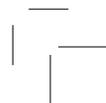


# **POLICY GUIDELINES ON 72-HOUR ASSESSMENT OF INVOLUNTARY MENTAL HEALTH CARE USERS**



**health**

Department:  
Health  
REPUBLIC OF SOUTH AFRICA



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### Foreword by Director-General

In line with the Bill of Rights contained in our Constitution regarding human rights, the Mental Health Care Act No. 17 of 2002 provides specific procedural protection for a person that is involuntarily committed to care, treatment and rehabilitation to prevent discrimination, violation of their rights and inappropriate restrictions on autonomy and liberty.

Involuntary or compulsory admission to mental health facilities and involuntary treatment impinge on personal liberty and the right to choose. For a minority of mental health care users involuntary admission and treatment can prevent harm to self and others and afford users the right to health care which due to their mental condition they are unable to manage voluntarily.

These Policy Guidelines are issued in line with section 21 of the National Health Act which prescribes that the Director-General must issue guidelines for the implementation of national health policy. The Policy Guidelines are aimed at providing guidance to Heads of Health and health care providers on the requirements for listing of facilities to conduct 72-hour assessments, the procedures to be followed when conducting 72-hour assessments on involuntary mental health care users and clinical management guidelines relevant to the 72-hour assessment procedure.

As with all other health interventions, 72-hour assessment must be conducted in a safe and secure ward. Due process regarding the application, assessment and approval for involuntary care, treatment and rehabilitation must be observed. Users that cannot give consent and are posing a danger to self and others require special attention and clinical management to ensure that they are not harmed or harm others. In this regard frequent observations and assessment should be conducted to determine the impact of the intervention.

I am confident that these Policy Guidelines will provide guidance to Heads of Health with regards to selecting and listing of health facilities as well as heads of health establishments and health practitioners in implementing the 72-hour assessment procedure.

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**MS MP MATSOSO**  
**DIRECTOR-GENERAL: HEALTH**  
**DATE: 21.03.12**

## 1. Introduction

Most people with mental disorders have the ability to make informed choices and decisions regarding matters affecting their lives. However, in those with severe mental disorders, this ability might be impaired.

The Mental Health Care Act No 17 of 2002 makes provisions that allow that for those with such impairments, others to act in their best interest and make decisions on their affairs. In this regard legislation provides for involuntary or compulsory admission to mental health facilities and involuntary treatment.

Involuntary admission to mental health facilities and involuntary treatment are highly controversial as they impinge on personal liberty and the right to choose. It also carries the risk of abuse. On one hand, it may be necessary to infringe on personal liberty and the right to choose by providing treatment and admission to prevent harm to self and others.

In line with international agreements, obligations and the Bill of Rights contained in our Constitution regarding human rights, the Mental Health Care Act No. 17 of 2002 provides specific procedural protection for a person that is involuntarily committed to care, treatment and rehabilitation to prevent discrimination, violation of their rights and inappropriate restrictions on autonomy and liberty.

In order for an involuntary admission and treatment to be legal specific criteria must be met which include, an application that may only be made by certain parties, examination by two mental health practitioners, one of which must be qualified to conduct a physical assessment, approval of the application by the head of the health establishment, admission for further assessment, care, treatment and rehabilitation for a period of 72-hours.

The Act provides procedures for the review of the decision for involuntary care, treatment and rehabilitation review by the head of the health establishment on expiry of the 72-hour assessment period as well as consideration by the Mental Health Review Board and by the High Court.

Wherever possible, like all other admissions to hospital, the 72-hour assessment must be done as near as possible to patients' homes. This requires that some of the general hospitals be developed to conduct 72-hour assessment of involuntary patients. This requires that the hospitals that have been listed for this purpose must provide a certain level of security, to accommodate such patients who may at times be difficult to care for.

## 2. Purpose

- 2.1. To guide provincial heads of health on the requirements for listing of facilities to conduct 72-hour assessments.
- 2.2. To provide procedures to be followed when conducting 72-hour assessments on involuntary mental health care users.
- 2.3. To provide clinical management guidelines on the assessment and treatment of mental health care users during 72-hour assessments.

