Strengthening primary care mental health services – lessons from the South African HIV programme

Mental health has been neglected by South African (SA) public health programmes despite an estimated 16% of South Africans experiencing common mental health disorders (CMDs) in their lifetimes. There is a need to focus on better integration of mental health services at primary care level driven by international (Sustainable Development Goal target 3.4) and national policies (including National Mental Health Policy of 2023 and National Strategic Policy for HIV, TB and STIs of 2023). To do this, many strategies can be adopted from the SA HIV programme, including nurse-led services with structured mentorship, comprehensive monitoring and evaluation using robust systems, inclusion of community services and case management focusing on clients' psychosocial needs. Increased programme funding is also needed to implement these cost-effective strategies.

Importance of mental health

The United Nations Sustainable Development Goal target 3.4 aims to reduce mortality from non-communicable diseases by 2030, with a focus on promotion of mental health and wellbeing.[1] Despite this, mental health has long been neglected by SA public health programmes. In a recent 15-country survey, the quality of mental healthcare in SA was rated 30%, the lowest of all health services surveyed.[2] However, recent SA government policies have recognised the need to strengthen mental health services and their integration with chronic disease services.[3,4] Integration is essential due to the high prevalence of CMDs (15.9% of South Africans), the high rates of comorbidity (43% of people living with HIV have a CMD), and the negative impact on adherence to chronic medication.[4,5]

Importance of integration of mental health into PHC

Integration into primary healthcare (PHC) makes services more accessible, affordable and acceptable (reduces stigma).[3,6] The ideal clinic model sets out standards for quality services at PHC facilities and ranks mental health service availability as essential, including mental health in the integrated management of chronic diseases.[7] PHC mental health services should include the provision of safe, effective medications and adjunctive, supportive therapy such as that provided by allied health professionals (for example psychologists and occupational therapists).[3]

Barriers/gaps to integration

Despite this mandate from the National Department of Health (NDoH), mental health services remain insufficiently integrated into PHC services.[5,8] Mental healthcare remains specialist-led and doctor-provided, with >50% of the total mental health budget spent on specialist psychiatric hospitals.[3,5] While the focus at PHC facilities has shifted from emergency psychiatric management to better caring for chronic down-referred clients, there remain substantial barriers and gaps to integration. For example, nurses drive service provision in SA's PHC system, but they remain unable to diagnose and manage common mental disorders without doctor support, despite recent advocacy.[4,5]

Lessons from ART programme

Funding

The mental health programme remains underfunded, receiving only 5% of the total national government public health budget in 2016.[3] The HIV programme, which is much better funded, receives significant amounts of donor funding in SA, but government spending makes up most of the budget.[9,10] To realise the changes needed for mental health, allocation of resources to the programme is essential.[3] National and global stakeholders, including government and donors, need to translate their recent recognition of the far-reaching consequences of continuing to neglect mental health into increased funding, or risk undermining the gains made in other areas such as HIV.

Nurse-led

One of the major successes of the HIV programme has been the decentralisation of antiretroviral therapy (ART) provision through task-shifting.[5,10] The Nurse Initiation and Management of ART (NIMART) course was a key tool in this process. The structured training and mentorship course was designed to provide professional nurses with the necessary skills and knowledge to independently manage clients living with HIV.[10,11] There is a shortage of specialist mental health service providers in SA, and therefore a similar approach is needed to first allow and then capacitate nurses to provide comprehensive mental health services.[5,8] An important step forward is the inclusion of mental health cases into adult primary care training, which is a requirement for PHC nurses to complete.[5] This has the advantage over NIMART of already being integrated into PHC training. However, a structured mentorship programme would likely substantially increase nurses' self-efficacy in managing CMDs.

Monitoring and evaluation

Global funding and targets drove the HIV programme toward effective monitoring and data-driven management.[10,12] An electronic programme monitoring system was implemented at PHC level to capture patient-level data.[13] In comparison, there is a dearth of data available from the mental health programme.[3] Mental health indicators are largely outdated for current programme priorities. The NDoH is in the process of developing an electronic medical records system, and it is crucial that mental health components become available within this system as soon as possible to realise increased priority for the mental health programme.

Community services

Community-based services are under-resourced and inadequately utilised to help people with CMDs live fulfilling lives outside of institutions.[5,8] HIV programmes have harnessed community-based organisations to provide services such as HIV testing and psychosocial support.[10] Given the magnitude of the mental health burden in SA, the strengthening of community-based organisations and their links with PHC facilities need to be prioritised.[3,5]

Case management to facilitate psychosocial support

In the HIV programme, case managers have been used to facilitate psychosocial support at health facilities. This role is frequently undertaken by lay counsellors with specific training in adherence, who provide targeted counselling and link clients to other support services.[14] Utilising a lay cadre allows case managers to be local community members who are capacitated to provide peer support. Mental health service users could similarly benefit from this strategy to address barriers to accessing care and adhering to treatment.

Conclusion

Comprehensive mental health services are not accessible at PHC level in SA. This undermines our ability to provide quality, person-centred care for chronic diseases. The mental health treatment gap is huge, and provision of care for all may seem unattainable. However, it is worth remembering that an ART programme of its current size in SA appeared aspirational in the early 2000s.[10] Strong mechanisms for building capacity at primary care and community level, strengthened monitoring and consistent funding are key to realising the mental health programme's potential. And, more importantly, political will strong enough to drive these conditions is essential.

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