PRACTICAL APPLICABILITY OF THE LAW ON CIVIL COMMITMENT OF MENTALLY ILL PATIENTS IN KINONDONI DIVISION AND MUHIMBILI NATIONAL HOSPITAL, DAR ES SALAAM, TANZANIA

By

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I, Dr Joyce Maswi Mugasa declare that this dissertation is my original work and that it has not been presented and will not be presented to any other University for a similar or other degree award.

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ABSTRACT

Background: Mental health legislations have the primary aim of protecting the rights of patients and providing appropriate care. Provision for civil commitment of persons of unsound mind is an important component of this. In Tanzania as elsewhere the law places responsibility on the police and court for the identification of persons of unsound mind to be cared for. The extent of knowledge and awareness of the provisions of mental health legislation among patients, their relatives and relevant professionals is unknown. The views and preferences of patients, their relatives and other stakeholders regarding the process of implementation of the law is also unknown.

Objectives: To determine degree of knowledge on mental health law among health workers, police officers, lawyers, judges, patients and their relatives as well as their opinion regarding the provisions of the law and its implementation

Materials and method: A cross sectional study was conducted among police officers, lawyers, doctors, nurses, patients and their relatives. Data was collected using an interviewer administered questionnaire for patient and relatives and self administered questionnaire for professionals.

Results: This study found that, the level of awareness of mental health law on civil commitment of mentally ill patient in Kinondoni division and Department of Psychiatry Muhimbili National Hospital, Dar es Salaam city was low (34.4%) and the level of knowledge was even lower (24.4%). Awareness of mental health law on civil commitment of mentally ill patients appeared to increase with increasing level of education. Adherence to the laid down procedures of the law was found to be poor among all participant groups studied.

Conclusion and Recommendations: This study indicates that the awareness and knowledge of mental health law on civil commitment of mentally ill patients is low. The level of awareness and knowledge should therefore be raised through education and training. There is a need to review the current law to bring it in line with the needs and requirement of relevant stakeholders and remove some of the barriers to its application. Such revision should be preceded by community based studies and consultations with relevant stakeholders.

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1.0 REVIEW OF LITERATURE

1.1 INTRODUCTION

Mental health legislations have the primary aim of protecting the rights of patients and providing appropriate care. Provision for civil commitment of persons of unsound mind is an important component of this. In Tanzania as elsewhere the law places responsibility on the police and court for the identification of persons of unsound mind that need to be cared for.[1] Several observational studies of civil commitment procedures highlight a discrepancy between the written law and the law in practice.[2]

In this country the difficulties in following laid down legal procedures may be attributed to shortage of human resources such as legal experts and medical doctors. Common experience indicate that law enforcement officers are often reluctant to follow laid down procedures for civil commitment as they feel that a person with an obvious mental illness should be admitted into a psychiatric hospital and treated without recourse to the law court. It is common experience in clinical practice to meet relatives of mental patients who express reluctance to involve law courts for civil commitment.

It is likely that many mentally ill patients are admitted to mental hospitals and treated without following the cumbersome legal procedures for civil commitment. It is not clear whether lack of knowledge of the provision of the law, cumbersome procedures outlined in the law or cultural attitude and practices regarding care of mentally ill patients is the compelling reason for lack of adherence to the requirements of the law.

The existing Mental Disease Ordinance of 1937 (Tanganyika Government 1937) adopted from the Indian Lunacy Act of 1927 is under the process of revision. It will be repealed and replaced by a proposed Tanzania Mental Health Act 2008, which relaxes some of the procedures for civil commitment. It is not clear how the law will meet the needs and expectations of the patients, their relatives and professionals. No study has been done that could have informed the ongoing process of revision of the law and any future amendments to it. Such a study should at least involve patients, their relatives, judiciary and mental health personnel. A study of this kind appears overdue.

1.2 BACKGROUND

The laws concerning the mentally ill differ among countries of the Western world. Compulsory care of people with mental illness is a complex domain of health care, with ethical, legal and treatment aspects.[3] In most European countries involuntary hospitalization represents the only case within the criminal legislation where detention is required for crime prevention. The justification offered is that mentally ill people in crisis, lacking insight to their condition, may become dangerous to others or themselves.[4] However, mental patients are not known to be particularly dangerous to the public. Studies on violence risk assessment stress that, among people without symptoms of substance abuse, there is no difference in the prevalence of violent acts between people discharged from psychiatric hospitals and ordinary members of the community.[5] Mental health laws that require the patient to be assessed as dangerous before they can receive involuntary treatment are associated with significantly longer duration of untreated psychosis, worse prognosis, increased risk for suicide and serious crime.[6, 7] The contribution of homicide perpetrated by mental patients also seems to be falling. While there was a 5-fold increase in homicide from 1957 to 1995 in UK, the proportion of homicides committed by people with mental health problems fell by 3% every year.[8]

