of the 24 universities identified on the DHET website, six (25%) responded and a total of nine questionnaires were completed.

The initial search for SAQA-registered qualifications for each university (as the accredited provider) yielded a search result of 7 215 qualifications. A narrowed search used these keywords: 'mental, neurological and substance use' to identify qualifications related to MNS disorders, and were examined for relevance and yielded a total of 136 qualifications. The 2009 National Qualification Framework (NQF) Level Indicator was used. In terms of SAQA-registered qualifications for MNS disorders per university (Figure 1), UCT had 19 qualifications, UKZN had 34 qualifications, University of Pretoria (UP) had 20 qualifications, Stellenbosch University (SU) had 18 qualifications, University of the Western Cape (UWC) had 11 qualifications and Wits had eight qualifications, representing 80.9% of relevant qualifications identified.

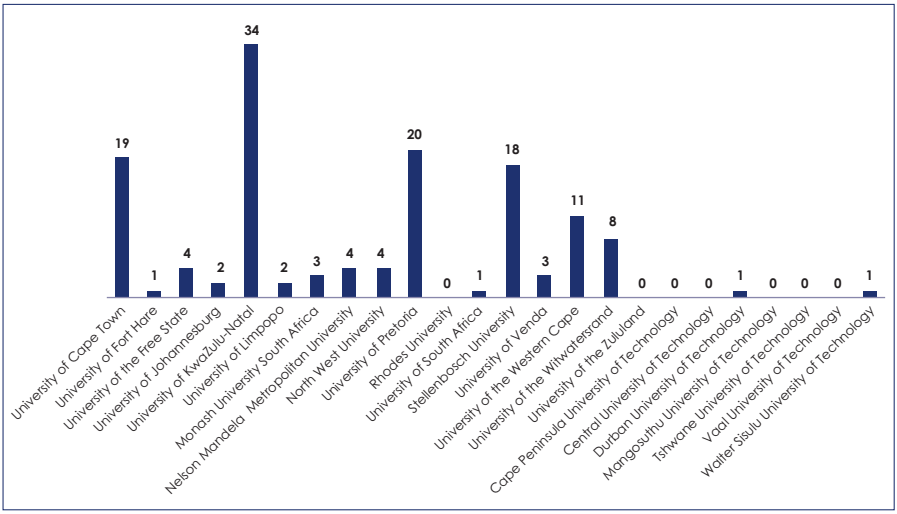

Figure 1: Number of Registered Qualifications related to MNS on the SAQA Database

Further sorting was done for programmes offered at UCT, UKZN, UP, SU, UWC, Wits, UFS, Monash University South Africa and NWU, which represented 121 (89%) of the 136 SAQA-registered programmes. Programmes ranged from NQF Level 05 (Certificates) to NQF level 10 (doctoral), with a mode of 52 (41%) for NQF level 09, followed by 37 (30%) for NQF level 08. Completed questionnaires were used to guide the qualitative analysis of the curricula in the universities' handbooks.

The MNS content according to modules of qualifications at each NQF level was identified as follows:

- NQF level 05: A single qualification (Certificate: Nursing: Mental Health) with a 50% mental disorder content in its modules.
- NQF level 06: A single qualification (Diploma: Nursing: Mental Health Nursing) with a 25% mental disorder content in its modules. In addition, UWC offered a winter school related to alcohol problems, hosted by the School of Public Health.
- NQF level 07: Ten qualifications (Bachelor degrees) with mental disorder content ranging from 1.3% to 33%, neurological disorder content ranging from 6.1% to 15% and no content specifically related to substance use disorders.
- NQF level 08: 17 programmes relating to MNS disorders. The mental disorder content ranged from 1% to 50%, neurological disorders ranged from 2.9% to 58%, and substance use disorders content ranged from 2% to 50%.
- NQF level 09: The Masters programmes had a content relating to MNS disorders. Mental disorder content ranged from 11% to 50%, neurological disorders content ranged from 33% to 100% and substance use disorder content was 67% because of a single programme that related specifically to substance use disorders.
- NQF level 10: The analysis of programmes at NQF level 10 (doctorates) indicated that the programmes' content relevance to MNS disorders was dependent on the exact focus of the area of research. This was true for each of the four programmes identified.

Limitations of the study:

- Although attempts were made to obtain all the handbooks from the various university websites, in some cases the information was not readily available. However, the information obtained was representative of more than 80% of the qualifications available.
- The questionnaire design did not make provision for detailed information to be obtained and it asked for the number of hours spent on each activity while the study utilised the number of credits per module and total programme credits to determine MNS disorder content.

- A number of programmes, such as the NQF levels 05 and 06 programmes, will not be continued into 2015 and will not be replaced by other programmes. In addition, more recent curricula due to be used from 2015 have not yet receive SAQA accreditation and therefore were not included in the study.
- It was not possible to determine the clinical MNS content of any of the qualifications.

The study reached the following conclusions:

- The MNS disorder content in qualifications was concentrated in NQF level 09 (41%) and NQF level 08 (30%) programmes.
- The mental disorder content was found in all NQF levels examined. Although NQF levels 05, 06 and 07 seemed to have a large mental disorder content, this was possibly related to the smaller programmes (that did not have a high credit value) and the allocation of all the credits for a module (such as an introduction to psychology module offered in first year) that related to mental disorders could have produced an exaggerated perception of mental disorder content.
- Only at NQF level 08 did the programme content include mental disorders, neurological disorders and substance use disorders.
- The programme content for MNS disorders reached 50% from NQF level 08 and 09. In general, the MNS disorders content increased in the higher NQF levels where programmes had a narrow focus on MNS disorders.

