THOUGHTS ON THE PLANNING OF MENTAL HEALTH SERVICES FOR SOUTH AFRICA

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There have been great advances in psychiatry during the past 30 years. Better facilities for care, modern methods of treatment (both psychological and physical), and the transition from custodial care to a therapeutic approach have revolutionized psychiatry. In many countries there is a tendency to arrange for the care of the mentally ill in the community rather than in large isolated hospitals. There is an increasing emphasis on prevention and early detection of mental illness; on early-treatment centres situated in the community, on after-care and rehabilitation and the maintenance of the chronic patient in the community, on day and night hospitals, and on domiciliary services. These developments are proving of economic and therapeutic advantage.

South Africa faces special mental health problems in its multi-racial and multi-cultural community. The complexity of these problems is heightened by urbanization of the non-White races in a time of changing values—especially by the effects of urbanization on tribal laws, customs and taboos.

Matters are further complicated by the shortage of trained personnel and by the size of the country—the uneven distribution of its population and the lack of any psychiatric services over vast areas, such as from Kimberley to the South West Coast and from the Cape Peninsula to the borders of Angola.

These are some of the features which call for a review of the country's mental health services, for bringing them into line with present-day needs, and for coordinated planning for the future, allowing for flexibility and adaptation to changing needs.

PRESENT SERVICES

Over 20,000 cases of mentally disordered patients are treated annually in the mental hospitals of the Union. It is estimated that there are 100,000 mental defectives in South Africa. At the Johannesburg General Hospital alone over 8,000 attendances are registered annually at the psychiatric out-patient clinics. Ten mental health societies have a patient attendance of some 8,000 *per annum.*

These figures only partially reflect the incidence and range of mental ill-health in the country. The actual size of the problem is infinitely greater and its cost to the State is enormous.

MENTAL HOSPITAL SERVICES

On 31 December 1957 the rated bed-capacity of the 13 mental hospitals in the Union for White and non-White mentally disordered and mentally defective patients was 14,943 for 18,561 patients.[8]

There is an acute shortage of doctors and nurses which handicaps the work of the mental hospitals. Early admittance of patients is difficult because of the inadequacy of available accommodation.[8] The heavy load of chronic patients in the hospitals intensifies the difficulties. The shortage of mental hospital accommodation for non-Whites is more acute than for Whites.

During the past 10 years there has been a change from custodial to therapeutic care. Many mental illnesses in which the prognosis was previously thought to be unfavourable show a marked improvement as a result of new methods of treatment, and a large number of patients are able to return to their homes and work. Even some chronic patients are being brought to a level of social recovery and are able to leave hospital, or are enabled to live more useful lives in hospital.

Despite the shortage of accommodation the admittance rate has, in recent years, increased and in some hospitals the discharge rate of new cases has increased to 70%.[8]

The voluntary-admittance rate is low compared to that obtaining in some places where the trend is for 80 - 90% of patients to be admitted on a voluntary basis.

This apparent lack of confidence in mental hospitals may, in some measure, be ascribed not only to the lack of public enlightenment concerning mental illness and the work done in mental hospitals, but also to little awareness of these matters in various professional groups.

Some mental hospitals are encouraging the community to take an interest in the patients, but the geographical factors often militate against these commendable efforts.

The mental hospitals provide training for the Diploma in Psychological Medicine for undergraduate medical students and training for occupational therapy students, and mental nurses.

Diverse Psychiatric Services

Psychiatric treatment is provided by various other bodies and institutions such as licensed nursing homes, homes and occupation centres for mental defectives, and mental health societies. Government and voluntary organizations assist in dealing with epilepsy, child welfare and physical handicaps. Prisoners are entitled to the benefit of psychiatric assessment.

School psychological services are provided. Special schools or special classes in schools exist for retarded children, and industrial schools and special schools for disturbed children cater for children from poor homes.

