INVOLUNTARY HOSPITALISATION

THE DISCREPANCY BETWEEN ACTUAL PRACTICE AND LEGAL REQUIREMENTS IN THE LENTEGEUR HOSPITAL (CAPE TOWN) CATCHMENT AREA

by

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ABSTRACT

The aim of this study was to document the safeguards inherent in the Mental Health Act (MHA) of 1973, and to examine the extent to which these are observed in practice.

The research was conducted at Lentegeur Hospital in Mitchells Plain, Cape Town. The population consisted of 726 certified patients who were admitted involuntarily (i.e. under Sections 9 and 12 of the MHA) from 01 January 1990 to 31 December 1990.

Data for each of these patients was collected from the admission register, clinical files, administrative files, and the certified post book. In addition, the official hospital statistics were examined. Measurements obtained included demographic data, the validity of the document contents, the validity of the certification process, and an overall measure of the validity of each of the certifications taking into account both document contents and observance of the time strictures set out in the MHA.

Twenty nine patients (4,0%) were admitted by Urgency (Section 12), and 697 (96,0%) on Reception Order (Section 9). The study focused mainly on the Section 9

patients, because of the small sample size for Urgency admissions. It was found that 609 (87,4%) of the 697 admissions were legally flawed in terms of document contents criteria and the time limits in the certification process.

Document content criteria were not fulfilled in: 3,0% of the Applications for Reception Order; 32,1% of Medical Certificates; 20,1% of Reception Orders; and 3,6% of Reports to the Attorney-General. In 40,0% of certifications the Report to the Attorney-General (G2/28) could not be traced.

Examination of temporal safeguards revealed that the least satisfactory aspect was the delay in the completion of the post-admission Report to the Attorney-General. It was found that 32,3% of these Reports were not submitted on time.

Reasons for the discrepancy ("gap") between legal standards and actual practice are discussed. Recommendations are made which could help minimise or eradicate this "gap". These include suggestions for changes in the document format, for the use of a certification booklet, for stricter control of late and inadequate documentation, and for inservice training of all those involved in the certification process.

PREFACE

This study represents original work by the author and has not been submitted in any form to another University. Where use was made of the work of others it has been duly acknowledged in the text.

The research described in this dissertation was carried out at Lentegeur Hospital, Cape Town, under the supervision of Dr. H. Olivier (Lentegeur Hospital) and Dr M. Nair (King Edward VIII Hospital, Durban).

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"To live is to battle with trolls
in the vaults of the heart and brain.
To write: that is to sit
in judgement over one's self."

Ibsen.

This quote from an Ibsen poem is very pertinent to the writing of this dissertation. Many hours were spent trying to write down my thoughts on this subject of involuntary hospitalisation. Often, the result of these efforts was a blank sheet of paper and a deeper sense of despondency. Obsessive deliberation was prominent, and very intrusive: "Is this study going to make any difference ?". However with encouragement and gentle prodding (and, sometimes, outright threats!) it has been completed. For this, I would like to thank all those who stood by me.

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BACKGROUND INFORMATION

The aim of the following is to provide some background information concerning the hospital where this study was undertaken, namely Lentegeur Hospital (LH). This includes information on geographical location, bedstate, population served, catchment area and community psychiatric clinics.

THE HOSPITAL

LH is a 1555-bed specialist psychiatric hospital in Mitchells Plain, Cape Town. It is a "teaching-equivalent" hospital for the University of Cape Town, Stellenbosch University and the University of the Western Cape. (This means that it is not officially a teaching hospital, but that training undertaken here is recognised as official accredited time by the statutory bodies of the different professional disciplines.)

The hospital has two sections, one for psychiatric patients and the other for mentally handicapped patients. The psychiatric side consists of 659 beds, of which 230 are reserved for acute psychiatric admissions (voluntary, consent or certified patients).

The remaining 429 beds are utilised as follows:

Adolescent Unit	(19 beds)
Drug Rehabilitation Unit	(30 beds)
Geriatric Assessment Unit	(30 beds)
Long-term Care	(180 beds)
Medium-term Rehabilitation Units	(40 beds)
Physical Clinic and Frail Care	(40 beds)
Specialised Psychotherapy Units	(90 beds)

The 230 "acute beds" are divided amongst seven general admission wards of 30 beds each, and two closed wards of 10 beds each. The certified patients involved in this study were admitted to these acute beds, depending on their district of abode. The closed wards are used for temporary admission of severely disturbed individuals who are considered to be a danger to themselves or to others, and in need of stabilisation.

There is also an outpatient department, and the hospital provides a community psychiatric service.

GEOGRAPHICAL AREA AND POPULATION SERVED

LH is one of the nine psychiatric hospitals that serves the Cape Province. The others are Valkenberg (Cape Town), Stikland (Bellville), Tower (Fort Beaufort), Elizabeth Donkin (Port Elizabeth), Fort England (Grahamstown), Komani (East London), West End (Kimberley) and Oranje (Bloemfontein, in the Orange Free State).

The Cape Province is divided into 110 magisterial districts (Central Statistical Services 1991a). Lentegeur Hospital admits patients from approximately 60 of the 110 magisterial districts (Appendix C). Although the hospital policy is to accept patients from all over the RSA, patients from other magisterial districts tend to be admitted to hospitals that are in closer proximity e.g. the Eastern Cape is served by the Komani, Tower, Elizabeth Donkin and Fort England hospitals. During 1990, the period under study, LH received certified admissions from 43 of these 60 magisterial districts.

However, until 1992 admission to LH (and most of the hospitals mentioned above) did not depend only on magisterial district of abode. Due to political and historical reasons, hospital psychiatric services in the RSA tended to be racially segregated. Thus, for example, in the Cape Town region, "White" patients tended to be admitted to Valkenberg Hospital or Stikland Hospital, and "Black" patients to Valkenberg Hospital. However, both Valkenberg and Stikland hospitals also admit "Coloured" patients, mainly from the areas immediately surrounding the hospital. Patients from Maitland (a suburb contiguous with Valkenberg Hospital), regardless of their racial group, would in most instances, have been be admitted to Valkenberg Hospital. However, there were no fixed guidelines for admission to a particular hospital based on place of residence, and it often occurred that "Coloured" patients from Maitland and other suburbs close to either Valkenberg or Stikland hospitals were admitted to LH.

It will be seen therefore, that although the policy at LH is to accept patients from all population groups in practice it has primarily served the "Coloured" population.

During the study period, 3804 (98,3%) of the total number of admissions to the hospital (3910) were "Coloured". The "Coloured" population of this catchment area (Western, North-Western, Northern, Central, Southern and South-Western Cape Province) is approximately 1,8 million (Central Statistical Services 1991b).

Thus, to a certain extent, the geographical location and the population served by the hospital can be seen to be interdependent. The blurring of the boundaries between the three hospitals in the greater Cape Town area may be regarded as the first tentative steps towards desegregation and rationalisation of services.

Hopefully, with the emergence of the "new South Africa" these artificial racial groupings will be abandoned. Service delivery will then depend on the proximity of services only, and will not be further complicated by racial groupings.

COMMUNITY PSYCHIATRIC CLINICS

Community psychiatric clinics at 129 points in the Cape Province, mainly in the 60 magisterial districts mentioned above, form an integral part of the service provided by LH, and stretch as far afield as Namaqualand, which is over 800 kilometres from the hospital.

Thus, patients who would normally be deprived of treatment due to lack of economic resources are able to receive ongoing treatment as near to their homes as possible.

During the period 01/11/89 to 30/10/90 a total of 236 new patients were seen at these clinics, and 66159 follow-up visits were made by patients to these clinics. In addition, community psychiatric clinic staff (mainly professional nurses) made 81 home visits to see new referrals and saw 3577 follow-up patients on home visits.

Chapter 1

INTRODUCTION

Over the past few decades, involuntary hospitalisation of the mentally ill has stimulated much discussion, the emphasis of which has varied from time to time.

Initially there was a period of fierce debate challenging the very concept of mental illness (Szasz 1961, Szasz 1963) and the ethics of the involuntary hospitalisation of those labelled as "mentally ill" (Szasz 1963, Szasz 1973), followed by counter-arguments and rebuttals (Treffert 1973, Chodoff 1976). It became apparent that a period of serious introspection was necessary, wherein mental health professionals had to examine their role in society, their allegiances, their expertise, their diagnostic systems, their concepts of mental illness and their management and treatment of the mentally ill (Szasz 1961, Szasz 1963, Laing 1967, Goffman 1968, Szasz 1973).

One of the aspects of management that required detailed scrutiny was the whole concept of involuntary hospitalisation. People who had been subject to this procedure began challenging the legal process and the individuals involved in the process, sometimes successfully (Schwitzgebel and Schwitzgebel 1980). This spurred on mental health legislation reforms, particularly in the USA. Model acts for commitment

were proposed (e.g. American Psychiatric Association's Model Law, the Stone-Roth Model and, the National Centre for State Courts' Guidelines for Involuntary Civil Commitment) and then enthusiastically supported or challenged (Appelbaum 1984, Appelbaum 1985, Rubenstein 1985, Zusman 1985, Appelbaum and Roth 1988). More recently, the emphasis has been to examine the effects of the reforms and to check how efficiently the law is translated into practice (Turkheimer & Parry 1992). The overall picture is that the "pendulum" (Appelbaum 1982) of opinion is swinging to a point which satisfies both legal ("civil libertarian") and medical ("paternalistic") concerns.

Psychiatrists have therefore become deeply embroiled in civil rights and legal issues. This is not necessarily a bad thing; as people who have chosen to serve a community, psychiatrists have to be answerable to that community. The problem arises when blame is apportioned for past "wrongs". It is mentioned in the "Guidelines for Involuntary Civil Commitment" (National Centre for State Courts 1986) that "the debate has pitted doctors against lawyers and has galvanised support for either a 'medical' or a 'legal' model for statutory reform of involuntary civil commitment". Although further discussion of this vexed issue is beyond the scope of this research, it does serve to remind us that psychiatrists labour under an almost unique dilemma, not shared by their other medical colleagues. The dilemma is that psychiatrists have a double allegiance: they have a role as agents for the patient on one hand, and agents for society or the social order on the other.

A resolution to this dilemma is not readily forthcoming. If psychiatrists were to divorce themselves completely from the whole civil commitment process, does a mechanism exist in society to address the needs of those it chooses to call "mentally ill"? If not, somebody has to provide care for them until such time that a satisfactory answer is found.

In the South African context these issues have not been publicly debated to the same extent as in Europe, Canada and the USA. However, the concerns expressed are universal and do occupy a prominent place in mental health circles in this country.

An area of concern is the impression that the safeguards in the South African Mental Health Act (MHA) are not always adhered to. In essence then, this research hopes to objectively examine the "gap" between legal standards and actual practice, if such exists. More importantly, it hopes to elucidate reasons why this should be so, and to make recommendations that may help to narrow or eliminate this gap.

This study will examine admissions under Section 9 and 12 of the Act using data collected at LH. It is hoped that similar work will be stimulated at other psychiatric hospitals in the country.

With this background, an attempt will be made to briefly review the vast literature on the subject of involuntary hospitalisation.

Chapter 2

REVIEW OF LITERATURE

2.1 HISTORICAL OVERVIEW OF THE TREATMENT OF MENTAL ILLNESS

2.1.1 INTRODUCTION

To provide the reader with an understanding of how present day certification procedures have come into being in South Africa, it is necessary to trace the historical origins of mental health care and legislation. It should be borne in mind that the main focus here will be on the situation in Western societies, as South African legislation and mental health practice is based on this foundation.

The treatment of mental illness is dependent on the prevailing ideology, and the theoretical conceptions of the nature of mental illness. Thus, in any society the treatment of mental illness is intimately related to attitudes, cultural values and norms, and social, economic and political conditions. Conrad and Schneider (1980 p.38) comment that "The madness-as-illness concept is a product of 2000 years of cultural and social development". They point out that illness has not always been the dominant concept. They note

that, even today, cultures which have had little contact with Western psychiatry (such as the Siberian Eskimos) rarely define madness as illness. In some societies therefore the idea of forced hospitalisation is of no consequence.

Furthermore, the history of mental illness reflects the uncertainties with regard to diagnosis, aetiology and treatment. Over the centuries, concepts of the causation of mental illness have fluctuated between demon possession, biological/physical, psychological and sociological theories.

However, advances made in the 20th century have shown that most major psychiatric conditions are associated with measurable biological and physiological changes. This lends support to biological theories of aetiology and validates biological treatment methods.

Based on the ideology prevailing at the time, treatment has been the responsibility of either the family of the individual or the Church, and in more recent times the State. Thus, the mentally ill were either left to "wander the streets"; were looked after by their families; entered monasteries; were placed in workhouses or jails; were taken into general hospitals; or in more recent decades placed in State hospitals. Thus, compulsory hospitalisation only becomes a valid concept and treatment option when a society deems it necessary.

Although laws were passed in ancient times regarding the care a mentally ill person received, it will become apparent that certification procedures and detention as a means of "treatment" are fairly recent developments.

2.1.2 ANCIENT SOCIETIES

In preliterate and ancient societies, and for many centuries to follow, superstition and religion played a major role in determining the treatment of mentally ill persons.

During the Stone Ages it is likely that mental illness was seen as a result of demon possession. Evidence for this comes from archaeologists (working in Great Britain, France and Peru) who have found large holes in the frontal region of the skulls of these early men. This practice is assumed to have been a crude surgical practice (trephining) which allowed the evil spirits who were causing the deviant behaviour to escape (Davidson & Neale 1982 p.8).

There are many references in the Old Testament to madness being as a result of supernatural powers and disobedience to higher beings. In Deuteronomy 28, for example, Moses warned his people that, if you "...will not obey the voice of the Lord your God or be careful to obey all his commandments... the Lord will smite you with madness, and blindness and confusion of mind" (Conrad & Schneider 1980 p.39). Thus, mental illness was not sanctioned in the community.

In Judaic culture however, it is likely that tolerance for mental abnormalities was somewhat wider. Whilst well-to-do patients were probably kept confined at home, others less well-off were left to wander on their own. The mentally ill were not seen as problematical. However, despite this attitude, they could not take part in religious ceremonies and, when judged incompetent, were assigned to a guardian. The

beginnings of legal procedures regarding mental illness are evident.

Like the ancient Egyptians and Chinese, the ancient Greeks believed, to some extent, that mental health resulted from a harmonious balance between Man and his universe. They had a holistic view, which is reflected in many of our present day thoughts about mental illness. It was the Greek philosopher Hippocrates in the 5th century BC who separated medicine from religion, magic and superstition, thus emphasising the holistic point of view (Davidson & Neale 1982 p.8). However, the belief in supernatural possession by gods or spirits still prevailed, and Greek society was thus divided in its approach to mental illness.

In general, treatment of mental disorders involved the integration of physical, psychic and spiritual factors. Amongst some of the more common "cures" were prayers, drinking of various brews and starvation. No institutional facilities, as we know them, existed for the treatment of the mentally ill. Individuals who were mentally ill were sometimes left to fend for themselves and seen as objects of contempt, ridicule and abuse. Those who were considered violent were kept at home or in a "house of correction", often in chains (Mora 1975 p.17).

Although no clear legal status was outlined for the mentally ill person, Plato's Laws stated that mentally ill persons presenting with "psychopathic behaviour" should be sentenced by a judge, to a house of correction for a term of not less than 5 years during which time their contact with the community was to be kept to a minimum. When this term of confinement expired, the "patient" was to be released if he showed

improvement, or if not, he was to be put to death (Mora 1975 p.17).

The Laws also held that, lunatics were to be kept in safe custody at home, and stiff penalties were to be given to relatives who did not take care of them. Definite rules were also to be followed in matters of competence in relation to marrying and leaving a will and other legal issues (Mora 1975 p.17).

The Roman concept of mental illness was similar to that of the Greeks, with minor variations. Superstitious practices and beliefs continued to determine the popular attitude towards the mentally ill, who were neglected, banned, or persecuted. They were deprived of freedom of action and were judged incompetent to control their own personal and business affairs. Thus, in the late Roman times, for the most part, those persons who were considered to be mentally ill were placed under the custody of relatives or guardians appointed by legal authorities. In addition, laws were passed which denied them rights to marriage, divorce, property, wills, and the ability to testify (Mora 1975 p.20). This was the first time that the question of legal responsibility was addressed. At the same time, Marcus Aurelius a Roman jurist, argued that, "Furiosus satis ipso furore punitur" (The madman is sufficiently punished by his madness and should not therefore be held responsible for his/her behaviour) (Clare 1976 p.328).

During the rule of the emperor Justinian (483-565 A.D.), a number of mentally ill patients were admitted to institutions for the poor and infirm. This was a major change from previous times, where the mentally ill had been left to wander or in the care of their families. Judges made the decision regarding detention, whilst doctors administered whatever harsh treatments were available (Mora 1975 p.20). One particular form of treatment was a crude form of electric shock (Conrad & Schneider 1980 p.40).

