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Appeals against assisted and involuntary admission under the Mental Health Care Act no 17 of 2002 in region A, Gauteng Province, South Africa, between December 2004 and December 2011

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Appeals against assisted and involuntary admission under the Mental Health Care Act No 17 of 2002 in Region A, Gauteng province, South Africa, between December 2004 and December 2011

Research Report

Submitted in partial completion of requirements for **MMed (Psychiatry)**

University of the Witwatersrand

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Johannesburg, 2015

DECLARATION

I, Dr Joanna Jane Taylor, declare that this research report is my own work. It is being submitted in partial fulfilment of the requirements for the degree of Master of Medicine in the branch of Psychiatry. It has not been submitted before for any degree or examination at this or any other University.

_____

_____ day of _____ 2015

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DEDICATION

For Richard, Lola, and Jason

ACKNOWLEDGEMENTS

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The staff at the Mental Health Review Board offices in Johannesburg for the access and assistance that they provided.

The patients navigating this imperfect system.

PRESENTATIONS

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LIST OF ABBREVIATIONS

Ch:	Chapter (referring to the Mental Health Care Act)
CHBH:	Chris Hani Baragwanath Hospital
CPD:	Continuing Professional Development
CRF:	Case Report Forms
CTR:	Care, Treatment, and Rehabilitation
DOH:	Department of Health
FTD:	Formal Thought Disorder
HHE:	Head of Health Establishment
HREC:	Human Rights Ethics Committee
IQR:	Intra-Quartile Range
MHA:	Mental Health Act of 1973
MHCA:	Mental Health Care Act No 17 of 2002
MHCU:	Mental Health Care User
MHRB:	Mental Health Review Board
MHRT:	Mental Health Review Tribunal
RMO:	Responsible Medical Officer
SAFMH:	South African Federation for Mental Health
UK:	United Kingdom

ABSTRACT

AIM: To evaluate the functioning of the appeal process against involuntary psychiatric hospital admissions under the South African Mental Health Care Act (MHCA).

METHODS: A retrospective descriptive record review was conducted to investigate the process and outcomes of all appeals lodged in Gauteng Region A between December 2004 and December 2011. Descriptive statistics were used to analyse the findings.

RESULTS: Inconsistencies were found in the nature and quality of documentation held at the Mental Health Review Board (MHRB). A documented decision of any kind was found in only 63.1% of cases. Mental health care users (MHCUs) who appealed on their own behalf were more likely to receive a decision from the board. Approximately one in two appeals waited for longer than the legislated 30 days before receiving a decision. 87.5% of appeals were dismissed. All those appealing against their admission stated that they were not mentally ill as part of their grounds for appeal. Legal representation was involved in only two of the cases. The most common reasons given by the Review Board for recommending ongoing admission included that the patient was still in need of care, treatment and rehabilitation, and that they were a danger to themselves or others.

CONCLUSIONS: The appeals process is not being widely utilised in this Region of Gauteng. Appeals received by the Review Board do not receive a standardised response and are not always administered in accordance with the legislative requirements.

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INTRODUCTION

The right to appeal against compulsory psychiatric admission is considered to be a safeguard against the misuse of mental health laws. Since 2004 South African mental health institutions have been governed by legislation that explicitly prioritises human rights including this one. This study hypothesised that it was not clear if the appeals process was functioning as it was intended to under the Mental Health Care Act No 17 of 2002 (the MHCA or the Act).

The aim of the study was to audit all appeals lodged in Region A of Gauteng between December 2004 and the end of December 2011, and to examine the relevant procedures and outcomes. The South African province of Gauteng at the time was served by two MHRBs, with their jurisdictions defined as Region A and B. These institutions fulfilled some of the human rights monitoring functions required by the MHCA. Region A covered southern Gauteng, including the densely populated central Johannesburg area and its outlying western districts. All levels of psychiatric care fall under the Review Board's domain. These include hospitals, outpatient clinics, and chronic care facilities. (1)

The objectives of the study included the following:

- To determine the rate of appeals
- To characterise the types of patients that appeal
- To establish the grounds on which appeals are lodged
- To establish the frequency with which the Review Board requested or provided the opportunity for oral or written representations
- To establish the outcomes of appeals
- To establish the extent to which reasons were given for these decisions and what these reasons were
- To establish links between characteristics of patients appealing and outcomes of appeals

CHAPTER 1 – LITERATURE REVIEW

1.1 Legislative background

The MHCA is recognised as one of the world's most enlightened mental health care enactments. (2) Drafted in a post-apartheid South African context acutely attuned to the imperative of safeguarding human rights and in an era of global legislative reform in the mental health field, it draws on the exacting humanitarian standards of these two contexts. It is an ambitious document that contains detailed provisions allowing for appeals against involuntary hospital admissions, outlines a right to representation during such appeals, and empowers MHRBs to hear them. It is not clear, however, to what extent the appeal provisions of the Act are being utilised by patients, and if not, why not. This study was an initial attempt to determine if the MHCA has lived up to its idealistic human rights promise in relation to appeals.

1.2 The Mental Health Care Act of 2002

The MHCA diverges from its predecessor, the Mental Health Act No. 18 of 1973 (MHA 1973) in both scope and values. Alongside its aim to offer care, treatment and rehabilitation that is integrated into the general health care system and into the community setting, is a striving to provide the least restrictive type of care possible and to ensure that concerns about safety of the general citizenry do not trump the rights of the mental health care user (MHCU). (3)

The term "mental health care user" is one that emphasises the agency of the patient. In no instance is this agency under more threat than that of "involuntary" admissions. The MHCA, in Section 1, defines "involuntary care, treatment and rehabilitation" as "the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others". (4) The related concept defined in that section is that of "assisted care, treatment and rehabilitation", whereby those "incapable of making informed decisions due to their mental health

status and who do not refuse the health interventions" (4) are provided with services. Both categories imply diminished capacity to make decisions, and the involuntary category applies when there is a clear lack of consent. Moosa and Jeenah (1) tallied applications for inpatient non-voluntary psychiatric care in Gauteng in 2008 at 3803, including 2526 assisted care cases and 1277 involuntary admissions. These numbers suggest that a limitation on patient autonomy is imposed in a significant number of admissions.

In order to facilitate medically sound and ethical care, mental health legislation has to allow for the swift treatment of those in urgent need of psychiatric attention whether they think they need it or not; while ensuring that those who legitimately believe that they do not need it have a chance to present their case. (4) With the appeals provision, the Act puts in place checks and balances to offset the sometimes necessary limitation of human rights, recognised in section 36 of the South African Constitution. (5)

1.3 The Right to Appeal

Australian commentators equate this right to appeal with the right to fair trial in criminal law, (6) and emphasise its fundamental importance particularly when issues of personal freedom, dignity, and bodily integrity are at stake. In a submission to a panel reviewing mental health law in 2009 it was suggested that this right is only meaningful if it can be exercised timeously, and with access to all necessary information and assistance. (6) The MHCA clearly and explicitly outlines the right of patients admitted without their consent to appeal, and the procedures governing such appeals. (4)

This right is usually discussed with reference to a list of human rights as enshrined in the South African Constitution and Bill of Rights. Another way to understand it is to return to first principles with regard to governance. John Rawls, one of the most influential 20th century political philosophers, suggested that when deciding on matters of policy, those in power should use a device that he named the "Veil of Ignorance". (7)(p118) The essential premise is that when making any decision one should place oneself in the position of the most vulnerable individual in society and proceed accordingly.

This exercise would be very likely in this context to result in robust mechanisms protecting the possibility of appeal by anyone inappropriately compelled to receive treatment for any condition.

In the case of appeals against assisted admission it would seem to be a contradiction in terms. No published discussion of this issue has been noted, but if the appellant is the patient and they are appealing against their admission, it follows that they should no longer be classified as assisted, since assisted patients by definition do not object to their admissions. It is conceivable that the appeal might be lodged by another interested party, for either more or less restrictive care.

Appeals against involuntary admission may be made by the patient or any other interested party within 30 days of the written notice of the decision to admit them involuntarily. The justification for the 30-day limit is unclear. The appeal is lodged by the completion of a dedicated form (MHCA Form 15), and must contain the facts and grounds on which the appeal is based. The Review Board then has 30 days in which to assess the case and publish its decision on MHCA Form 14. (4) These numbered forms, used to implement many of the functions of the Act on a day to day basis, are published with the Act itself in the Government Gazette. (8)

1.4 Informed non-consent

Despite its high ideals, the South African legislation seems to evade the issue of rights education for those under involuntary admission. Section 17 entitled “Knowledge of Rights” states that “[e]very health care provider must, before administering any care, treatment and rehabilitation services, inform a MHCU in an appropriate manner of his or her rights, unless the user has been admitted under the circumstances referred to in section 9 (1) *(c)*”. (4) The circumstances in question are those of admission without consent. This is precisely the situation in which the user’s rights are most compromised. The proviso is followed in later sections by an explanation of how and when that user’s rights must be explained, but with the caveat that this can be done when the treating clinicians consider the patient to be in a fit state. (4)

Informed consent, and the related concept of autonomy, are two of the most exhaustively discussed matters in the last half century of bioethics. Their full complexities are beyond the scope of this paper. One of the absurdities of modern medicine occurs when it seems that a patient will be denied an ever more sophisticated and potentially beneficial treatment due to the ever more sophisticated and potentially beneficial strictures of informed consent procedures. Manson and O Neill interrogate the at times inappropriate current incarnations of informed consent requirements, and suggest a move towards "communicative transactions" rather than static more polarised processes involving disclosure of information by one party and decision-making by the other. (9)(p.63) This seems to imply an ongoing process, and also a greater degree of collaboration in the interaction. An ongoing process of assessing first capacity to consent and then degree of consent is required during involuntary and assisted psychiatric admissions, and certainly during appeals procedures. This understanding, that capacity to consent is not static, may underlie some of the flexibility implied in the Act.

1.5 Grounds for involuntary admission

Many countries insist on dangerousness as a necessary condition for involuntary admission to hospital. In the era of mental health law reform since the 1970s, involuntary admission is often limited to those who are considered a danger to themselves or others. This is termed an "obligatory dangerousness criterion". (10)(p.251) In countries that do not have this obligatory criterion there is sometimes an option to admit involuntarily based on need for treatment where capacity for consent is impaired. Clinicians are particularly concerned with this imperative to admit. Mounting evidence about the neurobiological damage caused by untreated psychosis (11) (12) activates long held paternalistic "for your own good" instincts. The medical and ethical complexities of this area are relevant when evaluating review boards' decisions on appeals.

The existence of a mental illness itself is widely considered essential for involuntary admission. The relevant legislation in most countries contains a clause demanding the establishment of mental illness as the cause of the risk

posed to self or others. It is not enough to pose a danger, that danger must be considered to be linked to a mental illness. This raises questions around the definition of mental illness. Substance abuse and personality disorders are often excluded from this domain. (13) Some legislative environments prioritise the existence of mental illness and the need for treatment over concerns such as dangerousness. Finland, for example, requires severe mental illness with impaired insight, that a lack of treatment would worsen the condition or endanger the safety or security of the patient or others, and that other treatments or services are insufficient or inapplicable. (14)

Anderson and Eppard looked at clinical decision-making in involuntary admission assessments and identified nine “essential structural elements” employed by clinicians in making such evaluations. (15) These include phrases such as “intuitive reasoning” and “connection with the client”. In their very attempt to identify the reliable and systematic factors involved, they highlight the subjectivity of the process. Even the widely used tool of a risk assessment has been shown in some studies to be poorly predictive of any actual harm, (16) so even if we do accept the harm criterion as part of the involuntary admission calculus, we do not necessarily have a reliable way of assessing its significance in each case. These grey areas serve to highlight the crucial nature of any appeals process – both its existence and its functionality.

1.6 Utility of appeals

Aside from the more legalistic and rights-based arguments for a robust appeals mechanism, there are the clinical ones. A system that is experienced as responsive by its users may be more likely to foster confidence. Bindman *et al*. measured perceived coercion on admission and drew links to long-term community follow up. (17) They did not show a significant association, but the work raises the idea that we are concerned with patients whose interaction with the mental health services as a whole will usually be ongoing and multi-dimensional. A process whereby an individual can appeal a decision and be heard may well have valuable clinical effects, whatever the outcome of the appeal.

Mayers looked at mental health service users' experiences of sedation, seclusion and restraint. (18) It is during these procedures that individuals experience the most immediate and stark infringements on their bodily integrity, dignity, and freedom. Communication between users and service providers emerged as a prominent theme in the study by Mayers *et al*. The suggestion is that better communication could mitigate the perception of human rights abuses on the part of the patients. The appeals process, if functioning optimally, is a macroscopic version of that communication in the mental health care framework. It is the channel whereby patients have an opportunity to voice their concerns to the institutional system.

Weller discusses patient participation in tribunal hearings in terms of fairness, (19) but in so doing highlights potential benefits to future therapeutic adherence. She argues that people who are given a forum to have their case heard by a "respectful legal authority", and who feel that their case has been taken into account, are more likely to cultivate an "internal commitment" to the decision, and henceforth to adhere to it. (p.89)

1.7 Shift from courts to review boards

Under the MHA of 1973 patients were detained involuntarily at an institution under a "reception order". (20) The responsibility lay with the superintendent of that institution to assess the patient and report on their condition to the Attorney General or Director of Public Prosecutions, who acted as the *curator ad litem* to such patients. The matter had to then be referred to the Registrar of the High Court for that area, who presented it to a judge in chambers. The judge could order the further detention of the patient, but the patient, or his/her relatives and friends, could request an enquiry into the reasons and grounds for detention.

A notable difference in the legal requirements for involuntary and assisted admissions and appeals between the two Acts is the role of the courts. In line with global legislative reform the MHCA shows a prioritisation of the expertise of mental health care practitioners over judicial decision-making. (21) The creation of the MHRB provides for an independent organ with a multi-

disciplinary set of expertise and perspectives. Each board, according to section 20, consists of three to five persons, whose members must include one health care practitioner, one legal practitioner (a magistrate, admitted attorney, or advocate), and a member of the community served by that board (4). These boards have jurisdiction over decisions regarding involuntary and assisted admissions, and have taken over certain functions previously allocated to the courts. (4)

Ideally it would seem that the existence of a unit dedicated solely to these matters, and designed to contain the appropriate skills and experience, would streamline admission, review, and appeals processes for the benefit of patients and community members. The equivalent of these review boards elsewhere in the world are often called mental health tribunals.