Facilities for the treatment of chronic alcoholism and drug addiction are insufficient, although in the Transvaal much good work is done by the Rand Aid Association at Northlea for males and at Mount Collins for females. The work of The Gables in Johannesburg is worthy of note. In the Cape, the Provincial Administration has provided a special hospital — the Park Road Hospital — for the treatment of alcoholics.

In the Transvaal, the Provincial Administration provides some psychiatric services: at the Johannesburg General Hospital there is a Department of Psychological Medicine in the charge of a full-time Professor of Psychiatry, who is Head of the Department of Psychiatry and Mental Hygiene of the University of the Witwatersrand.

One ward of about 30 beds is available for psychiatric cases that are manageable in a general hospital setting. In addition, daily out-patient clinics are conducted and in-patient consultative and therapeutic services are rendered in all the wards of the Johannesburg General Hospital as well as in the related central groups of hospitals in Johannesburg and in the Baragwanath and Coronation Hospitals.

The Tara Hospital at Johannesburg caters for the treatment of patients suffering from the more serious and more urgent psychoneuroses and the minor forms of mental illness. The hospital also renders out-patient services for adults and children and provides in-patient care for emotionally disturbed children. In addition, provision is made for day-patients and for a therapeutic social club for ex-patients. A more recent development is the hospital's community domiciliary service.

Psychiatric training programmes have for some years been in operation at Tara Hospital for various professional groups:

A Diploma in Psychological Medicine is offered in association with the University of the Witwatersrand, and a postgraduate course is offered in neurological and psychiatric nursing. This training is recognized by the South African Nursing Council.

Courses in psychology applied to human relations are attended by senior nurses from general hospitals in training for the Diploma in Hospital Administration. Similar courses are offered to general hospital ward sisters. Student nurses in the final year of study for general nursing may attend special courses at Tara Hospital for 2 months.

In order to help health visitors deal with the large number of psychiatric and social problems which they encounter, a short course of training has been started. Health visitors have access to normal homes and so are in a position to help in protective mental health work. This development has a great potential value in the promotion of community care of the mentally ill. Social workers in voluntary agencies may join this course.

Posts for interns in clinical psychology exist at Tara Hospital. This experience is recognized by the South African Medical and Dental Council for registration in clinical psychology.

Provision is made in the training of occupational therapists and social workers for the students to receive psychiatric experience. In addition, there are courses for educationalists, and training groups are organized for professional workers whose disciplines have a direct or even an indirect bearing on mental health.

A course is also provided for general practitioners, who recognize that at least 50% of their cases have psychiatric or psychosomatic symptoms.

Outside Johannesburg, each of the larger public hospitals in the Transvaal has a part-time psychiatrist. In the Cape, the Provincial Administration provides a psychiatric service at the Groote Schuur Hospital. Reference has already been made to the hospital which caters for alcoholics in Cape Town. Posts for part-time psychiatrists exist outside of Cape Town in some of the larger provincial hospitals in the Cape, also in Natal.

Because the mental hospitals are short of accommodation and because there is, as yet, no generally developed psychiatric community service, general hospitals in all the Provinces are admitting (as medical emergencies) psychiatric patients with, for instance, self-inflicted wounds and toxic deliria or patients who have taken an overdose of drugs. For the same reasons, prison cells are still being used for the mentally ill awaiting admittance to a mental hospital.

In the larger centres of the Union there are child guidance clinics for White children. There is one clinic in Cape Town for non-Whites. The clinics are run by voluntary bodies, mental health societies, or universities. The clinics in operation are too few to have an appreciable effect as a protective service.

There is a great need for revision of our ideas regarding rehabilitation services. The sense in which the term rehabilitation is here used includes all the steps taken to assist a sick person to become a useful member of the community, and for a handicapped person to be raised to the highest level of social usefulness. In terms of this definition the facilities for the rehabilitation of the mentally ill are poorly developed. For example, sheltered employment is at present mainly oriented to the needs of the physically handicapped. Comparatively few cases of mental illness are dealt with at units for sheltered employment and these cases comprise mainly epileptics and mental defectives. The existing framework for sheltered employment makes little effective provision for patients suffering from the psychoses, the neuroses, and the various psychopathic states.

