Community psychiatry: An audit of the services in southern Gauteng

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Aim. To audit the community psychiatric services in southern Gauteng with a view to determining whether the objectives of the country's mental health legislation and policies are being achieved.

Results. Although southern Gauteng's community psychiatric clinics are situated in a primary health setting, primary health clinicians play no active role in the management of mentally ill patients. Care is supplied mainly by specialist psychiatrists, psychiatric registrars (in training) and psychiatric nurses. For first appointments, a mean of 2 patients are seen per doctor per clinic day for a mean duration of 30 minutes. For follow-up appointments, a mean of 17 patients are seen per doctor per clinic day for a mean duration of 8 minutes. The waiting time for new patient appointments is a mean of 6 months. Follow-up patients are seen once a month by nursing staff and approximately once every 4 months by doctors. An average of 1 in 5 patients is treated with oral atypical antipsychotics; in the majority of clinics, this is the total extent of care. However, where psychologists, social workers and occupational therapists are present, only 0.2% of all users have access to them.

Conclusion. The community psychiatric services, although better than those in some other countries, fall short of what is required by South African legislation and policies. General community health services ought to play an active role in the structure and delivery of psychiatric services by developing and strengthening the current limited services, with an emphasis on cost-effective and preventive approaches. Existing community psychiatric services, if so transformed, could serve as a model for other countries in Africa.

Mental illnesses result in severe distress, impaired productivity and diminished quality of life for the innumerable afflicted individuals and their families. The World Bank Report of 1993[1] and the Harvard World Mental Health Report of 1996[2] indicated that about 28% of all disabilities comprise mental illnesses and, furthermore, that 5 of the top 10 causes of disability are mental health problems. The reports projected that by the year 2020 mental health problems would comprise about 15% of the gross burden of diseases, and much more heavily to total disabilities.

Although there are no published data on the burden of mental illnesses in South Africa, the epidemiology of mental health disorders in South Africa is similar to that found in developed countries. Rapid urbanisation has exacerbated unemployment, violence, substance abuse, child abuse, HIV/AIDS and the disintegration of traditional social support networks and families. These factors probably contribute to the increasing incidence of mental disorders.

In the second half of last century, mental health care underwent restructuring on an international level. Mentally ill patients had been previously confined to 'institutions'; these were generally inefficient and authoritarian, with impenetrable barriers to the outside world, had various rituals and required huge expenditure. Patients developed institutional neuroses characterised by symptoms such as apathy, lack of initiative, loss of interest and submissiveness.[3] More recently, institutions began to be replaced by 'the community', a concept encouraging the development of alternative services including psychiatric units in general hospitals, community-based clinics, residential homes and day centres.

Mental health services in South Africa followed these international trends and were further supported by policy changes and new legislation. The White Paper for the transformation of health[4] proposed a comprehensive, planned and co-ordinated community-based mental health service at national, provincial, district and community levels. The new Mental Health Care Act[5] required that mental health services improve through a primary health care approach with an emphasis on community care. All these features were incorporated into a strategic objective of the Department of Health.[6]

It is evident that the main thrust of mental health care in South Africa had its foundations in community-based services; this resulted in a rapid process of de-institutionalisation – large numbers of chronically mentally ill patients were discharged from institutions for care within the community. However, concerns arose that, prior to the transformation processes, there was a lack of development of new services or strengthening of existing psychiatric services within the community. The funds that accrued from the de-institutionalisation process were not transferred to, nor were additional funds budgeted to bolster, the community-based services.

The foregoing facts motivated the opportunity and need to audit psychiatric services in a community-based setting. The basis for this evaluation was the community psychiatric services for adults in southern Gauteng because these were the most developed services in the country. Although the findings are not generalisable, they may provide some pertinent information and serve as a basis for further regional studies.

Aim

The objective of this study was to describe the southern Gauteng community psychiatric services with regard to geographical distribution, staff establishments and utilisation.

