



## Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice

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Legislation prior to 2002 tended to reinforce the alienation, stigmatisation and disempowerment of mentally ill patients in South Africa. In line with international developments in mental health legislation, the Mental Health Care Act (2002) was promulgated in South Africa. Its core principles – human rights for users; decentralisation and integration of mental health care at primary, secondary and tertiary levels of care; and a focus on care, treatment and rehabilitation – are progressive and laudable. However, the task of implementing the requirements of the Act at community and district hospital levels is fraught with problems. Lack of infrastructure,

inadequate skills and poor support and training undermine its successful implementation. Health workers already burdened with enormous workloads and inadequate resources struggle to manage mentally ill patients at district hospitals. The 72-hour observation is a particular area of difficulty throughout the country. This paper outlines the rationale and sense behind this legislation, discusses the problems encountered at the 'rock face', and offers solutions to the problem of translating principles into practice.

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### Historical background of mental health treatment in South Africa

Previous South African legislation relating to mental health (the Mental Health Act No. 18 of 1973) (MHA 1973) unashamedly focused on control and treatment of patients. Like most international mental health legislation before 2000, the overriding concern was the welfare and safety of the community. Human rights of patients was not a priority and was not addressed, as 'protection of society' was given priority over the rights of the individual. A reasonable degree of suspicion of mental disorder was sufficient to have a stranger, neighbour or relative 'certified' to a psychiatric institution, often far from the individual's home. Certification was wide open to abuse – jealousies, vendettas and prejudices often lay behind the certification of so-called 'patients' and the withdrawal of their personal liberty. At times, this form of detention was used for political ends to incarcerate and silence individuals or 'dissidents'. Once certified, patients had virtually no recourse to assistance from the law, and could languish in hospital, against their will, for weeks or months. Patients had no meaningful right of appeal or representation. Against this backdrop of human rights infringements, psychiatrists were forced to be doctor and gaoler.

Furthermore, the MHA 1973 reinforced the separation of mental health care from general health care. Psychiatric

services were stand-alone and not integrated into primary health care. Generalist medical practitioners were not required to take any responsibility for mental health. This resulted in many cases of behaviourally disturbed patients, who were desperately ill with serious medical disorders such as meningitis, delirium and metabolic disturbances, slipping through the net and being sent to psychiatric institutions lacking optimal medical care. Fatalities occurred, with patients dying of sepsis or metabolic disorders in the seclusion rooms of psychiatric hospitals.

Psychiatric services were also centralised in urban-based tertiary psychiatric institutions, far from the homes and communities of most patients. Mental illness in a rural village or remote town often meant transfer over great distances and lengthy incarceration far from home, family and place of employment. There was little or no care within the community.

Patients entering the health services system with acute mental disorders experienced a form of systemic traumatisation or structural violence.<sup>1</sup> Whether intentionally or not, the structure of the system disempowered, alienated and stigmatised the mentally ill. While individual intentions were usually good and humane, the structural evils inherent in mental health services and legislation meant that admission was a traumatic and damaging experience. Psychiatric service provision under the MHA 1973 was not truly based on the ethical principles of autonomy, beneficence, non-maleficence and justice.

### The Mental Health Care Act of 2002

The Mental Health Care Act of 2002 (MHCA 2002)<sup>2</sup> was promulgated in South Africa against a backdrop of positive international developments in mental health legislation.<sup>3-5</sup>

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Emanating from a new culture focusing on human rights within South Africa after the pivotal year of 1994, it was one of the legislations enacted to rid the country of its apartheid legacy. And with its history of mental health treatment, South Africa was in dire need of an act that reflected the new spirit.

The MHCA 2002 is based on a number of important principles:

1. People with mental health problems are regarded as 'users', since any individual is a potential user of mental health care services.
2. Services should offer care, treatment and rehabilitation to users.
3. The human rights of the mental health care user (MHCU) are not inferior to the welfare of general society.
4. All health care practitioners are also regarded as mental health care practitioners (MHCPs) and should take some responsibility for mental health needs.
5. Mental health care should be fully integrated with primary health care.
6. Users have a right to be treated near to their homes and within their communities, as far as possible.
7. Users have a right to be provided with care, treatment and rehabilitation, with the least possible restriction of their freedom.
8. Users have a right to representation, knowledge of their rights, and the right of appeal against decisions made by MHCPs.
9. Mental health review boards should be created to act as independent 'ombudsmen' [sic] concerned with the rights of the user, to review decisions made in terms of the Act, and to respond to and investigate appeals.

