Involuntary treatment of psychiatric patients in South Africa

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Abstract
Society deems that mentally ill patients who lack insight and judgement may be treated involuntarily in institutions as a way of protecting them and the society around them. The ethical principle of 'paternalism' supersedes the principle of 'autonomy'. In South Africa, the new Mental Health Care Act (MHCA), No 17, 2002 has raised the issues and profile of mental health and serves as an advocate for mental health care users. In accordance with this MHCA, a mental health care user may be treated involuntarily at a health establishment on an inpatient basis under very specific regulations that serve to protect the users' rights as much as possible. However, the implementation of involuntary treatment whilst upholding users' rights within a health care service, which is plagued by human resource and infrastructure constraints, is extremely difficult and likely to infringe on these rights. The understanding of the regulations and principles governing involuntary treatment is important as it is a means of helping users' who despite needing it, refuse such treatment. If it is done sensitively, respectfully and conservatively, we can both protect the users' and societies' interests whilst at the same time are compliant with the principles of the MHCA.

Key words: Commitment of Mentally Ill; Treatment; South Africa

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Introduction

It is recognized internationally that the majority of mental health care users should be treated voluntarily. They have the right to choose treatment on the basis that they have insight (they recognize that they have an illness) and good judgment (they know that they can get help from psychiatric providers).[1] As with patients with general medical illness, they also have the right to refuse treatment if they are capable of making decisions for themselves and do not pose a danger to themselves or others. However, not all mentally ill patients share these characteristics of insight and good judgment. When such a person refuses treatment, it may cause significant distress and potential danger for the family, community and the patient. Historically, societies have determined that they may be treated involuntarily in institutions as a way of protecting them and the society around them.

Although the institution (jails, madhouses, asylums, psychopathic hospitals, etc.), and the specific sites have varied, this principle has held firm for centuries. Over time these principles have tended to be abused, and some of the processes have been criticized as merely a way of eliminating deviance and maintaining social order. Families and communities, however, have consistently supported this mechanism as a way of helping ill people and preserving public safety. Patients, on the other hand, understandably have had mixed feelings about involuntary treatment.

The current system of involuntary treatment has improved greatly on older systems, with a much greater respect for the civil liberties of patients. The ethical basis for involuntary treatment generally derives from two important principles: paternalism and autonomy. As with many ethical issues, this protection of society needs continually to be balanced by respect for an individual's rights.[2] This conflict between paternalism and autonomy runs through many medical issues. In the case of involuntary treatment of mentally ill patients, because of impaired capacity and in the best interest of the patient and/or society, paternalism tends to supersede autonomy. Another principle is that of ''least restrictive'' means i.e. any infringement on a patient's autonomy should involve the absolute minimum restriction necessary to achieve society's end. If a patient needs care but can be managed as an outpatient, then outpatient involuntary treatment would be less restrictive than an inpatient involuntary treatment.

The percentage of mental health care users who may require involuntary admission has been estimated to be around 10%-15%.[3] In some countries such as Portugal and Denmark less than 5% of all admissions are involuntary.[4] In South Africa the incidence is unknown.

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LEGISLATIVE FRAMEWORK RELATING TO INVOLUNTARY TREATMENT

Mental Health Care Act, No. 17, 2002

In South Africa, a new Mental Health Care Act (MHCA) was passed in 2002.[5] The Act has raised the issues and profiles of mental health and serves as an advocacy for mental health care users (MHCU). It has the following objectives:

a) to ensure that appropriate care, treatment and rehabilitation are provided at all levels of the health service;
b) to change from the custodial approach of the past to one that encourages care in the community;
c) to entrench specific rights of people with mental disabilities so that they are not discriminated against, stigmatized and/or abused.

The MHCA goes further to eliminate distinctions between health professionals; moving the responsibility for clinical decisions away from the judiciary to the clinicians; introducing a 72-hour assessment period (which can take place at a general hospital) prior to further involuntary treatment. The Act requires the establishment of Mental Health Review Boards (MHRB). This quasi-judicial MHRB plays an extremely important role in protecting the human and health rights of people with mental illness and intellectual disability.