Discussion, Q&A

Prof Bronwyn Myers: What about the spread of curricula for substance use disorders and whether the curricula are concentrated in any of the provinces, or whether any gaps were noticed?

Response, Mr Ashley Govender: I did notice that the UWC and SU had good programmes relating to substance use disorders, whereas the other universities did not focus on this area.

Prof Bronwyn Myers: I had expected that there is a huge gap in terms of coverage by the other provinces because the Western Cape Provincial Department of Social Development has provided large amounts of funding to develop curricula around substance use disorders and has invested funding in all three universities in the province.

Mr Mark Lewis:

1) The South Coast Recovery Centre (SCRC) deals with substance abuse and about 40% to 60% of our residents are also dealing with other psychiatric disorders and are on psychiatric medication. There is an extremely close relationship between substance abuse and mental disorders and both have to be treated, with substance abuse being treated first. Relapse on substance abuse and how this triggers other disorders is an area that requires more work. The lack of education around substance abuse must be addressed. It is difficult to find course material to develop training in this area.
2) It is very difficult to get support specifically from provincial hospitals in order to do detoxification. This matter also requires attention.

Prof Crick Lund: Did you capture any information on the number of mental and neurological substance use disorder professionals that are being trained every year and the number currently in training? It would be interesting to know, for example, how many neurologists, psychiatrists, psychologists, social workers and counsellors are being produced every year.

Response, Mr Ashley Govender: This was not part of my brief, but perhaps it should have been. I think that a proper review of all the curricula drilling down into the course content would be useful.

Dr Lawrence Tucker: There are about 120 practising neurologists in the country and about 30 of them are in the state sector. In terms of throughput, we have 35 registrars in training at any one time, including all the medical schools, and one-third of these get through each year. This means that we produce eight to ten neurologists a year. In terms of specialist training, the Master of Medicine (MMed) Neurology and the MMed Psychiatry is the same qualification and used to be a qualifying degree for specialist practice. More recently, the colleges have taken over the role of administering the exit examination for the specialist qualification. The MMed is still required but is no longer an exit exam. It might be worthwhile looking to the colleges to see how many specialist degrees or specialist fellowships or diplomas are being issued. This would also give an idea of what expertise is in the country.

Prof Melvyn Freeman: I want to thank ASSAf for having commissioned this study. However, it is a little disappointing that not all the universities responded and this gives a distorted picture of the reality. The suggestions that we need to follow up and do more in-depth research might be in order. I do not understand how psychiatry training amounted to only about 67% dealing with all three of the areas. What did the other 33% deal with?

Response, Mr Ashley Govender: In drawing up the report I did not use the questionnaire. I used the SAQA website to download all the registered qualifications. I looked at the university handbooks to get details on the different programmes and modules offered by the institutions. If the modules related in any way to MNS disorders, the total percentage for the module credit was allocated.

Mr Sifiso Phakathi: Training of core competencies involves fundamentals that are added on. This mix needs to be understood especially in relation to task-shifting and task-sharing, and adding these on to the training.

Unknown person: I was intrigued by the fact that you said that SU and UCT are doing training in substance abuse, but I realised that these are not a core part of the curriculum for registrars. Not many of the psychiatrists go on to do this training. I was the last registrar participating in the six-month rotation at the old Avalon Alcohol Rehabilitation Unit and since then there has been no rotation at either SU or UCT on substance abuse, particularly alcohol abuse. I suspect that of the three different areas, the gap is substance use despite the fact that

one of our problems is dual diagnosis (psychosis with one or other substance use). The other gap is that very little attention is paid to public mental health. If it were not for Prof Lund and his team there would not be any public mental health being taught at UCT or at SU. An editorial in the 2013 *South African Journal of Psychiatry* lamented the lack of input from the college in the matter of ensuring that public mental health becomes a core component of registrar teaching. The Head of the College of Psychiatry made a commitment to the inclusion of public mental health as part of the curriculum for registrars.

Prof Inge Petersen: It would be helpful to look at more of the content in relation to the core competencies that we have identified in the human resource mix, and to look at how well this has been matched in terms of training. This would be an important future exercise. I also want to emphasise that public mental health is incorporated into the training for professional specialists and psychologists.

Prof Bronwyn Myers: What strikes me is the lack of a pipeline to the specialised courses, especially in relation to substance use disorders. It is difficult to attract people who already have a qualification for specialised training because we are not attracting them earlier on in their training. This is concerning because in the long term we will not be producing the number of people to fill the new posts in the speciality areas.

Unknown person: There is a growing demand for private dual diagnosis units. This is where the qualified people are being employed because the state sector does not provide places for them to use their qualifications. The state is not offering this service.

Dr Angelique Coetzee: I appeal to those responsible for curricula to take account of the fact that GPs cannot do courses that require them to leave their practices for long periods of time.

Prof Crick Lund:

1) I want to make another suggestion to take the work done by Mr Govender a step further. The IOM framework presented earlier is a useful lens to apply to the core competencies of the various professionals. It might be worth looking at the curricula in relation to those and the extent to which the curricula provides skills to detect, diagnose, treat and refer, and map core competencies onto the existing training curricula.

2) I would like to appeal for the case of psychologists in respect of the lack of evidence base in the training of clinical psychologists in this country. This requires a special focus.

Ms Annalie van den Heever: It is one thing to teach the modules in a classroom and another to put the training into practice. I feel that there is a need for training facilities in the clinical areas because nursing students need to be part of groups that are run by psychiatrists and they do not get the experience they require in terms of substance abuse dilemmas. Students do assessments on the patients and they all have to do the same clinical work. Psychologists and psychiatrists need to train the students at the clinical facilities.

Mr Mark Lewis: It is very difficult to get accepted to specialise in psychology. We need to consider whether we are allowing sufficient people to follow this specialised area.

