# Available resources and human rights- a South African perspective

It was with anticipation - and then with some surprise - that the long-awaited South African Mental Health Care Act, No 17 of 2002 (MHCA) was finally promulgated in December 2004. From one day to the next, we moved into a new dispensation for mental health care delivery in South Africa: the era of the ''new'' Mental Health Care Act, setting a historic ''before'' and ''after'' point of reference. The new legislation was generally welcomed, in particular for two principles that it advocates: the management of users in the least restrictive environment; and the comprehensive protection of the human rights of mental health care users.

It would have been reasonable to allow some time for clinicians to come to terms with the impact of the MHCA on day-to-day clinical decisions and procedures, as well as for different levels of management responsible for budgeting and for establishing these extended, integrated services to do likewise. But six years later, a consistent, strategic operational planning process has yet to emerge effectively at either a provincial or national level. There are notable externally funded exceptions from collaborative research groups such as the Mental Health and Poverty Research Program Consortium and the South African Stress and Health Study may.[1,2] No regular process for capital projects have been established through which mental health care facilities (including community-based day care centers) are being prioritized, upgraded and staffed according to minimum acceptable norms and standards.

The continued lack of resources has been the focus of a number of reports[3-5] with subsequent reports including reviews of facilities and regional services in Gauteng[6-11], Western Cape[12,13] and more recently, KwaZulu-Natal[14-16] and the Eastern Cape.[17]

## Available resources

Emerging from these reports is that, not only are clinical staff required to deal with an increased administrative burden but that day-to-day care still occurs mainly within the very same inadequate facilities and inappropriate spaces that existed before 1994. The capacity to safely contain users in, for example, acute 72-hour assessment units, and the clinical decisions related to referral of users to a more restrictive psychiatric hospital, are still determined mostly by the same pre-existing pressures of poor infrastructure and non-availability of staff. There has been no revision of resource requirements necessary to realize in practice the two core principles of: treatment in the least restrictive environment; and protecting the human rights of users.

In terms of funding Section 4 of Chapter 2 (MHCA) firstly explains that the legislation is intended to regulate mental health care in a manner ''that makes 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'' but Section 4 (ii) wields the controlling principle of ''within the limits of the available resources''. There has, however, been no concerted action since the implementation of the MHCA to establish what, and to ensure that, resources for mental health are actually available.

Routine financial information is not currently kept in a format which readily allows for an analysis of what mental health in an integrated health service budget, such as a regional hospital or a health district, costs. Adopting a ''bottom-up'' cost centre approach, a very limited project was recently undertaken in a local facility. Using activity-based costing to establish the actual cost of mental health care activities, it was calculated that 2.4% of the annual expenditure of a regional specialist hospital was afforded to mental health care, of which the bulk was for staff salaries.[18]

## Human rights

The specified human rights of users that need to be upheld by the MHCA require that care should occur in a physical space and with staff that is appropriate and conducive for this purpose. A provisional interpretation of what such a space may look like, in e.g. a 72-hour assessment unit, was undertaken as a pilot exercise to interpret the protection of human rights according to the MHCA, and to translate it into the required space and program for this setting.[19] According to this interpretation, the equal restriction of movement of voluntary, assisted and involuntary users admitted in one communal space, because of inadequate staffing, is a violation of users' human rights. The fact that additional dosages of pharmaceutical agents are required to chemically restrain users because of inadequate facilities and staffing is a violation of users' human rights. The failure of an institution with designated responsibility to ensure the safe containment of those involuntary users for whom it has accepted custody, is a violation of users' rights. In this pervasive climate of ignoring the principles of the current mental health legislation, the return at the end of the past financial year to the national Treasury of unspent health budgets of R813 million, is a gross, statutory violation of users' human rights.[20]

## Mental Health Review Boards

Mental Health Review Boards (MHRBs), the very structures that were established to monitor and guard users' human rights, currently seem to be flooded with their own administrative deluge created by the constant stream of uncontrolled paper work. Most MHRB's appear not to currently have the capacity to manage databases effectively or track the movement of users from the one facility to the other. It has also been reported, that MHRB's in some provinces like Limpopo have, six years later, not even been appointed. MHRBs often seem to make ''rubber stamp'' decisions and only reject submissions if documents demonstrate administrative mistakes such as incorrect dates or

incorrect numbering of routine periodical reports. As such, these actions hold no real significance for the individual care user, nor do they address any actual illegal or inappropriate admissions adequately or timeously.

**Organized psychiatric profession**

In 2007, a past president of the South African Society of Psychiatrists (SASOP) made a submission on conditions for mental health users to the South African Human Rights Commission.[21] The availability of resources to ensure the human rights of users has also been raised during the recent 16th National Congress of SASOP in October 2010. In a workshop on the MHCA, which included a number of officials from the national Department of Health, the final answer of the senior participating official on this issue was that human rights are acquired progressively through legal appeals to e.g. the Constitutional Court. This statement left delegates grappling with the scenario of how, currently disempowered mental health care users will muster enough financial and other support to effectively launch a successful legal challenge on this level. SASOP, as the local organized body of psychiatrists, will have to sustain concerted efforts, in collaboration with the wider medical fraternity and representative labor structures, to effectively advocate for acceptable conditions of service of mental health care workers and for adequate and appropriate care of their patients.

**Cost centers**

Given that the principle of ''available resources'' has been legislated as the determinant of the provision of adequate services, and thus, of the upholding of the stipulated human rights of users, it is essential that the availability of resources both in the provinces and nationally is being determined and monitored routinely and transparently. The imminent proposed implementation of a national health insurance system to extend more comprehensive health care to a larger proportion of the population should, per se, galvanize a renewed effort to describe, quantify and cost service packages and programs. That public mental health care services and units will have to offer defined services at a set price, poses the extending challenge of establishing the cost of integrated mental health care activities, as cost centers, on all levels of care and for all programs. Whether this exercise is undertaken within new integrative models for mental health care[22], or within existing models, a dispensation has to be achieved where human rights of mental health care users are not continuously and systemically violated by the non-delivery of services resulting from poor or absent financial information or decision-making.

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