Involuntary admission and treatment of mentally ill patients – the role and accountability of mental health review boards

M Swanepoel, LLB, LLM, LLD; **S Mahomed,** BCom, LLB, LLM, PhD

Department of Jurisprudence, School of Law, College of Law, University of South Africa, Pretoria, South Africa

Corresponding author: *M Swanepoel (swanem@unisa.ac.za)*

The involuntary admission or treatment of a mentally ill individual is highly controversial, as it may be argued that such intervention infringes on individual autonomy and the right to choose a particular treatment. However, this argument must be balanced with the need to provide immediate healthcare services to a vulnerable person who cannot or will not make a choice in his or her own best interests at a particular time. A study carried out in Gauteng Province, South Africa (SA), highlighted the fact that the annual rate of involuntary admissions increased by almost double from 2007 to 2008. This could indicate that healthcare providers are not treating patients without their consent only when this is absolutely necessary. Alternatively, it could indicate that healthcare professionals are more aware of the provisions of the Mental Health Care Act and relevant national policy guidelines. Or it could suggest that more patients are presenting with mental illnesses or disorders that require their involuntary admission. It remains for strategies to be developed that change negative perceptions and inequities for individuals with mental illness. Above all, the strategies should be underpinned by inalienable respect for mentally ill individuals – a concept that was blatantly disregarded in the Life Esidimeni case. In this article, we highlight the functions of mental health review boards and their accountability where involuntary admissions are concerned, while emphasising the protections for mentally ill persons as a vulnerable population group, as set out in the SA Constitution.

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The ethical principle and legal doctrine of informed consent is key to the provision of healthcare services. However, the traditional notion of informed consent sometimes proves to be impractical, and is often challenged. Such challenges are especially evident when involuntary admission to mental health facilities and involuntary treatment of a patient are contemplated. Individuals who suffer from mental illnesses or disorders are not incapable of making informed choices and decisions regarding their healthcare in all circumstances. However, there are situations in which an individual's ability in this regard is compromised as a result of a severe mental illness. The involuntary admission or treatment of a mentally ill individual is highly controversial as it may be argued that such intervention infringes on individual autonomy and the right to choose a particular treatment.[1] However, this argument must be balanced with the need to provide immediate healthcare services to a vulnerable person who cannot or will not make a choice in his or her best interests at a particular time. In this article, we highlight the functions of the mental health review boards and their accountability where involuntary admissions are concerned, while emphasising the protections for mentally ill persons as a vulnerable population group, as set out in the South African (SA) Constitution.

Mentally ill persons as vulnerable members of society and involuntary admissions

Mentally ill persons are a vulnerable group of people who are often victimised, stigmatised and ridiculed for their disorders, which can, in turn, result in their social isolation.[2] The lack of understanding of mental illnesses by society at large increases the discrimination that this vulnerable group faces on a daily basis. As a result of the constant barriers that mentally ill persons are exposed to, this vulnerable group is much more likely to die prematurely than the general population.[3] The vulnerability, lack of understanding of mentally ill persons and absence of accountability were highlighted in the Life Esidimeni tragedy, which saw over 100 patients die. The Mental Health Care Act No. 17 of 2002,[4] in its preamble, emphasises the Constitutional prohibition against unfair discrimination against people with mental or other disabilities, which resonates with respect for the rights to equality and human dignity as enshrined in our Bill of Rights.[5] It further recognises the need to 'promote the provision of mental healthcare services in a manner which promotes the maximum mental well-being of users of mental healthcare services and the communities in which they reside.'[4] Chapter 3 of the Act is specific to the rights of and duties owed to mental healthcare users, and emphasises the promotion of their best interests at all times. Section 8(1) of the Act further stresses that mental healthcare users must be 'provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life'. Steps must be taken to ensure that every mental healthcare user is protected from exploitation, abuse and any degrading treatment, and that determinations concerning the mental health status of any person must be based on factors exclusively relevant to their mental health status and not on sociopolitical grounds, economic status, cultural

or religious background or affinity.[4] Additionally, section 4 places the obligation for promoting the rights and interests of mental healthcare users directly on organs of the state responsible for health services.

The involuntary admission of mentally ill persons further exacerbates their stigmatisation, and may be argued as weakening their Constitutional protections. However, there are circumstances when involuntary admission is not only necessary but paramount to serving the best interests of the mentally ill individual and society at large. Chapter 5 of the Act sets out the requirements for voluntary, assisted and involuntary mental healthcare. Specifically, section 32 outlines that a mental healthcare user may only be provided with care, treatment and rehabilitation services without consent if: an application is made to the head of the health establishment, in writing; there is reasonable belief that the user has a mental illness of such a nature that (s)he is likely to inflict serious harm on him/herself or others; such intervention is necessary for the protection of the financial interests or reputation of the user; and at such time that the application is made, the user is incapable of making an informed decision and is unwilling to receive such intervention. Such application for involuntary care, treatment and rehabilitation may only be made by the spouse, next of kin, partner, associate, parent or guardian of a healthcare user, or by a healthcare provider when the aforementioned persons are unwilling, incapable or not available to make such application.[4] After the application is made, a medical practitioner and another mental healthcare practitioner must assess the physical and mental health status of the user for a 72-hour period, and establish whether the intervention should be continued.[4] Should the user become capable of making informed decisions, the user must make a determination regarding whether (s)he is willing to voluntarily continue with the intervention. However, this determination by the user is balanced with the user's best interests.[4]

