

Narrowing the care and treatment gap through a human resources for mental health plan: Key considerations

The number of people living with mental health conditions globally has recently surpassed 1 billion.^[1] In South Africa (SA), at least 16% of the population,^[2] and likely more,^[3] have a mental health condition. Mental disorders account for the highest burden of disease of any health condition (13.8%, compared with 11.8% for HIV),^[4] with an estimated annual economic cost of ZAR161 billion, ~4% of GDP.^[5] Despite this, as well as extensive policy commitments to improve population mental health, a 2019 national survey showed that >90% of South Africans with a mental health condition did not receive (formal) care.^[6] Research 10 years earlier had already found that only a quarter of people with mood, anxiety, or substance-use disorders had sought treatment in the preceding year, and <6% received adequate care.^[7]

The reasons for this large care and treatment gap are well documented. They include low prioritisation of mental health, stigma, poor awareness, denial of illness, language barriers, cultural conceptualisations of mental illness and the direct and indirect costs of accessing care. Many people in both rural and urban settings continue to consult traditional practitioners, particularly for mental health conditions.^[8] While these demand-side barriers are important, they do not fully explain the persistence of this treatment gap. A central and binding constraint remains the shortage and maldistribution of human resources for mental health. Long waiting lists, limited service availability and inequitable access persist across all provinces and levels of care, particularly in rural and underserved districts.^[9]

There is a critical need to develop a national human resources plan for mental health to address the supply-side constraints. As part of broader engagement on this issue, a multi-stakeholder round-table discussion convened in 2025 reached a clear consensus: narrowing the treatment gap will require fundamental changes to the current service and workforce model. These include greater use of digital technologies, expanded mental health roles for existing health workers and the development of new categories of mental health providers. Most importantly, mental health must be embedded more firmly at primary and secondary levels of care, with human resource allocations aligned accordingly.

SA, as of October 2025, has 1 078 psychiatrists and 3 463 clinical psychologists registered with the Health Professions Council of SA, equivalent to 1.7 psychiatrists and 5.3 psychologists per 100 000 population. Three decades after democracy, fewer than a quarter of psychologists in the country are black African.^[10] Critically, there are only 0.31 psychiatrists and 0.97 psychologists per 100 000 for the uninsured population^[5] – compared with the ratio of 7 psychiatrists and 9 psychologists in high-income countries.^[11] These figures reflect not only absolute shortages, but also deep inequities in access, distribution and representativity. While increasing the number of psychiatrists and psychologists is essential, this pathway is slow, costly and constrained by limited training platforms in the public higher education sector. The private higher education sector, despite its growth, remains largely excluded or severely limited in contributing meaningfully to the production of health professionals.^[12]

The round table meeting emphasised the need for expanding the mental health role for general medical practitioners as well as primary healthcare nurses through comprehensive inclusion of mental health in initial training programmes, ongoing training

in mental health and inclusion of mental health in the job descriptions of practitioners working at the primary care level. Moreover, creating incentives for medical officers in the public sector to sit the Colleges of Medicine of SA postgraduate diploma in psychiatry exam has the potential for creating a ‘mid-level psychiatrist’, while the training of registered counsellors, an existing cadre of mid-level psychologists recently added to the public sector staff establishment, was strongly encouraged.

There is now substantial evidence that appropriately trained lay practitioners can play a meaningful role in mental healthcare.^[3-15] In 2024, SA had ~50 000 community health workers (CHWs),^[16] representing a potentially significant resource for addressing demand-side constraints through mental health promotion, stigma reduction, basic screening, referral and support for service users and families. However, CHWs are already heavily burdened, and further expansion of their scope risks compromising effectiveness. A dedicated category of community mental health worker is a solution already utilised in numerous countries. For example, interpersonal counselling is practised in at least 31 countries on six continents.^[17] The use of social work auxiliaries demonstrates that task-sharing approaches can expand access when supported by appropriate training, supervision and referral systems.

Financial considerations are central to any human resources strategy. For example, the cost of employing one entry-level psychologist could fund ~15 CHWs, while the cost of one senior psychiatrist could support up to 50 CHWs. Such comparisons are illustrative rather than prescriptive. Decisions about workforce composition must consider the level of the health system at which workers are deployed, supervision requirements, training duration and costs, and overall cost-effectiveness. Framing these choices as binary trade-offs between professional and lay workers is unhelpful; a mixed, integrated workforce is required.

A comprehensive and carefully designed human resources for mental health plan (MHP) is therefore essential to narrowing the care and treatment gap. This plan must be grounded in existing policy and legislative frameworks, including the Mental Health Care Act 17 of 2002,^[18] the Mental Health Policy Framework 2023 - 2030,^[19] the 2030 Human Resources for Health Strategy^[20] and the National Health Insurance Act 20 of 2023.^[21] In addition, important Academy of Science of SA articles^[22,23] and the extensive local and international research that already exists must be actively engaged.

Consultation with service users, providers and civil society organisations is critical. However, consultation alone is insufficient. SA has no shortage of policies or evidence; the challenge lies in implementation. The options for strengthening human resources for mental health are well described, evidence based and increasingly feasible. In addition to the MHP, what is now required is sustained political commitment, co-ordinated planning and accountability to ensure that these options translate into meaningful improvements in access to care.

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