Review

South Africa's mental health human resources dilemma: from shortage to solution

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Aim

This paper investigates the critical shortage of mental health human resources in South Africa, exacerbated by longstanding socio-economic challenges and the COVID-19 pandemic. It assesses the current state of mental health human resources and proposes evidence-based recommendations aligned with national and international policy developments.

Method

An extensive review of scientific literature, national policies, and reports from multi-lateral bodies was conducted. The research was informed by three round-table consultation workshops held in 2021, attended by stakeholders working in national mental health and HIV response. Additional insights were drawn from engagements by the Foundation for Professional Development project staff with various stakeholders, including government departments, and provincial- and district-level staff.

Findings

The South African healthcare system's mental health sector faces significant challenges, including a severe shortage of specialised mental healthcare providers. The ratio of psychiatrists and psychologists to the population is critically low, especially in rural areas. Implementation of recent policy reforms, such as the National Mental Health Policy Framework and Strategic Plan 2023—2030, is hindered by insufficient human resources.

Conclusion

Urgent action is required to address South Africa's mental health human resources crisis. Recommendations include lifting restrictions on private-sector training of mental health professionals, optimising task-shifting, and embracing technological solutions like telemedicine. Addressing this crisis not only upholds the human right to health, but also mitigates economic losses due to reduced productivity from untreated mental health conditions.

Introduction

Approximately one in eight people globally live with a mental disorder.[1] According to the 2019 Global Burden of Diseases, Injuries, and Risk Factors Study, the age-standardised disability-adjusted life-year (DALY) rate for mental disorders was 1 426 per 100 000 people in 2019.[2] Of the estimated 970 million people living with mental disorders in 2019, an estimated 301.4 million suffered from anxiety disorders and 279.6 million from depressive disorders.[2] This crisis was greatly exacerbated by the COVID-19 pandemic. A 2023 umbrella review of systematic reviews estimated that during the pandemic, 30.8% of individuals experienced anxiety, 28.1% experienced depression, 44.2% experienced psychological distress, and 18.8% experienced post-traumatic stress disorder.[3] Another umbrella review estimated that the pandemic led to a 27.6% increase in depressive disorders and a 25.6% increase in anxiety disorders globally.[4]

The global mental health crisis has affected South Africa acutely by exacerbating longstanding underlying structural drivers of poor mental health, such as food

insecurity, lack of employment, and shortages of stable housing.[5] Even prior to the COVID-19 pandemic, mental health conditions had overtaken AIDS as the leading contributor to the disease burden, measured in DALYs at 13.8% in South Africa compared to 11.8% for AIDS.[6] The South African Stress and Health (SASH) study, a nationally representative survey conducted in 2004, found that the 12-month prevalence of any mental health disorder was 16.5%.[7] A recent University of the Witwatersrand study using symptom scales found that more than a quarter of South Africans reported moderate to severe symptoms of probable depression, ranging from 14.7% to 38.8%.[8] Access to care is low for those with common mental disorders, as a national survey conducted in 2019 found that 92% of the uninsured population needing mental health care did not receive it.[9]

Human resources for health are a global health priority, reflected in Sustainable Development Goal 3c, which advocates for a substantial increase in "the recruitment, development, training and retention of the health workforce".[10(p1)] Human resources for health also comprise the second building block of the World Health Organization (WHO) health systems framework.[10,11] However, many countries pay little attention to the mental health workforce. Of the 168 countries that responded to the WHO 2020 Mental Health Atlas, only 60% reported that their mental health policies and/or plans included human resource (HR) requirements, and only 39% stated that HR for mental health had been allocated according to an assessment of need.[12]

Furthermore, burn-out and psychological distress among healthcare workers (HCWs) have become global concerns, with over 20% of HCWs reporting symptoms of anxiety and depression symptoms during the COVID-19 pandemic.[13] These challenges have critical implications not only for HCWs' well-being, but also for health system performance and resilience.[13] Evidence indicates that mental health challenges among HCWs continue to persist even though the pandemic has come to an end.[14,15]

Given the global prioritisation of human resources for health, the overall shortage of human resources for health and related mental health crises in the country, and the high levels of stress, burn-out and depression among the Primary Health Care (PHC) workforce, this paper reviews the state of mental health HR in South Africa. Based on the findings, a set of evidence-based interventions are proposed that align with national and international policy developments and the recommendations contained in two Academy of Science of South Africa Consensus Reports.