## 3. Legislative framework

- 3.1. Constitution of the Republic of South Africa, 1996 (Act No 106 of 1996)
- 3.2. National Health Act, 2003 (Act No 61 of 2003)
- 3.3. Mental Health Care Act and its Regulations, (Act No. 17 of 2002)

## 4. Guiding principles

These guidelines are based on the following principles:

- 4.1. Any determination concerning the mental status of any person must be based on factors exclusively relevant to that person's mental status, and not on socio-political or economic status, cultural or religious background or affinity.
- 4.2. A determination concerning the mental status of a user may only be made or referred to for purposes directly relevant to the mental status of that user.
- 4.3. Every mental health care user must receive care, treatment and rehabilitation services according to standards equivalent to those applicable to any other health care user that improves his/her wellbeing and capacity.
- 4.4. Every person or health establishment providing care, treatment and rehabilitation services to a mental health care user must take steps to ensure that the user is protected from exploitation, abuse and any other degrading care, treatment and rehabilitation. Services must not be used as punishment or for the convenience of other people. Any abuse to the mental health care user must be reported accordingly.
- 4.5. The person, human dignity and privacy of every mental health care user must be respected.
- 4.6. The care, treatment and rehabilitation services administered to a mental health care user must be proportionate to his/her mental status and should intrude as

little as possible to give effect to the appropriate care, treatment and rehabilitation services.

- 4.7. Any person or health establishment that provides care, treatment and rehabilitation services to a mental health care user or admits the user without his/her consent must follow the procedures as prescribed in the Mental Health Care Act.
- 4.8. Applicable referral systems in the province must be considered when conducting 72-hour assessments.

### **5. Listing of facilities to conduct 72-hour assessment in terms of the Mental Health Care Act No 17 of 2002**

- 5.1. The listing of facilities to conduct 72-hour assessment must be done in line with the provincial plan for rendering health services.
- 5.2. Access and equity to mental health services must be assessed. It must be taken into consideration that mental health care users should be treated nearer to their homes as far as possible.
- 5.3. A minority of involuntary mental health care users may pose a danger to self, others and property, and in this regard facilities must have the required level of security to ensure the safety of users and staff.
- 5.4. Staff allocated in facilities that conduct 72-hour assessment must have the skill to assess and to diagnose mental disorders as well as to exclude underlying physical conditions which may have caused the clinical manifestation.
- 5.5. Section 12 of the Regulations to the Mental Health Care Act No 17 of 2002 prescribes that the head of provincial department must submit to all health establishments under the auspices of the State, private health establishments within the province, concerned, to the South African Police Service and the national department a list of the health establishments in each district in that province that provide the 72-hour assessments contemplated in section 34 of the Act.
- 5.6. The head of such provincial department must update the list on an annual basis indicating which health establishment falls in which district and submit that updated list to the bodies referred to in sub-regulation (1) of the Regulations to the Act.

## **6. Clinical management**

### **6.1. Clinical assessment**

- 6.1.1. Following an application for involuntary treatment and rehabilitation an examination and findings of a mental health care practitioner must be recorded in MHCA 05.
- 6.1.2. The application process involves an assessment by two mental health care practitioners; at least one must be qualified to conduct physical examinations as prescribed in section 34 of the Mental Health Care No 17 of 2002.
- 6.1.3. Following approval of the application for involuntary care, treatment and rehabilitation by the head of the health establishment a 72-hour assessment and findings of a medical practitioner or mental health care practitioner must be recorded in MHCA 06.

### **6.2. Risk assessment**

Assessment of risk should be carefully conducted in all mental health care users presenting with acute psychiatric disorders. The presence of an acute psychiatric disorder characterised by violence towards others should be carefully evaluated for risk of self-harm. The opposite is also true, for instance, users' suicidal ideation may frequently be accompanied by risk of homicide. Past behaviours are also very relevant when trying to predict risk. It is therefore crucial to obtain collateral information from family members, previous clinical records and referring health professionals wherever possible.

### **6.3. Risk in the absence of a psychiatric diagnosis**

Patients that pose a threat towards others in the absence of a DSM IV Axis I disorder should be referred to law enforcement authorities and should not be treated in a medical or health establishment that renders mental health services.

### **6.4. Disorders with psychotic features**

Mental health care users with psychotic disorders are at high risk of suicide or harming others if:

- 6.4.1. Command hallucinations instruct them to do so.
- 6.4.2. Psychotic symptoms are accompanied by prominent depressive features.