Unknown person: SAQA has spoken about horizontal articulation of programmes for many years. I am not sure if this has been implemented yet. I noticed in a study that I did that there is a very small focus on the child and adolescent aspect and this is where the damage is happening. More prevention is needed. We also need to get early treatment.

Dr Thirusha Naidu: It is a problem that we do not train enough psychologists in the country but I do not think that training more is the solution. We need specialised training and specialised mental health practitioners. Prof Petersen and PRIME have the right idea. We do not want to spend years training psychologists. We need more low-level cadres to break down competencies and task-sharing.

Prof Ashraf Kagee:

1) There is a case to be made for the evolving roles of clinical and counselling psychologists in public service to one that is more of management, supervision and support to other professionals who are in direct contact with patients.

2) The issue of training is complex. SU's Department of Psychology would love to train many more psychologists but we do not have the capacity to do so. We need many more clinical supervisors and it is very expensive. We only train ten students at Masters' level. It is not possible to increase that number even though there is a huge need in the country.

3) In terms of the scope of practice promulgated for clinical psychologists and counselling psychologists, it appears as if the counselling psychologists' role is limited to dealing with life challenges and developmental problems whereas clinical psychologists are allowed to assess and diagnose psychopathology. Many do not believe that there should be this differentiation.

Wrap-up and Closure for Day One

Prof Bronwyn Myers, MRC

Prof Myers highlighted the following recurring themes that were raised during the day's deliberations:

- There is a need for better data and evidence in order to build a business case for prioritising mental health and mental health interventions in PHC.
- Consumer voices are key and need to be strengthened in South Africa.
- There is a need for better integration or collaboration across sectors and government departments, and within sectors.
- A tailored approach to training and to developing the human resources mix for each health district moving towards implementation is required. A one-size-fits-all approach is unsuitable.
- It is necessary to focus on building strong collaborative teams.
- Technology, such as mobile health (mHealth), needs to be harnessed to achieve and support integration. mHealth could be used to assist with supervision, case finding and case detection.
- Capacity needs to be built for service planning.
- There is a clear need for additional resources, but the NHI is also an opportunity for harnessing additional resources.
- It is necessary to consider how the role of specialist mental health providers should evolve to meet the needs of a task-shifting and task-sharing approach.
- It is necessary to consider the current training curricula in relation to the human resource needs that have been identified within this approach.

DAY TWO

SESSION THREE: CHALLENGES AND OPPORTUNITIES FOR EFFECTIVE IMPLEMENTATION OF MNS DISORDERS CORE COMPETENCIES

Facilitators: Dr Bruce Altevogt, IOM and Prof Arvin Bhana, UKZN

Recap from Day One

Dr Bruce Altevogt, IOM

Dr Altevogt recapped on points raised under some of the recurring themes during the previous day's proceedings, as follows:

- Holistic care:
  - The importance of a holistic care model.
  - Health promotion, prevention, treatment and recovery.
  - Task-shifting and task-sharing, and the collaborative care model.
  - Address how providers relate to each other.

- Workforce capacity:
  - The need to balance implementation with realities of how much time and resource providers the DoH has, by:
    - considering the correlation between the needs and the existing capacity and doing an assessment in this regard;
    - considering the impact on the number of required FTEs;
    - balancing FTE 'investment' with health and economic benefits in order to ensure that investment impacts community health, individual health, as well as the economy as a whole;
    - considering how to ensure training and education programmes are developed in a coordinated fashion.
  - The need to understand the baseline training programmes by looking at who is doing what, modifying and expanding the survey of the current status of MNS disorders curricula at South African education and training institutions.

- Considering the role of mHealth and tele-health to increase capacities.

- Enabling a national dialogue:
  - The need for coordinated and ongoing national multi-sectorial dialogue, including all sectors represented at the workshop, as well as the private sector, and the possible role of ASSAf in convening this activity.
  - The need to engage and work with provincial and district leadership.
  - The challenge of leveraging existing guidance into formal policies.
  - The need to enable a stronger consumer and advocacy voice.
  - The collection of data to demonstrate the health and economic impact of MNS disorders.

Breakaway Session One: Provider Groups

Participants were invited to join one of the following provider groups:

1) Community/lay workers
2) Non-specialist, non-prescribing providers
3) Non-specialist prescribing providers (including nurses)
4) Specialist providers

The groups were given the following brief for their discussions:

- Using the framework of current mental health service providers from the case study presentation discuss whether there are other categories of health workers who also need to be represented in this framework in your provider groups.

- Identify the following:
- What should providers be trained in to meet service requirements within a task-sharing approach?
- What are they currently being trained in?
- What are the gaps?

Feedback from Groups

1) Community/lay workers

Rapporteur: Ms Charlene Sunkel

Are there other categories of health workers who also need to be represented in your provider groups?

The group comprises HIV counsellors, community health workers (under the DoH), social workers, social auxiliary workers, community development workers (under the DSD and NGOs), support group facilitators, advocacy group representatives (under NGOs), traditional healers, faith-based organisations and teachers in the educational sector.

What should providers be trained in to meet service requirements within a task-sharing approach, what are they currently been trained in and what are the gaps?

Chronic-care counsellors (DoH)

Training received by lay counsellors is diverse and should be standardised and resources should be made available for referral purposes. They should receive training to identify mental disorders and substance use disorders, and in psychosocial rehabilitation, human rights, as well as after care.