Method

An extensive review of scientific literature, national policies and reports from multi-lateral bodies was undertaken. Key terms: 'mental health' AND 'human resources for health' AND 'South Africa' AND 'shortage' were searched in Google Scholar and PubMed databases. Articles were included from the year 2000 onwards. Additionally, a range of national policies and strategies, global reports and guidance documents from multi-lateral bodies were reviewed using a descriptive policy analysis approach.

Also reviewed were reports from three stakeholder roundtable workshops held between 2021 and 2022 and convened by the Foundation for Professional Development (FPD) in collaboration with the South African National Department of Health (NDoH), the Centers for Disease Control and Prevention (CDC), and the United Nations Children's Fund (UNICEF). These workshops brought together stakeholders from government, academia, international agencies and civil society, and individuals with lived experience to discuss priorities for integrating mental health into HIV, tuberculosis (TB) and primary care platforms, as well as improving psychosocial support for children and adolescents. Themes included: healthcare worker mental health, stigma, burnout, moral injury, service access, and inter-sectoral collaboration. The proceedings were documented in two formal reports which were reviewed in this study to extract key insights that inform the development of policy and programmatic recommendations made in this paper. Additional contextual input was drawn from routine engagements by FPD project staff with government departments and provincial and district-level stakeholders.

Findings

The findings presented in this section are based on a review of 15 peer-reviewed journal articles and nine national and global policy or strategy documents. Four news articles are also cited, as they provide important context that was not available from the academic literature or policy and strategy documents.

Evidence of the scope of the mental health workforce shortage

This section draws on a global report as well as academic literature to assess the scope of the shortage of mental health human resources in South Africa.

According to the WHO's Mental Health Atlas 2020, the global median number of mental health workers is 13 per 100 000 population.[12] The number of mental health workers by population is strongly correlated to the wealth of the country. The median in high-income countries is 62.2 per 100 000 compared to just 0.9 per 100 000 in low-income countries.[12] In upper-middle-income countries (including South Africa), the median number of mental health workers was 14.7 per 100 000 in 2020, which decreased from 20.6 per 100 000 in 2017.[12] In high-income countries in 2020, there was a median of 10.7 psychologists and 8.6 psychiatrists per 100 000 population, whereas in upper-middle-income countries, these figures were 1.6 and 1.7, respectively.[12]

Findings from the academic literature also offer insight into the shortage of mental health workers in South Africa. According to Rensburg, et al., as of 2019, there

Table 1. South Africa's mental health workforce compared to that of other high middle-income countries per 100 000 population

	MH professionals per cadre per 100 000 population across healthcare settings		
	High middle-income country average	SA national average	SA PRPHC
Clinical Psychologist	1.47	2.6	0.47
MHMDs	0.87	0.43	0.37
MHNs	9.72	9.72	0.68
Psychiatrists	2.03	0.27	0.03

Source: De Kock and Pillay, 2018.[18]
Key:
MIC = middle-income country; MH = mental health; PRPHC = public rural Primary Health Care; MHMD = medical doctor (not specialised in psychiatry, but dedicated to MH); MHN = mental health nurse

were 1.52 psychiatrists per 100 000 people, based mainly in the private sector in Gauteng and the Western Cape Provinces.[16] However, as only 20% of them were working in the public sector, which is utilised by 80% of the population, the functional ratio was estimated to be 0.35 psychiatrists per 100 000 population.[16] The trend has worsened, as psychiatrist numbers fell from 850 in 2019 to 625 in 2022.[16] Thus, South Africa is falling behind the mental health workforce standards of other upper-middle-income countries. Of a list of 42 upper-middle-income countries, 24 countries had a greater ratio of psychiatrists per 100 000 population.[16] These figures are particularly alarming given South Africa's notable burden of mental disorders and the decreasing trend in the number of specialists mental healthcare providers. There are also shortages of psychologists, social workers and occupational therapists, and a lack of specialist mental health nurses.[17] Approximately 50% of public hospitals offering mental health services do not have psychiatrists, while 30% lack clinical psychologists.[17]