It appears then, that in ancient societies there was a shift from the purely supernatural to a more holistic understanding of mental illness. This resulted in diverse treatments. The beginnings of legislation concerning the mentally ill, and the concept of institutionalisation are also evident. During these times, the doctors' role was mainly in the administration of treatment. It will be seen that in later centuries their role changed to that of the "gatekeeper" to the institution.

2.1.3 THE DARK AGES

Conrad and Schneider (1980 p.41) comment that the return to supernatural beliefs in the Dark Ages, away from the more integrated view of the Greeks, put the clock back 1000 years. This had an enormous impact for centuries to follow, as will become evident below.

During the Dark Ages, around 3 A.D., the economy collapsed and intellectual life diminished due to an overextension of the Roman Empire. Churches grew in strength and Monasticism became a way of life expressing separation of the Church from the world (Davidson & Neale 1982 p.8). Care of the mentally ill was still primarily in the hands of families, who took them to shrines or monasteries to be prayed for.

2.1.4 THE MIDDLE AGES AND THE RENAISSANCE

The Middle Ages and the Renaissance continued to view mental illness from a religious stance. Mental illness was God's mode of punishment for sin, a way of testing an individual's strength or a warning to the individual to repent. Although medical opinions did exist, they did not flourish. Medical views were subordinate to theological ones. The Church instituted social control, and the main mode of treatment was exorcism. A minority believed that passions, and an imbalance of humours were responsible for mental illness, and could be treated using herbs. The Byzantine physicians practised a crude form of psychosurgery to relieve pressure in the skull, presumably the same as that used by Stone Age man (Mora 1975 p.26).

Until the 13th century there was no formalised law. The first systematic treatise in English Law concerning mental illness was in 1265 on the insistence of de Bracton and of the Archdeacon of Barnstable. They said "...an insane person is one who does not know what he is doing, is lacking in mind and reason and is not far removed from the brutes" (Loucas and Udwin 1974, in Clare 1976 p.338). They advocated the removal of responsibility from the insane.

During the 13th century, and for nearly 200 years thereafter, many mentally ill were burnt at the stake as they were believed to be witches. This was the start of the massive witch-hunts beginning in 1486 with the publication of "Malleus Maleficarum" by Henry Kramer and James Sprenger (Colp 1989 p.2134). Conrad and Schneider (1980 p.14) point out that the Church was being threatened from its powerful role of control and dominance. Individuals were beginning to question the role of religion in their lives. The witch-hunt enabled the Church to hold on to some of its power and credibility. Thus, the social order was maintained.

It was not until two centuries later, that protests emerged against such horrors. Johann Weyer, a German-Dutch physician, was among the first to reject publicly the belief in witchcraft and to condemn the witch-hunting practices. He offered an explanation for the so-called supernatural signs that witches exhibited, using the available medical and psychological knowledge of the time. At about this time, others were beginning to recognise the importance of the body-mind relationship, and the influence of social factors on mental well being (Mora 1975 p.34). This emphasis on emotional and social factors led to the development of a more humane understanding of mental illness.

However, Neugebauer examined the records from Lunacy Trials which started in the 13th century. He found only one example of demon possession, suggesting that this was not the only theory of mental illness during the Middle Ages. He notes that "The trials were conducted under the Crown's right to protect the mentally impaired, and a judgement of insanity allowed the crown to become guardian of a Lunatic's estate. The defendant's orientation, memory, intellect, daily life and habits were at issue in the trial" (Davidson &

Neale 1982 p.15). Laws during this period provided for dangerously insane and incompetent individuals to be confined to a hospital. This was the first time that confinement was made a law.

Around this time, there were hospitals specifically for the treatment of leprosy. When leprosy began to disappear, attention focused on the mad. The mentally ill were no longer allowed to roam the streets. They were either confined to leper colonies or driven out of town. In some parts of Europe they were put on to boats to arrive at other ports. However, the ports became aware of this, and eventually the mentally ill were not allowed to disembark. Thus, they became incarcerated on the boats, which Foucault (in Davidson and Neale 1982 p.15) called "ships of fools". The mentally ill travelled the rivers of Europe for the rest of their lives.

Around the 14th century many hospitals were built in some centres in Europe, with wings for the mentally ill. In other places, several institutions had been established specifically for the custody of mental patients. This was seen as a major breakthrough in the treatment of mental illness. The founding of the first mental hospital in Valencia in 1409 by the Spanish priest Father Gilabert Jofre, earned Spain the reputation of being the "cradle of psychiatry" (Colp 1989 p.2134). In the period from 1412 to 1489, five similar institutions were established in various cities in Spain, and in 1567, under Spanish influence, the first mental hospital was established in Mexico City (Mora 1975 p.37). Spain was therefore influential with regard to the hospital care of mental patients, in both the Old World and the New World.

Meanwhile, in the Arabian countries, a humanistic attitude towards the mentally ill prevailed. Numerous institutions, specifically for the care of the mentally ill, had been built in the Arab countries as far back as the 7th century (Colp 1989 p.2134). The atmosphere had to be relaxed, and the therapeutic regimen included special diets, baths, drugs, perfumes and musical concerts (Mora 1975 p.26).

It is probable that the Arabs exerted a major influence in shaping the Spaniards attitudes towards mentally ill patients. This fact is borne out by the many similarities between the early mental hospitals in Spain, and some of the Arab institutions that were apparently devoted to mental patients, such as the one built by Mohammed V in Granada in 1365.

It can be seen that during these centuries, more medical and legal attention was being focused on the mentally ill. There were several reasons for this. Firstly, the decline of the Church as the sole social control apparatus and secondly, the decline of other diseases such as leprosy. The mentally ill were no longer tolerated in Europe, and could no longer be left to wander the streets. Thus, active intervention in the form of laws and later on, hospitalisation or removal from society was beginning to evolve. Hospitalisation evolved from incarceration in "houses of correction" to confinement in leper colonies to admission to special wings of general hospitals and finally to placement in specialised mental institutions.

2.1.5 THE 17th AND EARLY 18th CENTURIES

The 17th and 18th centuries, known as the "Age of Reason", brought about some fundamental shifts in attitude, which resulted in reform. Foucault, author of "Madness and Civilisation", wrote that it was a time when there was a need to deny the "unreason" of the insane (Colp 1989 p.2135).

In England, the Elizabethan Poor Law Act of 1601 placed responsibility for the care of the poor, and frequently of the insane, on the local authorities. This led to the mentally ill being exiled from one community to another. On a more positive note, the Act deemed that the mentally ill were no longer a religious responsibility, and pensions were given to the families to help the mentally ill remain in the community (Scull 1982 p.17). The obvious inequities of this situation finally gave rise to some concern for the mentally ill and, concurrently, efforts to devise improved methods for their treatment.

Before the 17th century, the mentally ill often led a free wandering existence. The family and community were responsible and on occasion they were taken to various kinds of hospitals. Foucault claimed that "...society's debate with madness over reality was a public matter..." which could not be hidden (Conrad and Schneider 1980 p.41). The emergence of Capitalism in the 18th century saw a shift in ideology. Insanity was separated from other forms of deviance and dependence. This gave way to special institutions such as almshouses, workhouses, madhouses, and prisons. It has been said that this separation was not for the treatment of mental illness, but to ensure that society

could be protected. Thus, this shift appears to have been for social and economic reasons.

In the 17th century there was an abundance of hospital building. Many of these institutions were run by private individuals such as businessmen and clergy (Johnstone 1989 p.173). The traditional religious views were progressively balanced by advances in anatomy and physiology to reach a more organic understanding (Bloch and Chodoff 1981 p.16). Some of these institutions, however, left much to be desired as the mentally ill were objects of ridicule and scorn rather than receiving any form of adequate treatment. At Bethlehem (Bedlam) Hospital in London and Pennsylvania Hospital in America, for example, patients were regularly placed on exhibition, and could be viewed by the public for a set admission fee.

In 1744 an Act of Parliament (Mora 1975 p.41) established rules for the commitment of mental patients. During this period, also, the general public became increasingly aware of the plight of the mentally ill and increasingly repelled by the fact that they were either completely neglected or, even worse, restrained by the cruellest methods, such as ropes and chains.

In 1774 a physician's certificate became necessary for the commitment of any person to an institution. Up until then, judgement by a magistrate had been sufficient. Zachia, who was writing at this time questioned whether a physician rather than a lawyer or priest should evaluate the extent of responsibility for mental behaviour. He published "Quaestiones Medico-Legales" and this saw the beginnings of Forensic Psychiatry (Colp 1989 p.2135).

In terms of treatment, very little had changed. Therapies were similar to ancient ones, such as fear, restraint, starvation, and diets. By the end of the 18th century, although still limited in his therapeutic ability, the physician had become essential to the madhouse as the "gatekeeper". Between 1816 and 1845 various Acts were passed to ensure regulation concerning commitment and treatment in mental institutions. Hence, physicians had finally captured madness as their domain and their arena. By 1830 nearly all institutions had a medical director. Physicians had convinced Parliament to have their positions officially legislated as the dominant one with regard to mental illness. Ironically enough, although there had been a shift in ideology and the disease concept was accepted, there was no medical treatment.

Thus, during the 17th and 18th centuries there was a definite shift in ideology. Religion was no longer primarily responsible for the care of the mentally ill. Society now had to actively intervene. This resulted in the building of establishments specifically for the care of mentally ill individuals. With this secularisation, more and more legislation came into being to provide for the mentally ill. Individuals could now be legally committed to institutions. However, there was still no effective treatment for these people.

2.1.6 THE LATE 18th AND EARLY 19th CENTURIES

The changing structure of the economy, due to the Industrial Revolution, in 18th century England undermined the old order and brought about many changes. The class system came into operation. People who were unable to work and produce became a burden to society. In 1803, one in nine people were in receipt of poor relief, casual or permanent (Scull 1982 p.35). The ruling classes began to distinguish between able-bodied and non-able bodied, and the wage labour system was established. This in turn meant that the mentally ill became a burden, for they were seen as non-able bodied and as belonging to the lower classes.

Segregation of hospitals became the norm. General hospitals stopped admitting the insane as they thought them to be a risk to the safety of other patients (Scull 1982 p.41). Thus, the insane were channelled into special hospitals. In 1844, thirteen medical superintendents of mental asylums organised the Association of Medical Superintendents of American Institutions of the Insane (now known as the American Psychiatric Association), to standardise the administration and organisation of asylums (Colp 1989 p.2137). The 1845 Acts of Parliament directed that each English county provide an asylum to house the insane (Colp 1989 p.2137). "By making separate institutional provision for a troublesome group like the insane, a source of potential danger and inconvenience to the community could be remoulded to a place where such people could no longer pose a threat to the social order" (Scull 1982 p.41).

Scull (1982 p.49) continues to say that "Insanity was transformed from a vague, culturally defined phenomenon afflicting an unknown, but probably small, proportion of the population into a condition which could be authoritatively diagnosed, certified, and dealt with by a group of legally recognised experts...". Thus the medical and legal professions were becoming more and more involved in the management of the mentally ill.

It was during this period that reforms in treatment were advanced. Cruel methods of restraint were progressively abandoned and laws were passed, in many countries, concerning the protection and management of the mentally ill.

At the same time, in France, and in America to a lesser degree, importance was being given to individual human rights. Dr Percival published a formal statement on medical ethics. He declared that no one was to be admitted to a mental institution without a certificate signed by a physician, surgeon or apothecary. He favoured strict inspection of asylums for the maintenance of proper care. He emphasised provision of Writs of Habeas Corpus and other legal protection for inmates. At the same time Dr Hooker in America advocated early treatment in cases of insanity, examination by a committee composed of physicians who are properly qualified and prompt institutionalisation. These recommendations were not immediately put into practice, but occurred a century later (Bloch & Chodoff 1981 p.20).

2.1.7 THE LATE 19th CENTURY

Towards the end of 19th century there was an epidemic of state asylum building, and institutions became the treatment of choice. Unfortunately, this resulted in an increase in the number of asylum inmates which created a decline in "moral therapy" and which was replaced by custodial care, overcrowding and insanitary conditions.

It was hoped that institutionalisation would serve to isolate the mentally ill from the community and to develop a model society within the asylum, which would exemplify the advantages of an orderly, disciplined routine. Hospitalisation was to be a cure as it would remove the mentally ill from the community, and the alleged cause of mental disease. It would confine them, and create an order to compensate for the fluidity and disorder in society.

This increase in institutionalisation led to further legislation. Treacher and Baruch (1981 p.134) note that "...by the end of the 19th century (medicine) had consolidated its claim to be solely responsible for treating insanity, but it could only carry out this function within the constraints of a complex administrative legal framework."

The 1890 Lunacy Act established a series of complex safeguards against wrongful detention on the grounds of insanity (Treacher and Baruch 1981 p.134). This Act established a set of formal procedures involving petitions for the admission of persons into Lunatic asylums, which had to be supported by medical

certificates. A Justice of the Peace in Lunacy acted as the arbiter as to whether such a petition should succeed. Regular inspections were also established (Rose 1986 p.184).

Some individuals, such as John Stuart Mill criticised this state intervention or "paternalism". He felt that the State and psychiatry colluded in upholding the myth of "parens patriae", which implied that compulsory interventions were undertaken for the good of the suffering individual (Rose 1986 p.178).

Arguments concerning compulsory hospitalisation started around the 19th century and continue today. One such argument is that of Szasz who comments that "...in the final analysis, what makes a medical intervention morally permissible is not that it is therapeutic but something the patient wants. Similarly what makes the quasi-medical intervention of involuntary psychiatric hospitalisation morally impermissible is not that it is harmful but that it is something the so-called patient does not want" (Clare 1976 p.78).

Criticisms such as these forced psychiatrists, lawmakers and society at large to re-evaluate their approach to the mentally ill in general, and to involuntary hospitalisation in particular.

2.2 RECENT TRENDS

In this century, many contributions have been made towards the understanding and treatment of the mentally ill. For our context, we need only look at some of the important trends.

In Britain, the Mental Treatment Act of 1930 permitted voluntary admission to mental hospitals in certain circumstances. It promoted non-custodial treatment and the development of outpatient clinics (Rose 1986 p.185). Thus, more liberal policies in the 1930's encouraged the setting up of local outpatient clinics and aftercare facilities for patients.

The 1930's also saw a move towards electroconvulsive therapies, lobotomies and genetic theories (Conrad and Schneider 1980 p.55). This has been seen by some to be a step backwards (Heather 1976 p.80).

By 1950 optimism of the previous decades began to wane. In the USA, as in Europe, medical dominance of madness was a social and political rather than a scientific achievement. The discovery of the causative organism of syphilis in the late 19th century had been a major breakthrough for the medical profession in providing an organic rationale for other causes of insanity, setting the stage for a medical model of madness, which gained fresh impetus in this period. However, the view of the 19th century that all mental illness was somatic was to some extent alleviated by the psychoanalytic movement stemming from Freudian theory.

In 1953, the discovery of the beneficial effect of chlorpromazine in psychotic people was a major turning point in psychiatry. Thousands of patients could be released from mental hospitals, some of whom could return home to fairly normal lives. Many others could now continue living in the community whereas previously they would have required lengthy, or even lifelong, hospitalisation. However, the drug revolution of 1950's also led to the "revolving door syndrome" (Heather 1976 p.80), which refers to the fact that

patients are being continually readmitted back into to the hospital system.

In England and Wales compulsory hospitalisation was governed by the Mental Health Act (1959). This stated that a mentally ill patient could go to any kind of hospital for treatment on an "informal" (i.e. voluntary) basis or under compulsory order. It was recommended that as much treatment as possible must be on a voluntary basis. The Act did away with the Board of Control and Civil Commitment Proceedings. Medical practitioners now decided whether a persons illness warranted detention. However, it did not establish mechanisms for appeal against such decisions nor for general judicial reviews of detention. It was argued that medical practitioners' recommendations provided an inadequate safeguard against illegitimate detention. Thus, Mental Health Review Tribunals came about, but only a small number of cases were ever seen and it had only limited powers to discharge. The 1959 Act makes provision for patients to appeal under Mental Health Review Tribunal except where there is an order restricting discharge (Clare 1976 p.328). Due to the vagueness in the definition of mental illness in the Act, it was proposed that dangerousness should be introduced. Rose (1986 p.186) notes that "Only grave and genuinely probable future harm to others should form the basis of compulsory admission, and this prediction should be based upon recent overt acts". Clare (1976 p.328) comments that as the Act did not define what it meant by mental illness, and that "...the compulsory hospitalisation of persons deemed to be suffering from "mental illness" would seem to be a somewhat sophisticated process whereby society declares what it will and will not tolerate in the shape of unusual, deviant, and antisocial behaviour on the part of its individual members."