6.4.3. Persecutory delusions (sometimes accompanied by visual or olfactory hallucinations) are present and the patient fear for their lives

6.4.4. Delusions of being controlled by an outside force exist.

Proper sedation is often required if a patient is unable to engage the help available to address their problem or if the patient's anxiety levels remain high.

### **6.5. Special considerations when evaluating risk of suicide in depressed patients.**

6.5.1. Plan/type of plan: the risk is increased if a mental health care user has planned the method of suicide and the risk is generally higher the more violent the method.

6.5.2. Poor social support increases the risk while good social support is a protective factor.

6.5.3. Ask about homicidal ideation and distinguish between vague and specific threats that has a clear plan and intent to harm identified individuals.

6.5.4. The presence of an intense desire to die or to "take family members along" indicates a high risk.

6.5.5. Presence of psychotic features increases the risk.

6.5.6. The absence of a reason to keep on living increases the risk. Ask the mental health care user about possible reasons to keep on living (children, family, religion etc.).

6.5.7. Concomitant substance abuse increases the risk and makes the mental health care user's behaviour less predictable, especially while still under the influence.

6.5.8. Age: Elderly patients and children/adolescents are vulnerable to committing suicide but are often not considered high risk groups. Suicide is the second leading cause of death in adolescents, thus the need to assess risk.

6.5.9. Gender: men have fewer suicide attempts but their attempts result in death more often than women

6.5.10. Family history of suicide: a family history or suicide of a close friend or role model (copying) may increase the risk.

Frequency of follow-up visits needs to be individualized according to suicide risk and can vary between once a day to two-weekly during the first month of treatment or until a therapeutic response with antidepressants has been obtained. The suicide risk should constantly be re-evaluated until the Major Depressive Disorder is in full remission.

## **6.6 Disorders associated with decreased impulse control**

Mental state changes associated with a reduction in impulse control, such as mania, delirium, acute intoxication, dementia, mental retardation or brain injured patients should be regarded as additional risk factors.

## **6.7. Treatment**

6.7.1. Appropriate clinical intervention and treatment must be commenced as soon as possible in line with treatment protocols and treatment guidelines in consultation with psychiatry specialist where possible.

6.7.2. If the mental health care user does not warrant involuntary care, treatment and rehabilitation the user must be discharged. However, if the user warrants outpatient involuntary mental health care the user must be discharged subject to the conditions as prescribed in section 18 of the Regulations to the Act. If the mental health care user warrants further involuntary care, treatment and rehabilitation services as an inpatient the user is transferred to a designated psychiatric hospital for further involuntary care, treatment and rehabilitation services on an inpatient basis.

6.7.3. The quality of nursing care is important as mental health care users tend to attempt suicide even when hospitalized. Admission as such does not prevent a patient from committing suicide.

6.7.4. Short-term proper sedation is indicated in high-risk patients, even when hospitalized.

6.7.5. The mental health care user must be closely monitored for suicide.

6.7.6. Patients with substance abuse should be referred for detoxification.

## **6.8. Safety of other patients, staff and self**

6.8.1. The treating mental health care practitioner must ensure that health practitioners

and other patients are always safe when managing a violent patient. A rapid escape route must always be available. Security personnel or help must be available and patients should be disarmed before being evaluated. Staff must not confront a violent patient alone.

6.8.2. The South African Police Service must provide assistance if a person due to his or her mental illness, severe or profound intellectual disability is likely to inflict serious harm to himself or herself, others or property.