De Kock, et al. compared the ratio of mental health professionals to the population in South Africa as a whole against the ratio in rural areas, and found fewer mental health professionals per 100 000 population[18] (Table 1). Given that 40% of South Africa's population still lives in a rural setting, the distribution of the mental health workforce has a major impact on service availability.[18]

Regulatory and structural barriers to mental health workforce production

This section draws on national human resources for health (HRH) strategy documents, regulatory frameworks, and academic literature to examine structural and policy-level constraints in the production and deployment of mental health professionals in South Africa. The NDoH 2030 Human Resources for Health Strategy has a chapter on setting strategies and goals titled: 'Towards Business Unusual' but unfortunately, mental health receives almost no attention.[19] The extent of the mental health HRH crisis lies in antiquated regulatory structures, historical professional domain privileges, and outdated ideologies. Effective workforce planning will require confronting this vested interest and acknowledging that the primary purpose of a healthcare system and the embedded regulatory bodies should be to serve the interest of the country and its people, ensuring access to care and not hampering it. South Africa has reached the point that justifies 'business unusual'.

There is no doubt that there is an absolute shortage across the board in all categories of the mental healthcare professionals, psychosocial workers, and non-professional counsellors who are required to bring an end to this epidemic. The treatment of mental health conditions requires a multi-disciplinary team approach, and there is more than enough evidence supporting the fact that non-pharmacological therapy can be provided by trained lay counsellors and non-specialised health professionals.[20] This is hampered by various legislative instruments and regulations, and the power allocated to statutory bodies.

Although adjusting the scope of practice of all categories of healthcare professionals involved in mental health care and rehabilitation[21] would help to address the crisis, currently this requires lengthy submissions to statutory professional councils, and vested interests may well oppose any such change. Two consensus reports published by the Academy of Science of South Africa (ASSAf) provide expert policy guidance on health workforce education, regulation, and scope-of-practice reforms to strengthen mental health service delivery.[21,22] The first report, titled: 'Reconceptualising Health Professions Education' and published in 2018[22] recommended training of undergraduate and postgraduate specialists in the private sector, while the second, published in 2021, recommends rational scope-of-practice changes regarding providers' core competencies for improving the mental health care of the nation.[21] Implementation has been hampered by a political unwillingness to allow the private sector into the production of healthcare personnel, particularly doctors, of which South Africa has a shortage of around 60 000 compared to its socio-economic peers.

Where the private sector has gained a foothold in the production of HCWs, particularly in the training of nurses, changes in the accreditation process for training institutions and changes to nursing qualifications have

led to major disruptions of training institutions.[23] Furthermore, both the Health Professions Council of South Africa (HPCSA) and the South African Nursing Council (SANC) have placed restrictive quotas on intakes. South Africa has just one nurse per 213 people.[24] Of these, fewer than a third are younger than 40, and by 2035, 47% of all nurses will have retired.[25] The current nursing shortage has been estimated at more than 26 000 professionals, but this number is expected to reach more than 100 000 by 2030.[24]

Notably, of the thousands of students who enter Bachelor's degree programmes to study psychology, only 5% ever manage to gain entry to clinical psychology programmes due to intake restrictions placed by the HPCSA.[17]

Policy reforms and health system realities: impact on access to mental health care

This section draws on national policies, strategic plans, and academic literature to assess how recent reforms and health system realities affect access to mental health care in South Africa. The country's healthcare system is two-tiered, with an estimated 15.7% of the population covered by medical aid schemes and accessing private-sector medical care, while the rest of the population predominantly utilises government healthcare services.[26] The majority of South Africans, including most people living with HIV and TB, are dependent on the State for healthcare services. Health budget allocations for HIV/TB services relative to mental health services is disproportionately high. The total available budget for the HIV/TB response in the 2023/24 budget was R30.5 billion (R22 billion from the health budget, R7 billion from the U.S. President's Emergency Fund for AIDS Relief (PEPFAR), and R1.4 billion from the Global Fund,[27] while mental health received only approximately 5% of the health budget (provincial range: 2.1–7.7%), of which 86% was for in-patient care.[28] Clearly there is a major disconnect between disease burden and budget allocation around mental health.