Weller (19) interrogates the non-adversarial nature of mental health tribunals and how this intersects with human rights perspectives. The specialist tribunal system of review employed widely in mental health law since the 1970s (including in Australia, Canada, New Zealand, the United Kingdom, and now South Africa) can be seen as a hybrid system. Weller discusses its roots in the alternative dispute resolution movement and locates some of its principles in traditions of comprehensive law and feminist jurisprudence. Emerging from these theoretical contexts that are informed by such non-adversarial concepts as an “ethic of care” (p 85), the tribunal system is nevertheless embedded in a rights-based system, which seems to imply a degree of adversarial engagement. Weller attempts to frame this in a recently more nuanced human rights context. Her contention is that the disability movement, encapsulated in the *Convention on the Rights of Persons with Disabilities,* has shifted human rights discourse towards a focus on “interconnected, socially embedded processes” (p 87). Interestingly though it is also the disability movement whom she credits with driving the trend towards more frequent legal representation of patients at tribunals, a development that locates the tribunal process more firmly in an adversarial paradigm.

The seam of discussion that I have found most helpful in attempting to understand how best Review Board Hearings might be run seems to fall into

the theoretical realm of therapeutic jurisprudence. Much of this writing is concerned with how dispute resolution procedures could be designed to have more constructive outcomes. It seems particularly applicable to this study, which considers processes that are ideally located in a system that provides continuity of care, treatment and rehabilitation to individuals who will often have long-term relationships with the institutions concerned. Wexler (22) (p125) writes:

> ‘It is my thesis that therapeutic jurisprudence scholarship can contribute to the formulation of legal doctrine – process-driven solutions or otherwise – that can contribute to preserving relationships, to promoting dialogue rather than debate, and, in general, to diffusing anger, to curtailing contentiousness, and to turning down the volume so that creative problem-solving might ensue.’

The more nuanced scholars writing in this field seem to be concerned not merely with how we can mechanistically protect rights and be seen to be ticking all the right boxes, but with how to craft processes that are sensitive to the needs of vulnerable individuals, mindful of their long-term relationships with mental health services, and efficient in their use of scarce skills and resources.

Transparency and responsiveness are considered two of the ideals for any governing or administrative body to strive for in a functioning democracy. (23) The MHCA appeals process would seem to be a good indicator of how these qualities operate in practice. It is an especially apt measure because it involves individuals placed in a vulnerable and potentially powerless position. The access of mentally ill citizens to channels of review is not a given, and requires active safeguarding.

The MHCA dictates that when a person is admitted for involuntary care the head of the health establishment in question still has the initial responsibility to approve the application for admission but within seven days must submit a written request to the review board of that Region to approve further inpatient involuntary care, treatment and rehabilitation. (4) The review board is obliged to consider this request within 30 days of receipt of documents. (4) The review

board is charged by the Act with a duty to give any party involved an opportunity to make representations on the merits of the request and to send its decision in writing to the applicant and the head of health establishment (HHE). Under the Act it is only once the decision has been made to continue involuntary inpatient care that the documents are referred to the High Court for consideration.

The other instance in which the matter is referred to the High Court is when an appeal has been lodged with the Review Board against involuntary or assisted inpatient care and the Review Board has not upheld the appeal. The Review Board thus has the power to order treatment stopped and the MHCU discharged if their appeal is upheld; but if their appeal is rejected by the Review Board, the documents go to the Registrar of the High Court for review. (4) This addresses to an extent concerns over transparency of the new procedures. While there is great benefit in a system that works more efficiently, bypassing some of the cumbersome mechanisms of the court system; there is of course a danger of lack of visibility and/or accountability. This section of the Act ensures that when the MHCU reaches the end of the road with his/her appeal it does go to open court.

There are indications that the appeals process is being proactively managed in at least some Regions of South Africa. Whether a more proactive or interventionist approach is appropriate or not can be debated, but it seems that responsiveness and accessibility are evident in for instance the operation of the Western Cape MHRB. Bateman describes an organisation that actively educates MHCUs, families, and staff about the role of the MHRB and their rights under the Act. (24)

1.8 International comparisons

The Mental Health and Poverty Project make the startling claim that in most of Africa (they give a figure of 64% of countries) there is either no mental health legislation or legislation that insufficiently addresses human rights concerns. (25) They reviewed in one study the mental health laws of Ghana, South Africa, Uganda and Zambia and concluded that only the South African MHCA

met international best practice standards. With regards to protection against abuse or limitation of rights in particular, they found that the laws of Ghana, Uganda, and Zambia fail to incorporate these safeguards. The implication is that the provision for checks and balances such as appeals processes in the South African Act sets it apart. A gap in the literature exists concerning the practical application of these mechanisms.

Fistein, Holland, and Gunn attempt to compare mental health legislation from different Commonwealth countries. (26) Their attempt is systematic and detailed. They compare 32 Acts using standards derived from the Universal Declaration of Human Rights. Some of the trends they observe in legislative reform include an emphasis on treating for health rather than safety, and an emphasis on review mechanisms. Their analysis includes assigning each Act an “autonomy score” as a measure of its ability to safeguard human rights. This score is calculated from an evaluation of five “axes” that comprise diagnosis, therapeutic aim, risk, capacity, and review process. Of particular interest is their foregrounding of review processes, and their observation that “Review mechanisms provide a more robust safeguard against inappropriate detention than appeal processes, as they are not initiated by the patient, who may be subject to undue influence or lack resources to take a case to court.”(p17) They also note that the South African legislation comes close to being totally compliant with some of the most stringent human rights standards set by the World Health Organisation. Their study identified Acts from 11 African countries other than South Africa but stated that copies of this legislation could not be traced.

In many respects the South African MHCA seems more similar to the United Kingdom Mental Health Act of 1983 than to other mental health legislation. Other countries with similar legislation, particularly regarding appeals processes, include New Zealand, Australia, and Canada. Comparisons in this literature review therefore refer most often to these countries.

In 1959 legislative reform in the UK eliminated the role of magistrates in involuntary admission procedures, locating decisions in the realm of medical practitioners and social workers. (27) In 1983 an Act concerned specifically

with compulsory (involuntary) admissions instituted the equivalent of our MHRBs. They are designated Mental Health Review Tribunals (MHRTs) and include their own independent psychiatrists who assess patients in the case of appeals. They also elicit reports from the hospital treating team and may hear evidence from the patient and/or the mental health care providers. State funded legal representation for the patient is the norm at such appeals.

In both countries there is then further recourse to the general court system. According to a European Commission report, such litigation in the UK is increasingly common, with an accompanying “boom in legal practices specializing in mental health law”. (27) (p144) Interestingly, legal practitioners have begun to measure the 1983 Act’s provisions against other legislation safeguarding human rights and have won some of these challenges. This Act is currently subject to reform.

1.9 Appeals in the United Kingdom

In a study of why so few patients appeal, done in relation to the equivalent United Kingdom legislation in Oxford in 1993, the investigators found that one in two compulsorily detained patients were unaware of their right to appeal on their 13th day of admission. (28) This study further found that statistically significant predictors of an increased likelihood to appeal were higher educational levels achieved and previous psychiatric admission. Notably, the researchers evaluated the rate of appeal in that Region to be low (at one appeal in four compulsory admissions) and speculated that this indicated either that most patients had no objection to being in hospital, in which case they were misclassified, or that there were unacceptable obstacles to appeals being lodged. They highlighted that neither of these explanations indicated a just status quo.

The obstacles to appeal elicited by Bradley *et al*. from patients included practicalities such as access to writing equipment, in addition to the fundamental lack of knowledge about their rights as MHCUs. Among those who did not appeal, difficulty understanding written explanations of these rights was a significant finding. In the South African context of multi-

lingualism, low school completion rates, and comparatively low literacy levels (29), we can speculate that access to adequate information and ease of use of a written appeals process may well be even more decisive obstacles.

Penelope Weller gives a very vivid account of some of the practical obstacles cited by patients to their participation in tribunal hearings. (19) These include the timing of hearings relative to ward routines, and even having received electroconvulsive therapy, sedation, or changes in medication on the same day.

Shah and Oyebode (30) in a more extensive study of appeals to tribunals in the United Kingdom found that 35% of patients admitted under the relevant sections appealed, and that about 40% of these appeals were heard. These numbers are in line with those of Bradley et al (28) although slightly higher.

In recent decades the number of appeals made to mental health tribunals in the United Kingdom has risen steadily. (31) 50.2% of patients admitted under mental health legislation over a one year period appealed their admissions in one North-West London study published in 2009. This study found that more patients are lodging appeals but the success rate of appeals appears to be dropping. (31) By “success” the authors appear to mean the outcome sought by the patient. They speculate that the reasons for a greater proportion of unsuccessful appeals may include changing attitudes of the tribunals and also encouragement of appeals by legal practitioners who they suggest may in fact be actively soliciting clients, resulting in a greater volume of cases with doubtful merits. The researchers in this case were looking specifically at the relationship between ethnicity and appeals. They noted differences in rates of appeals between different ethnic groups but no discernible differences in outcomes along ethnic lines. Some of the factors they suggest might influence the ethnic differences include possible community or patient attitudes towards detention and biases on the part of clinicians or advocates when facilitating appeals. Differences in understanding of the appeals process itself are also suggested as a possible explanation.

Singh and Moncrieff (32) report that the percentage of detentions under the UK Mental Health Act resulting in appeals rose in the decade 1996 to 2006

from 34% to 81%. They observed no trend in the results of appeals. They make special note of the consequent increased workload.

1.10 Functioning of MHRBs

The existence of the review boards potentially increases access to justice for users whose rights have been denied. The boards are theoretically appropriately skilled, focused, and structured to make procedures efficient and responsive. The South African Federation for Mental Health (SAFMH) suggests that MHRBs form part of a trend in our constitutional democracy towards “bureaucratising rights”. Replacing certain functions of the courts, they are designed to provide oversight and recourse in an economical and accessible manner. (33) The SAFMH likens this approach to that of the panels created statutorily in the past decade to make decisions about sterilization procedures, refugee appeals, and parole of prisoners. A significant concern arises here about transparency. Allocating procedures such as appeals to such functionally circumscribed institutions could render them invisible. This is of particular relevance to the domain of involuntary mental health care, where the individuals concerned have already been removed from broader society and are uniquely vulnerable to abuse.

A small body of research is growing that gives us an indication of how the MHRBs are functioning. Each review board operates independently and is responsible only for its own jurisdiction, so it is unwise to make generalisations, but observations thus far raise grave concerns about their capacity to safeguard rights. A survey of 49 designated psychiatric care facilities in KwaZulu-Natal published in 2010 elicited significant dissatisfaction with MHRB involvement in and oversight of mental health care. (34) Observations include unacceptably long response times for review board decisions and a sense that “decisions of the medical staff at these hospitals were accepted by the Board without investigation, and that these hospitals lodged no complaints or appeals”. (p670) The investigators also report a perception that the MHRBs have demonstrated a lack of concern for suboptimal conditions in the facilities under their jurisdiction, despite their

specified role in investigating “abuse, neglect, and exploitation” (p670) of MHCUs.

Ramlall says MHRBs “are ideally and strategically placed between consumers and clinicians as well as the Health Ministry and Judiciary to advocate for mental health as well”. (35) There are some indications that in the Western Cape the board is fulfilling this potential. (24) (35) In other provinces the MHRBs are beset by obstacles including administrative, political, procedural, and capacity-related problems.

It is crucial to find out whether appeals procedures are functioning optimally through the MHRBs. The MHCA places an explicit emphasis on protecting human rights. One of the essential mechanisms for safeguarding rights, that of an appeal, was moved under this legislation from the domain of the courts into a less publicly accountable realm, that of the MHRB. Ideally this has resulted in more efficiency and access to appropriate expertise, removing some of the cumbersome requirements of the judicial system. If it has led to a more immediate and responsive oversight of the interests of MHCUs, a certain decline in visibility or transparency may be justified. This study was intended to shed some light on whether these procedures are functioning as intended.

CHAPTER 2 – HYPOTHESIS

The appeals process may not be functioning as it is intended to do under the Act.

CHAPTER 3 – AIMS

- To audit all appeals made against assisted and involuntary admissions to mental health care facilities in Region A of Gauteng since the inception of the MHCA in 2004 up to and including December 2011.
- Through an examination of the appeals lodged thus far, to contribute to an understanding of the nature and mechanisms of the appeal process as it is currently functioning.

CHAPTER 4 – OBJECTIVES

- To determine the rate of appeals relative to the total number of assisted and involuntary admissions during the period under scrutiny, including the total rate, per year, and per institution.
- To characterise the types of patients that appeal –for example along the lines of diagnosis, demographic criteria, familiarity with the system (for example whether patient or family member previously admitted), whether or not status was changed after admission, whether appellant was user or family member.
- Depending on the amount of information available, to establish the grounds on which appeals are lodged.
- To establish the frequency with which the Review Board requested or provided the opportunity for oral or written representations from applicant, appellant, independent mental health care practitioners, heads of health establishments, and/or others.
- To establish the outcomes of appeals. “Outcomes” will be understood here as the recommendations of the MHRB regarding further admission and or treatment, and may comprise orders to discharge the MHCU.
- To establish the extent to which reasons were given for these decisions and what these reasons were.
- To establish links between characteristics of patients appealing and outcomes of appeals.

CHAPTER 5 – METHODS

5.1 Design

This study was a retrospective descriptive record review.

5.2 Site of study

Data were collected at the MHRB offices in Johannesburg. Records of MHCUs who have appealed against their involuntary or assisted psychiatric hospital admissions since the inception of the MHCA were examined.

The total number of assisted and involuntary admissions for each year was also obtained, in order to evaluate numbers of appeals in relation to number of admissions under the Act.