In accordance with the MHCA, a mental health care user must be provided with care, treatment and rehabilitation (CTR) services without his or her consent (involuntarily) at a health establishment on an inpatient basis if at the time of making the application; there is reasonable belief that the mental health care user has a mental illness of such a nature:

a) that the user is likely to inflict serious harm to himself or herself or other;
b) for the protection of the financial interests or reputation of the user;
c) that the user is incapable of making an informed decision on the need for the CTR and is unwilling to receive the CTR required.

Regulations governing the Mental Health Care Act

According to the regulations No. 27117 of 2004 an application must be made to the head of a health establishment (HHE) by a spouse, next of kin, partner, associate, parent, or guardian i.e. someone who knows the user well and must have seen the user within the past seven days.[6] It can be a health provider if none of the above are available, able or willing to make application and application must state what efforts were made to contact one of the above.

If the HHE approves the application, he must instruct a medical practitioner and another mental health care practitioner (MHCP) to do independent assessments of the patient. They are to report back to him with their findings and recommendations. If involuntary CTR is recommended and approved by the HHE then within 48 hours the mental health care user must be admitted to a health establishment. The HHE must then request a medical practitioner and another mental health care practitioner to assess the physical and mental health status of the user for a period of 72 hours. The evaluation includes a multidisciplinary analysis of the users' medical, psychological, educational, social, financial and legal situation and records of any physical and pharmacological restraints.

Following the 72-hour assessment, the HHE must decide, on the basis of the MHCP reports, whether the mental health status of the mental health care user warrants further involuntary care, treatment and rehabilitation services on an inpatient basis. Alternatively the user can be discharged or converted to a voluntary or assisted inpatient or outpatient.

CONCERNS RELATED TO IMPLEMENTATION OF INVOLUNTARY TREATMENT

With the MHCA we have legislation that upholds MHCUs' rights. However, there are numerous difficulties in the implementation of involuntary treatment within a health care service that is plagued by human resource and infrastructure constraints. This is further complicated by a difference in interpretation by the different stakeholders.

Eligibility for Involuntary Care

Often patients with underlying medical illnesses present with psychiatric symptoms. The MHCA is explicit in that only if a user is suffering from a mental illness is the user eligible for involuntary treatment. "Mental illness" means a positive diagnosis in accordance with accepted psychiatric diagnostic criteria which must be made by a MHCP authorised to make such diagnosis.[5] This implies that any person presenting with psychiatric symptoms should first have a medical illness excluded (including emergency psychiatric and emergency substance abuse conditions). If following exclusion or stabilization of the medical illness, the patient is then diagnosed as having a mental illness and the conditions for involuntary treatment exist, then only should involuntary treatment be imposed on the user in accordance with the MHCA.

Predicting Dangerousness

Patients admitted involuntarily have higher incidences of "dangerous acts directed towards others" as compared to voluntary patients, although there are no significant differences when comparing the degree of harm.[7] The major problem with predicting dangerousness reflects the essential difference between law and medicine: lawyers demand certainty (guilty or innocent), while physicians accept probability (70% one-year survival). Dangerousness itself is a gray area, and lethality risk exists on a continuum. Society and the courts expect physicians to be able to predict with certainty as to which patients will be dangerous. However, physicians and mental health providers in general are relatively poor at making such predictions and with any degree of accuracy.[8]

Inquiries into a possible profile of those individuals that are likely to inflict bodily harm upon themselves or others reveal the following: history of dangerousness in the past year; disruptive and aggressive behavior during their previous hospital stays; residential and vocational instability, family disruption, and higher premorbid dysfunction.[9] Over two thirds of patients have a violent episode within the first 72 hours of admission to an acute psychiatric unit, suggesting that there is a relatively high degree of short term predictive validity.[10] Further, acutely psychotic patients who present some danger tend to be treated involuntarily compared to chronically ill patients, who despite volitional or cognitive defects and who refuse treatment, are perceived as not dangerous.

Staff competency

The essential task in a casualty setting is a relatively rapid evaluation and to delineate the factors which can be readily translated into a dispositional choice. Symptoms and not diagnosis tend to influence physicians judgments.[11] It is difficult for physicians to make a diagnosis of mental illness from a brief evaluation, let alone predict dangerousness. In South Africa these assessments are often done at district hospitals by general physicians who lack the skills and competency. This may result in inaccurate assessment of the need for involuntary treatment.