However, there is an opportunity to leverage the large government and donor investment into the HIV/TB response to rapidly increase access to mental health care for all people with mental health conditions. There is a very high prevalence of mental health conditions among people living with HIV (PLHIV). A 2018 international study found that 55.1% of PLHIV had one or more mental health disorders, and South African estimates range between 28% and 62%.[29] Since 2010, the South African HIV response has been integrated into PHC services, and national strategies including the National Strategic Plan for the Prevention and Control of Non-Communicable Diseases in South Africa[30] and the National Mental Health Policy Framework and Strategic Plan 2023–2030[28] (NMHPFSP) support incorporating mental health care into integrated PHC services. Since research has demonstrated that PLHIV with mental health conditions have poorer health outcomes,[31] investment in mental health care is a justifiable investment for the HIV/TB response.

Mental health services in South Africa are governed by the Mental Health Care Act of 2002, which outlines requirements for hospital- and community-based care.[32] Nevertheless, mental health services in South Africa continue to be provided predominantly through hospital-based care.[28] This model of care is not aligned with the mental healthcare needs of the population, as approximately three-quarters of common mental disorders are characterised as 'mild' to 'moderate' and do not require hospitalisation.[7] Furthermore, hospitals are often not able to meet the demand among those with more severe common mental disorders, as reflected in the SASH survey finding that only 28% of severe cases received treatment.[17] This has left a massive treatment gap, with a shocking 92% of the uninsured population with common mental disorders being unable to access care in 2019.[9]

There have been several positive developments. The National Strategic Plan for HIV, TB and STIs 2023–2028 (NSP) refers to mental health 144 times, compared to 12 times in the previous NSP. One of the major features of the NMHPFSP for 2023–2030 is a shift from hospital-based to community-based and primary care.[17,28] Mental health has been incorporated as one of the five major non-communicable diseases in the National Strategic Plan for the Prevention of Non-communicable Diseases 2022–2027.[30]

These policies largely depend on task-shifting, in which healthcare workers with fewer skills or less tailored training are given tasks that have not typically been part of their scope of practice.[33] Task-shifting may be pitched as the panacea for all shortages in the production of skilled healthcare workers, but this approach has limitations.[34] Nurses form the backbone of PHC service delivery and have been stretched to the limit. A pre-pandemic South African study of nurses providing HIV services found that 57% suffered from borderline to extreme depression.[35] South African studies estimate HCW burn-out to have been at 40% to 80% prior to the COVID-19 pandemic.[36] Among HCWs providing HIV/TB care, burn-out was associated with 3.2 times increased odds of reporting suboptimal care practice and negative attitude to work.[37] The COVID-19 pandemic dramatically increased all mental health conditions, but particularly burn-out and post-traumatic stress disorder (PTSD) among healthcare workers.[38] Additionally, compassion fatigue — which is the phenomenon of depletion and dysfunction in healthcare professionals brought on by extended exposure to work-related stress and direct contact with traumatised patients and families — is estimated to affect 80% of nurses in sub-Saharan Africa post COVID-19.[39] When this evidence is considered together, our caregivers may be in a worse mental health position than the public.

The NMHPFSP includes several positive commitments related to HR for mental health.[28] First is the commitment by the State to employ registered counsellors: four-year university graduates being considered as mid-level psychology professionals with specialisation in counselling, on the public service payroll.[28] In middle-income

countries like South Africa, registered counsellors can help to address the shortage of psychologists and psychiatrists while providing mental health care as specialised staff.[40] The second positive commitment is that of supporting exploration of the rescheduling of fluoxetine from a Schedule 5 drug to a Schedule 4 drug on the grounds that it is not habit-forming, which will allow nurses at PHC facilities to prescribe and dispense this anti-depressant.[28] Additionally, one of the NMHPFSP objectives is "to conduct mental health surveillance and research and strengthen innovation".[28(p32)] This mandate supports the integration of technological solutions such as telemedicine, digital triage tools, and algorithm-driven care co-ordination into the mental health system.