### Implementing the MHCA 2002

Anticipating the promulgation of the MHCA 2002, the KwaZulu-Natal Department of Health developed a strategic plan to guide the implementation of the Act in that province.<sup>6</sup>

Primary mental health care should be provided at community, primary health care (PHC), community health care (CHC) and district hospital levels. Generalists would therefore now be required to take an active role in offering care, treatment and rehabilitation to MHCUs. This includes outreach to CHC and PHC, outpatient care, screening and follow-up, appropriate referral and provision of short-term inpatient care for a period of 72 hours. This last requirement – the '72-hour observation' – proved to be a controversial and difficult function to implement.

The secondary level of mental health care should be located at regional hospitals, where a psychiatric unit with dedicated beds should be available. The regional team (including a

psychiatrist) is responsible for inpatient and outpatient care as well as provision of support and outreach to all clinics and district hospitals in that region.

Tertiary care should be located at designated psychiatric hospitals providing specialised services such as forensic psychiatry, child and adolescent psychiatry, addiction treatment and psychogeriatrics.

### The 72-hour observation

A major responsibility of district hospitals, in terms of the MHCA 2002, is to provide 72-hour admission and observation for MHCUs. This requirement has given rise to many problems, shared by most district hospitals throughout the country, which are very practical in nature and relate to operational aspects of implementing this legal requirement. The problems do not relate to the *idea* or *concept* of an observation period, but to their translation into practice.

In defence of the principle of a 72-hour observation period, there are several good reasons for this practice:

1. The most important is that, within a general medical environment, it allows for exclusion of medical causes of behavioural or psychiatric disturbance.
2. Many users recover sufficiently to be discharged within the first 72 hours (e.g. in substance intoxication or withdrawal, acute trauma, parasuicide and brief psychotic disorders). Unnecessary admission to a psychiatric institution is unfair on users as it may cause humiliation and shame.
3. Many MHCUs can receive care and treatment close to their homes and communities.

### Problems in managing 72-hour MHCUs

The reality of providing 72-hour observations at district hospitals is that most institutions encounter serious problems leading to suboptimal levels of care and occasional disasters, such as:

1. MHCUs heavily sedated throughout the observation period, preventing adequate review.
2. Highly agitated or psychotic MHCUs inadequately sedated and difficult to contain within general ward settings, leading to unsafe conditions.
3. Inappropriate medications or doses of medications used for behavioural control of MHCUs, sometimes leading to iatrogenic problems.
4. Inadequate screening of medical conditions; having been labelled 'a psych patient', the MHCU is thereafter neglected in terms of routine examination and investigation.
5. Failure, at district hospital level, to comply with the requirements of the MHCA 2002 with regard to completion of MHCA forms.



These problems are generic to district hospitals throughout the country and, importantly, relate to the practical implementation rather than the validity of the Act. The principles are sound; it is their day-to-day realisation that is problematic. Considering the deficiencies in district hospital service that conduce to these common practical problems, it is apparent that the following infrastructural and functional shortcomings exist:

1. Inadequate facilities for containing disturbed, aggressive MHCUs.
2. Inadequate skills of health workers in managing psychiatric patients.
3. Poor understanding and knowledge of the MHCA 2002 and its forms.
4. Inadequate medications, treatment protocols and guidelines as well as awareness of referral options.
5. The roles of the South African Police Services (SAPS) and Emergency Medical Rescue Services (EMRS) in respect of the management of MHCUs are not clear, and their involvement is often unhelpful.

## Solutions for improving mental health care at district hospitals

Translating legislation into reality with regard to the care of MHCUs at district hospitals has been difficult owing to practical deficiencies and lack of preparedness at service level. Other nations also struggle with the painful realities of implementing legislation within poorly resourced and inadequately prepared circumstances. Deinstitutionalisation in the USA became a politically expedient (and necessary) project, commencing during the 1960s. Large numbers of chronically institutionalised patients were discharged from psychiatric institutions with little planning or preparation in terms of community services, and many ended up on the streets as homeless people, or in prison.<sup>7</sup> In the UK, deinstitutionalisation during the 1980s was also difficult, but it was perhaps better prepared with its policy of 'Care in the community'.<sup>8</sup> So South Africa is not alone in the often painful task of transforming and modernising legislation and services in accordance with ethical principles of care.