Method

The study comprised a retrospective audit of community psychiatric services in southern Gauteng in 2005. The services are co-ordinated by the District Mental Health programme managers and the Division of Psychiatry at the University of the Witwatersrand. These authorities were consulted to obtain data on the geographical distribution of the services, service packages and staff establishments of the various clinics, and the psychotropic medications available for prescribing by doctors. Patient statistics were obtained from Human Information Systems at the offices of the regional directorates, and included the number of patients per month attending psychiatric clinics in the various districts. Information on psychotropic medication usage was obtained from the Medical Supplies Depot.

Attendance figures and staff complements at all clinics in the studied region were combined and expressed as means and averages across all the services. Descriptive statistics were computed as counts, percentages and means. All analyses were done using Statistical Package for Social Sciences 10.0 for Windows (SPSS Inc., Chicago, Ill.).

A limitation of this study is that assumptions and generalisations are statistically weak, and that contact time by clinicians is not necessarily an ideal measure of service delivery. However, we believe they are worth noting.

Results

Geographical distribution

Community psychiatric services for adults (>18 years old) are provided by the District Health Services. Southern Gauteng region is divided into 4 districts: Johannesburg Metro, Westrand, Ekhuruleni and Sedibeng. The adult population of the 4 districts, according to Census South Africa 2001,[7] was 2 579 767 (Metro), 514 459 (Westrand), 1 941 186 (Ekhuruleni), and 576 125 (Sedibeng), respectively. Most of the psychiatric clinics are located within primary health clinics (Table I). Although there are 21 clinics in the Johannesburg Metro, they are concentrated in the south, with a paucity of services in the northern segment of southern Gauteng (Table I).

Staff establishments

The Norms and Standards for Mental Health Care for people with severe psychiatric conditions were commissioned by the Directorate: Mental Health and Substance Abuse, Department of Health, in 1998. This tool is used to calculate acceptable levels of mental health care and human resources required for ambulatory care per 100 000 people. The minimum acceptable staffing norms thus calculated, and the multidisciplinary staff that provided services in 2005 in the districts, are listed in Table II.

Although the clinics are located in a primary health setting, primary health care professionals play no active role in the management of mentally ill patients. Care is supplied mainly by specialist psychiatrists, psychiatric registrars (in training), and psychiatric nurses with minimal – if any – support from psychologists, social workers and occupational therapists.

Utilisation of services

Based on clinic rosters, we established that psychiatry registrars and/or nurses provide care at these clinics ranging from 1 day per week to 1 day per month. The mean monthly attendance figures in the various clinics in the districts are listed in Table III. An average of 2 first-appointment patients are consulted per doctor per clinic day. The mean duration of first appointments is 30 minutes, and the wait time is 6 months. Follow-up appointments by doctors and nurses are, on average, once every 4 months and once a month, respectively. The mean duration of a follow-up appointment is 8 minutes for doctors and 10 minutes for psychiatric nurses. Psychologists, social workers and occupational therapists are not available at all facilities; only 1 in 500 of all users has access to them.

Psychotropic drugs available in the services are in accordance with the Essential Drug List (EDL) for Gauteng. This list was expanded in 2004 to include newer psychotropics with restrictions (Table IV).

The antipsychotics used are: oral typical (haloperidol, triluperazine and chlorpromazine) – 59.8%; intramuscular depot typical

Table I. Adult clinics in southern Gauteng

Metro	Westrand	Ekhuruleni	Sedibeng
Brixton	Azaadville	Actonville	Boipatong
Chiawelo	Bekkersdal	Alberton	Bophelong
Diepkloof	Brakpan	Boksburg	Empilisweni
Discoverers	Carletonville	Brakpan	Johan Heyns
Dobsonville	Hekpoort	Daveyton	Kookrus
Eldorado Park	Kagiso	Devon	Kopanong
Ennerdale	Khutsong	Duduza	Levai Mbatha
Hillbrow	Krugersdorp	Eden Park	Ratanda
Ivory Park	Mogale	Etwatwa	Sharpeville
Jeppe	Mohlakeng	Germiston	Tabitha Oord
Lenasia	Munsieville	Goba	Vereeniging
Lenasia South	Muldersdrift	Katlehong	
Lilian Ngoyi	Randfontein	Kempton Park	
Meadowlands	Swanieville	Kwa-Thema	
Mofolo	Toekomsrus	Nigel	
Orange Farm	Westonaria	Northmead	
Orlando		Springs	
Pimville		Tembisa CHC	
Rabie Ridge		Thokoza/Dresser	
Riverlea		Tsakane	
Townsview		Vosloorus	
Westbury		Zonkesizwe	
Zola			