In response to the NDoH recognising the shortage of mental health workers, the National Treasury issued a conditional grant to fund the appointment of mental health workers in the public health sector and to contract providers from the private sector, which began in the 2021/22 financial year.[28] In its Annual Performance Plan for 2023—2024, the NDoH reported that the conditional grant has "immensely contributed to improving access to and quality of mental health services and strengthened integration of mental health services into PHC in all provinces as envisaged by the Mental Health Care Act of 2002".[41(p40)] However, the effects of the conditional grant have not been felt nationwide, as the Western Cape struggled with shortages of staff at hospitals due to budget cuts that were introduced in 2023.[42]

Although these policy developments are long overdue and welcomed, implementation will be severely hampered if the acute shortage of specialised mental healthcare providers in the country is not addressed and if mid-level mental health practitioners are not widely employed by the government. The mental health crisis among mental health practitioners is a manifestation of a general crisis in human resources for mental health.

Discussion

Urgent action is needed to tackle this crisis, including lifting restrictions on the private sector around training mental health professionals, optimising task-shifting by easing work scope limits, and embracing technological solutions like telemedicine and artificial intelligence. Implementing the ASSAf recommendations as laid out in their consensus reports is crucial. However, even well-developed national policies have faced inconsistent implementation across provinces, largely due to resource constraints and uneven provincial capacity. This is reflected in the variable impact of conditional grants' usage across provinces.

Given the access gap, the cost of not providing access to care is not only paid for in human suffering and an infringement on health as a human right, but also in real economic terms. Globally, loss of productivity due to anxiety and depression is estimated to cost around USD1 trillion annually.[43] In South Africa, this cost is estimated at around USD3.6 billion per year (R65 billion),[44] representing an economic injection that would have an immense impact on the structural drivers of mental health conditions in the country. The WHO estimates that for every dollar spent on better care for anxiety and depression, there is a return of four dollars in better health and productivity.[45] Additionally, for every dollar invested in health and creating decent employment for health workers, the potential return is about nine dollars.[46] The WHO also demonstrated that half of the global economic growth over the last decade resulted from improvements in health, noting that for every added year of life expectancy, the economic growth rate is boosted by 4%.[46]

Solving the mental health human resources crisis should be a national priority, not only a health sector priority. When structures created to ensure quality of care either inadvertently or deliberately restrict access to care, leading to hundreds of billions of Rands in lost economic productivity and fuelling misery across society, it is time to radically review their role and mandate around workforce production.

While the findings of this review are based on academic literature and policy documents, the development of recommendations was informed by triangulating these findings with insights from stakeholder consultations and roundtable discussions. This process enabled the contextualisation of the evidence within the South African implementation environment and ensured that the recommendations reflect both published evidence and real-world perspectives from government officials, service providers, and individuals with lived experience. The alignment between the literature and stakeholder priorities further strengthens the relevance and credibility of the proposed solutions.

This research was subject to the limitations of narrative reviews, which cannot offer definitive guidelines or guarantee comprehensive synthesis of all available relevant literature. However, this review provides strong evidence that there is a shortage of human resources for mental health in South Africa – and this may serve as a starting point for future research, including systematic reviews. Additionally, although human resources are a critical tool for addressing the mental health crisis, there are aspects of mental health that cannot be addressed through medical intervention by HCWs. Addressing the social determinants of health and early childhood adversity is imperative for improving the mental health of South Africa's people.