Legislation is not easy to change, and many would argue that good legislation should not be changed but rather accommodated. This is true with regard to the MHCA 2002. Acknowledging that preparation at the 'rock face' was not adequate, the solution is not to discard the Act's principles or intentions but rather to accommodate its requirements in part through improvisation and in part through careful planning. This requires a commitment from health workers at all levels and, importantly, also requires commitment from administrators and Government. Mental health care has been sorely neglected in South Africa, and transformation of the

services requires political leadership and adequate funding. While we face many health challenges, that of providing a high and ethical standard of mental health care to all users should not be ignored.

Given the real problems encountered in managing MHCUs, what are some of the 'improvisations' possible at district hospital level? I suggest some of the following actions:

### Infrastructure

- At least 2% of beds in general wards at district hospitals should be made available for the care of MHCUs.
- Every district hospital should have at least one seclusion room for the care of aggressive, disruptive MHCUs during 72-hour observation.
- Every district hospital should have a dedicated psychiatric outpatient clinic.

### Human resources

- District hospitals should ensure that they have at least one medical officer with expertise in managing MHCUs and who is proficient in the practical application of the MHCA 2002.
- District hospitals should have full-time psychiatric nurses and part-time occupational therapists, psychologists and social workers for psychiatric services.
- District hospitals should insist on outreach and support visits from regional or tertiary MHCPs.

### Education and training

- District and community health workers require regular training updates on the MHCA 2002 and the use of MHCA forms. This must be repeated 6-monthly, as staff change regularly and the complexity of the Act requires refresher training. This is the responsibility of regional or tertiary MHCPs and the district office.
- Treatment protocols for managing mental disorders should be developed regionally for distribution to district and community level health workers.<sup>9</sup> Regular training updates should be provided on these protocols.
- District hospitals should second medical officers for occasional periods to tertiary psychiatric hospitals for training in the management of mental disorders. The value of achieving such skills and qualifications (e.g. Diploma in Mental Health) cannot be over-estimated.
- Local SAPS and EMRS personnel should receive regular training in their roles in respect of MHCUs and the requirements of the MHCA 2002. This is the responsibility of the district office.

### Other

- Copies of the MHCA 2002 and MHCA forms must be available at all district and community health institutions.



This is the responsibility of institutional managers and the district office.

- A District Mental Health Forum should be established in every district, including health workers, administrators, SAPS and EMRS representatives, community organisations and MHCU representatives.
- Regional or tertiary MHCPs have a responsibility to provide outreach consultation-liaison services, teaching and service development to secondary and primary services (e.g. monthly MHCP visits to district and regional hospitals).

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## Prevalence of sexually transmitted infections in women attending antenatal care in Tete province, Mozambique

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**Objective.** To determine the prevalence of *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG) and syphilis in pregnant women.

**Methods.** A cross-sectional study was conducted among women attending antenatal care clinics (ANCs). Blood samples were tested for syphilis using the rapid plasma reagin (RPR) and treponemal haemagglutination (TPHA) tests; CT and NG were diagnosed using a manual polymerase chain reaction assay on first-void urine samples. A socio-demographic questionnaire was completed. Results were compared with previous published data on sexually transmitted infection (STI) prevalence in Mozambique.

**Results.** Blood and urine samples were collected from 1 119 and 835 women, respectively. The prevalence of CT was 4.1%, and that of NG 2.5%. The RPR test was positive in 5.2% of the women, and 7.1% had a positive TPHA test. Active syphilis

was found in 4.7%. In univariate analysis, CT was associated with having had any level of education ( $p < 0.05$ ), reactive RPR and TPHA were associated with illiteracy ( $p < 0.05$ ), and TPHA was associated with age  $> 25$ . Multivariate analysis did not show any significant association. In comparison with published data from 1993, a decline was observed for CT ( $p < 0.05$ ), NG and syphilis ( $p < 0.001$ ).