## 7. Procedures to be followed when conducting 72-hour assessments

Involuntary Mental Health Care User (section 33 - 34)		
<b>Admission</b>	<p>Written application by spouse, next of kin, partner, associate, parent or guardian – if possible or HCP) MHCA 04</p> <p style="text-align: center;">↓</p> <p>(Two MHCPs examine user, submit findings to HHE X2 MHCA 05)M</p> <p style="text-align: center;">↓</p> <p>HHE decides (inpatient or outpatient care) and gives notice to applicant. MHCA 07</p> <p style="text-align: center;">↓</p> <p>Admission and continue with 72-hours assessment:</p> <p style="text-align: center;">↓</p> <p>Within 24-hours after expiry of 72- hours assessment MHCPs record the findings and outcome of 72- hours assessment MHCA 06</p> <p style="text-align: center;"><b>OR</b></p> <p>Warrants care on inpatient basis. Transfer to psychiatric hospital (which may be sections of general hospital designated as such) for further inpatient involuntary care. MHCA 06 Transfer MHCA 11</p> <p style="text-align: center;">↓</p> <p>In seven days HHE (72-hour assessment facility) must request MHRB to approve further involuntary admission.</p> <p style="text-align: center;">↓</p> <p>Notice given to applicant regarding decision and request to MHRB. 08</p>	<p>Applicant must have seen MH user within seven days of making the application</p> <p>If applicant is HCP reasons why application made by him/her, steps taken to locate user's relatives to be stated.</p> <p>The MHCP must not be the person making the application. One MHCP must be qualified to do a physical examination.</p> <p>Application not approved HHE informs applicant</p> <p>Discharge if no further care, treatment, rehabilitation is warranted MHCA 06</p> <p>Further involuntary admissions in psychiatric hospitals only.</p>

<b>Involuntary Mental Health Care User (section 33 - 34)</b>	
<p>MHRB must consider request within 30 days, notify applicant and HHE of decision and inform High Court if continued involuntary admission is necessary. MHCA 14</p> <p style="text-align: center;">↓</p> <p>MHRB must consider appeals in 30 days MHCA 15</p> <p style="text-align: center;">↓</p> <p>HHE on recommendation of treating MHCPs can convert user to voluntary assisted care or discharge user at any stage during admission.</p> <p style="text-align: center;"><b>OR</b></p> <p>Can discharge user as voluntary or involuntary outpatient .MHCA 12</p> <p style="text-align: center;">↓</p> <p>HHE may request transfer to maximum security facility if previously absconded or attempt to abscond</p> <p style="text-align: center;"><b>OR</b></p> <p>Inflict harm or risk of harm to others in HE. MHCA 19</p> <p style="text-align: center;">↓</p> <p>In case of emergency, can transfer with concurrence of HHE (max security), pending decision of MHRB MHCA 19</p>	<p>If appeal is upheld, user must be discharge MHCA 14</p> <p>Involuntary outpatient: schedule of conditions. MHCA 06 and MHCA 10</p>

## 8. Infrastructural requirements for facilities that conduct 72-hour assessments

- 8.1. The provision of 72-hour assessment services must be planned and organised according to the available resources and other appropriate factors in the province.
- 8.2. The building/s shall comply with all conditions and requirements prescribed by the applicable local authority, provincial and/or national departments and shall be issued with a Certificate of Compliance in terms of the National Building Standards Act.
- 8.3. The use of fittings and finishes in functional spaces must exclude elements of finish/texture that can pose as items of physical danger to inhabitants/staff, crafting of weapons and possibility for suicide.
- 8.4. All the building and structural requirements prescribed in the general health legislation should apply in facilities that conduct 72-hour assessments.
- 8.5. The design must avoid any item or furniture that can be used as a weapon.

- 8.6. The layout and design must allow for easy supervision and observation of users by staff at all times.
- 8.7. The layout and design must prevent areas of concealment for purposes of hiding or launching surprise attacks on others or staff.
- 8.8. The position of the nursing station should provide for secure and effective surveillance of all activities in the ward.
- 8.9. The layout and design should provide enough space to walk freely inside the ward.
- 8.10. The layout, design and finishes must allow for easy maintenance of the facility without hampering the orderly management of the ward and its users.
- 8.11. There must be a maintenance plan.
- 8.12. There must be provision for accommodation that does not facilitate unwanted sexual and physical contact between users.
- 8.13. Provision must be made for separate sections for males and females.
- 8.14. Adults must not be mixed with adolescents.
- 8.15. When appropriate and possible, users must have the opportunity to communicate privately with other users, their families and friends unless contraindicated on safety or clinical grounds.
- 8.16. Provision must be made for privacy and respect with regard to bathing, dressing and toilet needs, even in communal spaces.
- 8.17. There must be a secure, private space to keep personal possessions.
- 8.18. The rooms must be well ventilated with an adequate temperature control system.
- 8.19. The entrance to each room must be security controlled from the nursing station.
- 8.20. Consistent with the mental health care users' safety, all rooms must be monitored with Closed Circuit Television (CCTV).

