PRESS RELEASE / POSITION STATEMENT

SASOP GUIDE STATEMENT ON CLINICIANS AND DISCHARGED PATIENTS FROM LIFE HEALTH ESIDIMENI FACILITIES.

Background

At the end of May 2016, the Gauteng Department of Health (GDOH) has effected the decision to discharge about 1900 non-voluntary longer-term inpatients from Life Health Esidimeni (LHE). The immediate result of this development is that mental health care users (MHCSs) have in great numbers been hastily discharged and transported to different NGOs and other private locations across the province, while some went to Sterkfontein, Weskoppies and Cullinan hospitals.

Reports on the disorganized manner of the bulk transporting of these MHCUs have appeared in the media, while personal reports from families and from involved advocacy groups allude to totally inadequate locations (with MHCUs apparently sleeping on floors with no medication, no heaters or supervision), loss of clothes and possession, no accompanying documentation, etc. This experience in itself constitutes a sufficient level of stress to precipitate the relapse of several patients in this situation.

Several written attempts were made by SASOP during 2015 to engage with the Gauteng MEC of Health about the implications of the decision to terminate the existing contract with LHE at the time. After no official response was received, the SASOP decided in December 2015 as professional group of specialists, to support the advocacy groups SADAG and Section 27 and representatives of the families of patients, to approach the court for an interdict to not allow the GDOH to discharge patients without an adequate plan and resources available to do so. This application was however dismissed during March 2016, with the judge stating that doctors and not the Department of Health per se, nor the management of a facility, are responsible for the discharge of patients. Unfortunately, no written judgment as such were handed down in the matter. This view seems to imply that all responsibility to discharge patients is placed on the treating clinician with no reference to any requirement from the managers or department responsible to address the services, infrastructure or human resources required to do so. This ruling seems to suggest to the GDOH that it no longer needs to consult SASOP or other role players in terms of what was referred to a "settlement agreement".

Some of the effects of this outcome on treating clinicians at this stage are that:

- psychiatrists are instructed by community service managers in districts to be involved in the evaluation of mostly very inadequate NGO-facilities, with no reference norms and standards for such facilities
- community-based psychiatric services had to receive these additional MHCUs with no extra staffing or resources; and at the same time
- clinicians in acute facilities have to come up with solutions for (i.e. the discharge of) patients who are occupying acute beds, while there are no feasible placement options available with available places in NGOs being occupied by the recently discharged LHE MHCUs. In addition, it has also been a common experience that once an “incident” follows an inappropriate/premature discharge, that the first demand is for the clinician

to explain why this happened, with no reference to the responsibility of the service rendering authority to provide infrastructure and supportive systems and staffing.

Statement

The SASOP at this stage feels compelled to release another official statement in this regard and offer some guidance to clinicians in the Gauteng area, who are required now to be involved in the care and management of these MHCUs in the different, mostly inadequate residential and care settings across several districts:

- The SASOP refers to the Mental Health Care Act (MHCA), no 17 of 2002, which states in Section 4, that:

  " *Every organ of State responsible for health services must determine and co-ordinate the implementation of its policies and measures in a manner that:*
  (a) ensures the provision of mental health care, treatment and rehabilitation services at primary, secondary and tertiary levels and health establishments referred to in section 5(1) – i.e. psychiatric hospitals or care and rehabilitation centres;
  (b) promotes the provision of community-based care, treatment and rehabilitation services;
  (c) promotes the rights and interests of mental health care users; and
  (d) promotes and improves the mental health status of the population."

  This provision seems to indicate that the GDOH, as the respective organ of State, is responsible for the availability of adequate infrastructure and other resources required for adequate patient care on all these different levels of care.

  In addition, the National Mental Health Policy Framework and Strategic Plan (2013-2020) provides a detail exposition of what these responsibilities should entail.[1]

- The SASOP would want to argue that it is not reasonable, ethical or legally correct to adopt a position that the whole responsibility to discharge a patient from hospital, and in this case from non-voluntary long-term care, is falling only to individual treating clinical staff members, whether a medical practitioner, nurse or social worker. The SASOP would further argue that it remains the primary responsibility of the respective responsible authorities to ensure that adequate arrangements, facilities and staffing for the safe and acceptable care of such patients are available, whether in a health facility or a community-based location.