**Conclusions.** Compared with available data, a decline of STI prevalence was observed in our setting. This might be the result of community-based education programmes focusing on changes to sexual behaviour, as well as the widespread use of the syndromic approach to managing STIs and the expansion of syphilis screening in primary health care settings. However, STI rates are still high, and the problem needs more concrete and sustained efforts for its control.

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There is little information about the prevalence of sexually transmitted infections (STIs) in pregnant women in Mozambique. In Tete, a province in the country's north-west, recent data are not available. However, the province's

Directorate of Health reported an antenatal clinic (ANC) attendance rate of nearly 100%. This study set out to assess the prevalence of *Chlamydia trachomatis* (CT), *Neisseria gonorrhoeae* (NG) and syphilis in pregnant women attending urban health

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centres. It is important to detect these STIs in pregnancy as they are a significant cause of neonatal morbidity and adverse pregnancy outcomes.

## Patients and methods

### Design

A cross-sectional study on pregnant women attending ANC at two health care centres (in the towns of Moatize and Tete) was conducted.

### Study population and sampling

From March to July 2004, all women attending the above ANCs for the first time were invited to participate. After obtaining informed consent, a questionnaire including socio-demographic and medical details, as well as data on sexual behaviour, was administered.

Blood samples and first-void urine samples were collected. The samples were transported in cool-boxes to the provincial laboratory where they were frozen at  $-20^{\circ}\text{C}$  and transported in dry ice to the Microbiology Department of the Faculty of Medicine of Eduardo Mondlane University in Maputo. Here, syphilis serology was performed using treponemal haemagglutination (TPHA) and rapid plasma reagin (RPR) tests (Abbott biokit). RPR-positive samples were titrated. Urine samples were tested for CT and NG using a polymerase chain reaction (PCR) assay (Amplicor CT/NG, Roche). An RPR test was also done on site, and all RPR-positive mothers were treated with benzathine penicillin according to national guidelines.

### Data analysis

Data were entered using Epi-info (version 6.0). Analysis was made using SAS version 9.1.3 (SAS Institute, Cary, North Carolina, USA). Descriptive statistics, multivariate analysis and univariate logistic regression to infer trends in STI prevalence over time, were used.

A review of literature on STI prevalence was conducted via PubMed; also, the International AIDS Society and Health Alliance International-University of Washington websites were visited.

## Results

Of the 1 237 eligible women, 1 203 accepted and enrolled consecutively. Blood samples were collected from 1 119 study participants and first-void urine samples from 835.

### Socio-demographic data and sexual history

The mean age of the study population was 24.7 (range 14 - 45). Of the enrolled women, 1 057 (87.8%) had a stable marital status, 777 (64.6%) had some level of education, 306 (25.4%)

were employed, 808 (67.2%) were unemployed, and 48 (4.0%) were students.

The mean age at first sexual intercourse was 16.2 years (range 10 - 38). Only 20 (1.7%) of the women reported having had more than 1 partner in the last 6 months, while 221 (18.4%) reported that their partner had had other partners in the last 3 months. A history of STI was reported by 189 (15.7%), with 180 (15.5%) declaring to have been treated.

### Prevalence of STI

Of the women, 311 (25.9%) reported STI-related symptoms at the time of the visit: 247 (20.5%) had vaginal discharge, 22 (1.8%) genital ulcers, and 86 (7.1%) dysuria.

Of the 1 117 women tested for syphilis, 58 (5.2%, 95% confidence interval (CI) 3.9 - 6.5) were RPR reactive, and 78 (7.0%, 95% CI 5.5 - 8.5) had a positive TPHA test. Fifty-three women (4.7%) tested positive on both tests and were considered to have active syphilis. Among 36 reactive RPR samples, only 7 had a titre  $\geq 1:8$ .

Of the 835 women who gave a urine sample, 34 (4.1%, 95% CI 2.76 - 5.44) tested positive for CT, and 21 (2.5%; 95% CI 1.44 - 3.6) for NG.

