

The Mental Health Care Act: challenges and opportunities

An abridged version of an address delivered by Professor Christopher P. Szabo at a mental health Imbizo, hosted by Gauteng Health on the 21st November 2005

The Mental Health Care Act was promulgated in December 2004. Although this was not unexpected, the timing had certainly not been anticipated. Overnight the mental health care landscape was transformed. Not only had all of our professional designations been collapsed into a single entity of "mental health care practitioners", but our patients were now "users". One might say that this was purely semantics, still it was change and not change that one can recall ever having been canvassed about. But this was relatively minor. The Act brought with it an army of documentation driven by the new regulations. There was a sense of feeling overwhelmed. As time passed, that feeling seems to have abated or possibly one has simply gotten used to the feeling and learned to perform under such circumstances. Alternatively, we have mastered the situation and things are running smoothly. If that were the case, it is unlikely that we would be here today.

The Imbizo

So, is this Imbizo going to be yet another forum for simply airing grievances? One would hope that not only are problems identified, but that there is a consensus on the way forward with a firm commitment to ensure the necessary steps are taken to address the problems. Promulgation of the Act is one thing, successful implementation another. If the Act seeks to provide a framework and structure for optimal patient care then let us not lose sight of the patient, as ultimately they will be the losers and the Act will be self-defeating. As a consequence of ongoing difficulties and frustrations experienced by those at the forefront of implementation, an Imbizo was convened. The spirit of the Imbizo is firmly rooted in the ethos of a participatory democracy and is central not only to the political but also to the cultural traditions of our country. It serves to bring together all role players and stake holders, to engage freely and vigorously working towards consensus. Reviewing media reports, there appears to have been a focus in recent times on issues related to mental health, more specifically: service provision for mentally ill patients. Such an Imbizo for mental health is thus timely. Three media reports come to mind, namely the closure of the psychiatry ward at George Mukhari hospital, the concerns about community services generally and the abuse of mentally ill patients in Mpumalanga. These reports against a background of numerous hospitals not receiving accreditation due to not achieving acceptable levels of delivery. It seems that there has been a resurgence of scrutiny together with an expectation of change. Both are most welcome. However, for change to happen

we need the following: critical self evaluation, consultation and discussion between role players and a clear vision and strategy to move forward. Let us accept that ultimately whatever our designation i.e. clinical, clerical, management, we are all part of the same loop. A clinician might not always feel that this is the case. More often than not, clinical staff might feel that it is an "us" versus "them" situation whereby they and their patients are at the mercy of bureaucracy. This kind of perception creates a tension that serves no-one well. Bearing this in mind we turn to the Mental Health Care Act. A critical word in the Act's title is "care". This must be our guiding ethos, care for the patient. But for care to be effectively delivered it must go beyond an attitude and must encompass a comprehensive vision. Such a vision must be sensitive to the needs of the population being served. Optimally, psychiatric patients should be managed in the least restrictive manner possible, as close to their home as possible, and with appropriate professional and social support. Resources must be available and accessible. This is not so much a legal requirement, as a clinical imperative. As it happens, we now have an Act that legislates such an approach. In this regard, clinicians and legislators are in agreement hence there should be no problem. Yet the practical reality on a day to day basis is somewhat different. If this were not so there would be no Imbizo. In fact concern with mental health and mental health legislation is not a uniquely South African phenomenon.

An international perspective

In a report on mental health in the United States in the year 2000, the United States surgeon general (Dr David Satcher) stated that "The mental health system is highly fragmented" with many sufferers not seeking help due to stigma, lack of funds or an inability to navigate their way through a bewildering maze to get treatment.¹ Subsequent to this, a presidential directive led to the formation of the New Freedom Commission of Mental Health who were tasked by President Bush to identify problems in US mental health care and identify solutions.² The findings highlighted fragmentation of services and the difficulties of mentally ill people to receive coordinated care. To quote from the report:

Services and treatments must be consumer and family centred, and not orientated to the requirements of bureaucracies. Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery and on building resilience, not just managing symptoms.

The same report noted that even where treatment is received, the system is not organized to reintegrate patients into their communities and societies. Further, that there should be parity between mental health care and physical health care. Yet in spite of highlighting deficiencies, the report did not call for increased funding to address the identified deficiencies. Most recently, a United Kingdom based organization, the Institute for Public Policy Research stated that staying mentally well should be given the same priority as staying physically well.³ Their vision of mental health services by the year 2025 foresees mental health service delivery at a very local, neighborhood, level with what they term "access workers" who would be able to route people rapidly to specialist services. To achieve this they believe that policies are needed to maintain good mental health rather than just treating acute mental illness. In 2000, the World Health Organisation estimated that mental health problems accounted for 43% of all years lived with disability, with a recent report showing the most common reason for claiming incapacity benefits is now depression, whereas 10 years ago it was back pain. Most recently, President Bush unveiled an action agenda for mental health in the United States aimed at helping more patients to live in the community.⁴ This agenda is based on the earlier recommendations of the New Freedom Commission on Mental Health. Aside from the US and the UK, the situation for those with mental illness appears no better in Australia following the release of a report on investigations into Australia's mental health services.⁵ Two major systemic problems were identified i.e. under-funding and workforce shortages. To quote,

...the available evidence suggests that persons with mental illness still struggle on a daily basis to access appropriate health care or be treated with respect or dignity when they do enter our health care systems. Any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialized or neglected...

