Provider core competencies for improved
Mental health care of the nation

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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 (*No 67 of 2001*), which came into force on 15 May 2002. This made ASSAf the only academy of science in South Africa officially recognised by government and representing the country in the international community of science academies and elsewhere.

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List of Acronyms

Abbreviation	Description
ADHD	Attention Deficit Hyperactivity Disorder
AEAs	Ambulance Emergency Assistants
ANTs	Paramedics
APC	Adult Primary Care
ASSAf	Academy of Science of South Africa
ASW	Auxiliary Social worker
BAAs	Basic Ambulance Assistants
BCMP	Bachelor of Clinical Medical Practice
BSW	Bachelor's Degree in Social Work
CBR	Community-Based Rehabilitation
CBRWs	Community-Based Rehabilitation Workers
CBT	Cognitive-Behavioural Therapy
CCAs	Critical Care Assistants
CCGs	Community Caregiver
C4CSA	Council for Counsellors in South Africa
CHBCs	Community Home-Based Carers
CHW	Community Health Worker
CPD	Continuing Professional Development
CMSA	Colleges of Medicine of South Africa
CoBT	Competency-Based Training
CREATE	Community-Based Rehabilitation Education and Training for Empowerment
CRFs	Community Rehabilitation Facilitators
CRWs	Community Rehabilitation Workers
CYCWs	Child and Youth Care Workers
DALYs	Disability Adjusted Life Years
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DID	Disability Inclusive Development
DMH	Diploma in Mental Health

Abbreviation	Description
DR	Formal Diagnosis/Referral
DSD	Department of Social Development
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSMHT	District Specialist Mental Health Team
ECAs	Emergency Care Assistants
ECPs	Emergency Care Practitioners
ECTs	Emergency Care Technicians
EEG	Electroencephalogram
EMG	Electromyography
EMS	Emergency Medical Service
EN	Enrolled Nurse
ENAs	Enrolled Nursing Assistants
EPAs	Entrustable Professional Activities
FBOs	Faith-Based Organisations
FCPsych	Fellowship of the College of Psychiatrists of South Africa
FET	Further Education and Training
FETC	Further Education and Training College
FSDRS	Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015-2020
GAF	Global Assessment of Functioning
GBV	Gender-Based Violence
GPs	General Practitioners
HCT	HIV Counselling and Testing
HEIs	Higher-Education Institutions
HICs	High-Income Countries
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HR	Human Resources
HSRC	Human Sciences Research Council
HWSETA	Health and Welfare Sector Education Training Authority
ICF	International Classification of Functioning, Disability and Health
ICT	Information and Communications Technology
ID	Intellectual Disability
IOM	Institute of Medicine
KZN	KwaZulu-Natal
LMICs	Low- and Middle-Income Countries
M&E	Monitoring and Evaluation
MHCA	Mental Health Care Act
mhGAP	Mental Health Gap Action Programme
MhINT	Mental Health INTegration Project
MHCUs	Mental Health Care Users
MLHWs	Mid-level Health Workers
MLRW	Mid-Level Rehabilitation Worker
MNS	Mental, Neurological and Substance Use
NASA	Neurological Association of South Africa
NDoH	National Department of Health
NDMP	National Drug Master Plan

Abbreviation	Description
NGOs	Non-Governmental Organisations
NHI	National Health Insurance
NMHPFSP	National Mental Health Policy Framework and Strategic Plan
NPOs	Non-Profit Organisations
NQF	National Qualifications Framework
OSD	Occupation-Specific Dispensation
OT	Occupational Therapy/ist
OTA	Occupational Therapy Assistant
OTL	Outreach Team Leader
OTT	Occupational Therapy Technicians
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PHCNs	Primary Health Care Nurses
PHC-R	Primary Health Care Re-Engineering
PLWHIV	People Living with HIV
PN	Professional Nurse
RCWs	Rehabilitation Care Workers
RPL	Recognition of Prior Learning
SACLA	South African Christian Leadership Assembly
SACSSP	South African Council for Social Service Professions
SADC	Southern Africa Development Community
SAFMH	South African Federation for Mental Health
SAMRC	South African Medical Research Council
SANC	South African Nursing Council
SANDF	South African National Defence Force
SAPS	South African Police Service
SAQA	South African Qualifications Authority
SI	Screening/Identification
SMI	Serious Mental Illness
SMU	Sefako Makgatho Health Sciences University
SOP	Standard Operating Procedure
SW	Social Worker
TB	Tuberculosis
TC	Treatment/Care
THPs	Traditional Health Practitioners
UCT	University of Cape Town
UKZN	University of KwaZulu-Natal
UNODC	United Nations Office on Drugs and Crime
US	United States
WBOTs	Ward-Based Outreach Teams
WFOT	World Federation of Occupational Therapists
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule
Wits	University of the Witwatersrand

Forward

The Academy of Science of South Africa (ASSAf) is mandated to provide evidence-based science advice to government on matters of critical national importance. This consensus report is in fulfilment of this mandate.

Over two-thirds of people with mental, neurological and substance use (MNS) disorders do not receive the care they need worldwide. The South African government introduced a new Mental Health Care Act (No. 17 of 2002), which upholds the human-rights of people with mental disorders and, *inter alia*, promotes the decentralisation and integration of mental health services into general health care and the development of community-based services. More recently, the National Department of Health has adopted two new policies, the National Mental Health Policy Framework and Strategic Plan (2013-2020), and the Framework and Strategy for Disability and Rehabilitation Services in South Africa (2015-2020) both of which embrace the adoption of task sharing to increase access to mental health care services at district level. This report is in response to the need to close the treatment gap in South Africa and to assess the competencies of existing health care personnel and their ability to function in a task-sharing or task-shifting system.

The nine-member consensus study panel, under the leadership of Prof. Rita Thom, is to be commended on the quality of evidence that they have amassed to inform the recommendations. This report is a product of their voluntary commitment and I thank them for their dedication to the task and look forward to the debates that will ensue following the release of the report.

I thank all those involved in the preparation and production of this report, particularly the Academy staff who supported the panel in their work. The ASSAf Council would like to extend its sincere appreciation to the panel for the service they have rendered to the Academy. Funding from Janssen Pharmaceutica is also hereby acknowledged.

Professor Jonathan Jansen
President: Academy of Science of South Africa

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Prof. Rita Thom
Panel Chairperson

About this Report

This report is a comprehensive document reviewing current training programmes for various cadres of service providers who provide (or could provide) care for people with mental, neurological and substance use (MNS) disorders in South Africa. The review used national mental health and disability policies to develop a vision of contextually-appropriate services using a task-shifting disability-inclusive approach as a framework for the review.

The report consists of the following sections:

- An introductory section including the executive summary, background to, and methodology of the study.
- The body of the report consists of separate chapters for each category of service provider, with a detailed examination of current curricula measured against the core competencies identified by the researchers. Key findings are highlighted at the start of each chapter, as well in the concluding section of the report.
- The concluding section of the report summarises key findings, discusses limitations of the study and makes recommendations regarding the use of the report as well as for further research.

EXECUTIVE SUMMARY

The Academy of Science of South Africa (ASSAf/the Academy) has recognised the significant impact that mental, neurological and substance use (MNS) disorders have on the health of the South African population. Research conducted in South Africa has shown that approximately one in six South Africans suffer from such disorders at any one time. Research has also demonstrated a significant treatment gap with less than 25% of people who suffer from such conditions receiving treatment. South Africa has a shortage of specialist mental health care providers to meet the treatment need. National policies for the promotion of health, prevention, treatment and rehabilitation of ill-health and disability due to MNS disorders, therefore, promote the concept of task shifting to address the treatment gap. This means that lay and general health care providers need to be equipped with the necessary skills and specialist support to be able to address some of the burdens of MNS disorders. For this policy to be successful, training and support programmes need to be appropriate to the South African context.

Since 2012 the Academy of Science of South Africa has engaged in several processes to address this issue. In 2012, ASSAf attended and contributed to an Institute of Medicine Workshop and Report: *Strengthening Human Resources through development of candidate core competencies for mental neurological and substance use disorders in Sub-Saharan Africa*. In 2014, the Academy organised a South African workshop, which produced a report: *Proceedings of the workshop on the implementation of core competencies for mental, neurological and substance use disorders*. A key recommendation of this workshop was that an audit of existing training curricula be undertaken in South Africa to determine whether these training programmes are preparing providers for the needs of the South African population.

In 2015 the Academy established a multi-professional expert panel to undertake a consensus study: *Provider core competencies for improved mental health care of the nation*. As part of the study, panel members met regularly, reviewed documentation and engaged with stakeholders. This report is the outcome of these activities. While working within significant time and resource constraints, the emphasis has been on the formal health sector. However, the panel recognises that addressing MNS disorders requires a multisectoral approach and an attempt has been made to reflect this in the report.

The study presents a vision for a workable and appropriate system of health promotion, prevention, treatment, care and rehabilitation for people with MNS disorders, which is in line with national policies, including those addressing the social determinants of mental health and human development. Key findings and recommendations of the systematic review of training curricula of a range of health service providers, from community health workers, to generalist health care providers, allied health professionals and specialist mental health (and neurologist) providers include:

1. Community health workers and emergency medical service providers are trained in generic skills but lack sufficient appropriate mental health content knowledge and treatment-specific skills. It is recommended that specific training in general screening for mental disorders and management of chronic mental disorders (specifically around adherence to medication as well as how to access recovery-oriented rehabilitation) be included in community health worker training, Emergency service providers should be trained in recognition and management of acute psychiatric emergencies, including methods of de-escalation, calming and restraint.

2. Traditional healers play an essential role in the lives of many people with MNS disorders but have not yet been formally integrated into the healthcare system. Ongoing dialogue between traditional healers and formal health service providers should be encouraged to ensure collaboration between the two approaches for the benefit of people with MNS disorders.
3. There is an emerging nursing crisis in South Africa, and serious deficiencies in the proposed new nursing curriculum will result in graduates not being equipped to play their role in implementing the national policies around MNS disorders. However, the addition of mental health into the *Adult Primary Care Manual* will equip primary care nurses with some of the recommended competencies to provide adult primary mental health care, if there is training and mentoring to enable nurses to implement the guidelines. It is recommended that the new curriculum be reviewed in light of the significant treatment gap for MNS disorders in South Africa.
4. It is possible for lay/community health workers with appropriate training, mentoring and supervision to be able to provide task-shifted psychosocial interventions such as basic behavioural counselling, recovery-orientated rehabilitation and inclusive development for persons with disability arising from MNS disorders. However, necessary scope of practice and medico-legal issues of accountability need to be addressed. Staff in various categories would have to be audited in order to establish and certify their basic competencies, the missing essential skills addressed in their initial training and a programme of continuing education be afforded to all workers to maintain, refine and upgrade these skills. Supervision of their clinical practice by the mental health team and re-certification on a regular basis (5 yearly) is recommended. Where Continuing Professional Development (CPD) has been mandated by the professional body, these competencies could be included in the CPD requirements. A standardised curriculum with appropriate oversight mechanisms must be developed for this cadre of worker with due consideration of the limits of their scope of practice, including quality assurance.
5. While undergraduate and post-graduate medical training curricula for general medical practitioners and specialists such as Family Physicians, Psychiatrists (and subspecialist Psychiatrists) and Neurologists are of an appropriate and high standard, there is a lack of emphasis on equipping specialists to play the significant training and mentoring role required in a task-shifting environment. Specific training in this regard is recommended.
6. Across all categories of provider training curricula, there is insufficient training in the effective prevention and management of substance use disorders. Evidence-based interventions which include non-judgemental medical approaches as well as psychosocial interventions are recommended.

More detailed recommendations are made, as well as an outline of areas for further study, including addressing the particular needs of children, adolescents, the elderly and persons with intellectual disability. The report notes the need for significant societal and health-system transformation to realise the implementation of the recommendations.

Chapter 1: Introduction

1. Background

South Africa has a significant burden of Mental, Neurological and Substance Use (MNS) disorders and a large treatment gap.[1] For example, while one in six people has a common mental disorder, only one in four of these receives care.[2] In addition, people with severe mental illnesses such as schizophrenia and other psychotic disorders, suffer chronic and enduring illness which places a significant burden of care on their families and health services.[3,4] In the democratic era in South Africa, post-1994, health-service planners had to shift mental health care from a largely vertical custodial institutional system of care, which was racially segregated, to an integrated, comprehensive community-based system of mental health care in which all South Africans have equal access to quality treatment, care and rehabilitation. To this end, a new Mental Health Care Act (No. 17 of 2002) was promulgated in 2004.[5] The primary focus of this legislation is to ensure that the human-rights of people with mental disorders are protected. Treatment, care and rehabilitation are provided in the least restrictive environment possible, and as close to the individual's home and community as possible (within the state's available resources).

This legislation promotes the decentralisation and integration of mental health services into general health-care and the development of community-based services. More recently, the National Department of Health (NDoH) has adopted a new *National Mental Health Policy Framework and Strategic Plan (2013-2020)* (NMH-PFSP)[6] as well as a *Framework and Strategy for Disability and Rehabilitation Services* (FSDRS) in South Africa 2015-2020.[7] Both documents highlight the need for recovery-orientated and disability-inclusive approaches to mental health care and emphasise the intersectoral nature of services to meet the needs of people with MNS disorders. Both also acknowledge the scarcity of specialised service providers in South Africa and promote the concepts of task shifting and task sharing as strategies to increase access to comprehensive mental health care services at district level, i.e. services that include mental health promotion; prevention of mental ill-health; treatment; rehabilitation; and, disability-inclusive development.

Task shifting and task sharing involve the "rational redistribution of tasks among health workforce teams"[8] with mental health care provided by non-specialist health workers, under the training, supervision and support of specialist mental health workers. Given that district-based healthcare providers are primarily generalist health workers (with an envisaged increasing number of lay/community health workers), a way of increasing access is to equip these providers with skills that are normally within the scope of specialists, through providing focused training programmes, and enabling the more highly qualified and specialised professionals to play a significant training and mentoring role for generalist health workers and professionals.[9,10]

For this approach to be successful, it is vital to ensure that all levels of providers are adequately equipped with the necessary competencies to provide the needed services. At present, there is no clear strategy for ensuring that the necessary skills mix is available to implement the National Mental Health Policy Framework and Strategic Plan or the Framework and Strategy for Disability and Rehabilitation Services. There is a need for a consensus view in South Africa on the education and training needs of healthcare workers and other providers in MNS disorders given the national development agenda and its alignment with the United Nations Sustainable Development Goals.[11] To enable policy implementation, it is crucial that training programmes ensure that service providers are equipped with the necessary competences to undertake roles and functions pertinent to the MNS disorders. In addition, mechanisms for quality assurance of competences must be clarified and enforced, for example, through continuing professional development criteria.

The United States (US) Institute of Medicine (IOM) convened a meeting in Uganda in 2012 under the banner of *Strengthening Human Resources through the Development of Candidate Core Competencies for Mental, Neurological and Substance Use (MNS) Disorders in Sub-Saharan Africa*. Through this meeting[12] and the work that followed it, the IOM identified core competencies for healthcare providers for integrated mental health care using a task-sharing approach. This was followed by a workshop in Johannesburg in May 2014 hosted by the Academy of Science of South Africa (ASSAf) entitled *Implementation of Core Competencies for MNS Disorders.*[13] The purpose of the workshop was to assess how the core competencies identified at the Ugandan meeting could be implemented in South Africa (see Tables 1 and 2 in Appendix 1).

Subsequent to the workshop, a task team established by ASSAf met in March 2015 to take this process forward. The ASSAf MNS task team identified the need for a consensus study to:

1. Provide baseline data on what is currently offered in South African training programmes by different providers in the human resource mix for the delivery of integrated and comprehensive services for people with MNS disorders.

2. Adapt the Ugandan IOM core competencies framework for South Africa.
3. Map baseline data against the agreed-upon core competencies for South Africa.
4. Make recommendations for core competencies required of training programmes to the Health Professions Council of South Africa (HPCSA), as well as to other training and regulatory bodies.
5. Make recommendations to the National Department of Health and other government departments to inform service planning and development.

The study scope covered the World Health Organization (WHO) Mental Health Gap Action Programme (mhGAP) priorities, i.e. psychosis, depression, substance use disorders (including alcohol), child-developmental disorders, child-behavioural disorders, suicide, dementia and epilepsy.

1.1 Methodology

The study followed a standard academic consensus study methodology, adapted from that utilised by the US Academies of Science. The methodology involved:

i. Establishing a panel of experts with representation from as many of the different categories of health providers involved in MNS disorders as possible to guide and conduct the study.
ii. Convening regular panel workshops to define the study parameters with reference to the vision of a district-based, comprehensive mental health care service with adequate specialist support at district, regional and central level.
iii. Identifying contextually relevant core competencies for MNS disorders in South Africa. It should be noted that the ASSAf 2014 workshop had already reviewed the Ugandan IOM framework and decided to omit some of the competencies considered not to be relevant or repetitive. This consensus study, therefore, used the 2014 South African ASSAf workshop's competencies as the starting point for its work. (Refer Tables 1 and 2 (used with copyright permission) in Appendices 1 & 2.) The panel went through a systematic process of defining the core functions of each level of provider within the above envisaged system of care, and then proposed additional core competencies where these were not listed in the 2014 South African ASSAf workshop competencies. In addition, it was noted that there was insufficient emphasis on the recovery and disability inclusion domains, and proposals have been made in this regard, which are in the final list of core functions listed in Appendices 1 and 2. These were also used in the review, where relevant. The final list of core functions and competencies proposed from this project are listed in Tables 1 and 2 below.
iv. Identifying and approaching existing education and training programmes for access to their curriculum in document form.
v. Document review involved mapping the content of a curriculum against the identified core competencies in Tables 1 & 2 below, and highlighting strengths, gaps and challenges in the provision of care for people with MNS disorders.
vi. Consultation with relevant stakeholders at various points in the study.
vii. Producing a peer-reviewed report that is intended to be useful to service planners, providers and educators/trainers/mentors, and that provides recommendations for the achievement of quality mental health care in a district-based comprehensive and integrated system of care.

1.2 Some key concepts

Core competencies

A competency is the capability to apply a set of related knowledge, skills and abilities to successfully perform functions or tasks in a defined work setting. Competencies often serve as the basis for skill standards that specify the level of knowledge, skills and abilities needed for success, as well as potential measurement criteria for assessing competency attainment. A competency model is a collection of competencies that together define successful performance in a particular work setting. [14]

The education of health-service providers is an area that has attracted much interest over many years, and various methods have been suggested and implemented in the training of health professionals. From the early twentieth century, models of health professional training in high-income countries (HICs) have shifted from a 'traditional' approach (initial pre-clinical basic sciences training followed by clinical training) to a more 'problem-based/integrated' approach. Various models of health professional education have been implemented and evaluated in the United States of America and other HICs.[15] The concept of competency-based training (CoBT) has developed across health professions out of these more recent approaches.[16,17,18,19,20] Subsequently, the concept of 'entrustable professional activities' (EPAs) has been developed, and it is suggested that these are defined activities that need to meet prescribed standards before a trainee is considered competent to undertake such activities without supervision.[21] EPAs are considered a means to translate competencies into practice across professions and countries.[22] Of particular concern is the need for quality assurance of services

through regulated intra-professional monitoring and evaluation mechanisms, for example, continuing professional development requirements. Competencies associated with service administration and management that promote quality assured practices were not addressed in this review.

How do these educational concepts translate into the situation in low- and middle-income countries (LMICs), where task shifting or task sharing is a key strategy for increasing the available resources to meet the mental health needs of the population? In fact, they translate well. Competency-based training can be adapted to less-formal training environments, where time-based training may not be a requirement. The concept of EPAs can also be applied to those tasks which mid-level and generalist health workers can be trained to perform without or with minimal supervision. EPA thinking may help to clarify exactly which activities can be carried out independently by non-specialist providers and which require supervision.[23]

1.3 Integration of mental health into general health care/primary care and collaborative care

There is increasing recognition that South Africa, like other LMIC countries, is facing a quadruple burden of disease with associated disability and lost healthy years of life. This includes Human Immunodeficiency Virus (HIV) and Tuberculosis (TB); chronic non-communicable diseases of lifestyle (including hypertension and diabetes); injuries (road accidents and assaults); and, common mental disorders (depression and anxiety).[24] A key strategy for increasing access to mental health care and providing comprehensive care is, firstly, the integration of mental health care into general healthcare and, secondly, the integration of mental health promotion and disability prevention into intersectoral services at community level. There are various models for achieving these strategies, one of which is collaborative care between all service levels within the health sector. This model implies a standard health record, a case manager (or in some cases, a navigator), and the availability of specialist assessment and intervention at primary care or district level.[25] Another model for comprehensive care is community-based rehabilitation, a strategy advocated by the WHO for community development, disability prevention and disability inclusion through intersectoral collaboration.[26] This model implies the flexible deployment of human resources with MNS competencies to work within and across sectors to achieve optimal public mental health outcomes.

Context: A brief description of the vision for a district-based comprehensive and integrated mental health service using a task-sharing and task-shifting approach with specialist support.

There are three major categories of mental disorder:

- *Mental disorders secondary to other medical conditions*. These include delirium, dementia, and mood or psychotic disorders secondary to an underlying condition, for example, HIV and Epilepsy.
- *Serious mental illnesses*, including psychotic and major mood disorders (Bipolar Disorder and Major Depressive Disorder). Eating disorders, personality disorders, autistic spectrum disorders and some anxiety disorders are severe enough to be included in this category and require specialised intervention.
- *Common mental disorders*, which include depression, anxiety and substance use disorders (in all age groups, including children and adolescents).

In addition to this classification, people with intellectual disability (particularly severe and profound intellectual disability, which is often associated with mental and neurological comorbidity) should also be included when discussing MNS disorders.[b]

Co-occurring categories of mental disorder requiring long-term care and disability-inclusive interventions have not received sufficient attention. The Life Esidimeni tragedy highlighted this.[c] While services for people with mild and moderate intellectual disability are primarily the responsibility of the Departments of Education, Social Development and Labour, people with severe and profound intellectual disability are primarily the responsibility of the Department of Health.

It is not entirely clear which categories and what level of severity of mental illness are amenable to management at primary care level. It is critical that primary care health providers are aware of psychiatric presentations of certain medical and neurological conditions, since psychiatric symptoms often indicate a serious underlying physical or physiological problem. People with serious mental illnesses who are stable and not acutely ill can be managed by primary care non-specialist providers as long as there is sufficient multidisciplinary/professional support at the primary care/district level as well as at the specialist level. Many common mental disorders can also be managed medically, socially and functionally at primary care level. However,

a. Although epilepsy is a neurological and not a mental disorder it is often poorly managed in peripheral/rural areas. It may present comorbidly with intellectual disability, developmental delay and cerebral palsy. These and other co-occurring conditions place a high burden on mental health and rehabilitation services.

b. The Life Esidimeni tragedy involved the deaths of 143 people at unsuitable non-governmental facilities in the Gauteng province of South Africa from causes including starvation and neglect. It is named after the private healthcare provider from which psychiatric patients requiring long-term care were removed by the state.

these disorders may also be complex and/or treatment-resistant and then require a more specialised level of care. Psychological, social, rehabilitative and disability-prevention competencies are particularly pertinent at community level because they interrupt 'revolving door' hospital admissions by supporting persons with (or at risk for) MNS disorders towards recovery and well-being in the context of their daily life activities. Development-orientated interventions emphasis mitigating the social determinants of mental health through collaborative interdisciplinary and intersectoral practices that strengthen peer-led community initiatives and people's health movements.

In children, neurodevelopmental disorders include attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, intellectual disability and other developmental disorders that are a barrier to learning. Behavioural disorders (e.g. conduct disorder) in children are addressed in the mhGAP Intervention Guide,[27] but anxiety disorders, which are common in children, are not addressed. Besides medical and psychological interventions, children with special needs associated with the MNS disorders also benefit from habilitation services such as universal design for learning in the home, classroom and playground and, in the case of school leavers, access to supported employment programmes. With this in mind, competencies for the MNS disorders must allow service providers to operate both within and beyond the health sector to optimise intersectoral collaboration and increase access to health professional expertise.[c]

The emphasis in an intersectoral service orientation to the needs of people with MNS disorders is based on a recovery model and an inclusive development approach. Individuals are assisted in reaching their potential within the restrictions of their illness or level of disability in the context of their living, learning, working and socialising environments.[28] The ideal enshrined in the NMHPFSP and Mental Health Care Act (MHCA) No. 17 of 2002 is the provision of services in the least restrictive environment, as close to home as possible, *with an emphasis on ambulatory/outpatient and voluntary care as far as possible*. Hospital admission, especially involuntary admission, should be for acute episodes of severe mental illness only, and long-term institutional care should be reserved for people who cannot be safely cared for by their families. Recognising the burden of care on families, it needs to be emphasised that there are circumstances where individuals are better cared for in a good residential facility or in a hospital setting, rather than at home, and there needs to be a balance between outpatient and inpatient care facilities.[29]

Services should also be provided with an awareness of the social context of the individual, including their family (which is often their primary source of support) and their community. While treatment may need to provide for the individual with an MNS disorder, intervention should always include consideration of family and the community in which they live, and, therefore, programmes that promote mental well-being and prevent mental disorders are important aspects of the service. Also, given the lack of resources, group interventions may be useful as they are able to reach a larger number of individuals at one time, and also provide peer support for people with MNS disorders.

In terms of the National Mental Health Policy Framework and Strategic Plan, every district is expected to have a district specialist mental health (DSMH) team. This team is responsible for the promotion of mental health of the population of the district, and it is essential that they understand and actively mitigate the social determinants of the MNS disorders through partnering with sustainable community development initiatives.[11] In so doing, this team is also responsible for training and supervising all providers, intersectoral liaison and for engaging with non-governmental and community-based organisations, including traditional healers and faith-based organisations that play a role in preventing the onset of MNS disorders as well as providing for people with MNS disorders in the community in any way.

In addition, it is envisaged that each district should have access to a clinical specialist mental health (CSMH) multi-professional team, which is responsible for providing specialist clinical assessment or interventions for people with MNS disorders who cannot be managed at primary care level. How this clinical and recovery-orientated service is planned and delivered may differ according to the individual circumstances within a district and the available resources (see below).

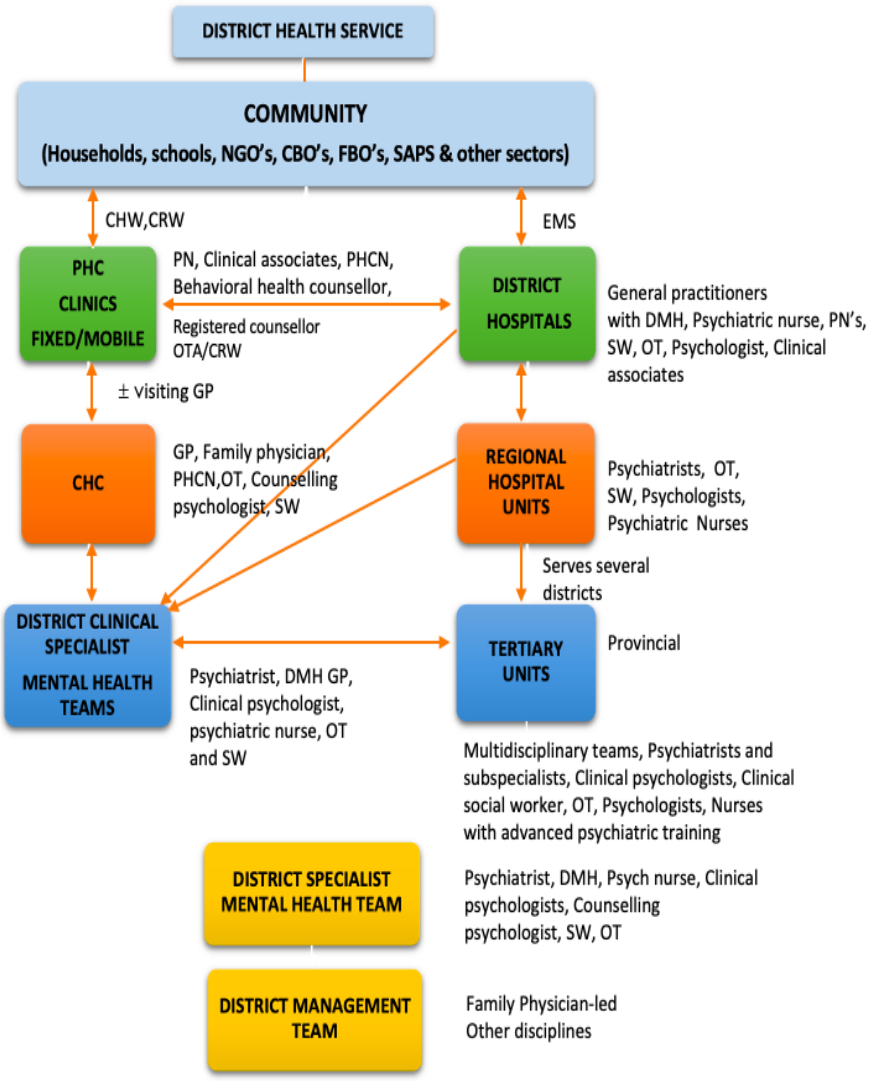
Ideally, both these teams should include a psychiatrist, (depending on available resources, or a family physician with interest in psychiatry and mental health, or a diploma in mental health), a psychiatric nurse and/or allied health worker/s with experience in psychiatry, recovery-orientated rehabilitation and mental health promotion. Districts must establish and fund posts for specialist MNS providers. However, given existing resource constraints and the maldistribution of specialist mental health professionals in the country, some creativity will need to be exercised in disadvantaged or rural areas where such posts may be difficult to fill. Use of outreach teams from hospitals or telemedicine technology may be useful in such contexts.

The Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015-2020 (FSDRS) endorses the International Classification of Functioning, Disability and Health (ICF)[30] as a framework for understand-

c. However, the scope of this study was limited to service providers in the health sector.

ing and addressing the disability dynamics associated with MNS disorders. At a population level, the FSDRS recommends the use of community-based rehabilitation (CBR)[30] as an intersectoral strategy for community development by preventing disability, promoting recovery and facilitating social inclusion. Rehabilitation professionals with experience in psychiatry and mental health in the district health service should be equipped to plan, consult and supervise individual, and group-based recovery programmes that target medical, psychosocial, educational and vocational rehabilitation needs. Given the scope of demand and the shortage of rehabilitation professionals in South Africa, CBR programmes should ideally be rolled out through task shifting selected rehabilitation and disability-related competencies to appropriately trained community health workers that are supervised by members of the CSMH.

The following system of care within the formal public health system is envisaged:



Entry into the health system for people with MNS disorders is usually through primary health care. This is either at the clinic or community-health centre level or through the ward-based outreach teams (WBOTs),[31] which refer on to the primary healthcare clinic. People with MNS disorders are screened at the clinic level, and a needs assessment is done. The primary healthcare nurse is the case manager and decides on further intervention. This can either be managed at primary healthcare level through prescription of medication (currently psychotropic medications can only be prescribed by registered medical practitioners), with referral to any or all the following interventions:

- Clinic-based behavioural health counsellor for psycho-education and a manualised counselling intervention for particular mental disorders. These counsellors will be supervised by registered counsellors employed at the clinic or psychologists employed in the district.
- Community-based rehabilitation (CBR) services coordinated by the occupational therapy team (Occupational Therapy Assistant (OTA), professional Occupational Therapist (OT)) through developing or networking with community resources outside the formal health system or with services in other sectors that can assist in providing disability-inclusive support and skills development to people with MNS disorders. CBR is advanced through task shifting and task sharing with community health workers/community rehabilitation workers (CHW/CRWs) who are supervised by registered professionals. Physiotherapists and speech-lan-

guage therapists are also positioned to facilitate medical rehabilitation and social inclusion of persons whose physical functioning is compromised by co-occurring mental, developmental and neurological disorders.
- Psychosocial therapy and legal/statutory guidance (if necessary) to individuals and their families/significant others from the social work team (Assistant Social- Worker (ASW), professional Social Worker (SW)) at the clinic or in the community.

At-risk persons screened by CHW/CRWs or existing patients should be referred by this cadre of worker to the WBOTs for follow-up in terms of assessment, intervention and adherence.

Should a person be identified as needing more specialised assessment or intervention, s/he is referred to the clinical specialist mental health team in the district. Depending on staffing structures, this team could take the form of an outreach team from an inpatient unit, but it is preferable that such specialist support is provided as a dedicated service in the district. Such a team should be multi-professional, and be able to provide direct clinical, psychosocial and rehabilitative services as well as provide collaborative care with primary healthcare practitioners.

Should a person need admission to hospital, s/he is referred to the district hospital for that area. The district hospital should be able to manage patients with serious mental illness requiring 72-hour assessments for involuntary mental health care users, as well as other patients who require acute admission who are voluntary or assisted mental health care users. The mental health care team at district hospital level should include nursing professionals with experience in mental health, a medical practitioner with experience in psychiatry (preferably a family physician with a Diploma in Mental Health), a psychologist, as well as representatives of the hospital social work and occupational therapy departments.

Patients who require further involuntary admission and patients with complex psychiatric problems should be referred to the nearest regional hospital with an acute psychiatric unit, or to the referral central/specialised psychiatric hospital for further assessment and intervention. Ideally, seamless bi-directional referral pathways should exist so that individual recovery plans and processes are coordinated and monitored by designated case managers in the WBOTs across all levels of care.

Once an inpatient has been stabilised, they should be referred back to the specialist clinical team, which should develop or adjust the patient's medical, psychological and functional recovery plan and decide on further community-based interventions. For example, a patient who has had an acute psychotic episode and has been admitted to a district, regional or central/specialised hospital, could be followed up by a psychiatrist/specialist mental health doctor for a period of time, or by a psychiatric nurse or Primary Healthcare (PHC) nurse, depending on the particular needs of that patient and available resources. The specialist clinical team should also refer to members of the psychosocial rehabilitation team (psychologist, occupational therapist, social worker, other community-based organisations). Ultimately, the patient should return home and should be followed up by the community health worker in the WBOT team and by the PHC nurse, once they are stable. Ideally, the patient (referred to as a mental health care user -MHCU) will be supported by a community health worker who has basic disability and rehabilitation competencies. Working within the CBR framework,[30] the community health worker will be supervised by a professional who, in partnership with the MHCU, develops and monitors a functional recovery programme. The first-level community worker needs to be continuously supported and supervised by relevant members of the mental health team. Telemedicine, the use of internet technology and smart phones/tablets, is important in this regard and should be used particularly in remote or rural areas. Relapse prevention is promoted when the MHCU is helped to embark on or resume productive engagement in living, learning, working and socialising activities, including membership of mental health activism and consumer self-help groups.

In summary, this system of care is aligned with the primary healthcare philosophy and potentially facilitates sustainable development. Public mental health services that engage with other sectors such as social development, labour, education and justice, as well as non-governmental organisations (NGOs) and faith-based organisations are positioned to address the social determinants of MNS disorders. The efficiency and effectiveness of multisectoral mental health care interventions hinge on transverse deployment and structural support of service providers. They need access to resources such as transport and workspace and alternative outcome indicators to record and monitor their productivity besides clinic attendance and bed-occupancy statistics. Managers concerned with disability inclusion in each sector, including public administration staff at municipal level should ideally be knowledgeable about the rudimentary principles of services aimed at mental health promotion, prevention and recovery.[e]

d. It was beyond the remit of this study to survey the competencies of staff who support the roll-out of intersectoral public mental health services.

Candidate core competencies: Across providers and disorders

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

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
TC.6	Demonstrates knowledge of treatment and care resources in the community
TC.7	Promotes mental health literacy (e.g. to minimise the 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
Rehabilitation/Disability Inclusive Development	
RD.1	Demonstrates knowledge of the International Classification of Health, Functioning and Disability
RD.2	Demonstrates knowledge of disability models across the lifespan

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

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
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)[e]
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
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)
Treatment/Care	
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
TC.28	Demonstrates knowledge of and ability to apply relevant legislation and policies and access to appropriate services

e. DSM: Diagnostic and Statistical Manual of Mental Disorders; ICD: International Statistical Classification of Diseases and Related Health Problems. The absence of a diagnostic guideline for disability such as the ICF is noteworthy.

TC.34	Reports information to relevant health-management systems
TC.36	Assists patients with access to other providers and helps to 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 healthcare providers
Rehabilitation/Disability Inclusive Development	
RD.1	Demonstrates knowledge and skill in community-based rehabilitation as an intersectoral strategy for community development
RD.2	Demonstrates ability to assess disability (interaction between environment and impairments, activity limitations and participation restrictions) arising from MNS disorders
Rehabilitation/Disability Inclusive Development	
RD.3	Demonstrates ability to plan, implement and evaluate recovery-orientated psychosocial rehabilitation programmes for individuals and groups
RD.4	Demonstrates knowledge and skill in assessing and modifying the environments in which people affected by MNS disorders live, learn, work, recreate and socialise to promote their participation and social inclusion
RD.5	Demonstrates knowledge and skill in assessing and enabling work readiness, work hardening, supported employment and/or income generation for people with disabilities (specialised providers)
RD.6	Demonstrates knowledge and skill in applying disability accessibility standards and universal design to promote learning and development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Chapter 2: Community Health Workers

Key Findings

Community health worker in WBOT teams, community rehabilitation workers and community care givers need additional content on MNS disorders in their training curricula as well as ongoing support, training and mentoring in screening community members for MNS disorder, supporting people with MNS disorders in their treatment and strengthening their competence to provide community-based rehabilitation. CHWs need clear career pathways with appropriate recognition and remuneration in the public health system.

Key points

This chapter focuses on provider core competencies in relation to improved delivery of services with regard to mental, neurological and substance use (MNS) disorders in South Africa, with a specific focus on the competencies of community health workers (CHWs). It is the intention of the PHC Re-engineering project that CHWs play a major role in the new municipal ward-based outreach teams (WBOTs). The chapter also includes a discussion of the role that community caregivers (CCGs) might be able to play in community settings. The chapter notes that the current training curriculum for CHWs provides an excellent foundation in generic skills, but proposes that the MNS disorders be added to the current cross-cutting fields and associated activities of CHW and that the existing activities pertaining to disability and rehabilitation be enhanced and, in so doing, reduce the need for a separate category of community rehabilitation worker or that this skills set becomes a domain of specialisation and career development for CHWs (see Chapter 6).

2.1 Introduction

CHWs are a heterogeneous group of people who have played a range of roles in different countries and times. The term generally refers to a cadre of laypersons, sometimes volunteers, who assist in the delivery of public health services, particularly in developing countries. Although the term CHW has a particular meaning in the South African public health context, the roles they have played in other countries have diverged, particularly when different health systems are compared. Other designations for CHWs have included village health workers, community health promoters, lay health workers, lay health advisors, family health agents, community health practitioners and home-based carers. Regardless of the description used or the particular scope of practice, most CHWs are laypeople without formal health profession training, who generally live in the communities they serve, and play a pivotal role in terms of health promotion, supporting community members with chronic or burdensome medical conditions, and building or strengthening the relationship between community members and local healthcare providers. This cadre of healthcare worker has played a critical role in low- and middle-income countries, particularly where communities experience a chronic shortage of skilled health care professionals, including medical practitioners, professional nurses and pharmacists.[32]

2.2 The historical context

South Africa has a rich legacy of CHW projects, some of which originated before and during the repressive years of apartheid, with its inequitable healthcare system based on race classification. Some of the country's first CHWs were malaria assistants who received training in the late 1920s in parts of Zululand and Natal. After 1948, despite the apartheid government instituting policies of racial segregation, supporters of social medicine initiated the 'health centre' movement, which sought to provide "unified health care to all sections of the people of South Africa".[33]

During this period, various non-governmental organisations (NGOs) and rural health initiatives were established by concerned health providers who wished to address the unmet healthcare needs of the black majority population, and, in particular, to provide various forms of primary healthcare. Most of the leadership of such projects comprised white male doctors and/or white female nurses, since very few black people had access to formal medical training during this period. Nevertheless, African CHWs played a key role in the development of such projects. In the late 1980s, the growing conviction that apartheid would soon be brought to an end encouraged progressive South African thinkers and academics to develop a range of new community health initiatives, many of which utilised CHWs in some capacity.[34]

From 1985 onwards, shifts in the disease burden persuaded some health programmes to shift their focus from attempting to improve infant and child health to addressing chronic lifestyle diseases and the insidious effects of infection with one particular virus, the human immunodeficiency virus (HIV). The scale of human suffering and initial high mortality rates in the first and second decades of the HIV/AIDS epidemic in South Africa, particularly in disadvantaged communities, together with government's reluctance to commit significant fund-

ing to address HIV/AIDS led concerned members in some communities to mobilise, organise and start local initiatives to address critical concerns in communities, such as home-based care and support; provision of HIV education and information about prevention; as well as ensuring that lay counsellors were available to staff HIV Counselling and Testing (HCT) sites.[35]

Lay volunteers and CHWs who wished to mitigate the impact of HIV/AIDS were not necessarily welcomed by all the staff at public-sector health facilities. While the South African Nursing Council (SANC) supported CHWs in principle, the reality was that many nurses engaged in intimidating and rude behaviour directed at CHWs. One social commentator noted that nurses mighthave felt that their role in PHC was being threatened by such a large number of volunteer CHWs joining the health sector. These prejudices were probably confirmed by later government proposals to formally recognise CHWs and integrate them into PHC.[36]

2.3 Acceptance of CHW's contribution to healthcare

Although the initial response of some healthcare workers in PHC settings to the emergence of CHWs was hostile, gradually the invaluable contributions that these individuals made at PHC level were acknowledged. In the early years of CHW involvement in PHC, one of the primary roles of CHWs was as lay counsellors in the national HIV counselling and testing (HCT) programme, which eventually led to the testing of millions of South Africans for HIV and later, to also screening for TB symptoms. Likewise, older female CHWs with limited formal education became champions in supporting and mentoring orphans and vulnerable children (OVC) who were rendered fragile by the loss of one or both their parents and sometimes too, by the burden of having to serve as the head of a household of young, dependent siblings of school-going age.

From 2003, the South African government introduced a policy of paying stipends to CHWs following basic training. However, this policy was not uniformly implemented countrywide, or implemented in the majority of the nine provinces. An official survey of CHWs in 2011 found that many had never received formal training, and most who had been trained had not received certification to provide evidence of their participation in training workshops. Until recently, most provincial health departments did not pay CHWs directly for their services. In 2011, the NDoH funded 1 260 NGOs, which, in turn, paid stipends to 41 000 CHWs. Unfortunately, not all NGOs were vigilant regarding timeous monthly payments to CHWs. CHWs in each of the provinces complained at various times about not being paid their stipends for two or more months, or always being paid late, and great dissatisfaction was expressed about the system of remuneration. However, this situation is currently in the process of change: the intention is that CHWs should become permanent employees of provincial departments of health and should be paid directly by the provinces, as is already the case for most other healthcare providers in PHC settings.[37]

In 2010, the NDoH launched a national PHC initiative,[38] which involved a shift away from the curative model of healthcare, oriented primarily in terms of responses to disease or ill health, towards a more person-centred healthcare system which aims to promote healthand to develop public awareness of what constitutes healthy lifestyles. The new South African approach is based on a Brazilian model known as the Family Health Strategy, which focuses on prevention of illness and promotion of healthy lifestyle choices.[39] The South African programme, called Re-engineering Primary Health Care, aims to support a preventive and health-promoting community-based PHC model. Implementation of the strategy was also intended to lay the foundation for the later introduction of National Health Insurance (NHI).