Social workers (DSD)

DSD social workers are often inadequately informed or trained in the areas of mental disorders and there is a gap between the referral systems used by social workers from the DSD to NGOs that specialise in mental health. Training required includes:

- Resources for referral purposes
- Identification of mental disorders and substance use disorders
- Psychosocial rehabilitation (a core function of social workers)
- Human rights (should form part of all the core competencies)

- Follow-up and hand-over of cases to NGO social workers
- Computer literacy, for all categories of providers in this group

Social workers, social auxiliary workers, community development workers (NGOs)

Training required is similar to that for DSD social workers. The NGOs sector develops training materials and provide training to communities and government departments, but the courses offered are not accredited.

Support group facilitators and advocacy group representatives

Training should include identification of mental disorders and substance use disorders, treatment options available, resources for referral purposes, human rights, support groups facilitation and psychosocial rehabilitation.

Traditional healers and faith-based organisations

Training required in this sector should include mental disorders and substance use disorders, resources for referral purposes and human rights.

Teachers

Teachers often play a vital role in the awareness and prevention of mental disorders and substance use disorders and teacher training should include these areas, as well as the identification of the conditions. Life-orientation teachers should be trained in doing basic counselling. Although districts provide psychologists to schools, teachers are often unaware of how to access these psychologists.

Challenges discussed by the group included:

- Mental disorders and substance use disorders are often not integrated and are treated separately. There is a need to provide integrated services and deal holistically with these disorders.
- The DSD deals with all areas of substance use whereas some areas, such as medication prescribing, is dealt with by the DoH.

Discussion, Q&A

Mrs Carol du Toit: Training programmes offered by NGOs to social workers and other health professionals who are registered with professional councils can be accredited as part of continuing professional development (CPD).

Unknown person: This category of service provider is the backbone of mental health services, as in the WHO model. They have a very important role. Promotion and prevention, as well as rehabilitation, are critical and are often downplayed. In training and in defining the competencies we need to focus on these aspects as well.

Mr Mark Lewis: After-care support structures are excluded from these discussions. Emphasis is on the primary care treatment, but without after-care support there will be more cases of relapse and resources will be wasted. The focus on after-care support is critical.

Prof Inge Petersen: A lot of community-based care is left to the NGOs sector. I think that the NGOs are doing an exceptional job but they are not receiving sufficient funding and support. They rely on subsidies and donor funding. This is not the way we want to treat our people with MNS disorders and it is a very serious problem. The DSD is not really willing to take up this matter. How do we motivate for greater subsidies to the NGOs in order for them to do this work?

---

2) Non-specialist, non-prescribing providers

Rapporteur: Prof Ashraf Kagee

Are there other categories of health workers who also need to be represented in your provider groups?

Points raised in discussion were:

- The group questioned whether the National Mental Health Policy Framework was adequate to include the range of service providers that are needed to address MNS disorders. The framework is rooted in the medical model and does not adequately address the holistic needs of

patients. The biopsychosocial model (and possibly the biopsychosocial spiritual model) is a more inclusive framework. There is a need for a deeper discourse in order to avoid repeating the patterns of the past and leaving assumptions unchallenged.

- It is important for each profession to understand the competencies of other professions and for there to be greater interaction among the different players who provide services to people with MNS disorders.
- Rehabilitation does not seem to be a priority and medication is only effective up to a point. Rehabilitation is needed to keep patients out of hospital. The medical model is therefore limiting and insufficient when looking at task-shifting.
- The model should be client-centred. Clients are also experts in their own right and can provide inputs into the process. The clients are key to the process.
- Family members need to be involved in knowing how to take care of those in their families who have MNS disorders.
- Pharmacists should be considered integral to MNS treatment. They have access to the entire pharmaceutical and medical profile of the patient and know about drug interaction.
- Professionals and other groups that should be included in the framework are:
    - Registered counsellors
    - Social worker auxiliaries (registered with Council for Social Work in terms of the supervision framework)
    - Child and youth care workers (who now have their own board and are regulated)
    - Caregivers
    - Occupational therapy professionals and technicians (who are trained specifically for working in communities)
    - School health nurses (professional nurses and enrolled nurses who work under their direct supervision)

- Existing policies do not allow some of the auxiliary professions to work in public health. There is a need for dialogue between government and professional bodies in this regard.

What should providers be trained in to meet service requirements within a task-sharing approach, what are they currently been trained in and what are the gaps?

- The existing resources (both profession and lay) should be used adequately, including NGOs, community-based organisations (CBOs) and volunteers.
- There is a need for inter-professional training in community-based education and development at fourth-year level.
- Core competencies should be identified among lay people and volunteers (persons without formal training).
- NGOs are not necessarily utilised effectively. NGOs could be used to present substance abuse training and awareness, and help increase the identification of people with MNS disorders for referral.
- The core competencies mix should:
    - understand what an MNS disorder is;
    - recognise an MNS disorder at a basic level;
    - know pathways for referral using the stepped-care model, with greater levels of specialisation across the referral trajectory.
- There is recognition for the involvement of spiritual leaders, faith healers and traditional healers as part of the treatment team as long as their counselling and advice do not contradict the other forms of treatment. Their role in treating MNS disorders needs to be clarified.
- There is a need for a reciprocal relationship with traditional and faith healers.
- Fluency in African languages among all providers of care, or the use of skilled, qualified interpreters is an important aspect to ensure communication between providers and between patients and providers.

- Community projects could be viewed as part of continuing treatment.
- Public awareness programmes could assist with early stage identification of MNS disorders in communities.
- Health promoters and social media have a role to play in prevention and promotion awareness.
- Available resources should be optimised.

Discussion, Q&A

Unknown person: In understanding what each provider can do and how to include faith healers and traditional healers, it would be important to interact and collaborate at a lower level and not only at a specialist level.

Prof Solomon Rataemane: What services of traditional healers should be included? This needs further discussion.