These findings follow national reform of mental health care in Australia which began in 1992, where Australia had been an international leader in developing mental health care policies based on deinstitutionalization and care in the community. As stated by one of the co-authors (Ian Hickie) of the report,

...Policies without implementation aren't worth the paper they're written on. The real danger is backlash. We have further increased stigma around mental illness by exposing the community to untreated people...

In the United Kingdom, mental health services are no less under scrutiny. Specifically in light of proposed changes to mental health legislation which critics believe would further burden an already "over-stretched and under-resourced" system of mental health care services⁶ and which was recently described as "unworkable, misconceived and would violate fundamental human rights".⁷ This against a background of government acknowledged problems concerning comprehensive mental health service delivery since the mid-1990's.⁸ A fascinating and cautionary finding from UK based research published in 1999 highlighted that since hospital bed closures and increased emphasis on community care had been implemented, the total

number of admissions had risen as had the proportion of "compulsory" admissions between 1984-1996, with an almost doubling of "compulsory" admissions during this time.⁹ The authors noted that the move to community care may have led to a paradoxical increase in the use of coercion i.e. "compulsory" admissions for the treatment of mentally ill patients. And what sort of acute facilities are such patients in the UK being admitted into? According to a report from 3 mental health NGO's, facilities that are filthy and overcrowded with staff that are demoralized.¹⁰ Such conditions have apparently led to an increase in compulsory admissions. This due to patients who require hospitalization, and are capable of being admitted as voluntary patients, refusing such admission thus leaving psychiatrists with no choice but to admit them using compulsory orders. A UK study highlighted the state of acute psychiatric facilities in 1998, with a specific call to improve the quality of such facilities at both a structural and staffing (especially nursing) level.¹¹ It seems that little has changed. This same study whilst not specifically addressing care in the community did note that attention should be given to improving community care. The implication being that rather than a hospital-community divide, there needs to be coordinated working between hospital and community based services.¹² One must state however that an emphasis on community care is not at the expense of hospital care.

Relevance to South Africa

What, if any, significance does this information have for South Africa? Firstly, South Africa's problems are not unique and should very definitely not simply be ascribed to our "developing nation" status. One would most certainly view the United States, the United Kingdom and Australia as "developed" nations. Secondly, to establish what, if anything, these developed nations are doing, or going to do, about their problems. Interestingly there are a number of inescapable commonalities, between the aforementioned developed nations and South Africa's situation. All of these commonalities are readily subsumed under the rubric of resources. The problems relate to staffing and facilities both hospital and community based. Moreover, the integration of services with continuity of care between services is equally problematic, not only between community and hospital based structures but also between agencies. Greater continuity of care is associated with higher levels of satisfaction amongst service users, but in this instance the continuity refers to continuity of care giver.¹³ Patients like to be seen by people they know and can trust. How does one create such continuity? Leadership and responsibility for all of these issues is critical, but where does that lie? Ongoing evaluation and benchmarking is required, but what standards are we to evaluate services against? According to Peter Tyrer (a professor of community psychiatry at the Imperial College School of Medicine in London), setting standards for mental health services has always been a difficulty.¹⁴ Aside from the emphasis on patient needs, what about families and their needs? This speaks of integration of both health and social services i.e. inter agency collaboration. What of bureaucracy? Clinicians have seen the exponential growth of non-clinical demands, with bureaucracy cited as the commonest reason for early retirement by psychiatrists in the United Kingdom and thus a major contributor to shortages in clinical staff in that country.¹⁵ The most sobering of reflections on new legislation related to mental health comes from an editorial by Rajee and Crichton (2005) in the British Medical Journal, namely "...new legislation

does not in itself provide improvements in clinical care or resources."¹⁶ But is that true? Technically, yes, if the legislation makes no provision for resource allocation. However, if resource allocation is central to successful implementation of legislation then it might indeed serve to contribute towards improved clinical care and resources.