The reforms of the 1930 Mental Treatment Act and the 1959 Mental Health Act maintained the status quo politically and economically. Productivity and economic growth was essential. There was very little change in terms of real human rights issues.

In the United Kingdom in 1970 there was a massive increase in compulsory admissions. Clare (1976 p.349) comments that when there is a fall in voluntary admissions and the proportion of compulsory admissions rises, this may be due to several factors. In particular, he notes that compulsory orders are simpler. Other factors are that certain regions have better aftercare facilities; some hospitals will not admit, particularly over weekends, if there is no compulsory order; inexperience of social workers; and distance from hospital.

It was only in the 1970's that lawyers became involved in mental health reform. They argued that many aspects of the system denied or violated the rights of the mentally ill, and that legal means should be used to right such wrongs. They argued for the limiting of psychiatrists' power, for the promotion of community health services, and for empowering the recipients of psychiatry (Rose 1986 p.186).

Rose (1986 p.178) comments that the history of mental illness and certification laws, have shown themselves not to be solely medical problems. He highlights four points which stress the interrelations between the disciplines of medicine, law, sociology and psychology when examining certification.

a. The patient's human rights can be violated. He/she can be detained against his/her will. Release from incarceration, when, and/or whether, is often out of the patient's control. It is decided upon for him.

b. Conditions of detention are usually out of the patient's control. Physical "treatments" can be administered without his/her consent.

c. Due to the lack of habilitation and/or rehabilitation facilities in the community detention often becomes the primary treatment of choice.

d. The patient can be denied the right to vote and denied access to court.

It is necessary to bear these points in mind, as from an historical perspective they only became linked when the shift from family 'care', to admission and the possibility of incarceration in State hospitals took place. These points have been referred to in the literature review where necessary.

2.3 THE SOUTH AFRICAN PERSPECTIVE

The history of mental health care in South Africa has been examined by Laidler & Gelfand (1971) and Minde (1974a, 1974b, 1974c, 1974d, 1975a, 1975b, 1975c). Foster (1990 p.30) has commented on the influence of European thinking in South African law and mental health practice. He has also explored the effects of the "race laws". He points out that developments in South Africa, though occurring much later, closely followed the pattern set in Europe.

By the turn of the 20th century, Foster (1990 p.30) notes that there were specific institutions for the insane, the medical profession was in control of insanity, legislation was enacted, and "racialisation" of mental illness was operational.

The first mental asylum was formally established on Robben Island in 1846. It also served as a leper colony. Prior to this the mentally ill were treated in much the same way as they had been in Europe when beliefs in demon possession and the supernatural prevailed. The asylum was racially segregated. There were numerous complaints regarding poor conditions. It was eventually closed as an asylum in 1930, and the following year patients with leprosy were moved to Pretoria.

The roots for contemporary psychiatry were formally laid down during the period 1876 to 1895 when asylums were established in each of the four provinces. These hospitals were also racially segregated.

In terms of legislation, the first Act was passed in Natal (Law 1 of 1868) which was based on British ideas. The Cape Act (Act 20) of 1879 was similar to the Natal Act. The present Mental Health Act (1973) was based on the Cape Lunacy Act (Act 35 of 1891) which has its origins in the English Lunacy Act. It was this 1891 Act which established detention procedures which are still operative today, outlining safeguards and penalties with regard to the treatment of the mentally ill. Race issues were not drafted into the Act.

Radical arguments, which were heard in Europe and the USA, such as the antipsychiatry lobby, hardly surfaced in South Africa and have only recently been addressed. Foster (1990 p.61) comments that the changes which were taking place in Western countries were evident in South Africa but at a "...slower pace and mainly concerning Whites and with little exposure of the fierce attacks against professionals or institutionalisation".

The recent trend in Europe and the USA towards voluntary admission and outpatient treatment has been evident in South Africa as well.

The literature on involuntary hospitalisation in South Africa is rather limited. Kruger (1980) has provided a detailed description of mental health legislation in South Africa. Kaliski et al. (1990) have discussed certification practices with regard to Sterkfontein Hospital in the Transvaal. Snyman (1984) has described, from a legal perspective, what appear to be the shortcomings in the law.

There is little doubt, however, that the spirit of mental health legislation in RSA is to find a balance between protection of the patients rights and protection of the community, whilst not depriving the patient of necessary treatment. Despite this, there is evidence that, in practice, this is not being fully achieved (Kaliski et al. 1990).

This situation (i.e. where the spirit of the law is not translated smoothly into practice) is not unique to RSA. The literature refers to this as the "gap" (Turkheimer & Parry 1992).

South Africa, unlike some other countries, is not a very litigation-conscious society. Furthermore, the majority of the population either does not have ready access to legal counsel (due, for example, to financial reasons or ignorance of their rights), or does not avail itself of what legal assistance is available (for example, due to mistrust of, or lack of faith in, the legal system). The chances that patients (or their families or guardians) will challenge an involuntary admission through the available legal channels are therefore small.

This may result in a casual attitude on the part of the various people (relatives, police, district surgeons, magistrates, hospital doctors) involved with the management of mentally ill persons generally, and with the involuntary hospitalisation of some of these mentally ill persons in particular.

This undesirable state of affairs (i.e. the possibility of a casual attitude creeping into what is a very serious business indeed) prompted the Director-General of the (now defunct) Department of Health, Welfare and Pensions to circularise a memorandum of guidelines, "...intended to assist...in the maintenance of a satisfactory standard of certification, in the best interests of those who are subjected to this Procedure" (Appendix B). The Department of Justice (undated), in its "Codified Instructions: Mental Health Act, 1973", clearly spells out the requirements of the law for each professional group involved with regard to the involuntary hospitalisation of the mentally ill. At the provincial level, the Executive-Director: Hospital and Health Services of the Cape Province (1989) directs the Medical Superintendents of all provincial hospitals to ensure that caution is exercised with the certification of mentally ill patients. He supports voluntary and/or consent admissions, stating that "Every effort should be made to use this method (voluntary or consent admission) rather than certification."

The researcher believes that the concerns expressed in these documents should be carefully noted by all persons involved in the process of involuntary hospitalisation.

2.4 SOUTH AFRICAN MENTAL HEALTH ACT

The assassination of the Prime Minister of South Africa, Dr H.F. Verwoerd, in 1966 led to the appointment of a Commission of Enquiry (the Rumpff Commission) into the control and management of mentally disordered persons in South Africa. Following a second Commission of Enquiry (the Van Wyk Commission) into the Mental Disorders Act of 1916, this Act was replaced by the Mental Health Act of 1973. The MHA, which governs the treatment and management of the mentally ill at present, came into operation in March 1975.

2.4.1 LEGAL CRITERIA FOR CERTIFICATION

Legal criteria for certification vary from country to country, and sometimes within countries. In the USA and Canada, for example, different states or provinces have adopted different legal standards.

In summary, legal standards vary from those emphasising the "need for treatment" to those concerned with "dangerousness". The former is seen to embody the "parens patriae" approach, which "emphasises the benevolent intent of the State to offer treatment to those in need of care", whereas the latter is seen to embody the "police power" of the State (Hoge, Appelbaum and Greer 1989). Modified criteria, the so-called Stone-Roth model (Stone 1976, Roth 1979), based on the "need for treatment" approach have been proposed. These criteria "address some of the major concerns of the civil libertarians, yet restore the paternalistic

approach of the earlier statutes" (Hoge, Appelbaum and Greer 1989).

South African law applies both the "dangerousness" and the "need for treatment" criteria in its civil commitment process.

2.5 ADMISSIONS UNDER THE MENTAL HEALTH ACT, 1973

The Act makes provision for four types of admission:

a. Voluntary admissions (Section 3);

b. Admission by Consent (Section 4);

c. Involuntary hospitalisation by Reception Order (Section 9); and

d. Involuntary hospitalisation by Urgency Application (Section 12).

Admissions under the different sections have different legal implications and the patients' legal status varies. At this point, a brief resume of the salient points for each type of admission will help to place the issue in context.

2.5.1 VOLUNTARY ADMISSIONS (SECTION 3)

In terms of this Section any person may, of his or her own accord, apply in writing to be admitted and treated at an institution. This Application has to be accompanied by an undertaking that the prescribed fees will be paid or by an application for exemption from such fees.

If the Medical Superintendent of the institution is satisfied that the person "understands the meaning and effect of the application" and that the person requires institutionalised treatment, the person is admitted for treatment.

Voluntary patients can obtain their discharge from the institution in the following ways:

a. if they (or their guardian) request it. In this instance, the Medical Superintendent has to discharge them within four days of the receipt of such a request;

b. if the Medical Superintendent certifies in writing that they are fit for discharge; and

c. if the court, or a judge or magistrate or the Secretary of Health directs that they be discharged.

Thus, voluntary patients appears to have a fair measure of control over their admission and discharge.

2.5.2 ADMISSION BY CONSENT (SECTION 4)

This is considered to be a form of voluntary admission. It applies to a voluntary patient who cannot give informed consent because he does not "understand the meaning and effect of the application". The underlying assumption appears to be that, if the patient does not oppose admission, there is consent.

The application for admission may be made by a guardian or near relative, or if such is not available, by a medical practitioner, social worker, clinical psychologist or nurse. This application also has to be accompanied by an undertaking that the prescribed fees will be paid or by an application for exemption from such fees.

The Medical Superintendent must be satisfied that the person is in fact not opposed to admission and treatment.

The mechanisms for obtaining a discharge from this section of the Act are as described for Section 3 admissions. An unexplained feature of the Act is that minors over the age of 18 years but who have not yet turned 21 years may request their own discharge, but in the case of those patients under 18 years of age or over 21 years of age, the original applicant has to make the application for discharge. The Medical Superintendent has the authority to discharge such

patient in the absence of such application, if the patient has recovered.

Throughout the literature, it is stressed that voluntary admission should be the norm, rather than the exception, and that compulsory admission must be limited to cases where it is absolutely necessary. The Percy Commission, which preceded the promulgation of the British MHA (as quoted in Kruger 1980 p.52) stated:

> "We recommend that the law should be altered so that whenever possible, suitable care may be provided for the mentally disordered patients with no more restrictions of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty. Compulsory powers should be used in future only when they are positively necessary to override the patient's own unwillingness or the unwillingness of his relatives, for the patient's own welfare or for the protection of others.
>
> ".... Acceptance of these principles should allow a considerable number of patients who now have to be certified, including many elderly senile patients, to be admitted informally, as to any other hospital or home."

This emphasis on voluntary and consent admissions is evident in the South African MHA as well (Kruger 1980 p.28).

2.5.3 INVOLUNTARY HOSPITALISATION

2.5.3.1 On Reception Order (Section 9)

This is a complex legal procedure involving an applicant, a magistrate, a District Surgeon (if available), general practitioners, the Medical Superintendent and doctors at the receiving psychiatric hospital, the Attorney-General, a Judge-in-chambers and the Secretary for Health.

The certification process (schematically represented in Fig. 1) is described briefly below, but will be examined in greater detail in Section 2.6.

a. The Application (done on Form G2/1): any person over the age of 18 years may apply to a magistrate for the reception to a psychiatric hospital of any person whom he believes is suffering from mental illness to such a degree that he needs admission.

b. Medical Certificates (done on Form G2/2): on receipt of the Application, the magistrate requests reports from two medical practitioners (one of whom, whenever practicable, should be a District Surgeon) on the mental status of the patient. The magistrate may see the patient personally, but need not necessarily do so.

c. Reception Order (done on Form G2/3): if (after consideration of all the information presented) the magistrate is satisfied that the patient is mentally ill, in need of treatment, and is refusing voluntary treatment, a Reception Order is issued. This Reception Order authorises the involuntary hospitalisation of the patient, for a period not exceeding 42 days. The patient is taken to the specific hospital designated by the magistrate for admission and treatment.

d. Report to the Attorney-General (done on Form G2/28): within seven days of admission, the Medical Superintendent of the hospital submits a medical report on the patient to the Attorney-General, who examines the documents, and if not satisfied, requests further reports or sees the patient personally. When satisfied, the Attorney-General submits them to a Judge-in-chambers.

e. Detention Order (done on Form G2/7): The Judge-in-chambers reviews the original documents (G2/1, G2/2 and G2/3) and the Medical Superintendent's report (G2/28), and determines what further action needs to be taken with regard to the patient. A Judge may decide that the patient be discharged immediately, or that the patient be detained further. In the latter instance, a Detention Order is issued. This Detention Order, in effect, allows for the indefinite detention of the patient. The assumption made is that the patient will be discharged by the Medical Superintendent when the patient is deemed medically fit for discharge.

f. Periodical Reports (done on Form G2/8): in order to monitor reasons for extended periods of detention, the Secretary for Health needs to be kept appraised of the patients mental and physical condition at set times during the patient's detention. For this purpose, the Medical Superintendent is required to submit periodical reports to the Secretary for Health annually for the first three years, thereafter in the fifth year, and thereafter every three years, in the month corresponding to that in which the patient was admitted.

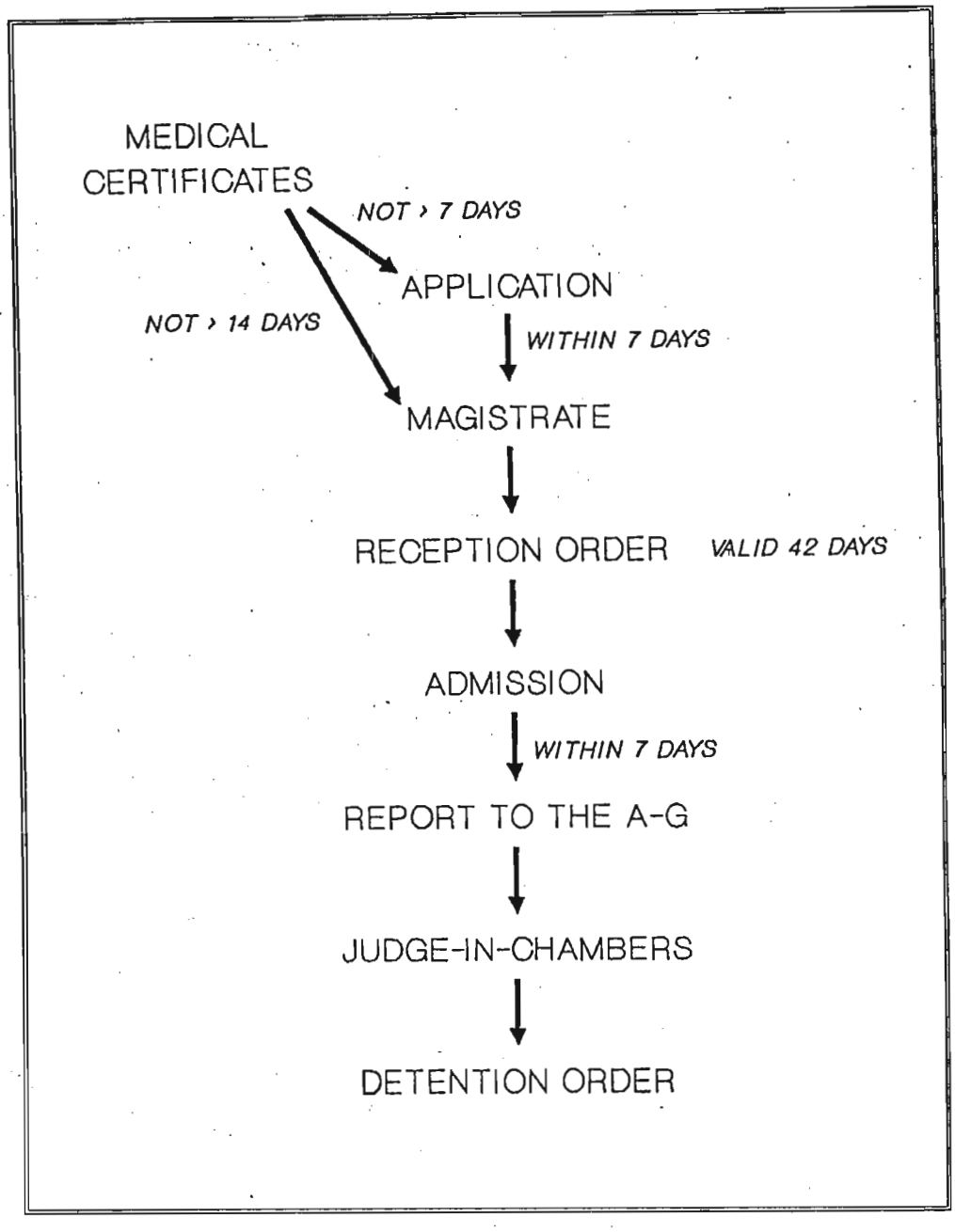

Figure 1: Certification process

2.5.3.2 By Urgency Application (Section 12)

The procedure for urgent/emergency involuntary hospitalisation differs only in the initial stages from the procedure outlined above for admissions by Reception Order:

a. Urgent Application (done on Form G2/6): any person over 18 years of age may apply for the urgent admission of a patient, furnishing reasons why the "patient is so ill that he is in urgent need of treatment which should not be delayed by formalities".

b. A Medical Certificate (done on Form G2/2), which must have been done not more than two days before the date of admission, must accompany such an Application.