Re-engineering Primary Health Care has three main streams (in addition to improving service delivery at primary healthcare clinics:[40]

- Establishing district-based specialist support teams, which should ensure delivery of priority healthcare to communities in the district, at PHC clinics, community health centres and district hospitals.
- Developing and strengthening school health services, which are to be delivered by a team led by a professional nurse.
- The creation of municipal ward-based outreach teams (WBOTs), each comprising a minimum of six CHWs, supported by environmental and health promotion practitioners, and led by an outreach team leader (OTL) who is usually a nurse.[31]

Each WBOT team is allocated a specified number of households, and each CHW takes responsibility to visit all these households regularly. The CHW aims to become acquainted with the individuals who live in each household and, as far as possible, should try to develop a friendly but professional relationship with each household member. A simple assessment process using specified standardised assessment tools is conducted with each household member to ascertain their health priorities and establish whether there are critical health issues that need urgent attention. If the assessment tools highlight one or more health issue or issues, or the household member raises one or more health issues in conversation, or alternatively, if the CHW strongly suspects that there is a current or chronic health issue which needs attention (based on personal observation),

then the CHW should inform the household member of their concern, discuss available options for referral or assistance to manage the health issue, and offer practical or emotional support to the individual to enable them to get to the referral agency or individual for a specified appointment time.

By mid-2016, WBOTs were functioning in 2 590 of South Africa's 4 392 local government wards.[41] KwaZulu-Natal (KZN) has been at the forefront of the PHC Re-engineering initiative. In 2011 the province discontinued provision of funding to NGOs, which had previously employed CHWs and paid them their stipends. The KZN Department of Health's policy for CHWs altered, and the province undertook to generate formal employment contracts for all individual CHWs. Such contracts routinely required CHWs to provide 20 days of service per month to the department.

The NDoH has developed guidelines for CHWs who are members of WBOTs. The components of WBOT integrated service delivery are well-definedand comprise the following objectives:[42]

- "Promote overall health and well-being within households and communities.
- Provide information, health education and promote healthy behaviour and disease preventions.
- Conduct structured household screening and profiling to identify health needs.
- Provide appropriate direct basic services, including treatment for minor health problems/needs, counselling and psychosocial support for individuals or households, as defined by the CHW scope of work.
- Facilitate appropriate referral for health, rehabilitation and social support services as needed for individuals or households.[f]
- Provide adherence support for people on medication and support follow-up care, including delivery of chronic medication.
- Facilitate community mobilisation and create awareness of health diseases through awareness campaigns and mobilise around community needs."

Furthermore, CHWs are expected to engage in cross-cutting activities (including health promotion, disease prevention, treatment and linkage to care, and referral) in the following fields:

- Maternal and newborn health
- Child health
- HIV/AIDS
- TB
- Hypertension
- Diabetes
- Palliative care
- Engaging with vulnerable groups such as older people and people with disabilities (this field could be extended, through additional training, to include mental health, community-based rehabilitation and disability-inclusive competencies).

The inclusion of MNS disorders to their field would extend the scope of and the sphere of the impact of CHWs. The deliberate placement of CHWs within WBOTs and their employment by the provincial health departments may redress some of the complaints reiterated by CHWs in various qualitative research studies conducted across various provinces over the past two decades. The most common complaints relate to poor remuneration; irregular remuneration; insufficient reimbursement for travel costs; the absence of job security; the lack of a clear career path; inadequate or no debriefings; absence of regular mentoring; and, CHWs being denied opportunities to access further training and personal development.[10,36]

2.4 Strengths

The recently printed *Community Health Worker and Outreach Team Leader Skills Development Package for In-service Training Facilitator Manual* (2018)[42] is an excellent and comprehensive resource for training. It provides a carefully worded and clear outline of the scope of practice of CHWs who are members of municipal ward-based outreach teams (WBOTs), and, in turn, suggests the competencies in relation to MNS disorders that such CHWs should have acquired.

The competencies which emerge from a close reading of the *Facilitator Manual* are:

- Demonstrates awareness of common signs and symptoms (SI.1) - is suggested by the training objective 'Conduct structured household screening and profiling to identify health needs', also by 'Asking a question to determine if a person is anxious or depressed', by 'Screening and/or referral and supportive care of serious mental health issues', and, finally, by 'During home visits, the specific responsibilities of CHWs include 'Screening and/or referral and supportive care of serious mental health issues'.

f. It is suggested that instead of creating a separate category of community rehabilitation workers the cross-cutting activities of CHWs should include disability awareness and basic rehabilitation skills in order to make appropriate referrals pertaining to the recovery, func tioning and social inclusion of individuals with disability.

- Provide the patient and community with awareness and/or education (SI.4) - is suggested by the training objective 'Provide information, health education and promote healthy behaviour and disease interventions'.
- Demonstrates cultural competence (SI.5) - is suggested by `Understand what it means to be culturally appropriate'.
- Demonstrates ability to screen for and use screening tools (SI.7) - is reflected in 'Screening in order to find out if there are any health- or social development-related problems with a community member' and 'Use the Health Promotion Tool and the CHW Household Tools effectively'.
- Demonstrates knowledge of required information for appropriate referral (DR.1) - is reflected in 'Referring community members to health facilities or community-based facilities' and 'Facilitate appropriate referral for … rehabilitation and social assistance when required'.
- Demonstrates knowledge of when to make an effective referral (DR.4) - is partly reflected in the outcome 'Facilitate appropriate referral for health, rehabilitation and social support services as needed for individuals or households'.
- Provides support to patients and families while in treatment and care (TC.1) - can be inferred from 'Screening and/or referral of families [with regard to] social pathology'.
- Identifies and assists patients and families in overcoming barriers to successful treatment and recovery (TC.2) - can be inferred from the training assignment question 'Describe steps you can take to help people use referrals or deal with barriers'.
- Initiates and/or participates in community-based care and treatment programmes (TC.5) - is suggested by 'Facilitate community mobilisation and create awareness on health diseases [sic] through awareness campaigns and mobilise around community needs'.
- Demonstrates knowledge of care and treatment resources (TC.6) - is demonstrated by 'Referring community members to health facilities or community-based facilities'.
- Monitors for adherence to, and side-effects of treatment (TC.9) - is shown in 'Provide adherence support for people on medication and support follow-up care, including delivery of chronic medication', as well as 'Establish and support adherence clubs for all chronic conditions', together with 'Provide support [to HIV-positive children] to adhere to treatment' and, finally, 'Support HIV and TB patients on treatment and promote disclosure'.
- Provides links between patients and community resources (TC.11) is suggested by 'Facilitate appropriate referral for health, rehabilitation and social support services as needed for individuals or households'.
- Identify strategies for re-engaging community members in care (TC.12) - is indirectly evoked in 'Identify available resources to support patients'.
- Promotes activities that aim to raise awareness and improve uptake of interventions (TC.13) - is reflected in 'Facilitate community mobilisation and create awareness on health diseases [sic] through awareness campaigns and mobilise around community needs' and 'List ways to engage the community'.
- Protects patients and identifies vulnerabilities (TC.14) - is inferable from 'Offer support to members of vulnerable groups, such as older people and people with a disability' and 'Behaving ethically and ensuring community members' right to confidentiality is respected'.
- Demonstrates respect, compassion and responsiveness to patient needs (TC.15) - is partially evoked in 'Communicating effectively'.
- Demonstrates ability in general counselling skills (TC.17) - is reflected in 'Provide counselling and psychosocial support for individuals and households, as defined by the CHW scope of work'.
- Demonstrates knowledge and skills to provide proactive follow-up and monitor outcomes of care (TC.40) - is revealed through 'Provide adherence support for people on medication and support follow- up care, including delivery of chronic medication'.
- Demonstrate knowledge of the International Classification of Health, Functioning and Disability (RD.1) and Demonstrate awareness of disability models across the lifespan (RD.2) - are inferred by outcomes, listed above, that are concerned with rehabilitation and disability.

What becomes clear from the manual, is that CHWs are expected to have a broad array of skills, but with limited applicability. They will only develop these skills if the following conditions are met:

- they receive correct and ongoing training and supervision of task-shifted functions;
- they receive ongoing and thorough debriefing; and,
- they receive mentoring from their WBOT leader (usually a professional nurse, or in the case of disability, a rehabilitation professional) so that they develop confidence and competence.

The CHW MNS-related competencies cover some of those listed in Table 1 (Candidate core competencies for all provider types) and a few of the competencies listed in Table 2. The range of competencies seems rather generalised and limited in scope but makes sense in terms of the broad objectives that CHWs are required to meet. Training needs to be strengthened to ensure specific and better coverage of MNS issues. Currently, as far as screening for MNS disorders is concerned, the following is found in the training materials: 'Ask a question to determine if a person is anxious or depressed'. And that CHWs specific responsibilities include:

'Screening and/or referral and supportive care of serious mental health issues on potential patients detected by the CHWs' (serious mental health issue is undefined). Disability awareness, functional recovery and community-based rehabilitation (see Chapter 6) could be addressed in future versions of the manual.

The NDoH has made a sensible and relevant policy decision in seeking to ensure that CHWs are able to sign annual contracts with all provincial health departments and hence obtain real job security and, more importantly, a sense that their contribution to PHC is significant and valued by other healthcare workers. What will make a difference in terms of the turnover of CHWs, and the extent to which WBOT teams are able to achieve meaningful impact, reflected in improved community health and disability inclusion indicators and higher patient retention rates, is sound and professional management of all WBOTs; sound and consistent mentoring of team members; the offer of regular debriefing sessions; and, inculcation of a work ethos that values health worker development and provides opportunities for all employees to travel their own career paths. In particular, the efficiency of CHW outputs will be enhanced with access to appropriate service infrastructure such as transport and mobile technology. The content of the training needs to be reviewed to ensure adequate attention is given to MNS disorders.

2.5 Outreach team leaders

The facilitator training manual for CHWs also specifies the scope of practice of outreach team leaders (OTLs). Their competencies overlap considerably and there is little discernable distinction between the competencies of OTLs and CHWs in relation to meeting the care and treatment needs of individuals with MNS disorders. However, OTLs should have the following general competencies in addition to those of the CHWs:

- they should be able to show strong leadership;
- they should be able to provide supportive supervision;
- their mentoring skills should be well developed; and,
- they should be able to foster a conducive, supportive healthcare environment which values ongoing learning throughout the lifespan of employees.

Standardised training and regulated employment of CHWs by the NDoH as integral members of the re-engineered national PHC service will advance the ideal of universal health coverage.[29] Ideally, besides working at a community level, this cadre of worker will also be equipped to work in residential facilities for people with SMI and severe/profound intellectual disability as well as Old-Age Homes.

A note on community home-based care:

As noted above, in the historical context, lay health workers in South Africa have been a diverse group with diverse skill sets. While the current training of CHWs, which equips them to operate as part of the ward-based outreach teams has national guidelines and a national curriculum, the same cannot be said for the training and accreditation of caregivers.[43] While there is some overlap in the competencies required of CHWs in a WBOT and caregivers in homes or residential facilities (such as palliative/hospice care or old-age homes or those for people with disabilities, such as severe or profound intellectual disability, serious mental illness, and/or physical disabilities), caregivers need additional competencies in terms of the provision of physical and emotional care. There is a need for national guidelines and standardised training and accreditation for caregivers.

Chapter 3: Nursing

Key Findings

Nurses in South Africa often perform expanded roles in the health service due to the shortage and uneven distribution of other health professionals. There is a critical shortage of nurses and this is likely to worsen in the future.

Nurses working in the district health service play a primary role in screening, assessment and case management of people with MNS disorders.

Psychiatric nurses (nurses with experience and or additional training in psychiatric nursing) can play a criticalrole in terms of supporting PHC nurses through training, providing assessments and possibly also by prescribing medication (should legislation allow this). With increased understanding of recovery and disability inclusion principles, they can also play a role in community-based rehabilitation programmes.

Nurses also play a role in managing people with MNS disorders in inpatient settings, whether at district, regional, central or specialised hospital levels. Psychiatric nurses are particularly important here, but auxiliary nurses and staff nurses are an under-utilised resource in terms of providing nursing care to people with MNS disorders in PHC and hospital settings.

Nursing curricula are currently being restructured, and there appears to be less emphasis on training nurses in psychiatry and mental health. It is of concern that the Advanced Diploma in Psychiatric Nurses has been phased out.

The last date for first-time entering students (at Nursing College or University level) for the combined nursing and midwifery '4 Diploma /Degree course' was 31 December 2019. Most Nursing Colleges (both public and private) have been accredited for offering the three-year 'General Nurse' (previously named the 'Staff Nurse' category) qualification. Students entering for this three-year Diploma course will be able to register for the one-year Post Graduate course to qualify as a Mental Health Nurse once they complete the one-year Post Graduate Diploma in Midwifery.

Most Universities have complied with the requirements for offering the four-year 'Professional Nurse' qualification. On graduation, the students will be registered as Professional Nurses and Midwives. They will be eligible to apply for entrance to the programme leading to registration as a Mental Health Nurse. This Post Graduate Diploma programme has not yet been fully curriculated (a South African Nursing Council core curriculum has been circulated for guidance and comment). It is important to note that the students currently registered in the four-year programme for 'Legacy qualifications' will emerge with and be registered in the current category – Registered Nurse (General, Community and Psychiatric) and Midwife.

The National Department of Health Adult Primary Care guide includes a section on mental health. However, adequate training, mentoring and access to referral resources is essential to support nurses working in primary care.

Key points

This chapter reviews the core competencies for MNS disorders of the current so-called 'legacy' (Table 3) nursing qualifications/current curricula. It makes recommendations for the future of nursing training for MNS disorders, with a particular emphasis on equipping nurses to work in a community-based, integrated system with task shifting and task sharing as a central principle to increase access to care for people with MNS disorders.

Nurses play a central role in healthcare throughout sub-Saharan Africa, as the first and, in many instances, the only point of contact with the formal healthcare system. Nurses often work in an expanded capacity to fulfil medical, pharmaceutical and surgical roles in under-resourced areas. However, nursing as a profession faces many challenges. Although accurate statistics are not currently available, there appears to be a shortage of nurses throughout South Africa, and it is anticipated that this is likely to worsen in the future.[44] Severalfactors contribute to this situation: an increasing burden of disease, an ageing population of all categories of nurses;[45] difficulties with retention of nurses within the public sector; declining interest in the profession by school-leavers/young people; nurse migration and emigration; and, marked inequities in the geographic distribution of professional nurses.

A review of nursing as a profession and nursing education to meet the health needs of the country has been in progress since 1994.[46] A nursing qualifications framework[47] has been developed and the various nursing categories and training requirements have been revised, leading to the development of new curricula for the various categories. The aim of this review has been to address critical healthcare needs as well as to develop an appropriately skilled nursing workforce for the South African population. The new curricula have been implemented and the students for the new courses enrolled from the beginning of 2020. Entrance to the 'legacy qualifications' was terminated in 2019. There has been some criticism of the final outputs of the review and re-curriculating process, with some questioning whether the changes will indeed address the challenges facing the country and the nursing profession.[48] Of particular concern for this project is the apparent neglect of mental health and psychiatric nursing in the new 'Professional Nurse- degree and the three-year Diploma in General Nursing curricula.

Historically, the extent and quality of mental health and psychiatric nursing education in South Africa has been uneven, with many categories of nurses having no training in this discipline. In the late 1980s, with the global trend towards integration of mental health care into general healthcare, the four-year nursing qualification (D4 – Diploma or degree) was designed to equip all professional nurses with some competencies in managing MNS disorders. While the need to address pressing healthcare needs in South Africa must be supported, it is critical that recognition is given to the central role that mental health plays in health in general. So, while there needs to be a focus on addressing the complex burden of disease in South Africa (HIV, TB, chronic diseases of lifestyle and assaults and injuries),[49] treatment of these disease burdens is less than optimal unless mental health issues are also addressed. There also needs to be recognition that MNS disorders themselves are part of the quadruple burden of disease, and among the top-10 conditions contributing to disability-adjusted life years lost (DALYs) in sub-Saharan Africa.[1]

The results of this consensus survey indicate that mental health and psychiatric nursing skills are scarce in all the current (legacy) nursing categories with the exception those qualified by means of the existing four-year diploma/degree and nurses with post-graduate (specialist) qualifications in psychiatric nursing and primary care. The newly implemented four-year professional nurse qualification prepares graduates for general nursing and midwifery but does not include psychiatric nursing.

However, it should be noted that the National Department of Health (NDoH) has produced an Adult Primary Care (APC) manual, as part of the Integrated Chronic Disease Management programme of PHC re-engineering, which includes assessment and management of MNS disorders, along with HIV and chronic non-communicable diseases.[50] Nurses working in primary care clinics are supposed to receive training in APC, and should, therefore, be able to manage the conditions described in the APC manual. An evaluation of a pilot project to improve the integration of mental health into chronic disease management in South Africa has been described by Petersen*et al.*[51]

3.1 Introduction: Major contribution of nurses to healthcare

Nurses play a fundamentally important role in healthcare in South Africa, and, indeed, throughout sub-Saharan Africa.[52] According to the head of the Division of Nursing at Stellenbosch University's Faculty of Medicine and Health Sciences, Prof. Anita van der Merwe: "Nurses are the first point of contact [for many patients], and in many rural areas they are the only point of contact" for access to healthcare and treatment. The World Health Organization (WHO) declares that nurses enable people-centred care to be brought closer to communities where it is most needed, thereby improving overall health outcomes and enabling health services in developing countries to achieve improved effectiveness".[53]

In the public sector (particularly in ambulatory care) professional nurses frequently carry out tasks which doctors or pharmacists have traditionally been expected to perform. The history of the development of the 'primary healthcare nurse' in South Africa is well described in Kautzky and Tollman's chapter in the *South African Health Review* of 2008.[54] Nurses' roles have expanded to include additional competencies such as assessing and treating common health conditions presenting at primary care, performing simple surgical procedures and, more recently, management of HIV/AIDS and providing antiretroviral treatment.

At the same time, nurses have delegated some of their basic care activities to healthcare workers with less training, such as staff nurses, enrolled nurse auxiliaries and community health workers. Further task shifting was introduced to meet the impact of the HIV/AIDS epidemic. Nurses delegated some of their traditional tasks to health workers who were in plentiful supply, such as community health workers, lay HIV/AIDS counsellors, treatment adherence counsellors and, more recently, members of ward-based outreach teams (WBOTs). Task shifting has generated positive outcomes, albeit with provisos: lower-level health workers need to be given thorough training to carry out unfamiliar tasks; they require mentoring and debriefing; and, they need opportunities for further career development.[55]

3.2 The nursing 'crisis'

In South Africa distinctive factors account for the shortage of skilled nurses: Dippenaar of the Health Systems Trust attributes the shortage to two primary factors:[56,57] Firstly, the merging and closure of nursing colleges in the late 1990s, which resulted in fewer nurses being trained in state facilities. Secondly, training by private hospitals has always been limited to training of sub-categories Enrolled Nursing Assistants (ENAs) and Enrolled Nurses (ENs)(also known as Staff Nurses) and the offering of the bridging course from EN to Professional Nurse, as these institutions were not permitted to train the four-year professional nurse category. They were accredited to offer post-basic specialist diplomas in various specialist areas (Operating Theatre Technique, Intensive Care Nursing , among others) to already qualified registered nurses). With the introduction of the new qualifications framework, five of these private educational institutions are in a better position than the public sector to train all categories of nurses, as they have already either achieved accreditation as private higher educational Institutions or are far advanced in the process.[57] Furthermore, and of major import, the South African nurse cadre is rapidly ageing: as older, more experienced nurses retire, their posts are unlikely to be easily filled by new nurse recruits.[46]

According to Rispel and Bruce:[58] "The country faces a nursing crisis, characterised by shortages, declining interest in the profession, lack of a caring ethos, and an apparent disjuncture between the needs of nurses on the one hand and those of communities served on the other hand." Nurses frequently leave the public health sector for better working conditions in the private sector or other countries, such as in Europe and the Middle East.

A recent national survey of South African nurses found that a large proportion in both public and private healthcare engage in moonlighting (i.e. they fill two or more nursing posts concurrently). Excessive working hours lead to increased sick leave, and half of all nurse respondents expressed a desire to leave the profession within the next 12 months because of work pressures and what they perceive to be poor remuneration. Countries in sub-Saharan Africa, including South Africa, have unequal distribution of nurses at different levels of healthcare, together with an inequitable geographic distribution. South Africa faces a chronic and worsening shortage of professional nurses at rural clinics. For example, in the *2015 South African Health Review,* Rispel and Bruce report that 62% of South African nurses work in the three provinces which are more urbanised (Gauteng, KwaZulu-Natal and the Western Cape), with just 38% distributed between the six other more rural provinces.[59]

Some PHC facilities lack staff in essential support roles, such as filing clerks, drivers, pharmacy assistants, cleaning staff and security personnel. Nurses may then be expected to fill these roles, in addition to their usual responsibilities. The result is the poorer performance of basic nurse competencies, low staff morale, burnout, higher turnover of nursing staff and poorer clinic health outcomes. Burnout is a concern for all health care providers, and nurses in the South African public health sector are at particularly high risk, especially in poorly staffed rural health facilities.[59]

3.3 Nurse education

The post-apartheid transformation of the public healthcare system culminated in the promulgation in 2005 of a new Nursing Act,[60] which altered the scope of practice of different nurse sub-categories and raised the bar in terms of requirements for South African Nursing Council (SANC) registration. A critical contributing factor was the development of a new National Qualifications Framework (NQF) driven mainly by the Department of Higher Education, instead of the NDoH and SANC, which had previously regulated nurse training and professional standards. Development of the NQF took over ten years.[g] Developing new regulations for nurses began in 1997 and the regulations have only just been promulgated. Unlike the development of the Scope of Practice, which happened relatively quickly, the promulgation of the regulations had been disastrously delayed. The reasons for this are unclear.

By 2009 the SANC had decided to align older nurse qualifications (the so-called 'legacy qualifications') with the NQF requirements, which meant that the training of new nursing practitioners would follow a substantially different curriculum. In 2015 Armstrong and Rispel[61] commented that nursing education was provided in a complex environment, which included 20 of the 23 public universities; 12 public-sector nursing colleges (with numerous satellite training campuses) which were the responsibility of nine provincial health departments; a nursing college run by the defence force; private nursing colleges run by three major private hospital groups; and, private, for-profit nurse training organisations. This confusing training environment led to considerable fragmentation of training. The public universities and public-sector nursing colleges were the only institutions permitted by law to offer an integrated training course leading to registration as a professional nurse, through a four-year degree or diploma, respectively.

g. Interview with Dr Susan Armstrong, senior lecturer Nursing Education, University of the Witwatersrand, on nursing education conducted by interviewer M.R. Hamilton, researcher, 2018.

SANC was the regulatory authority responsible for setting standards and accrediting nursing education institutions. SANC did not require newly qualified professional nurses with four years of training to write a national licencing examination but relied instead on nursing educational institutions' own quality-assurance systems (moderated by the university to which they were all required to be affiliated) to ensure acceptable standards of education and nurse competencies. However, the reality was an uneven quality of nursing education across the institutions. The professional nurses registered as such following the two-year 'bridging course' are required to write a national licencing examination. The number of these 'two-year upgrade' nurses is about to exceed the number of professional nurses who were the product of the four-year degree or diploma courses offered at universities and nursing colleges. There was even greater variability in the training of staff nurses and auxiliary nurses (with one year of training), although these two categories were required to write a national licencing examination.

Rispel and Bruce (2015)[58] have described nursing as a "profession in peril". Private colleges, which receive no state subsidy, previously trained auxiliary and enrolled nurses in what was known as the 'legacy curriculum'. However, changes in nursing policy mean that they are no longer entitled to do so since preference is given to university-linked nurse training. The transition from the old to the new policy – the so-called migration process – has not proceeded smoothly. Recruitment of younger people for nurse training to provide sufficient staff for new clinics and community health centres was inadequate, and the shortage of skilled nursing staff was expected to worsen dramatically. A survey of nursing education found that key informants criticised the lack of national staffing norms; sub-optimal governance by both the SANC and the NDoH; outdated curricula that were unresponsive to population and health system needs; lack of preparedness of nurse educators; and, the perceived unsuitability of the majority of new nursing recruits.[48]

3.3.1 Review of core competencies in the various nursing categories

This report focuses on provider core competencies in relation to improved delivery of services with regard to mental, neurological and substance use (MNS) disorders in South Africa, with a specific focus on relevant sub-categories where different categories of nurses have evident competence. The process of critically examining the core competencies of various nursing sub-categories to determine their capacity to meet the healthcare needs of individuals with symptoms of any of the MNS disorders began with the consideration of all nursing sub-categories currently recognised by SANC.

The 'legacy qualifications' have been phased out (and in the case of Enrolled Nurse Auxiliaries and Enrolled Nurses have already been stopped). It is not always clear whether the new programmes and scopes of practice are being referred to or whether it is the current nurses who are already qualified in the various categories and will remain on the registers for their lifetime, although the registers will be closed once the courses are phased out.[62]

Table 3 summarises the current 'legacy qualifications' which are still in process and the qualifications which are envisaged and, which, once the regulations are promulgated and the courses implemented at the educational institutions, will conform to the legislation.

Table 3: Legacy and new qualifications[h]

	New Qualifications		
Legacy qualification [regulation number]	**Educational qualification (and SAQA level)**	**Category**	**Comment**
Courses leading to registration as an Enrolled Nursing Auxiliary (ENA)[2176]	*National Higher Certificate (5) Now requires a level-4 entry qualification at an appropriate level on school certificate (C)*	*Registered Auxiliary Nurse*	*Standard Operating Procedure not yet available and although legacy equivalent qualification already phased out, no new nurses currently training at this level*
Courses leading to registration as an Enrolled Nurse (EN) [R2175]			*Already discontinued. Register closed at the end of 2018*
New category	*National Diploma (6)*	*Registered Staff Nurse (Currently designated)*	*Renamed 'Registered General Nurse'*
Bridging course for Enrolled Nurses leading to registration as a General Nurse or a Psychiatric Nurse [R683] 4-year diploma or Professional (4-year Degree) course leading to registration as a Nurse (General, Psychiatric and Community) and Midwife [R425]	*Bachelor's degree (Professional) degree (8)*	*Registered Professional Nurse*	*Will be registered as both a general nurse and a midwife. Will not commence earlier than 2020*
Diploma Course or Masters degree in Clinical Nursing Science leading to registration of an additional qualification (R212) e. Advanced Psychiatric Nurse Diploma course leading to Clinical Nursing Science, Health Assessment, Treatment and Care (R48)	*Post-graduate diploma (8)*	*Nurse specialist, e.g. Psychiatric Nurse Specialist; Advanced Midwife*	*Universities are currriculating/ have submitted curricula for approval and have been or are currently in the process of having the courses. Can only be offered to nurses who are in possession of a level-7 qualification on entry (3-year degree)*

Regulations relating to the approval of and minimum requirements for the education leading to registration as a nurse specialist or midwife specialist have yet to be promulgated.

3.4 Core competencies of auxiliary nurses with regard to MNS disorders

3.4.1 Introduction

The enrolled auxiliary nurse qualifications which are still largely in place are the so-called 'legacy qualifications'. Future plans aim to align this group of enrolled auxiliary nurses (ENAs) with the new qualification framework (NQF) and are to be known in future as registered auxiliary nurses (AN). Initially, a six-month practical training course was established, which equipped the ENA to assist more highly qualified nurses in hospitals and similar settings with elementary and practical tasks. This was phased out in the 1970s. The minimum requirement for entry to the auxiliary nurse training course was raised to Grade 12 or the NQF equivalent. The training course became a one-year higher certificate, which had to be completed at an accredited training institution.

h. This table is based on information provided in Circular 7 of 2016 and Circular 1 of 2018 of the South African Nursing Council.

Some 'fly-by-night' training institutions previously involved in offering auxiliary nurse training have had to close in recent years because of their inability to meet stringent SANC and NDoH regulatory requirements. However, some credible training institutions were also compelled to close because of the slow, inefficient bureaucratic processes which had to be followed in the accreditation process. The difference between the legacy course for auxiliaries and the proposed new one is that the exit level has changed. The scope of practice remains essentially the same, with nurses being held accountable for their own practice.

Currently, the only nurses able to qualify in this sub-category are those who can afford to pay the high costs charged for auxiliary nurse training provided by a limited number of accredited private-sector hospitals. The cost of enrolling in and attending the expanded training course for auxiliary nurses has risen sharply, which discourages many potential candidates from obtaining the qualification. While theoretically, the NQF provides opportunities for all categories of nurses (and anyone else in the country) to upgrade their knowledge and skills, this barrier applies to other categories of nurses too.

A particular challenge that requires close attention with regard to utilisation of auxiliary nurses in healthcare (and indeed, the same issue applies in different degrees to all the subcategories of nurse discussed) is the fact that auxiliary nurses trained in different time periods – and certainly those trained in so-called 'fly-by-night' institutions rather than at respected training centres – may have widely differing skills and varying degrees of proficiency with regard to the MNS competencies discussed in more detail below.

In mid-2017 the SANC reported that South Africa had 66 891 auxiliary nurses who were registered with the Council.[i] It appears that there is a mismatch between the supply of auxiliary nurses and the health sector demand for these nurses. The findings of a recent survey of South African auxiliary nurses are reported on the SANC's website.[63] This survey explored the perceptions and attitudes of candidates who had passed auxiliary nurse examinations in 2013/14. A large proportion of qualified auxiliary nurses who responded reported being unemployed. Rates of unemployment amongst respondents ranged from 44% in the Western Cape and 57% in the Free State, up to 74% in Gauteng. The highest provincial unemployment rate for recently qualified auxiliary nurses (87%) was reported by respondents in KwaZulu-Natal. The low uptake of auxiliary nurses into health-sector jobs is clear cause for concern and suggests that their competencies do not match the skills in highest demand in the health sector.

A few auxiliary nurses have sought ways to upgrade their skills to those of staff nurses. There are very limited opportunities in the health education system for nurses of this cadre to do so, and most such avenues are too costly for relatively poorly paid auxiliary nurses to be able to access. It would make professional sense and be humane for healthcare education and training to provide more avenues for auxiliary nurses to upgrade their skills levels wherever possible, and to offer subsidisation of the costs of their nurse retraining so that they can upgrade their professional status to that of a staff nurse – a greater professional competence. If such opportunities are not offered, South Africa is likely to see an ever-increasing number of trained and registered auxiliary nurses who are permanently unemployed.

The draft scope of practice for registered auxiliary nurses is wide enough to allow for them to work under supervision in the field of mental health (presuming that there will be general nurses (educated under the newly envisaged three-year diploma) or professional nurses with the appropriate level of competence to supervise them. However, relevant content on MNS disorders needs to be included in the new curriculum.

3.4.2 Core strengths and opportunities

The most recent scope of practice of auxiliary nurses (2013)[64] makes no specific mention of any competencies related to addressing the needs of patients with MNS issues. Auxiliary nurses are to provide 'elementary nursing care' and 'assistance and support'. They may also 'render basic first aid'. They may not diagnose health problems; devise a patient treatment plan; prescribe medication or treat any health condition. However, they are expected to keep accurate records regarding patients; abide by clear ethical standards; and, be open to expanding their knowledge of healthcare and supporting others to learn too.

Auxiliary nurses have the following competencies are relevant to MNS care and treatment:

- They demonstrate cultural competence (SI.5), as suggested in the SANC curriculum requirement that auxiliary nurses have to 'understand man (sic) … in his socio-cultural context' and they should be able to exhibit 'sensitivity to people of diverse backgrounds'.
- They should be able to offer emergency first aid (TC.4), since auxiliary nurses are described as having the capacity to provide 'basic first aid'.

i. Statistics retrieved on 28 May 2018 from the South African Nursing Council website. www.sanc.org.za.

- They are able to practise good therapeutic patient interactions (expressed through communication, relationship and attitude (TC.10), as reflected in the SANC requirement that they should be able to engage in 'sympathetic and empathetic interaction with health service consumers'.
- They should be able to demonstrate respect, compassion and responsiveness to patient needs (TC.15) since this competence is closely allied to the previously described competency.
- They should be able to document what they do in medical records (TC.38), albeit at an elementary level, since their scope of practice includes being expected to 'observe, record and report the health status of healthcare users'.[65]

3.4.3 Opportunities for an expanded role

It is suggested that with additional training of limited scope and with close supervision from a more qualified cadre of nurse, auxiliary nurses should also be able to fulfil the following MNS competencies:

- Provide the patient and the community with awareness and/or education (SI.4), albeit in simple and limited form.
- Provide support for patients and families while in treatment and care (TC.1), particularly practical forms of support.
- Identify and assist patients and families in overcoming barriers to successful treatment and recovery (TC.2).
- Promote very basic mental health literacy (TC.7).
- Provide simple links between patients and community resources (TC.11).
- Encourage treatment adherence – a component of competence Monitors for adherence to and/or side-effects of medication (TC.9).

In conclusion, given the practical task-oriented nature of auxiliary nurse training, their competence to assist in meeting MNS healthcare needs is limited. There are a number of opportunities for developing MNS specific competency training for auxiliary nurses. These have been listed in the above bullet points, and need to be explored further by the Health Professions Council and all training institutions involved in the training of auxiliary nurses.

3.5 Core competencies of staff nurses with regard to MNS disorders

3.5.1 Introduction

As pointed out earlier, this category of nurse has been renamed and will, after the publication of an amendment to the Act, be known as a 'general nurse'. Registered staff nurses were previously called enrolled nurses. Between 1985 and 2013, registration with SANC in this sub-category required successful completion of a two-year certificate course at a nursing college. The same difficulty with regard to auxiliary nurses in terms of 'fly-by-night' training organisations also applies to staff nurses who obtained their training in earlier periods as they may have limited knowledge and inadequate nursing competence.

In terms of the updated regulations of 2013, nurses will now be required to complete a three-year diploma at an accredited training institution. The two-year preparation of this category of staff nurses has been discontinued and the new category of a registered general nurse (currently still called staff nurse) cannot be compared with the current enrolled/staff nurse training.

It is important to note that staff (general) nurses trained in terms of the new regulatory framework will have a somewhat broader array of skills and greater professional competence than enrolled/staff nurses who were trained in terms of the previous regulatory requirements.

SANC reported that in Mid-2017, there were 66 641 staff nurses registered with the Council – an almost identical figure to the number of registered auxiliary nurses.[j] However, whereas there is significant unemployment amongst auxiliary nurses, there is a greater demand for staff nurses in both the public and private health sectors, albeit insufficient to absorb all newly qualified staff nurses.

Staff nurses were also surveyed in a similar manner to auxiliary nurses in 2013/14, and these results are also reported on the SANC website.[63] There was a lower unemployment rate amongst staff nurses compared to auxiliary nurses. The rate of unemployment among recently qualified staff nurses ranged from 12% in Mpumalanga and 21% in the Western Cape to a more worrying 42% in Gauteng, 50% in Limpopo, 68% in the Eastern Cape and the highest unemployment rate for staff nurses, as for auxiliary nurses, was again reported in KwaZulu-Natal (73%). This is a real cause for concern.

j. Statistics retrieved on 28 May 2018 from the South African Nursing Council website – www.sanc.org.za

3.5.2 Core strengths

Given the expansion of the duration of staff nurse training from two to three years, and with registration in a new category of 'registered general nurse' due to be implemented by 2020, it appears that these nurses should have more of the essential nurse competencies most in-demand in the South African healthcare system. Whereas auxiliary nurses are not permitted to work alone, i.e. without the supervision of a staff or professional nurse (although this may change if tasks are deemed to be within their new scope of practice), registered general nurses will be able to carry out a range of nursing competencies involved in caring for patients with less-complex medical, surgical and paediatric needs.

It is envisaged that over time many more currently registered auxiliary and staff nurses should be able to upgrade their professional competence to registered general nurse level if the facilities and resources are made available for them to do so. In the medium term, it is envisaged that the body of qualified staff nurses should become the largest component and backbone of the nursing corps in South Africa. It is, therefore, important that their training curriculum is adapted to more closely match the nursing needs in the health sector.

Given the current and ongoing shortage of professional nurses, many enrolled nurses already fill a gap. Hence, they probably already carry out tasks that are, in theory, far beyond their registered scope of practice, and yet in many cases, they are reported to be doing so very competently. The researcher employed in this project can allude to his involvement in 2016 in the NDoH on-site audit of human resources and staffing at all public-sector primary healthcare facilities across the Northern Cape.[k] A severe ongoing shortage of professional nurses was evident in the province (as well as, more alarmingly, unfilled posts at clinics with regard to filing clerks, cleaners, security personnel, pharmacy assistants and drivers). What was remarkable was how many of the facilities visited were kept functioning either through the support of a few professional nurses close to (or beyond) retirement age, or by highly motivated and committed younger staff nurses who shouldered responsibility for delivering comprehensive healthcare while also performing many of the maintenance functions at PHC facilities. Their contributions, far beyond the call of duty, enabled the provision of quality healthcare to continue for isolated Northern Cape communities, sometimes at high personal cost.

3.5.3 Opportunities for an expanded role

The most recent South African scope of practice for staff nurses,[65] as outlined in the *Government Gazette*, lists the following (rather generalised) array of competencies, none of which relate specifically to MNS disorders:

- Provision of nursing treatment and care of patients in all healthcare settings.
- Management of the nursing care of individuals, groups and communities.
- Provision of emergency care.
- Ensuring safe implementation of nursing care.
- Care of people with health conditions in all settings.
- Provision of care delegated by a professional nurse.
- Delegation of nursing care, ensuring that it is delegated only to competent individuals.

However, it appears that staff nurses should have the following competencies, which are of relevance to MNS care and treatment:

- Cultural competence (SI.5) - is not mentioned directly, but is implied in the SANC curriculum requirement for auxiliary nurses, and one can infer that staff nurses should be equipped with this competence too.
- Similarly, staff nurses should be equipped with the competencies previously specified for auxiliary nurses, namely Practising good therapeutic patient interactions (TC.10) and Demonstrating respect, compassion and responsiveness to patient needs (TC.15). The requirement that they are able to 'empower healthcare users' likewise fits with these two competencies, as does the specified competence to 'initiate and maintain a therapeutic relationship'.
- Staff nurses' capacity to 'diagnose and prioritise a nursing care plan' implies awareness of common signs and symptoms (SI.1), although their specific competence regarding MNS issues is likely to be limited.
- Their competence to refer on when necessary for other aspects of the patient's health care (DR.1) is implicit in their being able to make decisions independently regarding referral.
- The competence to protect patients and to identify vulnerabilities (TC.14) is clearly indicated by the requirement that staff nurses should be able to 'protect the human-rights of healthcare users' and 'advocate for the rights of healthcare users'.
- The ability to make a formal diagnosis (DR.8) and to select appropriate treatment based on the correct diagnosis (TC.19) is implicit in the more general staff nurse competence: 'diagnose and prioritise a nursing care plan', as well as the specification that they should be able to 'develop an integrated, comprehensive nursing care plan' and 'supervise' its implementation and progress (although MNS competence may be limited).

k. Personal communication: Mr Robin Hamilton.

- Competence in documenting patient records (TC.38) is shown by staff nurses' being required to 'create and maintain accurate records'. The mentoring and supportive role of staff nurses in relation to more junior healthcare workers (and especially in their relationship with auxiliary nurses) (TC.42) is reflected in the gazetted requirement that they should be able to 'create an environment and learning opportunities to foster professional growth'.

While monitoring for adherence to medication and monitoring for medication side-effects (TC.9) is not directly listed as being within the scope of practice of enrolled nurses, their being able to develop and supervise a nursing care plan for each patient being within their scope of practice (with medication being a possible component of such a care plan) means that staff nurses will generally have had the invaluable experience of monitoring adherence and side-effects. Furthermore, given the scale of South Africa's HIV/AIDS and TB epidemics, most staff nurses will have some experience of the care and treatment of HIV and TB, which is likely to have developed further competence and confidence in relation to TC.9.

3.5.4 Gaps

It appears that staff nurses can be expected to have many (although not all) of the competencies outlined in the ASSAf report Table 1 (p. 20)[65] that are recommended for 'all provider types'. However, there are particular competencies where staff nurses may fall short. These include:

- Recognises potential of risk to self and others (SI.2).
- Recognises basic knowledge of causes (SI.3).
- Demonstrates knowledge of other MNS disorders (SI.6).
- Demonstrates ability to monitor mental status (TC.3).
- Participates in community-based treatment, care and prevention programmes (TC.5).
- Demonstrates basic knowledge of the International Classification of Health, Functioning and Disability and demonstrates knowledge of disability models across the lifespan (RD.1 & 2, Table 1).

Some staff nurses may have acquired these competencies from greater exposure to MNS issues because of the particular health setting in which they work (e.g. in a PHC clinic which sees patients with MNS disorders regularly, or in an emergency room setting). However, most staff nurses will benefit from limited training of specific scope to acquire these missing competencies and should be able to do so without difficulty. It is strongly suggested that placement of staff nurses in health facilities or departments where MNS disorders are routinely managed (together with a clear mentoring plan) may well be an economical and effective way of developing such competencies, where they are poor or absent.

Given their generalised training, staff nurses are likely to have far fewer of the competencies listed in Table 2 (Candidate core competencies for non-specialised prescribers and specialised providers). It is suggested that the focus with regard to staff nurses should be on providing additional training and support to ensure mastery of all the missing Table 1 competencies, and where possible, more sophisticated Table 2 competencies.[66] However, the current critical shortage of nurse educators and mentors may be a barrier to the achievement of this goal.

3.6 Core competencies of professional nurses with regard to MNS disorders

3.6.1 Introduction

Until 2013 the South African requirement for registration as a professional nurse (PN) involved completion of a four-year nursing diploma at an accredited nursing college, or achievement of a four-year nursing degree at an accredited university. In 2013 SANC decided to alter this policy. There are three ways of qualifying for PN registration:

- complete a two-year 'bridging course' for enrolled nurses leading to registration as a professional nurse (general medical and surgical nursing only with no concurrent registration in the fields of psychiatric and community nursing or midwifery); OR
- provide evidence of a National Senior Certificate or equivalent qualification at NQF level 4, and complete an accredited (by a university) four-year college nursing diploma course; OR
- provide evidence of having a National Senior Certificate or equivalent qualification at NQF level 4, and complete a Bachelor's Degree in Nursing (B. Cur or B Nursing), an academic course of study over four years.[67]

In Mid-2017, the SANC reported that 77 920 PNs were registered,[l] which was insufficient to meet the national demand for this professional level in both the public and private health sectors. There have been varying estimates of the size of the national shortfall of professional nurses. In 2015 the national shortage of professional

l. Interview on Nursing Education conducted with S. Armstrong by M.R. Hamilton, researcher.

nurses was reported to be 20 815[m] although in 2016 another reputable expert claimed that the national shortage was almost double this figure – around 44 780.[56] We do know that the nurse numbers are flawed as SANC records the number of nurses on the register – and not those who are working.

Another issue of great concern is the skewed age distribution of professional nurses in South Africa: a high proportion of this category are older or close to retirement age (about half of PNs being over 50), while the proportion of those under 30 is a mere fraction of this: just 5%.[45] This is evidence of insufficient recruitment into the nursing profession in recent decades as a result of political change, as well as more and better paid, less onerous work opportunities opening up to women of all races. The conflation of these two trends is likely to be a critical national shortage of professional nurses, with deleterious impacts on national health indicators.

Nursing education now falls under the Department of Higher Education, rather than the NDoH, as was the case previously.[62] *The Strategic Plan for Nursing Education, Training and Practice* came into effect in 2013.[68] Many private nursing education institutions have not yet been accredited, and for those that are accredited, the new curricula are yet to be approved. There is also a critical shortage of nurse educators. Until SANC accredits and, together with the government, finalises and publishes updated scopes of practice for nursing, new qualifications cannot be offered. As of 2016, private training facilities have discontinued all training programmes and accepted no new students.

There is also currently a bottleneck in terms of offers of practicum experience. Professional nurse training requires that nursing students should have a year of practical experience in the public health sector. "On a year-to-year basis, there are not enough posts in the public sector for the students that complete their studies," according to the head of the Wits School of Public Health, Prof. Laetitia Rispel.[58]

The current four-year Bachelor of Nursing or B Cur degree and Diploma courses involve training in general nursing, psychiatric nursing, community health and midwifery. The new Professional Nurse Qualifications Framework focuses mainly on general nursing and midwifery. This has primarily arisen as a response to the national burden of HIV/AIDS, TB, diseases of lifestyle, and high rates of maternal and neonatal mortality and morbidity. The qualifications framework mentions the following two assessment outcomes:[69]

- 7.4 Nursing interventions are based on individualised plans that reflect a comprehensive and integrated assessment of mentally ill persons, and understanding of common emotional and behavioural disorders, as well as major psychiatric disorders (perceptual and severe mood disorders.
- 7.5 Interventions with mentally ill persons are consistent with generally accepted psycho-social techniques and contribute to the therapeutic management of these patients."