The way forward

The notion of challenges and opportunities captures a way of viewing the Mental Health Care Act. As opposed to clinicians battling bureaucrats for resources, legislation has put us on the same page i.e. finding ways of successfully implementing the Act. Much of the ethos of the Act is simply good clinical practice, but due to resource constraints it is an ethos that has been increasingly hard to live up to. As clinicians there is at some level an obligation to be our patient's advocates. The Act gives us leverage. Whilst the administrative burden of the Act is highly problematic, the Act itself should not be demonized. It is imperative however that appropriate staffing and materials are forthcoming. What of clerical staff to facilitate the process? There are no dedicated personnel, so clinicians are tasked with this responsibility. Thus precious patient care time is taken up by paperwork. Administrative inefficiency is inexcusable. Heads of Health Establishments need to not only understand their obligations and responsibilities in terms of the Act but they also need to ensure that these are fulfilled. The issue of Mental Health Review Boards adds another factor into an already complex mix. The acute units are inadequate, both structurally i.e. the physical environment and layout and in terms of staffing. But let us move beyond the hospital and into the community. Patients emerge from communities. What resources are there in the communities to adequately ensure that the least restrictive care as close to their point of origin is available to our patients? The flow of patients both to the hospitals and back to the community has to be a focus, with an emphasis on ensuring that up and down referrals are effected smoothly. Resources in the community need review, not only in terms of accessibility but also staffing and availability of medication. Specifically ensuring that medication prescribed in a hospital setting is available in the community setting. This means that tertiary level prescribing need not, and should not, be constrained by primary care availability. This is not a request for prescribing *carte blanche* but a call for appropriate prescribing with responsible use of agents that will see continuity of care. Home visits to track non-attendance, investigate non-compliance and support families is central to meaningful community care, as is the liaison between multiple agencies involved with a given patient. This speaks of vision and management capacity. One without the other will not lead to desired outcomes. The requirements of the Act demand action. Beyond difficulties with administration, are those of interpretation of the regulations (which do seem to differ from site to site, and at times between clinicians and Mental Health Review Boards) as well as an apparent lack of awareness by all role players of the Act.

Conclusion

The hope is that today's Imbizo will serve to bring together a spectrum of opinion detailing both immediate and practical problems related to the implementation of the Act as well as an understanding of how the Act can best serve those it seeks to. Such deliberations do not ignore the good work by committed personnel that takes place under current circumstances. This represents an opportunity for all stake holders to think seriously about how we

modernize our services and create a system that if we were personally in need of we would confidently use. In order to achieve that, one can do no better than quote Adetokunbo Lucas (2005)¹⁷ from a recent British Medical Journal editorial who said that:

...Africa needs balanced investment in human resources, infrastructure, drugs, logistics and other supportive services that will enhance the capacity to deliver health care..

Certainly in the domain of mental health, we have a legal requirement to do just that. One might argue that the Act should have been delivered into a framework that had accounted for the requirements, including budgetary aspects. As things stand it seems that we have to refine the framework to ensure meaningful implementation of the Act. This is the challenge, but also an opportunity.

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References

1. Charatan F. US mental health service is "highly fragmented". *British Medical Journal* 2000; 320: 7.
2. Josefson D. Presidential commission urges revamp of US mental health system. *British Medical Journal* 2003; 327: 248.
3. Kmietowicz Z. Mental health should have the same priority as physical health. *British Medical Journal* 2005; 330: 1408.
4. Lenzer J. Bush unveils mental health action plan. *British Medical Journal* 2005; 331: 592.
5. Sweet M. Australian state and federal governments are attacked on mental health care. *British Medical Journal* 2005; 331: 984.
6. Kmietowicz Z. New mental health bill may conflict with advice from the GMC. *British Medical Journal* 2002; 325: 678.
7. Dyer C. Draft mental health bill needs major overhaul, says committee. *British Medical Journal* 2005; 330: 747.
8. Court C. Government admits mental health service problems. *British Medical Journal* 1996; 312: 531-532.
9. Wall S, Hotopf M, Wessely S, Churchill R. Trends in the use of the Mental Health Act: England, 1984-96. *British Medical Journal* 1999; 318: 1520-1521.
10. Kmietowicz Z. Admissions to hospital under the Mental Health Act rise by 30% over 10 years. *British Medical Journal* 2004; 328: 854.
11. Ford R, Durcan G, Warner L, Hardy P, Muijen M. One day survey by the Mental Health Act Commission of acute adult psychiatric inpatient wards in England and Wales. *British Medical Journal* 1998; 317: 1279-1283.
12. Hadley TR, Goldman H. effect of recent health and social service policy reforms on Britain's mental health system. *British Medical Journal* 1995; 311: 1556-1558.
13. Cole A. Mental health plans are not being fully implemented in England. *British Medical Journal* 2005; 351: 592.
14. Tyrer P. The national service framework: a scaffold for mental health. *British Medical Journal* 1999; 319: 1017-1018.
15. Marshall M. Modernising mental health services. *British Medical Journal* 1999; 318: 3-4.
16. Darjee R, Crichton J. New mental health legislation. *British Medical Journal* 2004; 329: 634-635.
17. Lucas AO. Human resources for health in Africa. *British Medical Journal* 2005; 331: 1037-1038.