This allows the patient to be admitted to a psychiatric hospital immediately, where he may be detained for a period of not more than 10 days, but which may be extended on application to a magistrate to a period not exceeding 21 days. This is to allow time for the rest of the formalities described.

c. Reception Order (done on Form G2/3): the Medical Superintendent of the hospital submits the Application and Medical Certificate to a magistrate, who may treat it as an Application for a Reception Order (as above) and issue a Reception Order. Thereafter the process is identical. (If the magistrate refuses to issue a Reception Order, the patient must be discharged immediately, or detained in some other legal way).

2.6 SAFEGUARDS IN THE MHA, 1973

Attempts at reforms in mental health legislation have aimed at providing both procedural and substantive safeguards for patients (Hiday 1988). Procedural safeguards include prior notice to the patient (of intent to have him hospitalised against his will), the right to be present at the commitment hearing, the right to legal counsel, the right to call witnesses, regular court reviews, limited commitment periods, the right to appeal and the use of the "least restrictive alternative" in the management of the patient. Substantive safeguards refer to the standards used for involuntary hospitalisation and have been discussed above.

What protection exists, in South African law, for the individual who may be hospitalised against his will? Snyman (1984) has argued that the South African MHA does not have sufficient procedural safeguards. As mentioned previously, the standards for certification do incorporate the criteria defined as "substantive safeguards".

It would appear that, in the South African context, the protection against involuntary hospitalisation is from:

a. having the right to appeal against the hospitalisation, through the office of the Attorney-General. This appeal may be brought by the patient himself, by his family and/or guardian, or by a friend;

b. the assumption that the applicant, the magistrate and the medical practitioners exercise care before proceeding with the process of certification, and that they act in good faith;

c. the Medical Superintendent's Report to the Attorney-General; and

d. the Judge-in-chambers (who has to be convinced that the patient has to be so managed).

In the present MHA, therefore, some safeguards do exist to minimise the possibility of unjust, unwarranted or too casual certification (Appendix A). The following important safeguards will be examined in detail in this study, to ascertain to what extent they are observed in practice. (Section numbers refer to the Section of the MHA.)

a. Application for a Reception Order (Section 8):

   i. the Application must be sworn to or affirmed before a Justice of the Peace or a Commissioner of Oaths;

   ii. the Application must be handed to the magistrate within seven days of date of signing; and

iii. the Application may be accompanied by a medical certificate, dated not more than seven days before the Application was signed.

b. Issue of Reception Order (Section 9):

i. the Reception Order authorises the person to be received at an institution specified in the Order; and

ii. the magistrate shall not issue Reception Order if a period longer than 14 days has elapsed since the medical examination.

c. Period of validity of Reception Order (Section 11):

i. a patient cannot be held under a Reception Order for longer than 42 days.

d. Informing the Official Curator ad litem (Section 18):

i. the Medical Superintendent shall within seven days transmit the certification documents and the G2/28 to the Attorney-General, who is the Official Curator ad litem of the patient.

e. Rules for Medical Certificates (Section 22):

i. these reports must be dated;

ii. the medical practitioner must state whether the person is homicidal, suicidal or in any other way a danger to himself or others. If the patient does not fall into any of the above categories, the medical practitioner must indicate why the patient is considered "in need of treatment"; and

iii. the medical practitioner must solemnly declare that he is not prohibited by the Act from giving the certificate.

2.7 RATES OF INVOLUNTARY HOSPITALISATION

The rates of involuntary and voluntary admissions to mental hospitals in 43 countries have been examined by Curran and Harding (1978). Such comparisons may provide a yardstick for comparing certification practices between countries with different mental health legislation. In a similar vein, a more recent World Health Organisation study (Harding 1987) has shown that some of the more advanced European countries such as Denmark and Holland have detention rates of 2,5 per 100 000 population. The detention rates of England and Wales (8,5 per 100 000) and Austria (20 per 100 000) are considered to be high, and are seen as lagging behind as far as what may be achieved with proper laws and comprehensive community care networks. Until recently, Japan had a poor record with a rate of approximately 250 per 100 000 (Gostin 1987).

Examination of the South African statistics for the year ended 30 November 1991 (supplied by the Department of National Health and Population Development) reveals that a total of 9187 persons were admitted involuntarily, while 10969 were admitted voluntarily or by consent, to South African hospitals. Using the preliminary results of the Population Census of 1991 (Central Statistical Services 1991b), the total population of South Africa and its self-governing territories is roughly 35 million. The rate of involuntary hospitalisation, for the country as a whole, is thus in the region of 26 per 100 000 population. The approximate rate for the Cape Province is 62 per 100 000 population. The figure for the catchment area served by LH works out to roughly 38 per 100 000.

The figures provided above serve as a rough idea of the situation in South Africa, and no conclusions may be drawn from them. However, they do seem to indicate that, for South Africa as a the whole, the local figures compare not too unfavourably with some European countries (e.g. Austria), bearing in mind that the social and health-care infrastructures are very different. The figures may reflect other trends which require further (and rigorous) investigation: firstly, that there may be regional differences in South Africa; and secondly, bearing in mind the population served by LH, that there may be different rates for the different population groups demarcated in this country.

2.8 OVERVIEW

The treatment of the mentally ill can be seen as lying on a continuum between neglect on the one extreme and incarceration on the other. The ideal system would incorporate mechanisms to protect society from the mentally ill, to protect the mentally ill from society, to protect the mentally ill from harming themselves, and at the same time ensure adequate protection of the basic rights of those that society calls mentally ill.

Thus, from the history it is evident that there has been a shift in the treatment of the mentally ill along this continuum. This trend has been sustained in more recent times. It can be seen that more liberal policies in the 1930's encouraged the setting up of local outpatient clinics and aftercare facilities for former patients. The mood of optimism was increased by the discovery of new pharmacological treatments. But this drug revolution of the 1950's also led to the "revolving door syndrome".

Johnstone (1989 p.188) comments that, community clinics may not be the answer. She says that these clinics are still treating patients in the tradition of medical-style psychiatry, and that this is no better than treatment in hospital. She remarks that, the Royal College of Psychiatrists campaigns for "community treatment orders" known as the "long leash" which compels patients to take medication even after discharge neglects basic human rights. She feels that we should be moving towards a commitment to empowering rather than disabling, using a crisis intervention philosophy, with community based services, voluntary self-help organisations and preventive services (p.281).

Thus the emphasis should be on decreasing the impact that mental illness has on patients and their families. What has emerged recently is a community-oriented rather than a hospital-based philosophy; the increasing recognition of the value of other professionals in the prevention, treatment and rehabilitation of the mentally ill; and the importance of the public in general (and the family, in particular) in ensuring the well-being of the mentally ill.

Chapter 3

PATIENTS AND METHODS

3.1 STUDY DESIGN

The design was that of a retrospective, descriptive study.

3.2 STUDY POPULATION

On average, LH admits 4000 patients annually. During the period 01 January 1990 to 31 December 1990, the hospital admitted 3910 patients. A further 19 patients were accepted on transfer from other hospitals. Table I summarises the number of admissions, by section of the MHA and gender.

Table I: Number of admissions by section of MHA and gender

Section of MHA	Male	Female	Total
Section 3	162	130	292
Section 4	1 670	1 194	2 864
Sections 9 & 12	598	156	754
Total	2 430	1 480	3 910

According to the official hospital statistics, 754 (19,3%) of these 3910 admissions were involuntary hospitalisations, under Sections 9 and 12 of the MHA. The Admission Register, however, reflects that 749 patients were admitted under Sections 9 & 12. (This discrepancy of five patients may be accounted for by patients who were admitted either under Section 3 or 4, and subsequently certified). The researcher was able to locate and scrutinise the files of 726 of the 749 patients admitted involuntarily. These 726 patients formed the study group. Twenty three files could not be found in the hospital registry. In all likelihood, these files were in use elsewhere at the time of data collection. The reasons for this may be that the patient was readmitted, or had been transferred to another psychiatric hospital, or that the file was being used to write a report - for instance a mortality meeting summary, insurance report or a report to the Court. It is also possible that some files could have been lost.

3.3 DATA SOURCES

Due to the complex nature of the certification process, with its numerous legal requirements, a variety of sources of information were consulted and reviewed.

a. Admission Register: which records, for each admission to the hospital, the date of admission, name of patient, inpatient file number and the Section of the MHA under which the patient was admitted. This register was used to identify the individuals who were admitted involuntarily.

b. Clinical files: which record, amongst other data, the date on which the doctor or team decided that the patient was fit for discharge from the MHA, or for reclassification to another Section of the Act. The discharge diagnosis (DSM-III-R) was also obtained from this source.

c. Administrative files: in addition to having a clinical file, each patient admitted under the MHA has an administrative file. This file contains the originals (or photocopies) of the G2/1, G2/2, G2/3 and G2/28. These files also record the official (administrative) date of admission, reclassification or discharge.

d. Certified post book: which records all the G2/28 that were sent to the Attorney General, in accordance with the requirements of the MHA.

e. The official hospital statistics: for the inpatient and Community Psychiatric Services.

Population census estimates for 1990 were obtained from "Epidemiological Comments" (Department of National Health and Population Development 1989) and from the preliminary results of the 1991 Census (Central Statistical Services 1991b).

Ethics approval for the research was obtained from the Lentegeur Hospital Research and Ethics Committee, which acts on behalf of the Senior Medical Superintendent. Patient confidentiality and anonymity were ensured by assigning a research case number to each patient. Patient's names and file numbers were not used in the database.

3.4 METHOD OF DATA COLLECTION

Information from the LH admission register, clinical files, administrative files and the certification papers - G2/1, G2/2, G2/3 and G2/28 - was coded onto a data capture form by the researcher, for each subject in the study.

3.5 MEASUREMENTS

Data was recorded to enable reporting on the following:

a. An overview, including:

   i. number of each type of certificate found and number missing; and

   ii. a brief discussion of the Section 12 admissions.

b. General information on each admission, including:

i. number of Medical Certificates submitted, classified by magisterial district;

ii. duration of hospital stay;

iii. physical findings recorded in the Medical Certificates; and

iv. diagnoses recorded in the Medical Certificates.

c. A demographic profile of the patients admitted involuntarily.

d. Validity of each type of document required in the certification process, with special reference to the document contents. The validity had to be defined for the purposes of this study, and these definitions appear below.

e. The legal validity of the certification process, looking at the time elapsed between the various stages of certification, to check whether this complies with the legal standards. These measurements are also defined below.

f. An overall measure of the validity each of the certifications, taking into account both document contents and observance of time-strictures.

3.6 DEFINITIONS OF MEASURES USED

3.6.1 DOCUMENT CONTENTS

3.6.1.1 Application (Form G2/1)

A valid G2/1 was defined as one in which:

a. the date; and

b. the sworn declaration were correctly completed.

3.6.1.2 Medical Certificates (Form G2/2)

A medical certificate was considered valid if:

a. it was dated;

b. if all the "dangerousness" criteria for certification were commented upon;

c. if all the criteria were answered "No", then a reason had to be supplied why the person could not be admitted under section 3 or 4. This would fulfil the "need for treatment" criteria;

d. if a clear recommendation was made; and

e. if the sworn declaration was completed.

3.6.1.3 Reception Order (Form G2/3)

A Reception Order was considered valid if:

a. the date was filled in;

b. the patient was specifically directed to LH;

c. the seven factors (concerning the mental illness) which prompted the Magistrate to certify the patient were completed. None of them should be left blank i.e. the Magistrate had to commit himself either to a "Yes" or a "No" answer; and

d. at least one of the seven factors had to be answered "Yes".

3.6.1.4 Report to the Attorney-General (Form G2/28)

A valid G2/28 was defined as one where:

a. the date was clearly indicated; and

b. a clear recommendation was made to the Judge in Chambers regarding the handling of the patient, or if uncertainty regarding the mental state was clearly mentioned.

3.6.2 CERTIFICATION PROCESS

For the certification process to be valid certain time limits have to be adhered to. This ensures that a person is being managed on information that is currently relevant and not on old/historical information. Various time periods are strictly laid down in the law.

3.6.2.1 Delay between seeing the patient and making the Application

The first of these time limits is that the applicant must have seen the patient within the seven days preceding the date on which the Application was made. This period could not be computed directly from the data set. However, an indirect measure is available if we assume that when the sworn declaration was made, the Commissioner of Oaths or the Justice of the Peace (whichever may be applicable), specifically asked about this component of the sworn declaration. In these instances, it was assumed that the applicant had seen the patient in the preceding seven days, as he has sworn to this under oath. This has already been checked when the G2/1 was examined.

3.6.2.2 Delay between Application and Reception Order

The applicant then, within seven days, has to hand in this Application to a magistrate. It is difficult to work out how long the average magistrate needs to examine the Application, summon medical practitioners (if the Application is not accompanied by medical reports), examine the medical reports, then consider the information before him, and then issue the Reception Order if he sees fit. For the purposes of this study, it was felt that it would be reasonable to assume, that from the time a magistrate receives an Application, it may require (in certain extreme circumstances) up to a maximum of a further seven days before the magistrate is in a position to issue a Reception Order. (A greater period is difficult to justify even in the case of small towns which may not have a resident medical practitioner, for instance. One presumes, that if the patient is mentally ill to the extent that he/she requires involuntary hospitalisation, then all undue delay will be eliminated to ensure that the patient is taken for treatment promptly.) As a measure of the promptness in dealing with applications for involuntary hospitalisation, therefore, the delay between the Application and the Reception Order was used, calling it the "G1-G3 delay". In terms of the discussion above, a delay of greater than 14 days would not be easily justifiable if it came under question.

3.6.2.3 Delay between Medical Certificates and Reception Order

A magistrate may not consider Medical Certificates which are dated more than 14 days prior to the date of the Reception Order. This period was dubbed the "G2-G3 delay".

3.6.2.4 Delay between admission and Report to the Attorney-General

If the patient is admitted on Reception Order, the Superintendent has to submit a Report to the Attorney General within seven days of admission. This is referred to as the "Adm-G28 delay".

3.6.2.5 Duration of stay on Reception Order

No patient may be detained on a Reception Order for more than 42 days. We may refer to this as the "R.O. stay". If this period is longer than 42 days, and if a Detention Order has not been obtained in the interim, it is not permissible by law to continue holding the patient under Section 9 of the MHA.

3.7 COLLATION AND ANALYSIS OF DATA

Information from the data capture forms was entered directly into a computer database, using the EpiInfo (Version 5) programme. This is an integrated word processing, database, and statistical package especially designed for epidemiological work. All the statistical tests and charts used in this study are provided for in the package.

Chapter 4

RESULTS

4.1 OVERVIEW

Of the 726 patients whose files could be studied, 697 (96,0%) were admitted under Section 9, and 29 (4,0%) under Section 12 of the MHA. In certain cases, some of the legal papers were not found. Reasons for this, where available, are given in Chapter 5. Table II and Table III below summarise the document count.

Table II: Document Count: Section 12 admissions

Document	Found	Not found
Urgent Application (G2/6)	28	1
Medical Certificate (G2/2)	29	0
Reception Order (G2/3)	2	27

Table III: Document Count: Section 9 admissions

Document	Found	Not found
Application (G2/1)	671 (96,3%)	26 (3,7%)
1st Medical Certificate (G2/2)	686 (98,4%)	11 (1,6%)
2nd Medical Certificate (G2/2)	369 (52,9%)	328 (47,1%)
Reception Order (G2/3)	690 (99,0%)	7 (1,0%)

4.2 SECTION 12 ADMISSIONS

The urgency certifications form an interesting subgroup of patients admitted involuntarily. The tables below summarise the demographic data (Table IV) and the place of Urgency Application (Table V) for this category of patient.

Table IV: Section 12 admissions: Demographic data

Demographic data	Female	Male
Number	14 (48,3%)	15 (51,7%)
Age range in years **	24 - 47	20 - 41
Mean age (+/- SD)	35,5 (+/- 6,8)	29,1 (+/- 5,5)
Marital status		
Not recorded	4	0
Divorced	2	2
Married	4	4
Single	4	7
Widowed	0	2
Employment status		
Not recorded	5	2
Employed	2	6
Unemployed	7	7

** Note: There was no significant difference between the sexes with regard to mean age

Table V: Section 12 admissions: Place of Urgency Application

Place	Frequency
Greater Cape Town area	
Mitchells Plain (Lentegeur Hospital)	14 (48,3%)
Parow (Tygerberg Hospital)	4 (13,8%)
Wynberg (Groote Schuur Hospital)	3 (10,3%)
Other	
Bredasdorp	1 (3,4%)
Mossel Bay	1 (3,4%)
Worcester	5 (17,2%)
Urgency Application not found	1 (3,4%)
TOTAL	29 (100%)

As the number of Section 12 admissions is too small to allow for any meaningful analysis, this category will not be considered in detail in this study. This group of patients warrant a full study on their own; a much larger sample size is necessary for this. Therefore, this study will now concentrate on an examination of Section 9 admissions.