Table II. Minimum staffing norms and staff establishments for 2005

	Minimum norm (per population)				Actual staff establishment			
Category	Metro	Westrand	Ekhuruleni	Sedibeng	Metro	Westrand	Ekhuruleni	Sedibeng
Psychiatric nurses	39	12	39	12	31	8	31	8
Occupational therapists	29	3	10	3	0	0	1	0
Social workers	19	6	19	6	2	0	2	0
Psychologists	19	6	19	6	3	0	3	1
Psychiatrists	6	1	5	3	2	0	1	2
Medical officers	11	3	10	3	6	3	5	2

Table III. Mean monthly attendance figures in the districts for 2005

	Districts			
	Metro	Westrand	Ekhuruleni	Sedibeng
Total number of patients	9 573	3 015	6 067	2 894
Number of patients seen by nursing staff	6 989	2 214	4 349	2 159
Number of patients seen by registrars	2 584	801	1 718	735
Number of new patients seen by registrars	396	121	179	115

Table IV. Expanded EDL for community psychiatry in Gauteng

Level of care	Primary level (any doctor)		Secondary level (psychiatrist only)
Anti-depressants	Imipramine tabs 10, 25 mg		Clomipramine tabs 10, 25 mg
	Amitrlptyline tabs 25 mg		Paroxetine tabs 20 mg
	Fluoxetine tabs 20 mg		Citalopram tabs 20 mg
			Mianserin tabs 10, 30 mg
Hypnotics/anxiolytics	Diazepam tabs 5 mg and injection 10 mg/2 ml		Buspirone tabs 10 mg
	Clonazepam injection 1 mg/ml	Clonazepam tabs 0.5, 2 mg; drops 2.5 mg/ml	
	Lorazepam inj. 4 mg/ml	Lorazepam tabs 1, 2.5 mg	
	Oxazepam tabs 10, 15, 30 mg		
Neuroleptics	Zuclopenthixol acetate 50 mg/ml		Risperidone tabs 3 mg
	Chlorpromazine tabs 25, 100 mg		Trifluoperazine tabs 1, 5 mg
	Haloperidol tabs 0.5, 5 mg and inj. 5 mg/ml	Haloperidol tabs 1.5 mg	Zuclopenthixol tabs 2, 10 mg and 200 mg/ml depot inj.
	Flupenthixol depot inj. 20 mg/ml, 40 mg/ml		Thioridazine 10 mg tabs, 100 mg tabs
	Fluphenazine depot inj. 25 mg/ml		Clozapine tabs 25, 100 mg
			Sulpiride tabs 200 mg
Stimulants			Methylphenidate tabs 10 mg
Mood stabilisers	Carbamazepine tabs 200 mg, syrup 100 mg/5ml		Lithium carbonate tabs 250, 400 mg
	Valproate sod. tabs 200, 500 mg, syrup 200 mg/5ml, Valproic acid caps 500 mg	Valproic acid caps 150, 300 mg	
Anti-parkinsonian agents	Biperiden inj. 5 mg/ml		Biperiden tabs 2 mg
	Orphenadrine tabs 50 mg		
Psychosexual problems			Cyproterone acetate tabs 50 mg and depot inj.
Alcohol abuse			Disulfiram tabs 400 mg

(flupenthixol, zuclopenthixol) – 17.3%; and oral atypical (sulpiride, clozapine, risperidone) – 22.9%. The antidepressants used are tricyclics (amitriptyline, clomipramine) and selective serotonin re-uptake inhibitors (fluoxetine, citalopram, paroxetine).