Permission was initially sought for this study from the University Postgraduate Research Committee and the Human Research Ethics Committee (HREC), both committees of the University of the Witwatersrand. These bodies require an indication that the research site itself has given permission for the study to be conducted. In this case the MHRB were only prepared to give provisional permission – pending the approval of the two university committees. The two committees approved the study and then when data collection was being arranged the Review Board decided they needed to seek permission from the Mental Health Directorate, who referred the matter to the Department of Health (DOH), thus duplicating in part the HREC approval process, which includes DOH representation. These administrative setbacks added three months to the time it took to collect data.

5.3 Study population

The Review Board records of all MHCUs from Region A that had appealed against their involuntary or assisted psychiatric hospital admissions since the inception of the MHCA (commenced 15 December 2004). At the time the Region A Review Board served the western and central areas of Gauteng. All

facilities providing psychiatric care fell under its jurisdiction. This included private and public, in-patient and out-patient, acute and chronic institutions.

5.4 Sampling

- Sample size: dictated by how many appeals there have been. The intention was to limit sample size if necessary to 120 appeals but this was not necessary.
- Selection or recruitment of subjects: The “subject” in this case was a process, and the selection of subjects was by timeframe – all those that fell between 15 December 2004 and January 2012. This timeframe was chosen to cover the period from the inception of the current MHCA to the completion of data collection, including any pertinent documents available up to that point. The selection of documents was on the basis of relevance to the process.

5.5 Measuring tool or instrument

A data collection sheet was used to record information systematically (see appendix 1). A separate coding sheet was kept matching data sheet numbers to MHRB file numbers in case future reference to files was required. This was done in order to minimise opportunities for patient identification. Only the investigator had access to this sheet.

5.6 Data collection

Data were collected at the offices of the MHRB in central Johannesburg from October 2011 to January 2012. This had to be done during working hours.

The MHRB keeps a book in which they record each appeal against admission and each report of abuse or exploitation of a MHCU. This book contains records of all such items dating back to the establishment of the MHRB itself in 2005. No appeals were recorded in 2005. It is important to note that only appeals that reached the Review Board were considered.

Each MHCU admitted under the MHCA, (i.e. as an assisted or involuntary patient), has a file at the MHRB offices. Appeals documents for each user are kept in these files. This arrangement meant that more information was available about each appellant than initially predicted. For example it was not predicted that information about the mental state of each mental health care user on admission would be available. Had the appeals documents been kept separately, the information available would have been more circumscribed.

The file of each Region A user who had lodged an appeal or had one lodged on their behalf since the establishment of the board was requested. The MHRB allocated their own clerical staff to find the files. The researcher was not granted access to the filing room. Files were located over a period of approximately six weeks. When the researcher requested access to the logbook of all appeals to evaluate the number of missing files, a new search was conducted and another 12 files located that had previously been missing.

The researcher's data collection sheet was amended after examination of the first ten files. The original data collection sheet was designed on the assumption that access would be limited to the appeals documents themselves. Documents available in each file, however, included the forms completed on admission (Forms 4 and 5) and after 72-hour observations (Form 6). Additional available information included dates of admission, mental status, examination on admission, provisional diagnoses, and in some cases past psychiatric history.

Each available file was then reviewed, and data extracted as per the attached collection sheet. Five files out of 45 recorded appeals could not be located.

Information was also obtained from the Review Board about the total number of involuntary and assisted admissions in Region A for each year since the establishment of the board. This information was not available per institution.

5.7 Pilot study

A pilot study would have been invaluable to this project. It would have allowed for accurate prediction of sample size, and of the nature of the available information. Permission for such a study was denied.

5.8 Sources of bias

Bias may possibly have arisen due to the selectivity of information available on forms. This is addressed in the discussion of findings.

5.9 Ethics

Preservation of patient confidentiality was prioritised as addressed above. The research proposal was submitted to and approved by the Human Research Ethics Committee at its March 2011 sitting. The approval certificate is attached as Appendix 2.

CHAPTER 6 – DATA MANAGEMENT AND ANALYSIS

6.1 Data management

The MHCA forms were reviewed and data abstracted onto case report forms (CRFs) developed by the researcher. Free text fields captured on the MHCA forms (e.g. occupation and housing type) were categorised at the time of extraction into groups pre-specified on the CRFs (see appendix 1).

Data was entered into a Microsoft Excel® database by single user entry. Data was analysed using Stata™ v12.0 (Statacorp). Data was explored using ranges, histograms and/or quintile plots to identify implausible and outlying values. Implausible and outlying values were checked against the original forms and corrected where appropriate. Where these could not be corrected, implausible values were substituted with “missing” values.

6.2 Handling of variables

Since the final data set for analysis was small the two continuous variables (age and time from lodgement of appeal to decision) were categorised using the median distribution to limit the number of categories. These continuous variables were explored using tests for departure from normalcy and described using median and intra-quartile range if not normally distributed.

For descriptive purposes original categories as used on the CRF were used. In order to facilitate analysis of association between characteristics of appellants and outcomes of appeal categorical variables were re-categorized to reduce the number of categories.

Table 1: Categories as collected

Grounds for Appeal	Facts upon which appeal based	Mental State Examination on admission
• Not mentally ill • Wish to be cared for at home/discharged • Has recovered/improved • Did not agree to long admission • Was tricked into admission • Being abused • Rights violated • Incorrect treatment • Poor conditions in hospital • Wants other treatment modalities • Not danger to self/others • Damaging reputation • Willing to receive CTR elsewhere • CTR should be stopped • MHRB needs to hear more evidence • Objects to injectable treatment • Objects to treatment • Condition worsening • Family need them back/ children • Need to attend to affairs/ work • Cite MHCA • FTD evident in grounds given	• Not mentally ill • Rights violated • Being abused • Family or doctors have lied/malicious • Wants to seek treatment elsewhere/at home • Wants to use other treatment modalities • Claiming right to refuse treatment • Did not consent • Incorrect procedures followed • Has recovered • Admission too long • Not benefitting from treatment • Functions well outside • Unique circumstances cited • Livelihood in jeopardy/ attend to affairs • Not a danger • Too far to visit • FTD evident • None given	• Poorly groomed • Well groomed • Wasted • Alert • Sedated • Agitated • Cooperative • Uncooperative • Hostile • Violent • Aggressive • Unreliable • Guarded • Normal speech • Mute • Pressured speech • Reactive affect • Restricted affect • Euthymic • Dysphoric/irritable • Manic • Labile mood • Low mood • Apsychotic • Formal thought disorder • Normal thought form • Delusional • Objectively hallucinating • Disorganised behaviour • Psychotic • No insight • Poor judgment • Not suicidal/homicidal • Suicidal • Risk to self/others/dangerous • Refusing treatment/admission • Not completed/submitted

Table 2: Telescoping of mental state on admission data

General Condition / mental state	Dangerousness	Psychosis	Mood	Insight and judgement
Poorly-groomed	Agitated	Apsychotic	Normal speech	No insight
Well-groomed	Cooperative	FTD (formal though disorder)	Pressured speech	Poor judgement
Wasted	Uncooperative	Normal thought form	Reactive affect	Refusing treatment or admission
Alert	Hostile	Delusional	Euthymic	
Sedated	Violent	Objectively hallucinating	Dysphoric/irritable	
Unreliable	Aggressive	Disorganised behaviour	Manic	
Mute	Not suicidal/ homicidal	Psychotic	Labile mood	
Restricted affect	Suicidal	Guarded	Low mood	
	Risk to self/others/ dangerous			

6.3 Statistical methods

Missing data analysis was conducted to determine whether there were systematic differences in those with missing outcome data compared to those without.

For the primary objective of describing the characteristics of individuals lodging appeals, basic descriptive statistical methods were used. Given the small number of observations Fisher's exact chi-square test was used.

For the secondary analysis to determine whether there are associations between the available factors and the outcome of the appeal, the original intention was to utilise univariate logistic regression methods with the outcome re-coded as a binary variable of compulsory vs. non-compulsory care, with those admitted as "assisted users" being grouped together with the compulsory as an *a priori* recoding. Unfortunately, distribution of outcomes precluded use of logistic regression for some variables (sex, age category and occupation) as Stata™ contained no events resulting in univariate logistic regression models predicting outcome perfectly, despite categorical variables being re-categorised to reduce the number of categories.

Furthermore, the initial intention to construct multi-variate logistic regression models to predict outcomes of appeals, could not be meaningfully conducted. The use of multi-nomial logistic regression models with the outcome classified as non-compulsory, assisted compulsory and involuntary inpatients, was also explored but once again was complicated by limited number of observations. This is discussed further under Limitations in Chapter 10.8.

The results of the study have been reported in keeping with the STROBE guidelines. (36)

Table 3: Table of descriptive/explanatory variables

Variable	Scale of Measurements
Demographic : Age	Continuous – median, Intra-Quartile Range (IQR) and range.
Gender	Categorical
Occupation	Categorical as per CRF
Marital status	Categorical as per CRF
Suburb	Categorical as per CRF (divided into dwelling type and location)
Whether user is applicant/not	Categorical as per MHCA
If not, suburb of applicant	Categorical (divided into dwelling type and location)
Relationship to user	Categorical
Grounds for appeal	Categorical, CRF codes were developed after review of first 20 forms
Facts on which appeal is based	Categorical, CRF codes were developed after review of first 20 forms
Calendar year	Ordered categorical
Days from appeal to decision by the MHRB	Continuous
Place	Categorical
Whether submissions sought/not	Categorical
Conclusion of Review Board	Categorical
Reasons if given	Categorical

CHAPTER 7 – RESULTS

7.1 Overview

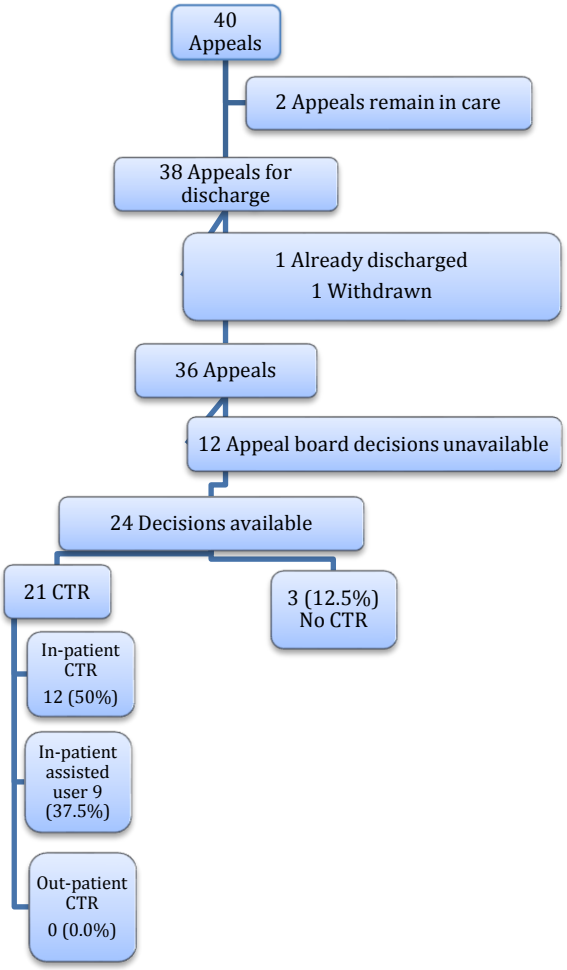
A total of 45 appeals were identified from the inception of the MHCA in 2004 through to December 2011. Files relating to five appeals were missing and two appeals were for individuals to remain in institutional care. These are described in the text below. Thirty eight appeals were included in the analysis (see Figure 1). Of these 16 (43.3%) were lodged in 2010/2011.

Characteristics of appellants at the time of appeal are presented in Table 5. Of the 38 appeals for discharge, 17 (45%) were male, 19 (51.4%) were less than 35 years of age, 20 (54.1%) were unemployed, 27 (75%) were single and 22 (50.5%) of the appeals were lodged by the user.

All of the 38 applicants (100%) stated they were not mentally ill, 26 (68.4%) claimed their rights were being violated, 13 (34.2%) cited socio-economic and/or family responsibilities, with a similar number wanting to undergo alternative treatment modalities, and eight (21.2%) felt conditions within the institution were unacceptable.

Users' diagnoses and recorded signs and symptoms at time of admission are presented in Table 6. Out of 38 applicants 17 (45.9%) had a diagnosis of schizophrenia on admission and ten (27%) were diagnosed with a mood disorder. No information regarding diagnosis was available for one applicant and 7 applicants had two diagnoses. With regards to information regarding domains with the exception of psychosis, the commonest category was that of "no information available".

Figure 1: Flow diagram of appeal process and outcomes



7.2 Number of appeals

It is not possible to comment on rates of appeal without more information about the length of the admissions. What is evident from the numbers available is that from the years 2006 to 2011 inclusive there were 45 appeals documented by the Review Board in Region A. The relation to the total numbers of assisted and involuntary admissions for each year is shown in Table 4.

Table 4: Total numbers of assisted and involuntary admissions for each year

Year	Assisted	Involuntary	Non-voluntary	Appeals	% of Non-voluntary Patients that Appealed
2005	19	119	138	0	0
2006	603	653	1256	1	0.08
2007	1443	284	1727	10	0.6
2008	1494	293	1787	7	0.4
2009	1382	507	1889	9	0.5
2010	1982	318	2300	6	0.3
2011	2215	147	2362	12	0.6

7.3 Grounds of appeal

All of the 38 applicants (100%) stated they were not mentally ill, 26 (68.4%) claimed their rights were being violated, 13 (34.2%) cited socio-economic and/or family responsibilities, with a similar number wanting to undergo alternative treatment modalities and eight (21.2%) felt conditions within the institution were unacceptable.

Some MHCUs cited that they were appealing because their family or the doctors had lied or tricked them into admission. These were included in the category “not mentally ill”.

Included in the category “violation of rights” were those who made allegations of abuse but did not complete Form 2.

The category “Socio-economic or family responsibilities” included some appeals justified on grounds such as “family needs them back” or “too far to visit”.