In practice, however, the emphasis is on need for care and patients accessing the most appropriate care and consideration of risk and danger to patient himself or herself rather than dangerousness to others. The World Health Organization (WHO) recommends the least restrictive environment possible for care of voluntary and involuntary patients.[9] Studies indicate that the lack of less restrictive alternative form of care is the criterion most crucial to the decision to compulsorily admit a patient.[10] A less restrictive alternative to inpatient detentions is what is called a compulsory Community Treatment Order (CTO).[11] This may be defined as a legal intervention to benefit persons with serious mental illness who need ongoing psychiatric care and support to prevent relapse, hospital readmission homelessness or incarceration, but have difficulties following through with regular community based treatment.[12] Psychotic individuals, foreigners and patients not living in a private household have been found to be more likely to be deemed as lacking a less restrictive alternative form of care and require civil commitment.[10] Some studies

showed that the availability of a less restrictive alternative form of care and patient willingness to cooperate dramatically decreased the risk of being civilly committed.[13] Other studies do not support this finding. [14] One feature of CTOs is that they are human resources intensive in terms of mental health providers and for that reason not perhaps an alternative to civil commitment that could be considered in Tanzania.

The responsibility for initiating care for mentally ill patients who are dangerous or in need of care is increasingly placed on police officers in many countries. The deinstitutionalization of the mentally ill and the shift to community based care in many countries has led to police playing an important role in the identification and management of acute psychiatric states.[15, 16] Indeed policemen are often the first to encounter psychiatric patients in emergency situations.[17]

There are two basic principles which direct police involvement with mentally ill people: first the police are entrusted with the power and authority to protect the safety and welfare of the community and second the State's 'parens petriae' (parental) authority, to care for and protect citizens with disabilities who are not able to care for themselves, such as acutely mentally ill people, often posing a threat to the community or to themselves.[18]

In many countries police involvement with mentally ill patients occurs in the following situations: a) The transfer of the person, who has refused psychiatric evaluation, from the community, to the emergency psychiatric department b) Following the district attorney's order and evaluation by two state psychiatrists the police is charged with the transfer of individual to the appropriate psychiatric unit for involuntary admittance c) Management of a violent episode in the community by a mentally ill patient d) Citizens' complaints about persons who are odd or have dangerous behavior due to their disturbed mental status within the police jurisdiction. [4]

In a study on Greek police officers' attitude towards the mentally ill it was found that 62.9% of the police officers believed that the transfer of the mentally ill should not be their responsibility. It was also found that 54.5% of the sample reported that they have received information concerning mental health, mainly from information leaflets, newspapers and

magazine. Three quarters (75.6%) of the respondent expressed a need for more information.[19] In another study on the attitudes of Canadian police officers towards the mentally ill found that most police officers accept the role of working with individuals with mental illness as part of their jobs and as an area in which they should receive specialized training. [16]

Research has also shown that it is not only police officers who have many deficiencies in knowledge in many key areas of the law regarding involuntary admission of mentally ill patients, but also emergency doctors and senior nurses.[20] A study done in Britain found that there is inadequate knowledge and understanding of the mental health act among professionals as well as patients and carers.[21]

In South Africa a new Mental Health Care Act was passed in 2002, however reports indicate that there are numerous difficulties in the implementation of involuntary treatment within a health care service that is plagued by limited human resource and infrastructure constraints.[22] In Kenya an evaluation of mental health services revealed that despite enactment of a new mental health legislation in 1989 the police and prisons are operating the 1944 legislations for reasons that are not clear.[23]

International variations in rates of involuntary admission are often connected to mental health law reforms. However, great differences between regions within countries have been shown in many countries.[24, 25, 26] It has been found that the attitude of the hospital administration was one of the influencing factors on rates of restraints and seclusion.[27] Others have found diagnosis, clinical presentation of violence and perceived threat, a diagnosis of manic psychosis and both actual and perceived risk for violence were associated with compulsory admission.[28] It is not clear to what extent these factors influence involuntary admission in the Tanzanian context. The law in Tanzania however clearly emphasis that the reasons for involuntary admission are inability to care for oneself, dangerous to self and dangerousness to others.

The law still operating in Tanzania states that: *"The police officers who has reason to believe that any person within the district controlled from his station is of unsound mind*

and is not under proper care and control shall immediately report the fact to the court and the court may cause such person to be brought before it. The court shall examine such person and if it thinks that there are grounds for proceeding further shall cause him to be examined by a medical officer and if satisfied that such person is of unsound mind and is dangerous or incapable of managing himself and proper person to be detained it shall record a finding and make a reception order for his admission into a mental hospital".[1] Zanzibar Island which is part of mainland Tanzania has a law that is similar to that of the mainland.[29]

1.3 CONCEPTUAL FRAME WORK

The process and outcome of mental health legislation should be informed by key stakeholders and opinions and experiences of patients and their relatives to be effective and applicable as represented in the following diagram, as the author conceptualized it.



Fig. 1 – Conceptual framework diagrammatic representation.