4.3 SECTION 9 ADMISSIONS

These results will be presented in five parts (the details of which were described in Chapter 3 p.54): General Information; Demographic Profile; Document Contents; Certification Process; and Overall Evaluation.

4.3.1 GENERAL INFORMATION

4.3.1.1 Number of Medical Certificates submitted

The number of first and second Medical Certificates found was reported in Table III. In Table VI below, the instances where a second certificate was submitted is cross-correlated with the magisterial district from which the patient was sent, giving the percentages. It will be noted that a second medical certificate was found in only 369 (52,9%) of cases.

Table VI: Section 9 admissions: Number of Medical Certificates by Magisterial District

Magisterial districts	Number of patients	Number of 2nd G2/2submitted
Greater Cape Town area		
Bellville	45	36 (80,0%)
Cape Town	10	10 (100,0%)
Goodwood	48	30 (62,5%)
Kuilsriver	10	9 (90,0%)
Simonstown	6	4 (66,7%)
Wynberg	203	58 (28,6%)
Other		
Beaufort West	7	7 (100,0%)
Bredasdorp	3	3 (100,0%)
Caledon	18	7 (38,9%)
Calitzdorp	6	0 (0,0%)
Calvinia	1	0 (0,0%)
Ceres	31	30 (96,8%)
Clanwilliam	4	1 (25,0%)
De Aar	16	16 (100,0%)
George	44	1 (2,3%)
Heidelberg	4	4 (100,0%)
Hermanus	7	7 (100,0%)
Kenhardt	10	0 (0,0%)
Knysna	22	22 (100,0%)
Ladismith	1	0 (0,0%)
Malmesbury	3	1 (33,3%)
Montagu	6	6 (100,0%)
Mossel Bay	9	7 (77,8%)
Namakwaland	4	1 (25,0%)
Oudtshoorn	25	25 (100,0%)
Paarl	22	5 (22,7%)
Piketberg	5	5 (100,0%)
Richmond	1	0 (0,0%)
Riversdale	9	3 (33,3%)
Robertson	5	4 (80,0%)
Somerset West	22	22 (100,0%)
Stellenbosch	6	5 (83,3%)
Strand	15	15 (100,0%)
Sutherland	1	0 (100,0%)
Swellendam	7	6 (85,7%)
Tulbagh	1	0 (0,0%)
Uniondale	4	2 (50,0%)
Vanrhynsdorp	1	0 (0,0%)
Vredendal	9	9 (100,0%)
Walvis Bay	1	1 (100,0%)
Wellington	5	5 (100,0%)
Williston	1	0 (0,0%)
Worcester	32	1 (3,1%)
Reception Order missing	7	
TOTAL	697	369 (52,9%)

4.3.1.2 Duration of hospital stay

The mean stay in hospital was 2,68 weeks. By the end of the third week 564 (80,9%) of patients had been discharged. In fact, 101 patients (14,5%) stayed one week or less. Only 21 (3,0%) stayed more than nine weeks. One patient was in hospital for 111 weeks.

4.3.1.3 Physical findings

Thirty six patients (5,2%) were found by the certifying doctors to have a physical illness, and five (0,7%) were thought to have a communicable disease. Fifty one (7,4%) were found to have injuries.

4.3.1.4 Diagnoses recorded in Medical Certificates

The certifying doctors diagnosed the majority of patients as having Schizophrenia or a schizophrenic spectrum illness (51,7%). The second largest category was mood disorder, which was diagnosed in 8,6% of the sample. A "psychosis" was diagnosed in 8,0% of the patients, and a toxic psychosis in 7,3%. Alcohol related conditions accounted for 4,1% of the sample, drug related conditions for 2,8% and Organic Brain Syndrome for 3,2%. The remainder of the sample (8,0%) consisted of a variety of diagnoses including "Functional Psychoses" and Personality Disorder. A diagnosis was missing in 6,3% of the sample.

The relative frequencies of diagnoses recorded in the Medical Certificates (with percentages in brackets) are summarised in Table VII.

Table VII: Diagnosis recorded on Medical Certificate

Diagnostic Category	G2/2 Diagnosis (N=686)
Schizophrenic Spectrum	355 (51,7%)
Mood Disorders	59 (8,6%)
"Psychosis"	55 (8,0%)
Toxic Psychosis	50 (7,3%)
Alcohol related	28 (4,1%)
Organic Brain Syndrome	22 (3,2%)
Drug related	19 (2,8%)
Personality Disorder	12 (1,7%)
"Functional Psychosis"	11 (1,6%)
Mental Retardation	7 (1,0%)
Dementia	5 (0,7%)
"Aggressive"	3 (0,4%)
Delusional Disorder	3 (0,4%)
Delirium	2 (0,3%)
Post Partum Psychosis	2 (0,3%)
Atypical Psychosis	1 (0,1%)
"Epilepsy"	1 (0,1%)
"Mental illness"	1 (0,1%)
"Suicidal and homicidal"	1 (0,1%)
Diagnosis Deferred	6 (0,9%)
Diagnosis Missing	43 (6,3%)

4.3.2 DEMOGRAPHIC PROFILE

The sample consisted of 555 males (79,6%) and 142 females (20,4%). The ages ranged from 12 years to 85 years. Age was not recorded in 25 cases (3,6%). One hundred and sixty (22,9%) were married persons, thirty one (4,4%) were divorced; eight (1,1%) were widowed and 458 (65,7%) were single. In 40 cases (5,7%) the marital status was not recorded. The majority, 528

(75,8%), were unemployed, while 115 (16,5%) were employed at the time of certification. In 54 (7,7%) of cases the occupational status was not reported. The demographic information is reported by gender in Table VIII.

Table VIII: Section 9 admissions: Demographic data

Demographic data	Female	Male
Number	142 (20,4%)	555 (79,6%)
Age range in years **	12 - 85	15 - 80
Mean age (+/- SD)	35,7 (+/- 13,1)	31,7 (+/- 11,4)
Marital status		
Not recorded	8 (5,6%)	32 (5,8%)
Divorced	9 (6,3%)	22 (4,0%)
Married	38 (26,8%)	122 (22,0%)
Single	81 (57,0%)	377 (67,9%)
Widowed	6 (4,2%)	2 (0,4%)
Employment status		
Not recorded	11 (7,7%)	43 (7,7%)
Employed	13 (9,2%)	102 (18,4%)
Unemployed	118 (83,1%)	410 (73,9%)

** Note: There was no significant difference between the sexes with regard to mean age

Certifications from 43 magisterial districts were received during the period under review. Patients were from both urban and rural areas of the Cape Province. Table IX gives the details of admissions according to magisterial district, together with a calculated rate of certifications from each district, per 100 000 population. It can be seen that the rate of

certification for the LH catchment area as a whole is 38 per 100 000 population.

Table IX: Section 9 admissions: Place of Issue of Reception Order

Magisterial district	Number	Rate
Greater Cape Town area		
Bellville	45 (6,5%)	41
Cape Town	10 (1,4%)	20
Goodwood	48 (6,9%)	31
Kuilsriver	10 (1,4%)	11
Simonstown	6 (0,9%)	28
Wynberg	203 (29,1%)	41
Other		
Beaufort West	7 (1,0%)	35
Bredasdorp	3 (0,4%)	24
Caledon	18 (2,6%)	39
Calitzdorp	6 (0,9%)	127
Calvinia	1 (0,1%)	8
Ceres	31 (4,4%)	99
Clanwilliam	4 (0,6%)	20
De Aar	16 (2,3%)	128
George	44 (6,3%)	112
Heidelberg	4 (0,6%)	50
Hermanus	7 (1,0%)	70
Kenhardt	10 (1,4%)	132
Knysna	22 (3,2%)	105
Ladismith	1 (0,1%)	11
Malmesbury	3 (0,4%)	4
Montagu	6 (0,9%)	45
Mossel Bay	9 (1,3%)	34
Namakwaland	4 (0,6%)	8
Oudtshoorn	25 (3,6%)	57
Paarl	22 (3,2%)	27
Piketberg	5 (0,7%)	21
Richmond	1 (0,1%)	40
Riversdale	9 (1,3%)	57
Robertson	5 (0,7%)	23
Somerset West	22 (3,2%)	74
Stellenbosch	6 (0,9%)	17
Strand	15 (2,2%)	90
Sutherland	1 (0,1%)	42
Swellendam	7 (1,0%)	34
Tulbagh	1 (0,1%)	5
Uniondale	4 (0,6%)	55
Vanrhynsdorp	1 (0,1%)	11
Vredendal	9 (1,3%)	45
Walvis Bay	1 (0,1%)	26
Wellington	5 (0,7%)	20
Williston	1 (0,1%)	36
Worcester	32 (4,6%)	47
Reception Order not found	7 (1,0%)	
TOTAL	697 (100%)	38

4.3.3 DOCUMENT CONTENTS

4.3.3.1 Application for Reception Order

The data below (Table X) refers to the 671 forms that were studied. It can be seen that 20 (3,0%) of the Applications for a Reception Order do not satisfy the requirement for validity of content.

Table X: Information in Application

Criteria	Completed	Missing
Date	668	3 (0,4%)
Sworn Declaration	652	19 (2,8%)
Date and Declaration	651	20 (3,0%)

4.3.3.2 Medical Certificates

Of the expected 697 first Medical Certificates, 686 were found. A second Medical Certificate was submitted in only 369 cases (52,9%). The tests for validity of content yielded remarkably similar results for both the first and second Medical Certificates. The results below are for the first certificate, and are tabulated as well for the sake of clarity (Table XI).

a. All forms were dated.

b. One hundred and three (15,0%) of certificates did not satisfy the content requirement for the "dangerousness" certification criteria, on the grounds that all three criteria (i.e whether the patient was homicidal, suicidal or dangerous) were left blank.

c. The next check examined certificates which had reported "No" to all three of the above criteria. In this instance a reason (which almost always fulfils the "need for treatment" criteria) had to be furnished as to why the patient could not be admitted as a voluntary or consent patient. If these certificates did not provide a reason they had in effect failed this check. There were 29 (4,2%) of certificates in this category.

d. In 109 (15,9%) certificates, the medical practitioner did not give a clear recommendation to the Magistrate. These included certificates where no recommendation was made at all, or where an ambiguous recommendation was made e.g. the practitioner recommended both section 3 and Section 12.

e. In all cases practitioners completed the section which requires them to swear that they are not excluded by Section 23 of the MHA from giving a certificate.

Table XI: Contents of Medical Certificates

Criteria	Yes	No
Date filled in	686 (100,0%)	0 (0,0%)
"Dangerousness" criteria completed	583 (85,9%)	103 (15,0%)
"Need for treatment" criteria completed	657 (95,8%)	29 (4,2%)
Clear recommendation made to Magistrate	577 (84,1%)	109 (15,9%)
Declaration done	686 (100,0%)	0 (0,0%)
All of the above done	466 (67,9%)	220 (32,1%)

In effect then, only 466 (67,9%) of Medical Certificates fulfilled the content requirements, whilst 220 certificates (32,1%) did not.

4.3.3.3 Reception Orders

As mentioned above, 690 Reception Orders were available for examination. The content check revealed the following.

a. The date was not recorded in 8 (1,2%) of the Reception Orders.

b. In 669 (97,0%) cases the patient was directed to LH. In 13 (1,8%) cases the patient was directed to either Valkenberg, Tygerberg or Wynberg Hospital. (The latter two are not psychiatric hospitals). In 8 (1,2%) cases there was no hospital specified in the Reception Order.

c. Check three was passed by 627 (90,9%) of Reception Orders. 63 (9,1%) of Reception Orders had left all seven factors (concerning reason for certification) blank.

d. Check four examined whether at least one of the seven factors had been answered as "Yes". In other words the Magistrate had to have at least one reason out of the seven for certifying the patient. 566 (82,0%) met the requirements of this test and 124 (18,0%) did not.

Taking into account all of the above parameters, 551 (79,9%) of the Reception Orders fulfilled the requirements for document contents, while 139 (20,1%) did not. This is set out in Table XII.

Table XII: Contents of Reception Orders

Criteria	Yes	No
Date filled in	682 (98,8%)	8 (1,2%)
Directed to Lentegeur Hospital	669 (97,0%)	21 (3,0%)
All certification criteria completed	627 (90,9%)	63 (9,1%)
At least one of the seven criteria fulfilled	566 (82,0%)	124 (18,0%)
All of the above done	551 (79,9%)	139 (20,1%)

4.3.3.4 Report to the Attorney General

In 279 (40,0%) cases there was no record of this report having been completed. The results refer to those 418 cases where the G2/28 was found, and are summarised in Table XIII.

Table XIII: Contents of the G2/28

Criteria	Yes	No
Document found	418 (60,0%)	279 (40,0%)
Date filled in	418 (100,0%)	0 (0,0%)
Clear recommendation made	403 (96,4%)	15 (3,6%)

a. All 418 had a date filled in.

b. The patient was considered not certifiable in 274 (65,6%) instances, certifiable in 129 (30,9%) and there was no clear recommendation in 15 (3,6%) forms.

Of the 418 forms found, 403 (96,4%) were valid for content, while 15 (3,6%) were not. The certification process can be considered legally flawed in these 15 cases as well as in the 279 cases where no G2/28 was done.

4.3.3.5 Overall validity of document contents

The number of certifications where all documents (G2/1, first G2/2, G2/3 and G2/28) were found and proved to fulfil the "content requirements" was 205 (29,4%). (This result is based on checking only one of the two Medical Certificates, because of the large number of missing second certificates. Were the second G2/2 included, the results would be even less favourable). Table XIV shows the summary results of the individual document checks performed.

Table XIV: Summary results for document contents

Criteria	Found and proves valid	
	Yes	No
Application	651 (93,4%)	20 (2,9%)
Medical Certificate	466 (66,9%)	220 (31,6%)
Reception Order	551 (79,1%)	139 (19,9%)
Report to the A-G	403 (57,8%)	294 (42,2%)
All of the above	205 (29,4%)	492 (70,6%)

4.3.4 CERTIFICATION PROCESS

The results on the important temporal safeguards, as described in Chapter 3, are reported on here.

4.3.4.1 Delay between seeing the patient and making the Application

This cannot be measured directly from the information in the certification papers. An indirect means of assessing this has been discussed in Chapter 3.

4.3.4.2 Delay between Application and Reception Order (G1-G3 Delay)

In this sample the G1-G3 delay ranged from 0 days to 445 days. The majority 642 (92,1%) were done well within the 14 day period, as can be seen in Table XV. Nineteen (2,7%) certifications did not fulfil this stipulation, and in a further 36 (5,2%) the delay could not be worked out either because one of the forms was missing or the date was missing on one or both of the forms.

Therefore, 19 certifications were invalidated by this check.

Table XV: Delay between Application date and date of issue of Reception Order

Delay	Number of certifications
Unable to calculate	36 (5,2%)
0 - 7 days	626 (89,8%)
8 - 14 days	16 (2,3%)
15 - 21 days	6 (0,9%)
22 - 28 days	1 (0,1%)
More than 28 days	12 (1,7%)
TOTAL	697

4.3.4.3 Delay between Medical Certificates and Reception Order (G2-G3 DELAY)

With regard to the delay between Medical Certificate and Reception Order it was found that the majority 661 (94,8%) were done well within the 14 day period allowed. In fact almost 80% were completed on the same day as the Reception Order was issued. In two cases a Reception Order was issued on certificates older than 14 days. An unexpected finding which occurred in 16 (2,3%) cases was that the Medical Certificates were done between one and four days after the Reception Order was issued. Table XVI sets out the details of this check.

Table XVI: Delay between Medical Certificates and Reception Order

Delay	Number of certifications
Unable to calculate	18 (2,6%)
MC done on day of RO	554 (79,5%)
MC done 1 day before RO	71 (10,2%)
2 days before RO	12 (1,7%)
3 days before RO	8 (1,1%)
4 days before RO	9 (1,3%)
5 days before RO	7 (1,0%)
18 days before RO	1 (0,1%)
23 days before RO	1 (0,1%)
MC done 1 day after RO	9 (1,3%)
2 days after RO	2 (0,3%)
3 days after RO	4 (0,6%)
4 days after RO	1 (0,1%)
TOTAL	697

4.3.4.4 Delay between Admission and Report to the Attorney-General (ADM-G28 DELAY)

One of the most important safeguards for an involuntary patient is the G2/28, which also has to be completed within 7 days of admission. In the sample 279 (40%) of patients were never reported on to the Attorney General. It can be seen from Table XVII that only 193 (27,7%) of patients were reported on in the period specified, while 225 (32,3%) of reports were done after the 7 day period allowed, ranging from 8 days to 310 days.