Other grounds of interest included concerns about reputation. These were classified under the category “Socio-economic and family responsibilities”. MHCUs stated that the psychiatric admission could damage their reputation, and linked this concern to a potential threat to their livelihood.

The form completed in order to lodge an appeal, MHCA Form 15, contains a section entitled “Grounds of appeal” and one entitled “Facts upon which appeal is based”. In the documents reviewed in this study there was no difference evident in the content included in these two categories. Often the same information was supplied in both sections. There was no consistency between appellants as to which information was placed in each section.

Quote from Data 30 (appeal upheld):

Grounds: “my moods are stable”. “I do not suffer from bipolar mood disorder”. “I do not have any diagnosed psychotic illness”. “I am held here against my will”.

Facts: “I did not consent to be held at a psychiatric hospital hence I am appealing for release to home”.

7.4 Records of proceedings

The quality of record-keeping across the appeals process appeared to be inconsistent. Some files contained no documentation related to the MHRB response to the appeal in question. Others contained detailed reports on the proceedings of the hearing held, with attached reports that had been requested from each member of the treating team. The findings of the MHRB were included in these reports for some appeals, presented on a MHCA Form 14 for others, and appeared to be missing in others. Other documents available in some files but not in others included copies of notice of hearings that had been faxed to the relevant mental health care establishments, and summons’s issued to appear at said hearings.

7.5 Hearings and representations requested

Records of actual hearings held appeared in 23 files. The MHRB requested representations from relevant parties for 28 of the appeals. Reports were requested from the treating team in 22 cases. Legal representation was involved in two of the appeals, but in no appeal process was such representation suggested or arranged by the MHRB. None of the appeal hearings or investigations included an evaluation by an independent psychiatrist.

7.6 Time periods (admission to appeal, appeal to hearing, hearing to findings, findings to discharge)

Most of the appeals reviewed in this study were lodged within 30 days of admission, as per the provisions of the Act. Twenty eight were within 30 days and six were lodged after 30 days. The median period was 8.5 days from admission to appeal, with an intra-quartile range of five to 23 days and a range of zero to 1879 days.

The period from lodging of the appeal to issuing of the decision by the MHRB is also stipulated in the Act as being no longer than 30 days. In this area the appeals reviewed here fell outside of this period as often as they fell within it. The median time from lodging of an appeal to receiving a decision from the board was 29.5 days, with a range of one to 326 days. 12 of the appeals received decisions within 30 days, nine between 30 and 60 days from appeal, and three took more than 60 days to receive an outcome.

The median number of days between submission of an appeal and the holding of a hearing was 22.5 days, with an intra-quartile range of 17 to 29 days. 17 of the appeals had hearings in less than 30 days and five took more than 30 days.

An attempt was made to collect data on the period from an appeal decision to discharge, but too much of this data were missing to draw any conclusions. Form 3's, on which discharges are recorded, were not available for most patients, but it cannot be assumed that this means they are still in hospital.

The median time from decision to discharge where this information was available was 49 days, with a range of five to 141.

7.7 Outcomes of appeals

In 24 (63.1%) of the cases under discussion a documented decision from the Review Board was found. In 14 (36.9%) no decision was in evidence from the files.

In only three (12.5%) of the appeal cases in which a decision was documented did the Review Board find that no further care, treatment, and rehabilitation (CTR) was appropriate. In these cases they specified that the MHCUs should be discharged. For twelve (50%) of the cases they ordered further involuntary inpatient CTR, and further inpatient CTR as an assisted user for nine (37.5%). They did not order outpatient involuntary CTR in any of the cases. Thus overall they concluded that 87.5% of the MHCUs under discussion should receive further inpatient care, and 12.5% (3/24) were to be discharged.

All three of the MHCUs whose appeals were upheld were female, under 35 years of age, and unemployed. In two of these cases the MHCU was the appellant. In the other case the appellant was a parent.

The most statistically significant association between any patient or appeal characteristic and outcomes was that more of the MHCUs who appealed on their own behalf received a documented outcome of any sort compared to cases in which the appellant was not the MHCU (p-value 0.015).

7.8 Rationale given for MHRB decisions

The reasons given by the MHRB for their decisions not to uphold appeals were distilled into categories as per Figure 2.

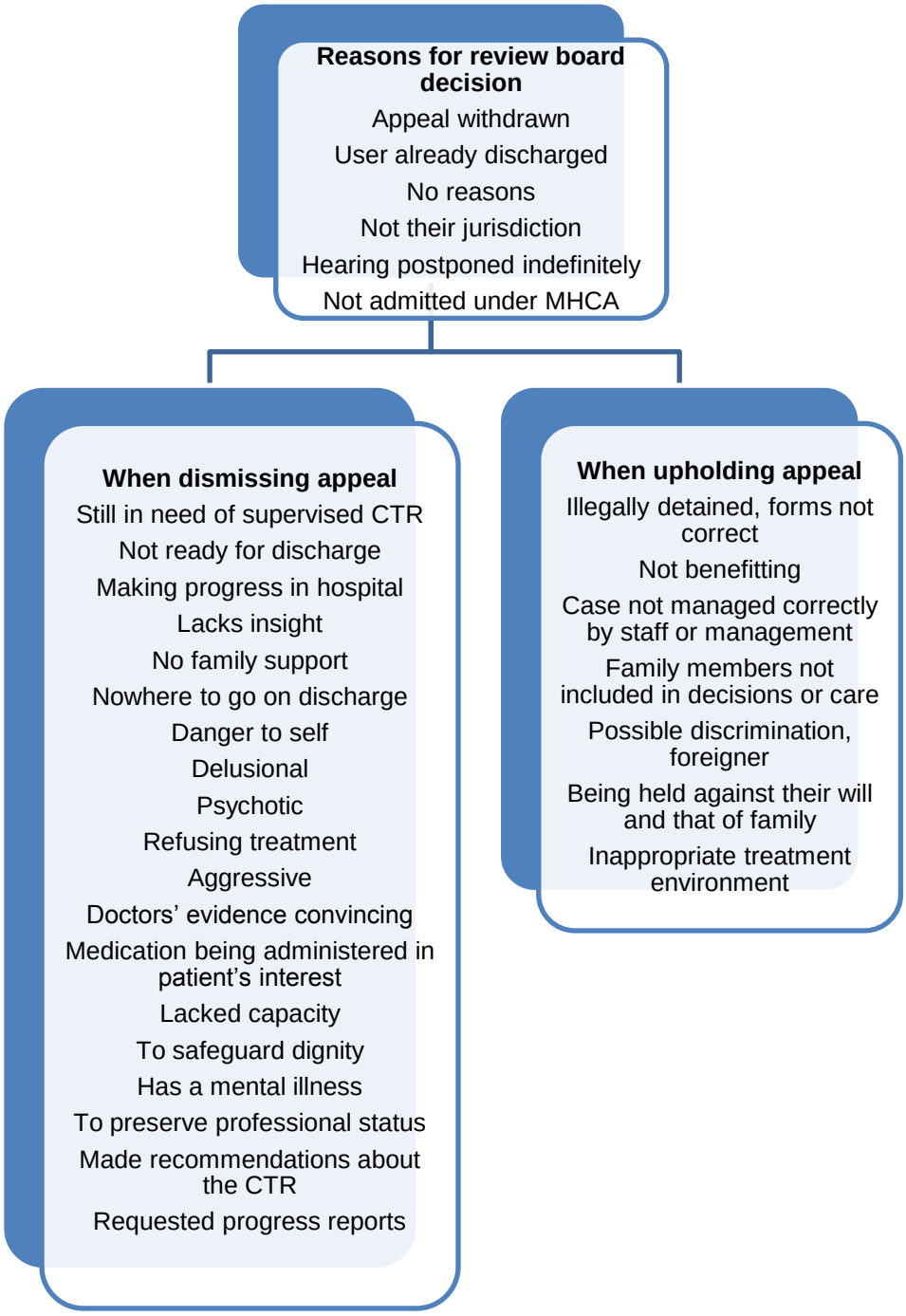
Data 30, appeal upheld, reasons cited as follows:

> ‘the police responsible for confinement of appellant did not follow required procedure. No MHCA 22 was filled by officer in charge.

Healthcare provider who consented committed irregular acts and did not initial her corrections when deleting and inserting two different dates. The HHE at CHBH violated the appellant's rights of movement, privacy, and dignity by administering medication without proper documentation. The MHRB therefore agrees with the appellant that she is being held against her will and without her consent. All CTR services administered to the MHCU to be stopped according to the accepted clinical practices and the user must be discharged by the HHE unless the user consents to CTR'.

Anecdotal evidence from colleagues suggests that this patient had lodged a first appeal at CHBH in December 2008 and those forms were lost.

Figure 2: Reasons given for Review Board decisions



7.9 Description of appeals to remain admitted

There were two such appeals found in this study. Both were lodged by family members of the MHCUs appealing against their proposed discharge.

The first was lodged by the next of kin of a 51-year old single patient on the grounds that there was nobody to look after her. She had been admitted on 3 June 1986 to Lifecare. The specific institution was not named in the file. Her diagnosis was noted as severe intellectual disability with no behavioural problems. The appeal was lodged on 7 Feb 2007. No summons's or requests for representation or documents were issued by the MHRB. There was no record of a hearing. No documented deliberations or rationale were in the file. There was a letter from the MHRB to the institution saying that the "appeal should be stayed" and the institution should seek placement for the patient at an NGO as decided by the board on 30 June 2006. Progress was also to be reported monthly to the board. It was also recommended that the family should be engaged in family therapy in preparation for reintegration. This decision was conveyed on 6 March 2007, 27 days after the appeal was made.

The second was lodged by the parent of a 27-year old single woman who had been admitted to Gateway House, a long-term residential psychiatric facility, on 6 July 2000 with a diagnosis of profound cognitive impairment. The appellant had obtained legal representation and the grounds for appeal were stated in terms of mentally ill patients having a right to care and not to be discriminated against. The facts on which the appeal was based included an account of the patient's attachment to her similarly impaired brother who resided at the same facility. Notably, a hearing was held on 29 March 2007, two days after the appeal was lodged. The head of health establishment was requested to attend the hearing. No documentation about proceedings or deliberations was available. The MHRB issued a report on 9 May 2007, 43 days after completion of appeal forms. The outcome was that the appeal was not upheld because the patient had in fact never been admitted under the MHCA. They stated that they had arranged for Gateway to postpone discharge while the family made alternative arrangements, and that the patient had been moved from Gateway on 20 April 2007.

Table 5: Summary table of characteristics of study population (n=38)

Variable		N	%
Gender *(n=38)*	Male	17	45%
	Females	21	55%
Age category *(n=37)*	<35 years	19	51.4%
	≥35 years	18	48.7%
Occupation *(n=37)*	Professional	7	18.9%
	Clerical	1	2.7%
	Manual	1	2.7%
	Self-employed	2	5.4%
	Student	3	8.1%
	Other	3	8.1%
	Unemployed	20	54.1%
Marital status (*n=36)*	Single	27	75.0%
	Married	6	16.7%
	Divorced	1	2.8%
	Widowed	2	5.6%
Dwelling *(n=37)*	House	19	51.4%
	Flat	10	27.0%
	Informal	3	8.1%
	Institution	1	2.7%
	Homeless	4	10.8%
Type of suburb *(n=32)*	Suburb	23	71.9%
	Township	9	28.1%
Applicant (n=37)	User	22	59.5%
	Parent	11	29.7%
	Spouse	1	2.7%
	Next of Kin	3	8.1%
Domains of appeal (part 1 and 2 of grounds for appeal combined) (n=38)	Not mentally ill	38	100%
	Rights being violated	26	68.4%
	Conditions in hospital	8	21.2%
	Socio-economic/family	13	34.2%
	Alternative treatment	13	34.2%
Number of stated reasons (in part 1 of form) (n=38)	0	1	2.6%
	1	10	26.3%
	≥2	27	71.1%
Number of stated reasons (in part 2 of form) (n=38)	0	1	2.6%
	1	15	39.5%
	≥2	22	57.9%
Calendar year of appeal (n=37)	2006-2007	7	18.9%
	2008-2009	14	37.8%
	2010-2011	16	43.3%
Level of Institution (*n=37)*	Psychiatric hospital	17	46.0%
	Academic hospital	13	35.1%
	Other	7	19.9%