MHL - Mental Health Legislation

AD - Advocate

JD - Judge

In this conceptual framework mental health legislation inputs from the legal system, law enforcement, patients, their relatives and health personnel are considered important. The process should also be informed by research findings. A legislation with inputs from all these areas is likely to be more applicable and practicable. A law that is an outcome of such a process is likely to be better understood, to take into account the sociocultural situation of the people, available human resource, infrastructure and financial constraints.

2.0 STATEMENT OF THE PROBLEM

The Tanzanian mental health law regarding civil commitment is clearly stipulated in the Mental Disease Ordinance as quoted above.[1] In our psychiatric setting it would seem that the laid down procedures regarding civil commitment are not adhered to. Instead a more informal procedural system has become a pattern. As such patients are admitted involuntarily by the medical doctor and the doctor advises the relative to obtain a reception order form from the courts within 72 hours. In practice the 72 hour time limit is not enforced and it may happen that a patient is involuntarily admitted and discharged without ever obtaining the reception order. However, the police and and legal system seem to accept the fact that "reliance is on the medical rather than judicial decision making for civil commitment". From the legal perspective unregulated civil commitment may be a concern that the human rights of the patient may be violated and involuntary admission may at times be for the relatives benefit rather than the needs of the patient.

There are many possible reasons why there is a discrepancy between the written law and how it is practiced. The procedures laid down are cumbersome and appear very difficult to implement. It is not in the best interest of the patient and those who are caring for them to delay his/her treatment. For example, how can an acutely psychotic patient seriously disturbed and refusing treatment be managed after regular working hours and weekends when the courts are not accessible? Should the mentally ill patient be picked up by the police and detained at the police station until the necessary court reception order is complete as required by the law and as such delay the patient access to needed treatment?

Awareness and knowledge of the law are likely to be factors facilitating or hindering effective application of procedures with regard to civil commitment, lack of which seems to be an overriding problem in this setting. However, the extent of knowledge and awareness of the provision of mental health legislation among patients, their relatives and relevant professionals is unknown. The opinion and preferences of patients, their relatives and other stakeholders regarding the process of implementation of the law is also unknown. There is also a lack of information on the extent to which the provision of the existing law is applied.

3.0 RATIONALE OF THE STUDY

This study, the first of its kind in Tanzania, will shed light on the extent of public awareness and knowledge of the legal procedures for involuntary admission, the barriers to implementing the law and the opinions and expectations of key players. The study may contribute to what may be put down in policy in this country. It will also inform the regulation of mental health services in the care of and protection of the rights of mentally ill patients as well as any future amendments to the law. The outcome will help stakeholders work towards making civil commitment an effective tool intended primarily to ensure mentally ill patients have access to services and to protect individuals and the public from harm.

4.0 STUDY OBJECTIVES

4.1 Aim of the study

This study aims to determine the degree of awareness and knowledge of the provision of the law among professionals, patients and relatives as well as the perceived and expressed expectations of patients and their relatives as to what would be most helpful in improving care with respect to civil commitment.

4.2 Hypothesis

1) Medical, law enforcement and legal professionals as well as persons with a mental illness and their relatives are inadequately aware of the provision of the mental diseases ordinance.
2) There is a discrepancy between requirement of the law and the expectation of patients and their relatives with respect to civil commitment.

4.3 Research questions

1) How well informed are legal and medical professionals, patients and their relatives regarding the provision of the Mental Diseases Ordinance

2) Who do patients, relatives and professionals consider the appropriate people to be responsible for deciding on the commitment of patients?

3) Is there dissonance between the requirement of the law and the expectations of patients and their relatives in the application of legal procedures for civil commitment of mentally ill patients?

4) How practical and applicable are the procedures of the law with regard to civil commitment?

4.4 Broad objective:

To determine the mental health law related knowledge among health workers, police officers, lawyers, judges, patients and their relatives regarding the provisions of mental health law as it relates to civil commitment of mentally ill persons as well as their opinions regarding its implementation.

4.5 Specific objectives:

1. To determine the level of knowledge of health workers, police officers, lawyers and judges, patients and relatives on the mental health laws as it relates to civil commitment of mentally patients.

2. To determine the opinion and preferences of health workers, police officers, lawyers and judges, patients and their relatives regarding the law as it relates to civil commitment of mentally ill patients.

3. To determine the proportion of health workers, police officers and lawyers and judges who follow procedures laid down in the mental health legislation.

4. To determine presence of any perceived barriers to practicing the mental health law.

5. To gather suggestions on how to improve knowledge on mental health laws as it relates to civil commitment and promote its practice.