Table XVII: Delay between admission and completion of the G2/28

Delay	Number of certifications
Done on day of admission	3 (0,4%)
1 day after admission	7 (1,0%)
2 days after admission	8 (1,1%)
3 days after admission	5 (0,7%)
4 days after admission	8 (1,1%)
5 days after admission	20 (2,9%)
6 days after admission	24 (3,4%)
7 days after admission	118 (16,9%)
Done day 8 - day 14 after admission	174 (25,0%)
Done day 15 - day 21 after admission	30 (4,3%)
Done day 22 - day 28 after admission	7 (1,0%)
Done day 29 - day 35 after admission	4 (0,6%)
Done day 36 - day 42 after admission	3 (0,4%)
Done more than 42 days after admission	7 (1,0%)
TOTAL	697

4.3.4.5 Duration of stay on Reception Order (RO-STAY)

A patient may not be detained on a Reception Order for longer than 42 days, unless a Detention Order has been obtained in the interim. The process for obtaining the Detention Order is initiated after the G2/28 has been submitted to the Attorney-General. It follows that if a G2/28 was not done (or not done on time), then a patient may only be kept in hospital for a maximum of 42 days. It was observed, in this sample, that 15 (2,2%) patients were detained for longer than the time allowed under a Reception Order. Table XVIII gives the details.

Table XVIII: Duration of stay on Reception Order

Stay on Reception Order	Number of certifications
Cannot be calculated	4 (0,6%)
42 days or less	678 (97,3%)
More than 42 days	15 (2,2%)
TOTAL	697

4.3.4.6 Overall check on temporal safeguards

When the entire process was tested in each of the 697 cases, only 173 (24,8%) complied with all the time limit requirements. In other words 524 (75,2%) of all involuntary hospitalisations were legally flawed with regard to the time limits stipulated in the certification process.

4.3.4.7 Content and temporal safeguards combined

If one were to examine both the document contents criteria and the time limits in the certification process, an alarming 609 (87,4%) of the 697 admissions were legally flawed, leaving only 88 (12,6%) of certifications as valid.

Figure 2 provides a graphic idea of the number of certifications that actually fulfil the criteria at each stage of the certification process. Each certification was examined, and only those that "passed" the check for a stage were then subjected to the next check. This allows us to identify the main problem stages in these certifications, and will be discussed in detail in Chapter 5.

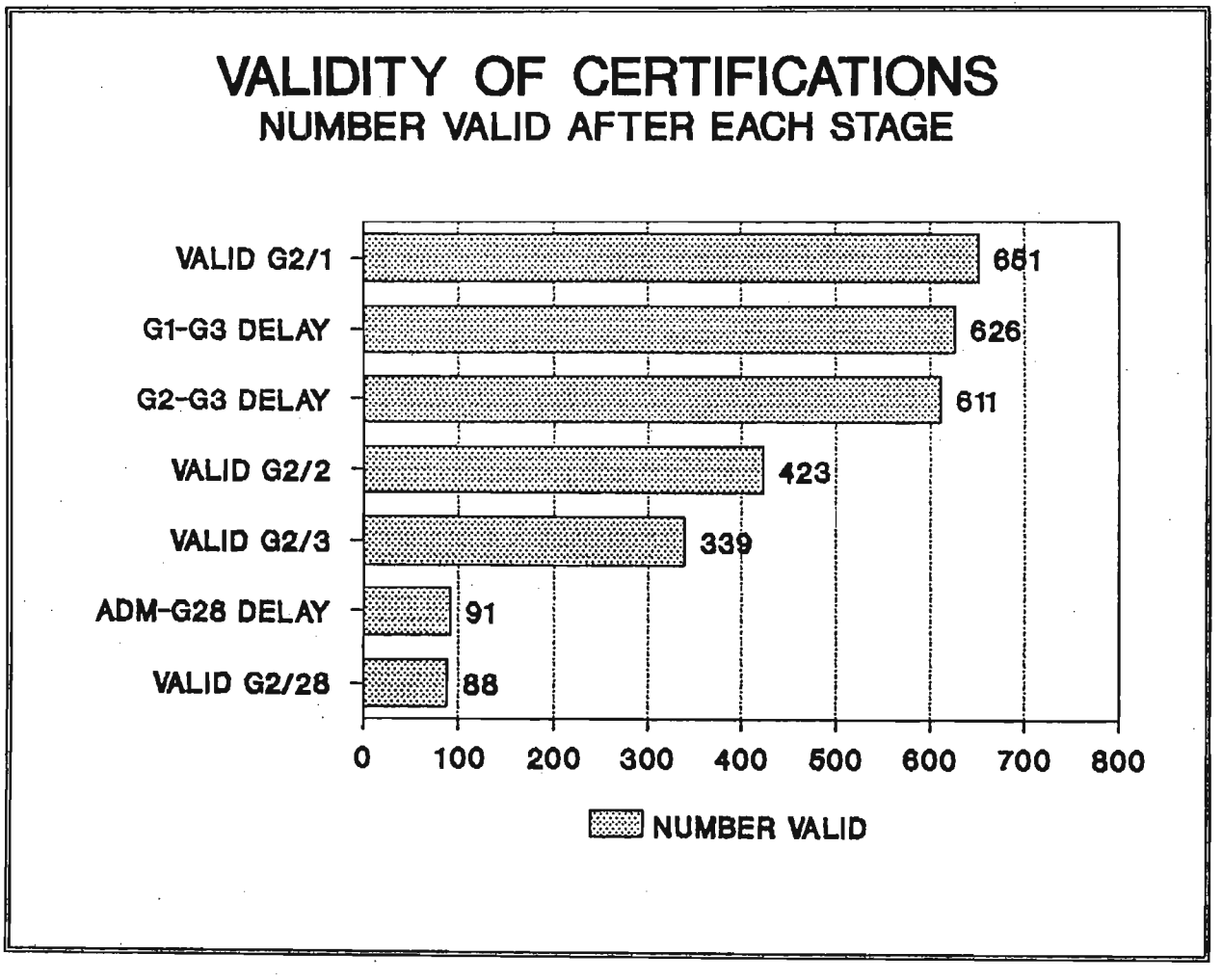

Figure 2: Validity of certifications at each stage.

Chapter 5

DISCUSSION OF RESULTS

In general, the researcher has found that this study raises as many (if not more) questions than it answers. This is not necessarily a bad thing, as it demarcates areas for further detailed study.

5.1 DEMOGRAPHIC FEATURES

The predominance of young males in this study group is similar to the findings of others, both in South Africa (Kaliski et al. 1990) and elsewhere (Shore et al. 1981, Segal et al. 1988). The findings of the Sterkfontein study (Kaliski et al. 1990), however, were that females made up roughly 32% of that sample, whereas in this study they formed only 20,4% of the sample. This may be a reflection on differences in the study population (with regard to cultural or socio-economic factors) or to regional differences in certification practices.

The predominance of single people is also similar to the findings of the other studies referred to above.

The figures for employment status cannot be scrutinised too carefully, as statistics for unemployment in the population are not readily available for comparison. Further study of this phenomenon could prove to be interesting. Are these people unemployed as a result of the effects (morbidity) of the mental illness?; is it a reflection of discriminatory employment practices against the mentally ill?; or is the unemployment rate no different from a matched sample from the general population?

The majority of patients, as expected, are from urban areas. Rates for certification (Table IX p.70) from each of the magisterial districts - calculated per 100 000 of population - do, however, indicate that further study of this area is warranted, as there appears to be a wide variation in certification rates. As an example, the magisterial district of George ("Coloured" population 39237 in 1990; 44 patients; certification rate 112) certified almost the same number of patients as Bellville (population 108 888; 45 patients; rate 45). The lower certification rate of Bellville, may be due to accessibility of services, as it is a developed urban area. However, this cannot be the only explanation, because Caledon (population 46 748; 18 patients; rate 38), Malmesbury (population 73 507; 3 patients; rate 4) and Oudtshoorn (population 43 595; 25 patients; rate 57) are "non-urban" magisterial districts with lower rates than George. One could ask whether this discrepancy is due to differences in services between these areas; or whether certification rates depend on accessibility of specialist (consultative) advice; or whether there are a greter number of severely disturbed mentally ill people in the George magisterial district; or whether the threshold for certification is lower in certain areas. If the answer to any of these questions is "Yes", then it would provide invaluable information for planning of

future mental health service delivery. Such questions need to be investigated thoroughly, and the problems have to be addressed if the "New Health Policy" for South Africa is to be successful.

5.2 GENERAL INFORMATION

5.2.1 DURATION OF HOSPITALISATION

Despite the fact that there are not too many stringent safeguards regarding prolonged involuntary hospitalisation in South Africa, it is clear from the results that, at LH at least, most certified patients have a brief hospitalisation. On the one hand, this is quite encouraging; but, on the other hand it raises some questions that need further study. For example, is the hospitalisation so brief because patients have to be discharged to make room for new incoming patients? Also, one may ask that if the stay was so brief (and presumably the patients were well / not certifiable at the time of discharge) then did they need certification in the first place?

These questions may be answered in part using indirect observations. With an admission rate of around 4 000 per year, the majority (82%, according to the official hospital statistics) of whom are the so-called "acute admissions" as opposed to "long-term" admissions, and noting that the hospital has 230 beds allocated for this type of patient, a simple calculation reveals that, statistically speaking there have to be roughly 14 cohorts (3200 divided by 230) of patients during the year. This implies that each cohort of patients spends roughly 26 days in hospital (365 divided by 14). This

is a very brief duration of stay, taking into account the nature and treatment of psychiatric conditions, and may indicate that circumstances (i.e. high admission rates) force a rapid turnover of patients. If this is the case, then the path ahead for mental health delivery is clearly outlined: we need to investigate ways of reducing the admission rate in order to reduce the enforced turnover, and thus provide those that need hospitalisation to be able to stay for a more realistic period of time for treatment. This may prevent the development of a "revolving-door" type of scenario.

To answer the second question, we need to compare the duration of stay for certified patients (18 days) against the hospital average for acute patients (26 days). Therefore, the figure for certified patients appears to be less than the average for acute admissions to the hospital. Could this be an indication that these patients are being accorded different treatment? Or does it mean that these involuntary patients, who presumably should have more serious mental conditions, get better sooner than those with less severe mental illness (i.e. those that did not require certification in the first place?). The answers to these questions may indicate the direction that needs to be followed for future mental health research conducted in the Cape Province and the rest of South Africa; namely research into service-delivery aspects, which will be followed by an implementation (of recommendations) stage and an evaluation (of interventions) stage.

5.2.2 PATIENTS WITH PHYSICAL CONDITIONS

The number of certified patients who had a physical illness, or communicable disease or had injuries is relatively small. From this study, it is not possible to determine what actually transpired during their admission. If further study of this aspect reveals that patients with these conditions are admitted to mental hospitals rather than first being sent to a general hospital, it provides us with a further avenue for improving the screening of patients for involuntary hospitalisation. Namely, we have to ensure that the provisions of the Act, which are very clear in this regard, are followed carefully. This would go a long way in reducing the problems encountered when physically ill persons are admitted to a mental hospital (Kaliski et al. 1990). Where should such screening occur? It seems evident, from the small numbers of patients involved, that general practitioners are largely providing this aspect of management, as it should be. If some patients happen to slip through the screening net, it is left to the admitting doctor at the psychiatric hospital to fulfil this role. Taking into account the inadequate medical and emergency facilities at psychiatric hospitals in general, it may be argued that an unnecessary burden and responsibility is falling upon the receiving hospital. Kaliski et al. (1990) have also expressed this concern with regard to patients sent to Sterkfontein Hospital.

5.2.3 GENERAL OBSERVATIONS ON DOCUMENTS

During the study, scrutiny of the documents raised some general points of concern. Some specific problems with the document contents were also noted, and are discussed in more depth later.

The general points will be listed, but not discussed further, as they occurred in isolated cases.

a. The different Departments of Health (e.g. National Health and House of Representatives, and in Natal, the Kwazulu Department) have different forms. This is needless duplication, and only serves to confuse users and waste money.

b. The spelling of the name of the person being certified differed from one form to the other, or even within a document. More rarely, different first names were used. Some may regard this as unnecessary "nit-picking", but the judiciary takes a rather more serious view of this (Department of Justice. "Codified Instructions" p.33).

c. Many parts of the Medical Certificates forms were left completely blank. This applied to parts as diverse as address, age, medical opinion on whether the patient had any physical illness / communicable disease / injury, medical opinion on dangerousness to self or others, and the recommendation to magistrate.

d. Some Medical Certificates were identical. The Act allows for a joint examination, although the "Codified Instructions" (Department of Justice) stress that the two doctors must examine the patient independently (p.12). Clarity is needed in this regard.

e. In some instances the "second medical certificate" was a carbon copy of the first.

f. The sections on the forms which require a "Yes" or "No" response were a source of much concern to the researcher. There was no standard way of indicating what the response was in actual fact. In some cases doctors circled their response, others ticked it while still others marked it with a cross. If there was consistency, this would be perfectly acceptable. However, in a few instances, doctors crossed out what was obviously the opposite of their intended response, presumably as these doctors felt they were "deleting what was not applicable". (In a few instances, the respondents seem to have carefully placed the centre of their cross in the dividing line between the "Yes" and "No" response, effectively giving no response, or an intentionally ambiguous one rather than stating that they did not know the answer!)

g. Reception Orders were also, in quite a few instances, glaringly deficient. The names of the doctors called in by the magistrate were not always completed. In some cases there was one name, but in others there was none. In one case there were three names recorded. In still others, a doctors name on the Reception Order

did not correspond with either of the Medical Certificates.

h. Another part of the Reception Order that was poorly completed was the grounds for issuing it. The form requires the magistrate to set out the grounds for granting the order, with either a "Yes" or a "No" response to each of seven questions. Some courts used poor photocopies of the form, with the bottom one or two questions cut off. Also, the points mentioned under "Medical Certificates" with regard to this type of question applied as much to Reception Orders. In addition, the question on psychopathy seemed to have been poorly responded to in the majority of instances.

Though these problems were not widespread, they need to be taken cognisance of, as they reflect on the care and concern exercised in completing the forms. Carelessness in this aspect gives the impression that the individuals concerned are not fully aware of the seriousness of certifying a person, thus depriving him/her of personal liberties.

Recommendations specific to these forms are made in Chapter 6.

5.3 DOCUMENT CONTENTS

5.3.1 APPLICATION FOR RECEPTION ORDER

In 26 (3,7%) of the 697 Section 9 admissions the G2/1 could not be found because the administrative file had been transferred to another hospital (1 case), a temporary administrative file was in use currently (2 cases), there was no G2/1 in the file (20 instances) or the patient was sent to LH with a Forensic Observation Report - accompanied by a Reception Order - instead of going through the correct certification process (3 cases).

Kruger (1980 p.58) reminds us that:

> "A Reception Order entails serious inroads into the rights of a patient, and it is vitally important that all actions in connection therewith be performed with the greatest care and circumspection...The Application for a Reception Order (G2/1) is an essential requirement upon which the issue of a Reception Order (G2/3) must be based. If such an essential requirement is not complied with, it vitiates all further proceedings based upon it."

This study has found that the Application (G2/1) stage was the least unsatisfactory aspect of the certification procedure. It is disconcerting, however, that even this fairly uncomplicated stage posed problems in some instances. In view of the clear guidelines there is little justification for the date or the affidavit not being completed. Furthermore, a

Magistrate should refuse to accept a G2/1 if it has these defects.

It is also of concern that such an important document as a G2/1 goes missing (or is not filed) in some instances. Although this occurred in a very small proportion of cases, every step must be taken to prevent such an event.

More worrying is the fact that Forensic Reports were substituted for the G2/1 (and, for the Medical Certificates) in three cases. Forensic Reports are issued under the provisions of the Criminal Procedures Act (Act 51 of 1977), and not of the MHA. As such, they may not be used to admit a patient for involuntary treatment under Section 9 of the MHA; the recommendation of the Forensic Psychiatrist may be used by the Magistrate/Judge as the basis for initiating the full procedure for involuntary hospitalisation under the MHA. If this is not done, then it can be argued that CRIMINAL justice procedures are being applied to a CIVIL certification, possibly rendering the certification process null and void. If such an admission is contested (after the 30 day period allowed in law for a magistrate to amend errors in documentation), then the patient will have to be discharged on this technicality. In many instances this may have few, if any, repercussions. Many of our certified patients are discharged well within thirty days of admission. However, the possibility exists that the "discharge on technicality" may be premature, and that a person potentially dangerous to others (e.g. assaultive or homicidal) or to himself (e.g. lacking in judgement and thereby getting himself into a dangerous or exploitable situation) would have to be sent out into the community.