Figure 3: Demographics of users

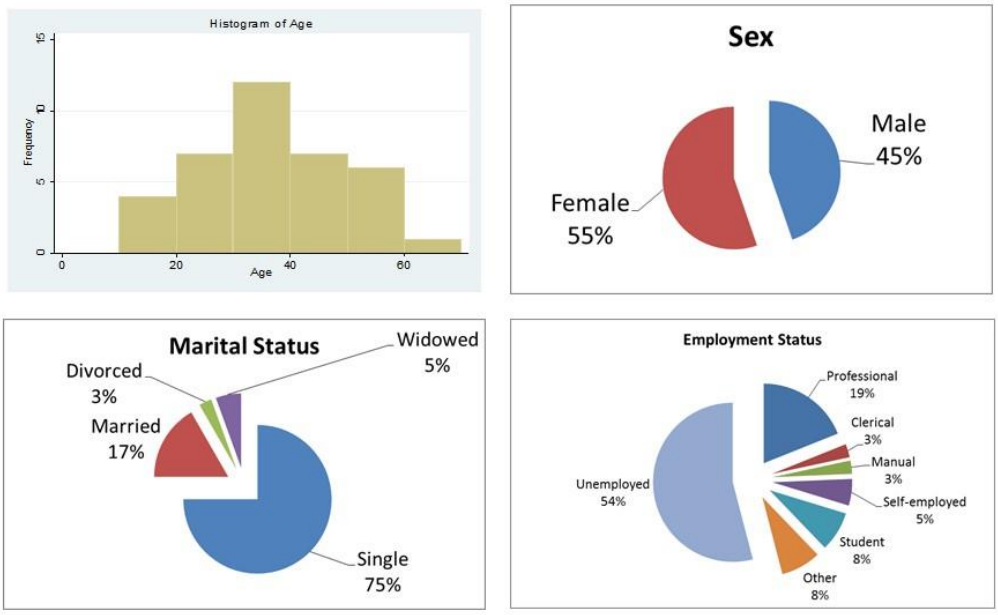


Figure 4: Identity of appellant

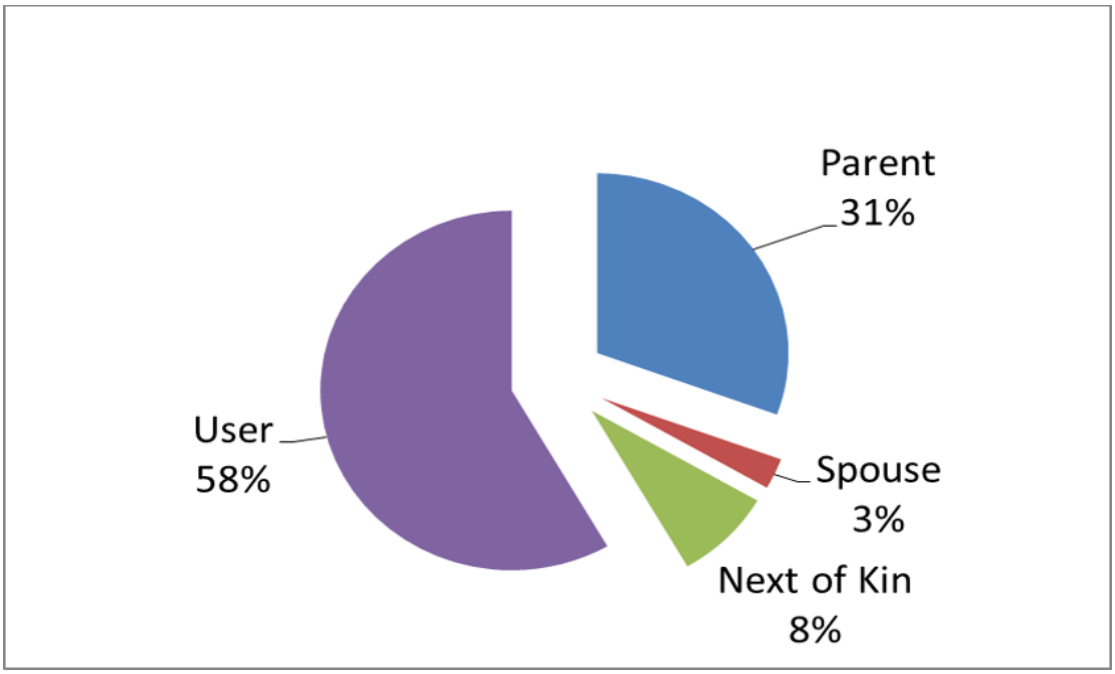


Table 6: Summary table of medical characteristics of study population (n=38) on admission

Variable		n	%
Diagnosis	Schizophrenia	17	45.9%
	Bipolar Mood disorder	10	27.0%
	Substance abuse	5	13.5%
	Other	12	32.4%
	No diagnosis	1	2.6%
Number of diagnoses on admission	0	1	2.6%
	1	30	79.0%
	2	7	18.4%
Information available regarding general condition, dangerousness, psychosis, mood, insight and judgment			
General condition	≥ 1 signs/symptoms of poor general condition recorded	11	28.9%
	≥ 1 signs/symptoms satisfactory general condition recorded	11	28.9%
	No information recorded	20	52.6%
Dangerousness	≥ 1 signs/symptoms dangerousness recorded	16	42.1%
	≥ 1 signs/symptoms of dangerousness noted as absent	5	13.2%
	No information recorded	19	50.0%
Psychosis	≥ 1 signs/symptoms of psychosis recorded	29	76.3%
	≥ 1 signs/symptoms of psychotic features noted as absent recorded	3	7.9%
	No information recorded	6	15.8%
Mood	≥ 1 signs/symptoms of mood disorder symptoms present	17	44.7%
	≥ 1 signs/symptoms of mood disorder symptoms noted as absent	8	21.1%
	No information recorded	18	47.4%
Insight	≥ 1 signs/symptoms of poor insight recorded	17	44.7%
	≥ 1 signs/symptoms of poor insight noted as absent	0	0%
	No information recorded	21	55.3%

Table 7: Appeal process and outcome

Variable	Median (IQR) or n (%)
Days from admission to appeal form signed (n=34)	8.5 (5-23)
Days from appeal to hearing (n=22)	22.5 (17-29)
Decision made by Review Board	
Yes	24 (66.6%)
No	12 (33.3%)
Median days from appeal to decision (n=24)	29.5 (22-43.5)
Days from appeal to decision by category (n=24)	
<=30 days	12 (50.0%)
>30 to ≥60 days	9 (37.5%)
>60 days	3 (12.5%)
Conclusion of Review Board (n=24)	
No CTR	3 (12.5%)
Involuntary CTR (in-patient)	12 (50.0%)
Involuntary CTR (out-patient)	0 (0.0%)
Assisted user (in-patient)	9 (37.5%)
Days from decision to discharge	49 (5-141)

Figure 5: Histogram of months from admission to appeal (n=25)

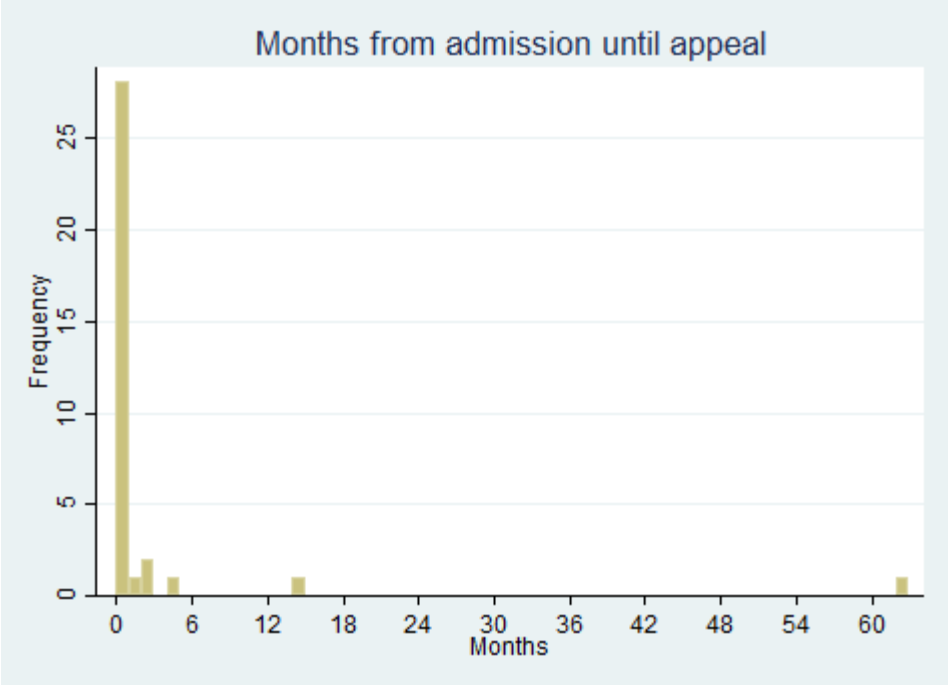


Figure 6: Histogram of months from appeal to decision (n=18)

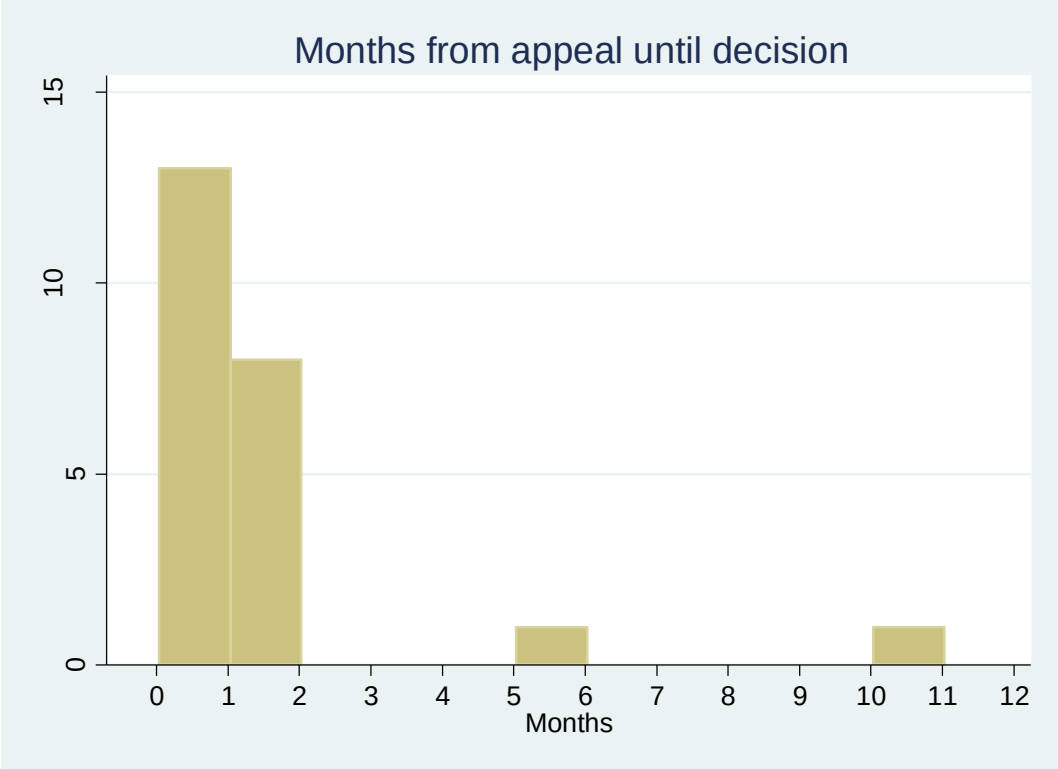


Table 8: Reasons for dismissed appeal

If Appeal Dismissed	n (%)
Still in need of supervised CTR	7 (33.3%)
Danger to self/others	6 (28.6%)
Has a mental illness	6 (28.6%)
Delusional	5 (23.8%)
Psychotic	5 (23.8%)
Lacks insight	4 (19.0%)
No or inadequate family support	4 (19.0%)
Doctors' evidence convincing	4 (19.0%)
Making progress in hospital	3 (14.3%)
Refusing treatment	3 (14.3%)
Made recommendations about the CTR	3 (14.3%)
Aggressive	2 (0.1%)
To safeguard dignity	2 (0.1%)
Not ready for discharge	1 (0.01%)
Medication being administered in patient's interest	1 (0.01%)
Lacked capacity	1 (0.01%)
To preserve professional status	1 (0.01%)
Requested progress reports	1 (0.01%)
Nowhere to go on discharge	0

Table 9: Univariable analysis of outcome and explanatory variables, with associated Chi-Square tests (n=38)

		Outcome n (row %)			p-value
Variable		No CTR	Assisted CTR	Involuntary CTR	
Gender	Male	0 (0)	6 (50)	6 (50)	0.207
	Female	3 (25)	6 (50)	3 (25)	
Age category	<35 years	3 (27.2)	5 (45.5)	3 (27.2)	0.17
	>=35 years	0 (0)	6 (50)	6 (50)	
Occupation (2 cats)	Active	0 (0)	7 (64)	4 (36)	0.275
	Unemployed	3 (23.0)	5 (38.5)	5 (38.5)	
Occupation (7 cats)	Professional	0	3 (60)	2 (40)	
	Clerical	0	1 (100)	0	
	Manual	0	0	1 (100)	
	Self employed	0	2 (100)	0	
	Student	0	1 (100)	0	
	Other	0	0	1 (100)	
	Unemployed	3 (23)	5 (38.5)	5 (38.5)	
Dwelling (2cats)	House/flat	2 (12)	9 (53)	6 (35)	1.00
	Other	1 (16.7)	3 (50)	2 (33.3)	
Dwelling (5cats)	House	1 (9)	8 (73)	2 (18)	
	Flat	1 (17)	1 (17)	4 (66)	
	Informal	1 (50)	1 (50)	0	
	Institution	0	0	1 (100)	
	Homeless	0	2 (67)	1 (33)	
Marital status	Single	2 (11.8)	5 (53)	6 (35)	0.528
	Married	0 (0)	3 (75)	1 (25)	
	Widowed	0	0	2 (100)	
Location	Suburb	2 (12.5)	7 (43.75)	7 (43.75)	1.00
	Township	1 (20)	3 (60)	1 (20)	
User is applicant	Yes	2 (11)	9 (50)	7 (39)	1.00
	No	1 (17)	3 (50)	2 (33)	
Relation to user (2 cats)	Parent	0 (0)	2 (67)	1 (33)	1.00
	Other	1 (33.3)	1 (33.3)	1 (33.3)	
Relation to user (7 cats)	Parent	0 (0)	2 (67)	1 (33)	1.00
	Next of kin	1 (33.3)	1 (33.3)	1 (33.3)	
Number of Grounds for appeal (part 1)	0	-	-		0.609
	1	0 (0)	5 (56)	4 (44)	
	>=2	3 (20)	7 (47)	5 (33)	
Domains of appeal (part 1 and 2 of grounds for appeal combined) (n=38)	Not mentally ill	3 (12.5)	12 (50)	9 (37.5)	
	Rights being violated	2 (12.5)	8 (50)	6 (37.5)	
	Conditions in hospital	1 (25)	2 (50)	1 (25)	
	Socio-economic/family	1 (12.5)	3 (37.5)	4 (50)	
	Alternative treatment	1 (11)	5 (56)	3 (33)	

Table 10: Univariable analysis of decision made and explanatory variables, with associated Chi-Square tests (includes those who appealed to stay)