It should be noted that, while SANC has published the above qualifications framework, curricula developed by education and training institutions have not yet been approved or accredited by SAQA or SANC. Concerns have been expressed that these new curricula will exclude the current level of clinical training in mental health and psychiatric nursing. This is likely to impact negatively on the competence of PNs to meet the demand for MNS care and treatment. Since the new qualifications framework and curricula for PNs have not yet been implemented, this study reviewed the current qualification.

3.6.2 Core strengths

The current exit-level outcomes for the B Cur degree specify a very comprehensive and rather daunting array of competencies which a nurse graduate is expected to have acquired. The generalised proficiencies include a grasp of a wide range of ethical issues in health; knowledge of the biological and natural sciences; the psycho-social sciences and of pharmacology; provision of nursing care throughout the human life-span in a variety of healthcare settings and different communities; management of healthcare units and health facilities; effective communication with a range of audiences; keeping abreast of contemporary medical research; continuous self-learning and mentoring of colleagues; applying knowledge meaningfully in response to individual, family and community needs; awareness of national legislative and policy frameworks for health; and, provision of patient care. The range of competencies align with the general consensus regarding professional nurse competence in more developed countries in the North but also take account of some of the burden of healthcare challenges more characteristic of developing countries in the South.

3.6.3 Strengths

With regard to MNS capabilities, according to its exit-level outcomes, B Cur graduates should have mastered a broad range of competencies relevant to MNS care and treatment. (They should already have all the competencies previously listed for auxiliary and staff nurses). PNs should notably have competence in all of the following areas:[n]

- Practises good therapeutic patient interactions (TC.10) – this competence is shown by 'Interpersonal skills

m. Statistics retrieved on 28 May 2018 from the South African Nursing Council website – www.sanc.org.za

n. Most of these are listed as 'associated assessment criteria' matched to exit-level outcomes. Attention could be given to selected out comes for nurses associated with the Framework and Strategy for Disability and Rehabilitation Services in South Africa

are used effectively to establish supportive and therapeutic relationships' and 'Planning is inclusive of the patient'.
- Demonstrates knowledge and skills to use information technology to improve treatment and care (TC.16) evidenced in 'Communicate effectively using a variety of media and technology, including computers'.
- Provides mentoring and support to other healthcare providers (TC.42) – shown in 'Mentoring activities are directed towards the development of others, according to their needs and their scope of practice'.
- Demonstrates knowledge and skills to provide proactive follow-up and monitor outcomes of care (TC.40) – shown in 'Support provided to patients recovering from illness prepares them for discharge … '. This also links with competence Assisting patient with access to other providers (TC.36), Link between patients and community resources (TC.11) and Identifies available resources … (TC.12).
- Provides the patient and community with awareness and/or education (SI.4) is evidenced by 'Community involvement in health care is promoted through information sharing and contact, which promotes ongoing collaboration with the community or group.' This also links to Communicates to the public about MNS disorders (TC.8).
- Demonstrates knowledge of standard drug regimens (TC.41) is indirectly suggested through the skill 'Treatment is initiated to manage common conditions (including prescribing and dispensing medication)'.
- Demonstrates knowledge and skills to consult with … other providers in the care team (TC.40) is shown by 'Management and leadership activities are directed towards the establishment of a team approach to health care …'
- The very broad SANC competence for PNs which is described as 'Nursing interventions are based on individualised plans that reflect a comprehensive and integrated assessment of mentally ill persons, and understanding of common emotional and behavioural disorders, as well as of major psychiatric disorders (perceptual and severe mood disorders)' suggests a number of different listed skills with regard to screening, diagnosis and treatment, including SI.1, SI.6, SI.7, SI.8, SI.9, DR.7, DR.8, DR.9, DR.10, TC.19, TC.21 and TC.41. This approach can also be linked with another SANC-defined proficiency: 'Interventions with mentally ill persons are consistent with generally accepted psycho-social techniques, and contribute to the therapeutic management of these patients'.
- Demonstrates knowledge and skills to use information technology to improve treatment and care (TC.16) is evidenced by 'Technology is used in the practice of nursing in ways that facilitate the effective diagnosis and treatment of illnesses and conditions'.

3.6.4 Core gaps

A critical exit-level outcome for the B Cur degree which suggests an invaluable possible addition to the set of recommended MNS competencies relates to the need for the healthcare provider to engage in self-care and emotional self-awareness (to reduce the risks of burnout and injury in the workplace). There is now extensive research evidence that particularly in healthcare professionals, conscious development of self-care reduces the incidence of burnout, enhances job satisfaction and can even contribute to better patient care. Mastery of this suggested additional competence is reflected succinctly in the relevant exit outcome: "Own personal development and management maintains emotional balance".

The key need of MNS care providers to be able to engage in sensitive and empathic communication with patients is reflected in both Practises good therapeutic patient interactions TC.10 and Demonstrates ability in general counselling skills (TC.17). However, such a sub-set of competencies is not directly reflected in any of the defined exit-level outcomes of South African professional nurse graduates (although there is a limited focus on basic communication skills, which is insufficient in dealing with MNS issues).[67] The absence of a subset of such competencies suggests a crucial gap that needs to be addressed, particularly since sensitive and empathic communication is a core aspect of more effective management of patients with MNS challenges. This aspect should be added to professional nurse training. The exit-level outcome 'Planning is inclusive of the patient' could be seen as approaching the issue of communication, but does not go far enough.

Professional nurses would also benefit from basic knowledge regarding disability and rehabilitation (RD. 1 & 2, Table 1). It is of particular concern that envisaged changes to the B Cur curriculum will have far less content related to MNS disorders. This matter needs to be taken up urgently through appropriate channels if a crisis in terms of both filling PN posts and meeting MNS care and treatment needs is to be averted.

3.7 Core competencies of primary care nurse specialists with regard to MNS disorders

3.7.1 Introduction

This category refers to nurses who are already registered with SANC as PNs, who have studied further and been awarded an additional qualification in primary care nursing. SANC was unable to provide statistics for the number of nurses who fall into this category. However, given the shortage of PNs, and since PNs with primary care nursing specialisation are a smaller subset of this group which already has a shortfall, it is highly

likely that there is a national shortfall of nurses with further specialisation, particularly given the clear focus of the public health sector on PHC.

A primary care nurse specialist has completed a post-diploma or post-degree course of study , which leads to an additional qualification focusing on PHC. However, nurses who have obtained such a specialist qualification are not necessarily guaranteed employment in a corresponding PHC post in the public sector, since appointment to such positions is dependent on several factors, including available funding; qualified individuals living in close proximity to such advertised posts, or such nurses being willing to relocate across the country and personally cover the costs of their relocation. Placement in a PHC or community centre is not necessarily the first choice of many nurses even if they have secured this desirable qualification since such settings are often poorly resourced and swamped by high patient demand. The location of some of these health facilities in remote areas may also mean that nurses end up working in dangerous or unsafe conditions.

In addition to this qualification, the NDoH has published *Adult Primary Care Guidelines* to assist nurses working in primary care settings. These include guidelines for MNS disorders.[70]

3.7.2 Core strengths

It is important to begin any discussion regarding the competencies of primary care nurse specialists by noting that they should already have all the MNS competencies of professional nurses mentioned in the previous sub-section. Yet, as with nurse categories already covered, the scope of practice of this cadre of specialist nurses makes little or no direct reference to competencies relating to MNS.

Nevertheless, the scope of practice of primary care nurse specialists makes additional reference to the following competencies:[71]

- Demonstrates awareness of common signs and symptoms (SI.1) – although this competence is not explicitly defined in the scope of practice, reference is made to the capacity of primary care specialists to be able to 'collaborate with peers and other health professionals regarding assessment, diagnosis and treatment'.
- Initiates and/or participates in community-based treatment, care and/or prevention programmes (TC.5) and Provides the patient and the community with awareness and/or education (SI.4) - are both covered by mention in the scope of practice of the primary care nurse specialist being able to 'Practise as an autonomous primary care nurse specialist … engaging in prevention and health promotion'.
- Demonstrates knowledge of treatment and care resources in the community (TC.6) – this competence is implicit in the ability of primary care specialists to 'liaise with a range of local health organisations, including pharmacies'.
- Promotes mental health literacy (e.g. through the minimising of stigma and discrimination) (TC.7) – this competence is addressed, perhaps obliquely, through the proficiency of primary care nurse specialists in 'approach[ing] users of healthcare in a non-judgemental way'.
- Demonstrates ability to select appropriate treatment based on an understanding of diagnosis (TC.19) – this highly useful competence is indirectly alluded to in a number of diverse skills described as falling within the scope of practice of primary care nurse specialists as follows: 'takes responsibility for own caseload', 'manages own caseload', 'performs and requests diagnostic investigations' and 'identifies problems … and 'distinguishes between drug-related and other health problems'. (However, it is important to note that the mention here of 'drug-related' problems should not be understood as pertaining to an understanding of, and ability to discern substance use or abuse issues in patients. In the context of PHC, this proficiency is more likely to mean having an understanding of the possible side-effects and interactions of prescribed, legitimate medication provided in a PHC setting, rather than a nuanced understanding of recreational drug use or abuse, which is a more common occurrence in an MNS patient population.
- Documenting of medical records (TC.38) is explicitly addressed through the primary care nurse specialist's competence to 'compile accurate and clear records'.
- Demonstrates knowledge and skills to make a formal diagnosis and formulation of a differential diagnosis (DR.8) – this competence is referred to in the primary care nurse specialist's acquired proficiency at 'making a differential diagnosis' (although she is likely to have had limited experience of making specific diagnoses relating to mental health, neurological and substance use disorders).
- Demonstrates knowledge of standard drug regimens (TC.41) – this competence is addressed through the primary care nurse specialist's proficiency in 'prescribing drugs according to legal protocols' (although it is important to note that her knowledge of drugs used to treat MNS disorders may be limited).

An additional and very useful core competence of primary care nurse specialists which is not listed as a required competence for healthcare providers who engage with individuals who have MNS disorders is the ability to 'identify health, psycho-socio-economic risk factors in the individual, the family and the environment'. Understanding broader systemic issues which increase the vulnerability of patients with MNS health concerns is a highly useful and sophisticated skills-set to employ in effectively diagnosing, treating and caring for this

group of patients. This competence is also aligned with the basic tenets of disability inclusion and rehabilitation.

3.7.3 Core gaps

As has previously been discussed regarding professional nurses, communication skills may also be underdeveloped in nurses with primary healthcare specialist qualifications, particularly empathic and sensitive communication. Once again, this crucial gap needs to be addressed, particularly since sensitive communication is a core aspect of the more effective management of patients with MNS challenges at PHC level. The Adult Primary Care Guideline, which is a tool of the re-engineering of PHC emphasises this aspect of service provision.[70] The gap in RD. 1 & 2 Table 1 must also be noted. Severe MNS disorders are associated with disability and the need for long-term recovery planning and monitoring through rehabilitative processes. Primary healthcare nurse specialists should be equipped to mediate patient access to community-based rehabilitation services.

3.8 Core competencies of professional nurses who have an additional qualification in psychiatric nursing, with regard to MNS disorders

3.8.1 Introduction

Professional nurses who are motivated to acquire expertise and professional competence in collaborating with psychiatry and other mental health services can choose to enrol for postgraduate (or post-diploma) academic study in psychiatric nursing which is on offer at a limited number of universities. Such further education is provided in the form of two courses leading to different qualifications but sharing most of the same curricula:

- The first option is to complete a Diploma Course in Advanced Psychiatric Nursing.
- The second is to complete a Masters' Degree in Nursing (Psychiatric Nursing Science) which demonstrates knowledge of disability models across the lifespan.

Both courses have been designated 'legacy qualifications', which means that they will probably be discontinued at some unknown future date. There is no current specialisation in psychiatric nursing listed on the Education and Training section of the SANC website.[63] Given the current shortage of MNS care and treatment competencies amongst nurses, this is cause for major concern.

Since both the Diploma and Masters courses are regarded as advanced qualifications, every enrolled student needs to be registered as a psychiatric nurse (with a basic qualification at the 4D level), and he/she also needs to be employed in a psychiatric context as a psychiatric nurse to obtain acceptance onto the course. Both courses are taught at a limited number of universities, including the universities of KwaZulu-Natal, Free State, Wits, Johannesburg, Pretoria, the Western Cape, Sefako Makgatho University and the Cape Peninsula University of Technology. On completion of the course, successful candidates are currently permitted to register with SANC as an Advanced Practice Nurse (Psychiatric Nursing).

The courses provide enrolled students with exposure to a broad and Important range of critical psychiatric issues. Their training experience should include exposure to and/or working with:[72]

- individuals with varying degrees of intellectual disability;
- children and adolescents who experience mental health problems;
- elderly people with mental health challenges;
- adults with severe mental illness which necessitates their long-term institutionalisation; and,
- adults with chronic mental illness of short duration, which permits treatment in the community or necessitates only brief hospitalisation.

The University of the Witwatersrand is one of the higher educational institutions which offers both psychiatric courses to professional nurses. According to the prospectus, the Advanced Diploma in Psychiatric Nursing and the Masters take one year and include lectures and reading materials which address the following specialist topics which have significant relevance in terms of contributing to the current national burden of mental illness:

- domestic and social violence;
- poverty, and its social and psychiatric consequences;
- crime, and its social and psychiatric consequences;
- child and adolescent psychiatry, including both diagnosis and assessment;
- substance use and abuse;
- crisis intervention, and rape and trauma counselling;
- individual psychotherapy, including solution-focused psychotherapy and cognitive-behavioural therapy (CBT);

- couple psychotherapy and family therapy;
- HIV/AIDS counselling;
- addressing the distinctive mental health issues experienced by women; psychopharmacology;
- prevention of mental illness and promotion of mental health;
- bereavement counselling;
- emergency psychiatric care, including management of suicidal and psychotic patients;
- the mental health of vulnerable populations, including refugees and offenders in prisons;
- people living with HIV (PLWHIV) and their vulnerability to mental illness; and,
- Intellectual disability.

This suggests that a formidable and impressive range of contemporary mental health issues are addressed in the advanced psychiatry qualification and given sound practicum placement so that graduates of this programme should be equipped with most of the competencies required to meet the MNS demand for care and treatment. Understanding the disability, recovery and rehabilitation needs of persons with MNS disorders (RD 1-6, Table 2) would enhance the range of competencies of the psychiatric nurse.

Graduates of this programme are expected to be able to:[73]

- Function as autonomous practitioners and full members of a multidisciplinary team (TC.39).
- Utilise the theoretical concepts gained from the study of biological, psychological, socio-cultural and spiritual models of care … [and] apply relevant approaches in professional practice according to the identified problems of clients, groups, families and communities.
- Assess and diagnose psychiatric disorders common in the community (SI.1, SI.6, SI.7, SI.8, SI.9, DR.3, DR.5, DR. 7-10).
- Manage, treat or refer patients presenting with these disorders to appropriate resources (DR.1, DR.2, TC.6, TC.11 and 12, TC.19, TC.21, TC.36, RD. 1 and 2).
- Demonstrate competence in the fields of individual and group therapy and counselling (TC.17).
- Demonstrate competence in the assessment and therapeutic intervention of problems experienced by individuals, groups, couples and families.
- Demonstrate the ability to assist clients' particular needs for support and education using the principles of HIV/AIDS pre- and post-test counselling, crisis-intervention skills, debriefing, and rape and trauma counselling.

The MNS competencies which are developed by such an advanced educational course are reflected in brackets after some of the bulleted items listed above. It is evident that such a programme is able to fill all the gaps in terms of basic MNS competencies not already developed in professional nurses [66] but such a programme goes a great deal further and is able to develop many of the more advanced competencies listed in Table 2.

Although the number of annual graduates is limited, the competencies developed will go far in developing the necessary skills required to address the unmet needs for MNS care and treatment. It is essential that educational programmes of this nature provided for nurses are permitted to continue, and that they enjoy generous funding for both the academic staff involved and of disadvantaged nurses who would benefit from attending such training but cannot afford the tuition fees.

Chapter 4: Medicine

Key Findings

There is a shortage and maldistribution of doctors in South Africa.

Medical practitioners receive comprehensive training in the diagnosis and management of people with MNS disorders. There are some gaps in training for competence in identifying and managing people with substance use disorders and in assessing disability and working with multidisciplinary teams in aiding recovery and rehabilitation for people with MNS disorders. Generalist doctors who complete the Diploma in Mental Health can play a more specialised role, in both outpatient and inpatient settings.

Clinical associates are trained to work alongside medical practitioners and can undertake clinical tasks under their supervision. Their training in MNS disorders is currently uneven.

Key points

The various categories of medical professionals trained in South Africa are well placed to provide services to people with MNS disorders. However, there is a shortage and maldistribution of such medical professionals. This review of curricula and competencies for clinical associates, general medical practitioners, family physicians and diplomates in mental health outlines the overall strengths of current training programmes as well as some of the gaps, in particular in the training of clinical associates. The ability of these providers to implement what they have learnt is largely dependent on a number of health-systems issues.

4.1 Introduction

This chapter focuses on provider core competencies in relation to improved delivery of services with regard to mental, neurological and substance use (MNS) disorders in South Africa, with a specific focus on relevant sub-categories of medicine. The chapter examines core competencies and gaps in the training of the following categories of medical professional registered with the Health Professions Council of South Africa (HPCSA):

- Clinical associates
- General Medical Practitioners
- Family Physicians
- General medical practitioners with a Diploma in Mental Health

General guidelines for training across the board in South African medical schools stress the importance of various forms of communication and characterise these as essential skills for medical professionals. These include being able to:[73]

- demonstrate both a patient/client-centered and community-centered approach in interactions with patients/clients and their families;
- practise good communication as a core clinical skill, recognising that effective communication between the healthcare professional and the patient/client can foster patient/client and professional satisfaction, as well as adherence and improved clinical outcomes;
- establish positive therapeutic relationships with patients/clients and their families characterised by understanding, trust, respect, honesty, integrity and empathy; and,
- respect patient/client confidentiality, privacy and autonomy."

In the past, doctor and nurse training in South Africa paid only fleeting attention to communication skills. Today there is extensive recognition that enhanced ability to communicate with both patients and other members of the

healthcare team is a pre-requisite if the best health outcomes are to be attained. Patients who experience good communication with their doctor are much more likely to be satisfied with their healthcare; more likely to divulge pertinent information for accurate diagnosis of health problems; more likely to follow the doctor's advice; and, much more likely to adhere well to prescribed treatment.[74]

4.2 Core competencies of clinical associates with regard to MNS disorders

4.2.1 Definition

The clinical associate is a mid-level health professional – a relatively new development in South Africa – intended to help address the chronic shortage of medical practitioners, especially in rural areas. The qualification was modelled on success in training a similar cadre of the health care worker in a range of other countries. The first clinical associates graduated at the end of 2010. The course is currently offered at the University of Pretoria, Wits University, Walter Sisulu University and Sefako Makgatho Medical University.[75]
Clinical associates are expected to finish their professional medical training in three years, on completion of which the degree of Bachelor of Clinical Medical Practice (BCMP) is awarded.[76] This is less than half the duration of the training required to produce general medical practitioners. Qualified clinical associates have to register with the HPCSA and are expected to follow a clearly defined scope of practice.

The most important principle in their scope of practice is that they are expected at all times to work under the supervision of a qualified medical practitioner. Clinical associates are expected to work primarily in district hospitals and to function as members of a collaborative healthcare team. They may also work in a private hospital or private practice, although even in these settings they are expected to remain under doctors' supervision. They are not permitted to provide healthcare as autonomous professionals, given their limited training. If a clinical associate is in doubt regarding a patient's diagnosis, assessment, prognosis or treatment, he or she should consult with the relevant doctor who provides ongoing supervision.

The clinical associate's scope of practice includes all medical services that fall within the ambit of the education, training and experience of the clinical associate, and which have been delegated by the supervising doctor. A further requirement is that such medical services must also fall within the scope of practice of the supervising doctor. A disadvantage of this is that a clinical associate is, therefore, in theory, prevented from developing more advanced skills than those of the supervising medical practitioner, and also may not carry out any aspect of healthcare that the supervising medical practitioner is also unable to also execute. In the training context and in the initial period of practice following graduation, this should be a firmly applied ethical principle. However, once the clinical associate has experienced a longer period of consistent, clear and ongoing mentoring from the supervising doctor (augmented as far as possible with input by health team members with complementary MNS competencies, such as counsellors, psychologists, nurses and occupational therapists), and the clinical associate has improved significantly with regard to professional competence, this principle may be applied less rigidly otherwise, some of the particular competencies unique to the clinical associate may too easily be ignored or forgotten (for example, having more skill than the supervising doctor in drawing blood, or in intubation). Flexibility in supervision and mentoring is essential if service provision by clinical associates is to be enhanced, and they are empowered to satisfy some of the unmet demand for medical care and treatment.

4.2.2 Core strengths

In terms of their defined scope of practice, clinical associates have the following competencies with regard to MNS care and treatment:[77]

- Demonstrate awareness of common signs and symptoms (SI.1) (although they will not be particularly well informed regarding mental illness, neurological conditions and substance use/abuse disorders unless they elected to receive the specialist training option for mental health during their initial training period).
- Demonstrates the potential for risk to self and others (SI.2) – suggested by 'High-risk situations and conditions in patients are timeously identified and appropriate action taken'.
- Demonstrates cultural competence (SI.5) – not directly mentioned but alluded to in 'Health information is shared inappropriate cultural and language terms' and 'Appropriate and sensitive attitudes to patient …. are demonstrated'.
- Demonstrates knowledge and skills in taking a patient history (SI.8) – evident in 'A relevant history is taken'.
- Provides support for patients and families while in treatment and care (TC.1) – this is alluded to as follows: 'A suitable environment is fostered to communicate with the patient and/or family'.
- Demonstrates knowledge of how to offer emergency first aid (TC.4) – as reflected in the competence, 'Emergency conditions are managed and referred appropriately'.
- Demonstrates knowledge of treatment and care resources in the community (TC.6) – alluded to in having 'knowledge of the local district health system in terms of referrals …'.

- Monitors for adherence to and/or side-effects of medication (TC.9) – referred to as follows: 'The prescription is explained to the patient (drug literacy, adherence)'.
- Practices good therapeutic patient interactions (TC.10) – this is not directly listed as a competence, but both the appropriate sharing of health information and 'Patient feedback and questions are facilitated' suggest this, as does 'Patient's needs and problems are identified by active listening'.
- Provides links between patients and community resources (TC.11) – this is evident in 'Knowledge of the local district health system informs practice in terms of referrals …'.
- Demonstrates respect, compassion and responsiveness to patient needs (TC.15) – this is perhaps best reflected in 'Appropriate and sensitive attitudes to patient, family … are demonstrated'.
- Demonstrates ability in general counselling skills (TC.17) – reflected in 'Basic counselling skills addressing the patient's needs are demonstrated'.
- Demonstrates the ability to select an appropriate treatment (TC.19) – this is referred to obliquely in 'The management plan is based on assessment'.
- Documents medical records (TC.38) – shown as 'Patient records … reflect all relevant information'.
- Demonstrates knowledge of standard drug regimens (TC.41) – this competence is suggested through 'Knowledge of standard treatment guidelines and the drugs in the essential drug list … including drug indications, contra-indications, side effects, interactions are demonstrated'.

Several competencies are not specifically listed in the clinical associate scope of practice, but such competence can be inferred, based on the generalist nature of the training. These additional skills are likely to include:

- Demonstrates knowledge of when to refer to the next level of care (DR.1).
- Identifies and assists patients and families in overcoming barriers to successful treatment and recovery (TC.2).
- Promotes mental health literacy (TC.7).
- Demonstrates knowledge and skills to use information technology to improve treatment and care (TC.16).

4.2.3 Core gaps

The level of proficiency which a clinical associate will exhibit with regard to these competencies in relation to MNS care and treatment will depend to a significant extent on how much coverage is given to mental health in the individual's three-year training programme. At the University of the Witwatersrand (Wits), for example, the rotation of mental health/HIV is one of five compulsory clinical rotations which students are expected to complete in their third year. Given that mental health and HIV share a rotation, and that HIV/AIDS is a complex and challenging area, the attention given to all aspects of mental health will not exceed half a rotation. Other universities offering clinical associate training are likely to face similar constraints in terms of needing to cover many crucial issues, all competing for teaching time.

The medical practitioner who is given responsibility for supervision when the clinical associate takes up his or her first formal professional post will also influence whether or not the clinical associate develops further competence in providing MNS care and treatment. If the medical practitioner has a personal interest or passion, or a particular aptitude for engaging with MNS issues, the clinical associate is more likely to develop greater competence and confidence. In the absence of these, competence and confidence may remain limited.

The competencies outlined are mostly limited to those listed in Table 1 of the ASSAf workshop report (2014).[11] However, some core competencies listed in Table 1 do not seem to fall within the defined scope of practice of clinical associates. Examples of such omissions include:

Demonstrates knowledge of other mental, neurological and substance use disorders (SI.6).

- Initiates and/or participates in community-based treatment, care and/or prevention programmes (TC.5).
- Communicates to the public about MNS disorders (TC.8), Protects patients and identifies vulnerabilities (e.g. regarding human-rights) (TC.14).
- Demonstrates knowledge of the International Classification of Health, Functioning and Disability (RD.1, Table 1).
- Demonstrates knowledge of disability models across the lifespan (RD.2, Table 1).

Given the shortened training given to clinical associates – professional nurses, for example, require training which is one-third longer - a clinical associate graduate is likely to have a broad but perhaps limited knowledge of MNS care and treatment, which will require expansion and elaboration in the workplace through ongoing learning and meaningful supervision provided by the relevant medical practitioner (and fellow healthcare team members), and sufficient time allocated to mentoring and further skills acquisition.
The clinical associate needs to always work under the supervision of a medical practitioner and cannot super-

vise other health providers or play a mentoring role, owing to their limited training and circumscribed scope of practice.

4.3 Core competencies of general medical practitioners with regard to MNS disorders

4.3.1 Introduction

General medical practitioners are required to complete an MB BCh/MBChB course of study at a medical school at any of eight South African universities (University of Cape Town, Stellenbosch University, University of the Witwatersrand, University of Pretoria, University of the Free State, University of KwaZulu-Natal, Walter Sisulu University and Sephako Makgatho Medical University). The degree takes six years and is followed by two years of internship served in a public-sector hospital and one year of compulsory community service, often involving a posting to a rural area with relatively limited supervision.

In terms of the ratio of medical professionals to the general population, South Africa compares unfavourably with other middle-income countries. Hence, many districts may have limited or even no access to medical doctors. Even in the private health sector, there are fewer doctors per population than in most countries. In 2013 an Econex report for the Hospital Association of South Africa painted a bleak picture of the shortage of doctors, with just 25 doctors in the public health sector and 92 doctors in the private sector per 100 000 people in South Africa, i.e. an overall national average of 60 per 100 00 population. In contrast, the global average is 152 doctors per 100 000 people. Even India (70), Brazil (189) and China (194) have higher doctor-population ratios.[78]

Variations within provinces in terms of the doctor-population ratio are important with obvious differences between very undeveloped, rural provinces and more urbanised, highly developed provinces. For example, a study published in 2017 examined the public-sector doctor-population ratios in districts of Limpopo, which is a mostly rural province. The ratio for Limpopo was 16.4 per 100 000 population. However, when the data were disaggregated by district, ratios varied considerably. In descending order, they were 33.7 per 100 000 for Capricorn, 20.2 per 100 000 for Waterberg, 9.8 per 100 000 for Sekhukhune, 9.7 per 100 000 for Mopani and 8.7 per 100 000 for Vhembe.[79]

It is uncertain how many doctors who have been trained in South Africa have emigrated in recent years. A useful proxy measure of doctor emigration is the proportion of newly qualified doctors who do not report for community service after completing their medical training, since registration with the HPCSA and being granted permission to practise requires proof of completion of the mandatory period of community service. Between 2004 and 2009, 17% of doctors who qualified in South Africa failed to report for community service. It is likely that most of these graduate doctors emigrated, with the majority moving to Canada, New Zealand, Australia, the United States or the United Kingdom.

Speaking at the 2016 Family Practitioners Conference, the head of the Department of Family Medicine at the University of KwaZulu-Natal, Prof. Cyril Naidoo, observed that five years after the 2011 graduation ceremonies for medical practitioners, less than half of these medical graduates remained in the country.[80]

Yet South Africa is much better served by doctors than most other African countries. South Africa shares the fate of many other low- and middle-income countries in the South, which train a range of skilled professionals, only to see their graduates leave for more developed countries where pay is higher and working conditions are less demanding.

In recent years the NDoH has taken various steps to remedy the national doctor shortage. These include arranging medical training for South Africans in Cuba; importing Cuban doctors to serve in remote parts of South Africa on short contracts; compulsory community service; extension of the medical internship period; and, the introduction of various financial incentives – such as scarce skills and rural allowances. In 2007 the government introduced an occupation-specific dispensation (OSD) policy, a financial incentive strategy aimed at attracting and retaining health professionals in the public health sector.

4.3.2 Strengths

With regard to recommended competencies needed to address the healthcare needs of individuals with MNS disorders, general practitioners (GPs) show evidence of being well equipped with all the competencies listed in Tables 1 and 2 for dealing with MNS disorders.[o]

GP's knowledge of MNS disorders (SI.6) is likely to be excellent since this training focuses not only on mental illness, but also pays attention to recognising various forms of substance abuse, as well as managing demen-

o. Focused predominantly on the Wits Medical School's curriculum outline for these two courses in psychiatry which medical students attend in their fifth and sixth years of study (GEMP3 and GEMP4), as these course outlines were the most informative of the limited number of curriculum outlines that South African medical schools made available.

tia and temporal lobe epilepsy, and how people living with HIV are more vulnerable to mental illness. GPs are also sufficiently competent to administer a 'mini-mental status examination', which fits with SI.9, since the patient's responses will allow the GP insight into their cognitive functioning, enabling a decision to be made regarding the necessity and urgency of referral.

GPs should have the competence to monitor adherence to treatment and its possible side-effects (TC.9), despite this skill not being explicitly mentioned in these psychiatry courses, since prescribing various forms of primary care medication sits comfortably with most GPs. Similarly, practising good therapeutic patient interactions (TC.10) is also not explicitly mentioned in the psychiatry course outlines, but would appear to be a core prerequisite and competence so that a GP is able to cultivate a healthy and open professional relationship with patients, as would demonstration of respect, compassion and responsiveness (TC.15).

GPs are able to play an important mentoring and training role concerning MNS care and treatment, firstly in terms of giving support, where time permits, to health providers such as nurses, community health workers and counsellors. They can also assist in enhancing the skills levels of lower- and mid-level healthcare providers (e.g. clinical associates) through occasional training and sharing of clinical expertise, where appropriate.
However, it is important that general practitioners are not overburdened by excessive responsibilities or an unreasonable workload, and that, as far as possible, they are able to delegate tasks to mid-level health providers, including clinical associates. They are at particularly high risk of burnout if this principle is not followed.

4.3.3 Gaps

There are several gaps evident in the MNS competencies of medical doctors trained in South Africa. First, many medical doctors have inadequate exposure to MNS disorders in their training, and frequent exposure is through placements in psychiatric hospitals. This provides them with minimal practical experience of managing MNS disorders in primary care clinics and community settings – which is the primary intended focus of care in our national Mental Health Policy and Strategic Plan Framework (2013-2020). Second, medical doctors have very little exposure during their training to integrated models of managing MNS disorders that are co-morbid with other pressing public health challenges in South Africa, such as HIV, tuberculosis and chronic non-communicable diseases. For example, depression, anxiety and alcohol-use disorders are highly prevalent in patients with chronic diseases, and require integrated stepped care models. Third, given the limited attention during training given to care and treatment of patients with substance use or substance abuse issues, it may be useful to strengthen this aspect of the programme, and/or provide later in-service training on management of such issues. Fourth, given the role of medical doctors in assessing eligibility for disability and other social grants, it is recommended that gaps in competencies associated with MNS disability, recovery and rehabilitation (RD.1 and 2 Table 1; RD. 1-6 Table 2) be addressed.

4.4 Core competencies of practitioners of family medicine with regard to MNS disorders

4.4.1 Introduction

Family physician training in South Africa aims to produce specialists who are able to not only practise family medicine competently in district hospitals but are also able to function as members of district-based healthcare professional teams which seek to improve healthcare outcomes in communities.

Qualification as a practitioner of family medicine requires completion of a primary degree in medicine (i.e. qualifying first as a general practitioner), and then gaining admission to a Masters' programme in Family Medicine at a South African medical school, together with finding an available registrar's post in one of the provincial Departments of Health.[81]

Training in family medicine takes four years, three of which involve working as a registrar. Family medicine registrar posts are preferentially located in the District Health Service (unlike most other medical specialist registrar posts which are located at tertiary hospitals). A candidate may, however, complete the Masters' degree in the required period of time, but opt to spend one of the three years not in a registrar's post, but in another appropriate clinical post where they can still be supervised.

At the end of the Masters' degree training, candidates have to pass examinations set by the College of Family Physicians, which comprise both written and clinical assessment, together with submission of a written research report completed during the study period.

Family physicians collaborate closely with clinical nurse practitioners. In the public sector, they are important members of district-based clinical specialist teams, where they collaborate with obstetricians and paediatricians, particularly with the objective of reducing South Africa's high maternal and child mortality rates. Linked to this objective is the need to prevent or reduce disability in children with special needs, especially

in dual-diagnosis neurology cases such as cerebral palsy, intellectual disability and epilepsy, and in sensory impairments (visual and hearing impairments). Knowing more about disability, habilitation and the role of rehabilitation professions will enhance the long-term case management of this complex paediatric population at a district level.

4.4.2 Core strengths

Family medicine practitioners bring to care and treatment of people with MNS disorders all the competencies of general practitioners (i.e. all the competencies listed in Tables 1 and 2), augmented by a particular orientation to work as a team member, a heightened sense of responsibility regarding working collaboratively with community members and building strong relationships with communities, together with further competence in developing community connectedness and synergies.[82,83,84] They are also responsible for planning services in the district health services.

Whereas general practitioners are only competent to 'provide patients … with awareness and/or education', family medicine practitioners are skilled enough to be able to extend awareness and/or education to the broader community.
While the general practitioner has limited awareness of community resources relating to treatment and care of MNS disorders, the family medicine practitioner develops more extensive knowledge of such resources, reflected in them being able to 'know the resources which are available in the community' (TC.6) and being 'able to use information technology to improve treatment and care' (TC.16). Two other distinctive competencies of the family medicine practitioner merit mention: their competence in employing a rights-based approach (TC.14): 'supporting patients and communities in standing up for their rights' and 'demonstrating a patient-centred approach to the patient using collaborative decision making'.

Family medicine practitioners should, therefore, be able to meet all of the care and treatment needs of patients with MNS disorders, as well as to mentor and train other healthcare providers, and to advise districts regarding difficult MNS cases (at primary care/district-hospital level).

Family medicine practitioners are able to play an important mentoring and strategic planning role with regard to MNS care and treatment, when time permits. Their expertise can also be shared wherever possible so that it can inform the work of medical practitioners, nurses and other health providers at a district level.

4.4.3 Gaps

There are several gaps evident in the MNS competencies of family medicine practitioners trained in South Africa. As with medical practitioners, it may be useful for these practitioners to have additional training regarding substance use and substance abuse issues. They would also benefit from an enhanced understanding of disability, recovery and rehabilitation (RD competencies in Tables 1 & 2).

4.5 Core competencies of general medical practitioners with a Diploma in Mental Health (DMH) with regard to MNS disorders

The Diploma in Mental Health (DMH)[85] is designed to give general practitioners increased competence and confidence in providing mental health care to patients. The course involves three months of full-time service in a psychiatric unit and working under psychiatric supervision, or alternatively six months of service in a general hospital setting which affords some psychiatric management of patients under a psychiatrist's supervision. Students also have to provide a portfolio of evidence showing that they have managed at least ten psychiatric cases which scan a broad spectrum of psychiatric disorders.

4.5.1 Core strengths

The practitioner with a DMH will have developed enhanced competence with regard to some aspects of screening and identification of MNS disorders, particularly having greater competence to engage in 'acute and chronic assessment' (SI.1). Furthermore, cultural competence (SI.5) is enhanced, since they can now understand the 'social factors of illness, including traditional healing' and take into account 'social-cultural factors in illness and treatment', which will enhance their cultural competence.

With regard to treatment and care, the general practitioner with a DMH should have further competence regarding use of the 'biopsychosocial approach', which should give them greater confidence to assess different levels of social, cognitive and physical functioning (DR.3; RD 1-6 Table 2).
This individual will also have a greater knowledge of 'mental health legislation', which will enable them to mentor and educate other health providers regarding legal issues.

The training provided by a DMH will also give the individual greater confidence and competence regarding:

- child and adolescent psychiatry;
- geriatric psychiatry; and,
- neuro-psychiatry.

The diploma also provides graduates with greater, in-depth knowledge of a wide range of psychopathology, building on the knowledge base and competence of medical practitioner training in this regard, hence enhancing competence in aspects of screening and diagnosis such as SI.6, SI.8, DR.3 and DR.8 and disability assessments that support RD.1-6, Table 2.

Although the diploma training provides input regarding various forms of counselling and psychotherapy, the training time allocated is insufficient to ensure that the practitioner with a DMH is able to provide a range of psychotherapy, as a trained counsellor or psychologist would be able to do. However, the practitioner should have sufficient knowledge to be able to provide more nuanced supportive counselling of patients; engage in simple counselling of traumatised patients; and, have conversations with couples and families who need further psychotherapeutic help to motivate such individuals to accept such intervention, and point them in the right direction to access the applicable form of psychotherapy. Likewise, the practitioner with a DMH should have sufficient knowledge about disability and rehabilitation (RD 1-6, Table 2) to point persons with MNS disorders in the right direction regarding intervention strategies to enhance their recovery.

General practitioners with a DMH should be able to provide extensive support to enable the skills development of other health care providers in district settings with fewer competencies. They will be especially useful to health providers who are less confident, and who experience practical challenges in caring for, treating and rehabilitating patients with MNS disorders. They will also be able to build stronger relationships with communities and to engage in considered psycho-education of community members regarding MNS disorders. Family physicians based in the districts are primarily responsible for planning, developing and monitoring services for MNS disorders. They may also provide clinical services at primary care and district-hospital level in general health settings, whereas a general practitioner with a DMH will be able to provide more specialised services for MNS disorders, including managing a psychiatric unit in a district or regional hospital, and providing more specialised outpatient services. Knowledge of community-based rehabilitation as a strategy for disability-inclusive community development (RD.1, Table 2) would be advantageous in enhancing the optimal utilisation of rehabilitation professionals at the district or hospital level.

4.5.2 Gaps

As for other categories of medicine, it may be useful for diplomates in mental health to have selected additional input regarding more effective management of substance use and substance abuse issues. They would also benefit from an enhanced understanding of disability, recovery and rehabilitation (RD competencies in Tables 1 & 2).


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Chapter 5: Emergency-Care Personnel

Key Findings

EMS providers play a role in pre-hospital care, primarily dealing with people with MNS disorders who are at risk of harming themselves or others.

Categories of emergency service personnel are currently being rationalised and the curricula are being reviewed and updated.

It is unclear whether EMS professionals receive sufficient content training for them to achieve competence in the management of emergency psychiatric situations.

Emergency services personnel are at high risk of burnout due to significant exposure to stressful or traumatic situations. There is insufficient training in self-care and fostering resilience in the curricula in this category of provider.

Key points

The categories of providers of emergency medical services in South Africa are being rationalised. Generic competencies for managing emergencies are taught, but there is insufficient content on emergency presentations of mental disorders in order to manage them safely and confidently.

5.1 Introduction

A critical cadre in health care provision is emergency-care personnel for whom oversight is provided by the Professional Board for Emergency Care, which was constituted by the Health Professions Council of South Africa (HPCSA) in 1998, and given its current name a decade later, in 2008.

Regulations published in the *Government Gazette* No. 23040, of 25 January 2002, define the general scope of practice of emergency care personnel as involving taking responsibility for:[86]

> "… the rescue, evaluation, treatment and care of an ill or injured person in an emergency care situation, and the continuation of treatment and care during the transportation of such persons to or between health establishments."

The Professional Board recognises seven sub-categories of emergency-care personnel in South Africa.[86] These are:

- Emergency care practitioners (ECPs)
- Paramedics (also designated as ANTs)
- Emergency care technicians (ECTs)
- Emergency care assistants (ECAs)
- Critical care assistants (CCAs)
- Ambulance emergency assistants (AEAs)
- Basic ambulance assistants (BAAs)
- Emergency-care orderlies

After 26 January 2018, the Board's register for basic ambulance assistants (BAAs) and ambulance emergency assistants (AEAs), and the register for paramedics who qualified by completing a one-year training course at a private college were all closed, and no new applicants were to be admitted to these registers after this date. However, emergency care personnel whose names were listed on these registers at the date of closure are entitled to retain their registration as emergency care workers, and are, therefore, permitted to continue in employment, functioning as a BAA, an AEA or a paramedic. In January 2020 registers for ambulance emergency assistants (AEAs) and for paramedics who qualify at universities of technology will also be closed.[86]

The last sub-category listed above, namely emergency-care orderlies, refers to providers of emergency care under the auspices of the South African Military Health Service, the arm of the South African National Defence Force (SANDF) tasked with delivery of health careto SANDF members and their dependents. The orderlies' provision of emergency care within a military context means that their role is more specialised, and their scope of practice is not as far-reaching as those of other emergency-care sub-categories. Hence they receive no further attention in this section.

5.2 Challenges

Emergency-care personnel in South Africa experience particular challenges unique to the country. Issues which confront emergency-care providers arise from South Africa's historical and social contexts: the impact of apartheid and labour migrancy; extremes in inequality; high rates of alcohol and substance abuse; ongoing gender-based violence, together with child abuse; high rates of road accident, injuries and fatalities; and, the ongoing devastating impact of HIV/AIDS.

A major challenge is imbalances in the geographic distribution of emergency-care personnel: services in highly urbanised, better-resourced provinces (such as Gauteng and the Western Cape) are more successful in recruiting and retaining emergency-care personnel and are able to attract better-qualified personnel than under-resourced, rural provinces (such as Limpopo and the Northern Cape). The uneven distribution of emergency-care personnel, together with roads in poorer conditions, leads to delays in the arrival of emergency services in under-resourced provinces, compared to the quicker response rates in more urbanised, better-resourced provinces. Delays in the arrival of emergency services result in poorly resourced provinces experiencing greater patient mortality and morbidity than more affluent provinces.[87]

In comparison with emergency-care workers in other countries, South African emergency-care personnel experience high rates of trauma, owing to the high incidence of violent crime; record rates of gender-based violence; the greater risks of homicide; and, disproportionately high rates of road accidents and road-accident fatalities compared with other countries.[88] Recent media reports have also highlighted an increasing number of attacks on emergency personnel when they respond to calls, leading to certain areas being seen as 'no go' zones for emergency staff. Emergency personnel experience of both primary and secondary trauma increases their risk of burnout.[89]

All these factors contribute to a high turnover in staff members, with trained and experienced emergency-care personnel leaving South Africa in search of better-remunerated (and far less onerous) positions in other countries. If South Africa is to have sufficient emergency-care personnel of appropriate calibre, it needs to implement measures which other countries have put in place to safeguard the personal and psychological health of emergency health care providers. These demonstrably effective measures include:[p]

- Shortened shifts (for example, eight rather than 12-hour shifts which many South African emergency-care personnel are required to work).
- Provision of regular, free and confidential counselling for emergency-care providers, irrespective of seniority.
- The availability of free professional trauma debriefing sessions to all emergency-care staff members, particularly individuals experiencing primary trauma, but also employees who undergo secondary trauma, which can also have a severe impact.