An estimated 10 - 15% of mental healthcare users worldwide require involuntary admission into a mental health facility.[6] The aforementioned percentages differ between countries as the degrees of service delivery and healthcare challenges vary. However, in less developed countries >75% of persons with serious mental illnesses do not receive treatment for their disorders.[7] This is particularly concerning, as an individual with a severe mental illness could pose a danger to him/herself and others. A study carried out in Gauteng Province, SA, highlighted that the annual rate of involuntary admissions increased, by almost double, from 2007 to 2008.[8] This could indicate that healthcare providers are not treating patients without their consent only when this is absolutely necessary. Alternatively, it could indicate that healthcare professionals are more aware of the provisions of the Mental Health Care Act and relevant national policy guidelines. Or it could suggest that more patients are presenting with mental illnesses or disorders that require their involuntary admission.

The functioning of mental health review boards and involuntary admissions

As this is an article of limited scope, focus is placed on specific provisions in the Mental Health Care Act with regard to admission procedures and decisions regarding further care, treatment and rehabilitation services.

Mental health review boards are quasi-judicial structures that have been established in terms of the Mental Health Care Act.[4] The establishment of mental health review boards by members of the executive council in provinces commenced in 2005. By April 2019, more than 20 mental health review boards had been established in all provinces. These boards serve as 'watchdogs' when it comes to mental health-related issues, and are required to determine that mental institutions comply with the provisions of the Mental Health Care Act, and therefore ensure that the rights of individuals with mental illness are protected.

The powers and functions of review boards as stipulated in the Act are to:[4]

- consider appeals against decisions of the head of a health establishment;
- make decisions with regard to assisted or involuntary mental healthcare, treatment and rehabilitation services;
- consider reviews and make decisions on assisted or involuntary mental healthcare users;
- consider any 72-hour assessment made by the head of a health establishment, and make decisions to provide further involuntary care, treatment and rehabilitation;
- consider applications for transfer of mental healthcare users to maximum security facilities; and
- consider periodic reports on the mental health status of mentally ill prisoners.

As quasi-judicial authorities, review boards must, within their legal powers, administer their functions with clear knowledge and understanding of the intentions of the Mental Health Care Act. It is therefore important that proper and continuous systems be put in place to ensure effective functioning of the mental health review boards.

A review board may determine its own procedures for conducting business.[4] Whenever a review board considers a matter that involves a health establishment where one of the members of the review board is a mental healthcare practitioner, that mental healthcare practitioner may not be involved in the consideration of the matter.

Mental health review boards, *inter alia*, oversee different procedures. When a person presents with symptoms of mental illness at a health establishment, that person must be assessed to determine if a medical condition exists. If a medical condition exists, the person must be managed and stabilised by medical specialists. According to section 25 of the Act (voluntary care, treatment and rehabilitation services), a voluntary mental healthcare user who submits voluntarily to a health establishment for care, treatment and rehabilitation is entitled to appropriate care, treatment and rehabilitation services and referral to an appropriate establishment.

The procedure differs with regard to assisted and involuntary mental healthcare users.[4] Assisted care, treatment and rehabilitation services mean that a user is not capable of making an informed decision, but is not refusing treatment. Involuntary care, treatment and rehabilitation services mean that a user is not capable of making an informed decision and is also refusing treatment. However, the user requires such treatment for his or her own safety and the safety of others. If, following stabilisation at a health establishment, the user is diagnosed as having a mental illness and the conditions for either emergency admission and treatment without consent, involuntary treatment or assisted treatment exist, then only can the procedures of the Mental Health Care Act be applied.

Of importance are the specified Mental Health Care Act Forms (MHCAFs) that have to be completed by health establishments. Institutions do not always comply with the provisions of the Act, which creates a range of serious practical problems. If the relevant procedures are not followed, this means that the patient is illegally admitted, and can lead to liability issues. For example, with regard to an emergency admission or treatment without consent, a MHCAF 01 has to be completed by a mental healthcare practitioner. This document must be forwarded to the mental health review board for review.

With regard to assisted users, an application for admission is made on a MHCAF 04. This document must be commissioned by a commissioner of oaths, and the date of application and date of commissioning must be the same. Following this, the user must be assessed by two mental healthcare practitioners, for which purpose MHCAF 05s are used. One of the two mental healthcare practitioners must be qualified to conduct a physical examination. These two practitioners must conduct their own assessments of the patient, and not copy the findings of their colleague, which unfortunately often happens in practice. The practitioners who complete the MHCAF 05s cannot complete the MHCAF 04 as well. When these assessments have been done, the head of the health establishment has to complete a MHCAF 07, in which the mental health review board is informed of the decision of the health establishment with regard to future care, treatment and rehabilitation. The mental health review board then completes a MHCAF 14 with a recommendation for future care, treatment and rehabilitation. The board must ensure that all documentation is in order and that the user is indeed legally admitted. One review board member completes the form, another review board member countersigns the form, and it is then signed by the chairperson of the board.