Response, Prof Ashraf Kagee: We did not go into this in depth. The fact that many people in communities go to traditional healers as a first point of call indicates that there should at least be a referral pathway from a traditional healer to a clinic where treatment is offered and there could be some kind of collaboration with traditional healers in enhancing adherence to medical regimens and so on. This requires some level of thought and comprehensive understanding of the role of traditional healers.

Unknown person: There will have to be some indication of how the different groups engage with each other (not only with traditional healers) in terms of training, roles, their particular skills sets, etc.

Ms Tania Rauch-van der Merwe: There is an apparent underlying inter-measurability of paradigms. As long as we engage in binary communication we will not make progress. In our new curriculation, we have replaced one of the basic sciences with anthropology in the second year. Part of the module is a range of lectures in traditional healing. This is one way to try to include everyone in the community.

3) Non-specialist prescribing providers (including nurses)

Rapporteur: Dr Katherine Sorsdahl

Are there other categories of health workers who also need to be represented in your provider groups?

- Current non-specialist prescribing providers included professional and registered nurses, who are allowed to prescribe depending on the schedule, medical doctors and GPs.
- Although there are some gaps, there are also opportunities, such as clinical associates who have the potential to prescribe if trained appropriately, as well as pharmacists.

What should providers be trained in to meet service requirements within a task-sharing approach, what are they currently been trained in and what are the gaps?

- There are numerous gaps in the training that is being provided.
    - Nurses are trained in basic pharmacology and doctors as well, depending on the year they graduate and the different institutions.
    - GPs could do a six-month course to learn to prescribe various medications, but are not in a position to leave their practices in order to follow the full-time course.
    - No training is available for substance use but nurses could be trained to do detoxification.
    - All nurses and other providers in this group should be trained in screening, identification, diagnosis, treatment modalities and referral, including interactions related to overdose symptoms and danger management, and drug interactions.
    - Basic counselling education advice is also important particularly in terms of therapeutic alliance and client-centred approach, and it will help with referral processes in the stepped-care models.

- Refresher courses are essential in order to keep pace with the latest evidence.
- Supervision, feedback and reflection are other very important aspects of training required in order to ensure sustainability over time and throughout the stepped-care model.

4) Specialist providers

Rapporteur: Dr Laila Asmal

Are there other categories of health workers who also need to be represented in your provider groups?

- Psychiatrists and psychologists are reasonably well represented.
- Specialist nursing, advanced nursing, and family physicians are other categories of health workers who should be represented as part of the specialist provider group.
- Public health medicine specialists have a huge role to play especially in terms of system and epidemiology skills that can be used for partnering with psychiatry specialist providers.
- In addition, these specialists have undergraduate medical training which can be valuable for patient interaction.

What should providers be trained in to meet service requirements within a task-sharing approach, what are they currently been trained in and what are the gaps?

- It is recognised that mental health specialists have an identity as a collective and are a skilled group.
  - Their role as specialist providers is to filter down skills, or task-shifting, but also to see difficult cases and to be task-sharers.
  - Specialists should not be protective of their skills as there is too much work to be done.

- Specialists have a collective set of skills but are deficient in their public mental health approach.
- Challenges include the creation of an interface between university and community in terms of clinical skills, research and translating evidence into practice.
- Specialists lack community-engagement skills, advocacy skills and the ability to filter skills down.

Discussion, Q&A

Dr Lawrence Tucker: The group raised the important point that this could have been a summary of a meeting ten years ago. How are we going to ensure that this time we are going to be able to implement at least part of what we are intending to do? This issue must be addressed as part of the obstacles to implementation. We should avoid becoming despondent.

Prof Arvin Bhana: This important matter should be added as one of the actions from the workshop, together with some clear recommendations concerning the next steps to be taken.

Mrs Carol du Toit: Has any thought been given to the involvement of the DSD as the lead department with regards to substance abuse in this country, particularly in terms of legislation, policy and so on?

Dr Laila Asmal: This point should be added to the group's report.

Breakaway Session Two: Sector Groups

The sectors were grouped as follows:

A) NGOs, civil society organisations (CSOs) and advocacy groups

B) Health professional and education bodies/councils/associations

C) Academia

D) Government

The groups were requested to discuss the role that the specific sectors should play in relation to addressing the gaps in training across the service provider groups.

Feedback from Groups

A) NGOs, CSOs and advocacy groups

Rapporteur: Prof Bronwyn Myers

What role should your sector play in relation to addressing the gaps in mental health training across the service provider groups?

The following key points were raised during the discussion:

- The need to increase awareness of available training materials in the NGO sector.
- Many NGOs and CBOs have a national footprint with training portfolios that have been developed to address community needs, but these resources are underutilised. The valuable training material could be harnessed to help address the gaps in mental health training for MNS disorders in the country. In order to do this, there needs to be better collaboration and linkages between NGOs and the health sector so that the skills present in the NGO sector could be utilised.
- Inter-departmental collaboration and better coordination are necessary in order to respond adequately to MNS disorders and to impact on

training, which currently occurs in silos (for example, the DSD focused on training for substance use disorder and the DoH focused on training for mental health).

- In-service training should incorporate interactions with people with lived experiences. People with lived experiences have a vital role to play in training. Engaging with these people could help sensitise professionals to real experiences of people, how they experienced symptoms and what treatment helped them. They need to be included in the development of policy and guidelines that could lead to service improvement and help address stigma around MNS disorders.
- Students studying mental health-related courses should be placed in NGO/CBO sectors and community settings as part of training. This would provide many experiential learning opportunities and would:
  - assist to close the gaps in training;
  - expand the cadre of people available to provide mental health services in CBOs;
  - help break down barriers between health providers and communities.
- The sector could help health professionals understand that their clients are whole people with multiple needs, and more than just their MNS disorders.
- The sector has a role in educating the public about when to seek help, how to navigate the referral pathways and seek appropriate resources for their MNS disorders.
- The sector plays an important role in community engagement as there is an understanding of a systems approach and holistic service delivery, as well as communities and community dynamics, and could contribute this knowledge to panel discussions concerning clients.
- NGOs and CBOs are deeply involved in research. Findings from the research should inform treatment and service development.
- The sector has collective experience and expertise in needs-based MNS disorder prevention.