		Decision made		p-value
Variable		**Yes**	**No**	
Gender	Male	12 (71)	5 (29)	0.506
	Female	12 (57)	9 (43)	
Age category	<35 years	11 (58)	8 (42)	0.737
	35 years and above	12 (67)	6 (33)	
Occupation	Active	11 (65)	6 (35)	1.00
(2cats)	Unemployed	13 (65)	7 (35)	
Occupation	Professional	5 (71)	2 (29)	
(7cats)	Clerical	1 (100)	0	
	Manual	1 (100)	0	
	Self employed	2 (100)	0	
	Student	1 (33)	2 (67)	
	Other	1 (33)	2 (67)	
	Unemployed	13 (65)	7 (35)	
Dwelling	House/flat	17 (59)	12 (41)	0.683
(2 cats)	Other	6 (75)	2 (25)	
Dwelling	House	11 (58)	8 (42)	1.00
(5 cats)	Flat	6 (60)	4 (40)	
	Informal	2 (67)	1 (33)	
	Institution	1 (100)	0	
	Homeless	3 (75)	1 (25)	
Marital status	Single	17 (63)	10 (37)	0.523
	Married	4 (67)	2 (33)	
	Divorced	0	1 (100)	
	Widowed	2 (100)	0	
Location	Suburb	16 (70)	7 (30)	0.681
	Township	5 (56)	4 (44)	
User is applicant	Yes	18 (82)	4 (18)	0.015
	No	6 (47)	9 (53)	
Relation to user	Parent	4 (33)	8 (67)	0.321
(2cats)	Other	4 (67)	2 (33)	
Relation to user	Spouse	0	1 (100)	
(4 cats)	Next of kin	3 (100)	0	
	Parent	3 (27)	8 (73)	
	Associate	0	1 (100)	
If not user, residence of applicant	House/flat	5 (42)	7 (58)	
	Other	1 (50)	1 (50)	
Grounds for appeal	0	0	1	0.039
	1	9 (90)	1 (10)	
	>=2	15 (56)	12 (44)	

Domains of appeal (part 1 and 2 of grounds for appeal combined) (n=38)	**Not mentally ill**	**24 (63)**	**14 (37)**	
	Rights being violated	16 (62)	10 (38)	
	Conditions in hospital	4 (50)	4 (50)	
	Socio-economic/family	8 (62)	5 (38)	
	Alternative treatment	9 (69)	4 (31)	
Facts on which appeal is based	0	0	1 (100	0.217
	1	8 (53)	7 (47)	
	>=2	16 (73)	6 (27)	
Calendar year of appeal	2006-2007	7 (100)	0 (0)	0.059
	2008-2009	9 (64)	5 (36)	
	2010-2011	8 (50)	8 (50)	
Days from appeal to decision	<30 days	9 (90)	1 (10)	0.729
	30-<60 days	6 (75)	2 (25)	
	>=60 days	3 (100)	0	
Institution	Specialist hospital	12 (71)	5 (29)	0.203
	Academic hospital	6 (46)	7 (54)	
	Other	6 (86)	1 (14)	

CHAPTER 8 – DISCUSSION

8.1 Number of appeals

The article by Bradley *et al*. (28) assumes that a rate of one appeal per four compulsory admissions is low, and incompatible with patients being both involuntarily admitted and aware of their right to appeal. This was the lowest appeal rate found in the articles cited in this study. The appeals examined in this study for Gauteng in 2011, the year with the highest number of appeals, comprise 12 out of 2362 involuntary and assisted admissions. If we entertain the hypothesis that one in four is low, then the Gauteng Region A figures are remarkably low, even given significant contextual differences.

United Kingdom appeals have continued to climb in number every decade since the 1995 study. (32) This development is not widely heralded as an indicator of appropriate protection of patient interests. Concerns have been raised about burdening an already stretched mental health care system with procedural obligations. This administrative load taxes the capacity of all participants. Interestingly the outcomes of appeals to tribunals have been shown seldom to differ from the recommendations of the treating clinicians. (30) This has prompted some commentators to suggest that at least some of the checks and balances in the compulsory admissions system might be better fulfilled by other practices, such as hospital managers' hearings. (37) These suggestions are at odds though with an increasingly litigious environment. There are human rights advocates and theorists who hold that only an adversarial system offers sufficiently robust mechanisms when the potential errors have such grave consequences for individual liberty and bodily integrity. (6) This South African study suggests that in Gauteng Region A the appeals process is certainly not overused, and that when considering how best to open up access to appeals processes policy-makers might look also at processes that are less formal and administratively complex.

Missing information has implications at every level of this study. Only appeals recorded in the book kept by the MHRB itself were identified and examined. It

is not known if there were appeals attempted by patients that never left the wards concerned, or were never forwarded by institutions to the MHRB, or reached the MHRB but were not recorded in the book. One of the possible elements of this study was to try to match information from the mental health care institutions themselves to that available at the offices of the MHRB. This endeavour was deemed unnecessary for the purposes of the study, but might have given some clarity about other missing information that could be skewing the results.

The Western Cape MHRB reported six to ten appeals and complaints received by their office each week in 2011, compared to one to two per month in 2005 (24). Again, direct comparisons are impossible. This study compared only one Region of the Gauteng MHRB. However, the Western Cape board attributes their rise in numbers of appeals in part to a concerted effort on the part of the board to educate MHCUs about their rights and to train the relevant staff appropriately. This effort includes the provision of a “rights card” on admission that includes contact numbers for the MHRB. (24) Such an intervention almost certainly creates more work for the Review Board, including perhaps the fielding of spurious and time-consuming complaints. It may be concerns about this type of development that deter other boards from disseminating information in this way. Increased access to the board by MHCUs does, however, create a more substantial role for the organisation, which may be relevant to matters of policy review and budgetary allocations in addition to the evaluation of human rights protection.

8.2 Grounds of appeal

Every appeal in this study included a claim that the MHCU was not mentally ill. This can be viewed in terms of the insight of patients and family members and also points to the unique nature of this type of admission. It is in fact often included in legislative criteria for involuntary admission that the individual lacks insight into their condition. Almost by definition, involuntary patients will dispute the need for treatment and it could therefore be argued that each one should be appealing. Such a scenario would be cumbersome, time-

consuming, a resource burden, and would probably compromise the standard of care provided. An “ideal rate” of appeals is very difficult to estimate.

The use of “threat to reputation” as grounds for appeal is significant in relation to the grounds used for making patients involuntary. The grounds in the “tick box” section of the South African MHCA forms include “poses a threat to reputation”. The use of threat to reputation as a reason to justify involuntary psychiatric admission is not well interrogated in the literature. Even the authoritative texts address it only tangentially. Peele and Chodoff, for instance, refer to preservation of professional status as a means of enforcing acceptance of treatment. (13)

Claims that family and/or doctors had lied or tricked MHCUs into admission relate to the issue of consent and also to that of insight. Of course a claim that family members lied in order to effect admission has to be taken seriously in an appeals process. Collateral information often plays a significant role in decisions around admission and it is conceivable that such information could be distorted, selectively conveyed, or in fact fabricated. This is another area in which the assisted category is problematic. A 72-hour observation is not required in order to classify a patient as an assisted user. If a patient is made assisted without a 72-hour observation, the collateral information received will therefore be more heavily weighted in this situation than in an involuntary admission where the team has had more opportunities to evaluate an individual’s condition directly. The resulting limitation on the patient’s freedom though is in many respects similar. This is a crucial consideration if it is possible that a patient has in fact been admitted to hospital due to the ulterior motives of someone else.

Psychiatry has historically been implicated in forms of social control, including suppression of political dissent (38) and exertion of patriarchal power (39). The express purpose of checks and balances, such as appeals processes, is to prevent such abuses of power. They are mechanisms based on worst case scenarios. It is for this reason that they often seem cumbersome and unnecessary in the context of daily clinical practice. History shows though that the system of institutional psychiatric care is open to abuse, whether we

consider the case of Siegfried Sassoon's lengthy asylum stay after his public opposition to the Second World War (40) or apartheid South Africa's shameful history in this regard. In 1984 the World Psychiatric Association was petitioned by members of the international psychiatric community to expel the Society of Psychiatry of South Africa because of its collusion with the apartheid government. (41) The concerns raised were based not only on human rights abuses committed in psychiatric hospitals, but specifically also on the misuse of psychiatry for political ends. In profoundly repressive political regimes an appeals process might seem futile, but even then a judicial process might have overridden a political one.

The specific objection to injectable treatment contained in one appeal is interesting in light of the difference between admission and treatment. In some international legislation a firm distinction is made between refusal of admission and refusal of treatment, and overriding one does not necessarily involve overriding the other. In other jurisdictions an involuntary admission confers carte blanche to administer involuntary pharmacological treatment. For example, in the South African context once a patient has been classified as involuntary separate applications do not have to be made to administer pharmacological treatment against their will. Winick argues that courts and moral philosophers have always given bodily integrity particular consideration, thus drawing distinctions between incarceration for protection of self or others and active forms of physical or mental treatment. (42) Certain forms of treatment almost always require a further application for administration without consent. In many countries, including South Africa, electroconvulsive therapy, for instance, is regulated by stringent and specific regulations and licensing requirements. (43) New Zealand Mental Health Tribunals have specifically designated powers in addition to reviewing the legal status of people admitted under their Mental Health Assessment and Treatment Act of 1992. These include the appointment of psychiatrists to determine whether treatment is in the best interests of individuals that objects to treatment, and whether electroconvulsive treatment is appropriate in each case. (44)

The duplication of information between the categories “Grounds for appeal” and “Facts upon which appeal is based” may indicate a conceptual problem with the forms. This distinction between grounds and facts is one commonly employed in a legal context. The difference is not immediately apparent to a lay person. This perhaps points to an underlying assumption by the drafters of the legislation that legal assistance would be in place for each appellant. If that extrapolation is unfounded, what can be said is that the forms are not user-friendly.

8.3 Records

Missing data was a crucial finding at every level of the appeals process. The system appeared not only entirely inconsistent from one case to another, with detailed and comprehensive records available for some appeals and virtually no documentation for others, but also displayed no evidence of due process employed for the missing documents. These documents are required by law to be complete. The regulations of the Mental Health Care Act state that:

> 15. Consideration of appeals by Review Board
>
> (1) If an appeal against a decision contemplated in section 27(9) and 33(8) to provide assisted or involuntary care, treatment and rehabilitation is made to a Review Board, the secretariat of that Review Board must ensure that all documentation in terms of section 29 and 35 of the Act is obtained and delivered to the members of that Review Board at least one week prior to the appeal being considered by that Review Board.
>
> (2) The secretariat of a Review Board must in writing and by registered post inform the appellant, the person referred to in section 27(1) or 33(1) of the Act, the relevant mental health care practitioners, the head of the health establishment concerned and any other person whom the Review Board considers to be important to the appeal hearing, of the date of the appeal and whether written or oral representation, as appropriate, must be made to the Review Board. (45)

This study found no evidence of any coherent system in place for tracking missing documentation. There was no discernible channel of accountability for incomplete records or halted proceedings. This is not to say that these systems and procedures do not exist, but they are not transparent and were not accessible to the researcher. The MHCA itself gives each review board some leeway to decide how best to conduct its business in Chapter IV Section 24 (Procedures of Review Board), (4) but what is not in doubt is that they must have agreed-upon procedures. Matters cannot be conducted on an ad hoc basis. The Act also states in its Chapter IX Regulations 66(1)(p) that “The Minister may, after consultation with all relevant members of the Executive Council, make regulations on matters concerning the powers, functions, guidelines for exercising these powers and functions and reporting obligations of a Review Board.” (45) The Regulations of the Act (Chapter 7, Section 39) are much clearer about the specific records required to be kept at hospitals, rather than at the Review Board itself. It is possible that the architects of the legislation envisaged a much more efficient collaborative relationship between hospitals and oversight bodies, in which duplication of records would be unnecessary and all decisions clearly communicated. In the absence of such administrative cooperation and coherence it would seem prudent for the Review Boards to keep their own complete records. It might be justifiable to set a time limit on the maintenance of records such as appeal documents. Once a decision is clearly communicated to the hospital it may be unnecessary to maintain detailed records for longer than the period during which a court review would be allowed. It would perhaps be unreasonable to expect the Review Board to maintain such files only for research purposes, although this imperative might be considered.

The administrative failure evident in the poor record keeping extends beyond the appeals process. The difficulty establishing accurate information about appeals is located in a deeper murkiness about the legal status of the MHCUs under the authority of the Review Board. Janse van Rensburg (46) attempted to track the legal status after 12 and 24 months of MHCUs who had undergone 72-hour assessments at Helen Joseph Hospital in 2007. He found that due to the nature of the record-keeping at the Review Board it was not

possible even to ascertain the legal status of the majority of users at a given point in time. He identified in particular a failure on the part of the Review Board to “legalise” the admissions “through the timely return of instructions by means of the MHCA Form 14”. (46)(p 320) His alarming conclusions include that “This inadequate oversight of admission procedures and of the changing legal status of users is indicative of the poor capacity of the MHRBs to discover human rights or other violations.” (46)(p320) This statement is certainly consistent with the findings of this study. Observations by the researcher during data-capturing included that the obstacles to gathering information lay as much in the administrative chaos as in any wilful bureaucratic hindrance or secrecy.

It may be that part of what is required is a clarification of the obligations of the hospitals and those of the review boards with regard to maintenance of records and updating of legal status of users. This is located in broader questions about duties of care, as articulated by Peele and Chodoff who interrogate the ethics of involuntary treatment and deinstitutionalisation from a broad policy level through the legislative implications down to the clinical requirements. (13) They highlight the difficulties of locating accrediting bodies or oversight functions within hospitals themselves, raising the obvious issue of vested interests of the hospital in particular outcomes.

8.4 Hearings and representations requested

The most salient findings here are the lack of legal representation and independent psychiatric evaluations across the board. Two of the appellants in this study had legal representation. From the information available it appeared that this representation was arranged and paid for by the appellants themselves. In none of the proceedings was the question of legal representation raised by the MHRB.