PLANNING FOR FUTURE DEVELOPMENT

Every one of the fields mentioned needs' development, whether at protective, curative, after-care or rehabilitative levels. The manner in which these services are likely to be expanded in the future has been discussed elsewhere.[2,4,5,9-16] In this article I shall confine myself more specifically to a few concepts which should be applied when designing and planning a modern mental health service, making the best possible use of limited resources.

1. *Realistic Plans*

The plans should be realistic. The medical and nursing staffs of the existing mental service, the government administrators, and the public will have to be convinced that the scheme is workable and that it will benefit all concerned.

As a result of hospital overcrowding and the shortage of personnel, doctors and nurses will have to be convinced that their work will be made easier. It is therefore necessary to elicit their support, otherwise it is highly unlikely that the scheme will work. It must also be borne in mind that administrators are more likely to approve of plans that can be started without involving them in any great financial or political responsibilities. Moreover, improvement in

community attitudes to psychiatry is a necessary prerequisite for successful planning for the future in this field.

2. *Small Treatment Centres*

It is estimated that less than 10% of all mentally ill patients need admittance to a mental hospital. The trend is to avoid the building of large expensive permanent mental hospitals, and to treat patients in the community, in their homes, at work, at school, in out-patient clinics, at day or night hospitals, at therapeutic social clubs, in psychiatric sections of general hospitals, and in small mental hospitals where active treatment can be carried out. Community services should be a coordinated extension of such small treatment centres and the provision of suitably trained personnel should be specially stressed in these units. This system must be managed as a whole in which continuity of treatment for each case, from the inception of treatment to the rehabilitative stage must, as far as possible, be ensured.

The psychiatric hospital of the future may be visualized as the headquarters and the training and research centre of the local mental health organization with only a small residential unit for special treatment and investigation.

The foregoing measures would ease the work of doctors and nurses, because most of the patients would be treated as ambulatory patients. Gross overcrowding which impedes mental hospital reform will therefore be reduced. It has been found elsewhere that many patients, formerly admitted to mental hospitals, can be successfully treated as out-patients. Doctors welcome this trend. Furthermore, compared to hospitalization, out-patient treatment is relatively inexpensive and it is preferred by the community. The prestige of mental hospitals overseas depends to a great extent on efficacy of their out-patient work. Electroconvulsive therapy is given on an out-patient basis at the hospital as well as at mental health society clinics. Out-patient treatment of this nature is safe and reduces the number of admissions to hospital. Moreover, through the out-patient clinics closer links are established with general medicine, especially if these clinics are conducted in a general hospital.

3. *'Open' Hospitals*

The 'open' hospital for the treatment of mental disorder is one of the present trends. Security measures are believed to be necessary for only a small minority of patients. Patients are encouraged to come voluntarily for treatment, as they would to any other hospital. Hospital staffs are assuming more positive attitudes. Opposition from nursing staff is sometimes experienced in the beginning, but when they find that their work is made easier after the first ward has been opened, they usually request an extension of the open-ward system to other wards.

4. *Community Attitudes*

The following steps should be taken in an attempt to improve the attitudes of the community towards psychiatry:

(*a*) Psychiatric activities should be integrated with general public health work, or at least coordinated with it.

Wherever services are provided for health care in the home, at work, or at school, mental health care should be an integral part of these services and should be oriented towards promotion of mental health and the prevention, early detection, treatment, after-care and rehabilitation of the mentally ill.[3] The staffs of the general hospital and the mental hospital should work in collaboration. When possible, social workers of the mental hospital and the local authority and health officers of voluntary and State-sponsored services concerned with mental health and the welfare of discharged patients, should work together and have a place in a psychiatric domiciliary service. Where such services do not exist, they should be developed as the need arises as part of a preconceived coordinated plan. For financial reasons these services may have to be developed singly, or in sparsely populated areas they may have to be modified or trimmed to suit local needs.