- Most NGOs facilitate support groups and engagement of people in support groups and could contribute to after care and ongoing support of patients once they exit the health-care system.
- NGO sector subsidies are limited and there are shortfalls in funding, which hampers their ability to adequately fulfil their role at community level.
- The sector has an advocacy role to play within the health system and with policy, to address stigma and the lack of policy and guideline implementation. More funding is required in order to fulfil this role.
- Police need basic training in their role within the mental health system, particularly in relation to involuntary admissions.

B) Health professional and education bodies/councils/associations

Rapporteur: Dr Angelique Coetzee

What role should your sector play in relation to addressing the gaps in training across the service provider groups?

The key points raised in discussion in relation to the role of the sector in addressing the gaps in training of service provider groups, were:

- Undergraduate student training
    - Entry into understanding social and psychological sciences should come earlier in training of all health professions. Students should be introduced to psychology in the first to third years of study before psychiatric rotation in the fourth year onwards.
    - There is a need for more training in substance abuse. Some universities offer training, but performance assessment shows that it is often not taken very seriously.
    - Standardisation of training and curricula across professions, including new professions that are registered and regulated (for example, social work auxiliaries, and child and youth workers) is important.
    - Nurses need to be trained to participate more effectively in the

team (for example, in screening and assessment of MNS disorders).

- Ongoing supervision and support are required in diversifying skills and knowledge down the cadres. Psychologists already have these skills base, for example, motivational talks, facilitating groups, imparting skills on a group level, but some of the supervision would be specific to particular professions.
- More integration is required between professions during training in order to consider best management of the patient.

- Postgraduate student training
  - Research skills with respect to implementation in a clinical setting need to be taught at both undergraduate and postgraduate levels.
  - More integration between professions is necessary during training in order to consider best management of the patient.
- Induction, orientation and ongoing training
  - There is a need for greater standardisation between the different professions and a need to build a bridge between hospital-based and outpatient-based treatment and support.
  - Councils should review all the ethical guidelines for induction to avoid malpractice.
  - Induction should be compulsory for all health professions, and take on a multi-sectorial responsibility.
- Refresher courses
  - Service providers: Health professionals should impart skills and share knowledge with other groups and levels.
  - Psychiatry: This area is very pertinent to primary diagnosis, particularly as 60% of patients have some form of MNS disorder, which is not necessarily identified in routine medical examinations.
  - CPD points need to be revisited: Practitioners require CPD in a range of areas. CPD workshops in MNS disorders are recommended for attendance by all levels of practitioners.

- Scope of practice
    - Scope of practice tend to be violated by practitioners who are delaying to refer patients to relevant specialists (for example, paediatricians treating attention deficit hyperactivity disorder (ADHD) and educational psychologists treating psychiatric patients).
    - The public should be made aware of the scope of practice of the various health professions.
    - Scope of practice issues differ in private and public practice. In private practice the scope of practice relate to which profession receives payment.
    - Scope of practice for each profession would have to be clarified and ring-fenced.

C) Academia

Rapporteur: Dr Katherine Sorsdahl

What role should your sector play in relation to addressing the gaps in training across the service provider groups?

The group felt that an audit was required to look at SAQA accreditation in order to map the landscape in terms of all of the cadres of social and health-care providers. Skill transfers would become clearer once this has been established.

The following key points were raised in discussion:

- In terms of specialist providers, it is necessary to ensure that standards and expertise in the country are of a high level, and to perpetuate training of particular disciplines, avoiding producing many poorly trained professionals.
- The transfer of skills is needed to equip people to be able to help patients with MNS disorders.
- There needs to be a dialogue between different institutions. For example, neurology organises annual meetings of heads of departments from

different institutions in a variety of areas of expertise, providing the opportunity for knowledge transfer.

- It is necessary to ensure that students are equipped with evidence-based interventions in order for them to be able to help patients successfully. This could be done together with ASSAf.
- The HPCSA could integrate public mental health as a core competency. This would ensure that all training is uniform and allow systems to be set up making task-shifting more feasible.
- Collective decisions need to be made with regards to public mental health and more discussion on integration of mental health into the core competencies is necessary. This would allow for a blueprint for purposes of comparison over the years.
- Cost-effective and mainstream web-based teaching and applications should be utilised for training.

D) Government

Rapporteur: Dr Robin Allen

What role should your sector play in relation to address the gaps in training across the service provider groups?

The following key points were raised in discussion:

- The National Mental Health Policy Framework is already in place but it has to be translated and made applicable to every district and province of the country through customising a generic model. Willingness to buy into the generic model is crucial.
- In order to develop models, a situational analysis or audit should be conducted to look at the cadres of social and health-care providers and to verify whether the appropriate systems are in place in each province or district in accordance with the framework.
- Training should not only be offered at higher levels of government as much of what happens on the ground will inform the implementation of the framework.

- The establishment of a mental health directorate as outlined in the framework should be insisted upon. Once the directorate is in place, each province will have a starting point from which training systems that have been customised for the particular situation in each province, would be put in place.
- Training needs to be focused on a population-based model, which requires a paradigm shift from the previous models.
- Those providing training should be appropriately accredited.
- Substantial expertise is available and should be utilised to provide skills in the different areas.
- Current mental health providers should be upskilled.
- District specialist teams must be appointed, in accordance with the framework. Once the teams are in place, there needs to be clarity with regard to the gaps and the system requirements.
- Government should have input to the curricula content and scope of practice of the various professions, and how they should meet the needs of the country. Government should also engage with the professional bodies in this regard.
- Provision of funding for training needs to be clarified.