In European tribunals legal representation for patients has become the norm. The European Court of Human Rights has gone so far as to say that even patients who have not requested a lawyer may be considered to have had their rights breached if they are not represented. (47) This is in such stark

contrast to the South African status quo that it begs the question of applicability. The limited success in implementing the MHCA in South Africa has been discussed above. Resources and skills do not yet stretch to meeting even the basic administrative and procedural imperatives of the Act. Some might argue that advocating for expansion of the rights protections is not only unrealistic under South African constraints, but could in fact jeopardise current service provision by spreading resources more thinly or creating additional administrative and other demands. A further question to ask is what value legal representation adds to the process. The presence of lawyers can be seen to entrench an adversarial atmosphere in a hearing. A New Zealand study found that the participation of legal representation did not significantly alter the outcomes of hearings but did appear to worsen delays. (48)

Mental Health Review Tribunals generally allow legal representation but do not require it. (19) The South African Act entrenches the right to representation at such hearings, (4) but makes no clear recommendations about how this right should be realised. There are arguments to be made that such representation should not be routinely necessary in these hearings. In the interests of accessibility, affordability and efficiency it might be better to design processes that are fair and inclusive without the involvement of lawyers. Some argue that the involvement of lawyers can be counterproductive in a solution-oriented process, and others take it further to claim that it can be counter-therapeutic. (19) This approach does not sit easily in the territory of safeguarding rights though, and raises as many questions as it answers about how to provide checks and balances while offering a less legalistic framework.

Nilforooshan, Amin, and Warner also take issue with the influence of legal practitioners in the potential skewing of the appeals process. They suggest that, particularly if such practitioners are encouraging patients to appeal unnecessarily, they may be burdening the system inappropriately. They assert that “given that appeals are expensive and often confrontational and counter-therapeutic (patient and consultant are pitched against each other in an

adversarial and legalistic milieu neither feels comfortable with) perhaps it is time to overhaul the appeals process". (31)(p290)

Another interesting aspect of legal representation is the evenness of the playing fields. Jones and Nimmagadda (49) claim that an unhelpful asymmetry is created when the patient at a MHRT is represented by a lawyer specialising in mental health law and the "responsible authority" or hospital is represented only by the treating doctor. It is noteworthy that this also sets up a marked dual role, and potential conflict of interest, for the responsible medical officer (RMO) treating doctor, who is giving clinical evidence and has an ongoing therapeutic relationship with the patient, but is also representing the hospital at the tribunal or hearing. Coates (47) makes a similar point, using the concept of equality of arms in legal representation. He suggests that the state has an obligation to fund symmetrical legal representation for the parties involved in a tribunal. He cites the example of Northern Ireland where this convention is in place. In his opinion this "allows a fuller, more considered, and indeed expert appraisal of the evidence". (47)(p426) Anticipating objections based on resource scarcity, Coates reminds the reader that the courts, considering tribunal delays, have found that cost does not negate the state's obligation to fund issues of human rights. (47)

Jones and Nimmagadda raise concerns about the lack of specific training provided to the clinicians for this particular quasi-legal role, and the arising inequality in the tribunal proceedings. Interestingly they conclude that consultant psychiatrists accept this role as appropriate but recognise gaps in their training in this regard. (49) Their conclusion is that both postgraduate training and continuing professional development (CPD) should address the relevant competencies. In South Africa the formal training curriculum (50) and the clinician-driven CPD programs contain input on expert testimony largely geared towards the courtroom situation and forensic context, but very little can be found about review board hearings in particular. This should perhaps be understood partly in the context of the frequency with which they take place but, to return to the study in question, there may be a cause and effect aspect to consider. One can speculate that clinicians who feel ill-equipped to

execute their own role in review board hearings will be unlikely to contribute to a robust and accessible process for MHCUs.

8.5 Time periods in appeals process

It must be noted that for only 24 of the appeals lodged was the MHRB decision evident from the available documentation. Therefore for this analysis N was 24.

One of the interesting findings here is that most of the appeals reviewed were lodged within 30 days of admission. Implications of this could be that patients don't wish to appeal after 30 days, that they are deterred from doing so at the health establishments (in accordance with the Act), that they do so but the appeals are not forwarded, or that the MHRB does in fact refuse to consider such appeals. Once again, data from the individual institutions would be helpful in differentiating the likelihood of each of these scenarios. Members of the MHRB informed the investigator that they do not enforce the 30-day limit because they do not want to compromise MHCUs rights to have their concerns aired. It is interesting, however, that so few were found in this study that fell outside of the 30-day period. There are many possible explanations for this, including the possibility that as patients' mental states improve during the course of longer admissions they become less inclined to appeal.

Decisions from the Review Board, on the other hand, seemed often to take considerably longer than 30 days, thus contravening the Act in a significant way. Half (50%) of the decisions reviewed here were published more than 30 days after the lodging of the relevant appeal. Three of them (12.5%) were published more than 60 days after the appeal.

While these delays are significant, the problem of delays does not appear to be unique to the local context. The problem of delayed tribunal hearings has been noted elsewhere, with factors such as inadequate administrative practices and missed report deadlines cited as reasons. (30)

8.6 Outcomes of appeals

In 36.8% of the appeals under discussion no documented decision or recommendation from the MHRB could be found. This is an important finding with regard to both process and actual outcomes. Missing documents are an unacceptable outcome in a process such as this one that might, among other considerations, be subject to legal review. Aside from missing information, lack of a decision in this context amounts to a default outcome. If the MHRB did in fact not issue a decision in some of these cases CTR would presumably have proceeded as though no appeal had taken place. It is possible that the MHRB communicated its decisions in some cases directly to the health establishments concerned without any documentation.

Without a control group we cannot characterise patients who appealed, but the finding that all those whose appeals were upheld were female is in line with a Swiss study in which women were three times as likely as men to be discharged as the result of an appeal. (51) The study concerned did make some headway in characterising appeals and their outcomes. The researchers looked at appeals against compulsory admission and treatment during that year in the canton of Basle-City. They described 118 appeals per 320 compulsory admissions. Of the appellants 75% were schizophrenic, whereas only 27% of all admissions were schizophrenic. Women were three times more likely to be discharged as a result of the appeal and were found to have shorter compulsory admissions. Isolation and compulsory treatment were noted to be used more in male patients. (51) Shah and Oyebode's study found that patients more likely to appeal were younger, had English as a first language, and were more commonly detained on grounds of protection of others, or self and others, as opposed to protection of self only. (30) This Gauteng study could not draw conclusions without a control group, but found 45.9% of appellants had an admission diagnosis of schizophrenia.

The statistically significant association found in this study between the MHCU lodging the appeal themselves and being more likely to receive any decision from the MHRB may be the result of bias or confounding variables. It may, for example, indicate something about their mental state or educational level that

they are able to undertake such a process on their own behalf. It is possible though that there is a more direct link, that an appeal from the MHCU on their own behalf prompts a more efficient response from the MHRB, or that having lodged an appeal on their own behalf the MHCU is more likely to follow up through the treating team, thereby placing pressure on the MHRB.

In 37.5% of cases in which a documented decision was available, the Review Board recommended further CTR as an assisted inpatient after an appeal. This means that a MHCU actively refusing admission to the extent that they lodged an appeal was classified as a patient "incapable of making informed decisions due to their mental health status and *who do[es] not refuse* the health interventions" as defined in section 1. (4) There seems to be a logical inconsistency here. One possible explanation for this might be that the MHRB prioritises the "least restrictive type of care possible" provision in the Act above the technicalities of the categories.

8.7 Rationale for MHRB decisions

The reasons provided by the MHRB for their decisions for the most part emphasised that patients were mentally ill, lacked insight, were still in need of treatment, or a danger to themselves or others. Some of the reasons given suggested unfamiliarity with diagnostic categories. In two cases the report from the Review Board included an assessment that the MHCU concerned was suffering from "a delusional disorder". In each case there was evidence of psychosis, but in neither case was the working diagnosis of the treating team that of delusional disorder. This may seem to be a pedantic observation but it does suggest a possible deficit in the training provided to board members, who are required to be able to communicate convincingly with mental health professionals.

The board also cited inadequate family support as a reason for continued CTR in four cases. This may be a pragmatic response to specific circumstances but is not described in literature or practice guidelines as a valid reason for involuntary care. A more appropriate response to that

particular problem might be to change the legal status of the patient and address the practical issues of ongoing care and accommodation.

In four cases in which appeals were dismissed the board also stated that the evidence of the doctors was convincing. This indicates a weighting given to clinical opinion, in a process that has already been shifted away from the formal legal environment into a more medical domain. Several commentators have expressed concern that tribunals are not rigorous enough in their approach to medical evidence in particular. Suggestions are that they tend to accept it at face value, that they don't apply consistent evidentiary rules to it, and that they don't sufficiently interrogate risk assessments that may in fact be controversial or at least open to debate. (19) (52) Weller points out that this trend casts into doubt the ability of tribunals to safeguard rights. (19)

Previous studies have noted the tendency of tribunals to give considerable weight to the opinion of the treating doctors involved (30) (52) (53). Peay found that 84% of tribunal decisions reflected the advice of the responsible medical officer. In hearings or tribunals that do not employ independent psychiatric evaluations it is interesting to consider which factors should carry more weight than the evidence of the treating team.

Two particularly interesting justifications used by the board for continued CTR were to safeguard dignity, and to preserve professional status. These are clearly important considerations when providing CTR to patients, but are not frequently cited reasons for involuntary admission.

8.8 Limitations

Several of the problems encountered were predicted in the research proposal. The investigation was limited by the information available in the files accessed, as is often the case with retrospective record reviews. Information was often incomplete. The investigator relied on assistance from the Review Board for access to confidential and potentially contentious documentation. Even where the necessary forms were completed thoroughly and legibly, there were gaps that made it difficult to seek certain associations.

The sample size is very small. This was defined by the number of appeals lodged with the Review Board. It meant that few conclusions could be drawn statistically.

The generalisability of this study is limited. Legislative differences across countries make it difficult to apply the findings to other contexts and implementation inconsistencies between provinces and Regions create similar obstacles.

Data on whether the patient was assisted or involuntary at the time of appeal were not collected. This information was difficult to access because of inconsistent use of Form 14's, but could have been sought more actively or elsewhere, for instance, at the health establishments concerned. Form 7's could also have been used where available to clarify this issue. This information could also have been collected from Forms 5[1] and 6, but those are only applications and do not clarify status as approved by the MHRB.

The study design might have been significantly improved with the benefit of a pilot study. As it stands, this study might form the basis for improved questionnaires for a later study.

One of the stated aims of this study was to characterise patients that appeal. A control group would have assisted greatly in this endeavour. Without a control group it is possible to describe the patients who have appealed but not, for instance, to make any conclusions about which patients might be more likely to appeal. This study was unable to draw conclusions in this territory. Future studies incorporating control groups might provide interesting insights.

Similarly this study was unable to calculate a rate of appeals due to a lack of information about length of admissions concerned.

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[1] Forms 5, 6, and 7 refer to forms published in the Government Gazette with the MHCA. Form 5 is entitled Examination and Findings of Mental Health Care Practitioner Following an Application for Assisted or Involuntary Care. Form 6 is entitled 72-Hour Assessment and Findings of Medical Practitioner or Mental Health Care Practitioner After Head of Health Establishment Has Granted Application For Involuntary Care, Treatment and Rehabilitation. Form 7 is entitled Notice By Head of Health Establishment On Whether To Provide Assisted Or Involuntary Care, Treatment and Rehabilitation.

Multivariate logistic regression could not be conducted as only three patients were discharged as a result of their appeals. The feasibility of conducting multivariate logistic regression is determined by the number of events (D) in the sample. Since only three patients were discharged in this case, conducting multivariate logistic regression is not feasible as it results in empty sets. The inability to conduct this was not considered a protocol deviation as it could not be anticipated in advance of collecting the data. It has no bearing on the validity of the analysis conducted or the interpretation thereof.

Discussion and analysis in this study were limited to a degree by the legislative heterogeneity in the mental health field. This makes it difficult to draw direct comparisons with other systems. This is further complicated by the problem of disciplinary or interpretative limitations. Ideally a topic such as this requires both legal and psychiatric knowledge, with some agility between the two. The university environment would seem to be the right one to foster an interdisciplinary collaboration in this field. This was no doubt undertaken around the drafting of the current legislation. Ongoing legislative review and refinement will require further such shared efforts.

CHAPTER 9 – CONCLUSION

The appeal process in the MHCA is one of the essential components of the human rights emphasis of the Act. This process is currently flawed to an extent by legislative factors and to a greater degree by problems with capacity and implementation.

Problems related to the Act itself include the 30-day provision, the ambiguity of the “assisted” category, the nature of the appeal forms (Form 15) and an evasive approach to informed consent.

More practical obstacles to a just and accessible process include inadequate rights education, poor availability of representation or assistance, absence of independent psychiatric assessment, inconsistent capacity of panel members to evaluate mental health parameters, a lengthy and inconsistent process to achieve a decision, suboptimal record keeping, weak links with the broader justice system, and lack of visibility and approachability of the MHRB.

The dire state of record-keeping by the Review Board has implications not just for the appeals process but for their ability to serve other key functions such as keeping track of all non-voluntary psychiatric admissions.

Currently it would seem that the function of the courts, with the associated transparency and legal rigour, has been replaced by a somewhat ad hoc and much less visible system lacking in medical or administrative meticulousness.

An explicit evaluation of the role of the appeal process is necessary on the part of mental health care providers, review board members, and the mental health directorate. If the assumption is that this process in its ideal form is too resource-heavy, cumbersome, and legalistic, then alternative methods for MHCUs to have their concerns addressed need to be considered. An example might be regular visits to each ward, involving direct contact between board members and users.

CHAPTER 10 – POSSIBLE RECOMMENDATIONS

1. Streamlining of forms. For example, “Grounds for appeal” and “Facts upon which appeal is based” to be clarified as categories or collapsed into one section.
2. Inconsistencies or ambiguities in the Act, such as the 30-day provision, to be re-evaluated
3. The development of a rational approach to rights education for this patient population.
4. Review of the assisted category.
5. Representation or assistance to be considered for appellants. In some cases legal representation might be appropriate. Other types of support in navigating the system could be mobilized.
6. More involvement of psychiatrists in the operations of the Review Boards, for example independent psychiatric assessment as a possibility in complex cases if not all.
7. Improvement in training of panel members and all who participate in hearings.
8. A more proactive role for the board itself. This could include raising awareness and monitoring functions, such as providing safeguards against hospital staff blocking appeals. The possibility of active reviews as opposed to patient-driven appeals could also be considered.