Recommendations

Based on this review, the following recommendations are proposed:

- The mental health epidemic should be declared a national emergency, allowing the Minister of Health the powers to promulgate regulations to remove barriers that hinder access to mental health services.
- A time-limited commission to review and approve the change of scope, as proposed in the ASSAf re-

port, should be established: Provider core competencies for improved mental health care of the nation.[21]
- The overlapping mandates that the HPCSA, South African Pharmacy Council and SANC have with the Council for Higher Education and Quality Council for Trades and Occupations should be removed to enable and incentivise the private sector to produce HCWs for mental health in rural areas.
- Production of medical specialists in the private sector, as proposed in the consensus report of the ASSAf, should be allowed: Reconceptualising health professions education.[22]
- An investment case for a comprehensive workforce planning unit based at an academic institution should be developed to execute accurate needs assessments and projections to ensure that the supply of mental health professionals meets the population's needs.
- Mental health support services should be provided for healthcare workers who are at high risk of burnout and psychological distress. This includes counselling services, stress management programmes, and peer support networks.
- The structural factors that influence burn-out should be addressed, including workplace characteristics such as heavy workload, insufficient staff, difficult working conditions, and lack of resources.[47]
- Adding a mental health target to annual continuous professional development requirements should be considered in order to keep all health professionals updated on the latest practices and innovations in the field.
- A sensible hub-and-spoke model, informed by a collaborative care model for mental health that utilises telemedicine and technology solutions, should be developed, along with mapped referral pathways that define a patient's journey.[48] This should start with lay counsellors being trained to use validated algorithms to screen and triage clients and provide evidence-based counselling at the community level. These counsellors can refer clients, either through technology or other means, to providers such as general practitioners, PHC nurses and registered counsellors, who can offer pharmacological and/or counselling services. These PHC providers should be linked to hospital-based services, where multi-disciplinary teams of healthcare professionals with additional mental health training have access to mental health specialists.
- Digital tools must be implemented in consideration of South Africa's persistent digital divide. Technological solutions should be deployed in ways that do not further marginalise under-resourced or digitally excluded communities. Hybrid models that combine in-person and remote care, along with investments in community-based digital access points (e.g. clinics, libraries, or mobile outreach units equipped with connectivity), may help to ensure equitable roll-out and sustained access across geographic and socio-economic lines.
- National policies and strategic plans should be translated into provincial implementation plans with linked budgets. Implementation of these plans must be monitored by government and external stakeholders.

Conclusion

The assessment of South Africa's mental health human resources reveals a stark reality: the healthcare system is under-resourced and overstressed, particularly in mental healthcare provision. The COVID-19 pandemic exposed and exacerbated existing challenges, underscoring the urgent need for strategic interventions. This paper highlights the necessity of a multi-faceted approach to address the mental health human resource crisis effectively.

Several critical lessons emerged from the review and stakeholder consultations. Firstly, policy reforms must be accompanied by practical implementation strategies and sufficient resource allocation. Without adequate funding and support, well-intentioned policies will fail to produce tangible outcomes. Secondly, task-shifting, while valuable, requires rigorous training and supervision to ensure quality of care. A scale-up of the placement of mid-level mental health professionals such as registered counsellors within PHC facilities could go a long way towards closing the gap in access to care for individuals with common mental disorders.

In conclusion, addressing the mental health human resources crisis in South Africa necessitates innovative solutions, committed investment, and co-ordinated action. Regulatory bodies, academic institutions, professional councils, and the national and provincial Health Departments must work together to dismantle the systemic barriers that constrain workforce development, limit training capacity, and restrict task-sharing. Without urgent, collaborative reform, the promise of equitable mental healthcare will remain out of reach for millions.

Abbreviations

Abbreviation	Description
ASSAf	Academy of Science of South Africa
CDC	Centers for Disease Control and Prevention
DALY	disability-adjusted life-year
FPD	Foundation for Professional Development
HCW	healthcare worker
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa

Abbreviation	Description
HR	human resources
HRH	human resources for health
NDoH	National Department of Health
NMHPFSP	National Mental Health Policy Framework and Strategic Plan
NSP	National Strategic Plan for HIV/AIDS, STIs and TB
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PHC	Primary Health Care
SANC	South African Nursing Council
SASH	South African Stress and Health
TB	tuberculosis
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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