5.3 Core competencies of emergency care practitioners wit regard to MNS disorders

Overarching gaps in core competencies of emergency-care practitioners:

Training of emergency-care staff regarding burnout and the development of personal and professional resilience. Emergency health personnel need to be able to recognise early warning signs of burnout in themselves and their co-workers; they should understand how to effectively manage burnout and the valuable role of self-care in burnout prevention; and, they should be able to develop unique tactics and strategies to maximise self-care and enhance long-term personal resilience.

5.3.1 Introduction

Emergency-care practitioners (ECPs) are the most highly qualified sub-category of emergency-care personnel. ECPs are required to complete a four-year degree at tertiary level to be eligible for admission to the ECP register of the Board to practise in South Africa. Emergency-care practitioners are specialists in the field of pre-hospital emergency care and rescue, focusing on the management of critically ill or injured patients. They are also known as advanced life-support practitioners. There are 633 individuals listed on the ECP register for South Africa.[90] Toqualify as an ECP, an individual has to meet the following requirements:[91]

- They need to provide evidence of having obtained a school-leaving certificate with a minimum achievement of 50% in Mathematics, Life Sciences and Physical Sciences, and a minimum grade of 60% in English.
- They need to pass a fitness assessment, undergo a phobia evaluation process, and submit to a comprehensive medical examination prior to applying for admission to ECP studies.
- Finally, they are required to complete a four-year Bachelor of Health Science degree in Emergency Medical Care.

p. Telephonic interview with a South African paramedic by M.R. Hamilton, interviewer on 20 September 2018.

5.3.2 Core strengths

An individual who is awarded the degree of Bachelor of Health Science in Emergency Medical Care and is subsequently registered as an ECP is likely to demonstrate a limited range of competencies in managing MNS disorders, mainly in relation to managing patients who manifest with acute substance abuse, as well as patients who present as psychotic, aggressive, severely depressed, homicidal or suicidal. ECPs are also highly skilled in short-term management and containment of victims of child abuse and/or gender-based violence (GBV), as well as management of adult and paediatric seizures.[91]

Hence ECPs should be equipped with the following core competencies in the specialised areas listed above:

- Demonstrate awareness of common signs and symptoms (SI.1).
- Recognise the potential for risk to self and others (SI.2).
- Demonstrate cultural competence (SI.5).
- Demonstrate the ability to screen for and use screening tools (SI.7).
- Demonstrate knowledge of when to refer to the next level of care (DR.1).
- Demonstrate skills in assessment of relative levels of social, cognitive and physical functioning (DR.3).
- Demonstrate skills in using various functional assessment tools (DR.5).
- Provide support for patients (and sometimes families too) (TC.1).
- Demonstrate knowledge of how to apply emergency first aid (TC.4).
- Practise good therapeutic patient interactions (TC.10).
- Provide links between patients and community resources (TC.11) (to a limited extent – in other words, transfer to the nearest-available medical facility).
- Protect patient and identify vulnerabilities (TC.14).
- Assist patients with access to other providers (TC.36).
- Document medical records (TC.38).
- Demonstrate knowledge of standard drug regimens (TC.41) (albeit usually only drugs which need to be used in an emergency context).

Given the emergency focus of their work, ECPs will be highly skilled in screening and identification of the types of patient described above, and also have moderately developed skills in formal diagnosis and referral. However, their skills will be most specialised in relation to treatment and care, since their brief is only to contain patient distress and/or life-threatening conditions and to deliver the patient rapidly and safely to more comprehensive health services. They are not involved in medium- or long-term management of these patients. Their high levels of competence mean that ECPs should be able to mentor, teach and supervise emergency health personnel with lower levels of skill, i.e. sub-categories described in detail below.

5.4 Core competencies of paramedics with regard to MNS disorders

5.4.1 Introduction

Paramedics (also designated ANTs) are a sub-category of emergency-care personnel which falls immediately below ECPs in terms of professional competence. Paramedics were previously able to obtain a qualification through two approaches:

- They could qualify as a paramedic by completing a training course to become a critical-care assistant. The course was completed in one year, and enrolment was through a private college, OR
- They could obtain a Diploma in Emergency Medical Care, by enrolling at an academic university or a university of technology which offered this qualification. The diploma course extended over a minimum period of three years.[91]

However, in January 2018 the option to qualify as a paramedic by following the first approach fell away, as the register for this qualification was officially closed. Existing paramedics who had qualified in previous years by completing the one-year training course would still have their qualification recognised and could continue to be employed, however, no further individuals will be admitted to the paramedic qualification by means of this register.[90]

Hence the only available means to obtain the appropriate qualification and registration as a paramedic now necessitates the completion of the three-year diploma course through an academic university or university of technology. From January 2020 the option to complete the four-year diploma at a university of technology will fall away and obtaining the three-year diploma at an academic university will become the only option to qualify as a paramedic.

The existence of two different, somewhat incongruent ways to obtain registration as a paramedic has a considerable impact on the competencies of the trained individuals. The discussion later regarding paramedic competencies is primarily applicable to those individuals who qualified by obtaining a three-year diploma

– and it is entirely unclear to what extent paramedics who were awarded the year-long qualification can be regarded as having a comparable array of proficiencies, which is of some concern. The long-term impact of the consolidation of the training requirements to obtain registration as a paramedic is, however, likely to be positive: the overall competence of paramedics is likely to be more consistent and homogeneous, and the mean competence should be greater.[92]

Currently, to qualify for selection for the three-year diploma training course at a university, an individual first needs to satisfy some additional conditions:[90]

- They should have a School Leaving Certificate with a minimum achievement of 60% in English, and 50% in Mathematics, Life Sciences and Physical Sciences.
- They are expected to pass a fitness assessment, undergo a phobia evaluation process, pass a swimming proficiency test, and submit to a comprehensive medical examination.
- They are required to undergo a structured personal interview.

According to the Professional Board, at the time of writing, there were 1 524 registered paramedics in South Africa.

5.4.2 Core strengths

As is true for ECPs, paramedics who obtained the three-year diploma are likely to demonstrate a high degree of expertise in a limited number of MNS competencies.[q] As for ECPs, these competencies almost always involve managing patients who manifest with acute substance abuse, as well as dealing with patients who present as psychotic, aggressive, severely depressed, homicidal or suicidal. Paramedics should also be skilled in short-term management and containment of the survivors of child abuse and/or GBV, as well as management of adult and paediatric seizures.

The proficiencies of a paramedic include being able to:[90]

- Demonstrate awareness of common signs and symptoms (SI.1).
- Recognise the potential for risk to self and others (SI.2).
- Demonstrate cultural competence (SI.5).
- Demonstrate the ability to screen for and use screening tools (SI.7).
- Demonstrate knowledge of when to refer to the next level of care (DR.1).
- Demonstrate skills in assessment of … social, cognitive and physical functioning (DR.3).
- Demonstrate skills in using various functional assessment tools (DR.5).
- Provide support for patients (TC.1) (and sometimes also families).
- Demonstrate knowledge of how to apply emergency first aid (TC.4).
- Practise good therapeutic patient interactions (TC.10).
- Provide links between patients and community resources (TC.11) (to a limited extent – namely transfer to the nearest available medical facility).
- Protect patient and identify vulnerabilities (TC.14).
- Assist patients with access to other providers (TC.36).
- Document medical records (TC.38).
- Demonstrate knowledge of standard drug regimens (TC.41) (albeit usually only drugs used in an emergency context).

Despite the difference in the training duration, the proficiency of a well-trained paramedic is expected to be almost identical to that of an ECP.

5.5 Core competencies of emergency care technicians with regard to MNS disorders

Emergency care technicians (ECTs) are entitled to register with the Professional Board for Emergency Care after completion of an accredited two-year diploma. A total of 1 126 ECTs are currently registered with the HPCSA. This sub-category of emergency health care provider plays a vital role in the provision of pre-hospital emergency care within South Africa.

A registered ECT should be able to routinely and independently administer and perform certain medical interventions. Medications which are rarely administered and procedures which are less often performed, or which are invasive or potentially harmful to the patient, require an ECT to consult with an ECP or with a medical officer, before carrying out the relevant procedure. Hence certain clinical conditions and certain types of patient may be beyond the scope of practice of an ECT: here medical treatment will need to be provided

q As discussed earlier, this outline of paramedic competencies may not necessarily apply to paramedics who were registered by the Board after obtaining the one-year qualification.

by a more qualified person, such as an ECP or a medical officer. ECTs are expected to transport emergency-care patients promptly and safely to the nearest appropriate medical facility.[91]

An ECT is expected to exhibit limited aptitude when compared to ECPs or paramedics regardingall of the following competencies:[90]

- Demonstrate awareness of common signs and symptoms (SI.1).
- Recognise the potential for risk to self and others (SI.2).
- Demonstrate cultural competence (SI.5).
- Demonstrate the ability to screen for and use screening tools (SI.7).
- Demonstrate knowledge of when to refer to the next level of care (DR.1).
- Demonstrate skills in assessment of social, cognitive and physical functioning (DR.3).
- Demonstrate skills in using various functional assessment tools (DR.5).
- Provide support for patients (TC.1) (and sometimes also families).
- Demonstrate knowledge of how to apply emergency first aid (TC.5).
- Practise good therapeutic patient interactions (TC.10).
- Provide links between patients and community resources TC.11 (to a limited extent – namely transfer to the nearest available medical facility).
- Protect patient and identify vulnerabilities (TC.14).
- Assist patients with access to other providers (TC.36).
- Document medical records (TC.38).
- Demonstrate knowledge of standard drug regimens (TC.41) (albeit usually only drugs which need to be used in an emergency context and are most frequently used).

Although an ECT is able to carry out some of the emergency tasks and interventions that an ECP or a paramedic is sufficiently proficient at, an important proviso needs to be made with regard to ECTs: ECTs are not permitted to carry out these functions or tasks independently or autonomously. At all times, ECTs need to work under the supervision of, and with the careful guidance of an ECP or a medical officer.

5.6 Core competencies of emergency care assistants with regard to MNS disorders

5.6.1 Introduction

In order to register as an emergency care assistant (ECA) with the Professional Board for Emergency Care, an individual, needs to obtain a Higher Certificate in Emergency Medical Care, with the course having a minimum duration of a year. To secure admission to higher certificate training, the applicant should have either a Senior Certificate (if the application to study was made prior to or in 2009), or if from 2010 onwards, a National Senior Certificate or a National Vocational Certificate. An ECA is also required to pass medical fitness and physical fitness evaluations before being admitted into training. ECA graduates are expected to be competent to practise basic and intermediate emergency care in rural and urban contexts, utilising a multidisciplinary approach.[93]

According to the Professional Board, the Higher Certificate should be understood as being an entry-level qualification. After qualifying, an ECA is required to work under the close supervision of an ECP, an ECT or a Medical Officer, mainly in and around an ambulance. In general, the ECA provides more of a supportive service in the pre-hospital context.

5.6.2 Core strengths

Given adequate supervision, together with ongoing mentoring and debriefing, an ECA is expected to have limited skill in the execution of the following competencies:[90]

- Demonstrate awareness of common signs and symptoms (SI.1)(albeit awareness of only the most common presentations is expected).
- Recognise the potential for risk to self and others (SI.2).
- Demonstrate cultural competence (SI.5).
- Demonstrate the ability to screen for and use a limited number of screening tools (SI.7).
- Demonstrate knowledge of when to refer to the next level of care (DR.1).
- Demonstrate skills in assessment of … social, cognitive and physical functioning (DR.3). (here too, very global forms of assessment are mastered by the ECA, rather than the more specialised and complex forms of assessment which trained ECPs, ECTs, paramedics or medical officers should have mastered).
- Demonstrate skills in using a relatively limited range of functional assessment tools (DR.5).
- Provide practical (rather than psychological) support for patients (TC.1).
- Demonstrate knowledge of how to apply emergency first aid (TC.4).
- Practise good therapeutic patient interactions (TC.10).

- Provide links between patients and community resources (TC.11) (although for ECAs, this is likely to involve simply transportation of the patient to an appropriate medical facility which is close).
- Assist patients in simple ways to obtain access to other providers (TC.36).
- Document medical records in a rudimentary form (TC.38).
- Demonstrate basic knowledge of standard drug regimens (TC.41) (albeit this usually only involves those drugs which are most frequently used, and where administration of the drug by the ECA involves no significant risk for the patient).

5.7 Core competencies of ambulance emergency assistants (AEAs) with regard to MNS disorders

Ambulance emergency assistants (AEAs) were previously permitted to register with the Professional Board and to practise after providing evidence of having completed a training course with a duration of at least three months. This qualification is no longer regarded as compliant with any of the unit standards in the South African National Qualifications Framework (NQF). This sub-category of emergency care personnel has the second-largest membership: at the time of writing some 10, 092 AEAs were registered with the Board. Based on the Professional Board's Clinical Guidelines, it is evident that AEAs have a substantially limited scope of practice, and that their competencies do not correspond to the core competencies required for MNS care and treatment.[90]

5.8 Core competencies of basic ambulance assistants (BAAs) with regard to MNS disorders

Basic ambulance assistants (BAAs) were previously permitted to register with the Professional Board for Emergency Care after completing a recognised and appropriate six-week course of study. However, this sub-category of the emergency-care worker is currently being phased out. This group has the largest membership of all emergency-care personnel in South Africa: at the time of writing 50 823 individuals were registered with the Board as BAAs.[90] Based on the Professional Board's Clinical Guidelines, it is evident that a BAA has a very limited scope of practice, and that their skill set is unrelated to the specified core competencies for MNS care and treatment.

Chapter 6: Occupational Therapist

Key Findings

This category includes occupational therapists (OTs), community rehabilitation workers (CRWs) and occupational therapy assistants (OTAs).

This category of providers is the most highly trained and skilled in the full range of rehabilitation including physical, psychosocial, educational, vocational and community-based programmes for individuals, groups and populations. As with medical professionals, there is a shortage and maldistribution of occupational therapists in South Africa.

Competency-based training in MNS disorders in OT curricula is generally adequate.

The role of all rehabilitation professionals including physiotherapists, speech-language therapists and audiologists in MNS disorders must be strengthened, given the functional sequelae of co-occurring mental, developmental and neurological disorders.

The crucial contribution of this group of providers is not optimised in the WBOT in the PHC-re-engineering plan.

There is a need to train more mid-level workers in this category.

Key points

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013) includes disability as a dimension of diagnosis for MNS disorders. The DSM-5 uses the World Health Organization Disability Assessment Schedule (WHODAS 2.0) to replace the DSM-IV-R Global Assessment of Functioning (GAF) Scale.[93] Occupational therapist competencies address impairments, limitations of activity and participation restrictions as dimensions of disability by assessing and enabling people's functioning in the occupations of everyday life. Functioning is promoted by pragmatically and scientifically addressing the dynamic interactions between person(s), environment(s) and activity(ies) with due consideration of personal and contextual factors. A disability focus situates occupational therapy competencies for MNS disorders within and beyond the provision of therapeutic services in hospitals and health clinics. The profession also contributes to health promotion and disability prevention through its competencies in comprehensive rehabilitation and disability-inclusive community development.

6.1 Introduction

This chapter discusses core competencies and gaps of South African health care workers with training and professional skills in occupational therapy at all levels of the health service, including competencies required to address the functional and disability-related sequelae of MNS disorders in the education, labour, social development and justice sectors. The following sub-categories are, therefore, discussed further below:

- Registered occupational therapists (OT).
- Occupational therapy technicians (OTT) and assistants (OTA).
- Community rehabilitation workers (CRW). While this category does not fall under the statutory regulations of occupational therapy, it is addressed here in anticipation of future developments in the re-engineered district health system (see Chapter 1).[94]

In this chapter, disability is used as an umbrella term for the impairments, activity limitations and participation restrictions that arise from a health condition, taking into account environmental and personal factors that interact bi-directionally with all these constructs.[95] *Impairment* is a problem in body function or structure (for example, signs and symptoms associated with schizophrenia); an *activity limitation* is a difficulty encountered by an individual in executing a task or action (for example, dysfunction in performing the activities of everyday life due to a mood disorder or problems in meeting responsibilities at home, school or work due to substance abuse); and, *participation restriction* is a physical, attitudinal or systemic barrier that prevents inclusion in life situations (for example, stigma towards or lack of reasonable accommodation in the workplace for persons with psychiatric disorders or social determinants such as poverty and rurality). Disability is thus, not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and mind and features of the society in which he or she lives. Promotion of healthy lifestyles and prevention of disability associated with MNS disorders from an occupational therapy perspective involves:

- early detection and remediation of biopsychosocial impairments;
- ongoing functional assessment and rehabilitation of performance difficulties in life activities and roles; and,
- modification of physical and attitudinal environments to promote equity, social inclusion and participation in health-promoting occupations.

In this chapter rehabilitation refers to "a goal-directed, time-bound and personalised process designed in collaboration with individuals, groups and communities to prevent or reduce the impact of disability".[96] Rehabilitation enables people of all ages to reach optimal levels of human development and biopsychosocial functioning in the living, learning, working and social domains of life.[96] Comprehensive rehabilitation includes psychosocial, physical, educational, vocational and community-based dimensions, all of which require bi-directional and intersectoral referral pathways, extending from community-based/primary to tertiary and specialised levels of care.[97]

The *psychosocial rehabilitation* process is recovery orientated and extends beyond symptom relief to longitudinal social support, skills development and restoration of community participation. The recovery model affirms that people with severe or enduring mental disorders, including neurological and substance use disorders can attain and fulfil meaningful roles in society if a range of support structures are put in place. *Physical/medical rehabilitation* makes use of physical methods such as exercise and provision of assistive devices and may, for example, be indicated for persons with neurological impairments that impede mobility or communication. *Educational (re)habilitation* is pertinent to the early detection and prevention of MNS disorders because it addresses the developmental needs of individuals especially, children and youth with special needs, including barriers to learning.[98] *Vocational rehabilitation* is indicated for individuals of working age with health-related impairments that restrict productive functioning in the worker role. Its primary aim is to optimise work participation and livelihood generation, important goals for interrupting the poverty-disability cycle associated with MNS disorders. Vocational rehabilitation is a core occupational therapy competency. It includes pre-vocational skills development, assistance with reasonable accommodation in the open labour market, work-programme design in supported and sheltered employment facilities as well as income-generation in the informal work sector. *Community-based rehabilitation (CBR)* is a strategy within community development for the equalisation of opportunities for adults and children with disability through rehabilitation, poverty reduction and social inclusion.[99] It is implemented through the combined efforts of disabled people, their families and communities, and the appropriate health, education, vocational and social services. *Disability inclusive development (DID)* is a subset of broader, inclusive social development programming that focuses specifically on the reduction of poverty and inequality by ensuring that people with disabilities are included in and benefit equally from development efforts.[100]

The competencies of OTs, OTTs, OTAs and CRWs described in this chapter pertain to their role and scope in the promotion of healthy occupational patterns and the prevention and reduction of disability and ill-being through comprehensive rehabilitation.

6.2 Core competencies of registered occupational therapists with regard to MNS disorders

6.2.1 Scope of practice

Occupational therapy describes client-centred health providers concerned with promoting health and well-being and preventing disability through occupation.[101] In occupational therapy, occupation refers to the activities of everyday life, including self-care, work, learning, play, leisure and social activities that people of all ages engage in as individuals, as members of families and within communities. Social roles such as learner, parent, worker, friend, citizen, etc. are enacted through particular occupations in different contexts. The primary goal of occupational therapy is to enable people to participate in health-promoting occupations that match their abilities, express their interests and meet their role-related needs and aspirations. Occupational therapists achieve this goal by working with people to enhance their ability to engage in the occupations they want to do, need to do, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

Occupational therapy is indicated for individuals of any age when their ability to carry out their life activities is temporarily or permanently impaired by a health condition or when environmental limitations and structural barriers in society prevent them from engaging in occupations that would enable them to thrive or place them at risk of ill-health. Occupational therapy competencies draw on clinical knowledge derived from the health sciences (such as anatomy, neurology, physiology, kinesiology, medical conditions and psychiatric disorders); conceptual knowledge of human and social sciences (such as sociology, psychology and disability studies); and, professional knowledge and skills (such as rehabilitation science and occupational science). This array of evidence-based knowledge and skills equips occupational therapists to address the disability-related issues associated with MNS disorders through the health promotive, preventative and therapeutic use of occupation. In particular, occupational therapists taking an occupational perspective on human and social

development are equipped to join a multi-pronged workforce (for example, law enforcement, town planners and social development practitioners) in addressing the social determinants of MNS disorders.

6.2.2 Professional education

The degree of Bachelor of Science (Occupational Therapy) is a four-year tertiary qualification. There are currently eight education programmes in South Africa which produce between 300 and 350 occupational-therapy graduates annually. Graduates have to complete a year of compulsory community service before they are entitled to register with the Health Professions Council of South Africa (HPCSA) and practise as occupational therapists. The curriculum of each occupational therapy education programme is evaluated every five years by the Education Committee of the Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics, to ensure compliance with the Standards of Practice of the HPCSA for Occupational Therapists,[102] which are, in turn, based on the South African Qualifications Authority (SAQA) Framework for Occupational Therapists[103,104] and the legislated scope of the profession.[101] In addition, all curricula are designed and evaluated for alignment with the World Federation of Occupational Therapists (WFOT) Minimum Standards for the Education of Occupational Therapists.[103] Practitioners are required to deliver professional services in accordance with practice and ethical standards set by the Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics, which falls under the HPCSA. In mid-2017, the latest date for which figures were available, there were 5 021 occupational therapists (OTs) in South Africa registered with the HPCSA.[r] The low remuneration and limited career pathways offered to occupational therapists in the public sector has meant that individuals with this qualification are more likely to work in private practice, in the private or NGO sector in a range of capacities, or to seek employment overseas.

6.2.3 Strengths

Analysis of occupational therapy education curricula indicates that OTs can provide services aligned with all the SI (screening/identification), DR (formal diagnosis/referral)and TC (Treatment/care) competencies as they pertain to all health care provider types across MNS disorders (SI. 1-6; DR. 1-2; TC. 1-16), and, in particular, (RD. 1-2). OTs can provide services within their professional role and scope for most of the SI, DR and TC competencies that pertain to non-specialised prescribers and specialised providers across MNS disorders (SI. 1-10; DR. 1-10; TC. 1-42) and, in particular, (RD. 1-6). An emphasis is evident in OT curricula on 'client-centred goals' and draws attention to the strongly person-centred focus of the profession (TC.10, 14, 15, 36). This focus suggests that OTs are competent to address people's occupational aspirations with due consideration of the social contexts and physical environments within which they function (DR. 2, 4; TC.11-13). Choice and utilisation of appropriate assessment tools including contextually situated observation of people in their lived environments and roles is therefore a major component of OT professional reasoning. The complexity and specificity of occupational therapy reasoning isreiterated in the use of 'defined protocols and algorithms' for assessment of and interventions for occupational performance (DR.3,5; RD. 2,4). Taking an occupational perspective on the social determinants of health, OTs are equipped to partner with community stakeholders in inclusive development initiatives that target the mental health consequences of social inequality, poverty and marginalisation (Table 2: RD. 4)

OTs have competencies to provide physical, psychosocial, educational and vocational rehabilitation to meet the functional needs of persons with physical, sensory and psychosocial disability (RD. 3,5,6). The specificity of the competencies in each of these types of rehabilitation is contingent upon further training and clinical experience with various types of MNS disorders. OTs also have competencies to design, implement and monitor occupation-based programmes for individuals, groups and populations in communities (TC. 5,6) and institutions (such as old-age homes, children's and youth care centres, prisons, psychiatric hospitals and psychiatric and consultation-liaison wards in general hospitals, and specialist MNS health care clinics and rehabilitation centres) (TC. 34,39). Finally, occupational therapists are able to provide mental health support, mentoring, CBR supervision and basic disability-inclusive training for non-specialist community workers (TC. 36,40,42).

6.2.4 Core gaps

The OT scope of practice precludes 'Demonstrate knowledge and skills to make a formal diagnosis and formulation of differential diagnosis' (DR.8) and 'Demonstrate ability to make a diagnosis according to an algorithm (not considered a clinical diagnosis)' (DR.10). Similarly, rather than having the competence to demonstrate ability to determine severity level (DR.9), the scope of practice of OT practitioners refers instead to being able to identify the 'prioritised functional problem', which, in turn, enables the multi-professional team to make a formal diagnosis including the level of disability. DR.9 is therefore, both a strength and a gap. Although OTs can utilise various OT-specific assessment tools (DR.5) and are informed about the use of diagnostic systems such as DSM-5 or ICD-10 (DR.7), they are not competent to make a formal or differential diagnosis across all MNS categories (i.e. they are not competent in relation to DR.8 or DR.10). While OTs may be able to discern

r. Data from the website of the Health Professions Council of South Africa - https://hpcsa.co.za/. Accessed 15 May 2018.

non-adherence to medication or detect the basic side-effects of such medication (TC.9), they are not competent or legally allowed to prescribe or to monitor the use of such medication (TC.41).

6.3 Core competencies of occupational therapy technicians (OTTs) and occupational therapy auxiliaries (OTAs) with regard to MNS disorders

6.3.1 Introduction

An Occupational Therapy Auxiliary (OTA) describes a person with a one-year training certificate, while an Occupational Therapy Technician (OTT) is defined as an individual with a two-year training occupational therapy diploma or its equivalent (280 credits).[104] Training equips OTAs to practise mainly in hospital or institutional settings, whereas OTTs are equipped to practise in both institutional and community settings, comprising rural and urban areas. Training of OTAs has been discontinued in South Africa since 2007. At the time of writing (2018), there was also no provision for OTT training in South Africa. OTAs are in the process of being replaced by OTTs. The OTA register at HPCSA will be phased out once the last OTAs on the register have migrated to the OTT category through further training and upskilling, or have left the profession through natural attrition. In providing for the registration of mid-level occupational therapy workers (i.e. OTTs), the HPCSA seeks to ensure that OT rehabilitation services reach as many people as possible, especially in under-served communities. In mid-2017, 488 OTTs and 85 OTAs were registered with the HPCSA.[s] OTT services have to be delivered under the supervision of an HPCSA-registered occupational therapist. Any prospective training course for a two-year OTT diploma or upskilling through short courses for continuing professional development needs to be registered with the HPCSA Professional Board for Occupational Therapy, Medical Orthotics, Prosthetics and Arts Therapy.

6.3.2 Core strengths

Analysis of existing and proposed curricula for occupational therapy mid-level workers indicate that OTTs can provide services aligned with Table 1 SI, DR, TC and RD competencies as they pertain to all providers across MNS disorders, under the direct supervision of a registered occupational therapist. OTTs should have awareness all common signs and symptoms of MNS disorders (SI.2); be able to recognise obvious risk to self and others (S1.2); have an understanding of causes insofar as they are able to understand 'risk factors' (SI.3); be able to provide patients and communities with basic awareness and education (SI.4); and able to demonstrate cultural competence (SI.5). In addition, they are able to recognise persons who are relapsing and who require inpatient care (TC.3, SI.10), and they know when to refer to a higher level of care or when to refer to another health provider (DR.1, 4). They can ethically apply limited, basic task-shifted sub-competencies associated with (RD. 1,2) by working under the direct supervision of an OT.

While OTTs do not have the competence to independently meet any of the Table 2 SI, DR, TC or RD competencies for non-specialised and specialised providers across MNS disorders, they should be able to carry out basic sub-components of these competencies with guidance from an OT. The degree of supervision required will vary, depending on the service setting and years of experience working with a particular population within the MNS disorders. They should also be able to feed data obtained through their work to an OT for integration into a comprehensive OT service (RD.1-6).

6.3.3 Core gaps

Limits in terms of practice relate to the circumscribed training content of OTT curricula, and such limits are enforced by the HPCSA for the protection of patients. OTTs do not have competence to work without supervision from an OT. Hence their work is primarily supportive in the provision of the range of OT services for MNS disorders. This category of health provider cannot fulfil any of the following competencies: interpret referrals for occupational therapy (DR.1 and 2); engage in primary diagnosis or conduct mental status examinations (DR.3-10); conduct or interpret standardised tests used by occupational therapists; or make decisions about treatment, rehabilitation or disability inclusion (TC.1-42; RD.1-6) without the input of, and monitoring by a qualified, registered OT.

6.4 Core competencies of community rehabilitation workers (CRWs) with regard to MNS disorders

6.4.1 Introduction

There are a multitude of community health and rehabilitation workers in South Africa whose designation is defined by often confusing and overlapping terminology. This cadre of worker tends to be either voluntary or employed at minimum wage or stipend by non-profit or non-governmental organisations. Mid-level health workers (MLHWs) tend to be formally registered with health boards, while community health workers (CHWs) are not, and MLHWs usually receive more formal training than CHWs. The latter are almost all previously trained

s. Statistics downloaded on 15 May 2018 from the Health Professions Council of South Africa website –https://hpcsa.co.za/

community home-based carers (CHBCs). Current CHBC training does not include training in counselling, disability or rehabilitation. Community rehabilitation workers (CRWs) are usually CHWs who have been upskilled. There is also a distinction between rehabilitation care workers (RCWs) and CRWs depending on the aspects of community-based rehabilitation (CBR) covered in their training. Historically CRWs had three different designations, depending on the institution from which they received training. For example, Community-Based Rehabilitation Workers (CBRWs) were trained by the South African Christian Leadership Assembly SACLA (Cape Town) or by the Tintswalo Wits Rural Facility (University of Witwatersrand). Community Rehabilitation Facilitators (CRFs) are trained by Community-Based Rehabilitation Education and Training for Empowerment (CREATE) (Pietermaritzburg) and RCWs by the Division of Disability Studies, University of Cape Town for a Higher Certificate in Disability Practice (Rehabilitation Care and Support).

The National Mental Health Policy Framework and Strategic Plan (2013–2020)[6] makes provision for CHWs to conduct community rehabilitation and counselling activities. It emphasises a recovery model of mental health care, while also reflecting the activities of health promotion and prevention prioritised in PHC-R.[105]The proposed PHC-focused mid-level rehabilitation worker (MLRW) will be specifically trained in these areas and will work under the supervision of rehabilitation therapists.[105,106] Whether they are going to be called mid-level workers or whether they will be recognised by the HPCSA and employed by the State with an NQF laddered career path towards a health professional qualification is unclear at this point. It is envisaged that selected psychosocial interventions identified for delivery by trained non-specialist health care workers could also be included in their training, (see Chapter 1) with appropriate supervision from other mental health care practitioners (for example, nurses and therapists) in accordance with guidelines for task shifting provided by the WHO (2008).[107] The inclusion of MLRWs in the community mental health workforce provides a feasible vehicle for impactful disability prevention and the delivery of supervised community rehabilitation services to larger numbers of people of all ages with MNS disorders and other disabling health conditions associated with the quadruple burden of disease in South Africa.

6.4.2 Core strengths

Analysis of the CRW and RCW curricula, together with document surveys conducted regarding the competencies of RCWs for the MNS disorders, suggest that this cadre of worker should have awareness of all common signs and symptoms (SI.1); be able to recognise the obvious risk to self and others (S1.2); have an understanding of causes insofar as they are able to understand 'risk factors' (SI.3); be able to provide patients and communities with basic awareness and education (SI.4); and, demonstrate cultural competence (SI.5). In addition, they are able to recognise persons who are relapsing and require inpatient care (TC.3, SI.10), and they know when to refer to a higher level of care or when to refer to another health provider (DR.1, DR.4). They are able to ethically apply limited. basic task-shifted sub-competencies associated with (Table 1 RD.1 and RD.2) by virtue of working under the direct supervision of rehabilitation therapists.

CRWs and RCWs have basic competence to provide support for persons and their families while in treatment and care (TC.1), and to demonstrate respect, compassion and responsiveness to their needs (TC.14, TC.15*)*. Through their connectedness to their communities, CRWs and RCWs are able to identify and assist persons and families in overcoming barriers to treatment and recovery (TC.2) and to help people access available resources *(*TC.6, TC.11, TC.12). They also have the capacity to communicate with members of the public about MNS disorders (TC.8) and to engage in activities that raise awareness and improve the uptake of such services (TC.13). They are able to report back to the relevant health management systems (TC.34). They are able to engage in documentation and reporting of their activities (TC.38); and, they are able to provide proactive follow-up and to monitor outcomes of care (TC.40). In addition, they have basic competencies in the health and empowerment components of CBR, which includes physical, psychosocial, educational and vocational rehabilitation-focused tasks that are delegated and shifted to them, under the direct supervision of OTs and other rehabilitation professionals (RD. 1-6).

6.4.3 Recommendation

In order for this important cadre of health worker to render a competent and effective community-based rehabilitation and disability inclusion service in the medium to long term, additional policy measures need to be put in place similar to those proposed for behavioural health counsellors on pages 89-94. They should become permanent employees within the health system and function as members of a team with appropriate support including supervision, mentoring and in-service training from rehabilitation professionals. They should be remunerated fairly and given employment benefits including graded certification along a designated and formally regulated career path.

Chapter 7: Psychology

Key Findings

This category includes psychometrists and registered counsellors, clinical, counselling, educational, industrial and research psychologists.

There is a shortage and maldistribution of these professionals across the country.

This report proposes the introduction of a category of lay worker called a behavioural health counsellor who could work in community and primary care settings as a way of increasing access to psychological services. There is evidence that this category of provider can effectively deliver manualised psychological interventions.

All providers of psychological services should provide evidence-based psychological interventions. Currently, there is a lack of standardisation of training and curricula across institutions.

Providers of psychological services for people with MNS disorders should primarily be employed in the district health service.

Training in management of substance use disorders is only addressed to a limited extent.
In clinical psychology programmes, there is greater emphasis on various modalities of individual psychotherapy rather than community-based, recovery-oriented approaches to psychosocial disability and rehabilitation.

Key points

As for other providers mentioned in this report, psychologists of all categories are a scarce resource and mainly concentrated in urban areas. People in disadvantaged and rural areas have very limited access to psychological services. This chapter advocates for a task-shifting approach to the provision of psychological services and proposes a new category of provider called a behavioural health counsellor, who can be trained to deliver a structured, manualised counselling intervention for selected MNS disorders which is integrated with general health care. In addition, it is noted that there is a need for a more standardised approach to the training of all categories of psychologists, making use of evidence-based approaches. It emphasises that psychological services at all levels should be primarily ambulatory and therefore posts need to be created in the District Health Service for providers of psychological services, in particular for registered counsellors (graduates with a B Psych Degree). Clinical psychologists should play a greater role in training and mentoring/supervision of generalist health providers and mid-level workers in the provision of psychological services.

7.1 Introduction

This chapter focuses on provider core competencies in relation to improved delivery of services for MNS disorders in South Africa, with a specific focus on relevant sub-categories of health care provider which fall under the ambit of psychology.

The process of critically examining the core competencies of various psychology specialist qualifications for their relevance in meeting the health needs of individuals with MNS disorders began with a consideration of the full list of sub-categories of psychology currently recognised by the Board of Psychology, which is a division of the HPCSA. The Board identifies and describes the scope of practice of the following sub-categories:

- Registered counsellors
- Psychometrists
- Counselling psychologists
- Clinical psychologists
- Neuro-psychologists
- Educational psychologists
- Industrial psychologists
- Research psychologists

This report proposes that an additional sub-category of health care provider whose members should be able to provide essential, basic, evidence-based counselling in primary care and community settings should be

included in this group of providers who are recognised as contributing meaningfully to MNS service delivery. The proposed title for this new health care provider is *behavioural health counsellor* (see the following section for the rationale behind this proposal).

7.2 Core competencies of behavioural health counsellors with regard to MNS disorders

7.2.1 Introduction

There is a chronic shortfall of health care providers in the South African health care system who are able to provide a limited range of psychosocial counselling and psycho-education to encourage individuals to make healthier lifestyle choices. This form of intervention is a high priority if the increasing South African health care costs owing to a growing burden of chronic disease (including HIV, diabetes and hypertension) caused by risky health behaviours is to be averted timeously. Health services need to find creative ways to reduce the treatment gap for MNS disorders, including providing psycho-education to increase public awareness of the common manifestations of mental illness such as depression and anxiety, and substance use problems, including hazardous and harmful alcohol use and their impact on physical health, and to reduce the stigma regarding mental illness and substance use.

It is suggested that a new category of counsellor be created within the health care system, with the title of behavioural health counsellor, in alignment with international and local evidence of their effectiveness.[108, 109] Many lay counsellors who are already in part-time or full-time employment by non-governmental organisations (NGOs) or (more rarely) by provincial departments of health, are suitable for recruitment into this new cadre of a health care worker. They include lay counsellors employed to conduct HIV testing and counselling (HTC), to provide adherence counselling for antiretroviral treatment and tuberculosis treatment, and to run support groups ('clubs') for people living with HIV (PLWHIV) and increasingly other chronic diseases which (it is proposed) could include mental disorders. Several motivational proposals have been made over a decade or longer for the work of lay counsellors (particularly those providing invaluable services regarding HIV/AIDS) to be formally recognised and appropriately remunerated. It has furthermore been suggested that these individuals with important skills in helping people manage their health behaviours should be granted permanent employment status and the accompanying employee benefits. Some of the lay counsellor population have been redeployed in permanent positions as community health workers, who are members of ward-based outreach teams or WBOTs (see Chapters 1 and 2). However, the employment status of lay counsellors who have not been absorbed into WBOTs is tenuous and their career trajectory remains unclear. This is problematic as it leads to low morale, high staff turnover, poor productivity and less-promising outcomes.[110] Their employment as behavioural health counsellors, as outlined below, is likely to strengthen the capacity of these health care workers and exponentially increase their contribution to health care.

The proposal is that individuals employed as behavioural health counsellors should be expected to have at minimum a school-leaving certificate, in addition to which they should be given six months' in-service training, which should cover the following competencies:

- Basic training in communication skills, to enable such counsellors to engage in respectful conversations with clients to encourage such clients to perceive the benefits of making small but meaningful changes to their behaviour which would shift them in the direction of a healthier lifestyle.
- Training in a simple model of counselling which utilises a problem-solving approach, and which could be employed during individual or group sessions with clients, to address elementary issues.
- Provision of psycho-education to individuals and groups regarding the elements of a healthy lifestyle, including a balanced diet, moderate exercise, rest and sleep, risks associated with smoking, alcohol and other substance use and recommendations to reduce associated health risks.
- Counselling of patients regarding adherence to treatment, including tuberculosis treatment and antiretroviral treatment for people living with HIV, as well as adherence to prescribed treatment of hypertension, diabetes and other chronic diseases. Their skills could be extended to treatment adherence in persons with chronic mental disorders.
- Psycho-education regarding the most commonly occurring forms of mental illness (depression and anxiety), hazardous/harmful alcohol use and severe mental disorders.

Training of behavioural health counsellors should be supported by the development of appropriate psycho-educational materials for them to use after their training as well as basic counselling manuals that structure the content of counselling sessions and prevent drift to non-evidence-based ways of working. Such materials should employ simple, coherent messages, utilise all official South African languages, and be visually engaging. Provision of accessible, standardised psycho-educational materials will also help ensure that even over time, key communications messaging by behavioural health counsellors remains consistent and scientifically accurate, and accessible to the public. Such psycho-educational materials should cover key messag-

ing for communities regarding MNS disorders and their management including basic principles of disability inclusion and rehabilitation, as well as healthy lifestyle choices.

Research evidence shows that this echelon of health care workers could be developed into a useful, affordable and invaluable additional human resource in an already overstretched public health care system.[110]

Behavioural health counsellors should be required to be affiliated to a nominated, reputable South African professional body which could provide sufficient oversight such as the Health Professions Council of South Africa (HPCSA).

The Council for Counsellors in South Africa (C4CSA) is a reputable private association that meets the needs of trained lay counsellors who are not eligible for membership of professional statutory bodies such as the HPCSA or the South African Council for Social Service Professions (SACSSP). The Council has minimum standards for membership; charges a low annual membership fee; requires ongoing evidence of competence from member counsellors and participation in further training; provides ethical guidelines for lay counsellors; and, delivers an advisory service about professional ethical issues. Hence the C4CSA could assist in ensuring that behavioural health counsellors meet minimum educational and training requirements to qualify for registration; that they are provided with an ethical code of conduct for their work (and offered guidance regarding ethical issues); and, are informed about opportunities for continuing training and development to ensure their skills levels remain relevant. The Council should also have the authority to discipline behavioural health counsellors for unprofessional or unethical conduct and to instil a sense of personal pride regarding professionalism and career development.

Nevertheless, for behavioural health counsellors to render a competent and effective service in the medium to long term, additional policy measures need to be put in place:

- Behavioural health counsellors need to become permanent employees within the health system, rather than being seen as dispensable casual or temporary workers, with the accompanying risk of demotivation, poor job performance and high turnover.
- They should function as members of a team. It is crucial that they receive appropriate support and help where needed from health providers with greater MNS competence, and that they are not isolated, nor have inappropriate tasks allocated to them.
- They should be remunerated fairly and given employment benefits, usually mandatory when skilled individuals are taken into permanent employment in the public sector (such as paid annual leave, maternity and sick leave, co-payment into a designated pension scheme or retirement funds, etc.)
- Behavioural health counsellors should have a designated career path within the health sector, with opportunities for further skills development (such as developing additional expertise in engaging with young people, with older persons or with another population demographic, or developing more in-depth knowledge within a particular interest area, such as components of a healthy diet or addressing substance use disorders). Counsellors with longer service within the health sector should be afforded recognition and offered an opportunity to mentor others, and to transmit their acquired knowledge to younger, inexperienced colleagues. There should be possibilities for promotion and opportunities to take on additional responsibilities in behavioural health counselling (such as expanding psycho-education into other sub-communities or assisting the education sector in the health education of young people).
- Individuals in this subcategory should receive appropriate, short, in-service training and re-training as soon as they are taken into permanent employment, i.e. further training should be provided beyond their six-month trial period and the crucial initial training, including competency assessments. All behavioural health counsellors benefit from periodic refresher training to re-instil enthusiasm and reinvigorate their practice. Regular training will also enable updating of their knowledge base and increase their awareness of current, important research about healthier lifestyle choices.
- They should receive supervision, mentoring and regular debriefing from a psychology care provider with greater expertise who also works in the health sector. Ideally, this would be a registered counsellor with a B Psych qualification and workplace experience. In the absence of a registered counsellor, the responsibility of mentoring and debriefing should be assigned to an appropriately trained clinical, counselling or educational psychologist, or to a social worker, all of whom have the competence to carry out these tasks. Peer-to-peer supervision could also be considered in areas where specialists are lacking as well as the use of digital and telephonic supervision.
- Behavioural health counsellors can receive further technical support regarding medical issues from a professional nurse or doctor.
- They can also receive technical support regarding the functioning of their clients in the activities of daily life for the promotion of a healthy lifestyle and disability inclusion from an occupational therapist who works as a member of the district specialist health team.

7.2.2 Core strengths

Since this is a new proposed category of a health care provider, there is no readily available scope of practice for behavioural health counsellors.[t] However, the role description above would align well with the following competencies:

- Demonstrates awareness of basic signs and symptoms of depression, anxiety and substance abuse (SI.1).
- Provides the patient and the community with awareness and/or education (SI.4).
- Demonstrates cultural competence (SI.5).
- Provides support for patients and their families while in treatment and care (TC.1).
- Identifies and assists patients and their families in overcoming barriers to successful treatment and recovery (TC.2).
- Demonstrates knowledge of treatment and care resources in the community (TC.6).
- Promotes mental health and substance use literacy (especially to reduce stigma and discrimination (TC.7) – this is a particular strength of the behavioural health counsellor, and perhaps where they can make a significant contribution.
- Communicates to the public about MNS disorders (TC.8) – again, this will be a core strength of this cadre of health care worker.
- Monitors for adherence to and/or side-effects of medication (TC.9) – this is a core strength of the existing body of lay counsellors, already utilised by the provincial health departments to support the HIV/AIDS and TB care and treatment programmes. Monitoring treatment adherence in the MNS disorders is a signifant strategy to prevent relapse.
- Provides links between patients and community resources (TC.11).
- Identifies available community and social resources to support patients (TC.12).
- Demonstrates knowledge of the International Classification of Health, Functioning and Disability (RD.1, Table 1).
- Demonstrates knowledge of disability models across the lifespan (RD.2, Table 1).