- 8.21. Panic buttons should be installed in each room to summon additional staff and help from elsewhere in the facility
- 8.22. The windows and doors to the single rooms must be burglar proofed.
- 8.23. Doors of the single rooms must be solid core, reinforced and must lock from outside.
- 8.24. Safe and secured treatment rooms must be available for medical procedures and other neurological/or physical assessments.
- 8.25. Main entrance to the unit/ward must be security controlled.
- 8.26. The door at the main entrance must be solid core, reinforced and lock from outside.
- 8.27. The observation room door must allow for adequate observation by staff.
- 8.28. The seclusion room or maximum-security room where applicable must be situated close to the nursing station to allow for constant supervision by staff.
- 8.29. Mental health care users in the rooms must not be able to lock themselves from inside the rooms or inside cupboards.
- 8.30. All cupboards and wardrobes in rooms if any must be fixed to the walls.
- 8.31. The beds in the rooms must be immovable.
- 8.32. Fire and water-resistant mattresses should be used.
- 8.33. Windows should not be glazed with breakable glass and must prevent escape of users.
- 8.34. Windows and open spaces must be so constructed as to prevent suicide attempts.
- 8.35. Floors must be slip-resistant when wet.
- 8.36. Mirrors, if any, must be made of safety glass and be mounted to the wall.

- 8.37. There must be fire detection systems in the facility.
- 8.38. Electrical fittings should be recessed / concealed and be tamper-proof from within the rooms.
- 8.39. Light switches and heating systems must be centrally controlled.
- 8.40. The materials, finishes and workmanship used for toilets and hand basins must be as durable and unbreakable as is reasonably possible.
- 8.41. Toilets, bathrooms and showers should provide for individual privacy and safety.
- 8.42. The ceiling must be out of reach of mental health care users.
- 8.43. Hot water supply should be thermostatically controlled to prevent injury to users and staff.
- 8.44. The temperature of hot water should be designed and maintained to deliver a maximum temperature of 45°C at any point of use.
- 8.45. All fittings or furniture must avoid sharp corners or edges, which could pose a risk of injury to users.
- 8.46. All areas must be able to be kept clean and homely.
- 8.47. A rest room must be provided for staff on duty, which must be located within the nursing unit.
- 8.48. Toilet facilities must be provided for staff on duty.
- 8.49. Facilities must take cognizance of infection control policies applicable to health care.

## 9. Scenarios where 72-hour assessments can be conducted

The table below outlines the different scenarios where 72-hour assessments can be conducted:

### SCENARIO 1

DESCRIPTION	ADVANTAGES	DISADVANTAGES
1. An observation room in a medical ward of a hospital listed to conduct 72-hour assessments.	<ul style="list-style-type: none"> <li>The patient will be admitted and handled as an inpatient facilitating the 72-hour assessment.</li> <li>The same staff in the medical ward will be observing the patient.</li> <li>There will be a continuous supply of professional nurses and medical officers.</li> <li>72-hours for observation can be continuous for proper evaluation by the medical staff.</li> <li>The patient will be admitted nearer to his/her family.</li> <li>This room can be used for multipurpose.</li> <li>Promotes integration of mental health into primary health care.</li> <li>Minimises stigma attached to mental illness.</li> <li>Improves skills and knowledge to all health workers on mental health.</li> <li>All investigations required will be catered for.</li> </ul>	<ul style="list-style-type: none"> <li>(a) The mental health care user might be noisy at times and disturb physically ill patients.</li> <li>(b) The mental health care user may need extra security in the ward for assistance.</li> <li>(c) The mental health care user may be neglected and mismanaged due to negative staff attitudes and lack of capacity.</li> <li>(d) There may be serious adverse events due to the lack of supervision and poor risk management.</li> </ul>

### SCENARIO 2

DESCRIPTION	ADVANTAGES	DISADVANTAGES
<ul style="list-style-type: none"> <li>A health establishment that is designated to serve as a psychiatric hospital <b>OR</b></li> <li>A ward that is part of a health establishment (general hospital) that is designated to serve as a psychiatric hospital.</li> </ul>	<ul style="list-style-type: none"> <li>The patient when diagnosed with a mental health problem can stay and be treated by the specialized staff in the health establishment.</li> <li>There will be dedicated mental health practitioners.</li> <li>Conducting 72-hour assessment in health establishments (general hospitals) that have a ward designated as a psychiatric hospital promotes family involvement and participation.</li> </ul>	None





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