Overall Response by the National DoH

Prof Melvyn Freeman

Academies are meant to do scientific research of the highest order and to bring together the cleverest minds that exist around the world to do in-depth studies on particular issues of concern to the world, to draw up reports and advise governments on how to move forward with regard to particular issues. Through its involvement in the workshop, government did not wish to have a situation where it told ASSAf what advice should be given. ASSAf should think out of the box and come with innovative solutions to issues that the DoH has been struggling with for some time. Perhaps a good balance has been struck during the workshop deliberations, which have highlighted the need to change the mental health policy framework and focus on the human resources and core competencies needed to take the framework to implementation. Inputs from government, from those who have contributed to the policy development, and from outside thinking during the workshop have informed the process that would be taken to new levels.

Implementation remains a challenge. Although integration of mental health into the PHC system and the requisite human resources and core competencies have been discussed for many years, and a policy framework is in place, implementation has dominated the discussions. The AIDS epidemic has interrupted government's priority plans of 20 years ago and has shifted the focus of the DoH over that period. This unfortunate situation has meant that other priorities have been neglected. In addition, the MDGs and the three health targets within the MDGs have been the focus of attention for the DoH, making it difficult to elevate the priority of other items on the agenda. Mental health has been on the NHC agenda on a number of occasions and there has been a commitment to ensure improvement of mental health service delivery. It was anticipated that as the HIV epidemic became controlled, there would be more thinking, time and focus on other areas of health-related priorities. In this sense, this workshop has been an opportune occasion to address key elements, and to rethink certain aspects of the model and the roles of various players in the system.

However, it would be detrimental to create a situation where core competencies are identified and the relevant training is given before setting up structures and ensuring that the necessary resources are available for implementation. The core competencies could be put in place for utilisation at an appropriate time. There is much work to be done at all levels, particularly at provincial and district levels, in terms of assessing what is available, what is possible, who needs to be trained to do what and how to find the resources to do what has to be done. The South African economy is in a downturn and the country lack additional resources to cater for the huge demands in numerous areas. Health would be a victim of this situation. It is important to be cautious and avoid forging ahead to identify core competencies and to do training without the necessary structures and funding in place.

Summary and Proposed Way Forward

Prof Bhana invited suggestions from participants on the way forward, recognising the importance of this initiative and the need to ensure that the impetus of this workshop would be maintained.

Participants contributed the following input with respect to the way forward:

- The focus going forward should be on things that can be done and can commence immediately, such as inter-professional dialogue and sharing.
- An audit of training curricula, not only in relation to what is covered in mental health courses, but also the number of professionals that are being trained across the field, who are being trained, what are they being trained for, to do what and at what level.
- The select group that attended the workshop should be expanded to include other key stakeholders in the fields that are part of the discussions, particularly provincial representatives, people from government departments (other than the DoH) and academic heads of departments. Better representation would help to move the discussion forward.
- More can be done, particularly in local areas. Participants could consider establishing forum groups that included all levels of professionals in MNS disorders and contributing to a shift in thinking about mental

health care. Models that are functioning well can be replicated and expanded into other districts.

- The workshop proceedings report should be made available to the representative organisations with the possibility of holding another workshop as there is a need for more dialogue.
- Perhaps ASSAf should utilise its neutral standing to convene a diverse group of stakeholders who can meet on an ongoing basis and discuss how to improve the quality of care for MNS disorders in South Africa.
- Integrating a more public mental health approach into existing training programmes is an important step, particularly from the perspective of training as a socialisation process. Professionals could begin to be developed into thinking in a particular way and equipped to work in a particular way. It would be very useful to begin doing the groundwork in preparation for the introduction of the NHI and the re-engineered of the health-care system, which would be implemented over the next ten to 15 years.
- Much had been discussed and many great ideas have been shared about how to promote task-sharing and task-shifting within the current environment and what immediate steps could be taken in this regard. Several challenges highlighted should be documented.
- Participants should consider how to take these discussions forward in their communities in order to bring about a shift in emphasis in how training should be done and what students should be trained to do, and subtle changes to current training models could be made.
- More emphasis should be placed on resourcing the existing facilities for treatment of substance abuse and improving service delivery at these facilities.
- More coordination of all services is needed between government departments and the NGO sector. Optimal utilisation of existing resources is of primary importance.
- Meetings between various professional councils, to address training curricula requirements could start immediately.

- All participants should initiate action in their fields and according to the National Mental Health Policy Framework and Strategic Plan. Continued contact should be maintain by holding follow-up meetings. Progress reports could be produced at these meetings.
- Most academic programmes would probably be amenable to engaging on these issues and integrating a public mental health perspective into training programmes. Perhaps ASSAf should serve as a coordinating body and identify a grouping to convene and promote this within the academic sector, and government should do likewise.

Closing Remarks

Prof Roseanne Diab, ASSAf

The possible role of ASSAf in taking the discussions forward would be through the establishment of a Forum on MNS disorders. The Academy's Standing Committee on Health would support the ASSAf Council's approval of such a move. The Forum would bring together people from diverse sectors, recognising the need to expand the current workshop to include other key players (DSD, provincial government, business and academic sectors), and create an ongoing dialogue that will encourage an exchange of ideas. The Forum should not become a platform that frustrated those in the business of implementation. The purpose of such a Forum will be to shed light on critical issues that require specific studies to be done in order to gather evidence to take to government.