7.2.3 Core gaps

It is crucial to recognise that the core contribution of this sub-category of health care worker will be in relation to psycho-education, brief, structured mental health and substance use counselling, and treatment adherence. If selected behavioural health counsellors receive further training, their scope of practice could be extended beyond these competencies, but only under the strict monitoring and supervision of a more experienced health professional within the psychology sub-category.

7.3 Core competencies of registered counsellors with regard to MNS disorders

7.3.1 Introduction

Like psychometrists, registered counsellors are mid-level psychology professionals. To qualify for registration, they must complete an accredited B Psych degree with a specialisation in counselling rather than in psychometry, including a six-month, full-time internship. On completion of the degree and internship, candidates must pass a national examination before being entitled to register with the HPCSA and practise as a registered counsellor.

Registered counsellors focus on basic psychological screening, together with short-term, supportive, compensatory and routine psychological counselling interventions. They must refer individuals who require more complex or advanced psychological treatment to more qualified professionals. They are also required to work under the guidance of a qualified psychologist.

7.3.2 Core strengths

According to the HPCSA, registered counsellors may "perform a range of supportive and compensatory psychological interventions with children, adults, families and communities".[111] This definition seems surprisingly vague, particularly when it does not specify the provision of counselling to individuals or couples, which seems the most logical intervention for this type of health care worker. However, this function accords with Provides support for patients and families (TC.1) and Demonstrates ability in general counselling skills (TC.17).

One of their developmental roles is to "train and supervise mental health assistants"[u], which makes sense in the light of registered counsellors enjoying more advanced training than the latter group does. Playing this

t. The interface and distinctions between the proposed role of behavioural health counsellors and the functions of health promotion officers in WBOTs needs clarification.

u. Mental Health Assistants could appropriately be replaced with the new category of Behavioural Health Counsellor.

mentoring role could also relieve some of the pressure on registered psychologists higher in the hierarchy but fewer in number. They could also be utilised to oversee and supervise the work of the suggested new category of behavioural health counsellors.

In addition, the registered counsellor could play an important role in modelling for the benefit of behavioural health counsellors appropriate ethical conduct (including professional-patient boundaries), along with how to be respectful and non-judgmental towards patients with mental health and substance use challenges.

7.3.3 Core gaps

A core function of the registered counsellor is "to perform primary mental status screening".[112] This seems like a narrow definition which includes Demonstrates awareness of signs and symptoms (SI.1) and Demonstrates ability to monitor mental status (TC.3). The implication seems to be that if registered counsellors are to make an effective contribution to mental health service provision, their capabilities in assessing for signs and symptoms of mental illness and substance use disorders need to be expanded. In particular, the exclusion of diagnostic and neuropsychological tests from their scope of practice needs to be reconsidered. Use of such instruments could be permitted with relevant training under the guidance of a suitably qualified psychologist. Despite being a mid-level qualification, the category of registered counsellor has been assigned a very limited and sometimes overly vague list of competencies by the HPCSA. Core competencies (Table 1) which could be added, because they are capable of being adequately addressed at this level, include:

- Recognises the potential for risk to self and others (SI.2).
- Provides the patient and community with awareness and/or education (SI.4).
- Demonstrates cultural competence (SI.5).
- Demonstrates knowledge of other mental, neurological and substance use disorders orders (SI.6).
- Demonstrates ability to screen for and use screening tools (SI.7).
- Demonstrates knowledge of when to refer to next level of care (DR.1).
- Initiates and/or participates in community-based treatment, care and/or prevention programmes (TC.5).
- Promotes mental health literacy (TC.7).
- Practises good therapeutic patient interactions (TC.10).
- Demonstrates respect, compassion and responsiveness to patient needs (TC.15).
- Demonstrates knowledge of the International Classification of Health, Functioning and Disability (RD.1).
- Demonstrates knowledge of disability models across the lifespan (RD.2).

Registered counsellors play a particularly important role in substance use services where there is a dearth of appropriately qualified health professionals. With some additional training in evidence-based psychosocial models for substance use disorders, this category of health worker could operate as addiction counsellors and would be able to provide high-quality care to individuals and families affected by substance use, and also identify and address co-occurring mental health problems. They are already used by private providers in this capacity but are not reimbursed for such work in the public service.

Since registered counsellors have psychological skills that extend beyond a grasp of elementary psychology, it would be useful, once they have acquired sufficient experience of working in a clinic setting, for them to assist with group debriefing of certain other health care workers, such as nurses and occupational therapists. This would fit with Provides mentoring and support to other health care providers (TC.42) and would lighten the burden which registered psychologists carry in terms of providing extensive debriefing to most other health care workers. Instead, registered psychologists in a health setting could shift their focus to mentoring and oversight of the work of registered counsellors and, where necessary, trauma counselling.

7.4 Core competencies of psychometrists with regard to MNS disorders

Psychometrists are entitled to obtain registration with the HPCSA and to practise after four years of study and proof that they have served a short internship. According to the HPCSA,[112] "The role of the psychometrist is to make psychological assessment accessible In order to promote the psychological wellbeing of the diverse South African population".

South African HPCSA regulations restrict the scope of practice of psychometrists to administering and scoring a limited range of psychological test instruments and specifically exclude them from the administration of test instruments to assess psychopathology or levels of functioning and disability. Hence they are currently not permitted to use any test instruments which assess for any form of mental illness. However, it is suggested that if their scope of practice could be amended to include administration of elementary screening tools for anxiety, depression and substance use. They could be employed in a primary health care setting, under the supervision of a registered counsellor or a clinical or counselling psychologist, to conduct such elementary screening, shifting the burden of this task from nurses and/or clinical or counselling psychologists.

Psychometrists are, however, permitted to measure cognitive functioning, aptitudes and interests. Hence they can be readily utilised in educational settings such as schools, working under the close supervision of an educational psychologist, and assist in screening child and adolescent learners who present with poor scholastic performance or behavioural challenges. At present, their scope of practice is limited to common developmental disorders occurring in childhood and does not extend to substance use problems and other risk behaviours. Their training should be extended to ensure that it covers a broader range of potential behavioural challenges (particularly as substance use often begins in early adolescence). Psychometrists could be delegated to use educational screening tools to ascertain the underlying problem and provide preliminary feedback to a supervising educational psychologist, who could then make appropriate decisions and recommendations for remedial intervention or counselling within the education system. In this way, psychometrists could make a useful contribution to the mental health and well-being of children and adolescents.

7.4.1 Core strengths

Psychometrists would, therefore, be able to contribute with regard to children and adolescents in relation to the following competencies:

- Awareness of common signs and symptoms (SI.1).
- Recognising risk to self and others (SI.2).
- Providing community and patient awareness and education (SI.4).
- Demonstrating cultural competence (SI.5).
- Providing support to patients and families (TC.1).
- Assisting patients and families to overcome barriers to treatment and recovery (TC.2).
- Ability to offer emergency first aid (TC.4).
- Promotion of mental health literacy (TC.7).
- Providing links between patients and community resources (TC.11) and identifying resources to support patients (TC.12).
- Promoting activities to raise awareness and improve uptake of services (TC.13).
- Demonstrate respect, compassion and responsiveness (TC.16).
- Demonstrates knowledge of the International Classification of Health, Functioning and Disability (RD.1).
- Demonstrates knowledge of disability models across the lifespan (RD.2).

These competencies relate essentially to all provider types. However, psychometrists will also have more specialist competence for children and adolescents regarding Ability to screen and use screening tools (SI.7); Skill in the assessment of social, cognitive and physical functioning (DR.3); and, skills in using functional assessment tools (DR.5).

7.5 Core competencies of counselling psychologists wth regard to MNS disorders

Counselling psychologists are required to have a Masters degree, which takes a minimum of six years, including serving a year of internship in a registered institution, as well as a period of community service.

According to the HPCSA, the scope of practice of counselling psychologists is to "assess, diagnose and intervene with people in dealing with life challenges and developmental problems to optimise psychological well-being".[112] To a significant extent, the work of clinical and counselling psychologists overlap. However, the exposure of the counselling psychologists during training to a more limited range of psychopathology.[113] Essentially focusing on individuals who are struggling with life challenges or diagnosed with adjustment disorders (and excluding more severe and potentially disabling forms of mental illness such as bipolar disorder or psychoses), means that counselling psychologists are best equipped to work with more functional individuals, and less likely to be hospitalised for mental illness, particularly on an involuntary basis. Therefore, they are well qualified to work in community settings in the district health service.

7.5.1 Core strengths

With regard to screening and identification, counselling psychologists need to be aware of the limits of their scope of practice, and to avoid working beyond these boundaries by referral, wherever possible, of more disabling forms of mental illness to clinical psychologists and/or psychiatrists. This is not clearly explained in the HPCSA scope of practice for this group, and it would be useful for this caveat to be made more clearly and overtly, including competencies in disability and rehabilitation (Table 2.1-6)

With regard to SI.1 and the screening competencies of counselling psychologists, 'common signs and symptoms' need further delineation. There needs to be an explicit definition of what constitute 'less common signs and symptoms' which are beyond the competence of a counselling psychologist working in a primary care setting in terms of screening and identification. Clearly, such exclusionary criteria might comprise signs of psy-

chosis, major depression and delusional disorder. Training and competencies need to be explicitly expanded to include substance use disorders (currently absent from training or severely limited in scope).

Counselling psychologists are particularly skilled at identifying the complexities of 'developmental problems', psychopathology in response to 'life challenges' and 'disorders of adjustment', and such aspects of screening and diagnosis should be added to the core competencies of this category of health professional.[114] There needs to be a more explicit explanation of what constitutes lifestyle challenges. Historically, psychologists have received limited training in recognising and addressing substance use disorders. As this is in its own right a lifestyle challenge but also often accompanies trauma, and disorders of adjustment, the role of counselling psychologists in assisting clients with these problems needs to be clear.

The scope of practice of counselling psychologists refers to the implementation of 'psychological interventions', while core competencies list 'Demonstrating ability in 'general counselling skills' (TC.17). However, there is no explicit mention in the list of a core competence which all counselling psychologists acquire, namely providing psychotherapy (whether for individuals, couples, families or groups). This is a more advanced skills-set than counselling, and arguably of great importance in the effective management of MNS disorders. Counselling psychologists are well equipped to model for registered counsellors how to run structured support groups for mental health patients and their families, and to mentor registered counsellors as they develop the appropriate interpersonal skills.

Since counselling psychologists undergo an additional two years of training in comparison with registered counsellors, they should be able to facilitate groups in a more sophisticated way than the latter, i.e. they could facilitate family therapy groups and psychotherapeutic groups which focus on the interpersonal dynamics of their members.

They should also be able to mentor registered counsellors and behavioural health counsellors in three critical areas:

- discerning signs of risk to self and others, and what action to take ('emergency first aid') (SI.2 and TC.4);
- discerning severity of presenting psychopathology (including substance use disorders) and responding appropriately (DR.9); and,
- understanding necessary forms of referral for different presentations of mental illness and substance use disorders (DR.1).

In practice, given a broad enough exposure to psychopathology during their internship training, experienced counselling psychologists should be able to carry out most of the core competencies identified for all providers, together with the additional competencies listed, apart from:

- Demonstrates the ability to select appropriate treatment based on an understanding of diagnosis (TC.19).
- Demonstrates knowledge of standard drug regimens (TC.41).

Counselling psychologists are also well equipped to have greater involvement in the debriefing of a range of health care workers working in primary health care settings, including nurses, clinical associates, occupational therapists, medical practitioners and psychiatrists. They can also provide training of psychology health workers with lower levels of training in enhanced counselling skills, identification of common mental disorders and self-care. Furthermore, they could train industrial and educational psychologists in the identification and management of a broad range of mental disorders.

7.5.2 Core gaps

Although knowledge of standard drug regimens is not currently a core competence for counselling psychologists, it is suggested that a rudimentary knowledge of basic pharmacology and when pharmacology may be a helpful adjunct to psychotherapy with regard to life challenges and disorders of adjustment would be a useful competence to add to their scope of practice. This would not be with the intention of equipping counselling psychologists to prescribe medication for patients, but rather enable them to discern when patients are taking incorrect dosages of drugs, inappropriate combinations of medication or experiencing serious side-effects, and to make the appropriate referral to other health care workers.

7.6 Core competencies of clinical psychologists with regard to MNS disorders

Clinical psychologists are required to have a Masters degree, which takes a minimum of six years, including serving a year of internship in a registered institution which provides exposure to a wide range of psychopathology, as well as a period of community service, prior to registration with the HPCSA.

In South Africa clinical psychologists should constitute an invaluable group of professionals to draw upon to help address the unmet needs for the care and treatment of individuals with MNS disorders. However, the low remuneration offered to clinical psychologists in the public sector has meant that they are more likely to work in private psychotherapeutic practice or in the private sector in a wide range of capacities, where they are better remunerated than the public health sector. The ongoing shortage of clinical psychologists in the public sector has meant that most of the burden of the management of more severe mental illness has been passed on to any nurses with minimal psychiatric training or experience, and to already overburdened psychiatrists.

7.6.1 Core strengths

Clinical psychology interns should receive exposure to a wide range of psychopathology. They are often placed in state psychiatric institutions where they deal with patients with severe mental illness. These include psychoses, which are often co-morbid with substance use disorders, severe antisocial personality disorder, paraphilias and so on. It is essential that clinical psychology internship placements also include a rotation in community and primary care settings, both to expose trainees to practice in these environments, and to prepare them to supervise and train B Psych Counsellors, Behavioural Health Counsellors and non-specialist health workers, using a task-sharing approach. Clinical psychologists' broad exposure to psychopathology will be similar to that experienced by psychiatric registrars, although their scope of practice with regard to the management of such psychopathology, particularly relating to legal aspects and psychopharmacology, will be more limited.

Given the training provided, the HPCSA defines the scope of practice of the clinical psychologist more broadly than for any other sub-category of psychologist, with a focus on life challenges, developmental issues, and psychopathology or psychiatric disorders.[113] However, it is unclear why both psychopathology and psychiatric disorders are listed in the scope of practice, or whether this suggests that the HPCSA sees these categories as different.

In practice, experienced clinical psychologists should be able to carry out most of the core competencies identified for all providers, together with the additional competencies listed, apart from:

- Only partial competence in Demonstrates ability to select appropriate treatment based on an understanding of diagnosis (TC.19).
- Lack of competence in Demonstrates knowledge of standard drug regimens (TC.41).
- Partial competence in disability inclusion and comprehensive rehabilitation technologies (CBR, vocational, psychosocial, assistive technology) (Table 2: RD. 1-6).

The scope of practice of clinical psychologists mentions implementation of 'psychological interventions', while core competencies refer to demonstrating an ability in 'general counselling skills' (TC.17), but it is noteworthy that there is no explicit mention of the core competence of most clinical psychologists, namely the provision of short-, medium- and long-term psychotherapy (whether individual, couple, family or group). This is a more advanced skills-set than counselling, and arguably has crucial importance in the effective management of MNS disorders.

Clinical psychologists are also well equipped to have greater involvement in the support of a range of higher-level health care workers working in primary health care settings, including nurses, clinical associates, occupational therapists, medical practitioners and psychiatrists. They can also provide training and supervision to psychology health workers with less/narrower training in psychopathology, as well as counselling psychologists and industrial psychologists.

7.6.2 Core gaps

Developing an understanding of standard drug regimens is not currently in the scope of practice of clinical psychologists. Knowledge of basic pharmacology in relation to MNS disorders could be a useful addition to their scope of practice, enabling them to discern medication challenges which patients experience and to make the appropriate referral to more highly qualified health care workers such as nurses, medical practitioners and psychiatrists for revaluation of pharmacology, where necessary. Training needs to be extended to ensure a greater focus on the diagnosis and treatment of substance use disorders and co-occurrence of these with other mental disorders, given the increasing burden in the country and within psychiatric and health services and rehabilitation (Table 2: RD.1-6).

7.7 Core competencies of neuro-psychologists with regard to MNS disorders

Neuro-psychologists are required to have a Masters degree, which takes a minimum of six years, including serving a year of internship with an appropriately registered institution which provides exposure to a range of

neurological pathology and dysfunction, as well as a period of suitable community service. It is a relatively new category of registration.

According to the HPCSA, the scope of practice of neuro-psychologists is to:[v]

- assess, diagnose, and intervene in the psychological disorders of people experiencing neuropathology or compromised functioning of the central nervous system;
- diagnose, and evaluate psychological disorders caused by neurological conditions and differentiate them from other psychological and non-neurological disorders;
- treat, and rehabilitate the psychological disorders of people suffering from central nervous system dysfunction;
- refer patients to appropriate professionals for further assessment or intervention;
- advise on policy development, based on neuropsychological theory and research;
- design, manage and evaluate neuropsychologically based programmes;
- design, manage conduct, report on, and supervise neuropsychological research;
- train and supervise other registered psychological practitioners in neuropsychology; and,
- conduct psychological practice and research, adhering to the scope of practice of neuropsychologists.

7.7.1 Core strengths

Apart from psychiatrists and neurologists, neuro-psychologists are the only category of health care provider with general competencies regarding screening, identification, diagnosis, referral, and care of individuals with a broad spectrum of neuropsychological disorders and disabilities. Their scope of practice should thus cover almost all the competencies in Tables 1 and 2 (i.e. both broad and more specialised competencies), but only in relation to neurological issues – i.e. excluding full competence regarding mental health and substance abuse. However, even in relation to neurological disorders, neuro-psychologists will lack the following competency:

- Demonstrates knowledge of standard drug regimens (TC.41).

Given focused additional training concerning psychopharmacology, from experienced psychiatrists and/or neurologists, neuro-psychologists should be able to develop limited additional competence in relation to TC.41, although prescription of drugs would need to be conducted by medical practitioners.

Neuro-psychologists are well equipped to support and mentor a range of higher-level health care workers working in primary health care settings in relation to neurological disorders, including other categories of psychology, nurses, clinical associates, occupational therapists, and medical practitioners. They can also provide training in management of neurological issues and help develop appropriate district-level interventions and programmes to address unmet needs for neurological diagnosis, screening, care and treatment, in addition to helping create effective prevention programmes, and assessing efficacy of neurological care and treatment interventions.

7.8 Core competencies of educational psychologists with regard to MNS disorders

The scope of practice of educational psychologists is focused on 'assessment, diagnosis and intervention In order to optimise functioning in the broad context of learning and development',[111] which suggests that they have limited skills to offer in a primary healthcare setting. However, their focus on children and young people and 'psychopathology in relation to development'[55] suggests that they may be a useful additional resource to draw upon with regard to addressing the mental health needs and risk behaviours of younger patients, particularly given the shortage of healthcare workers with knowledge or experience of addressing the mental health needs of children and adolescents. They should ideally be placed in the school health services (one of the streams of re-engineered Primary Health Care.[93]

The competencies of educational psychologists could be drawn upon in a primary health setting in the following ways:

- mentoring other healthcare workers regarding developmental, mental health and substance use issues in relation to children and adolescents;
- modelling and supporting other sub-categories of psychology to support groups for children and young people who attend primary healthcare for mental health and substance use issues; and,
- advising on universal design for learning in home, education and play environments (Table 2: RD.6)

v. Information downloaded from Health Professions Council of South Africa website - https://hpcsa.co.za/

n addition, educational psychologists could help in the bridging of primary healthcare services in mental health and in education, making referral in both directions easier and collaborative case management possible (e.g. referral of learners in schools with mental health and substance use issues into primary health care, and communication with schools to ensure appropriate support is provided at schools to children and young people with these challenges).

7.8.1 Core strengths

Educational psychologists' competence is essentially limited to children and adolescents, and primarily in relation to cognitive and learning difficulties, with some knowledge of broader psychopathology regarding this age group. Hence educational psychologists should be able to cover all the competencies listed for this sub-group of the population, with the proviso that with regard to more severe psychopathology they would benefit from the additional input of experienced clinical psychologists, professional nurses with advanced psychiatry training, paediatric occupational therapists and or psychiatrists.

7.9 Core competencies of industrial psychologists with regard to MNS disorders

Industrial psychologists are required to fulfil all the requirements for a Masters degree (including a research component), to serve an internship in a workplace setting and complete a period of community service before they are permitted to register with the HPCSA. The scope of practice of industrial psychologists limits their work to workplace settings, to addressing the challenges which arise in workplaces and to meeting the needs of individuals for vocational guidance and assistance in making appropriate career choices. Although industrial psychologists are not equipped to address the care and treatment needs of MNS patients in a health care setting, they have the skills and competence to:

- Detect conflict in the workplace and discern the roots of such conflict.
- Design interventions to strategically address the underlying causes of workplace conflict.
- Identify individuals who are particularly vulnerable to work stress and burnout and offer appropriate support and assistance.
- Identify individuals who are using maladaptive coping mechanisms (e.g. substance use) to cope with stress and burnout.
- Design workplace intervention programmes to reduce stress and equip all employees with appropriate skills to manage stress more appropriately.
- Identify individuals in workplace environments who manifest symptoms and signs of mental illness and substance use.
- Provide confidential and safe referral systems to enable such individuals to access care, treatment and work rehabilitation including supportive employment and reasonable accommodation confidentially and safely by health providers with the requisite skills.
- Provide organisations, managers and employees with training regarding all aspects of dealing with diversity and difference including reducing stigma towards employees with mental health and substance use problems and creating an enabling environment for employees with substance use problems, to support their return to work and full functioning, and to reduce their risk of relapse.
- Train management regarding leadership, team-building and how to create a healthy workplace environment which takes account of cultural diversity.

7.9.1 Core strengths

Industrial psychologists will be able to make a limited but important contribution to MNS screening, diagnosis and care, focused primarily on diagnosis of less-severe psychopathology, and essentially those forms which are more likely to manifest in the workplace. They will also be able to assist in management of workplace conflict, refer on for care, treatment and rehabilitation where needed, and demonstrate cultural competence and management of diversity (including mental health and neurodiversity) in workplace settings. Hence their competence will be primarily in relation to competencies for all provider types, particularly the following:

- Awareness of common signs and symptoms (SI.1).
- Recognising risk to self and others (SI.2).
- Providing community and patient awareness and education (SI.4).
- Demonstrating cultural competence (SI.5).
- Providing support to patients and families (TC.1).
- Assisting patients and families to overcome barriers to treatment and recovery (TC.2).
- Ability to offer emergency first aid (TC.4).
- Promotion of mental health and substance use literacy (TC.7).
- Providing links between patients and community resources (TC.11) and Identifying resources to support patients (TC.12).

- Promoting activities to raise awareness and improve the uptake of services (TC.13).
- Development of appropriate and enabling workplace policies for addressing substance use in the workforce.
- Demonstrate respect, compassion and responsiveness (TC.16).

They also have competencies in workplace adjustments for disability inclusion and reasonable accommodation (Table 2 RD.2, RD.4 and RD.5).

7.10 Core competencies of research psychologists with regard to MNS disorders

Research psychologists are required to have completed a Masters degree in research psychology and to design, complete and write up the results of a research study of adequate scope, prior to registration with the HPCSA.

In terms of their scope of practice, research psychologists are not permitted to engage in psychological assessment of individuals who present with MNS difficulties, nor are they permitted to deliver psychotherapeutic services. However, they have a unique set of skills in the planning, development and completion of psychological research studies. This, together with a particular expertise in devising and implementing monitoring and evaluation (M&E) programmes means that they are able to play a unique and valuable role in MNS care, treatment and rehabilitation programmes, namely, ensuring that programme M&E takes place regularly and that M&E processes are objective, cost-effective and provide clear and useful outcomes.

Research psychologists are able to meet the need for M&E in MNS care, treatment and rehabilitation in various ways:

- They are able to devise M&E tools to determine the efficacy of different aspects of programmes and their cost-effectiveness.
- They can design an efficient, thorough ethnographic research strategy to determine the obstacles and barriers which different categories of MNS patients encounter in attempting to access MNS care, treatment and rehabilitation services. The findings of such research contributes to the development of better care, treatment and recovery orientated, community-based services, and increased uptake of health care services by MNS patients and their families.
- They can develop simple, objective tools to measure levels of client satisfaction regarding health services and provide a confidential, user-friendly problem-reporting mechanism. These provide useful feedback to health care workers to improve MNS service delivery.

Chapter 8: Social Work

Key Findings

Social work services are provided by professional social workers and social auxiliary workers. Child and youth care workers also work under the supervision of social workers and provide essential support to children in need of care and in residential care settings.

Social work services include interventions to secure the social and family well-being of individuals with MNS disorders and social workers are skilled in providing individual and group interventions.

Social workers are trained in the management of people with substance use disorders however, it is not clear how much of this training is evidence-based according to current international standards.
There is a shortage of social workers in the public sector, particularly in health departments and very limited training of clinical social workers.

Key points

This category of providers includes professional social workers (including those with further training as clinical social workers), as well as mid-level workers (including social auxiliary workers and child and youth care workers). There is a severe shortage of social workers in South Africa. Registered social workers can work in independent private practice. The majority of social workers employed in the public sector are employed by the Department of Social Development, while there are limited numbers employed by the Department of Health. Social workers are particularly skilled at providing group interventions and receive the most training of all MNS providers in the management of substance use disorders. However, this chapter provides a critique of the current approaches to intervention in substance use disorders in South Africa. There is very limited training at academic institutions in clinical social work. Clinical social workers play an invaluable role in specialist multidisciplinary mental health care teams.

8.1 Introduction

This chapter focuses on provider core competencies In relation to improved delivery of services for MNS disorders in South Africa, with a specific focus on relevant provider sub-categories which fall under the ambit of social work.

The process of critically examining the core competencies of various social work practitioners for their relevance to meeting the health needs of individuals who exhibit symptoms of any of the MNS disorders began with consideration of the full list of sub-categories of social work practitioners currently recognised by the South African Council for Social Service Professions (SACSSP). The SACSSP identifies and describes the scope of practice of the following sub-categories which fell within the general ambit of social work:

- Social workers (including clinical social workers)
- social auxiliary workers
- child and youth care workers
- auxiliary child and youth care workers
- student social workers
- student social auxiliary workers
- student child and youth care workers
- student auxiliary child and youth care workers.

The last four categories listed refer to individuals currently engaged in studies or training for social work, and hence have limited competencies and cannot work independently. They are permitted to engage in a limited range of social work activities and then only with supervision provided by an academic who trains social workers, or supervision from a qualified, experienced social worker. Further discussion regarding the contribution of the socialwork profession to MNS treatment and care is, therefore, limited to the first four categories listed.

In addition, the role of clinical social workers, who have undergone further training in managing MNS issues, will also be examined.

8.2 Severe skills shortages

Recent statistics for the number of registered social workers in South Africa are not readily available, nor does the SACSSP website provide such information. However, in 2013, in response to a question in Parliament, the Department of Social Development (DSD) reported that the country faced a s shortage of registered social workers. The DSD said that South Africa needed a total of 68 498 social workers, but as at June 2013 (the most recent date for which figures were then available), there were only 16 164 social workers registered with the SACSSP. This reflected a shortfall of 76% or nearly three out of every four social workers required to address the country's need for social- support services.

A Human Sciences Research Council (HSRC) study published almost a decade ago (2008)[115] found that a high proportion of social workers were overburdened by excessively high caseloads and many were burnt out. The study said 63% of child welfare social workers had a caseload in excess of 60, while 36% had caseloads exceeding 100. In some understaffed non-governmental organisations (NGOs) social workers were found to have caseloads exceeding 300, and, in such circumstances, the risk of negligence was believed to be almost unavoidable. Further data referred to an estimated 1.2 million orphaned and vulnerable children (OVC) in South Africa (mostly as a result of the impact of HIV and AIDS). NGO and government welfare services together were only able to reach around 200 000 of these, leaving a further million OVC to fend for themselves. The shortfall of social workers in South Africa is ongoing. Although social workers are potentially capable of making an important contribution to MNS care, the long-term national shortage of qualified individuals in this profession and the demand that social workers take primary responsibility for social-service provision means that there is a very limited number of social workers likely to be available for posts in the public health sector.

The role of the NGO sector in social-development services:

The mental health NGOs are currently responsible for the provision of in-service training to child and youth care workers as well as recently graduated social workers. NGOs are also responsible for peer-led organisations and community-based mental health recovery programmes that address psychosocial rehabilitation, work readiness and reasonable accommodation in the work/school environment.

8.3 Core competencies of child and youth care workers with regard to MNS disorders

The primary contribution made by the child and youth care workers in South Africa to social care usually occurs in NGOs or within institutional settings (such as homes for children and youth), where the target population is a particular subset of vulnerable youth and children. Child and youth care workers are rarely employed outside these contexts. Given appropriate training, they are able to make an important contribution to meeting the MNS needs of this young and vulnerable population within their specific institutional context, and, in particular, to identify and assist in the treatment of children and youth at risk for MNS disorders.

To register as a child and youth care worker, an individual has to satisfy one of the following criteria:[116]

- Obtain a professional degree in Child and Youth Care equivalent to an NQF Level-8 qualification registered with the South African Qualifications Authority (SAQA), OR
- Obtain the degree of B Tech Child and Youth Development at NQF Level 8, provided that the applicant also submits a portfolio of evidence, showing that he or she has met the outcomes reflected in the professional degree referred equivalent to NQF level 8, OR
- Prior to 2014, have obtained a degree in Human Sciences equivalent to an NQF Level-7 qualification and approved by the Council plus theoretical and experiential learning in child and youth care equivalent to 24 calendar months, supported by a portfolio of evidence, OR
- Prior to 2014, have obtained a qualification in Child and Youth Care equivalent to an NQF Level-6 qualification and approved by the Council plus experiential learning in child and youth care equivalent to 12 calendar months, supported by a portfolio of evidence.

The scope of practice of a child and youth care worker comprises:[1,2]

- developmental assessment of children and youth;
- the behavioural management of an individual child or youth, or a group of children or youth;
- design and implementation of programmes for children and youth based on their identified developmental needs;
- care and development of children and youth which enables their physical, emotional, spiritual, cognitive and social survival and development needs to be met;
- supervision of children and child and youth care workers; and,
- provision of training in child and youth care work.

Hence a child and youth care worker should show competence in the following areas with regard children and youth, particularly those who are at risk:

- Skill in assessment of the social, cognitive and physical functioning of children and youth (DR.3).
- Knowledge of appropriate information for referral (DR.4).
- Skill in using various functional assessment tools appropriate to children and youth (DR.5).
- Practice of good therapeutic relationships with children and young people (TC.10).
- Identify resources to support vulnerable young people and children (TC.12).
- Protect children and youth from harm and respect their human-rights (TC.14).
- Select appropriate treatment (i.e. develop programmes) based on an understanding of the individual's diagnosis (TC.19).
- Keep accurate records regarding care of young people and children (TC.38).
- Work as a member of a multidisciplinary team in support of children and youth at risk (TC.39).
- Mentor and support other child and youth care workers, and, in particular, supervise and oversee the work of auxiliary child and youth care workers (see below) (TC.42).
- Knowledge of the International Classification of Health, Functioning and Disability (Table 1: RD.1).
- Demonstrate basic skills in assessment and management of disability (Table 2: RD.2, RD.4, RD.6).

Child and youth care workers (CYCWs) have a particular responsibility to identify as early as possible children and young people at risk for MNS disorders and refer them for prompt care and treatment, In order to reduce the risk of development of further difficulties in adulthood. They also have a pivotal responsibility to develop prevention programmes for vulnerable children and youth and to provide age-appropriate psycho-education for children and young people regarding MNS disorders and mental health (SI.4 and TC.7). The only reference to any specific MNS disorder-related competency is:

"Describe how to manage substance abuse and addiction in the workplace", which is an elective option, and does not even appear to address the issue in children and adolescents under the care of the CYCW.

8.4 Core competencies of auxiliary child and youth care workers with regard to MNS disorders

To register as an auxiliary child and youth care worker, an individual has to satisfy the following criteria:[2]

- Obtain a Further Education and Training (FET) Certificate in Child and Youth Care equivalent to an NQF Level-4 qualification registered with SAQA, OR
- Obtain theoretical and experiential learning prior to the commencement of compulsory registration approved by the Council equivalent to 1 650 notional hours, provided that the applicant submits a portfolio of evidence, proving that the candidate meets the outcomes reflected in the FET Certificate in Child and Youth Care Work.

The scope of practice of an auxiliary child and youth care worker includes the following, always with supervision from a registered child and youth care worker:[2]

- provision of basic and developmental care of children and youth where their physical, emotional, spiritual, cognitive and social needs are protected;
- application of behaviour management and support techniques in routine child and youth care work;
- assistance in implementation of programmes and activities for children and youth based identified developmental needs;
- participation in developmental assessment of children and youth;
- undertaking of basic child and youth care work administration;
- participation in a multidisciplinary team;
- implementation of life-space work in the routine child and youth care work context; and,
- promotion of the rights of children and youth.

It needs to be noted that auxiliary child and youth care workers are only entitled to work under the supervision of a registered child and youth care worker. Their competencies include:

- Skill in the assessment of social, cognitive and physical functioning of children and youth (DR.3).
- Skill in using various functional assessment tools appropriate to children and youth (DR.5).
- Practice of sound therapeutic relationships with children and young people in their care (TC.10).
- Identification of resources to support vulnerable young people and children (TC.12).
- Protection of children and youth from harm, and respect for their rights (TC.14).
- Keeping accurate records regarding the care of young people and children (TC.38).
- Working as a member of a multidisciplinary team in addressing the vulnerabilities of youth and children (TC.39).

Although they are not able to initiate programmes, auxiliary child and youth care workers can assist in prompt and early identification of children and young people at risk for MNS disorders and refer to their supervisors for appropriate decisions regarding care and treatment. They also have an important role to play in the roll-out of prevention programmes for vulnerable children and youth, and provision of mental health psycho-education for children and young people, including how to seek help when necessary (SI.4 and TC.7). Their competencies regarding children with disabilities associated with MNS disorders (for example, developmental delay arising from a dual diagnosis of intellectual disability, cerebral palsy and epilepsy) are unclear (Table 2: RD.2, RD.4, RD.6).

8.5 Core competencies of social workers with regard to MNS disorders

A social worker has to have obtained a school-leaving certificate, and subsequently satisfied the criteria for admission to study in a Department of Social Work attached to one of 18 recognised higher-education institutions (HEIs) in South Africa accredited to offer social work training. According to the South African Qualifications Authority (SAQA),[117] a South African Bachelor's Degree in Social Work (BSW) is a qualification obtained after four years of study and is the equivalent of an Honours postgraduate degree in other fields. SAQA stipulates that the BSW degree should equip learners with the following core skills:

- An ability to challenge structural sources of poverty, inequality, oppression, discrimination and exclusion.
- Knowledge and understanding of human behaviour and social systems, along with the skills to intervene at appropriate places in the environment to promote social well-being.
- Competence to assist and empower individuals, families, groups, organisations and communities to enhance their social functioning and enhance their problem-solving capacities.
- Promoting, restoring, maintaining and enhancing the functioning of individuals, families, groups and communities by enabling them to accomplish tasks, prevent and alleviate distress and use resources more effectively.
- The ability to provide social work services which protect especially people who are vulnerable, at risk or unable to protect themselves.
- Knowledge and understanding of the South African and global welfare contexts and an ability to implement the social-development approach in social work services, and
- Skills to work effectively within teams, including multi- and inter-disciplinary teams.

The scope of practice of a social worker enables her or him to execute all of the following tasks:

- supervise the work of a maximum of two auxiliary social workers;
- plan the provision of social welfare services;
- provide therapeutic services to clients;
- render statutory services to clients, for example, in terms of the Child Care Act of 1983; and,
- write statutory reports or reports concerning therapeutic interventions.

The South African social work profession aims to promote social change and to encourage problem-solving with regard to human relationships. It works towards the empowerment of the clients of social services, so as to enhance their well-being. Since it utilises theories about human behaviour and the effects of social systems on people, at its best social work is able to intervene strategically to secure maximum benefits for its clients.

If adequately trained, South African social workers should be well equipped to deal with many of the consequences of social inequality, poverty and marginalisation, including the effects of unemployment, child abuse, gender-based violence, crime, substance abuse and addiction, and HIV/AIDS.

Few of the skills listed above align directly with the core competencies required for MNS services, apart from some specified competence to engage with substance abuse and addiction, a particular set of skills which is critical, since it is seldom a core competency for members of other professions.

8.6 Core competencies to address substance use disorders

The current therapeutic interventions of most South African social workers with regard to those who have substance use problems tends to be limited to:

Counselling regarding the long-term and damaging impact of substance use on the individual user and his or her immediate social network. However, in practice such counselling too often assumes the form of a one-way conversation with the user, employing implicit or explicit threats to withdraw or withhold social grants and other privileges, should the substance use continue.

- A second common intervention which social workers use with substance users (especially those abusing alcohol) is to refer such individuals to rehabilitation services - either residential treatment programmes (which

are generally very costly) or to an outpatient treatment facility. There are very limited places available in residential rehabilitation programmes provided by the public sector and funded fully by the state. Indeed, such referral often means being added to a waiting list until a place becomes available.
- Therapeutic social worker interventions regarding substance use are often ineffectual in the absence of the user's personal motivation to change their problematic behaviours regarding use.

According to the United Nations Office on Drugs and Crime (UNODC), criminalisation of individuals' substance use has been shown worldwide to be an ineffectual strategy and to have additional high social and health costs (including high incarceration rates),and hence should be generally avoided in terms of effective interventions.[118] Similarly, the UNODC has described the widely prevalent model of understanding, often associated with Twelve-Step treatment approaches to substance use or abuse, which views all substance use as an addiction, and symptomatic of so-called 'brain disease' has been exposed as unhelpful and in itself stigmatising of people who use substances.[119] Very little policy attention is given to the development of a multipronged workforce (for example, law enforcement, town planners and social development practitioners) that could collaborate with health professionals in addressing the social determinants of substance abuse.

The South African National Drug Master Plan (NDMP) 2013-2017, unfortunately, addresses few of the concerns listed above and instead utilises a disease-model approach; engages in policies which increase stigmatisation and isolation of users; and looks to law-enforcement strategies to curb substance use, together with rehabilitation of users as a specified primary outcome. However, it does acknowledge the need to provide better recreational facilities and diversion programmes for so-called 'vulnerable populations' to reduce substance use and abuse; speaks to a multidisciplinary approach; and, makes mention of a harm-reduction approach, although limiting this to needle-substitution programmes for injecting drug users. The definition of harm reduction in the National Drug Master Plan needs to be expanded to include educating the broader population, particularly young people, about safe and responsible use of alcohol and other substances as well as opiate-substitution therapy for those using opiates.

In South Africa, there is extensive research evidence that the use and abuse of alcohol cause more social harm than use and abuse of all other substances combined. The 2011 Global Status Report on Alcohol and Health published by the World Health Organization[120] estimates the average annual adult per capita alcohol consumption over the period 2003-2005 in South Africa as 7,0 litres for recorded alcohol, 2,5 litres for unrecorded alcohol and 9,5 litres in total. The total figure is more than 50% higher than the corresponding figure for Africa as a whole. The 2008 South African youth risk behaviour survey among learners in Grades 8 to 11 provides evidence of the extent of alcohol use and abuse amongst school learners. Some 41% of males and 30% of females admitted that they had a 'drink' of alcohol on one or more days in the month before the survey, and 34% of males and 24% of females admitted to past-month 'binge' drinking (i.e. imbibing five or more 'drinks' within a few hours on one or more days in the month before the respective surveys). Here nuanced psycho-education on the safe use of alcohol in schools and community settings would be a more effective intervention than the employment of fear messages in Information and Communications Technology (ICT) campaigns.

As Kalichman *et al.*[121] have demonstrated through the *Phaphama Bammelwane* study, multi-level interventions involving community education coupled with training men to act as agents of change and to alert the community to the risks of HIV associated with heavy alcohol use can show long-term benefits.

In South Africa, the research evidence is clear that public health messages about the dangers of alcohol and drug use, as well as drug testing, have been largely ineffectual in curbing such use. A South African Medical Research Council (SAMRC) briefing in 2012 reported that family parenting programmes, environmental classroom programmes, skills-building interventions, and life skills and social-skills classes relating to drug use were much more effective in dealing with alcohol and substance abuse.[122]

Messaging regarding substance use or abuse needs to be augmented with a harm-reduction approach[123] (as has been shown to be effective in addressing the harms of injecting drug use), and by public education on what constitutes safe and responsible use of alcohol and other substances. This work needs to be situated in a broader initiative to address the underlying drivers of substance abuse, including social norms relating to substance use, harmful masculinities and social exclusion. Community-based interventions based on occupational science that address alcohol consumption as a collective occupation and facilitate social-change processes towards occupational substitution (for example, healthy time-use patterns and lifestyle choices) have had demonstrable impact amongst pregnant women in rural wine farming communities with high incidence of Fetal Alcohol Spectrum Disorder.[124]

Social workers' engagement with clients involved in substance use has been shown to be more effective when they:

- engage purposefully with the client to assess their self-perception of substance use;

- are able to persuade the client that substance use is in itself problematic, i.e. has negative consequences for the client and/or for others in the client's immediate social circle;
- work towards enhancing the client's social connection to other members of the community, rather than stigmatising or isolating them;
- the client shows evidence of readiness to begin to change their behaviour in terms of use;
- the client receives meaningful social support for change in user behaviour; and,
- the client is willing to commit to participating actively in an available rehabilitation or change programme.

For substance use and abuse to be addressed adequately and to ensure that MNS treatment and care has a meaningful impact on substance users, it will be necessary for social workers to develop the following additional competencies and skills:

- Rather than seeing the client's substance use as a symptom of 'brain disease' or a reflection of individual failure and/or individual pathology, social workers need to understand substance use in its specific social context, just as they do for other social challenges.
- Crucial contributory factors to substance use such as poverty and the lack of accessible social and recreational facilities need to be addressed through structural community interventions.
- Social workers need to focus on alleviating users' social isolation by building social connectedness in communities.
- Engaging in substance use as a form of self-medication needs to be better understood and, where appropriate, referral made for more appropriate psychiatric assessment and medication of the user.

8.7 Core strengths

Social workers are equipped in terms of their scope of practice to do all of the following:[125]

- Provide the patient and community with awareness and/or education ((SI.4).
- Demonstrate knowledge of when to refer to the next level of care or other providers (DR.1).
- Demonstrate knowledge of providers for specialised care within the community (DR.2).
- Provide support for patients and families while in treatment and care (TC.1).
- Identifies and assists patients and families in overcoming barriers to successful treatment and recovery (including especially stigma and access to social support) (TC.2).
- Initiates and/or participates in community-based treatment, care and/or prevention programmes (TC.5).
- Demonstrates knowledge of treatment care and resources in the community (TC.6).
- Promotes mental health literacy (especially regarding stigma (TC.7).
- Provides links between patients and community resources (TC.11).
- Promotes activities that aim to raise awareness and improve the uptake of interventions (TC.13).
- Protects patients and identifies vulnerabilities (TC.14).
- Demonstrates knowledge of, and ability to apply relevant legislation and policies, and access to appropriate services (TC.28).
- Assists patients with access to other providers (TC.36).
- Demonstrates knowledge and skills to consult with other providers in the treatment/care team (TC.39).
- Demonstrates knowledge and skills to provide proactive follow-up (TC.40).
- Provides mentoring and support to other health care providers (TC.42).

A number of core social worker strengths emerge from a perusal of this list, particularly focused on supporting patients and their families through the treatment and care process and making use of their extensive knowledge of available community resources for support, including providing a formal referral to such resources. Few other members of the health care team are likely to share experienced social workers' potentially comprehensive knowledge of community resources across the range of health and social services.