(*b*) The public should be educated and kept informed by adequately trained educators. At the same time the need for caution and discretion regarding the facile generalizations of uncritical secular 'missionaries' should be stressed.

Active participation which, according to the theory of education, is the best guarantee of thorough understanding and effective learning, can sometimes be obtained by the organization of 'open days' for visiting the hospital; occasionally by inviting volunteer helpers to the establishment; in many cases by establishing working relations with all sorts of fellow citizens such as industrial leaders, teachers, legislators and administrators.[4]

Parents are an important factor in the modification of community attitudes. If they understand mental illness within their own families, they will be in a position to condition the attitudes of future generations, and to influence other families showing prejudice.

(*c*) Active forms of treatment that can be applied without segregation of patients should be developed.

5. *Mobile Psychiatric Clinics*

In the sparsely populated areas of South Africa where there are no psychiatric services, the establishment of well-staffed mobile psychiatric clinics needs consideration. Where there is no mental hospital a headquarters should be established from which a mobile team can operate. This team should preferably be attached to a general hospital where provision can be made for the training of staff, for records to be kept, for storage, and ultimately for special investigations to be carried out. Amongst the non-urbanized non-White communities, who are accustomed to care for their mentally sick, this tradition should be preserved; in these cases the mobile team should only supervise and prescribe treatment.

'Elsewhere a treatment centre can be set up, consisting of a number of very simple buildings in which the patients and their families can live. The adjacent headquarters then serve as a base for the treatment of out-patients as well as of residents. Non-medical staff should be recruited locally; and since their duties will be almost entirely custodial, they can be untrained, even illiterate. In fact, illiteracy is sometimes an asset as unsophisticated patients may mistrust a literate person. One of the main advantages of this system is that it enables patients to be treated in their home environment and the relatives not only see what is going on but also help with the nursing. For the incurable socially unacceptable patient, who cannot be admitted to these treatment centres, other arrangements must be made. But the hope of recovery should never be abandoned, nor should the patient be allowed to sink into a state of social dilapidation.'[4]

The mental health of South Africa's non-White population needs special mention. Mental-health problems and group attitudes which arise from the country's multi-racial and multi-cultural structure require research. The need for training non-White psychiatrists, clinical psychologists, and mental nurses cannot for long be disregarded.

6. *The Long-stay Unit*

In urban centres the long-stay unit is a necessary complement of the short-term active treatment centre.[1,4,10] The central custodial type of hospital is undesirable; the 'working village' and 'farm colony' are good alternatives.

7. *Community Services*

The development of community-treatment facilities in rural and in urban centres does not require the provision of expensive purpose-designed buildings. Most of the services contemplated can be provided by the conversion of existing buildings sited in the community it is proposed to serve. The principal expense should be in the recruiting, training and appointment of personnel.[15]

8. *Multi-professional Effort*

It is recognized that mental health work requires a multi-professional effort in which the other branches of the science of Man, including the social sciences, are full and active partners.[7] Modern dynamic psychiatry cannot work in isolation; it needs to work in cooperation with all the health and social agencies for the effective prophylaxis, treatment, after-care and rehabilitation of mental illness. The workers in the field of mental health need to work in close partnership with the Provincial health and educational services, public health and maternity services, baby clinics, child-guidance and marriage-guidance clinics, school-medical services, mental health and child-welfare organizations, and with all other health services and social services including the voluntary agencies.

9. *Rehabilitation*

Facilities for the rehabilitation of the mentally ill need to be modified to meet their special needs. For example, the criteria which allow an individual to enter sheltered employment must be relaxed (at present 50% productivity is prescribed). Sheltered employment is still unfortunately viewed as an end or terminal phase rather than as continuation of treatment for the mentally ill. More flexible scales of pay should be instituted.

In addition, if the patient is enabled to keep in close touch with his home, his friends and his work during his stay in hospital, he will find it easier to pick up the threads again after leaving hospital.