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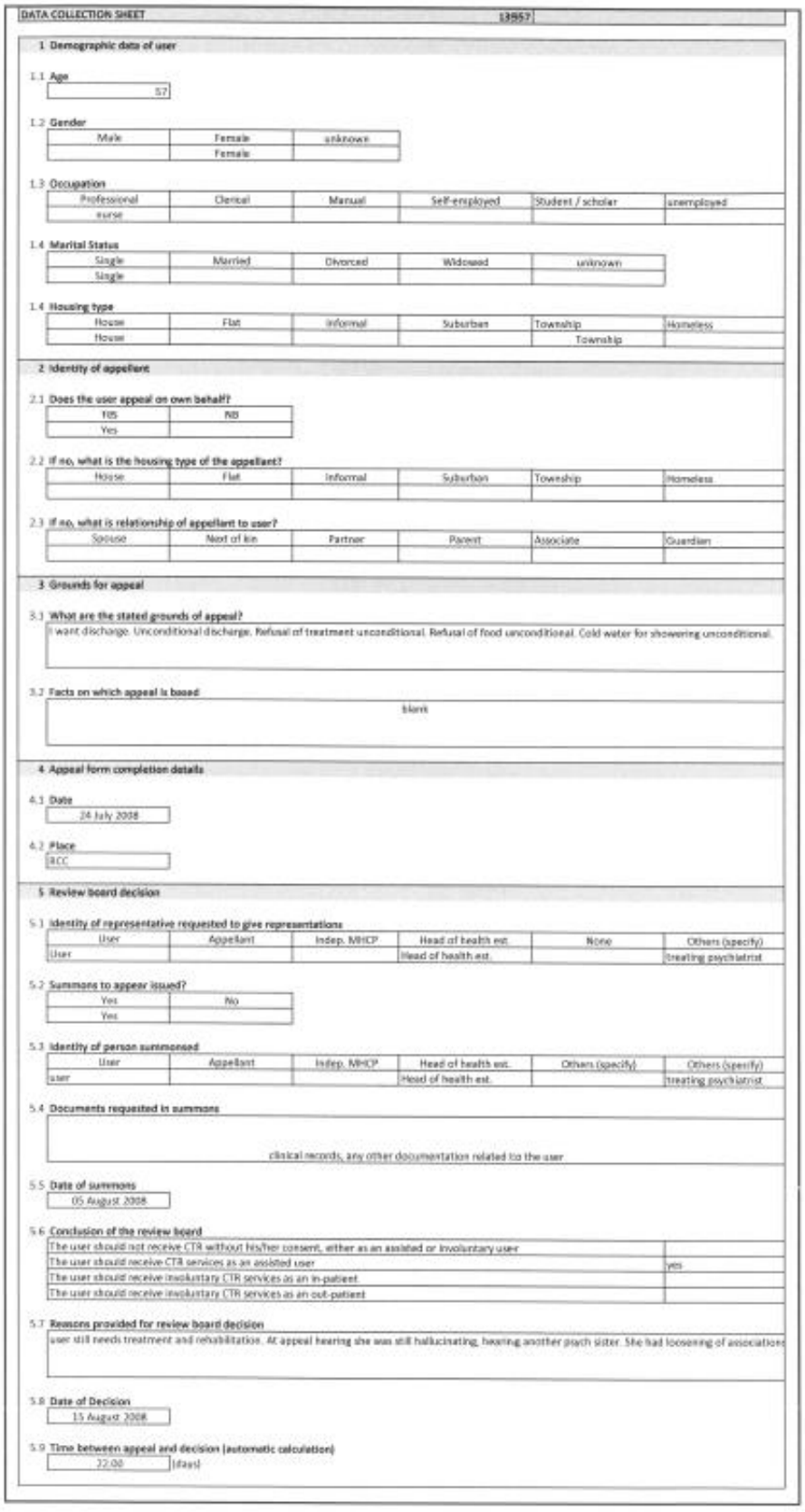
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APPENDIX 1



DATA COLLECTION SHEET 13957

1 Demographic data of user

1.1 Age
57

1.2 Gender

Male	Female	unknown
	Female	

1.3 Occupation

Professional	Clerical	Manual	Self-employed	Student / scholar	unemployed
nurse					

1.4 Marital Status

Single	Married	Divorced	Widowed	unknown
Single				

1.4 Housing type

House	Flat	Informal	Suburban	Township	Homeless
House				Township	

2 Identity of appellant

2.1 Does the user appeal on own behalf?

YES	NO
Yes	

2.2 If no, what is the housing type of the appellant?

House	Flat	Informal	Suburban	Township	Homeless

2.3 If no, what is relationship of appellant to user?

Spouse	Next of kin	Partner	Parent	Associate	Guardian

3 Grounds for appeal

3.1 What are the stated grounds of appeal?
I want discharge. Unconditional discharge. Refusal of treatment unconditional. Refusal of food unconditional. Cold water for showering unconditional.

3.2 Facts on which appeal is based
blank

4 Appeal form completion details

4.1 Date
24 July 2008

4.2 Place
ACC

5 Review board decision

5.1 Identity of representative requested to give representations

User	Appellant	Indep. MHCP	Head of health est.	None	Others (specify)
User			Head of health est.		treating psychiatrist

5.2 Summons to appear issued?

Yes	No
Yes	

5.3 Identity of person summonsed

User	Appellant	Indep. MHCP	Head of health est.	Others (specify)	Others (specify)
user			Head of health est.		treating psychiatrist

5.4 Documents requested in summons
clinical records, any other documentation related to the user

5.5 Date of summons
05 August 2008

5.6 Conclusion of the review board

The user should not receive CTR without his/her consent, either as an assisted or involuntary user	
The user should receive CTR services as an assisted user	yes
The user should receive involuntary CTR services as an in-patient	
The user should receive involuntary CTR services as an out-patient	

5.7 Reasons provided for review board decision
user still needs treatment and rehabilitation. At appeal hearing she was still hallucinating, hearing another psych sister. She had loosening of associations

5.8 Date of Decision
15 August 2008

5.9 Time between appeal and decision (automatic calculation)
22.00 (days)

APPENDIX 2

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Dr Joanna Taylor

CLEARANCE CERTIFICATE	**M110335**
PROJECT	An Audit of Appeals Against Involuntary and
Assisted	Admissions Under the Mental Health Care Act No 17 of 2002 in Region A, Gauteng Province ,South Africa
between	December 2004 and December 2010
INVESTIGATORS	Dr Joanna Taylor.
DEPARTMENT	Department of Psychiatry
DATE CONSIDERED	25/03/2011
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 25/03/2011 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Dr Mike E Smith

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

APPENDIX 3

Mental Health Care Act Forms

DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 04

DEPARTMENT OF HEALTH

APPLICATION FOR ASSISTED- OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Section 27(1) or 33(1) of the Act]

I hereby apply for assisted care or involuntary care for:

Surname of user .....

First name(s) of user .....

Date of birth ..... *or estimated age* .....

Gender: Male ☐ Female ☐

Occupation ..... Marital status: S M D W

Residential address: .....

.....

.....

.....

.....

Surname of applicant .....

First name(s) of applicant .....

Date of birth of applicant ..... (must be over 18 years of age)

Residential address: .....

.....

.....

.....

.....

Relationship between applicant and mental health care user: (mark with a cross)

Spouse ☐ Next of kin ☐ Partner ☐ Associate ☐

Guardian ☐ Health care provider ☐ Parent ☐

(If user is under 18 this application must be made by the parent or guardian)

MHCA 04

DEPARTMENT OF HEALTH

APPLICATION FOR ASSISTED- OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Section 27(1) or 33(1) of the Act]

I hereby apply for assisted care or involuntary care for:

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Occupation ..... Marital status: S M D W

Residential address: .....

.....

.....

.....

.....

Surname of applicant .....

First name(s) of applicant .....

Date of birth of applicant ..... (must be over 18 years of age)

Residential address: .....

.....

.....

.....

.....

Relationship between applicant and mental health care user: (mark with a cross)

Spouse ☐ Next of kin ☐ Partner ☐ Associate ☐

Guardian ☐ Health care provider ☐ Parent ☐

(If user is under 18 this application must be made by the parent or guardian)

I last saw the user on ....., ... at .....
(date) (time) (place)
(The applicant must have seen the user within seven days of making this application)

Where the applicant is the health care provider:
If the spouse, next of kin, partner, associate, parent or guardian is unwilling to make the application, state the reasons why: .....
.....
.....
.....
.....

If the spouse, next of kin, partner, associate, parent or guardian is incapable or not available to make the application, state the steps that have been taken to locate them:
.....
.....
.....
.....
.....

I, the undersigned, am of the opinion that the above-mentioned person is suffering from a mental illness / intellectual disability for the following reasons: .....
.....
.....
.....
.....
and believe that assisted- or involuntary care, treatment and rehabilitation is needed because
.....
.....
.....
.....
.....

In the case of an application for involuntary care:

I further give reasons which show that the person is so ill that he / she will not accept treatment as a voluntary mental health care user or cannot be admitted as an assisted mental health care user

.....

.....

.....

.....

.....

I also attach the following information in support of my application (if available)

- Medical certificates
- History of past mental illness / intellectual disability
- Other: .....

  .....

Print initials and surname.....

Signature: .....

(Applicant)

Date: .....

Place: .....

Note: Applicant must sign under oath

MHCA 05

DEPARTMENT OF HEALTH

EXAMINATION AND FINDINGS OF MENTAL HEALTH CARE PRACTITIONER FOLLOWING AN APPLICATION FOR ASSISTED- OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Sections 27(5) and 33(5) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Occupation ..... Marital status: S M D W

Residential address: .....

.....

.....

.....

.....

Date of examination: ..... Place of examination: .....

Category of designated mental health care practitioner: .....

Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health

.....

.....

.....

.....

(a) Are there signs of injuries? Yes ☐ No ☐

(b) Are there signs of communicable diseases? Yes ☐ No ☐

If the answer to (b) or (c) is Yes, give further particulars:

.....

.....

MHCA 05

DEPARTMENT OF HEALTH

EXAMINATION AND FINDINGS OF MENTAL HEALTH CARE PRACTITIONER FOLLOWING AN APPLICATION FOR ASSISTED- OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Sections 27(5) and 33(5) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ⊙ Female ○

Occupation ..... Marital status: ○S ○M ○D ⊙W

Residential address: .....

.....

.....

.....

.....

Date of examination: ..... Place of examination: .....

Category of designated mental health care practitioner: .....

Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health

.....

.....

.....

.....

(a)	Are there signs of injuries?	Yes	⊙	No	○
(b)	Are there signs of communicable diseases?	Yes	○	No	⊙

If the answer to (b) or (c) is Yes, give further particulars:

.....

.....

Information on user received from other person(s) or family (state names and contact details)

.....

.....

.....

Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places):

.....

.....

.....

Mental health status of the user at the time of the present examination:

.....

.....

.....

Type of illness (provisional diagnosis):

.....

.....

.....

In my opinion the above-mentioned user

Has homicidal tendencies	Yes ○	No ◉
Has suicidal tendencies	Yes ○	No ◉
Is dangerous	Yes ○	No ◉

Recommendation to head of health establishment – application for assisted care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes ○ No ◉

The user is suffering from a mental illness / severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for their own health and safety or the health and safety of others Yes ○ No ◉

If Yes, this should be on an inpatient or outpatient basis: Inpatient ○ Outpatient ◉

Give reasons:

.....

.....

Recommendation to head of health establishment – application for involuntary care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes ○ No ◉

The user is willing to receive care, treatment and rehabilitation services Yes ○ No ○

In my view, the user is likely to inflict serious harm on him / herself or others Yes ○ No ○

In my view, care, treatment and rehabilitation is necessary for the user's financial interests and reputation Yes ○ No ○

The user should receive involuntary care, treatment and rehabilitation Yes ○ No ○

If No, would you recommend that the user receive assisted care? Yes ○ No ○

I ..... (name of mental health care practitioner) hereby declare that I have personally assessed .... (name of mental health care user) at ....(name of health establishment) on ..... (date).

.....

Signature

Date: .....

Place: .....

G.P.-S. 004-9635

DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 06

DEPARTMENT OF HEALTH

72-HOUR ASSESSMENT AND FINDINGS OF MEDICAL PRACTITIONER OR MENTAL HEALTH CARE PRACTITIONER AFTER HEAD OF HEALTH ESTABLISHMENT HAS GRANTED APPLICATION FOR INVOLUNTARY CARE, TREATMENT AND REHABILITATION

[Section 34(1) of the Act]

Surname of user .....

First name(s) of user .....

Date of birth ..... or estimated age .....

Gender: Male ☐ Female ☐

Occupation ..... Marital status: S M D W

Residential address: .....

.....

.....

.....

.....

Date of beginning of 72-hour assessment: .....

Place of assessment: .....

Category of designated mental health care practitioner for example "nurse", "psychologist" or "medical practitioner": .....

Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health

.....

.....

.....

(a) Are there signs of injuries? Yes ☐ No ☐

(b) Are there signs of communicable diseases? Yes ☐ No ☐

If the answer to (b) or (c) is Yes, give further particulars:

.....

MHCA 07

DEPARTMENT OF HEALTH

NOTICE BY HEAD OF HEALTH ESTABLISHMENT ON WHETHER TO PROVIDE ASSISTED- OR INVOLUNTARY INPATIENT CARE, TREATMENT AND REHABILITATION
[Sections 27(9), 28(1) and 33(8) of the Act]

I ..... hereby consent / do not consent
(name of head of health establishment)
to the inpatient assisted care, treatment and rehabilitation / involuntary care, treatment and rehabilitation* of .....
(name of user)
The findings of two mental health care practitioners concur that the user –

(a) should / should not receive assisted care, treatment and rehabilitation services as an outpatient / inpatient; or

(b) must / must not receive involuntary care, treatment and rehabilitation services

I am satisfied / not satisfied, that the restrictions and instructions on the mental health care user's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

The reasons for consenting / not consenting are as follows:
.....
.....
.....

Print initials and surname.....

Signature: .....
(head of health establishment)
Date: .....
Place: .....

* Delete what is not applicable
[Copy to applicant, mental health care user and Review Board]