A particular strength that social workers can bring to MNS services is their contextual understanding of problematic behaviour. They are particularly skilled at understanding dysfunctional patterns (including MNS disorders) within the individual's social or family context. Their sensitivity to context enables them to readily perceive and comprehend the nature of contextual stressors, including social causes and contributors to the development and, even more importantly, the persistence, of mental illness. (Although this is not a direct reflection of Demonstrates cultural competence (SI.5), it can be seen as requiring at minimum a more developed cultural sensitivity on the part of social workers.)

The focus in social work training on ethical issues and a rights-based approach also equips social workers with the particular aptitude to be an advocate for patient's or client's human-rights, and to offer onward referral for legal assistance when such rights have been formally breached. Social workers, like psychologists, should be attuned to issues regarding stigma about MNS issues, and able to help co-ordinate psycho-educational campaigns to enlighten communities and patients, and assist in stigma reduction. In this regard, social workers and occupational therapists are complementary partners for planning, coordinating, and supervising

(through task-shifting functions) the roll-out of district–level, community-based rehabilitation programmes (Table 2: RD.1-6).

The training of social workers to carry out a coordinating function possibly makes them natural team leaders it provides them with the skills to ensure that various aspects of care and treatment (apart from the more clinical aspects, which they will have little direct knowledge of), are fully integrated and coherent. Their formal training, which is usually not within a health context, may also lend them credibility and objectivity in enabling dialogue to take place between different members of the health care team, particularly when conflict arises. Finally, social workers are, next to psychologists, the professional group best equipped to provide regular debriefing and to mentor other members of the health team in their personal and professional development.
It is nevertheless important to make the cautionary comment that the current general shortage of social workers, and their exit from work in the public sector owing to non-competitive salaries, means that the available pool of potentially skilled social workers who can be drawn upon to carry out these important functions is likely to be very limited, unless the number of trained and retrained social workers grows exponentially within the near future. In addition, those social workers who are competent and available are likely to be overburdened and at high risk of burnout.

8.8 Core gaps

There is no evidence in the current scope of practice of social workers that they have the requisite skills to be competent in the following areas:[126]

- Demonstrate awareness of common signs and symptoms (SI.1).
- Demonstrate knowledge of required information for effective referral (DR.4).
- Demonstrate skills in using various functional assessment tools (DR.5).
- Demonstrate knowledge and skills to make a formal diagnosis and formulate a differential diagnosis (DR.8).
- Demonstrate ability to assess severity level (DR.9).
- Demonstrate ability to monitor mental status (TC.3).
- Demonstrate ability to use information technology to improve treatment and care (TC.16).
- Demonstrate the ability to select appropriate treatment (TC.19).
- Demonstrate brief advice on symptom management (TC.21).
- Demonstrate knowledge of appropriate drug regimens (TC.41).
- Demonstrate knowledge of the International Classification of Health, Functioning and Disability and knowledge of disability models across the lifespan (Table 1: RD.1, RD.2).

It is, however, unclear from the current scope of practice of social workers whether or not they have the requisite skills to:

- Recognise the risk of harm to self and others (SI.2).
- Have basic knowledge of causes (SI.3).
- Demonstrate knowledge of other MNS disorders (SI.6).
- Demonstrate the ability to screen and use screening tools (SI.7).
- Demonstrate an ability to apply contextually appropriate diagnostic systems (DR.7).
- Demonstrate an ability to make a differential diagnosis (DR.10).
- Demonstrate ability to offer emergency first aid (TC.4).
- Demonstrate the full range of rehabilitation and disability inclusion competencies (Table 2: RD. 1-6).

These gaps point to social workers generally lacking clinical knowledge and experience, which is likely to limit their ability to screen or to diagnose without additional training. Their understanding of MNS disorders is likely to be primarily psycho-social in nature, which is a useful addition to the biomedical perspective, which is the dominant frame of reference in the health care sector. However, social workers employed in a health setting need to be cautious and avoid being drawn into screening and diagnostic work, unless they have had substantial supplementary training to fill the gaps in their knowledge. This limitation limits their understanding of drug regimens and prevents their being available to assess the severity of MNS conditions.
Although assessment of risk to self and others is not mentioned explicitly as a core competence in the available resources on social workers' scope of practice, it seems important for social work training to incorporate some critical input regarding this key proficiency.

8.9 Core competencies of social auxiliary workers with regard to MNS disorders

8.9.1 Introduction

According to the Department of Social Development (2014), a social auxiliary worker provides supportive and complementary services to social workers. Such services are required to be "rendered by a social auxiliary worker under the supervision of a social worker to further the aims of social work".[126]

Social auxiliary workers focus on the following three key areas:

- prevention of social problems;
- provision of developmental services; and,
- social care.

To register as a social auxiliary worker, an individual must be in possession of a Grade 10 or equivalent certificate or an NQF level-3 qualification. They can then enroll as learners at any of the Further Education and Training College (FETC) providers affiliated to the Health and Welfare SETA (HWSETA) accredited to provide social auxiliary worker training. The FETC training lasts 12 months: 30% comprises the acquisition of relevant theory, while 70% involves practical workplace training.[w]

The social auxiliary worker qualification may be obtained either through entering into a learnership or without a learnership agreement being in place. A learnership refers to formal workplace learning process, which has a structured learning component and specific practical work experience, which leads to awarding of the NQF qualification. The learnership should be registered with the Department of Labour in terms of the Skills Development Act of 1998. A learnership agreement is entered into for a specific period between the learner, employer, and training provider.

Meeting any of the four following criteria enables registration with the SACSSP as a qualified social auxiliary worker:

- Possession of a Certificate in Social Auxiliary Work issued by the SACSSP.
- Possession of a FET Certificate in Social Auxiliary Work issued by an accredited provider with the HWSETA.
- Possession of a qualification that the SACSSP regards as equal to or higher than the FET Certificate, which may include individual assessments of applicants.
- Completion of two year-long courses in the subject of Social Work at a recognised university that include both theoretical and experiential learning.

A qualified social worker is usually expected to supervise the work of no more than two social auxiliary workers. The scope of practice of social auxiliary workers is as follows:

- Prevention, education and development programmes (such as life-skills education, economic empowerment, managing stress and conflict, preparation for the different stages of the human life-cycle, recreational programmes for specific people at risk).
- Community-based care (such as direct services aimed at addressing basic needs such as food, clothing and transport) and community or group needs (such as establishing community-based care facilities).
- Accessing and establishing resources (e.g. educating communities about how to access and use available resources, and capacitating communities and groups to establish resources) (DR.1, TC.5).
- Practical support (such as material support, practical support, emotional support, practical arrangements, recruitment of volunteers and aftercare services).
- Administrative support (such as opening social-service files, keeping records, taking minutes of meetings, keeping statistics).
- Conducting simple research tasks (such as completing questionnaires, processing research data or implementing research findings).

According to SACSSP, the scope of practice of the social auxiliary worker specifically prevents them from doing the following:

- functioning independently of a registered social worker (i.e. they cannot work autonomously);
- planning the provision of services;
- providing therapeutic services;
- becoming involved in statutory services, for example, in terms of the Child Care Act of 1983. However, an social auxiliary worker may assist with reunification services for families after statutory social services have been provided, or
- writing statutory reports or reports about therapeutic interventions.

All these tasks fall outside the scope of practice of a social auxiliary worker and can only be carried out by a registered social worker, according to SACSSP.

22. Information downloaded from the South African Council for Social Services Professions - https://www.sacssp.co.za/Registrations/download

8.9.2 Core strengths

Social auxiliary workers have a set of skills which is constrained by the lower entry-level set for obtaining access to this professional sub-group, together with very limited training and a less academic form of learning than that provided to social workers. In addition, their ability to provide a flexible service is constrained by the requirement that they receive supervision from a social worker.

Social auxiliary workers can best provide the following forms of practical support to MNS services: engaging in community psycho-education and prevention campaigns; providing patient and family support, albeit of a more practical nature; and, ensuring that the prescribed social support takes place. They could also augment the practical support required by community health workers in the provision of basic disability inclusion, recovery and community-based rehabilitation services (Table 1: RD.1 & 2).

Where they can be most useful is in carrying out life-skills education (especially of young people) under suitable supervision; supporting recreational and patient networking initiatives; and, the delivery of practical support such as the provision of nutritional supplementation and assistance with transport and clothing. Where they detect problems in service delivery or support, it is crucial that they communicate these issues to a more senior team member who is able to take appropriate remedial action.
This means that given the appropriate support from a registered social worker, social auxiliary workers should be competent to:

- Provide the patient and/or community with awareness and/or education (SI.4).
- Provide support for families and patients while in treatment and care (TC.1).
- Identify and assist patients and families in overcoming barriers to successful treatment and recovery (TC.2), albeit under close social worker supervision.
- Initiate and/or participate in community-based treatment, care and/or prevention programmes (TC.5; RD.1).
- Demonstrate knowledge of care and treatment resources in the community (TC.6)
- Provide links between patients and community resources (TC.11).
- Identify available resources to support patients (TC.12).
- Promote activities that aim to raise awareness and improve the uptake of interventions and use of services (TC.13).
- Assist patients with access to other providers (TC.36).

8.9.3 Core gaps

Social auxiliary workers should not engage in any supervisory or mentoring activity; neither do they have the competence to provide counselling or to deal with clients' emotional or psychological difficulties. Their knowledge of the legislative framework is likely to be very limited or non-existent, and so they cannot make decisions themselves about patient care and treatment. While their observations within support groups and community settings could be usefully fed into team deliberations about optimal patient care and treatment, they should not be expected to make such decisions. They also are likely to have only a rudimentary understanding of the ethics of care, and of human-rights violations.

It is unclear how many registered social auxiliary workers there are in South Africa, and how many of them are available to work in a health care setting. This cadre of the provider are candidates for basic training in disability inclusion and community-based rehabilitation (Table 1: RD.1; RD.2).

8.10 Core competencies of clinical social workers with regard to MNS disorders

8.10.1 Introduction

A clinical social worker is an individual who has a degree in social work, is registered with SACSSP as a social worker, and has practised as a social worker for a minimum of two years, and is thereafter awarded a higher qualification, namely that of clinical social worker. This higher qualification is currently only awarded at a limited number of higher educational institutions in South Africa, usually after an additional two years of study, which includes practicum experience. Institutions offering this qualification include the Department of Social Development at the University of Cape Town (UCT),[127] and the Department of Social Work at the University of Johannesburg.[128]

The educational institutions offering the clinical social worker qualification may differ in their focus, particularly to what extent psychopathology is covered, and whether practicum involving adult and child psychotherapy is a central component of the training programme. Hence the discussion which follows regarding core competencies needs to be read with caution. The description of core strengths is based closely on the de-

scription of the UCT clinical social worker training programme. It may not necessarily apply in every detail to other training programmes.

8.10.2 Core strengths

A qualified clinical social worker will have all the core strengths of the registered social worker, together with additional competencies:

- Awareness of common signs and symptoms (SI.1).
- Ability to screen and use screening tools (SI.7).
- Knowledge and skills in taking patient history (SI.8).
- The ability to conduct a mental status examination (SI.9).
- Knowledge of required information for effective referral (DR.4).
- Knowledge of and an ability to apply contextually appropriate diagnostic systems (DR.7).
- Knowledge and skills to make a formal diagnosis and formulation of differential diagnosis (DR.8).
- An ability to determine severity level (DR.9).
- An ability to make a diagnosis based on severity level (DR.10).
- An ability to monitor mental status (TC.3).
- Ability in general counselling skills (TC.17).
- Ability to render aspects of disability inclusion, recovery and comprehensive rehabilitation (Table 2: RD. 1-6).
- Ability to select appropriate treatment based on an understanding of diagnosis (TC.19).

It should be noted that the last competency should not be understood as including knowledge of drug regimens and psychopharmacology.

Provided that clinical training during the two-year course includes sufficient exposure to both adult, and child and adolescent psychopathology, as well as practicum experience of how to provide psychotherapy to adults, together with psychotherapeutic interventions for children and adolescents, the qualified clinical social worker may have an almost comprehensive set of competencies required to address MNS disorders, with the exception of in-depth knowledge of drug regimens (TC.41). Apart from not having the competence to prescribe medication or to monitor its efficacy, the clinical social worker appears to have an advanced skills-set in relation to the effective management of MNS clients. The skills-set would be comparable to that of a clinical psychologist.

In this regard, if they were available in sufficient numbers and could be attracted to work in public health care, clinical social workers would not only be available to mentor and debrief other members of the health care team, but could also carry out the following additional functions, over and above what social workers are competent to do:

- Provide individual and couple psychotherapy, which is at a more sophisticated and advanced level than Demonstrates ability in general counselling skills (TC.17), and may even be of comparable quality to the psychotherapy which clinical and counselling psychologists are able to provide.
- Similarly, provide group psychotherapy to patients and/or their family members.
- Assist in training other members of the health team with regard to basic psychopathology and its management.
- Mentor and supervise other health team members in developing rudimentary counselling skills.
- Assist registered social workers to improve their own competencies, particularly in relation to SI.1, SI.7, SI.8, SI.9 and TC.17.

Given their wide range of competencies, this qualification would be a very useful focus area for policy development and additional funding in the MNS planning process.

8.10.3 Core gaps

There are no evident gaps. Although clinical social workers lack knowledge of psychopharmacology and drug regimens, it does not seem to be appropriate for them to be given training in these areas, given that their primary training is not biomedical, and they can be of greatest benefit in assisting clients with psychosocial and socio-economic issues.

8.10.4 Recommendations

- The Department of Social Development should encourage training institutions to intensify their recruitment of school-leavers into social work training, to help reduce the substantial current shortage of social workers.

- The curriculum for social work at all 18 training institutions should be revised. It should cover mental illness and mental health comprehensively and provide training in the use of screening and assessment tools. Future social work graduates should then be better equipped to address mental health in communities, including the provision of psycho-education (for both individuals and groups), and stigma-reduction activities targeting community prejudice regarding people with mental illness. Strengthening competencies in disability inclusion, recovery processes and comprehensive rehabilitation will also be beneficial in advancing their contribution to DSMHTs and WBOTs.

8.10.5 Conclusion

Social workers are trained to address the social well-being of the most marginalised. Their understanding of human behaviour in challenging environments is a unique skill set, enabling them to make a critical contribution to multidisciplinary mental health teams. Inclusion of MNS disorders in the social work curriculum should enhance social workers' capacity to address MNS disorders. There is an urgent imperative to incorporate mental health care into generic social work practice, in order to more effectively render services to this vulnerable population.

Finally, the size of the social-work workforce needs to increase substantially in the immediate future, to meet the demand in South Africa for qualified social-work practitioners.

Chapter 9: Psychiatrist

Key Findings

Psychiatrists work in community and hospital settings. They can provide specialised assessments and interventions in both settings. They should play a significant role in training, mentoring and supervision, as well as provide a clinical consultation service for patients with complex MNS disorders. Sub-specialists provide services in their areas of speciality, including child and adolescent psychiatry and mental health, forensic psychiatry, neuropsychiatry, addiction psychiatry, and the psychiatry of old age.

Training of specialist medical practitioners in family medicine, neurology and psychiatry take place in all medical schools, and the Colleges of Medicine of South Africa conduct the final exit examinations, ensuring that standards are consistent across the training institutions.

Specialists who graduate have a full range of competencies for providing treatment, care and rehabilitation for people with MNS disorders in their particular fields.

Psychiatrists are trained particularly to work in multidisciplinary team settings.

There should be a greater focus on training specialists to provide training and mentoring support to generalist categories in a task-shifting and task-sharing approach.

Training of psychiatrists (and neurologists) is primarily hospital-based, which is at odds with the policy of community-based care.

Key points

The training of psychiatrists in South Africa is conducted by the eight medical schools and is standardised through the establishment of a single exit examination conducted by the College of Psychiatrists of South Africa. The College has developed a set of core competencies for general psychiatrists as well as sub-specialists in forensic, child and adolescent, geriatric, addiction and neuro-psychiatry. Registered psychiatrists are competent in the management of all aspects of MNS disorders (except for conditions outside of the ambit of neuropsychiatry which are typically managed by a specialist neurologist), and are able to train, supervise and mentor other health service providers. The introduction of training in public mental health equips psychiatrists to plan and organise services. However, psychiatrists are a scarce resource, and as with other mental health specialists, there is an inequitable distribution of these specialists, with the majority concentrated in the private sector in urban areas. In the public sector, they are largely hospital-based, with insufficient posts in district-health services where they could be most effectively utilised. Training of psychiatrists also occurs predominantly in academic and specialised hospitals. It is recommended that the academic platform is reviewed with more emphasis on training.

9.1 Introduction

This chapter focuses on provider core competencies for improved delivery of services with regard to mental, neurological and substance use (MNS) disorders in South Africa with a specific focus on the medical specialisation of psychiatry.

The core competencies of the registered South African psychiatrist will be examined first to determine to what extent they are able to meet the care and treatment needs of individuals with MNS disorders. Thereafter higher specialist sub-categories of psychiatry currently recognised by the College of Psychiatrists of South Africa are scrutinised to discern their relevance to addressing these needs. The sub-categories are:

- Neuro-psychiatry
- Geriatric psychiatry
- Forensic psychiatry
- Child and adolescent psychiatry
- Addiction psychiatry

9.2 Core competencies of a registered psychiatrist with regard to MNS disorders

9.2.1 Introduction

To register as a psychiatrist with the Health Professions Council of South Africa (HPCSA), a medical practitioner is required to obtain a Fellowship of the College of Psychiatrists of South Africa (FCPsych), and has to follow the process outlined below:

1. She/he should have completed an MBBCh/MBChB degree at a South African medical school, including completion of an internship and a year of community service as a general practitioner (GP).
2. The applicant may be required to work as a medical officer under one of the academic departments of psychiatry for six months to one year before being accepted into a registrar post (specialist in training).
3. The applicant then trains as a registrar under supervision. Such training should include:
   a. supervised experience of community psychiatric services for at least three months;
   b. similar supervised expertise of a child psychiatric clinic or child guidance unit for at least three months;
   c. working as a staff member of an approved psychiatric hospital or unit for at least one year;
   d. supervised experience and training in the fields of neuropsychiatry, emergency and crisis care, care of geriatric patients, alcohol and substance abuse/dependence, mental handicap, and forensic psychiatry at recognised institutions;
   e. training and supervised experience in psychotherapy, with the submission of a portfolio of psychotherapy cases, and which includes at least two short cases and one long case (which is written up and examined); and,
   f. completion of a research report for an MMed at the relevant university.
4. The individual is required to undertake and pass the Part 1 examinations of the College of Psychiatrist and/or a university MMed (Psychiatry) degree, comprising papers for Clinical Neuroscience, Behavioural Sciences and Introduction to Psychiatry. This is usually completed in the first year of training.
5. Following completion of the major training components, the individual is required to undertake and pass Part 2 examinations, which comprise three written examinations, an Objective Structured Clinical Examination, a clinical 'long' case and an oral examination.
6. The individual is also awarded an MMed degree in Psychiatry from the relevant university on successful completion and examination of the MMed research report.

9.2.2 Core strengths

Given the extended period during which both theoretical knowledge is acquired and clinical skills are developed before final qualification as a psychiatrist (including work experience in a range of mental health care settings), a registered psychiatrist should have an extensive array of 268 listed competencies which extend far beyond the comprehensive set of MNS competencies which the individual acquires through completion of their initial training in medicine. Psychiatric training and registrar experience enable further refinement of these skills. Some of the defined competencies of the registered psychiatrist are described below, with the corresponding MNS competency given in brackets.[129]

With regard to screening and identification, the scope of practice of a psychiatrist provides extensive evidence that psychiatrists have all the listed MNS competencies. For example, they should be able to:

- Recognise the signs and symptoms that accompany psychiatric disorders (SI.1), (SI.6).
- Assess and document patients' potential for self-harm or harm to others (SI.2).
- [Engage in] competent application of appropriate biological and psychosocial theories to advance an aetiological hypothesis (SI.3).
- Sensitively communicate with people with mental health problems, carers … and members of the general public (SI.4).
- Appreciate social/cultural/political contexts (SI.5).
- Elicit a complete clinical history, including a psychiatric history (SI.8).
- Conduct a mental status examination (SI.9).
- Conduct a disability assessment' (Table 2: RD.2).

The psychiatrist's array of competencies cover all aspects of formal diagnosis and referral since they are expected to understand:

> The epidemiology, aetiology, psychopathology, clinical features, and natural history of psychiatric disorders and psychological reactions in people with mental health problems and mental illness and carers, including concepts of disability (environment, impairment, activity limitations and participation restrictions), recovery and comprehensive rehabilitation (CBR, vocational, psychosocial, educational, assistive technology) (Table RD. 1-6).

They are also expected to be competent to 'perform a comprehensive specialist psychiatric assessment of culturally diverse people with mental health problems and mental illness of all ages'.
Hence, for example, a psychiatrist is able to:

- use various functional assessment tools (DR.5);
- understand and apply contextually appropriate diagnostic systems (DR.7);
- 'construct formulations of patients' problems that include a differential diagnosis' (DR.8); and,
- determine level of severity (DR.9).

There is similar comprehensive coverage of treatment and care. A registered psychiatrist should, for example, be able to complete all the following:

- Emergency psychiatry: assess the urgency of relative cases and prioritise accordingly *and* manage emergencies (TC.4).
- Understand adherence and show a clear understanding of side-effects (TC.9).
- Clearly, considerately and sensitively communicate with people with mental health problems (TC.10).
- Demonstrate the ability to recommend appropriate treatment in the context of the clinical management plan (TC.19).
- Apply relevant legislation appropriately at all times with reference to established codes of practice (TC.28).
- Demonstrate the ability to concisely, accurately and legibly record appropriate aspects of the clinical assessment and management plan (TC.38).
- Work with other clinical members of the team and understand their roles (TC.39).
- Demonstrate ability to prescribe appropriate, rational and evidence-based pharmacological treatments (TC.41).
- Teach psychiatric colleagues and other allied health care professionals (TC.42).

The registered psychiatrist has various proficiencies in addition to the core competencies. These include being able to:

- conduct therapeutic interviews, i.e. collect and use clinically relevant material;
- carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states;
- considerately and sensitively communicate with people with mental health problems and mental illness, carers, other health professionals and members of the general public;
- collaborate effectively with people with mental health problems and mental illness, carers, other health professionals and members of the general public;
- develop and show appropriate leadership skills, including providing leadership to a multidisciplinary team within a health setting and in the community; and,
- as a health advocate, be knowledgeable about and be able to apply the principles and processes of mental health promotion and psychiatric disorder prevention.

This extended array of competencies enables the registered psychiatrist to:

- consult to district health care teams and other higher-order bodies involved in health care provision;
- train general health practitioners who wish to develop further MNS proficiency;
- mentor medical practitioners and nurses with a particular interest in psychiatric care;
- collaborate with health providers who have counselling and psychological skills in caring for MNS patients;
- collaborate with health providers who have expertise in disability inclusion, recovery and comprehensive rehabilitation; and,
- inform the development of policies and protocols for specialist aspects of MNS prevention, care, treatment and rehabilitation.

9.2.3 Gaps

There are no gaps in terms of being able to meet the needs of MNS patients for care and treatment, and the psychiatrist's array of competencies in this regard. However, currently, most of the training of psychiatric registrars take place in tertiary and specialised hospital settings. There is less emphasis and exposure to community settings. The recent development of a curriculum in public mental health aims to address some of these deficiencies and to equip psychiatrists with the competencies needed to work in district health services and to guide recovery orientated and community-based rehabilitation programmes for disability inclusion and community development. Consideration could be given to adjusting the academic training platform to include more time spent in community settings. There should also be greater emphasis on the psychiatrist's role as a teacher and mentor of generalist health service providers in the context of the lack of psychiatrists, particularly in rural areas.

9.3 Core competencies of a registered psychiatrist with a certificate in the sub-speciality of geriatric psychiatry with regard to MNS disorders

9.3.1 Introduction

To be awarded a certificate in the sub-speciality of geriatric psychiatry a candidate has to:[130]

- be registered as a specialist psychiatrist with the HPCSA;
- have not less than 18 months satisfactory full-time experience as the holder of a clinical appointment as a sub-specialist trainee. Training must occur under the direction of a registered geriatric psychiatrist within an accredited psychiatry geriatric unit. The minimum duration of full-time training is 24 months. Part-time training of up to 50% of the time is recognised up to a maximum of four years of training;
- have submitted a satisfactory geriatric psychiatry portfolio of learning; and,
- pass an examination in geriatric psychiatry within two years of completing the training outlined above.

9.3.2 Core strengths

The proficiencies of a psychiatrist who has been awarded a certificate in the sub-speciality of geriatric psychiatry include being able to:[131]

- assess, diagnose, investigate and manage geriatric mental health problems;
- understand the basic neurosciences that are important in the assessment and management of geriatric cases;
- know and use investigative modalities in the geriatric context;
- provide assessments and manage geriatric cases;
- know relevant ethical, legal and policy requirements in geriatric practice;
- make sound judgments, and to be able to communicate with various stakeholders in geriatric mental health services;
- competently manage state patients in respect of administrative, clinical, rehabilitative and ethical issues;
- know and use geriatric assessment scales;
- manage and rehabilitate mentally disordered patients with empathy and due regard to principles of good practice; and,
- provide leadership within the multidisciplinary team, to trainees, and to other relevant lay and professional groups.

9.4 Core competencies of a registered psychiatrist with a certificate in the sub-speciality of forensic psychiatry with regard to MNS disorders

9.4.1 Introduction

To be awarded a certificate in the sub-speciality of forensic psychiatry, a candidate psychiatrist has to satisfy the following requirements:[132]

- be registered as a specialist psychiatrist with the HPCSA;
- have not less than 18 months satisfactory full-time experience as the holder of a clinical appointment as a sub-specialist trainee. Training must occur under the direction of a registered forensic psychiatrist within an accredited forensic psychiatry training unit that is associated with an academic department of psychiatry. The minimum duration of full-time training is 24 months. Part-time training of up to 50% of the time is recognised, up to a maximum of four years of training;
- have submitted a satisfactory forensic psychiatry portfolio of learning; and,
- pass an examination in forensic psychiatry within two years of completing the training outlined above.

9.4.2 Core strengths

The proficiencies of a psychiatrist who has been awarded a certificate in the sub-speciality of forensic psychiatry include being able to:[133]

- assess, diagnose, investigate and manage forensic mental health problems (these include both criminal and civil judicial contexts);
- know basic neurosciences in the assessment and management of forensic cases;
- know and use investigative modalities relevant to the field of forensic psychiatry;
- provide assessments and manage forensic cases;
- acquire knowledge of relevant ethical, legal and policy requirements in forensic practice;
- make sound judgments, and be able to communicate with various stakeholders in the forensic mental health services;

- competently manage state patients and mentally ill prisoners in respect of administrative, clinical, rehabilitative and ethical issues;
- develop knowledge and use of currently used forensic risk-assessment approaches;
- manage and rehabilitate mentally disordered offenders with empathy and due regard to principles of good practice;
- provide leadership within the multidisciplinary team, to trainees, and other relevant lay and professional groups; and,
- have a professional and empathic attitude and approach at all times towards remand detainees, patients, caregivers and colleagues.

9.5 Core competencies of a registered psychiatrist with a certificate in the sub-speciality of child and adolescent psychiatry with regard to MNS disorders

9.5.1 Introduction

A psychiatrist who has been awarded a certificate in the sub-speciality of child and adolescent psychiatry has to:[134]

- be registered as a specialist psychiatrist with the HPCSA;
- have not less than 18 months satisfactory full-time experience as the holder of a clinical appointment as a sub-specialist trainee. Training must occur under the direction of a registered child and adolescent psychiatrist within an accredited child and adolescent psychiatry unit. The minimum duration of full-time training is 24 months. Part-time training up to a maximum of four years is also acceptable;
- have submitted a satisfactory child and adolescent psychiatry portfolio of learning; and,
- have passed an examination in child and adolescent psychiatry within two years of completing the training outlined above.

9.5.2 Core strengths

An individual who is awarded a certificate in the sub-speciality of child and adolescent psychiatry a candidate will demonstrate the following competencies:[2]

- assess and diagnose child and adolescent psychiatric problems in a wide range of settings;
- understand the basic sciences underlying normal and pathological development in children and adolescents;
- know investigations relevant to the field;
- manage child and adolescent psychiatric problems in various settings;
- know relevant ethical, legal and policy requirements, with regard to children and adolescents and their families, and apply them appropriately;
- make sound judgments, exercise empathy and apply good interpersonal skills in relation to children and adolescents and their families;
- provide leadership within the multidisciplinary team, to trainees, and other relevant lay and professional groups; and,
- initiate planning and promotion of programmes for mental health education within a community context.

9.6 Core competencies of a registered psychiatrist with a certificate in the sub-speciality of addiction psychiatry with regard to MNS disorders

9.6.1 Introduction

A psychiatrist who has been awarded a certificate in the sub-speciality of addiction psychiatry has to:[135]

- be registered as a specialist psychiatrist with the HPCSA;
- have not less than 18 months satisfactory full-time experience as the holder of a clinical appointment as a sub-specialist trainee. Training must occur under the direction of a registered addiction psychiatrist within an accredited psychiatry addiction unit. The minimum duration of full-time training is 24 months. Part-time training up to a maximum of four years is also acceptable;
- have submitted a satisfactory addiction psychiatry portfolio of learning; and,
- pass an examination in addiction psychiatry within two years of completing the training outlined above.

9.6.2 Core strengths

A psychiatrist who is awarded a certificate in the sub-speciality of addiction psychiatry is expected to have developed competency to:[136]

- assess in detail a range of substance use disorders and specific associated comorbidities, formulate a clear, differential diagnosis and an etiological formulation of the case;

- provide a holistic plan of treatment, including competence in the delivery of evidence-based pharmacological, psychological, and social treatments of both the substance use disorder and comorbidities, including dealing with issues like risk assessment and management, social reintegration and optimising psychiatric, psychological, social and physical functioning;
- apply cost-effectively biological and psychosocial investigative techniques relevant to addiction psychiatry;
- understand relevant international and local policy issues, including policies around prevention work, harm reduction and other public health issues relevant to the field of addiction care;
- contribute to the development of clinical guidelines, pathway to care, treatment protocols, recovery and comprehensive rehabilitation protocol programmes and policies relevant to addiction care;
- develop a basic understanding of issues related to special treatment populations, including in-prison treatment and court diversion, homeless patients and employer-assisted programmes;
- provide leadership within the multidisciplinary team, to trainees, and other relevant lay and professional groups;
- provide focused advice on the management of patients with substance use disorders who are suitable to be managed by practitioners on a primary and secondary level of care;
- foster positive attitudes towards people with substance use disorders, to act as advocates for these patients; and,
- demonstrate knowledge relevant to ethical and legal aspects relevant to substance use disorders and their comorbidities.

9.7 Core competencies of a registered psychiatrist with a certificate in the sub-speciality of neuro-psychiatry with regard to MNS disorders

9.7.1 Introduction

A psychiatrist who has been awarded a certificate in the sub-speciality of neuro-psychiatry has to:[137]

- be registered as a specialist psychiatrist with the HPCSA;
- have not less than 18 months satisfactory full-time experience as the holder of a clinical appointment as a sub-specialist trainee. Training must occur under the direction of a registered neuro-psychiatrist within an accredited neuro-psychiatry unit. The minimum duration of full-time training is 24 months. Part-time training up to a maximum of four years is also acceptable;
- receive satisfactory supervised experience and training, as defined in the curriculum, in the fields of clinical neuropsychiatry, applied neurology, applied neuropsychology, applied neuro-imaging, psycho-pharmacology and relevant psycho-legal aspects;
- have submitted a satisfactory neuro-psychiatry portfolio of learning; and,
- passed an examination in neuro-psychiatry within two years of completing the training outlined above.

9.7.2 Strengths

A psychiatrist who who is awarded a certificate in the sub-specialty of neuro-psychiatry is expected to be proficient in the following:[138]

- accurately describe neuropsychiatric features of neurologic disease, and link their relationship to the underlying condition in terms of time course, severity, phenomenology and prognosis;
- assess medically unexplained neurological symptoms, including the use of appropriate special investigations to rule other medical conditions;
- construct a clear but comprehensive diagnostic formulation, incorporating the underlying neurologic disease with its neuropsychiatric manifestations;
- generate an appropriate management plan targeting key symptom clusters, psycho-social needs and long-term rehabilitation;
- communicate the conclusions of neuropsychiatric assessments clearly, accurately and in appropriate detail to colleagues, patients and families;
- have a broad overview of common and important neurologic diseases with respect to their epidemiology, aetiology, clinical features and management;
- systematically appraise and record the presence of cognitive, affective, psychotic, and behavioural or emotional disorders in patients presenting with another medical condition;
- utilise investigations;
- initiate, and maintain, where appropriate, biological, psychological and social management including disability inclusion strategies, of neuropsychiatric disorders; and,
- integrate management with neuroscience colleagues, as well as referrers and providers at primary and secondary levels of care.

Chapter 10: Neurologists

Key Findings

Neurologists are primarily hospital-based in the public sector. They should play an important role in training and in providing mentoring and clinical consultation services to PHC and for patients with complex neurological disorders.

Key points

The training of neurologists in South Africa is conducted by the eight medical schools and is standardised through the establishment of a single exit examination conducted by the College of Neurologists of South Africa. The College has developed a set of core competencies for neurologists. Registered neurologists are competent in the management of all neurological disorders, and are able to train, supervise and mentor other health-service providers. There is a severe shortage of neurologists in the country, with the majority concentrated in the private sector and in urban areas. In the public sector, they are hospital-based. Training of neurologists occurs in academic hospitals. Given the severe shortage, it is recommended that neurologists play a role in training and supervising generalist health practitioners working in community settings.

10 Introduction

According to the Regulations for Admission to the Fellowship of the College of Neurologists of South Africa,[139] the general scope of practice of a neurologist comprises:

- the ability to treat or deal effectively with the clinical problems of neurology at a specialist level without supervision;
- detailed knowledge of common neurological conditions;
- detailed knowledge of medicine relevant to neurology; and,
- broad knowledge of psychiatry, neurosurgery and neuro-ophthalmology relevant to neurological conditions.

The Neurological Association of South Africa (NASA) reports that although about 130 neurologists are affiliated to the association, the number currently active and practising is closer to 100.[x] As is true for many other medical specialists in South Africa, this figure suggests a severe shortage of neurologists, particularly outside the major metropolitan areas and in predominantly rural provinces, and more especially in the public health sector.

In order to register as a specialist neurologist in South Africa with the HPCSA, a candidate has to:

1. Have been qualified to practice medicine for a period of not less than four years, including the year of internship.
2. This should include the following training:
   a. Full-time appointment as a registrar in a Department of Neurology recognised by the College of Medicine of South Africa (CMSA) for three years, OR
   b. Full-time appointment as a registrar in a Department of Neurology recognised by the CMSA, for a minimum period of two years six months and approved experience in neuropathology for a maximum period of six months, OR
   c. Full-time appointment as a registrar in a Department of Neurology recognised by the CMSA, for a minimum period of two years and full-time appointment as a registrar in general medicine, psychiatry, neurosurgery or neuro-ophthalmology for a maximum period of one year.
3. Pass Parts 1 and 2 Neurology Examinations concurrently (or pass Part 1 Neurology Examinations and subsequently pass Part 2 Examinations).
4. Thereafter apply for admission to the fellowship of the College of Neurologists of South Africa. If a two-thirds majority of the senate of the College of Medicine of South Africa assents, then admission to fellowship is granted, and the candidate is entitled to engage in professional practice as a registered neurologist.

10.1 Core competencies

According to the College of Neurologists of South Africa, a neurologist should have comprehensive knowledge of:

x. Information downloaded from the website of the Neurological Association of South Africa - https://www.mynasa.co.za/

- the structure and function of the nervous system;
- basic concepts underlying the electroencephalogram (EEG), nerve conduction and electromyography (EMG);
- basic concepts and mechanisms of immunology, genetics and molecular biology
- basic concepts in neurochemistry and neuropharmacology;
- applied neuro-anatomy, neurophysiology, neuropharmacology and neuropathology; and,
- technical terms, facts, concepts, principles, laws, methods and procedures as applied to the practice of neurology.

In addition, a neurologist is expected to be able to:

- elicit a clinical history from a patient or relative (or another person able to provide the history);
- perform a competent physical examination;
- demonstrate neurological signs, and appropriately interpret clinical signs;
- combine the information obtained from a patient's history and examination to reach a diagnosis or differential diagnosis for the patient, and to solve clinical problems;
- from this process and based on supplementary laboratory, neurophysiological and radiological investigations, formulate a rational plan for further management of the patient with due regard to prioritisation, cost-effectiveness and holistic care;
- interpret radiological, laboratory and other investigations relevant to the management of neurological conditions;
- exhibit a thorough knowledge of neurological disorders;
- demonstrate effective therapeutic skills;
- exhibit a clear understanding of the importance of following an evidence-based approach to disease management and basic statistics;
- demonstrate knowledge of physical, biomechanical, sensorimotor and neurocognitive and psychosocial rehabilitation to make appropriate referrals to relevant professionals;
- demonstrate knowledge of disability inclusion, disability assessment (especially for functional medico-legal assessments) and habilitation including assistive devices and universal design for learning to make appropriate referrals to relevant professionals; and,
- treat patients with appropriate professional courtesy.

A qualified neurologist should understand the neurological manifestations of general medical disorders and should have a thorough knowledge and understanding of:

- Disorders of the pyramidal and extrapyramidal systems
- Disorders of co-ordination
- Disorders of the sensory system
- Disorders of the peripheral nervous system
- Disorders of the cranial nerves
- Disorders of higher function, language, mood and behaviour
- Disorders of the autonomic nervous system
- Disorders of consciousness
- Disorders of the spinal cord
- Disorders of muscle, the myoneural junction and the anterior horn cell
- Epilepsy and related disorders
- Sleep disorders
- Infections of the nervous system
- Cerebrovascular diseases
- Demyelinating conditions
- Metabolic conditions – inherited and acquired
- Developmental diseases of the nervous system
- Degenerative diseases of the nervous system
- Diseases of the nervous system owing to nutritional deficiency or alcohol
- Neurotoxicology, including disorders caused by physical and chemical agents or drugs
- Headache
- Pain syndromes
- Neuro-trauma
- Neoplasms of the nervous system

Given that every neurologist is required to have already qualified as a medical practitioner, and to have at least four years of experience in this capacity, they will already have mastered the full list of MNS competencies listed in Tables 1 and 2, in relation to neurological disorders (but not mental or substance abuse disorders). Therefore, neurology training will enable competencies as follows:

- Be particularly adept at screening and identification of a broad range of neurological disorders and conditions (SI.1-0).
- Be highly skilled at formal diagnosis (including differential diagnosis) of a range of neurological conditions, and be able to assess severity (DR.1-10).
- Be able to develop highly appropriate and tailored treatment plans for patients with neurological conditions and advise regarding long-term management of patients who present with these conditions (TC.1-16).
- Carry out skilled therapeutic neurological interventions or direct other health care providers how such interventions should be made – a distinctive and additional competence (variants of TC.19, TC.21).
- Provide neurological patients, their families and communities with psycho-education regarding neurological conditions and issues (a variant on TC.7, which refers to 'promoting mental health literacy', TC.8).

Neurologists should be able to work collaboratively with neuro-psychologists, and, to some extent, a collaborative relationship will also be possible with psychiatrists, psychiatric nurses, physiotherapists, occupational therapists and (with regard to children and neurological conditions) educational psychologists. The critical national shortage of neurologists means that whenever possible, neurologists should seek, wherever appropriate, to share their knowledge and expertise with other health providers.

This extended array of higher-order competencies will enable a registered neurologist to:

- consult when necessary with district health care teams and other higher-order bodies involved in health care provision, particularly with regard to the managent of neurological issues, and plan for care and treatment of neurological disorders;
- wherever possible, educate, train and mentor medical practitioners who wish to develop further proficiency in care and treatment of neurological disorders (TC.42);
- advise other healthcare providers regarding the most appropriate and cost-effective care and treatment of patients with these disorders; and,
- contribute to the development of policies and protocols for neurological care and treatment, particularly regarding prevention issues.

Chapter 11: Key Findings and Discussion

11.1 Cross-cutting findings across all categories of providers

1. There is insufficient exposure to MNS disorders in the training programmes of generalist healthcare providers (except for general medical practitioners) and therefore a lack of core competencies to prevent, assess and manage these disorders in primary care settings.
2. There is limited training in substance use disorders, in terms of evidence-based approaches to prevention, early detection and brief interventions across all categories of providers. Even some specialist mental health professional training programmes do not mention core competencies with regard to assisting people with substance use disorders who are referred from primary care services (e.g. social workers, occupational therapists and all categories of psychologists).
3. While this project focused on adult MNS disorders, it is noted that there is insufficient training in child and adolescent MNS disorders in most training programmes. There is a subspecialist qualification for psychiatrists, but there are less than 50 such specialists in the country, and task shifting and task sharing in terms of looking after child and adolescent mental health is critical. Addressing child and adolescent MNS disorders also requires a multi-sectoral approach with cadres in other sectors aside from the health sector requiring the development of competencies in this regard.
4. There is limited emphasis on community-based rehabilitation as a strategy for intersectoral community development.
5. There is limited emphasis on the recovery model and a disability-inclusive approach to the treatment and comprehensive rehabilitation of people with MNS disorders at both generalist and specialist levels.
6. There is limited emphasis on competencies associated with the role of health professionals, as members of a multi-pronged transdisciplinary task force (for example, town planners, social-development practitioners, occupational scientists) in addressing the social determinants of the MNS disorders.
7. The training platform of specialist mental health care providers is generally hospi-centric, and there is currently insufficient exposure to community-based settings during training,
8. There are limited posts in community-based settings for qualified specialist mental health care providers. This is a barrier to the implementation of the country's mental health policy and legislation which promotes community-based care in the least restrictive environment possible. The NHI policy and legislation currently situates all specialist mental health professionals in hospital settings, which also contradicts the country's policy for MNS disorders.
9. There is limited attention to developing leadership, teaching and supervision competencies in specialist mental health care provider training programmes for them to provide the required support in a task-shifting and task-sharing environment.

11.2 Summary of identified core functions for each category of provider and key points from the review of the mapping exercise

Providers are listed and discussed below in terms of five primary categories.

11.2.1 Lay health workers

Community health workers are 'lay' health workers with limited training. They include community health workers (CHWs) in ward-based outreach teams (WBOTs), as well as laypeople trained in other specific roles (e.g. community care givers, community rehabilitation workers [see section: comprehensive rehabilitation services], behavioural health counsellors [see section: providers of psychological services]).

Community caregivers are generally employed by NGOs in residential and day-care facilities for people with Severe Mental Illness (SMI) or severe/profound intellectual disability (ID). They are generally supervised by professional nurses and/or social workers. Their role is to provide physical and psychological support to these individuals. Community caregivers register with the Department of Social Development and have to provide evidence of training from an appropriate institution.

Traditional healing practitioners and providers who fall under ***faith-based organisations*** could also play a significant role in helping people with MNS disorders (see Appendix 3).

Community health workers in the WBOT teams: Their primary roles are to screen for and identify people with MNS disorders who need referral, as well as to follow-up patients with chronic mental illnesses to encourage adherence to medication and other recovery-oriented interventions.