Bias of information

Current clinical assessment techniques are biased in their approach and may account for at least part of the inaccurate assessment of need for involuntary treatment. Most admissions are made on the basis of an unstructured clinical interview and historical information provided by the patient, families and/or social sector service staff. Thus, all three informational contexts represent sources of bias that color the admitting clinicians judgment.

Patients may have an active stake in the outcome of the psychiatric admission evaluation. If they desire hospitalization they will exaggerate and confabulate their type and degree of symptom severity. This is especially true of chronically mentally ill patients with multiple hospitalizations.[12] Patients who do not desire hospitalization often present more realistic symptom constellation and are probably less likely to confabulate their symptom type or severity. In fact, these patients may often attempt to mislead interviewers as to the true nature of their symptoms in an attempt to lead interviewers into believing they do not require treatment. Clinicians may overlook these patients who present with less dramatic, internally based symptoms and tend not to involuntarily treat as readily as those who manifest more extrinsic symptoms.

Finally, the families and social service sector staff who escort patients to emergency rooms may also be introducing a bias into the system.[13] These escorts independently determine the need for inpatient hospitalization and are likely to be strong advocates for involuntary treatment.

Resource Constraints

In South Africa, psychiatric hospitals are utilized to determine whether a user necessitates involuntary treatment. Because of a limited number of specialized psychiatric hospitals, even district and regional hospitals are pressured into admitting these involuntary patients and conducting 72 hour assessments. The facilities in most of these hospitals are not designed for the provision of such care. Patients of different age groups are not separated and locked and unlocked sections are not always available. In addition, de-institutionalization of psychiatric patients and the lack of beds at private institutions places extra burden on the limited resources of our health establishments.

A detailed position statement is required to enumerate what resources and services are needed to provide the same high-quality care for involuntary as for voluntary patients.[14] The treatment of involuntary patients should be considered "psychiatric intensive care," with attention given to the needs for special staffing, training, ancillary services, and funding. It is also imperative that district and general hospital's willingness to accept involuntary patients should be contingent on their being able to control such admissions and not being the provider of last resort.

72 hour assessment

The act provides 72 hours for an assessment to take place before further involuntary care can take place.[4] It is during these first 72 hours that the patients are most aggressive and require some form of restraint imposed on them. The 72 hour period is the maximum that a person can be admitted on an involuntary basis for the purpose of psychiatric examination. Once a person has an involuntary examination and the 72-hour period expires, they cannot undergo a further consecutive 72 hour assessment. This also raises the issues of infrastructure and resource constraints at most of the designated institutions that conduct 72 hour assessments and the ethical and moral issues of enforcing this assessment, which is integrally tied with further infringement of patients' rights, at said facilities.

Advocacy

Forcible detention in a hospital can be a distressing, difficult, and an embarrassing process. Patients who are treated involuntarily generally protest and seek to be discharged as rapidly as possible. It is a frightening experience even when a patient can see the benefits later.[15] This coercion and the loss of autonomy often result in patients being unwilling to accept the follow-up treatment and services that may prevent their relapse and rehospitalization.[16,17] This impact of coercion may be mitigated if patients feel "respectfully included in a fair decision-making process" and their autonomy is respected as far as possible.[18-22] Patient advocacy also reduces the antagonism between staff members and patients.17,23 It is justified on the grounds of ethics, justice, and rights and may improve compliance with aftercare and reduce hospital use.[24]

Conclusion

Generating and maintaining a cooperative clinical relationship between care giver and patient can be difficult for mental health service providers in this country. They may have to override patients' objections and advocate involuntary treatment in facilities that are often not conducive to proper care and not in the least restrictive environment. It is questionable as to whether this involuntary treatment is preserving patients' sense of autonomy and is good patient advocacy.

The understanding of the regulations and principles governing involuntary treatment is important for physicians wherever they practice. It is a means of helping users', who despite needing it refuse such treatment. When it is done sensitively, respectfully and conservatively, we can both protect the users' and societies' interests whilst at the same time comply with the principles of the MHCA. It is also important for all stakeholders to ensure that the correct conditions exist at the facilities that conduct involuntary treatment.

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