5.0 METHODOLOGY

5.1 Description of the study area:

The study was conducted in Kinondoni Division and Muhimbili National Hospital (MNH) Department of Psychiatry and Mental Health which serves the mentally ill population of Kinondoni Division. This division is one of the 4 divisions of Kinondoni municipal council, others being Magomeni division, Kawe division and Kibamba division. Kinondoni division has 9 wards namely Makumbusho, Hananasif, Magomeni, Kijitonyama, Ndugumbi, Mwananyamala, Mzimuni, Kinondoni and Tandale. According to the Tanzania Population Census 2002, the division has a total population of 331,227 of which 166,401 are male and 164,826 are female.[31]

The MNH located in Ilala Municipality is a tertiary referral and teaching hospital, with a service delivery system that serves four catchments areas Kinondoni, Magomeni, Ilala and Temeke. The Department of Psychiatry and Mental Health at MNH houses a 70-bed in patient psychiatric unit and an outpatient services to the four catchment areas. The Department provides mental health services for persons with a wide range of mental disorders, it is currently the only formal in-patient unit in the region and hence most patients that require in-patient care in the municipalities of the region will invariably receive such care at this facility. The area was selected for convenience due to easy accessibility, financial constraints, logistic consideration, and time limitation.

5.2 Study Population

This study comprised of police officers, government lawyers who were stationed at Kinondoni division at the time of study, patients and their relatives who live in Kinondoni division and those who were attending outpatient clinic at Department of Psychiatric, MNH during the time of the study. It also involved mental health providers who were stationed and available at MNH psychiatric unit at the time of the study.

5.3 Study Design

This was a descriptive cross sectional study design, using a quantitative method. The study was conducted in Kinondoni division and Department of psychiatry, MNH Dar es Salaam city for a three months period between August 2008 and October 2008.

5.4 Inclusion Criteria

Inclusion criteria were as follows:

- Professionally qualified police officers, lawyers, judges, and mental health provider who gave consent.
- Patients of 18 years and above who were mentally stable and who gave consent.
- Relatives who were 18 years and above who gave consent.

5.5 Sample Size

The estimated sample size N was computed using the formula below,

$$N=\frac{Z^2P\,(100-P)}{d^2}$$

Where,

N=Estimated Sample Size

Z=is the standard normal deviate, which is 1.96 on using the 95% confidence interval.

P=estimated proportion of respondent who have the knowledge on mental health law which is 30%

d =margin error of 6%

Therefore;

$$N=\frac{(1.96^2)\,30\,(70)}{6^2}$$

N=224

The sample size comprised:

- 224 Patients and relatives
- 224 Police officers
- All lawyers in Kinondoni division who were available at the time of the study
- All mental health providers who were available at the time of study at Department of Psychiatry, MNH

5.6 Sampling Procedure:

5.6.1 Police

A list of names of all police stations in Kinondoni division was obtained from the Regional Police Commander which amounted to 4 police stations. At the police station level, 56 consecutive police officers from each police station who consented to participate were interviewed till when the sum of 224 was reached. Two male police officers and an estimated 50% of female police officers who were requested declined to participate.

5.6.2 Health facility

All available trained health workers providing mental health services at MNH at the time of the study who consented were interviewed. There were 61 in total. Every third patient who was mentally stable at the time of the study and relative who escorted their patient to MNH psychiatric out patient clinic and who consented was interviewed up to a total of 224. None of the health workers declined to participate.

5.6.3 Court

A list of courts located in Kinondoni division were obtained from Kinondoni regional court, there was a total of 4 primary courts. At primary court level all government lawyers who were available at the time of the study and consented were interviewed. There were 15 in total. None of the lawyers declined to participate.

5.7 Data collection instrument

Data was collected using an interviewer administered questionnaire for patient and relatives as the literacy level among some patients and relatives was assumed to be low by the researchers. Self administered questionnaire for professionals comprising of closed ended questions. The principal investigator constructed the questionnaire based on the objectives of the study. The questionnaire had 43 questions, categorized into 6 main sections, namely demographic characteristics, section for lawyers, section for doctors, section for nurses, section for patients, section for patients' relatives and section for all participants. Initially the questionnaire was prepared in English then it was translated into Kiswahili. The Kiswahili version was used for the study and the time to complete it ranged between 20- 30 minutes.

5.8 Selection and training of research assistants

Two research assistants who were fluent in Kiswahili and who were qualified medical doctors were recruited. They were trained on the study protocol, research procedures, study instruments and data generation procedures.

5.9 Pre-test of instrument

Prior to the main study, a pre-test of the instrument was conducted with 30 participants in mid July 2008 in Ilala district, in order to asses the applicability of the questionnaire items and time used to complete it. Questions that were found difficult to understand and were refined.

5.10 Ethical consideration

Ethical clearance was sought from the Muhimbili University College of Health and Allied Sciences Research and Publication Committee (Appendix No 10.3). Permission was also sought from Tanzania Police Force through Regional Police Commander who provided an introductory letter to Officer Commanding District of Kinondoni Districts. (Appendix no 10.5). Also permission from the Court of Appeal of Tanzania was obtained and an introductory letter to the Regional and Primary Court of Kinondoni Districts was provided (Appendix No 10.6).

