RESPONSE FROM THE CHAIRPERSON OF THE SOUTH AFRICAN SCHOOL PSYCHOLOGISTS' ASSOCIATION (SASPA) TO THE NATIONAL DEPARTMENT OF HEALTH'S WHITE PAPER ON NATIONAL HEALTH INSURANCE FOR SOUTH AFRICA

May 2016

Preamble

This report is submitted by the Chairperson of the South African School Psychologists' Association (SASPA) in response to the Minister of Health's call for public comment on the White Paper National Health Insurance for South Africa (10 December 2015).

SASPA is a non-profit, professional association which represents the unique needs, concerns and interests of psychologists engaged in the delivery of comprehensive psychological services to children, adolescents and families within a school environment. A primary aim of SASPA is to contribute to the mental well-being of all people in South Africa.

Our executive board includes clinical, counselling and educational psychologists working in the following State institutions:

1. Charlotte Maxeke Johannesburg Academic Hospital
2. Delta Park Remedial School
3. Gauteng Department of Education
4. Lantern Remedial School
5. North West University
6. Randburg Clinic School
7. St Vincent School for the Deaf
8. University of Johannesburg
9. University of the Witwatersrand

Members of SASPA are regulated by a Constitution which is in line with and promotes values enshrined in the South African Bill of Rights, and adheres to ethical guidelines in accordance with international best practice standards. Our Constitution can be found on the SASPA website (www.saspa.org.za).

We would like to thank the Minister of Health for this opportunity to submit comments on the White Paper NHI Policy document. Through the Integrated School Health Policy and the National Policy Guidelines for Child and Adolescent Mental Health, the Department of Health and the Ministry of Health has made significant effort towards recognising the importance that schools can play in community based service.

This submission positively acknowledges and supports the ideal of providing equitable and sustainable healthcare to all South Africans. The specific aims of this submission are to highlight the contribution that school-based mental health clinics and educational psychologists can make towards community based service.

The Role of Educational Psychologists

Whilst this report focuses on school-based mental health clinics and the role of educational psychologists, it is submitted that educational psychologists should not be limited to working only in schools. Educational psychologists are well trained in various clinical procedures with adults, children, families and groups. The inclusion of educational psychologists at all levels of service delivery (municipal ward, district care, regional hospital based, central hospital and specialist hospital based care) can help facilitate both preventative and curative care. It is submitted that services rendered by educational psychologists should form part of all benefit packages. The present submission focuses mostly on the role of educational psychologists in school settings.

The preamble to the Mental Health Care Act (Act No. 17 of 2002) recognises that "health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services". The Act aims to make the best possible mental health care, treatment and rehabilitation services available to the population, equitably, efficiently and in the best interest of mental health care users within the available resources, to co-ordinate access to mental health care, treatment and rehabilitation services, and to integrate the provision of mental health care services into the general health services environment [Section 3]. According to the Act, it is incumbent on every organ of

State responsible for health services to ensure the provision of mental health care, treatment and rehabilitation services at primary, secondary and tertiary level and to promote community-based care, treatment and rehabilitation services [Section 4]. Section 8 of the Act requires that every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop full potential and to facilitate his or her integration into community life.

It is noted that the NHI will be guided by the principles of the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency. This is in keeping with the Mental Health Care Act, which, in Section 6, demands that health establishments must provide mental care, treatment and rehabilitation services at the appropriate level and within the professional scope of practice.

Educational psychologists are not education specialists or remedial therapists. Educational psychologists must be recognised, by the Department of Health, as mental health care workers. The Department of Health must include educational psychologists in their post establishment at all levels of service delivery (municipal, ward, district care, regional hospital based, central hospital and specialist hospital based care).

Educational psychologists are competent in diverse psychological acts that include the evaluation, diagnosis and treatment of behaviour, mental processes, emotions and personality. These skills should not be restricted and under-utilised in the NHI, but acknowledged and promoted.

Child and Adolescent Mental Health in the South African Context

Ensuring the optimal development of all children poses a considerable challenge in South Africa. In addition to addressing the effects of apartheid and underdevelopment, poverty-related illness such as childhood infectious diseases and malnutrition remain widespread, and many children face barriers to optimal health and development as a result of the HIV/AIDS epidemic. Violence and injuries constitute a further cause of premature deaths and disability, whilst a growing burden of non-communicable diseases is also evident. All these circumstances compromise the mental health of children and adolescents.