10. *Community Care*

Community-care schemes such as exist in Amsterdam need consideration.[5]

11. *General Hospitals*

Psychiatric units in general hospitals must be developed.[12-16]

TRAINING OF PERSONNEL

The first requisite for giving effect to the foregoing principles is the availability of suitably trained staff. The country must provide for the training and re-training of personnel to meet the needs of the multi-racial and multi-focal population.

Training must cover such a wide and multi-disciplinary field that it is unlikely to be able to take place at once. Nevertheless, the financial burden of mental illness and its toll on human happiness must receive urgent attention, and every effort must be made to provide and retain trained staff for the country's mental health services.

Training programmes must be kept up to date and made more attractive. Staffing needs and conditions of service require constant evaluation and adaptation to changing needs and values. By these means it will perhaps be possible to attract people to work in the psychiatric field.

With regard to the place of psychiatry in the medical faculties of our Universities, Professor H. C. Rümke, in a personal communication, writes:

'The establishment of full-time professorships in psychiatry at South African medical schools must be regarded as a necessity if the development of the country's mental health services is to keep pace with changing concepts in this field.'

There are 80 practising psychiatrists for a population of 13 million. To meet the shortage additional training facilities (including bursaries) must be established; psychiatric research must be encouraged (finance and facilities must be made available); and study leave as an incentive to recruitment of personnel needs very serious consideration.

Suitable training must be provided for doctors in industry. Neurosis is said to be the largest single cause of absenteeism in industry.[6] Training must also be provided for nurses and social workers employed in industry, as well as for personnel managers.

The improvement and extension of mental health education in medical and nursing colleges, teachers' training colleges, schools of social welfare and other professional training schools, is one of the central objectives for World Mental Health Year. Already there is evidence of improvement in the training in some fields. A course of psychology applied to human relations has been included in the revised syllabus of training for general nurses, and it is stated that 3 months' experience of psychiatric nursing for all student general nurses is desirable.

The syllabus of training for health visitors now includes a section on social and mental health problems.

At one of the training colleges for teachers, school principals are receiving instruction to enable them to deal with emotional problems in children, staff, and parents. This is one of the protective measures which requires emphasis in mental hygiene. Teachers at all levels from nursery school to university should be aware of the early signs of mental breakdown. Such training must lead to early referral for treatment; to research in child psychiatry, and so to the extension of psychiatric and psychological services for children, e.g. child-guidance clinics, psychological services for schools, etc.

The psychiatric needs of patients should be brought to the attention of doctors in public health,[3] obstetricians, paediatricians, general practitioners, midwives, parents, officials working in maternal and child-care departments, speech therapists, persons in charge of children's institutions, homes for defectives, boys' and girls' clubs, and selected workers in voluntary agencies. These examples illustrate the importance of training non-psychiatric personnel in mental health principles.

There are many problems associated with student mental health which call for the training of student counsellors for universities, for training colleges for nurses and for other institutions where students are in training.[17] The need for providing more training facilities for clinical psychologists, as required for registration purposes by the South African Medical and Dental Council, is self-evident.

With regard to social workers, opinions appear to be divided on the question of specialization in the psychiatric field. The need for training with a psychiatric orientation is, however, beyond dispute.

The training of the multi-disciplined team for a community service is essential for, with the exception of social workers, all other members will require instruction for working in the community. Social workers already have this training.

It is estimated that South Africa has a potential nursing force of 25,000. If all nurses had had even an elementary training in mental health and if some were provided with opportunities for advanced training in psychiatric nursing, it is not unreasonable to believe that the battle against mental illness would be greatly facilitated.

SUMMARY

1. South Africa's mental health services require development in keeping with the revolution which is at present taking place in the field of mental health.

2. Mental-health problems arising from the multi-racial and multi-focal structure of the country's population must receive attention.

3. The planning of mental health services depends on the availability and retention of suitable personnel. The need for establishing attractive training and re-training programmes and incentives to undergo such training is seen as the starting point for the further development of the country's psychiatric services.

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