All participants were informed verbally about the purpose of the study and requested to participate. Patients and relatives were informed that acceptance or refusal to participate in the study had no consequences to their treatment in any way. Participants were also informed that they were free to withdraw from the study at any time and free to decline to answer any question if they felt uncomfortable. Participants were assured of confidentiality and the questionnaires were anonymous and as such did not record name of participant at anytime. It was also indicated that there was no specific benefits to the individual participants, however the study results would add to the present knowledge about the mental health law on civil commitment Participants completed written informed consent forms (Appendix No 10.7).

5.11 Data entry and analysis

Immediately after data collection, all questionnaires were checked for completeness. All questionnaires were complete and included for analysis. The data obtained was stored by the principal investigator in an office in a secure environment. Epi info version 6 template questionnaire was prepared and responses coded (pre coding of questionnaire) by the principal investigator. Pre-coded data was then entered by principal investigator. Data cleaning was done simultaneously during and after data entry. After data cleaning, data analysis was done using SPSS software version 13. Frequency tables of relevant variables and cross tabulations were prepared to explore the association between dependent and independent variables. Statistical associations involving categorical variables were assessed using chi-square test. A level of 0.05 was used to assess statistical significance in differences or association being examined.

6.0 RESULTS

Socio-demographic characteristics of participants

A total of 524 participants were interviewed, 224 police officers, 224 patients and relatives, 61 mental health providers and 15 magistrate/lawyers. Table 1 summarizes the demographic characteristics of the surveyed sample. The results revealed that there were more males (67.7%) than females. The large proportion of males reflects the preponderance of males among police officers and patients. Most participants were aged between 35-45years (38.2%). The majority were married (62.4%) and forty percent with secondary education (40.8%).

Table 1: Frequency distribution table of socio-demographic characteristics of study participants

Social demographic variables	Totals (N)	Percentage
Age		
<25	43	8.2
25-34	148	28.2
35-44	200	38.2
45-54	114	21.8
55 and above	19	3.6
Sex		
Male	355	67.7
Female	169	32.3
Marital Status		
Single	151	28.8
Married	327	62.4
Divorced	33	6.3
Cohabiting	7	1.3
Widowed	6	1.1
Level of education		
No formal education	9	1.7
Primary education	145	27.7
Secondary education	214	40.8
College education	109	20.8
University education	47	9.0
Occupation		
Doctors	12	2.3
Nurses	45	8.6
Police officers	224	42.7
Lawyers/Magistrate	15	2.9
Patients	114	21.8
Social workers	4	0.8
Patients relatives	110	21

6.1 Awareness of existence of mental health law in relation to civil commitment

Table 2 summarizes the level of awareness of the mental health law among the participants. The results showed that most of the participants (65.6%) were not aware of the mental health law.

Table 2: Frequency table for awareness of existence of mental health law in relation to civil commitment

Awareness	Total (n)	Percentage
Yes	180	34.4
No	344	65.6
Total (N)	524	100

6.2 Knowledge of the mental health law

Table 3 shows that only a quarter (24.4%) of the participants who were aware of the mental health law know that according to the law the police are responsible for identifying the mentally ill patient in the community. Most participants placed the responsibility on doctors (46.1%) followed by relatives (27.8%). An even smaller percentage assigned responsibility to lawyers and judges (1.7%)

Table 3: Frequency distribution table of responses of study participants who were aware of the mental health law assigned responsibility for identifying people of unsound mind in the community

Responses on whose responsibility for identification of people of unsound mind in the community	Total (n)	Percentage
Relative	50	27.8
Police Officer	44	24.4
Doctors	83	46.1
Judges	3	1.7
Total (N)	180	100

6.2.1 Police awareness of their role and responsibility in relation to the mental health law for civil commitment

Only slightly more than half of police officers (51.8%) were aware that it is their responsibility to identify the mentally ill patient in the community who need involuntary treatment.

6.2.2 Knowledge of mental health law among relatives

Only (2.7%) of the relatives were aware that it is the judge who determines the mentally ill patients who need to be involuntarily treated. The majority (85.5%) reported it to be the doctors' responsibility (See table 5).

Table 4: Frequency table showing patients' relatives knowledge of the mental health law regarding who determines the commitment of patients.

Response on whose responsibility	Total (n)	Percentage
Doctor	94	85.5
Judge	3	2.7
Relatives	13	11.8
Total (N)	110	100

6.2.3 Judges/Magistrates knowledge on mental health law

Among the 15 lawyers who responded to the questions, 9 scored them all correct, 5 scored two correct and 1 scored all incorrect. This indicates that overall judges/lawyers are conversant with the mental health law.

6.3 Practice of mental health law as it relates to civil commitment

6.3.1 Police practice and mental health law

Table 5 summarizes the extent to which the police observe the law with regard to involuntary admission. The majority (88.4%) of the police officers responded to taking patients directly to the psychiatric facilities. As few as (5.4%) of police officers take involuntary mentally ill patients to the court first for a judge to determine patient's need to be committed which is required by the law.