In a study by Kleintjies et al (2006), the overall prevalence of child and adolescent mental disorders in the Western Cape alone was assessed to be 17%. The rates for selected disorders were as follows: generalized anxiety disorder - 11%; depression and dysthymia - 8%; posttraumatic stress disorder - 8%; oppositional defiant disorder - 6%; attention deficit hyperactivity disorder - 5%; enuresis - 5%; social phobia - 5%; conduct disorder - 4%; separation anxiety disorder - 4%; agoraphobia - 3 %; bipolar disorder - 1%; obsessive compulsive disorder - 0.5% and schizophrenia - 0.5%. The national census (Statistics South Africa, 2014) records that 0-19 year-olds comprise 40 % and 0 - 4 year-olds comprise more than 10% of the population. Suicide in adolescents is a significant cause for concern. South Africa has the 8th highest rate of suicide deaths in the world (Burns, 2011). The highest suicide deaths in South Africa occur in persons 15-19 years old and persons 10-14 years old (Schebusch, 2005; Herman et al.2009). According to a study conducted by Herman et al. (2009), 21% of South African high school students have attempted suicide. Mental health services for children and adolescents thus need to be prioritised.

Presently, South Africa's mental healthcare resources are wholly unequipped to handle the burden. Over 85% of patients are dependent on public health-sector services and less than 16% receive treatment. Treatment of children and adolescents are grossly inadequate. Only 1.4% of outpatient facilities, 38% of acute beds in general hospitals and 1% of beds in psychiatric hospitals are for children and adolescents (Burns 2011).

Despite indications that psychology is a growing profession, there is a shortfall of psychological services. The number of psychologists available to respond effectively in various capacities is wholly inadequate. According to the most recent statistics provided by the Health Professions Council of South Africa (30 May 2016), South Africa has a total of 2,657 clinical psychologists, 1,466 counselling psychologists and 1,382 educational psychologists.

The number of educational psychologists per province includes:

1. Eastern Cape 48
2. Free State 18
3. Gauteng 795
4. KwaZulu-Natal 141
5. Limpopo 27

6. Mpumalanga 38
7. Northern Cape 5
8. North West 33
9. Western Cape 277

According to the National Department of Health's Mental Health Policy Framework and Strategic Plan for 2013-2020, less than 10% of all psychologists work within the public health sector. Even less work within the education sector, as the Department of Education does not allow for the allocation of psychologist posts to schools.

In 2001, the Department of Education adopted the Education White Paper 6 on Special Needs Education. According to this document, psychologist posts were to be taken out of all schools and relocated to education district offices. In line with this document, the job description of psychologists employed by the Department of Education was also changed from providing clinical work (individual therapy and assessment services) to administrative tasks and policy implementation. Therefore, as of 2001, no state owned school qualifies for a psychologist post. Some schools employ psychologists, but they are not paid by the state. These schools pay their psychologists either through parent-body fundraising or in teacher posts. The salaries paid to psychologists in these two scenarios are considerably less than the occupation specific dispensation (OSD) reimbursement rates which psychologists earn at education district offices and in the health sector. As a result, schools are unable to attract or retain psychologists easily. Employing educational psychologists in schools would greatly help to alleviate the paucity of mental health needs for children and adolescents.

The Importance of Mental Health to Education

Mental health is directly related to children's learning and development. It encompasses or intersects with interpersonal relationships, social-emotional skills, behaviour, learning, academic motivation, certain disabilities, mental illness, crisis prevention and response, school safety and substance abuse. Each of these issues affects not only the success and well-being of the individual learner, but also the school climate and outcomes for all learners (National Department of Health, 2002).

School-Based Mental Health Care

School-based mental health services should include a broad spectrum of assessment, prevention, intervention, post-intervention, counselling, consultation, therapeutic and referral activities and services to help facilitate a safer and healthier learning environment for all learners. Preventive mental health programs and services can target all children in all school settings, with a focus on decreasing risk factors, building resilience, providing a positive, friendly, and open social environment at school, and ensuring that each learner has access to community and family supports that are associated with healthy emotional development. Services should also be available for group or individual assessments and psychotherapy for learners in need.