Regarding involuntary healthcare users, the same procedure is followed as above, but there is additional documentation that must be completed. Two MHCAF 06s have to be completed after assessment by two mental healthcare practitioners. This assessment has to be done over a period of 72 hours. One of the two mental healthcare practitioners has to be a medical practitioner, and the other any one of the other categories of mental healthcare practitioners. Those practitioners completing the MHCAF 05s are also allowed to complete the MHCAF 06s, provided that one is a medical practitioner and that new individual assessments are done. If the decision is made for further care, treatment and rehabilitation services, the head of the health establishment must complete a MHCAF 08. A mental healthcare user cannot be admitted as an involuntary user if there is no completed MHCAF 08. If the user must be transferred to another psychiatric hospital, a MHCAF 11 must be completed. All these documents are sent to the review board for review, and the board members complete a MHCAF 14. Only if all the documents are in order can the user be deemed to be legally admitted under the provisions of the Mental Health Care Act.

From a practical point of view, review boards still struggle to make institutions fully comply with the provisions of the Act. This is due to a lack of proper training for hospital staff, and also to a lack of resources. These assessments take time, and hospital staff is limited.

With regard to time frames for the submission of forms, all original MHCAFs must be submitted to the mental health review board within 7 days of the head of the health establishment signing the MHCAF 07 and (if necessary) MHCAF 08. Regarding assisted users, the MHCAF 07 must be completed within 3 days of completion of the MHCAF 05s. With regard to involuntary users, the MHCAF 08 must be completed within 3 days of completion of the MHCAF 06s. Once the user is admitted under the Act, the Act supersedes all other conditions and processes. The user's rights are now limited to ensure the safety of the user, his or her property, hospital staff and the environment. If the user is assessed at a later stage and his or her condition does not warrant inpatient admission but still requires monitoring and supervision, the user can then be managed as an involuntary outpatient under very strict conditions.

The accountability of mental health review boards

As mental health review boards act as the watchdog over mental health, there should be some accountability if things go wrong. They could be charged with the following, which includes what they were accountable for with regard to the Life Esidimeni saga:

- They could have been given notice to attend an enquiry, as prescribed terms of section 21(2) of the Mental Health Care Act.[4]
- They are entitled to legal representation to represent them at the enquiry, and they are liable to pay their own legal fees.
- They are able to give evidence to the enquiry in the form of documentation or through witnesses.
- If the hearing or enquiry holds that they are not fit to hold office, they may present any relevant mitigating circumstances to assist the chairperson in determining the appropriate sentence.

Some relevant charges with regard to Life Esidimeni would include:

- They failed to intervene in dangerous situations.
- They could be guilty of not acting in the public interest.
- They might have failed in ensuring that the best possible mental healthcare, treatment and rehabilitation services were made available to organisations.
- They might have failed to execute their mandate or responsibilities as provided in section 19 of the Mental Health Care Act read with the mental healthcare guidelines and mental healthcare regulations, and this could compromise the rights and interest of mental healthcare users.

These charges could be brought, as these are the types of crimes that can be committed against mentally ill people.

Conclusion

Even though individuals suffering from mental illness are among the most stigmatised, discriminated against, marginalised, disadvantaged and vulnerable members of society, it is to be noted that rapid progress has undoubtedly been made regarding SA's dedication to the improvement of mental healthcare and the regulation of the mental healthcare profession in the country. For example, government has included clauses in the Constitution protecting the rights of individuals suffering from mental illness, including the right not to be discriminated against (the right to equality),[5] the right to bodily and psychological integrity,[5] the right to dignity[5] and the right to access to healthcare services,[4] and has also promulgated extensive domestic legislation, for example, the Mental Health Care Act, which established the existence of mental health review boards. As discussed above,

review boards have been created to ensure more supervision and accountability of care within healthcare establishments, and to ensure that individuals suffering from mental illness are protected during periods of vulnerability.[4,8] However, it is imperative that processes are not rushed or flawed, and that accountability is emphasised when the treatment of mentally ill patients is concerned. Unfortunately, the Life Esidimeni tragedy highlighted the extent to which things can go wrong when accountability is weakened.

It remains for strategies to be developed that change negative perceptions and inequities for individuals with mental illness. We suggest that guidelines be drafted on the accountability of the review boards, as no such guidelines currently exist. Some charges that could be used against review boards are also discussed above. Above all, the strategies should be underpinned by inalienable respect for mentally ill individuals. No matter how similar or how different mentally ill individuals might otherwise appear to be from other people in their communities, they should not be denied their equal share of opportunities to thrive as human beings. There is a moral and ethical requirement for society to respond to the suffering of the innocent. It is indeed a matter of recognising the importance of justice as a basic human need for the mentally ill, as for everyone else.[9]

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