LIBRARY

Table 5: Frequency table on extent to which the police observe the law with regard to involuntary admission.

Response of police on practices of mental health law	Total(n)	Percentage
To psychiatric facilities	198	88.4
To court	12	5.4
To relatives	2	0.8
To police station	12	5.4
Total (N)	224	100

6.3.2 Relatives adherence to the law with regard to involuntary commitment procedures

Only (1.8%) of the relatives follow the procedure as laid out in the law for involuntary admission. The majority (95.5%) take their involuntary patients directly to psychiatric facility instead of seeking the assistance from the police and taking them to the courts of law.

6.3.3 Mental health providers practice of mental health law

100% of doctors reported that they admit the mentally ill patients without a court reception order and request relatives to go to court for reception order thereafter. The majority of the doctors do fill out the medical certificates but not routinely. Most of them indicated that in fact they only complete the medical certificates occasionally. Most of the nurses 71.1% reported that they accept the patient during admissions without court orders and tell the relatives to go to court for the reception order. However majority of them (97.5%) report that they ensure that the reception order is obtained by checking patient's files. More than fifty percent (63.4%) indicated that they always check files.

Table 6 shows the association between awareness of mental health law and participants level of formal education .The awareness of mental health law increase with increased level of formal education. Having university education was more likely associated with increased awareness of mental health law compared to lower educational levels. This was statistically significant ($x^2 = 69.3$, $p<0.0001$)

Table 6: Association between awareness of mental health law and level of education.

Level of education	Awareness of mental health law				Total
	Yes	%	No	%	
No formal education	0	0	9	100	9
Primary education	22	15.2	123	84.8	145
Secondary education	67	31.3	147	68.7	214
College education	60	55	49	45	109
University education	31	66	16	34	47
Total	180	34.4	344	65.6	524

$X^2 = 69.3$, $p< 0.0001$

6.4 Practical applicability of the mental health law in relation to civil commitment

About half of participants 48.9% were not familiar with the law. Among those who were familiar only 6.1% thought that it was not practical at all, 30.3% thought that it was somehow practical, whereas 10.5% thought that it was practicable and 4.2% perceived it as very practical. Interpretation of this finding is complicated by the large proportion of participants who were not familiar with the law. The finding however that 36.4% of those who were familiar thought that it was not practical or only somehow practical suggests that the law as currently constructed is difficult to implement.

6.5 Perceived barriers to practicing the mental health law

More than half of participants (53.4%) who knew the law felt that patients and relatives are reluctant to go to court for civil commitment of the mentally ill patient. Nearly half of them felt that doctors do not insist that patients be first taken to court, suggesting that doctors do not adhere to the law (42.2%). Three quarters (75%) of the respondents were not aware of the existence of criteria for involuntary admission (not tabled).

6.6 Suggestions of study participants on how to improve practice of mental health law

6.6.1 Involuntary admission procedures

In this study most participants (66%) suggested that patients should be admitted for treatment in a psychiatric facility and then relatives to go to court to obtain court order as shown in Table 7.

Table 7: Frequency table showing participants opinions on how to improve the practice of the mental health law with regard to involuntary admission procedure.

Participants Opinion	Total (n)	Percentage
Patients to be admitted then relatives to go to court to obtain the court order	346	66
Patient to be brought before the court before admission	74	14.1
Special medical/nursing personnel to escort them during transfer from community to court then to hospital	104	19.8
Total (N)	524	100

6.6.2 Responsibility for final disposition

Table 8 indicates the suggestions made by study participants with regard to final disposition of commitment of the mentally unwell patients. The majority (81.5%) of study participants strongly felt that doctors should take increased responsibility for civil commitment, while (7.1%) suggested family and a smaller proportion of them (0.5%) thought it should be the responsibility of a social worker.

Table 8: Frequency table showing participants opinions on how to improve the practice of mental health law with regard to responsibility for final disposition.

Participants opinions responses on final decision to commit involuntary patient	**Total (n)**	**Percentage**
Family	37	7.1
Attending doctor	425	81.5
Police	11	2.1
Judges/ lawyers	4	0.8
Religious leaders	42	8
Social workers	5	0.5
Total (N)	524	100

6.6.3 Need for further community education on application of mental health law.

Majority of participants expressed need of getting more knowledge on application of mental health law (98.1%).

7.0 DISCUSSION

7.1 Awareness and knowledge regarding provision of mental health law

This study found the level of awareness of the mental health law on civil commitment of the mentally ill patient among police, health care providers, patients and their relatives in Kinondoni Division and Department of Psychiatry, MNH was low (34.4%). Most participants (65.6%) were not aware of the existence of the law suggesting that with this low level of awareness observation of the law is likely to be proportionally and adversely affected.