Discussion

The fundamental principles of community psychiatry include: comprehensive services, with treatment reasonably close to the patient's home; continuity of care; and patient participation.[8] Psychiatrists in a community setting, in addition to direct clinical care, are expected to provide home assessments and reviews, psycho-education and early detection screening of most psychiatric disorders.[9-11] They are meant to work in partnership with medical specialists, family caregivers, special needs groups, and public and private agencies in the community. Furthermore, community psychiatric services are also intended to improve the mental health wellbeing of the community by promoting mental health awareness, teaching skills to develop resilience, and challenging stigmatisation.[12]

It would appear from our audit that community psychiatric services in southern Gauteng do not meet all the principles and objectives described above. There are insufficient numbers of community psychiatric clinics to meet the needs of the ever-increasing population of the area. The few clinics in operation are not geographically accessible to all users, are moreover servicing excessively large numbers of patients, and may not be able to deal effectively and comprehensively with their mental health problems in the short contact time available.

Moreover, staff complements are considerably less than the minimum norms recommended by the Department of Health. Specialised psychiatric personnel provide their services only once a week or once a month, and there is little or no support for patients at other intervals. The predominant focus is on direct clinical care with a limited choice of psychotropic medication. There are minimal (if any) multidisciplinary approaches to care, rehabilitation and integration of users back into society.

For the large population in this region, there is inadequate provision of community mental health services, and modern psychiatry does not seem to exist for them. For those patients entering the system, there is insufficient ongoing care, monitoring and psychosocial support.

Recommended strategies to improve services

National mental health policy must be formulated by professionals from the field of mental health as well as public health administration, economics, education and social sciences. Mental health clinics that are geographically accessible to all users need to be established or developed in all districts. The services should incorporate district and regional hospitals so that a system of networking and referral at all levels exists, and all facilities be supported with human and material resources in accordance with the national staffing norms. Active recruitment and retention, through incentive-based approaches, of specialised personnel to work in the community may be considered. In order to achieve these objectives, services have to be adequately financed; the budgets from shut-down institutions should be made available to community services.

The World Health Organization (WHO) Expert Committee (1975)[13] stated: 'In the developing countries, trained health professionals are very scare indeed; clearly, if proper health care is to be brought within reach of the mass of the population, this will have to be done by non-specialized health workers at all levels, from the primary health workers to the nurse or doctor working in collaboration with and supported by more specialized personnel. Primary health care workers would need to be trained and provided with guidelines on the principles of basic mental health care. Inherent in this concept is that specialized/teaching institutions should assume a role of providing technical input in the form of human resource development, capacity building, evaluation and development of locally acceptable models of care to enable the system to become strong and dynamic. The approach will not only relieve the congestion at the teaching hospitals but also provide health care assistance at an early stage with tremendous cost-effectiveness in the long run.'

The World Psychiatric Association (WPA) and the London-based National Institute of Clinical Excellence (NICE) issued evidence-based guidelines in 2002 which recommended that oral 'atypical' antipsychotic drugs be considered as the first-line choice of treatment for newly diagnosed schizophrenia and for patients with unacceptable adverse effects caused by 'typical' agents. It is imperative that a wider choice of the newer atypical antipsychotics and antidepressants be made freely available for clinicians to prescribe according to guidelines.

In collaboration with other sectors such as education, social welfare, medical education, legal agencies and other non-governmental organisations, the mental health care programme would become more comprehensive and effective in achieving its targets.

Conclusion

Health is held to be a fundamental birthright of every individual. Mental health policies should conform to general socio-political and moral precepts and scientific disciplines. Policymakers must seek informed opinion, active involvement and co-operation

from professionals and the public. This approach should also be reflected in the structure and functions of clinics, with evidence of the development and strengthening of resources in these units. Furthermore, greater emphasis should be placed on cost-effective, active and preventive approaches, and due consideration be given to the established norms and customs of the local population. The local community psychiatric services, thus transformed, could serve as a model for other African countries.

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