This kind of Forum will be an ideal opportunity to exchange views reflective of those who attended. ASSAf does not regard such a consultative Forum, as an opportunity to make firm recommendations to government. However, the Forum could highlight issues that may require subsequent in-depth studies, which would follow a strict methodology that will ensure that relevant evidence is gathered and deliberated on by a panel of experts. The purpose of such a study will be to produce evidence-based recommendations that could be referred to government. ASSAf would stand by the recommendations and work very hard, together with government, to ensure implementation.

In summary, ASSAf would take the following actions:

- A Forum on MNS disorders would be established and would meet on a regular basis.
- The Forum would be used to advise on a particular study with a focused set of key questions. Ideas for a possible study would perhaps begin to be formulated based on the workshop proceedings report.
- One of the recurring ideas raised concerns the need for a situational analysis of training curricula in relation to mental health programmes, as well as mental health professionals and this certainly needs to be taken further.

ANNEXURE A: ATTENDANCE LIST

Dr Robin ALLEN	Lentegeur Hospital/Department of Health (Western Cape Province)
Dr Bruce ALTEVOGT	Institute of Medicine of the US National Academies
Dr Laila ASMAL	Stellenbosch University
Prof Arvin BHANA	University of KwaZulu-Natal
Dr Angelique COETZEE	South African Medical Association
Ms Claudia CORREIA-MARQUES	Helen Joseph Hospital
Prof Roseanne DIAB	Academy of Science of South Africa
Mrs Carol DU TOIT	South African National Council on Alcoholism and Drug Dependence (Durban)/South African Council for Social Service Professions
Prof Melvyn FREEMAN	Department of Health (National)
Mr Ashley GOVENDER	Consultant
Ms Naazia ISMAIL	The South African Depression and Anxiety Group
Ms Julie-Ann JACOBS	SANCA
Prof Yasmien JEENAH	University of the Witwatersrand
Prof Ashraf KAGEE	Stellenbosch University
Dr Taskeen KHAN	World Health Organisation, South Africa
Ms Julia KUHN	Helen Joseph Hospital
Mrs Louina LE ROUX	SANCA (National)
Mr Mark LEWIS	South Coast Recovery Centre
Prof Crick LUND	University of Cape Town
Ms Lebo MAKGAE	Academy of Science of South Africa

Ms Constance MANYELI	Academy of Science of South Africa
Mr Sikhonjiwe MASILELA	Department of Health (Gauteng Province)
Ms Tumelo MATLALA	Academy of Science of South Africa
Ms Phakamile MNGADI	Academy of Science of South Africa
Mrs Magdeline MOGOTSI	University of Limpopo
Ms Mathapelo Anne MOKGOSI	Arephuthaneng
Dr Saiendhra MOODLEY	Public Health Association of South Africa
Prof Yusuf MOOSA	University of the Witwatersrand
Ms Heidi MORGAN	University of the Free State
Mrs MmaLerato MOSHOESHOE	Tshwane District Health
Makete MOTAUNG	Department of Health (Gauteng Province)
Prof Bronwyn MYERS	Medical Research Council
Mrs Marousi MZONDI	Department of Health (Gauteng Province)
Prof Pamela NAIDOO	Human Sciences Research Council
Dr Thirusha NAIDU	Psychological Society of South Africa
Mrs Nkateko NDALA-MAGORO	University of Pretoria
Funeka NGCAKAU	University of Pretoria
Mr Mzamo NTATISO	Monash University, South Africa
Ms Lorraine NTWANA	SANCA (Midrand)
Prof Peter NYASULU	Monash University, South Africa
Dr Akinwumi OGUNROMBI	Obafemi Awolowo University, Nigeria
Dr Modupe OGUNROMBI	University of Limpopo
Prof Inge PETERSEN	University of KwaZulu-Natal
Mr Sifiso PHAKATHI	Department of Health (National)

Mrs Sandra PRETORIUS	SANCA (Boksburg)
Ms Anne RAJCOOMAR	SADAG
Prof Solomon RATAEMANE	University of Limpopo
Ms Tania RAUCH-VAN DER MERWE	University of the Free State
Prof Helen REES	Wits Reproductive Health & HIV Institute
Prof. Carolus REINECKE	North-West University
Mrs Madira SEHOLE	Tshwane District Health
Mr Ian SHENDELANA	Academy of Science of South Africa
Ms Nomvula SIBANYONI	Department of Health (National)
Prof Tholene SODI	Health Professions Council of South Africa
Dr Katherine SORSDAHL	University of Cape Town
Ms Charlene SUNKEL	Central Gauteng Mental Health Society
Lian TALJAARD	SADAG
Ms Tebogo TLADI	Department of Health (National)
Ms Sebolelo TSEEKE	SANCA (Johannesburg)
Dr Lawrence TUCKER	Neurological Association of South Africa
Ms Annalie VAN DEN HEEVER	University of the Witwatersrand
Dr Annatjie VAN DER WATH	University of Pretoria
Dr Paulina VAN ZYL	University of the Free State
Mrs Marcelle ZIPERSTEIN	Life Randwest Care Centre
Ms Heather ERASMUS	Write Connection, Scribe
Ms Robyn ARNOLD	Write Connection, Scribe
Ms Rina MARAIS	Write Connection, Scribe

Academy of Science of South Africa (ASSAf)
1st Floor Block A, The Woods
41 De Havilland Crescent
Persequor Park

PO Box 72135
Lynnwood Ridge 0040
Pretoria, South Africa

Tel: +27 12 349 6600, Fax: +27 86 576 9520
www.assaf.org.za

ASSAf
ACADEMY OF SCIENCE OF SOUTH AFRICA