11.2.1 Key points

- Current training appears to provide CHWs with the required core competencies but it is unclear whether they receive sufficient training **content** on MNS disorders and related disabilities in order to perform appropriate screening, manage emergencies, refer appropriately and provide ongoing adherence support.
- It is critical that CHWs receive ongoing support, training and mentoring from professional nurses or their equivalent.
- It is also critical that career pathways including training, post and salary structures for CHW are formalised in the public health sector in support of the primary healthcare philosophy.
- CHWs have played a pivotal role in the HIV epidemic and roll-out of HIV counselling and testing, as well as in providing adherence support. With adequate training and support, they could play similar roles in MNS disorders.
- The basic competencies of CHWs should be expanded to include disability and rehabilitation. They will only be able to follow up on basic task-shifted recovery-oriented interventions with additional training in disability and rehabilitation and concomitant supervision by rehabilitation professionals.
- There is a need for national guidelines and standardised training and accreditation for community-based caregivers, providing home-based care.
- As part of the PHC Re-engineering project, training courses have been implemented in parts of South Africa to upskill CHWs with disability awareness and competencies to execute task–shifted, community-based rehabilitation services under the supervision of rehabilitation professionals and/or other members of the DSMH teams. Their competencies, at very basic level of proficiency, with regards to the MNS disorders must be strengthened to increase their impact especially in under-served rural communities.

11.2.2 Primary health care nurses (PHCNs) and other providers of nursing care

PHCN's primary role is screening and assessment of people presenting with symptoms of MNS disorders. They play a limited role in terms of initiating medication (the extent to which they will be able to do so in future depends on further work in terms of rescheduling of psychiatric medications), but they should be able to follow up patients who are stable on medication and to identify difficulties with adherence, side-effects, etc. They are the case managers of these patients, and decide on further referral/intervention, either within the PHC clinic or in the community, or by referral to more specialised services, including rehabilitation programmes. Psychiatric nurses (nurses with experience and/or additional training in psychiatric nursing) can play a very important role in terms of supporting PHC nurses through training, providing assessments and possibly also by prescribing medication (should legislation allow this). With increased understanding of recovery and disability inclusion principles, they can also play a role in community-based rehabilitation programmes.

Nurses also play a role in managing people with MNS disorders in inpatient settings, whether at district, regional, central or specialised hospital levels. Psychiatric nurses are particularly important here, but auxiliary nurses and staff nurses are an under-utilised resource in terms of providing nursing care to people with MNS disorders in PHC and hospital settings.

11.2.2.1 Key findings

- Nurses are the backbone of the health service in South Africa and often perform an expanded role owing to a shortage or uneven distribution of other health professionals.
- There is a critical shortage of nurses in South Africa, which is likely to worsen in the near future.
- The nursing curricula are currently being restructured, and so-called 'legacy' nursing categories are being phased out and replaced with new categories.
- The mapping exercise shows that mental health and psychiatric nursing skills are scarce in all the current (legacy) nursing categories, with the exception of those qualified through the existing four-year diploma/degree and nurses with post-graduate (specialist) qualifications in psychiatric nursing and primary care. The new, not yet implemented, four-year professional nurse qualification prepares graduates for general nursing and midwifery but does not include psychiatric nursing. It is unclear how much exposure to psychiatry and mental health will be included in the new curriculum. It is also a concern that the Advanced Diploma in Psychiatric Nursing has been discontinued.
- As part of the PHC Re-engineering project, training courses and a manual for adult primary care (APC) has been developed for professional nurses working in primary care clinics. This includes training and information on presentations of MNS disorders as well as assessment and management thereof. Evaluation of pilot projects to strengthen the management of MNS disorders at primary care level suggest that mental health system strengthening, as well as ongoing support and mentoring is essential in order for nurses to implement these interventions (including screening, assessment, management and appropriate referral).[3]

11.2.3 Generalist medical practitioners and other providers of medical services

These include emergency medical-service (EMS) personnel, clinical associates and general medical practitioners. These professionals play an important role in the diagnosis and management of mental disorders at PHC level. Here they deal primarily with people with common mental disorders but should also be involved in managing people with chronic severe mental illness who are stable. At this point, doctors are the only generalist providers who can prescribe psychotropic medication and are particularly important in terms of identifying underlying medical conditions that require treatment. They should initiate psychotropic medication when necessary, and support follow-up by nursing staff (PHC and psychiatric nurses). They should also be competent in assessing disability and collaborating with other mental health professionals concerned with recovery and rehabilitation through appropriate referral.

Generalist medical practitioners are primarily responsible for the inpatient treatment of people with MNS disorders at district-hospital level. Family physicians and doctors with the Diploma in Mental Health can play a more specialised role, in both outpatient and inpatient settings.

EMS personnel and clinical associates are important members of this group of providers and have specific but limited roles to play in the provision of treatment, care and rehabilitation of people with MNS disorders. EMS providers play a role in pre-hospital care, primarily dealing with people with MNS disorders who are at risk of harming themselves or others. Clinical associates are a recent cadre of professional that has been developed to specifically play a role in supporting doctors where they are in short supply, for example, in rural areas.

11.2.3.1 Key findings

- South Africa lacks sufficient doctors to address the health needs of the population but is relatively well-supplied with doctors compared to other Southern Africa Development Community (SADC) countries. However, there is a maldistribution of doctors: approximately 60% work in the private sector, and there is also a concentration of both private-sector and public-sector doctors in urban areas, with limited coverage of rural areas. A recent review of community service highlights the benefits of exposing young graduates to work in under-served areas, but also emphasises the need for better supervision by, and availability of senior medical staff.[140]
- Medical practitioners at all universities receive sufficient training in the core competencies required to manage people with MNS disorders at primary care level. Training in psychiatry is also part of the two-year internship training for all medical graduates. However, only one month is allocated to psychiatry in the programme, which is insufficient, given the burden of disease and disability due to MNS disorders. It is also important to review the site of such exposure. It may not be useful for interns to spend more time in psychiatric hospital/inpatient settings, but more useful for additional time to be spend in community mental health settings
- Awareness of psychosocial and vocational rehabilitation and disability-inclusive approaches would strengthen multi-professional collaboration at district level. If possible, interns should participate in community-based rehabilitation programmes to learn about the social determinants of mental health and psychosocial recovery by working alongside CHWS/CRWs.
- Training in the management of people with substance use disorders is largely limited to managing detoxification in people with depended use, and there is very limited training in brief interventions and harm-reduction approaches.
- Categories of emergency-service personnel are currently being rationalised and the curricula are being reviewed and updated. The review found that they receive training in the required competencies to execute their core functions. However, as is true of other generalist providers, it is unclear whether EMS professionals receive sufficient content training for them to achieve competence in the management of emergency psychiatric situations.
- The role of clinical associates is still quite fluid, and the competencies of these professionals are not as clearly defined as for other professionals. They can play an important role in assessment, psycho-education, and monitoring of people with MNS disorders, given appropriate training and working under the supervision of a medical practitioner, and in collaboration with rehabilitation professionals. Clinical associates would also benefit from disability studies.

11.2.4 Providers of psycho-social care and treatment and rehabilitation

11.2.4.1 Providers of psychological services:

- ***Laypeople*** who have been trained as behavioural health counsellors working in PHC clinics, as well as a range of community-based lay counsellors (usually in NGO settings)
- ***Psychometrists*** who play an important role in conducting assessments (in children and adults)
- ***Registered counsellors*** (with a four-year B Psych qualification)

- ***Clinical and counselling psychologists*** who primarily work in the health services and related NGOs
- ***Psychologists outside the health sector*** who could also play a role include ***educational psychologists*** (in schools and educational settings), ***industrial psychologists*** (in workplace settings) and ***research psychologists*** (in tertiary educational institutions).

All providers of psychological services should provide evidence-based psychological interventions. Depending on their level of training and skills, this might include psycho-education; manual-based structured interventions for specific conditions or circumstances; counselling; and, various forms of psychotherapy. They can also, with additional training, provide rehabilitation using universal design in learning environments, as well as psychosocial and vocational rehabilitation.

Providers of psychological services for people with MNS disorders should primarily be employed in the district health service. There may be some need for psychological services in acute inpatient psychiatric settings, but the main setting for such services should be in the community. Clinical psychologists also play an important role in specialised services at regional, central and specialised psychiatric hospitals. Registered counsellors, as well as more specialised clinical and counselling psychologists, should play a very important mentoring and supervisory role for those providers with fewer skills or at a lower level of care.

11.2.4.2 Key findings

- The Psychology Board of the HPCSA is currently undertaking a review of the scope of practice of all categories of registered professionals. It is important that this process does not undermine the ability of the country to implement task shifting and task sharing to provide the most marginalised communities with access to psychological services.
- As with medical practitioners, there is a maldistribution of professional psychologists, with most working in the private sector in urban areas. There is, therefore, difficulty in accessing psychological services in the public sector, particularly in rural areas.
- There is evidence that trained and supervised lay ***'behavioural health counsellors'*** can effectively deliver manualised psychological interventions for depression and for promoting lifestyle change and adherence to medication in chronic non-communicable diseases and HIV. The inclusion of chronic mental illness in medication adherence is recommended.
- There is a lack of standardisation of training and curricula of psychologists across training institutions, with insufficient attention sometimes given to providing graduates with evidence-based competencies.
- Training in management of substance use disorders is only addressed to a limited extent.
- In clinical psychology programmes, there is a greater emphasis on various modalities of individual psychotherapy rather than community-based, recovery-oriented approaches to psychosocial disability and rehabilitation.

11.2.5 Providers of social work services:

Social work services are provided by professional social workers and social auxiliary workers. Child and youth care workers also work under the supervision of social workers and provide essential support to children in need of care and residential care settings.

Social work services include interventions to secure the social and family well-being of individuals with MNS disorders. These often include financial/material interventions. However, social workers also provide clinical services for couples, families and communities. They are skilled in providing individual and group interventions. According to their curricula, social workers should receive more training in the management of people with substance use disorders than other professionals, but this is not always true. (As already mentioned, substance use disorders are a major cross-cutting issue.)

11.2.5.1 Key findings

- There is a shortage of social workers in the public sector (particularly health services), and, therefore, a lack of social worker resources for assisting people with MNS disorders in clinical settings. Problems are reported regarding recruitment and retention.
- Social workers are well-placed to provide interventions for people with substance use disorders but receive limited evidence-based training in this important area.
- Training of clinical social workers is only provided at a handful of institutions.
- As with other mid-level and generalist providers, child and youth care workers should have generic skills in terms of children and adolescents with MNS disorders, but it is not clear whether they receive sufficient content input on these disorders to assist them in appropriately identifying children and adolescents under their care who need further/more specialised intervention.

11.2.6 Comprehensive rehabilitation services:

This category of providers is the most highly trained and skilled in the full range of rehabilitation including physical, psychosocial, educational, vocational and community-based programmes for individuals, groups and populations. This category should provide guidance to the team in encouraging recovery and following an intersectoral and disability-inclusive approach with individuals, groups and populations including disability, peer-led and mental health activist organisations. It includes occupational therapists (OTs), community rehabilitation workers (CRWs) and occupational therapy assistants (OTAs). Their focus is on human occupation, i.e. what people do every day, and they use various methods in partnership with service users to promote disability inclusion and recovery of functioning in self-care, learning, play, productivity including work and livelihoods and social participation. The role of all rehabilitation professionals including physiotherapists, speech-language therapists and audiologists in MNS disorders must be strengthened, given the functional sequelae of co-occurring mental, developmental and neurological disorders.

11.2.6.1 Key findings

- Occupational therapists and associated mid-level workers are well placed to provide recovery-oriented interventions for people with MNS disorders as well as to participate in activities that promote mental health and prevent disability.
- The crucial contribution of this group of providers is not optimised in the WBOT in the PHC-re-engineering plan.
- Competency-based training in MNS disorders in OT curricula is generally adequate.
- Similar issues exist regarding maldistribution of providers of occupational therapy and rehabilitation services as with other professionals involved in assisting people with MNS disorders.
- Training more mid-level workers would assist in increasing access to recovery-oriented, community-based rehabilitation through task shifting and supervision by members of the DSMH team.
- There is currently only one formal (i.e. NQF aligned and university certified) training programme for CRWs in South Africa in the Division of Disability Studies, University of Cape Town. There are currently no training programmes for OTAs in South Africa.

11.2.7 Specialist providers (including family physicians, neurologists and psychiatrists)

Family physicians work in the districts and are responsible for planning and implementation of health services, including services for MNS disorders. They also research on health needs and evaluate interventions on a public health scale. They provide a clinical consultation service to PHC for patients with complex disorders (which should include MNS disorders).

Neurologists are primarily hospital-based in the public sector. They should play an Important role in training and in providing mentoring and clinical consultation services to PHC and for patients with complex neurological disorders.

Psychiatrists work in community and hospital settings. They can provide specialised assessments and interventions in both settings. They should play a significant role in training, mentoring and supervision, as well as provide a clinical consultation service for patients with complex MNS disorders. Sub-specialists provide services in their areas of speciality, including child and adolescent psychiatry and mental health, forensic psychiatry, neuropsychiatry, addiction psychiatry, and the psychiatry of old age.

11.2.7.1 Key findings

- Training of specialist medical practitioners in family medicine, neurology and psychiatry take place in all medical schools, and the Colleges of Medicine of South Africa conduct the final exit examinations, ensuring that standards are consistent across the training institutions.
- Specialists who graduate have a full range of competencies for providing treatment, care and rehabilitation for people with MNS disorders in their particular fields.
- Psychiatrists are trained particularly to work in multidisciplinary team settings.
- There should be a greater focus on training specialists to provide training and mentoring support to generalist categories in a task-shifting and task-sharing approach.
- Training of psychiatrists (and neurologists) is primarily hospital-based, which is at odds with the policy of community-based care.

Chapter 12: Conclusions and Recommendations

Limitations of this study and recommendations for further research

This review did not include a review of methods for assessing core competencies, which could be the scope of another project.

12.1 Promotion of mental well-being and prevention of mental disorder

This project has focused primarily on the treatment, care and rehabilitation of people with MNS disorders in the public health service. However, planning and provision of promotion and prevention programmes should also be competencies of all levels of providers. A recent workshop conducted under the auspices of the Academy of Medicine in the United Kingdom, to which associated Academies were invited, identified priority topics for research in this area, aligned to the Sustainable Development Goals.[141] Further research in this area in South Africa is recommended.

12.2 Other sectors/traditional health practitioners

Owing to a lack of time and resources, this project had to be limited to formal public health sector providers/services. However, as noted above, the provision of treatment, care and rehabilitation of people with MNS disorders is a multisectoral responsibility. Further work needs to be done to determine core competencies of providers in other sectors in terms of the treatment, care and rehabilitation of people with MNS disorders.

Traditional health practitioners and those linked to faith-based organisations also play a significant role in providing services for people with MNS disorders. These are often an entry point into systems of care. These providers, therefore, could play a significant role in identifying people with such disorders, and in some cases, have worked co-operatively with health services in providing for the mental health and spiritual needs of individuals. Again, a determination of core competencies for these groups is beyond the scope of this study but is an essential task which needs to be undertaken in the future. Appendix II provides some information on the history and current challenges faced by traditional health practitioners.

12.3 Children and adolescents/schools

Acute care for children and adolescents is provided for at primary care clinics. School health services are a key pillar in the re-engineering of primary care. School health nurses provide health services to children in schools and are members of the PHC team at the local primary care clinic. Children and adolescents under the age of 18 years comprise 34% of the population, and child and adolescent MNS disorders are common and an important cause of disability and distress. Providers at all levels should be competent to screen for and identify common childhood mental disorders, which usually present with developmental delay, emotional and/or behavioural symptoms and/or learning difficulties. Given the burden of disease, the fact that many mental disorders begin in childhood, and that early intervention is most effective in childhood and adolescence, it is essential that treatment, care and rehabilitation should be provided for children and adolescents. Many of the competencies that equip service providers to deal with adult MNS disorders would equip them to deal with child and adolescent MNS disorders. However, there are specific developmental issues that are important to consider, which have an impact in terms of the assessment as well as management of children and adolescents, in particular, appropriate developmental stimulation, and universal design for learning and handling of challenging behaviours in the home, the classroom and play spaces. The extant literature indicates that properly trained and supervised teachers can provide evidence-based developmental and behavioural interventions with improving results over time. While psychologists and occupational therapists are positioned to provide supervision and consultation, their profession-specific competencies suited to the education sector were not addressed in this review. The contribution of supervised CHWs/CRWs with basic task-shifted habilitation[y] competencies will go a long way to soften the burden of care placed on households caring for children with special needs. A further study exploring the specific competencies required to provide services to children and adolescents is recommended, especially around young adults with MNS disorders who are transitioning between school, post-school education and training, and work.

y. Habilitation refers to services for those who may not have ever developed a skill, such as a child who is not talking as expected for his or her age.

12.4 The elderly

South Africa also has an ageing population, and a high burden of chronic non-communicable diseases as well as HIV infection, which result in a significant burden in older people. Dementia secondary to cardiovascular disease and HIV infection, as well as Alzheimer's, is an increasing problem. There are specific competencies required of providers working with elderly people living with MNS disorders, which could also be explored in further study.

12.5 Need for evidence-based implementation research

Existing projects which have evaluated a task-shifting approach to MNS disorders in South Africa have demonstrated that implementation is feasible, as long as sufficient health service management and specialist mental health provider support exists.[3] It is important that such projects demonstrate that the task-shifting approach can be scaled up widely across the country while maintaining quality. Standardised outcome measures that demonstrate recovery and improved functioning in people with MNS disorders participating in community-based rehabilitation programmes should be factored into DALY calculations. [142]

12. 6 Quality assurance of service-provider curriculum

A key limitation in this review was the inability to look into issues of quality within the mental health workforce curriculum. The review was not able to locate and interrogate competency assessment strategies in the different service provider curricula. More needs to be known about how these competencies are monitored and maintained to ensure the quality of the services provided.

12.7 Other recommendations

12.7.1 Health systems issues

1. There are a range of government departments involved in providing services for people with MNS disorders aside from the Department of Health. Formal structures for liaison between these departments exist at national, provincial and district level. It is important that these structures be utilised utilised to improve intersectoral collaboration for the benefit of people with MNS disorders. Most importantly, a shift towards addressing the social determinants of the MNS disorders will require transdisciplinary liaison in research, education and services.
2. Posts in the public sector: In order for recommendations regarding new or existing cadres of providers in this report to be implemented, there is a need for posts to be created for these providers. In this regard, recognition of behavioural health counsellors and community health/rehabilitation workers through accreditation and the establishment of posts and a career path within the public sector is essential. In addition, more posts for registered counsellors (with a B Psych degree) should be created. Posts for psychiatrists and other mental health specialists should be created at the district level, rather than relying on outreach services from hospital employees.

    - ***The conceptual frameworks for health, well-being and universal healthcare coverage in national policies should include disability prevention, comprehensive rehabilitation and disability-inclusive community development.***
      A critical barrier to a development approach is the entrenchment of the biomedical model of public health. To date, the burden of disease and associated burden of disability do not receive equal attention in health-system programmes, health-workforce planning and health-worker education. For example, community-based rehabilitation and its related workforce are not factored into the re-engineered district health system (i.e. WBTs) or the National Health Insurance Plan. The role of comprehensive rehabilitation as a poverty-reduction strategy is under-acknowledged in critical health policies. For example, rehabilitation services (and CBR in particular) are not seen as a component of Primary Health Care Re-Engineering (PHC-R), because disability is not considered in vertical health programmes at primary level. Despite mandatory community health service and having the requisite competencies for practice in different public sectors, especially in rural and under-served areas of the country, the potential contribution of rehabilitation professions to reduce the burden of disability associated with MNS disorders and the quadruple burden of disease in South Africa remains under-utilised. Special needs schools run by NGOs who employ OTs, psychologists and social workers working together with children with MNS disorders in the community are a good model.

    - ***Access to the services of rehabilitation professionals and associated mid-level and community workers is as decentralised and intersectoral as possible to advance the prevention of disability associated with MNS disorders.***
      Creating compulsory community service and general posts for rehabilitation therapists in social development, education, labour, correctional and other state sectors would go a long way to-

wards taking the service delivery strain off the health sector. Rehabilitation services are currently medicalised and structured into vertical programmes with little or no scope for integration with priority public health programmes such as mental health; non-communicable diseases; maternal, child and women's health; injury and violence as well as HIV, AIDS and TB. The ASSAf 2018 consensus study report on reconceptualising health professions education in South Africa acknowledges the International Classification of Health, Functioning and Disability as an inter-professional care and collaboration framework. However, the ASSAf 2018 document only focuses on doctors, nurses and pharmacists based on the apparent assumption that health is primarily a biomedical and disease issue rather than a resource for living that may be addressed beyond the health sector by a range of service providers including rehabilitation professionals.

- ***The NDOH and various professional boards to put measures in place to coordinate and formalise the statutory regulations for CHWs/CRWs pertaining to their scope of practice, training, registration, supervision, employment conditions and career pathways.***
  The lack of clarity with regards to their supervision must be addressed and formalised. Certain documents state that rehabilitation professionals will supervise them, and other documents state that nurses will do it. Task shifting should be approached with considerable forethought, collaboration, strong management and suitable supervision structures. Defensiveness about role blurring can be avoided through training, facilitation of effective communication, and inter-professional education and teamwork. However, this will require dedicated support from experienced rehabilitation professionals, as well as continued collaboration between Higher-Education Institutions, the NDoH and the HPCSA, in order to produce sustainable results.

- ***Formalise the mental health care of healthcare service providers, many of whom are prone to MNS disorders themselves.***
  Public health sector service providers work at the coalface of social trauma. As frontline workers, they experience secondary traumatisation within service systems characterised by structural and systemic violence. They don't necessarily have the resilience to deal with complex and dysfunctional service systems or the unrelenting emotional cost of caregiving. The Kunjani (how are you) Programme should be incorporated in public-service environments to promote social capital amongst managers, clinicians and administrators thereby positively affecting organisational culture, service climate and workforce well-being.

12.7.2 Registration/accreditation with professional boards

1. Nursing
2. Scope of practice issues

In order for task shifting and task sharing to be successful, professional registration bodies and professionals need to recognise the need for their scope of practice to be shared in some areas with professionals or service providers with a lower level of qualification. For example, behavioural health counsellors will provide psychological interventions that are typically the scope of registered psychologists. Nurses may provide nurse-initiated antidepressant medication, typically only within the scope of medical practitioners. Issues of accountability, however, need to be clarified when task shifting takes place, and interventions need to be evidence- and guideline-driven, with adequate supervision by professionals with higher levels of qualification.

12.7.3 Training issues

1. Academic training platforms for all health service providers should be expanded from central academic hospitals to district-based community health services.
2. Disability studies should be included in MNS service provider curricula.
3. Substance use and abuse: Across almost all categories of a provider (with few exceptions), there is a need to expand training to develop simple competencies of providers in managing substance use and abuse. The following competencies are recommended:
   a. recognise common signs of substance use or abuse;
   b. talk to users of health services about substance use non-judgementally;
   c. deliver simple harm-reduction health messages; and,
   d. refer, where necessary, to more specialised care and treatment services.

These recommendations are based on the following widely accepted principles in managing and treating substance use/abuse:[143]

a) Substance use and abuse is a significant problem in South Africa and embraces not only use of illegal drugs, but also abuse of prescribed drugs and over-the-counter medication, together with using the two legal substances which contribute to the highest share of social harm, namely, alcohol and tobacco.[144,145]
b) Substance use always occurs in a social context. Many practices around the use of substances have become normative and established within cultural formations. For example, men who drink is a cultural

idiom associated with various forms of masculinity. In the long term, managing substance use involves understanding the function that it serves for the individual (e.g. self-medication, distraction, management of pain or psychological trauma) and addressing the social context. These are the issues that require understanding and amelioration.

c) Judgemental discussion and moralising about substance use silences users and leads them to conceal from providers future use or scale of use. Reduction in use and/or abuse is possible through building trusting relationships with users.

d) Harm reduction is an option for all providers. It includes conventional programmes of methadone substitution or needle exchange for intravenous drug users, as well as simple ideas such as encouraging users to limit their consumption, limit contexts and times of substance use, or use the substance in ways leading to less harm (e.g. nasal inhalation of certain drugs rather than drug injection, or switching to a cigarette brand with lower nicotine and tar).

e) Conventional rehabilitation services for substance abuse have low success rates and are costly: few affected individuals can obtain access to such services. Hence it is important to address the health impact of substance use using a range of strategies and utilising every possible contact with a user.

f) Addressing substance use and abuse meaningfully involves not just treatment of individuals, but also addressing the social conditions (including poverty, unemployment, gender-based violence and lack of recreational opportunities) which nurture and promote their use. Policies and legislation that help to protect communities from easy access to substances, particularly alcohol, by regulating where, when and to whom alcohol may be sold have been developed for South Africa and must be implemented.[146,147] The implementation of policies that help protect communities from easy access, especially to alcohol, warrants attention by law-enforcement agencies for example, where taverns are established, how late they can stay open, selling to minors and the like.

Final Comment

The effective implementation of the service-provider core competencies for the MNS disorders identified in this consensus study hinges on two assumptions: access to contextually responsive health workforce education and efficient service environments that promote intersectoral collaboration for human and social development. Appropriately competent service providers can help the healthcare system to transform if policy-makers and managers are responsive to this imperative. A developmental view of human well-being, rather than a medicalised view of the MNS disorders directs services towards health promotion, disease prevention, primary care and people-centred community services. This report will remain a paper exercise if the onus continues to rest on the represented range of health professionals to treat people's illnesses without changing the conditions that made them sick in the first place. People's daily living conditions will only improve when the inequitable distribution of power, money, and resources is addressed.[8] The organisational space and capacity to act effectively on health inequity, therefore, requires investment in training policy-makers, service managers, financial planners, health practitioners and the public in understanding and minimising the social determinants of the MNS disorders. The WHO (2016:2) ebook on the social determinants of health titled *Its Time: Transforming Health Workforce Education for the Sustainable Development Goals*[148] seeks to provide technical support to Member States in formulating and implementing evidence-based policies and strategies to strengthen and transform their workforce education and service environments. The social determinants of the MNS disorders are by their very nature complex, and, to a large degree, context-specific. The transformation of health workforce education will extend the competencies identified in this report to a much wider range of stakeholders to strengthen their social capital as well as the health and development systems in which they operate.

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Appendix 1:

Core functions for each category of provider proposed by current Consensus Study

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
CLINICAL CARE - SCREENING, ASSESSMENT, DIAGNOSIS, MEDICAL TREATMENT				
Community workers	Community Health Workers (WBOT)	Certificate courses	Home visits; targeted screening for mental illness, follow-up adherence for MNS disorders; mental health literacy; linking families to care and support	HEALTH
Community workers	Health Promoters (Facility-based)	Certificate Course	Mental health literacy; Group-based education on health issues	HEALTH
Non-specialised non-prescribing	Emergency medical service providers	Further Education and Training Certificate: EMS	Management of acutely disruptive patients with possible mental illness	HEALTH
Non-specialised non-prescribing	Enrolled nurses (Facility-based)	1-year Certificate	Inpatient and outpatient nursing care; includes basic screening, psychosocial support	HEALTH
Non-specialised non-prescribing	Staff nurses (Facility-based)	Diploma	Inpatient and outpatient nursing care; includes targeted screening (including for relapse), psychosocial support; issue medication	HEALTH
Non-specialised non-prescribing (currently)	Professional nurses (Facility-based)	Diploma or Degree (optional: Post-Basic Diploma in Clinical Nursing Science)	Screening for and assessment of MNS disorders; case management; supervision of enrolled and staff nurses; and 1 designated to supervise community health workers per clinic; limited nurse-initiated antidepressant treatment); manage serious side-effects of medications	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
CLINICAL CARE - SCREENING, ASSESSMENT, DIAGNOSIS, MEDICAL TREATMENT				
Community workers	Community Health Workers (WBOT)	Certificate courses	Home visits; targeted screening for mental illness, follow-up adherence for MNS disorders; mental health literacy; linking families to care and support	HEALTH
Community workers	Health Promoters (Facility-based)	Certificate Course	Mental health literacy; Group-based education on health issues	HEALTH
Non-specialised non-prescribing	Emergency medical service providers	Further Education and Training Certificate: EMS	Management of acutely disruptive patients with possible mental illness	HEALTH
Non-specialised non-prescribing	Enrolled nurses (Facility-based)	1-year Certificate	Inpatient and outpatient nursing care; includes basic screening, psychosocial support	HEALTH
Non-specialised non-prescribing	Staff nurses (Facility-based)	Diploma	Inpatient and outpatient nursing care; includes targeted screening (including for relapse), psychosocial support; issue medication	HEALTH
Non-specialised non-prescribing (currently)	Professional nurses (Facility-based)	Diploma or Degree (optional: Post-Basic Diploma in Clinical Nursing Science)	Screening for and assessment of MNS disorders; case management; supervision of enrolled and staff nurses; and 1 designated to supervise community health workers per clinic; limited nurse-initiated antidepressant treatment); manage serious side-effects of medications	HEALTH
Non-specialised non-prescribing	School Health Nurses (Facility-based; part of WBOT team)	Diploma or Degree (optional: Post-Basic Diploma in Clinical Nursing Science)	Screening for MNS disorders in children and adolescents in school; linkage to mental health care and educational support for inclusive education; mental health literacy;	HEALTH (EDUCATION)

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
CLINICAL CARE - SCREENING, ASSESSMENT, DIAGNOSIS, MEDICAL TREATMENT				
Specialised non-prescribing (but possibly limited prescribing)	Psychiatric nurses (District-based)	Advanced Diploma in Psychiatric Nursing; Masters in Psychiatric Nursing	Links patients with severe mental illness between inpatient and outpatient care; assess patients with mental illness who are referred to specialist mental health services; provide emergency treatment and care; provide psychosocial support; review patients with chronic mental illness; refer to psychosocial rehabilitation & support disability-inclusive development; supervision and support to PHC nurses and community health workers (WBOT), component/ member of District Specialist Mental Health team	HEALTH
Specialised non-prescribing (but possibly limited prescribing)	Child Psychiatric nurses (District-based)	Advanced Diploma in Psychiatric Nursing; Masters in Psychiatric Nursing (child psychiatry)	Assess children and adolescents with mental illness who are referred to specialist mental health services; provide emergency treatment and care; provide psychosocial support; review patients with chronic mental illness; refer to psychosocial rehabilitation & support disability; inclusive development; supervision and support to PHC nurses and community health workers (WBOT), component/ member of District Specialist Mental Health team	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
CLINICAL CARE - SCREENING, ASSESSMENT, DIAGNOSIS, MEDICAL TREATMENT				
Non-specialised non-prescribing	Clinical Associates (Facility-based)	Bachelor of Clinical Medical Practice	Works under the supervision of a medical practitioner; performs any task delegated by a medical practitioner; Assessment and management of emergencies at a district hospital; medical treatment of MNS disorders under supervision	HEALTH
Non-specialised prescribing	PHC doctors (Facility-based)	Undergraduate MBChB	Diagnose MNS disorders in primary care settings. Prescribe primary level medications; review patients referred by PHC nurses, psychologists, social workers & rehabilitation professionals ; supervise PHC nurses; refer complicated cases to family physician or psychiatrist; refer to rehabilitation (psychosocial, vocational, community-based) & psychotherapy services; supports disability inclusive community development	HEALTH
Non-specialised prescribing	Family Physicians (Facility-based - district hospitals and CHCs)	M Fam Med / Diploma in Mental Health	Provide an integrated care service - link mental health care needs with other healthcare needs; Planning, coordination and organisation of services; Review patients referred by PHC doctors, nurses, psychologists, social workers and/ or rehabilitation professionals; supervise PHC doctors;	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
CLINICAL CARE - SCREENING, ASSESSMENT, DIAGNOSIS, MEDICAL TREATMENT				
Specialised prescribing	Psychiatrists (Facility-based - district specialist mental health team or hospital - secondary or tertiary)	MBChB, MMed, FC Psych	Diagnose psychiatric disorders in patients referred from primary level care; act as consultation to family physicians and primary care doctors; manage complex cases who have failed to respond to primary level interventions - provides medical and psychological treatments; refers to rehabilitation (psychosocial, medical, vocational, educational, community-based) services; supports disability inclusive community development; for district psychiatrists: provide planning, coordination, training and supervision for district mental health services	HEALTH
Specialised prescribing	Subspecialist psychiatrists: Neuropsychiatrists; child and adolescent psychiatrists; Addiction psychiatrist; Forensic Psychiatrists (Facility-based at tertiary level, but may do outreach)	Certificates in subspecialty though the College of Psychiatrists	As above, but mainly in area of subspecialty; receives referrals from general psychiatrists; provides teaching and supervision to lower level categories of health service providers	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
CLINICAL CARE - SCREENING, ASSESSMENT, DIAGNOSIS, MEDICAL TREATMENT				
Specialised prescribing	Neurologist	MBChB, MMed, FC Neurologist	Diagnose neurological disorders in patients referred from primary level care; manage complex cases who have failed to respond to primary level interventions - provides specialised medical treatments; provides training and supervision of generalist health workers; refers to rehabilitation & psychotherapy professionals; supports disability inclusive development	HEALTH
Non-specialised non-prescribing	Pharmacist (Facility-based - CHCs and hospitals); pharmacist assistant - basic and advanced	B Pharm / Certificate/Diploma	Dispense and issue psychotropic medications; educate patients on effects and side-effects; provide training to generalist health workers	HEALTH
PROVIDER CATEGORY	**PROVIDER**	**TRAINING**	**CORE FUNCTION**	**SECTOR**
PSYCHOSOCIAL CARE, TREATMENT AND REHABILITATION/RECOVERY/DISABILITY-INCLUSIVE FRAMEWORK				
Community workers	Behavioural Health Counsellors (Facility-based)	Formal/ Matric (Mhint developing certificate in behavioural health counselling)	Provide manualised, structured, evidence-based counselling for common mental disorders (depression, anxiety, substance abuse); adherence and lifestyle counselling)	PILOT MHINT/ PRIME/MRC/ HEALTH
Community workers	Community Rehabilitation Workers	Advanced Certificate in Disability and Rehabilitation (UCT, FET COLLEGES)	Implements basic (supervised) community & home-based psychosocial rehabilitation (activities of daily living) (in particular around comorbidity)	PILOT IN WESTERN CAPE/ SOCIAL DEVELOPMENT

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
PSYCHOSOCIAL CARE, TREATMENT AND REHABILITATION/RECOVERY/DISABILITY-INCLUSIVE FRAMEWORK				
Community workers	OT assistant/OT technician	Diploma	Works under the direction of OT; work with task-oriented psychosocial rehabilitation programmes in groups; income generation and vocational rehabilitation	HEALTH/SOCIAL DEVELOPMENT
Community workers	Auxiliary social workers	Formal - Certificate or diploma	Work under the direction of Social Worker; does casework, providing access and linkage to social services; mental health literacy Implements basic (supervised) community & home-based psychosocial rehabilitation (activities of daily living)	SOCIAL DEVELOPMENT
Community workers	Care workers; child & youth care workers (e.g. children's homes; juvenile detention centres; community psychiatric residential facilities; forensic settings; old age homes)	Formal/ Matric (FET colleges - child and youth; older persons)	Screen and manage high-risk behaviours; monitor emotional and social development in an informal setting; refer appropriately	EPWP/ SOCIAL DEVELOPMENT

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
PSYCHOSOCIAL CARE, TREATMENT AND REHABILITATION/RECOVERY/DISABILITY-INCLUSIVE FRAMEWORK				
Non-specialised non-prescribing	Occupational Therapists (Facility-based, school-based and community-based)	Undergraduate (BSc OT); Post-graduate (MSc OT)	Plan, deliver and coordinate comprehensive community-based, school-based and facility-based (physical and psychosocial/ educational/ vocational) rehabilitation; in-service training and supervision of OTTs OTAs and CRWs); screen and assess functional ability (learning, working etc.) provide disability-inclusive community development	HEALTH, EDUCATION, SOCIAL DEVELOPMENT, LABOUR/ JUSTICE)
Non-specialised non-prescribing	Social Workers (Facility-based and community-based)	Undergraduate BA SW; Post-grad: MA SW in Clinical Social Work or Psychiatric Social Work	Perform statutory casework; provide clinical social work services; provide community development programmes; plan, deliver and coordinate comprehensive psychosocial support geared towards re-integration)	SOCIAL DEVELOPMENT/ HEALTH/ EDUCATION/ LABOUR/JUSTICE
Specialised non-prescribing	Registered counsellors (Facility-based and community-based)	B Psych	Assess for common mental disorders and substance abuse; provide evidence-based counselling interventions; train and supervise behavioural health counsellors	HEALTH
Specialised non-prescribing	Counselling Psychologists (Facility-based and district-based)	Masters Psych (Counselling)	Assess for common mental disorders and substance abuse; conduct psychometric assessments; provide evidence-based counselling interventions; train and supervise registered counsellors; mental health literacy	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
PSYCHOSOCIAL CARE, TREATMENT AND REHABILITATION/RECOVERY/DISABILITY-INCLUSIVE FRAMEWORK				
Specialised non-prescribing	Educational Psychologists (Schools and districts)	Masters Psych (Educational)	Conduct neuro-developmental and educational assessments; provide counselling to school pupils and families; advise school and education departments on psychological services for learners, including promotion, prevention and treatment programmes	EDUCATION
Specialised non-prescribing	Clinical Psychologists (Facility-based - hospitals and CHC's or part of district specialist team)	Masters Psych (Clinical)	Diagnose MNS disorders; conduct psychometric assessments; provide evidence-based psychological therapies; train and supervise registered counsellors and lay counsellors in the provision of counselling interventions; participate in multidisciplinary/ district mental health teams	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
MENTAL HEALTH SERVICE MANAGEMENT/DISABILITY INCLUSIVE DEVELOPMENT				
Health and social service managers	Facility managers (Facility-based)	Master's in Public Health (Various)/ Higher Certificate in HealthCare Services Management	Plan and provide integrated primary mental health care; endorse comprehensive services (promotion, prevention, cure, rehabilitation - psychosocial, vocational, educational, community-based, palliation); adhere to staffing, medication and information systems norms	HEALTH/SOCIAL DEVELOPMENT
Health and social service managers	District managers (District-based)	Master's in Public Health	Plan and provide integrated primary mental health care at district level, including ambulatory care, inpatient care in district hospitals and intersectoral collaboration for mental health promotion, prevention, treatment and community-based rehabilitation (including psychosocial, vocational, educational and medical rehabilitation); ensure adequate staffing and infrastructure to meet mental health needs of the community being served; endorse disability inclusive development	HEALTH/SOCIAL DEVELOPMENT
Health and social service managers	District mental health coordinator (currently usually a psychiatric nurse)	Advanced Diploma in Psychiatric Nursing; Masters in Psychiatric Nursing	Plan, coordinate and implement mental health-specific activities for the district in keeping with the district mental health plan	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
MENTAL HEALTH SERVICE MANAGEMENT/DISABILITY INCLUSIVE DEVELOPMENT				
Health and social service managers	District disability coordinator (currently located in municipalities)		Plan, coordinate and implement mental health-specific activities for the district in keeping with the district mental health plan	HEALTH/SOCIAL DEVELOPMENT
Health service managers	Hospital managers (Hospital-based at district, regional, central and specialised hospitals)	Medical Management qualification from the School of Public Health (CMSA)	Plan and provide comprehensive primary, secondary or tertiary mental health care; endorse comprehensive services (promotion, prevention, cure, rehabilitation - psychosocial, vocational, educational, community-based - , palliation) ; adhere to staffing, medication and information systems norms	HEALTH

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
MENTAL HEALTH SERVICE MANAGEMENT/DISABILITY INCLUSIVE DEVELOPMENT				
Health and social service managers	Provincial managers (Province-based mental health and substance abuse coordinator/directorate)	Master's in Public Health	Take leadership in implementing the national mental health policy framework through the development of provincial mental health plans for services at primary, secondary and tertiary levels of care; work closely with the provincial disability coordinator to implement the rehabilitation and disability strategy; ensure provincial level intersectoral collaboration for mental health promotion, prevention and community-based rehabilitation (including psychosocial, vocational, educational and medical rehabilitation); ensure adequate staffing and infrastructure to meet mental health needs of provincial populations being served; endorse disability inclusive development; Monitoring and evaluation of implementation/ service quality	HEALTH/SOCIAL DEVELOPMENT
Health service managers	Provincial managers (Province-based disability coordinator)	Master's in Public Health	Support the implementation of the national mental health policy framework. Implement the strategic framework for disability and rehabilitation	HEALTH/SOCIAL DEVELOPMENT
Health service managers	National managers	Master's in Public Health	Provide technical support to provinces for policy implementation and the provision of comprehensive (promotion, prevention, rehabilitation, palliation) mental healthcare, including advocacy for people with MNS disorders	HEALTH/SOCIAL DEVELOPMENT

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
OTHER				
Community workers	Correctional service officers	Further Education and Training Certificate: Corrections Services	Mental health promotion, prevention and rehabilitation (including psychosocial, vocational, educational and medical) of offenders with MNS disorders during incarceration; mental health promotion, prevention and community-based rehabilitation (including psychosocial, vocational, educational and medical) & social re-integration of ex-offenders /parolees with MNS disorders;	
Non-specialised non-prescribing	Lawyers	LLB	Identifies need for and requests specialist mental state and functional assessments of cases presenting with MNS disorders pre, during and post-trial/litigation; refers to mental health services (psychiatric; psychotherapeutic & rehabilitative)	

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
OTHER				
Non-specialised prescribing	Occupational health practitioners	MB Ch B; BSc Nursing	Screen for and diagnose MNS disorders in workplace settings/ industry/labour environments. Prescribe primary level medications; review patients referred by psychologists, social workers & rehabilitation professionals; refer to supported employment & vocational rehabilitation professionals (occupational therapists, job coaches); refer to psychotherapy services	
Community workers	Police officers	Policing BTech UNISA; Policing NDip UNISA, VUT/ Short course on Mental Health Care Act for SAPS from National DoH	Identification and management of acutely disruptive persons with possible mental illness; transport and referral to appropriate level of mental health care;	
Community workers	Teachers, school counsellors	B Ed	Identify & screen children & youth in psychosocial distress or crisis; refer to appropriate school health and/or primary health care services; implement mainstreaming & disability inclusive education with support from developmental, rehabilitation and psychotherapy specialists; liaison with primary caregivers for learning & behavioural support	
Community workers	Traditional Healers	Registered with Traditional Healer Statutory Council	Diagnoses ailments & prescribes traditional herbal & counselling remedies in compliance with the Traditional Healers Act of 2007;	

PROVIDER CATEGORY	PROVIDER	TRAINING	CORE FUNCTION	SECTOR
OTHER				
Community workers	User groups	Informal	Provide support groups & opportunities for social participation, learning new skills; enable user-led research; campaign for destigmatisation of mental illness and social inclusion of persons with psychosocial disability;	

Appendix 2:

Final list of core competencies developed by current consensus study

This is a comprehensive list of all core competencies identified in this consensus study. Generally they begin with the most basic competencies and end with highly specialised competencies. It is suggested that this list be used by academic/training institutions in reviewing/preparing curricula for providers to enable them to deliver appropriate services to people with MNS disorders.