5.3.2 MEDICAL CERTIFICATES

Of the expected 697 first Medical Certificates, only 686 were found. Of the 11 that were missing, three can be accounted for because the Forensic Report was used for certification, as discussed above. One assumes that the other 8 may have been misplaced, misfiled or not filed, as it is unlikely that these patients were sent in on Reception Order without the Magistrate having called for even one Medical Certificate. A second Medical Certificate was submitted in only 369 cases (52,9%). This is a more serious concern. The Act allows for certain instances where only one Medical Certificate may be used for certification; however, this should only apply where only one medical practitioner is available e.g. in small or isolated rural communities. This concession should not apply in the case of large cities and towns, but was found to occur frequently in the certifications examined in this study (Table VI p. 66). One questions why certain of the larger magisterial districts submitted only one Medical Certificate in such a high percentage of certifications, for example Wynberg (71,4%); Goodwood (37,5%); Caledon (61,1%); George (97,7%); Paarl (77,3%) and Worcester (96,9%). Magisterial districts of comparable or smaller size ensured that the patient was seen by two doctors in all instances (e.g. Cape Town, Oudtshoorn, De Aar, Knysna, Somerset West and Strand) or in a large percentage of cases, for example Bellville (80%) and Ceres (96,8%).

When the contents of these documents were examined, one fact stood out: doctors were very meticulous about filling in dates and completing the declaration (which is required under Section 23 of the Act)! All the Medical Certificates had the date completed, and in all cases the declaration was done. Unfortunately though,

other parts of the G2/2 were not as carefully completed. In a fairly large percentage of cases, whole sections were left completely unanswered e.g. the "dangerousness" criteria (in 15,0%), and the "need for treatment" criteria (in 4,2%). The reasons for these two sections being poorly completed cannot be supplied by a study of this nature, and speculation in this area could prove very contentious. It is important to probe for possible explanations, though, as this may define what interventions are necessary and how these may be implemented. The points mentioned above may indicate a reluctance on the part of some doctors to commit themselves to an answer, or to a lack of appreciation of the weight placed in the law on their opinion in these aspects, or to an unawareness of the requirements of the law in this regard, or to lack of knowledge, or in some cases even to negligence. The actual reasons may have to be teased out by a study which specifically sets out to examine this issue. Such a study would lay the foundation for incisive interventions which will remedy the difficulty.

5.3.3 RECEPTION ORDERS

The seven missing Reception Orders may only be accounted for by filing delays / errors or if the document was mislaid, as it is legally not possible for a patient to be admitted under Section 9 without a Reception Order. Steps must be taken to rectify this.

No explanation is apparent as to why patients directed to another mental hospital (Valkenberg) were admitted to LH. It is equally unclear why, in 8 cases, no hospital was mentioned in the Order. It is not known why these patients were admitted to LH (and not to Valkenberg or Stikland), or who made the decision to

bring them to LH, and on what grounds. It is possible that the ambulance personnel, for example, made this decision based on their knowledge of the approximate catchment areas (see the section on "Background" for details) or based on the racial classification of the patient. Whilst it may be seen as a trivial issue by some, it could be argued that the superintendent of LH had no authority to detain these patients.

Magistrates are expected to set out the grounds upon which they decide that a person is so severely mentally ill as to require hospitalisation against his will. This study found that in 63 instances (9,1%), this part of the G2/3 had been left completely blank. In 124 cases (18,0%), not even one of the seven criteria listed in the form had been answered in the affirmative (Table XII p.75). This situation is not justifiable at all. The essence of the magistrates' role is to elucidate why the person in question needs to be admitted under this Section of the MHA, and in not making this clear a magistrate could be considered as being neglectful in this aspect. The reasons for such shortcomings in Reception Orders need investigation, as discussed above with regard to Medical Certificates. It can be seen from Table XII (p. 75) that only 551 (79,1%) of all Reception Orders were faultless in <u>all</u> parameters examined. From another point of view this means that just over one-fifth of Reception Orders were flawed, thereby legally invalidating the admission.

5.3.4 REPORT TO THE ATTORNEY-GENERAL

It is very disturbing that in 279 (40,0%) cases there was no record of the G2/28 having been completed. It seems unlikely that these were never done. The reasons for this Report (which is one of the most important safeguards in the MHA) not appearing in the administrative or clinical files of patients has to be thoroughly investigated, and any inadequacies which become apparent after such an enquiry must be rectified.

Only 15 (3,6%) of the reports studied did not make a clear recommendation. Thus, although there seemed to be only a minor problem with regard to this aspect of the G2/28, it is suggested that doctors be mindful of the purpose of this report, and always try to provide a clear opinion to the Attorney-General.

It must be remembered that the certification process can be considered null and void in the 279 cases where no G2/28 was done.

5.4 CERTIFICATION PROCESS

5.4.1 DELAY BETWEEN APPLICATION AND RECEPTION ORDER

The G1-G3 delay in 35 (5,0%) certifications was greater than 7 days, and in a further 36 (5,2%) the delay could not be worked out either because one of the forms was missing or dates were missing on one or the other form. Thus, an important component of the MHA is not being carried out, namely that a Reception Order must be based on recent information. The accountability for such an occurrence may be placed squarely on the shoulders of the magistrate concerned.

5.4.2 DELAY BETWEEN MEDICAL CERTIFICATES AND RECEPTION ORDER

Although the majority 661 (94,8%) of Medical Certificates were done well within the 14 day period allowed, steps must be taken to ensure that all are done within this period. Also, it needs to be explained how it came about that, in 16 (2,3%) cases, the Medical Certificates were done between one and four days after the Reception Order was issued. If it is found that that the Reception Order was issued and only later a medical opinion was asked for as a formality, then this is a serious problem and needs to be addressed. A magistrate is not authorised by the MHA to make this type of decision. In not getting a medical opinion, and especially if there is a delay of a few days in getting it, the magistrate could inadvertently be compromising the health of the patient

if, for instance the patient has a treatable organic cause for his mental symptoms.

5.4.3 DELAY BETWEEN ADMISSION AND REPORT TO THE ATTORNEY-GENERAL

In the sample, 225 (32,3%) of reports were done after the 7 day period allowed, ranging from 8 days to 310 days. This defeats the purpose of making the Report, which (in part) is intended to ensure that patients who do not require certification are not detained in hospital unnecessarily. On the other hand, it is intended to provide information to the Attorney-General, to allow the matter to be brought before a Judge. If this Report is not done on time, the certification process is stalled at this stage, and a Detention Order will not be obtained, and the hospital is then obliged to discharge the person within 42 days, or initiate a new Application for a Reception Order. In either instance, the patient's best interests may be compromised: he may be detained longer than necessary, or he may have to be discharged on a technicality even though he is in need of treatment. This phenomenon of late and/or missing G2/28 reports needs further investigation.

5.4.4 POSSIBLE PROBLEM AREAS IN THE PROCESS

When one notes that 609 (87,4%) of all certifications studied for a one year period were in some way legally imperfect, one is compelled to state that a hard and serious examination of the reasons for this need to be made. It would be frivolous to assume that this problem is unique to one hospital or one province. The literature points to this phenomenon (i.e. the "gap") as being not uncommon world-wide (e.g. Turkheimer and Parry 1992). Furthermore, studies in Canada (Paredes et al. 1990) and Australia (Baxter et al. 1986) have found this to be the case as well. As far as the researcher is aware, there are no South African studies for comparison.

However, arising out of this study, certain areas of the certification process stand out as being most problematical, and it is these areas that need careful study and rectification. These include the instances where only one medical certificate is submitted, quality of document contents, adherence to time-limits, and the Report to the Attorney-General.

5.5 CLOSER MONITORING OF INVOLUNTARY HOSPITALISATION

It seems evident, from the findings of this study, that a fairly large "gap" exists between the intended spirit of the MHA and how this is translated into practice. Over 87% of all certifications in this study did not meet the existing safeguards.

The study has found that problems exist at every stage of the certification process, to a lesser or greater degree. Different persons / professional groups are responsible for ensuring that each stage is in compliance with the legal standards. A Commissioner of Oaths has to ensure that the G2/1 applicant signs an affidavit; each medical practitioner, when completing his G2/2, understands that his input is regarded as having being done under oath; the magistrate is expected to ensure that "flawed" documents will not be used to base a Reception Order upon; the hospital superintendent, via the G2/28, has to recommend whether or not a patient requires involuntary hospitalisation; the Attorney-General has to be satisfied that all documentation and reports are up to standard and completed on time; and, the Judge-in-chambers, after considering all this information, has to decide whether the patient should continue to be a Section 9 patient or not. Despite all these controls, the legal standards are only being met in just over one-tenth of cases. It is a high priority for all people involved in this process to ensure that this unsatisfactory scenario is rectified as soon as possible.

5.6 INCREASED PROCEDURAL SAFEGUARDS

Following on the discussions concerning existing safeguards, it is appropriate to remind ourselves at this point that, even if we were to achieve a satisfactory level of practice within the ambit of the existing mental health legislation, we would soon be pressured (by the international community and from within our own shores) to re-examine some aspects of the MHA. More than a decade ago, Snyman (1984) expressed concerns about the lack of procedural safeguards. Whilst much has changed in the arena of

mental health reforms in this time, with the "pendulum" having swung away from the radical reforms proposed by the civil libertarian lobby, it remains a high priority that at least some of the concerns expressed by this lobby be addressed. In this, we can learn from the experience of other centres that went through the same process a decade or two ago, and we may be able to adapt their guidelines to our situation. With our country standing on the threshold of full international acceptance (academic and otherwise), we cannot afford to adopt a "reactive" approach. What is required is a pro-active strategy, which will ensure that, when academic recognition becomes imminent, very little stands in the way.

Chapter 6

CONCLUSIONS AND RECOMMENDATIONS

The recommendations arising out of this study may easily be implemented in the near future. The MHA of 1973 is undergoing revision, and some of the findings of this study may be relevant to the amendment process. In the meantime, it would also be possible for magistrates, general practitioners, district surgeons and hospital superintendents to examine the circumstances insofar as their own areas of practice are concerned, and if necessary, to try and "iron out" any difficulties that may exist.

6.1 DOCUMENT FORMAT

The general points of concern, as discussed in Chapter 5 p.89, may point to problems with the formats of the documents themselves, or with the instructions contained therein, or to some ambiguities or lack of clarity in some sections. There is also a fair amount of duplication of basic information, it seems. The following suggestions are thus appropriate.

a. Some parts of the forms could be redesigned (after consultation with the various users of the forms), possibly put through a pilot test in a small catchment area to iron out difficulties not thought of during the discussions, and then issued for general use.

b. The inclusion of clear instructions, regarding even some minor aspects (e.g. on how to indicate a "yes/no" response) may also enhance the quality of responses in these forms. In fact, some colleagues have felt that the response boxes should be done away with, and the person filling in the form must write out his response.

c. Only one standard form be used throughout the country, and not different forms from different Administrations (e.g. House of Representatives or Kwazulu).

6.2 DOCUMENTS NOT FOUND

A fair number of documents were not found. There seem to be various reasons why this may have happened. Some were probably never submitted, whilst some may have gone missing. The suggestions for minimising or eradicating this problem follow.

a. Loose sheets of paper may be more easily misfiled, misplaced or lost. It may help to have all the documents in booklet form, rather than as separate sheets of paper. Each such booklet would contain instruction pages which would give brief guidelines for the correct completion of the forms. Such a booklet would contain an Application for Reception Order, an Application for Urgency Reception, a section for each of the Medical Certificates, a Reception Order form, a Report to the Attorney-General and a Detention Order. Periodical Reports need not be included, as nowadays the vast majority of patients stay in hospital for less than one year. Where applicable, there could be second and third copies of each document, in the form of tear-out pages. The magistrate dealing with the Application would retain one copy of the G2/1, each of the G2/2 and of his Reception Order. The hospital would do the same, retaining a copy of the G2/28 as well. The booklet, with the originals / first copies would be sent to the Attorney-General for submission to a Judge-in-chambers. When the Judge has decided on what further action has to be taken (e.g. if he orders that the patient be discharged, or if he issues a Detention Order), this would also be done in the same booklet. At this stage the booklet could be returned to the hospital for filing, and both the Attorney-General's office and the magistrate would have retained duplicates of the documents on their files. In the event of an enquiry, the relevant documents would be immediately available for reference.

b. Such a booklet will obviate the need for duplication of some information (e.g. demographic data) which is found with the current forms.

c. If the suggestion of a booklet is not acceptable, then measures have to be taken at the local hospital level to minimise the problem of documents going missing. The filing system has to be upgraded and/or the resources allocated for this aspect have to be expanded.

6.3 LATE AND INADEQUATE DOCUMENTATION

It is desirable that more efficient and effective controls and checks be introduced to ensure that the legal requirements are met in this regard.

a. A magistrate should totally refuse to accept the G2/1 or either of the Medical Certificates if they are late or not up to legal requirements; he should ask that they be corrected before a Reception Order is issued. This would have the advantage of providing immediate feedback and a form of "in-service training" to those concerned.

b. The Attorney-General would provide this same prompt service to hospital doctors regarding their G2/28. Furthermore, the Attorney-General could also assist magistrates with regard to the Reception Orders, and point out inadequate G2/1 and G2/2 documentation that the magistrate may

have missed. When busy people (like general practitioners, district surgeons, magistrates and hospital doctors) are asked to spend time to resubmit correct forms, it is very likely that mistakes and omissions will not be repeated too often!

c. A magistrate should not accept only one Medical Certificate too easily. It is unlikely that there is only one doctor available in a larger town, let alone in a large, urban district such as Wynberg. The second (independent) medical opinion is an important component of our legislation, and if necessary, private practitioners should receive adequate remuneration for providing their services in this regard.

6.4 REPORT TO THE ATTORNEY-GENERAL

This requires special mention, as it provides the Attorney-General and Judge-in-chambers with an "expert" or "informed" opinion with regard to the psychiatric status of a patient. To ensure that this report fulfils the purpose for which it is meant, mechanisms have to be in place at both an internal (i.e. hospital) level and an external (i.e. the Attorney-General's office) level.

6.4.1 INTERNAL MECHANISMS

A very important role is assigned to a Hospital Superintendent in the MHA, who has to ensure that the tasks entrusted to him are correctly carried out by those to whom they have been delegated. In the face of large admission rates and rapid turnover of patients, one can understand that this is no easy task. The suggestion, which may lessen the burden in this regard is that an enquiry be started to trace the main hitches in the existing system, and how they may be overcome. LH, being geographically very spread-out and with seven wards admitting acute patients, presents a huge challenge with regard to communication and transmission of mail between different parts of the hospital. Aspects which may need to be scrutinised more carefully are listed below.

a. Who has responsibility for ensuring that a G2/28 is done on time?

b. Who should ensure that these reach the administration section on time?

c. Who should keep track of all involuntary admissions, and provide a reminder service to doctors who have a G2/28 outstanding?

d. When, in the seven day period allowed for this report, should this reminder be provided?

e. How will the person who is requested to provide this service manage to keep track of this?

f. How will it be ensured that the typing (and typographical corrections) are done promptly, thus allowing the papers to be submitted to the Attorney-General?

Once these questions have been addressed, and a protocol is established, it would certainly improve many facets of this Report to the Attorney-General.

6.4.2 ATTORNEY-GENERAL

a. It has already been suggested above that the Attorney-General liaise with hospital doctors, to promote prompt and correct documentation.

b. It would also be helpful if the Attorney-General's office is made aware, at the time of issue of the Reception Order (rather than at the time of admission), that a patient is being sent to a particular hospital. In this way, the Attorney-General would have extra time to monitor G2/28, and to apply pressure if any G2/28 is outstanding.

c. With regard to the suggestion above, it would appear that Section 55 of the MHA of 1973, which was rescinded by the Mental Health Amendment Act (Act No. 52 of 1988) could be reviewed, and possibly re-introduced with the requirement that "A magistrate who issues a Reception Order under this Act shall without delay give notice of the order to the Attorney-General".

6.5 INSERVICE TRAINING

Many legal and ethical complexities surround the certification process, and it is not surprising that errors are made by all persons involved. Whilst it is taken for granted that everyone is acting in good faith, it is of concern that the errors, when examined in combination, invalidate over 87% of certifications. It is therefore suggested that the highest priority be given to adequate training of all persons who may become (or are) involved in dealing with patients who may be involuntarily hospitalised.

a. Ideally, this training would be provided by special teams, consisting of personnel who have first-hand knowledge of the practical aspects of certification. Each psychiatric hospital could be asked to organise an adequate number of such teams to cover their catchment area.

b. Such teams would have the brief to provide refresher courses for qualified doctors, whether working in the community (as general practitioners or district surgeons), in general hospitals or psychiatric hospitals.

c. Courses for undergraduate medical students should be designed by such teams, to provide clear <u>practical guidelines</u> for the students, many of whom will go into general practice.