### Risk factors for STI

In univariate analysis, first sexual intercourse before 18 years old was associated with a positive STI test result ( $p < 0.05$ ). Furthermore, CT was associated with having any level of education ( $p < 0.05$ ), and active syphilis with illiteracy ( $p < 0.05$ ). A positive TPHA test was associated with age  $> 25$  ( $p < 0.05$ ). None of the STIs tested for was associated with self-reported STI symptoms: 25.2% of women with an STI reported STI-related symptoms, compared with 23.4% of uninfected women. Stepwise multiple logistic regression analysis revealed that none of the following variables were independent predictors for having an STI: age, marital status, occupation, level of education, age of sexual debut, number of partners, STI-related symptoms, and STI-related symptoms in the partner.

### Trend over time

Two previous studies in ANC settings in rural Mozambique demonstrated high prevalences of CT and NG. In 1993, a prevalence of 7.9% (95% CI 3.5 - 12.3) and 7.0% (95% CI 3.5 - 10.5), respectively, were reported, and in 2002 of 7.5% and 14%, respectively.<sup>1,2</sup> In 1985, a nationwide survey showed high variations in syphilis prevalence from one province to another: 1.6 - 9.8% with TPHA or FTA-Abs, and 4.5 - 16.5% with VDRL;<sup>3</sup> Tete province was not included in this study. High prevalence rates for syphilis were also reported in 1993 (15%),<sup>1</sup> 1994 (12.2%),<sup>4</sup> 2002 (15%)<sup>2</sup> and 2006 (9.5%)<sup>5</sup> (Table I).

Comparing the reported 1993 ANC data with our data, a decline in CT prevalence from 7.9% to 4.1% was observed ( $p < 0.05$ ); and in NG from 7.0% to 2.5% ( $p < 0.005$ ). Active



Table I. Trends of STI prevalence in pregnant women, different studies, Mozambique, 1993 - 2006

	Studies by authors by publication date					
	Liljestrand 1985 (nationwide) N=1 468	Vuytsteke 1993 (Inhambane province) N=201	Cossa 1994 (Zambezia) N=1 728	Loscertales 2002 (southern Mozambique) N=262	Montoya 2006 (Sofala province) N=4 487	ICRH 2004 (Tete province) N=1 203
<i>C. trachomatis</i>		7.9%		7.5%		4.1%
<i>N. gonorrhoeae</i>		7.0%		14%		2.5%
Syphilis (RPR/VDRL)	4.5 - 14.6% (VDRL)			15% (RPR)	9.5% (RPR)	5.2%
Syphilis (TPHA/MHA- TP/FTA-Abs)	1.6 - 9.8% (TPHA/ FTA-Abs)		12.2% (MHA-TP)			7.0% (TPHA)
Active syphilis (RPR and TPHA pos.)		14.6%				4.7%

syphilis fell significantly from 14.6% (95% CI 9.7 - 19.5) to 4.7% ( $p < 0.001$ ).

## Discussion

Our data are in line with the decreasing trend in STI prevalence reported in several sub-Saharan countries.<sup>6-8</sup> This decrease shows that the increased efforts to combat STI are not fruitless.

In Mozambique, syphilis screening at ANCs was introduced in 1979 and made a key element of the national 5-year plan in 1995, with an increased number of women tested and treated. As a result, the syphilis prevalence among pregnant women in central Mozambique decreased from over 14% in 1998 to under 8% in 2004.<sup>9</sup> Improved health care services since the civil war era, the introduction and scaling up of the syndromic approach to managing STIs, and antenatal screening for syphilis and adequate treatment with penicillin, might also have played an important role. Community-based prevention activities also resulted in an increased awareness of STI symptoms with a consequent modification of risky sexual behaviour and changes in health attitudes. Cates *et al.*<sup>10</sup> showed that community education resulted in early recognition of symptoms and health-seeking behaviour, and was an important element in controlling syphilis.

In Mozambique, control of STIs is an important element of ongoing programmes to control the devastating HIV/AIDS epidemic. Our data show that the prevalence of STIs is indeed starting to decline. However, an effect on the HIV epidemic has not been observed; HIV prevalence in pregnant women (15 - 49 years) rose from 11% in 2000 to 16% in 2004.<sup>11</sup> This paradox may be explained by the mature HIV epidemic, with most HIV transmission occurring outside core groups with high STI rates.<sup>12</sup> Hence, in settings with a generalised HIV epidemic

like Mozambique, STI control should be complementary to other HIV prevention strategies, including condom promotion, reduction of risky sexual practices, and voluntary counselling and testing, among others.

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