Candidate Core Competency
Screening
S1.1 Demonstrates awareness of common signs and symptoms
S1.2 Recognises the potential for risk to self and others
S1.3 Demonstrates basic knowledge of causes
S1.4. Provides the patient and community with awareness and/or education
S1.5 Demonstrates cultural competence
SI.6 Demonstrates knowledge of other mental, neurological, and substance use (MNS) disorders
SI.7. Demonstrates the ability to screen for and use screening tools
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
SI.11. Demonstrates knowledge and skills to assess patients and determine level of care needed
SI.12. Identifies cases during home visits
SI.13. Demonstrates knowledge and skills to identify high risk patients or treatment complications (e.g. children, breastfeeding women)
SI.14. Demonstrates knowledge and skills to assess patients at risk of relapse
SI.15. Demonstrates knowledge and skills to conduct a physical exam
SI.16. Recognises primary manifestations of other disorders (e.g. conversion disorder, anxiety)
SI.17. Recognises comorbidities that cause secondary epilepsy
SI.18. Recognises physical features that might indicate an underlying condition other than epilepsy (e.g. skin lesions, deformities)
SI.19. Recognises serious neurological disorders that may present with seizures or epilepsy (e.g., central nervous system infections, other infections, stroke, tumours)
Assessment
A.1. Demonstrates knowledge of when to refer to next level of care/other provider/specialist
A.2. Demonstrates knowledge of potential providers for specialised care within the community
A.3 Demonstrates ability to make a diagnosis according to an algorithm (not considered a clinical diagnosis)
A.4 Demonstrates skills in assessment of relative levels of social, cognitive, and physical functioning
A.5 Demonstrates knowledge of required information for effective referral
A.6. Demonstrates skills in using various assessment tools
A.7 Demonstrates knowledge and skills in diagnosis of psychosocial factors related to condition
A.8 Demonstrates an understanding of and ability to apply contextually appropriate diagnostic systems (e.g. Diagnostic and Statistical Manual of Mental Disorders (DSM), International Statistical Classification of Diseases and Related Health Problems(ICD)
A.9 Demonstrates knowledge and skills to make a formal diagnosis and formulation of differential diagnosis
A.10. Demonstrates ability to determine severity level
A.11. Demonstrates ability to interpret laboratory results
A.12. Demonstrates knowledge about status epilepticus and other types of seizures

A.13. Demonstrates ability to diagnose alcohol use disorders and related problems
A.14. Demonstrates psychological interview skills
A.15. Demonstrates ability to conduct a neuropsychiatric evaluation
16. Demonstrates knowledge of indications when electroencephalogram (EEG) and/or neuroimaging is needed for epilepsy
17. Demonstrates ability to interpret EEG and neuroimaging reports
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 programs
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
TC.16. Demonstrates knowledge and skills to use information technology to improve treatment and care
TC.17. Demonstrates ability in general counselling skills
TC.18. Demonstrates ability to administer brief interventions
TC.19. Demonstrates ability to select appropriate treatment based on an understanding of diagnosis
TC.20. Initiates, organises, and/or facilitates self-help or support groups
TC.21. Provides brief advice on symptom management
TC.22. Demonstrates skills to provide psychosocial interventions
TC.23. Conducts relapse prevention programmes
TC.24. Demonstrates skills in home visitation
TC.25. Assists with adjustments following discharge
TC.26. Demonstrates competence in the delivery of evidence-based therapies
TC.27. Advises patients and families on taking medications properly
TC.28. Demonstrates knowledge of and ability to apply relevant legislation and policies and access to appropriate services
TC.29. Demonstrates knowledge of drug interactions
TC.30.Provides appropriate forms of therapy (e.g., individual group, family, marital)
TC.31. Demonstrates knowledge of community-based rehabilitation approaches
TC.32. Educates patients about side effects, contraindications, etc.
TC.33. Demonstrates skills to provide long-term support and/or care
TC.34. Reports information to relevant health management systems
TC.35. Demonstrates knowledge and skills to dispense medications
TC.36. Assists patients with access to other providers and help coordinate efforts
TC.37. Provides advice on symptom management
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
TC.43. Demonstrates knowledge and skills to prescribe, monitor, and adjust medication per patient response and in consultation with other providers
TC.44. Demonstrates ability to offer work, social, and recreational activities in a welcoming atmosphere
TC.45. Demonstrates skills to provide structured clinical interventions
TC.46. Manages acute hospitalisation of patients with severe conditions pending review/transfer to specialist
TC.47. Demonstrates knowledge and skills to treat comorbidities according to level of training
TC.48. Provides team members with skills in assessment, treatment and follow-up
TC.49. Screens for adverse events and allergies
TC.50. Demonstrates knowledge and skills to supervise treatment and care/follow-up care by other providers
TC.51. Manages inpatient treatment and care
TC.52. Provides follow-up and referral for patients with active epilepsy; recognises status epilepticus and referral as an emergency
TC.53. Demonstrates mental health promotion skills to prevent depression
TC.54. Demonstrates knowledge and skills to provide medication management for complex cases, including second- and third-line medications and mood stabilisers
TC.55. Supervises complex regimens requiring more than one drug
TC.56. Administers long-term interventions
TC.57. Demonstrates knowledge and skills to provide structured psychosocial interventions, individual and group (e.g. interpersonal psychotherapy, cognitive behavioural therapy (CBT), problem-solving therapy (PST))
TC.58. Defines and initiates a treatment plan
TC.59. Demonstrates knowledge and skills to apply various modalities of psychotherapy to treat patients
TC.60. Recognises when to consult prescriber about appropriateness of prescription (e.g., wrong dose, critical drug interaction)
TC.61. Develops and administers a rehabilitation plan in consultation with the primary care provider
TC.62. Demonstrates skills to monitor and assist in rehabilitation
TC.63. Provides supervision of complex cases, including those with neurological comorbidities
TC.64. Manages status epilepticus
TC.65. Demonstrates knowledge and skills to treat serious neurological disorders that may present with seizures or epilepsy (e.g. CNS infection, stroke, tumour)
TC.66. Administers modified electroconvulsive therapy (ECT)
TC.67. Demonstrates knowledge of drug dosing for children and adults, titration (both first-line drugs and adjuncts)
TC.68. Demonstrates knowledge and skills in treatment of cases complicated by infectious (e.g. HIV/AIDS) and non-communicable diseases
TC.69. Demonstrates knowledge and skills to provide a full range of psychological therapies
TC.70. Demonstrates knowledge of when to initiate treatment if a comorbid neurological condition exists
TC.71. Demonstrates knowledge and skills for the selection of patients for surgical management

TC.72. Demonstrates skills to provide social intervention — addressing social problems that led to/are maintaining depression
TC.73. Demonstrates knowledge and skills to manage refractory epilepsy
TC.74. Demonstrates knowledge and skills in management of psychiatric comorbidities
TC.75. Demonstrates knowledge and skills in management of pseudo-seizures
Rehabilitation/recovery/disability-inclusive development
RD.1 Demonstrate awareness of community-based rehabilitation
RD.2 Demonstrates awareness of community-based rehabilitation as an intersectoral strategy for community development
RD.23 Demonstrates ability to recognise functional limitation arising from MNS disorders and refer for assessment
RD.4 Demonstrates knowledge of the International Classification of Health, Functioning and Disability
RD.5 Demonstrates knowledge of disability models across the lifespan
RD.6 Demonstrates knowledge and skill in community-based rehabilitation as an intersectoral strategy for community development
RD.7 Demonstrates ability to assess disability (interaction between environment and impairments, activity limitations and participation restrictions) arising from MNS disorders
RD.8 Demonstrates ability to plan, implement and evaluate recovery orientated psychosocial rehabilitation programmes for individuals and groups (specific to OT/SW)
RD.9 Demonstrates knowledge and skill in assessing and modifying the environments in which people affected by MNS disorders live, learn, work, recreate and socialise to promote their participation and social inclusion Specific to OT and SW
RD.10 Demonstrates knowledge and skill in assessing and enabling work readiness, work hardening, supported employment and/or income generation for people with disabilities (OT)
RD.11 Demonstrates knowledge and skill in applying disability accessibility standards and universal design to promote learning and development (teachers, educational psychologist, school health nurses)

Candidate core competencies for South Africa proposed at the 2014 ASSAf workshop

These competencies were used in the review of current training curricula. Rehabilitation and disability inclusive development competencies were added by this consensus study and were also included in the review.

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

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
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
Rehabilitation/disability-inclusive development (RD)	
RD 1.	Demonstrates knowledge of the International Classification of Health, Functioning and Disability
RD.2	Demonstrates knowledge of disability models across the lifespan

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

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
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.6	Demonstrates an understanding of and ability to apply contextually appropriate diagnostic systems (e.g. DSM, ICD)

DR.7	Demonstrates knowledge and skills to make a formal diagnosis and formulation of differential diagnosis
DR.8	Demonstrates ability to determine severity level
DR.9	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
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
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
TC.17	Demonstrates ability in general counselling skills
TC.18	Demonstrates ability to select appropriate treatment based on an understanding of diagnosis
TC.19	Provides brief advice on symptom management
TC.20	Demonstrates knowledge of and ability to apply relevant legislation and policies and access to appropriate services
TC.21	Reports information to relevant health management systems
TC.22	Assists patients with access to other providers and help coordinate efforts
TC.23	Documents medical records
TC.24	Demonstrates knowledge and skills to consult with other providers in the treatment/care team
TC.25	Demonstrates knowledge and skills to provide proactive follow-up and monitors outcomes of care
TC.26	Demonstrates knowledge of standard drug regimens
TC.27	Provides mentoring and support to other healthcare providers

Rehabilitation/disability-inclusive development (RD)	
RD1.	Demonstrates knowledge and skill in community-based rehabilitation as an intersectoral strategy for community development
RD.2	Demonstrates ability to assess disability (interaction between environment, impairments, activity limitations and participation restrictions) arising from MNS disorders
RD.3	Demonstrates ability to plan, implement and evaluate recovery orientated psychosocial rehabilitation programmes for individuals and groups
RD.4	Demonstrates knowledge and skill in assessing and modifying the environments in which people affected by MNS disorders live, learn, work and socialise to promote their participation and social inclusion
RD.5	Demonstrates knowledge and skill in assessing and enabling work readiness, work hardening, supported employment and/or income generation for people with disability arising from MNS disorders
RD.6	Demonstrates knowledge and skill in applying disability accessibility standards and universal design to promote learning and development

Appendix 3:

Traditional Health Practitioners

Introduction

Traditional health practitioners (THPs), also known as traditional healers, have been an integral part of the history and culture of South Africa for centuries. People who subscribe to African cultural beliefs see traditional healers as playing an important role in their healthcare and helping to ensure their well-being. Today there are estimated to be over 200 000 traditional healers across the country. Traditional healers have formed over 100 different traditional healer associations to represent them.[1]

Until recently, traditional healers have operated relatively independently of government regulation, although many worked through organisational structures, such as the Traditional Healers Organisation, which has more than 29 000 members.

It is estimated that between 70% and 85% of black South Africans consult THPs and up to 97% of people living with HIV/AIDS first use complementary medication or medication prescribed by a traditional healer before starting antiretroviral treatment. According to Zabow (2007),[2] THPs are popular and widely consulted even in urban areas, and this applies particularly with regard to mental health issues. For some black South Africans, this is because they believe in bewitchment as a cause of mental illness, and therefore consulting a THP is then the logical solution to the problem.[3]

However, urbanised, more affluent black South Africans do not necessarily subscribe to the notion of bewitchment. Other Africans may utilise the services of traditional healers because they perceive them as able to invoke the ancestors (given that traditional African cosmology ascribes great importance and power to previous generations, especially those who are deceased). The powerful use of ritual in some forms of traditional healing may have particular importance for certain clients. Finally, there are those that wish to consult a THP, as well as a practitioner of Western medicine, in the same manner, that people of European ancestry might take homoeopathic medicines and utilise Western health services.

In 1999 Ensink and Robertson reported the findings of a study in Cape Town which explored African patients' utilisation of both traditional medicine and Western psychiatry. In their sample of 62 psychiatric patients, they found that 71% had consulted a traditional healer within the previous year: 34% had consulted faith healers, 24% had visited diviners, and 13% herbalists. A total of 53% had utilised Western general medical services in the same time.[4] Other studies of Africans' usage of both Western medical services and THPs have found that a significant proportion use both services, without necessarily seeing such practices as conflicting.

A recent systematic review of the effectiveness of traditional healers in treating mental illness found evidence that traditional healers can provide effective psychosocial interventions, and, particularly, that their interventions could help to relieve distress and improve symptoms in common mental disorders such as depression and anxiety. However, in the case of severe mental illnesses such as bipolar and psychotic disorders, the review found that traditional healing was insufficient, and referral to conventional psychiatric services was necessary to obtain better treatment outcomes.[5]

1.1 Inclusion of traditional healers in the health system

In the late 1970 the inclusion of THPs to informal healthcare systems was endorsed by the World Health Organisation and other developmental agencies. However, the apartheid government at that time had no desire for the public health sector to develop a closer relationship with African traditional healers, since African medical practices were seen as 'barbaric', 'primitive' and 'heathen', a continuation of the prejudiced views held by the first white settlers who came into contact with black Africans, around the beginning of the nineteenth century.[6]

In the previous three decades, health providers in South Africa who utilised a Western scientific epistemology in providing care and treatment to patients with mental health challenges have come to see the benefits of collaboration with traditional African health practitioners.[2] However, *how* to work together is less clear.
Even after the first South African democratic elections took place in 1994 and a new government was installed that aspired to represent all South Africans, the newly constituted National Department of Health made no immediate moves to alter South African health policy, In order for the health system to work with and be more inclusive of traditional healers.[7]

Since 2000 the South African government has taken steps to include traditional healers in combating HIV/AIDS. THPs are referred to in the current plan (*South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022*) and were also involved in the development of the current and three previous National Strategic Plans.[8] There is evidence that given appropriate training and support, traditional healers are able to support national HIV/AIDS interventions in a range of ways: to educate community members about HIV/ AIDS (particularly dispelling myths and providing information regarding prevention); to encourage uptake of antiretroviral treatment and adherence to treatment; to conduct basic TB screening and refer patients with any signs to public health facilities; and, to mitigate against HIV/AIDS stigma in the community.

Despite the commitment to inclusion of traditional healers, there was no regulatory framework in place until 2007, when the Traditional Health Practitioners Act was promulgated. The Act defines traditional health practice as follows:[9]

"The performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicines or traditional practice and which has as its object:

1. the maintenance or restoration of physical or mental health or function; or
2. the diagnosis, treatment or prevention of a physical or mental illness; or
3. the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or
4. the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childhood and death."

The Act provided for:[2]

- The establishment of an interim Traditional Health Practitioners' Council
- The provision of a regulatory framework, to ensure the efficacy, quality and safety of traditional health care services, and
- Management and control of the registration, training and practice of traditional health practitioners, both qualified practitioners and students in training.

1.2 Inauguration of the Interim Traditional Health Practitioners Council

In early 2013 the Interim Traditional Health Practitioners Council, appointed by the Minister of Health, was finally inaugurated. In terms of legislation the Council comprises no more than 22 members, which includes the following:

- One THP representative per province (i.e. nine in total)
- A representative of each of the four recognised THP categories, i.e.:
  - A diviner *(sangoma)*
  - A herbalist *(inyanga)*
  - A traditional birth attendant *(ababelethisi),* and
  - A traditional surgeon *(inqibi)*.
- A traditional tutor, i.e. an individual involved in the training of THPs
- A student of traditional health practice, i.e. someone currently undergoing training to become a THP
- A legal expert
- A member of the Health Professions Council of South Africa who is a medical practitioner
- A member of the South African Pharmacy Council who is a pharmacist
- Community representatives, and
- Representatives of the National Department of Health.

The sections of the Act that enabled the Council to become functional came into effect on 1 May 2014. The interim Council was granted extensive powers to oversee the registration and regulation of the practice of THPs by setting practice standards.[10]

1.3 Proposed regulations

In November 2015, after consultation with the interim Council, the Minister of Health published Traditional Health Practitioner Regulations and requested comments from interested parties.[11] Rene Street of the Environment and Health Research Unit at the South African Medical Research Council (Durban) commented on the regulations in an editorial published in the *South African Medical Journal* in April 2016. She criticised the proposed regulations, saying that their lack of substantive detail left a great deal of room for interpretation and speculation. She pointed out that the entire regulatory framework for traditional healers, students and trainers was described in a document of just four pages.[12]

1.4 Registration as a THP or as a THP student

The Act stipulates that nobody can practise as a THP unless they are registered with the Council. The conditions laid down for registration of an applicant THP include that the THP must submit:

- proof that they are a South African citizen (i.e. they should produce a South African identity document (it is unclear whether or how foreigners offering traditional healing services will be accommodated here);
- proof of the highest standard passed at school (i.e. provide a certified copy of a school-leaving certificate, if any);
- an unspecified number of character references provided by members of the community who know the applicant but are not related to them;
- proof of qualification as a THP (if any); and,
- payment of R200.

The Act provides no clarity regarding what happens if the THP cannot produce all three documents.

1.5 Admission to THP training

A further schedule of the Regulations states that all THPs "must undergo education or training at any accredited training institution or educational authority or with any traditional tutor" (see below).
In comparison with the unclear criteria for registration as a currently practising THP, the minimum requirements for registration as a student THP are clearly outlined. No individual is permitted to start a THP traineeship unless he or she is registered as a student with the Council. The student must provide proof that:

- he or she is a South African citizen, by producing a South African identity document
- he or she has a certificate showing that he or she has attained adult basic education and training (ABET) level 1 or its equivalent (which should ensure basic literacy and basic numeracy);
- the length of the training to be provided;
- he or she is above the minimum age (18 years for students in training to become a herbalist or a diviner, and 25 years for students in training to become a traditional birth attendant or a traditional surgeon); and,
- a minimum period of training needs to be attended: the minimum period being one year to become a diviner, a herbalist or a traditional birth attendant, and five years to become a
- traditional surgeon.

Following the completion of training, a registered THP student is required to submit a logbook to the Council that provides details of observations and of procedures in which the student acquired competency during training, In order to qualify for registration in the relevant THP category.

1.6 Minimum training standards

Another schedule of the Regulations states that all THPs have to "undergo education or training at any accredited training institution or educational authority or with any traditional tutor". The relationship between the schedule regarding registration and the schedule regarding training is unclear, i.e. whether registration is delayed or conditional on a THP having undergone specific training.

In terms of the Act, an 'accredited institution' means "an institution, approved by the Council, which certifies that a person or body has the required capacity to perform the functions within the sphere of the National Quality Framework (NQF)". Unfortunately, the proposed THP Regulations do not list specific content or define a curriculum for training: the section under minimum standards for student training provides a very general outline of what is expected. In the list of supporting documents for trainers, a request is made for copies of teaching or learning materials. However, an actual process for vetting the submitted curricula is not provided. It is also unclear how the submission of training materials by individual THPs will culminate in a national training programme under the NQF. The submission of teaching/learning materials is one aspect of a broader discussion about intellectual property rights, including the protection of indigenous knowledge and knowledge of indigenous plants.[13]

1.7 Accreditation of THP trainers and training institutions

The regulations impose additional responsibilities on traditional healers, which may be costly and time-consuming. For example, the proposed regulations require traditional healers to undergo training at an accredited training institution, to ensure that the profession complies with universally accepted healthcare norms. But how, when or where this training will take place is unclear, as there are no current accredited training institutions. A prospective trainer will have to register with the Council at a cost of R500. They would need to

provide a list of their qualifications and details of the course modules, practical skills that would be acquired and duration of training. But the minimum skills or qualifications are not defined in the regulations. Trainers are expected to produce copies of their teaching and learning materials. This may have serious implications for intellectual property rights. Training institutions also need to consider that the various sub-categories of traditional healer have widely divergent training needs.

1.8 Sub-categories of traditional health practitioner

THPs are not a homogeneous group, and it is important to understand the different roles that various types of health practitioners may play. There are four recognised categories of THP in terms of legislation: diviners, herbalists, traditional birth attendants and traditional surgeons. It is commonplace for a THP to integrate into their practice of healing more than a single approach.

1.9 Core competencies of diviners with regard to MNS disorders

1.9.1 Introduction

A diviner or *sangoma* is usually female and operates within a traditional religious context. A diviner is perceived to act as a medium between the present world and the ancestors of the individual who visits the diviner and seeks help. Inexplicable illnesses are diagnosed by interpreting messages from the ancestors. A diviner is usually respected within the community in which she operates. She generally is understood as not choosing her profession, but instead receiving a calling directly from her ancestors to become a diviner. Those who are called then undertake an apprenticeship with a fully qualified and experienced diviner.[a]

1.9.2 Minimum training standards

In terms of the Traditional Health Practitioner Regulations of 2015, to qualify for admission to training as a diviner, a candidate needs to:

- provide proof that he or she is a South African citizen (usually by producing a South African identity document);
- have a certificate showing that he or she has attained adult basic education and training (ABET) level 1 or its equivalent; and,
- be at least 18 years of age.

The training of a diviner should be last at least 12 months. Minimum competencies are merely listed as diagnosis, the preparation of herbs and traditional consultations.

1.10 Core competencies of herbalists with regard to MNS disorders

1.10.1 Introduction

A herbalist or *inyanga* specialises in the use of herbal medicinal potions to treat disease and illness. A herbalist is often but not always male. Herbalists are generally not 'called' to their profession, unlike diviners, but rather make a personal choice to enter this field. Herbalists do not profess to have divine powers. A herbalist is expected to possess extensive knowledge of curative herbs, natural treatments, and medicinal mixtures of animal origin. Their comprehensive curative expertise is expected to include preventive and prophylactic treatments, and they make extensive use of rituals and symbolism to assist in healing. Some herbalists become specialists in their field, renowned for their knowledge and skill. [b]

The Traditional Health Practitioner Regulations of 2015 states that to qualify for admission to training as a diviner, a candidate needs to:

- provide proof that he or she is a South African citizen (usually by producing a South African identity document);
- have a certificate showing that he or she has attained adult basic education and training (ABET) level 1 or its equivalent; and,
- be at least 18 years of age.

The training of a herbalist should take at least 12 months. Minimum specified competencies are the identification and preparation of herbs, sustainable collection of herbs, dispensing of herbs, and conducting a

a. Information downloaded from: https://theculturetrip.com/africa/south-africa/articles/different-types-healers-south-africa on 27 September 2018.

consultation with a client.

1.11 Core competencies of traditional birth attendants with regard to MNS disorders

The principal role of a traditional birth attendant (TBA) is to attend to women during pregnancy and labour, as well as the postnatal period. Their practices may include providing advice or instructions as to what to eat and what not to eat; provision of herbal remedies for pain, sickness or discomfort; abdominal massages; offering psychological comfort to mothers and providing them with a sense of security. The TBA assists with the delivery of the child and advises the new mother on how to care for the infant. TBAs play an essential role in the delivery of healthcare to pregnant mothers in South Africa, as reflected in the fact that rates of home delivery of between 40% and 60% are found in some rural provinces such as the Eastern Cape.[15]

TBAs are respected in rural communities for their understanding of childbirth, their knowledge of problems associated with pregnancy, and their ability to assist with deliveries.[b]

TBAs have been described as an important resource to identify pregnant women at risk of complications during childbirth and to encourage timeous referral to the public healthcare system for further management. There is also some evidence that training of TBAs in HIV/AIDS can reduce the incidence of risky practices for HIV transmission during childbirth, and results in fewer complications during childbirth.[16]

The Traditional Health Practitioner Regulations of 2015 states that to qualify for admission to training as a traditional birth attendant, a candidate needs to:

- provide proof that he or she is a South African citizen (usually by producing a South African identity document);
- have a certificate showing that he or she has attained adult basic education and training (ABET) level 1 or its equivalent; and,
- be at least 25 years of age.

1.12 Core competencies of traditional surgeons with regard to MNS disorders

The Traditional Health Practitioner Regulations of 2015 states that to qualify for admission to training as a traditional surgeon, a candidate needs to:

- provide proof that he or she is a South African citizen (usually by producing a South African identity document);
- have a certificate showing that he or she has attained adult basic education and training (ABET) level 1 or its equivalent; and,
- be at least 25 years of age.

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Appendix 4:

ASSAf Consultative Workshop report

Report on ASSAf Consultative Workshop held at Caesar's Palace conference centre, Ekurhuleni on 16 October 2018 for the ASSAf consensus study: What do we need to provide improved mental health care for the nation? Provider core competencies for mental, neurological and substance use (MNS) disorders within a task-shifting/sharing framework

1 Introduction

The purpose of the consultative workshop was to provide an opportunity to gather together key stakeholders involved in the training of health service providers, as well as those responsible for policy, planning and implementation of services for people with mental, neurological and substance use (MNS) disorders in South Africa, to present the draft findings of the consensus study to stakeholders, and to obtain their feedback and reflections on the findings. The deliberations and findings of the workshop were seen as a critical input to help refine the study, as well as to identify systemic challenges or shortcomings which should be addressed.

2 Welcome

Rob Hamilton, an external consultant to the ASSAf project, welcomed everyone to the workshop. He extended particularly warm greetings to those participants who had travelled long distances in order to attend the meeting. Contextualising the consultative workshop, he pointed out that South Africa faced s significant burden of mental, neurological and substance use (MNS) disorders, and a huge treatment gap. Although 16% of South Africans were believed to have a common mental disorder, only one in four individuals needing care and treatment were able to access the services they needed. The consultative workshop was part of a broader process of identifying cost-effective strategies to narrow the treatment gap in South Africa significantly.

3 Feedback on consensus study progress findings

The study in context

The chairperson of the ASSAf consensus study, Prof Rita Thom, outlined the historical development of the consensus study, and progress to date. An overview of the main findings of the comprehensive report on core competencies followed, together with a description of cross-cutting issues and challenges. (See Chapter 10 for further details.)

4 Breakaway group discussions

Following Prof. Thom's presentation and an opportunity for participants to ask questions for clarification, workshop participants were divided into three breakaway groups, each of which was tasked with looking closely at the findings of particular sub-categories of health provider. An effort was made to include a diversity of participants into each group. The three groups were**:**

- ***medical care providers***, including emergency medical staff, medical practitioners, clinical associates, family physicians, neurologists and psychiatrists
- ***primary care providers***, including community health workers, auxiliary nurses, staff nurses, professional nurses and health promoters, and
- ***psychosocial service providers***, including social workers, occupational therapists, counsellors and psychologists.

The breakaway groups were asked to try to answer three questions in their group discussions:

1. To what extent did the findings reflect the **core competencies** of the service providers?
2. To what extent did the findings reflect the major **gaps**?
3. What **changes** needed to be made to the findings, and were there any **additional comments** that should be made?

In a plenary session which followed the small group discussions, a representative of each breakaway group provided feedback to the consultative workshop about issues raised in that group. Feedback from all groups is summarised below in terms of three over-arching categories: systemic issues, provider competency issues, and important issues which should be noted but which were beyond the scope of the study.

A. Systemic issues

A systemic issue which was raised, and which was described as critical was the importance of distinguishing clinical competencies from competencies related to management, planning, coordination and policy development in a community-based system (public mental health competencies). Across the board, more robust and comprehensive training was provided in clinical competencies, compared to the development of other competencies. Another critical area which has been identified as a gap is the competence in specialised providers to provide training and mentoring to other (usually less specialised providers. For example, members of district specialist mental health teams needed to be well trained in public mental health skills listed here, in contrast with members of clinical specialist mental health teams, whose focus was primarily on clinical issues, and for whom clinical training was sufficient, but who also need competence in providing training and supervision.

Adherence wherever possible to the principle of continuity of care was perceived to be a crucial aspect of effective MNS care and treatment. Such continuity would enable health providers to develop long-term professional connections to MNS clients (rather than have connections which were always brief, disrupted or discontinuous). Adopting a public mental health approach, as well as ensuring strategic utilisation of clinical specialist mental health care teams were perceived as necessary for the development of such provider-patient relationships. There was general acknowledgement of the value of clinical specialist mental health teams, but certain challenges were also identified in the implementation of teams at district level. One participant said that team members needed to translate competence into practice. Another idea which was repeatedly expressed was that clinical specialist mental health care teams should not be permanently stationed at regional, central or specialised hospitals, but that they should instead be mobile, i.e. teams should travel around districts in the rendering of MNS services. Further criticism was that the terms of reference of clinical specialist mental health (outreach) teams needed to be reviewed, as they appeared to be too broad. Ideally, they should be employed by, and fall within the ambit of, the district health services.

As discussed above, supervision, debriefing and mentoring of MNS service providers at all levels were described as either inadequate or erratic, or as sometimes not done at all. Specialist mental health providers (including professional nurses with additional training in psychiatry, nurses qualified as primary health care practitioners, family physicians, clinical psychologists, neurologists and psychiatrists) – were not fully utilised in the provision of essential supervision and mentoring. Future training of these provider sub-categories should have an additional focus on the development of competencies in supervision, debriefing and mentoring, participants said. In addition, planning of MNS care and treatment should make more strategic use of specialist competencies in these areas.

Participants argued that an absence of widely accepted norms for MNS care and treatment in the public health sector was a barrier to effective provision of care and treatment. Other participants commented on limited numbers of public-sector posts for mental health services established at primary health facility level and district level.

Various individuals commented on structural or social barriers which deterred medical doctors, occupational therapists and some psychologist sub-categories from providing mental health care and treatment (despite these professional providers having received specific training to deliver such services). These barriers were seen as including:

- the stigma of mental illness in many communities;
- lack of support from more experienced mental health specialists to enable these providers to deliver care and treatment; and,
- Insufficient focus on mental health during internships and the period of community service served by medical doctors (for example, during a two-year internship doctor were generally allocated a single month for mental health care, compared to four months allocated to other areas of specialisation which were assigned greater priority). An equivalent focus on MNS care and treatment is needed from the beginning of the basic training of all health professionals consistently through to their completion of internships and periods of community service.

One workshop participant said that collaborative care was not possible; rather, what appeared to take place was referral for MNS disorders either up or down the public health care system, which was an obstacle to effective delivery of the care and treatment of mental illness. It was necessary to consider a more holistic approach for capacitating health providers regarding MNS competencies. Fragmentation of MNS services needed to be addressed. Likewise, one participant said, unwarranted competition between health providers in delivering MNS care and treatment should be discouraged, since only through cooperation and collaboration could the country's health providers effectively address all the care and treatment needs of people with MNS disorders.

In one breakaway group, the smooth transportation of sedated MNS patients was described as problematic because of difficulties in securing transportation by members of the South African Police Service (SAPS). In terms of the law, SAPS members are expected when necessary to assist in the provision of such transportation. However, SAPS personnel are often reluctant to assume this responsibility since they lack the confidence and competence required to deliver the service. A suggestion was made that SAPS members should receive additional training regarding the transportation of such MNS patients, since in rural areas with poor service coverage by emergency medical services, the services rendered by SAPS personnel were critical. (Training materials to equip SAPS members in this regard were developed in 2004-5 and are still available within the SAPS.)

Different views emerged regarding what the core competencies of mid-level service providers should be. However, there was general agreement regarding the need to consolidate various sub-categories of community-based worker into fewer groups, and on the need for training to focus on a limited number of essential competencies. It was important to fully empower mid-level employees to provide the services that communities required of them. Mid-level providers needed formal training, career paths and recognition of their skills and experience. Recognition of prior learning (RPL) was essential.

Another workshop participant stressed the importance of returning to core principles to ensure equity, social justice, human rights and transformation in MNS service provision. A further fundamental principle was identified as taking into account the views and experiences of mental health service users in implementing mental health care and treatment programmes.

It was felt that training of all MNS health providers should include an additional focus on members of different provider categories sharing with each other their unique and distinctive roles within the MNS patient care and treatment algorithm. In particular, biomedical and psychosocial aspects of care and treatment needed to be understood as complementary, rather than being seen as conflicting.

Finally, there were questions asked about the process used in the consensus study to arrive at the core competencies and whether consideration had also been given to the issue of co-competencies.

B. Provider competency issues

Members of each breakaway group focused their discussions on whether or not the draft document which had been circulated before the meeting was an accurate reflection of the competencies of providers who were within the ambit of that group; they identified and attempted to correct any inaccuracies' they were requested to add important additional comments. This section summarises comments made in all three breakaway groups regarding all categories of health provider.

When the competencies of **medical practitioners** (doctors) were discussed, the consensus was that clinical training with regard to MNS competencies was sound, apart from systemic constraints deterring practice of learned competencies described in the previous section. However other systemic issues affecting doctors were also identified, for example junior medical doctors in some provinces were not permitted to initiate treatment with fluoxetine, which thus prevented them from delivering a full range of general psychiatric care in their clinical work.

Participants said that the University of KwaZulu-Natal (UKZN) Medical School was engaged in decentralisation of the doctors' training platform for all clinical training, for example by involving all districts of the province in the training process. All UKZN medical students are required to spend time working outside of Durban, and this also ensured constant discussion about health platforms. The MB Ch B curriculum was taught largely by family physicians, to try to further develop primary care practitioners. Medical schools at the University of Cape Town, Stellenbosch University and the University of the Witwatersrand were currently engaged in similar processes.

Emergency medical services (EMS) workers needed to have their competencies defined in greater detail, participants said. EMS curricula did not address all the core competencies identified, and in particular, the issues of psychological first aid and crisis intervention were not adequately addressed during training. One of the challenges of EMS training was that it failed to contextualise different emergency procedures – instead, teaching was sometimes piecemeal. Mental health content needed to be a core component of EMS curricula. The Board which oversaw EMS providers should be approached to develop further guidelines for training in mental health competencies.

Clinical associates were given limited training in a few MNS areas. However, often their training was provided by lecturers who had little or no experience of psychiatry. If more clinical associates could be trained, they might be able to play a more significant role in rural areas, where few doctors were available to render

services. Clinical associates based in rural settings care were often utilised in casualty services, where they made a vital contribution. Currently, Wits University was piloting an initiative to enhance the training of clinical associates, and the project could help inform broader expansion of training and curriculum development for clinical associates at other training institutions.

Family physicians were described as a professional resource which was not fully utilised. Previously family physician training had required completion of a psychiatric rotation, but this condition had been discontinued, mainly owing to challenges with training platforms, for example, psychiatrists who provided mental health training were usually based at regional or district hospitals, whereas family physicians were mainly trained within district health services (including at district hospitals). There were various ways to address the problem, for example, placement of psychiatric registrars in primary care clinics could assist with the training of family physicians, but such a change would require discussion between departments of psychiatry and family medicine, as well as with provincial health services.

Career **medical officers with specialisation in psychiatry** could be a useful resource in the district mental health services. One possibility would involve introducing a two-year training of medical officers in psychiatry, who were proficient in district and community level work. An offering of this nature would enhance the work of the district specialist mental health teams, especially in districts where there were no psychiatrists or doctors with psychiatric experience. The Diploma in Mental Health from the College of Psychiatrists is a qualification that is currently available for this cadre. It would be an incentive if departments of health recognised this qualification and remunerated diplomates appropriately through the Occupation Specific Dispensation.

Psychiatrists are essentially trained to become clinical providers, but there was far less focus in their training on community psychiatry, participants said. In particular, psychiatrists' involvement in supervision, training and leadership received less attention, which was unfortunate since these important roles in public mental health services could be assumed particularly well by psychiatrists. Changes to the training platform for psychiatry were critical, including enhanced training in leadership, mentorship, training and supervision. Such modifications could be included in the new public mental health curricula currently in the process of development at some universities. Advocacy was also a critical function of psychiatrists (as it should also be for psychologists, OTs and professional nurses, participants said).

Few psychiatrists currently felt sufficiently competent to engage in medico-legal work or to conduct forensic psychiatry assessments (especially for criminal cases) or to provide care and treatment to children and adolescents with mental health problems. It was felt that core training of psychiatrists needed to include sufficient curriculum content on forensic psychiatry, as well as on child and adolescent psychiatry, to enable all psychiatrists to acquire the competence to provide services in these areas.

The only comment made about **neurologists** was that they needed greater exposure to psychiatry during their training.

Social workers were seen as generally competent to screen for mental disorders, but they were not competent to diagnose. Only clinical social workers are provided with training (at a Master's degree level) which focuses specifically on mental health. Social work training needs to incorporate further input on psychopathology, including management of severe mental illness, and psychoeducation of the families of individuals with severe mental illness. Additional training of social workers in basic counselling skills would also be helpful. The quality of social work placements is very important to the acquisition of competency since if satisfactory supervision and mentoring in placement settings are missing, graduate social workers will not have developed the necessary skills. With inadequate supervision, there is also the risk that social work graduates will only acquire generalised competencies but lack more specialist skills.

Participants were of the opinion that recommendations about how various sub-categories of **psychologist** should contribute to MNS care and treatment could not be finalised while the scope of practice of the sub-categories was still under discussion. The decision by the Board for Psychology about the competencies of the various sub-categories should be known by December 2018 and would help to inform such recommendations.

With regard to **registered counsellors**, participants said that there was no uniformity in the training provided for them by different training institutions. Registered counsellors were seen as competent to screen for mental disorders but they are not seen as competent to diagnose mental illness. The Board for Psychology needed to clarify whether or not registered counsellors could supervise and/or mentor other care providers, one participant suggested.

There was extensive discussion at the consultative workshop regarding the role to be played by **behavioural health counsellors**, a proposed new sub-category of lower-level counsellor. Concerns that were raised about

behavioural health counsellors included which regulatory body should be involved in overseeing their work, and what the entry-level requirements for admission to training for this health provider category should be.

The scope of practice of **occupational therapists (OTs)** should be expanded, participants said, and there should be explicit acknowledgement that OTs are competent to prevent and treat neurological disorders. **Community rehabilitation workers (CRWs)** were identified as playing an important role in the referral process for patients requiring physical rehabilitation. **Occupational therapy assistants (OTAs)** and **occupational therapy technicians (OTTs)** were also seen as able to play a more significant role in community-based mental health care outreach.

Some participants were concerned that **community health workers** (CHWs) exhibited no competencies related to MNS disorders, and that their job specification did not include the ability to screen for, and to refer people with signs and symptoms of mental illness. However, this is not the case – the training curriculum for CHWs specifically mentions their being trained to screen for anxiety and depression, and to be competent to refer individuals with 'more serious mental illness' to appropriate services (see Chapter 2 for further details).

C. Important issues beyond the scope of the study

Art, drama and music therapists were not included in the consensus study, but participants acknowledged the potentially important contribution that they could make at community level. They should be more widely valued as professionals who could make a critical contribution to care. However, greater numbers of each therapist needed to be trained to enable their impact to be felt. It was suggested that posts could be created for these providers in the public health sector.

Faith-based communities are an extensive and often, experienced resource for counselling and community engagement. It was suggested that future planning about the development of MNS competencies include them.

Traditional health practitioners (THPs) already played a critical role in mental health care, and so it was crucial that future work on competencies engaged with the THP sector. Traditional healers are able to work closely with primary health care providers. It was considered important to ensure greater involvement of traditional healers in identifying potential mental health service users (MHSUs). Traditional healers saw mental disorders as broader than a biomedical diagnosis, and they also included aspects of spirituality in their understanding of disorders. MHSUs frequently first consulted THPs. The care provided by traditional healers could embrace all those affected by an individual's mental health issues, i.e. potentially members of the individual's extended family. An identified gap in MNS care and treatment was the public health sector's failure to involve traditional healers in identifying individuals with MNS disorders, providing training to enable THPs to make appropriate referrals, and assisting THPs with training to provide counselling and to encourage adherence to treatment. Better integration of THPs and mental health professionals in the provision of mental health care and treatment is required.

5 Concluding discussion and the way forward

Discussion following feedback from the breakaway groups focused on how the process should be taken forward. The following points were made regarding what needed to be done, and received general assent from those who were present at the consultative workshop:

- The outputs of the consensus study should ideally align with the deliberations of the Human Resources (HR) Planning Committee in the National Department of Health.
- Reorientation and a move to more holistic care are essential, rather than mental health care merely being inserted into other health care and treatment programmes.
- The crisis in nurse education and the shortage of trained nurses are pressing issues which merit urgent and ongoing attention.
- With regard to professional nurse training, clarification is urgently needed regarding the extent to which psychiatry is to be covered in the new training curriculum.
- Continued incorporation of a robust psychiatry component in the general nursing qualification needs to be advocated for. There was general agreement that professional nurses need to have more than an elementary knowledge of psychiatry.
- Enrolled nurses were seen as an underutilised resource. In the light of the chronic shortage of professional nurses in South Africa, it was critical that enrolled nurses received enhanced training in care and treatment of MNS disorders, and continuity of care.
- Traditional health practitioners (THPs) and lay workers who are linked to faith-based organisations (FBOs) need to be taken into consideration and consulted in any future planning regarding mental health service provision.
- Future planning regarding provider competencies in MNS care and treatment should also engage with the Department of Social Development (DSD).

- While the national and provincial departments of health are primarily responsible for the care and treatment of people with mental illness and neurological disorders, the task of addressing substance use disorders in South Africa rests mainly with the Department of Social Development (DSD). There was agreement that future discussions regarding provider competencies related to, and the care and treatment of people with substance abuse disorders should engage with the DSD.
- Mental health promotion and prevention of MNS disorders fell outside the scope of the consensus study. However, there was general agreement amongst delegates that mental health promotion should be prioritised as a matter of urgency, and that this required the health sector to work more closely with the education and social development sectors, including the Department of Basic Education (DBE), the Department of Higher Education and Training (DHET) and the DSD.
- Acknowledgement of the importance of rehabilitation services at all levels - clinic, district and province - was crucial to reduce the long-term burden of MNS disorders. Occupational therapy providers and rehabilitation workers need to be fully incorporated into district mental health planning.
- It is critical for mental health promotion and mental health interventions focused on children and young people to be prioritised since this life-stage is often when mental illness and substance abuse first manifest. MNS care and treatment of young people is cost-effective and could help reduce the long-term burden of MNS disorders in the adult population.
- An intersectoral framework to address MNS care and treatment is essential for any meaningful impact to be achieved and for there to be a real reduction in the MNS burden experienced in South Africa. The framework needs to be inclusive of not only the health sector, but also of traditional health practitioners, the education sector, social development, non-profit organisations (NPOs), organised labour, community-based organisations, and mental health care user advocacy groups.

Appendix 5:

Consultative workshop participants

#	Title	Name	Surname	Organisation
1.	Dr	Fasloen	Adams	University of Witwatersrand
2.	Ms	Merle	Blunden	Port Elizabeth Mental Health
3.	Professor	Bonginkosi	Chiliza	University of KwaZulu Natal
4.	Dr	Ingrid	Daniels	Cape Mental Health
5.	Professor	Pat	De witt	Occupational Therapy Association of South Africa
6.	Dr	Tumi	Diale	Psychological Society of South Africa
7.	A/professor	Madeleine	Duncan	University of Cape Town
8.	Professor	Tharina	Guse	Professional Board for Psychology
9.	Mr	Rob	Hamilton	Clinical psychologist / Consultant
10.	DR	Marie Elizabeth	Kruger	Professional Board for Social Work
11.	Professor	Gayle	Langley	Academy of Science of South Africa (panel member)
12.	Professor	Crick	Lund	University of Cape Town
13.	Mr	Moses	Mahlangu	North Gauteng Mental Health
14.	THP	Buang	Malatji	Traditional Healers Organisation
15.	Mr	Siphiwe	Manana	Traditional Healers Organisation
16.	THP	Phephsile	Maseko	Traditional Healers Organisation
17.	Ms	Linah	Masemola	Mngoma Development Institute
18.	THP	Phumeza	Mathenjwa	Traditional Healers Organisation
19.	Mr	Prince	Mathibela	North Gauteng Mental Health Society
20.	THP	Zanele	Mazibuko	Traditional Healers Organisation
21.	Ms	Jennie	McAdam	Health Professions Council of South Africa
22.	THP	Sellwane	Mokgatsi	Traditional Healers Organisation
23.	THP	Glenda	Mokoena	Traditional Healers Organisation
24.	Ms	Moshibudi	Molepo	Department of Health and Social Development
25.	Mr	December	Mpanza	Rural Rehabilitation South Africa
26.	Dr	Dr Nkeng Evah	Mulutsi	Department of Health
27.	Professor	Bronwyn	Myers	Medical Research Council
28.	Professor	Inge	Petersen	University of KwaZulu-Natal
29.	Ms	Laetitia	Petersen	University of the Witwatersrand
30.	Dr	Khutso	Phalane-Legoale	Academy of Science of South Africa
31.	Ms	Mafoko	Phomane	Rural Health Advocacy Project
32.	Dr	Yogan	Pillay	National Department of Health
33.	Ms	Tsili	Ramoro-bi-Msikinya	Gauteng Department of Health
34.	Dr	Lesley	Robertson	University of the Witwatersrand
35.	Ms	Kelebogile	Seotloe	Academy of Science of South Africa
36.	Mr	Ian	Shendelana	Academy of Science of South Africa
37.	Ms	Dudu	Shiba	National Department of Health
38.	Professor	Leslie	Swartz	Stellenbosch University
39.	Professor	Christopher Paul	Szabo	University of the Witwatersrand
40.	Professor	Rita	Thom	University of the Witwatersrand/ASSAf