The advantages of School-Based Mental Health Care are as follows:

1. Providing psychological services in schools greatly improves accessibility of services for many families that would not otherwise have access to such services,
2. Educational psychologists at schools will be able to see families more immediately and long term, thus reducing long waiting lists at clinics and hospitals, and providing quicker relief from symptoms,
3. Avoid transport costs that many families cannot afford,
4. Early intervention can slow down the development of longer term problems,
5. School-based mental health services eliminate the need for transportation of learners to and from off-site appointments and facilitates parent participation in mental health appointments, because many parents live within walking distance of neighbourhood schools. These advantages may encourage more parents to seek mental health care for their children and more learners to self-refer for treatment.
6. School-based mental health services provide clinicians with unparalleled access to children in need of mental health services.
7. In addition to eliminating barriers to access to care, school-based mental health services offer the potential to improve accuracy of diagnosis as well as assessment of progress. One of the major challenges to providing mental health services to learners is gaining access to information concerning the functionality of the learner in various environments. Schools have a wealth of opportunities to acquire information on how learners deal with physical and social stresses and challenges and on how they perform in the academic setting, on community-related roles in which children engage, and on the nature and extent of many sorts of interpersonal relationships.

8. Their presence in schools enables mental health professionals to guide teachers on ways to follow up on a child's therapy in the classroom.
9. Educational psychologists working in schools can provide community outreach services in the communities in which these schools are based and address issues pertaining to prevention

Research on School-Based Mental Health Care Clinics

1. Kaplan, Calonge, Guernsey and Hanrahan (1998) found that adolescents with access to school-based mental services were 10 times more likely than learners without such access to initiate a visit for a mental health or substance abuse concern. The convenience and comfort of having school-based mental health services may also promote a longer-lasting commitment to following through with all recommended therapy.
2. A 2006 study in the American Journal of Public Health (Vol. 96, No. 9) found that teen pregnancy rates dropped significantly among adolescents attending high schools with school-based mental health clinics.
3. A 2003 study in the Journal of Adolescent Health (Vol. 32, No. 6) found that learners were 21 times more likely to make mental health-related visits to school-based mental health clinics than to community health clinics.
4. Research has shown that school-based mental health clinics can help reduce absenteeism and costly emergency room visits. One study showed that inner-city learners were 21 times more likely to make mental health-related visits to school-based health clinics than to facilities outside their schools (Journal of Adolescent Health, 2003).
5. Another study found that learners served by school-based mental health clinics had fewer discipline problems, course failures and school absences (Journal of School Health, 2000).
6. Mental health clinics inside schools also can save tax money (American Journal of Public Health, 2010).
7. Catron, Harris, & Weiss (1998) reported that 96% of individuals referred for school-based counselling followed through with consultations, compared to only 13% of individuals referred for community based treatment.

8. Anglin, Naylor, and Kaplan (1996) concluded that adolescents who reported mental health symptoms to care providers at school-based clinics were more likely to receive treatment than were learners who reported mental health symptoms to care providers in other settings.
9. In a study of expanded school mental health programs conducted by Bruns, Walrath, Glass-Siegel, Acosta, Anderson, and Weist (2004), respondents in schools with school-based mental health clinics were more likely to refer learners with suspected emotional and behavioural problems to mental health professionals than were respondents in other schools, thus making it more likely that learners in these schools would receive the services they need.

The following information highlights the potential reach of school-based mental health clinics:

1. In Baltimore, Maryland, the University of Maryland's School Mental Health Programme (University of Maryland, 2003) served 23 schools in the Baltimore City public school system during the 2002-2003 school years and provided services to 2,208 learners including:
    - 4,490 teacher consultations
    - 2,832 family contacts
    - 11,436 individual therapy sessions
    - 369 group therapy sessions
    - 2036 prevention group sessions
2. In Hamilton County, Ohio, the Children First Plan (Children First Plan, 2002) served 13 schools. Services were provided to more than 8,000 learners through the implementation of 291 programs during the 2000-2001 academic years. Some examples of programs include:
    - 1,000 learners participated in social skills training
    - 2,974 learners participated in conflict management training
    - More than 5,000 hours of case management and counselling services were provided.
3. In Dallas, Texas, nine youth and family centres, each one located on a school campus, provided health and mental health services to more than 3,040 learners in 204 schools during the 1999-2000 academic year (Hall, 2000).

4. Multnomah County, the Multnomah County Health Department, in collaboration with several school districts, provides health and mental health services for learners in 13 school-based health centres. During the 2000-2001 academic years, the centres served a total of 6,961 learners and received 34,357 patient visits. 6,420 of those visits were for mental health issues (Multnomah County Health Department, 2001). Examples of mental health services included:
    - 4,529 learner and family contacts
    - 20,301 staff contacts
    - 2,273 community outreach contacts
    - 27,103 total contacts

Conclusion

Given the historical under-servicing of the psychological needs of the majority of South African learners, this is an exciting and opportune time for South Africa to benefit from the evidence supporting school-based psychological services. School-based mental health clinics offer the promise of improving access to the psychological prevention, diagnosis and treatment of mental health problems of children and adolescents.