From those who were aware of the existence of the mental health law, only a quarter (24.4%) of them knew that it is the police officers' responsibility to identify the mentally ill patient in the community Many of the participants (73.9%) placed responsibility for identifying people of unsound mind on doctors and relatives. This reflects the difficulties all concerned had in appreciating the involvement of police and courts in civil commitment of mentally ill patients. The difficulty seems to be while it is a fact that police do not have mental health expertise they are never the less very often actively involved in assisting and managing the mental ill within the community in our setting. In the ideal situation with respect to civil commitment *'the institutions of mental health and justice are meant to join together becoming in effect one actor within a treatment control system which has as its function and aim to take care of mentally ill patients that need intervention from both institutions for effective management'*.[2] This is probably not how the public conceptualize the relationship between the two institutions, nor how the police experience the relationship in practice. In a review of the interface between the police service and mental health services with regard to civil commitment, it was found that whilst police felt that the number of calls that they receive was a significant drain on their resource, they did not argue that they had no role in responding to disturbances within the community. Their major concern was in relation to lack of mental health workers support that they had available when they did respond.[32]

Lack of information may be due to failure to involve the community in the process of development of policy and law on mental health, inadequate dissemination of the law after

enactment, lack of public education on the practical procedures of the law and low literacy level of the population. A similar finding has been reported in a study done in UK on section 136 of the Mental Health Act of 1983 that addresses civil commitment of mentally ill patients where it was found that there was deficiency of knowledge in many key areas of that section among all groups surveyed that included accident and emergency doctors, senior nurses and police constables.[11]

In this study only 51.8% of police officers were aware that it is their responsibility to identify people who might be of unsound mind and proper people to be cared for. A half of the police officers were not even aware of their responsibility in this regard. This result is in stark contrast to those of other countries such as the USA, where police officers colleagues clearly agree that dealing with mentally ill is part of their duty.[32, 33]

In this study only 11.8% of the participants reported that they have received information about mental health law, 98.1% express their wish for more information. This rate is higher than 75.6% found in a study conducted among Greek police officers.[10] There are similar findings in Scotland and New Zealand.[34, 35] One wonders are the police equally misinformed about other laws they need to implement in their daily practice as law enforcers.

Increased level of education was associated with increase in the level of awareness of the mental health law on civil commitment of mentally ill patients among participants. It was found that none of the participants who have no formal education were aware of the mental health law, but most of those with university education were aware. It is possible that participants who reached secondary level of education and beyond had better access to media influences such as newspapers, posters and television programs. Education may also make it easier for individuals to process and understand the rationale for the law and it's laid down procedures with regard to civil commitment. These are parallels on other subjects, for example, it has been shown that as people acquire more education their hygiene improves and their responsiveness to public information programs increases.[36] Therefore, the increase of the level of basic education will most likely increase the level of

awareness of mental health law on civil commitment of mentally ill people, through reading newspapers, posters and television programs on mental health law.

7.2 Practice of mental health law

With regard to the extent to which police officers in practice implement the law, it was found that only 5.4% of police officers take the involuntary mentally ill patients to the court while most of them (88.4%) took them directly to psychiatric facilities. Their lack of awareness and knowledge as to what is required of them as law enforcers with regard to the implementation of the law is the most obvious explanation. One would like to think that the police act primarily in the best interest of the patient to get needed treatment as soon as possible. In our setting it is also possible that the police respond to the wishes or pressure of relatives to take their patient directly to the psychiatric facility. Of course it is also very possible that the police find the law with regard to civil commitment too cumbersome and too much of a drain on their resources and just ignore it.

As stated earlier the Kenyan police and prison officer continued to operate the 1944 Mental health Legislation right through this decade. This is despite that fact that the new mental health law was passed in 1989. [23] This is a forewarning for us. It would not sit well if twenty years down the road police are operating out of the 1927 Lunacy Act. [1]

Adherence to the law by patients' relatives was also studied and revealed that only 1.8% of the relatives follow the procedure laid out in the law for involuntary admission. Overall the findings of this study clearly indicate that the mental health law on civil commitment is not practiced by the key players. As already indicated the majority of mentally ill patients are admitted directly to mental hospital without passing through the court as laid out by the mental health law. Relatives are more likely to be primarily concerned with getting their patient the care they urgently need rather than the legalities. It is also understandable that relatives would not wish their patient to be doubly stigmatized by not only having an uncontrolled mental illness but also police involvement in their first line management. So it is as if it were the laid down procedures for civil commitment is essential in written law but do not need to be strictly adhered to.

7.3 Practical applicability of the mental health law

About 50% of the respondents did not know of the law and only 4.2% felt it was implementable. The fact that lack of knowledge was identified in many key areas of the mental health law and it is no surprise that it is not followed. But why is it not followed by those who are aware and know the laid down procedures for civil commitement?