Guide to clinicians

While The SASOP would still want to urge clinicians to provide the highest standard of professional care in individual situations, comprehensive notes should be made in patients' clinical records on the particular limitations regarding available infrastructure and resource in each case scenario. Furthermore, as far as the assessment of facilities are concerned, the official and active involvement of the Office of Health Standards Compliance (OHSC) must be achieved.

1. Clinicians in the community

   - **Assessment and certification of physical facilities** - It should be noted that the expectation that clinicians should be evaluating the suitable of a particular dwelling or building for the safe and ethical housing of patients falls beyond a medical professional or psychiatrist's formal professional scope of practice. Especially if such opinions, in the absence of acceptable standards, will be used afterwards to "certify" any particular facility as such.

- **Additional clinical responsibility of patients arriving at NGOs in the districts** – Part of the expecting adequate arrangements that were required before the transfer of patients occurred, should have been to ensure adequate medical and nursing support on site as necessary.
- **Additional clinical load on community psychiatry services in the districts** – It is noted that these services have not been expanded to accommodate the increased demand on community psychiatric services. Community-based psychiatrists are advised that the additional load on existing clinical staff must be carefully monitored and reported, while considering the acceptable norms for such case load must be considered to request additional staffing where necessary.

2. Clinicians in acute facilities

- **Availability and purpose of acute psychiatric beds** – The specific mandate of acute units in e.g. general hospitals (district, regional, tertiary and central) should be considered
- **Relapsing of stable patients resulting from their removal from LHE** – The expected increase in relapsing patients who were recently discharged from LHE should be monitored and respective hospital managements should be alerted and involved
- **Waiting patients in Emergency Departments** – There is already an increased demand on inpatient psychiatric beds in acute units of general hospitals, with the result at some hospitals, of patients waiting on trolleys for several days for a bed to become available in the unit.
- **Responsibility to discharge patients** – If it is the judgment of the clinician that a patient can't be safely or successfully discharged home, then such a long-term patient should in the interim remain in the hospital, despite the reality that this may "block" and acute bed.
- **Responsibility to "find solutions" of placement** – Clinical staff members, and in this case mostly individual social workers, are expected to find solutions for placement from an outdated list of possible NGOs, who are already overrun by the patient load from discharged LHE patients
- **Premature/inappropriate discharge** – Early discharge as a result of the pressure on acute psychiatric beds has become a much greater risk under the current circumstances. Clinicians should apply caution and circumspection in this regard and should continue to adequately document clinical findings and risk implications in this regard.
- **Resistance from families/NGOs to accept discharged patients** - Families and some NGOs have, often with good reason, resisted the discharge of their family members, once admitted to a hospital. Their arguments are often pertaining to physical space constraints, as well as their limited capacity to manage long-term care users at home with nobody to supervise or assist their family member, especially during the working day.

3. Clinicians in specialized facilities(Sterkfontein, Weskoppies, Cullinan)

- **Prior agreements with the management** of these facilities were reached including the provision of additional staff to care for the additional numbers at each hospital. The creation of new posts for this purpose must be monitored and reported on.
- The lack of placement facilities, in addition to blocking acute beds, also **hinders the transfer of reclassified State patients** from the forensic psychiatry wards to appropriate placement facilities. This then creates an additional crisis with respect to the bed availability for new state patients referred by the courts. This leads to the risk of once again having a long waiting list for State patients, with the consequence that these patients are then required to wait for long periods in prison before transfer to the appropriate mental health care unit for the introduction of optimal care.

4. <u>Recommended community-based day-care centers and a designated budget to employ community mental health care teams</u>

   Referring to the National Mental Health Policy Framework and Strategic Plan (2013-2020),1 in particular Objective 4 on "Infrastructure and capacity of facilities." Clinicians should aim to promote the principles of safe and adequate community-based care to managers and departments, including:

- A comprehensive community-based services model which includes staffed psycho-social rehabilitation day-care centers;
- Assertive community-based programs of discharged patients to promote adherence
- A designated "ring-fenced" budget for mental health care services in general hospitals, as well as in the different districts.

In conclusion
The SASOP has noted with concern that, despite the past months of highly publicized concern about the resources required to not only care for the about 1900 patients discharged from LHE, that the Gauteng MEC for Health, Ms Qedani Mahlangu, has unfortunately not made any specific mention in her budget speech this week, of existing or additional funds available for mental health service in Gauteng Province.

Johannesburg, 3 June 2016