Brandon Swanepoel
Educational Psychologist
Chairperson, South African School Psychologists' Association (SASPA)

References:

1. Allison, M. A., Crane, L. A., Beaty, B. L., Davidson, A. J., Melinkovich, P., & Kempe, A. (2007). School-based health centres: Improving access and quality of care for low-income adolescents. *Paediatrics*, *120 (4).*
2. Anglin, T. M., Naylor, K. E., & Kaplan, D. W. (1996). Comprehensive school based health care: High school learners' use of medical, mental health, and substance services. *Paediatrics, 97*, 318-330.
3. Burns, J. K., (2011). The mental health gap in South Africa-Human rights Issue. *The Equal Rights Review, 6,* 99-113.
4. Brindis, C.D, Klein J, Schlitt, J. (2003). School-based health centres: accessibility and accountability. *The Journal of Adolescent Health, 32(6)*, 98-107.
5. Bruns, E.J., Walrath, C., Glass-Siegel, M., & Weist, M.D. (2004). School-based mental health services in Baltimore. Association with school climate and special education referrals. *Behaviour Modification, 28(4),* 491-512.
6. Catron, T., Harris, V.S., Weiss, B. (1998). Post treatment results after 2 years of services in the Vanderbilt School-Based Counselling project. In Michael H. Epstein & Krista Kutash, et al. (Eds.). Outcomes for children and youth with emotional and behavioural disorders and their families: Programs and evaluation best practices (pp. 633-656). Austin, TX: Pro-Ed, Inc.
7. Department of Education. (2001). Education White Paper 6: Special Needs Education - Building an inclusive education and training system. State Press: Pretoria.
8. Department of Health. (2013). National Mental Health Policy Framework and Strategic Plan 2013-2020. State Press: Pretoria.
9. Department of Health and Basic Education. (2012). Integrated School Health Policy. State Press: Pretoria.
10. Department of Health. (2003). National Policy Guidelines for Child and Adolescent Mental Health. State Press: Pretoria.
11. Department of Health. (2002). National School Health Policy and Implementation Guidelines. State Press: Pretoria.
12. Department of Health (2001). National Policy Guidelines for Youth and Adolescent Mental Health. State Press: Pretoria.

13. Herman, A., Stein, D.J., Seedat, S., Heeringa, S.G., Moomal, H., Williams, D.R. (2009). The South African Stress and Health (SASH) study: 12 month and lifetime prevalence of common mental disorders. *South African Medical Journal, 99 (5), 339-34.*
14. Jennings J, Pearson G, Harris, M. (2000). Implementing and maintaining school-based mental health services in a large, urban school district. *Journal of School Health, 70(5)*, 201–205.
15. Juszczak, L., Melinkovich, P., Kaplan, D. (2003). Use of health and mental health services by adolescents across multiple delivery sites. *The Journal of Adolescent Health, 32(6),* 108-118.
16. Kaplan, D.W., Calonge, B.N., Guernsey, B.P., Hanrahan, M.B. (1998). Managed care and school-based health centres. Use of health services. *Paediatric Adolescent Medicine, 152,* 25– 33.
17. Kleintjes, S., Flisher, A.J., Fick, M., Railoun, A., Lund, C., Molteno, C., Robertson, B.A. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa, *South African Psychiatry Review 9(3), 157-160.*
18. Kleintjes, S., Lund, C., Flisher, A.J., and MHaPP Research Programme Consortium (2010). A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. *African Journal of Psychiatry, 13*, 132-139.
19. McNall, M.A., Lichty, L.F, Mavis, B. (2010). The Impact of School-Based Health Centres on the Health Outcomes of Middle School and High School Learners. *American Journal of Public Health, 100, (9)*, 1604–1610.
20. Reddy, S.P., James, S., Sewpaul, R., Koopman, F., Funani, N.I., Sifunda, S. Josie, J., Masuka, P., Kambaran, N.S., Omardien, R.G. (2010). Umthente Uhlaba Usamila-The South African Youth Risk Behaviour Survey 2008. Cape Town: South African Medical Research Council.
21. Ricketts, S.A., Guernsey, B.P. (2006). School-Based Health Centres and the Decline in Black Teen Fertility During the 1990s in Denver, Colorado. *American Journal of Public Health, 96, (9)*, 1588–1592.
22. Schebusch, L. (2005). *Suicidal Behaviour in South Africa.* Pietermaritzburg, University of KwaZulu-Natal Press.