The cumbersome legal procedures for civil commitment of mentally ill patient may also be a contributing factor to non adherence for those who know the laid down procedures. Early access to mental health care of people detained under the act can be achieved if the legislation is clearer and more flexible. A modification in the written law allowing the transfer from one place of safety to another, namely the police station to the psychiatric facility, or the community direct to psychiatric service and then proceed with the legal requirements, using the same section under which the person was detained. This in fact is simply legalizing what is currently practiced. This will legally empower the police to transfer people from the police station to a hospital or directly from a public place to a hospital, with strict safeguard in place to reduce the possibility of inappropriate admissions. Similar recommendations have been made in other countries.[30] It is hoped that this issues will be addressed in the New Mental Health Act 2008 [37]

7.4 Perceived barriers of practicing mental health law

Most of the participants perceived that patients and relatives are reluctant to go to court for civil commitment of mentally ill patients. Certainly, this may be due to the lack of knowledge amongst the relatives. But as already discussed relatives are more likely to be concerned with getting their uncontrollable aggressive patient under control as quickly as possible. For them that is admission to an acute facility where doctors takes full responsibility. All relatives seem to wish for is not to bypass the legal requirements but put it on hold. Once their patient is admitted relatives in this setting have not been known to refuse the doctor's request to obtain the reception order. For relatives the stigma may be another deterrent to involving the police as already discussed.

7.5 Suggestions on how to improve practice of mental health law

Most of the participants (66%) suggested that the patient should be admitted to hospital first and later relatives go to court to bring reception order as is in fact the practice. Also most (81.5%) of the study participants strongly felt that doctors should take increased responsibility for civil commitment, while a small proportion(7.1%) suggested family and a few (0.5%) thought it should be the responsibility of a social worker. The majority of participants expressed the need of getting more knowledge on application of mental health law (98.1%). In this study significant deficiencies in knowledge of mental health law on civil commitment is probably a major contributing factor to non adherence to the law but not the only one. Other potential contributing factors were not addressed in this study

7.6 Limitation of the study

This is the first study of its kind to be done in Tanzania and the region, therefore there was no preexisting information retrievable regarding the extent of knowledge and awareness of the mental health law, attitudes towards the principles and actual practice with regard to its implementation. Therefore, there was no information and culturally relevant experience to build on in conducting the study and in formulating implications of the findings. The scope of the study had to be of necessity limited in terms of sample size and geographical area covered due to constraints of time and resources. It was for example not possible to do a qualitative study which would more clearly elicit cultural attitudes towards civil commitment and preferred procedures to be followed. With such low level of knowledge about the law it becomes difficult to be certain whether lack of observation of the law is due to ignorance only or other factors suggested by the findings. The fact that 50% of female police officers declined to participate in the study is a limitation and may be a possible source of bias.

8.0 CONCLUSION

The level of awareness of the law on civil commitment of mentally ill patient in Kinondoni division and Muhimbili National Hospital, Department of Psychiatric and Mental Health is low (34.4%). This low level of awareness among participants may be explained in part by lack of involvement of the community in development of policy and relevant legislation, but more so by lack of any serious on going effort to sensitize people towards the mental health law on civil commitment of mentally ill patients. In addition, most participants who are expected to be aware of the law actually lack knowledge on various basic procedures of the law regarding civil commitment. Only 24.4% among those who were aware of the mental health law on civil commitment knew that it is the police's responsibility to identify mentally ill patient in the community and to transfer them to psychiatric hospital via the courts.

Knowledge of mental health law was deficient among all groups studied with exception of lawyers who were found to have the greatest level of knowledge. This deficiency of knowledge was accompanied by poor practice of mental health law. It was found that, the level of education is one of the determinants of knowledge of mental health law on civil commitment of mentally ill patients, that is those with higher level of education had higher level of awareness of mental health law on civil commitment of mentally ill patients than those with lower level of formal education and no formal education.

The most common suggestion made by participants to improve the practice of the mental health law was that patients to be admitted to hospital first then relatives to go to court and deposit medical certificates with accompanying applications for admission. The final responsibility for civil commitment would still rest with judges of courts of law who would examine the patient at their discretion and make any necessary adjustment as deemed fit.

9.0 RECOMMENDATIONS

The low level of awareness and knowledge on mental health law should be raised through education and training and continually sensitizing the community about the law and its intended purpose. Education and training on the mental health law should be part of the curriculum for professionals involved in implementing, namely nurses, doctors, police and social workers. Also adequate training should be provided to professionals. This would likely result in greater adherence to law, particularly if it is made less cumbersome, more practible and flexible.

The study has shown that most of participants who knew the law thought that it was not practicable. There is a need to review the current law to bring it in line with the needs and requirement of relevant key players. Barriers to the application of the mental health law should be minimized. Revision of the law should be preceded by community based studies and consultations with relevant key players and stakeholders.

It is hopeful that the findings from this study will have some impact on the New Mental Health Act 2008 [37] before final enactment, dissemination and future amendments. Further studies need to be done to explore other factors which may contribute to difficulties in practicing the mental health law as it pertains to civil commitment.

When the New Mental Health Law 2008 is enacted for implementation in the future we should take every step to ensure that the police are well grounded on the laid down procedures.

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