Training programmes of this type are already in place in some centres abroad (Spaulding 1985), and could be adapted to suit the local needs.

In summary, this study found that present practices regarding certification are often inadequate. Modification of present practices is greatly needed, in order to deliver a service which adheres to the spirit of existing mental health legislation and ensures that patients' rights are protected and promoted.

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Appendix A

SAFEGUARDS IN THE MENTAL HEALTH ACT

Examination of the MHA reveals that the following safeguards exist, to minimise the possibility of unjust certifications.

a. Under Section 8 (Application for a Reception Order).

The applicant has to:

i. set out the grounds for believing that the person is mentally ill to such a degree that he should be commited to an institution;

ii. state his/her relationship to the person, and if the applicant is not a near relative, state why such an application is being made by the applicant instead of by a near relative;

iii. have seen the person within the seven days immediately preceding the Application

iv. sign an affidavit or solemn declaration in relation to the points above; and

v. hand the Application to the magistrate within seven days of date of signing.

b. Under Section 9 (Issue of Reception Order).

The magistrate:

i. may examine the person for whom the application is being made;

ii. shall call to his assistance two medical practitioners, who are not prohibited under Section 23, who must jointly or separately examine the person concerned, and report their findings to the magistrate;

iii. if satisfied that the person is mentally ill to the degree that commitment is indicated, issues a Reception Order authorising the person to be received at an institution specified in the Order;

iv. shall not issue Reception Order if a period longer than 14 days has elapsed since the medical examination; and

v. may accept a Medical Certificate which accompanies an Application, as if he had called in the medical practitioner to his assistance.

c. Under Section 11 (Period of validity of Reception Order).

i. A patient cannot be held under a Reception Order for longer than 42 days.

d. Under Section 12 (Procedure in cases of urgency).

The requirements are as follows:

i. the applicant must have seen the patient not more than two days prior to the Urgency Application;

ii. the Medical Certificate must contain a statement that the matter is one of urgency;

iii. the Medical Certificate must not be older than two days;

iv. the Medical Superintendent must inform the local magistrate of the urgent admission "forthwith";

v. if a medical practitioner is disqualified (in terms of Section 23) from giving a certificate, two new medical practitioners have to be called in by the superintendent, who must submit these new Medical Certificates to the magistrate;

vi. if the magistrate refuses to issue a Reception Order, the superintendent must be notified "forthwith", and the further detention of the patient under this section shall then be unlawful; and

vii. urgent admissions may not be detained for more than 10 days; this period may be extended by the magistrate to 21 days.

e. Under Section 18 (Informing the Official Curator ad litem).

i. the superintendent shall within seven days transmit the certification documents and the G2/28 to the Attorney-General, who is the Official Curator ad litem;

ii. the Curator ad litem shall "as soon as possible" transmit the report (or further report, which may have been requested) to the registrar of the court in the area of jurisdiction of the hospital; and

iii. the registrar shall "without delay" lay such reports before the Judge-in-chambers, for consideration under Section 19.

f. Under Section 19 (Powers of the Judge-in-Chambers).

The Judge:

i. may issue an order for further detention (Detention Order), for such period as he deems necessary;

ii. may summon the patient and the Curator ad litem to appear before him to show cause why the patient should not be declared a mentally ill person, and why his detention should not be confirmed;

iii. may direct that the person be discharged immediately; and

iv. the registrar shall transmit any order made or direction given by the Judge to the person in charge of the patient.

g. Under Section 20 and Section 21.

i. Any person detained may request an enquiry into the reasons for his admission.

ii. The guardian, near relative, or a friend of any person detained may request an enquiry into the reasons for the admission.

h. Under Section 22 (Rules for Medical Certificates).

In addition to the facts relating to the mental illness, the medical practitioner must state:

i. any further facts observed on any other occasion that are indicative of mental illness in the patient, and the approximate date of that occasion;

ii. any information given to him by any other persons indicating mental illness in the patient, together with the names and addresses of these persons;

iii. the type of mental illness;

iv. the factors that may have caused the mental illness;

v. whether the person is homicidal, suicidal or in any other way a danger to himself or others;

vi. what treatment has been given;

vii. what the physical findings are; and

viii. that he is not prohibited from giving the certificate by Section 23 of the Act.

i. Under Section 23 (Persons prohibited from giving Medical certificate).

The following persons are not allowed to give a Medical Certificate:

i. applicant for the Reception Order;

ii. the superintendent, medical practitioner or the licensee of the institution to which a patient is to be admitted under the Reception Order;

iii. the husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister, sister-in-law or the partner, principal or assistant of any person referred to above, or of the patient or the guardian or trustee of the patient;

iv. the Secretary of Health or a member of a Hospital Board; and

v. the husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, or the partner, principal or assistant of the other medical practitioner giving such a certificate.

j. Under Section 25 (Periodical Reports).

Periodical Reports have to be submitted:

i. annually for the first three years;

ii. in the fifth year; and

iii. thereafter every three years, in the month corresponding to the month in which the patient was admitted.

k. Under Section 26 (Amendments to documents).

   i. Corrections may be made to the G2/1, G2/2 or G2/3 within 30 days of issue of Reception Order, with the permission of the magistrate.

l. Under Section 75 (Medical Certificates).

   i. Any Medical Certificate will be regarded as having being given under Oath.

Appendix B

GUIDELINES TO MAGISTRATES AND DISTRICT SURGEONS

GUIDELINES TO MAGISTRATES, DISTRICT SURGEONS AND MEDICAL PRACTITIONERS INVOLVED IN CERTIFICATION OF MENTALLY ILL PATIENTS UNDER SECTION 9 OF THE MENTAL HEALTH ACT, 1973.

This memorandum is intended to assist the above Professional Staff and Magistrates in the maintenance of a satisfactory standard of certification, in the best interests of those who are subjected to this Procedure.

CERTIFICATION OF A MENTALLY ILL PERSON UNDER SECTION 9 OF THE MENTAL HEALTH ACT OF 1973.

I. The Mental Health Act can be regarded as a model Act protecting both the community and the individual.

II. A recent survey of admissions to psychiatric Hospitals has shown that in cases from certain areas, there is a 60% disagreement between reasons made for certification prior to admission and the observations by the Hospital Team.

Some of the reasons for this discrepancy can be considered:

1. The Application for committal is inadequate or is made for social reasons.

2. Delay in admission to a mental hospital after completion of documents, for example, patients held in Police cells.

3. In the case of a transient stress reaction or drug induced disturbance one can understand that there may be some change in a few days.

4. The mental condition appears as a symptom of some underlying physical condition.

5. The disturbing truth is also that certification might have become too casual in many instances. It is hoped that this document will assist in rectifying this state of affairs.

III. WHO SHOULD BE CERTIFIED

Only patients who suffer from a mental illness as defined in the Act who are regarded to be in need of treatment in their own interests or the interests of the community and who refuse to undergo such treatment should be certified.

A mental illness is defined in section I (xi) "as any disorder or disability of the mind"

According to Section 9 (3) certification must only be considered in "Those mentally ill persons who should be detained". The law does not allow a casual attitude towards certification.

IV. PROTECTION OF THE INDIVIDUAL AGAINST INDISCRIMINATE CERTIFICATION

The Act provides for two professional groups to offer this protection.

1. Medical practitioners

2. Magistrates.

A. TASK OF MEDICAL PRACTITIONERS

The certifying doctor, whether district surgeon or medical practitioner is the first protector. In acting in that capacity he must remember that a Psychiatric Hospital is not as well-geared for treating acute medical conditions a Provincial Hospitals and certainly not geared for treating acute surgical conditions or even serious medical conditions.

It is for this reason that the new Medical Certificate G2/2 deals with the physical aspects of any patient in paragraphs (i) to (iv). It is only logical to conclude that should any physical condition be found during examination that this be treated in a suitable environment as treatment of this condition may itself lead to a disappearance of the psychiatric symptoms or at least prevent early deaths after admission to a psychiatric hospital due to undue delay in obtaining medical treatment.

It is therefore a must and a first priority to do a physical examination on any patient being brought for certification and details entered on the form G2/2.

Patients who are severely dehydrated, injured, suffering from pneumonia or any acute physical illness should not be referred to a psychiatric hospital even if they are grossly mentally disturbed. Although "Certifiable" the priority No.1 is care of their medical condition.

If there is no obvious physical defect during general physical examination it is important to recognise the presence of disturbance of consciousness, as this is the prime symptom which indicates the presence of an organic brain syndrome. A disturbance of consciousness is suggested when orientation and memory are disturbed.

The other important fact to take note of, once it is obvious that the physical condition of the patient does not militate against certification is to realise that the vast majority of mentally ill individuals do not need to be certified and are willing to accept treatment.

The medical practitioner must therefore also give consideration to this matter. The Department regards it as so important that special space has been allocated under the Declaration on page 3 of the form G2/2, where the medical practitioner must specifically make a recommendation as to whether it is necessary to have the patient certified or not.

In formulating these reports the medical practitioners must act independently and refrain from relying on what the other person had said.

It is often noted that the two Medical Certificates on the Form G2/2 are signed by two different doctors, but the reports are identical. This has led a Honourable Judge President to express the view (which is shared by his brother judge) that the sort of reports being presented to Judges and upon which they are being asked to act are most unhelpful.

It is imperative that each medical officer reaches an independent finding after an independent examination of the person referred for certification.

B. TASK OF MAGISTRATE AS RECOMMENDED BY DEPARTMENT

The Mental Health Act of 1973 states in Chapter 3, Section 9 (2)a that a Magistrate may make additional enquiry into the Mental condition of a person and may summon any person to appear before him as a witness to testify with regard to the mental condition of that person.

According to Section 9 (3) of the Act the Magistrate upon consideration of all the evidence relating to the mental condition, including his own observations with regard to such conditions, is satisfied that such a person is mentally ill to such a degree that he should be detained as a patient..... etc.

This implies that if a magistrate is not satisfied with the evidence, he need not issue a Reception Order. An important guideline is paragraph (iii). If there is any indication that the physical health is affected he should delay issuing a certificate until the patient has received adequate treatment for his physical condition.

The Magistrate, not being a doctor, may summon additional reports before certification. Our Community Staff and Social Workers are only too willing to be of additional assistance where it is practicable even for them to go and see the patients.

In the case of remote offices where the physical condition is unsatisfactory, but the patient's mental condition makes it difficult to institute treatment of the physical condition the Magistrate can instruct the District Surgeon to consult telephonically with the nearest psychiatric hospital psychiatrist on advice on how to calm the patient down to enable him to undergo physical treatment first.

Medical Superintendents of all psychiatric hospitals arrange for a 24 hour emergency medical service at the hospital for in-patients. These medical practitioners are available for telephonic consultation by District Surgeons.

V. CONCLUSION

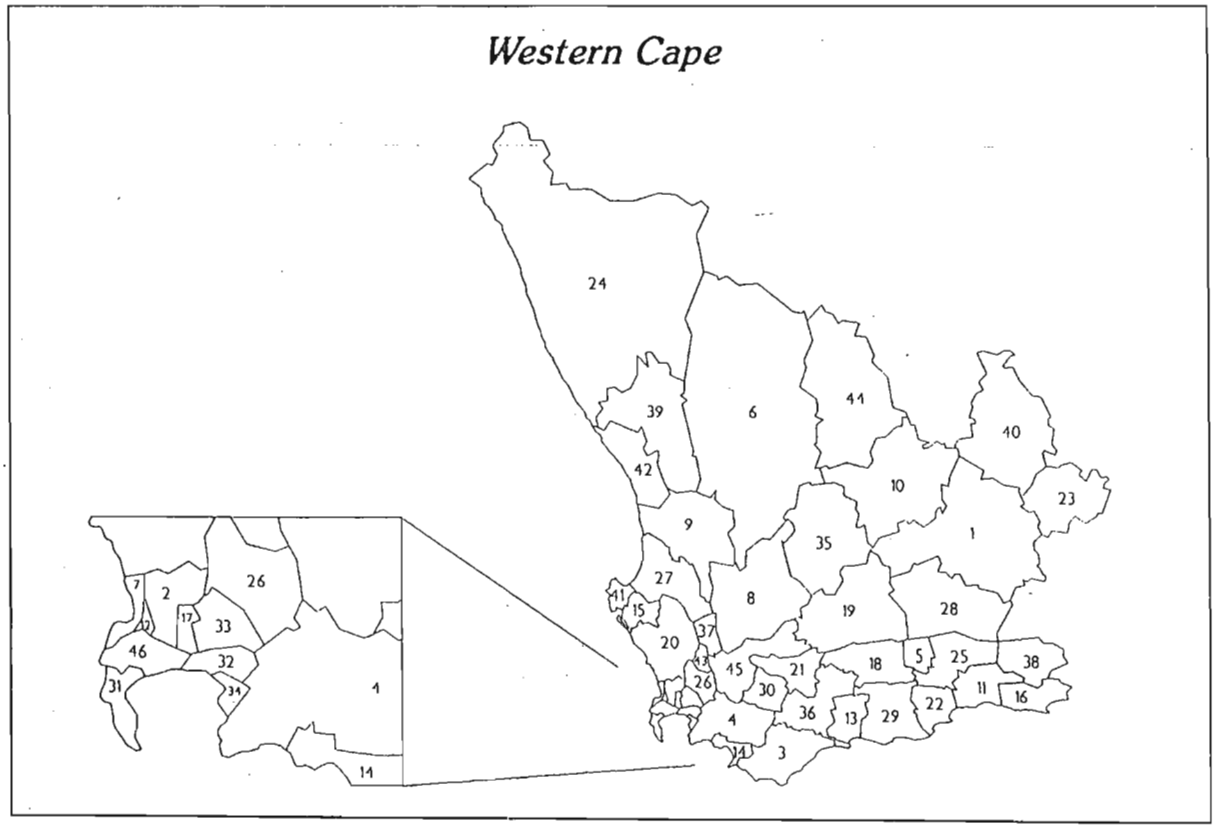
There is concern about the number of patients who are being sent to psychiatric hospital suffering from organic states when they would be better off treated in a General Hospital.

There are also the legal and ethical conditions to be considered when it is borne in mind that by certification the person is deprived of many of his rights and the view is expressed that those who certify the patient (Medical practitioners and Magistrates) only proceed with this step if they are satisfied that in doing so the best interests of the patient are served.

J.P. ROUX
DIRECTOR-GENERAL; HEALTH, WELFARE AND PENSIONS

Appendix C

MAP OF MAGISTERIAL DISTRICTS OF THE CAPE PROVINCE

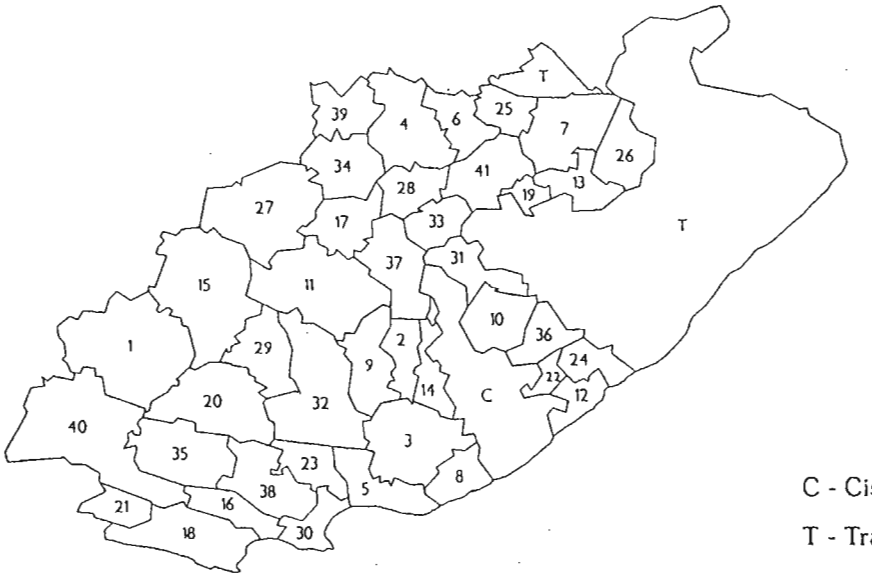


Estimated population - 1992 — *Western Cape (Development region A)*

Map Ref.	District Name	Asian	Black	Coloured	White	Total
1	Beaufort West	10	5 122	24 172	6 404	35 708
2	Bellville	752	4 831	129 013	132 896	267 492
3	Bredasdorp	4	765	15 774	5 314	21 857
4	Caledon	22	12 316	55 786	13 958	82 082
5	Calitzdorp	1	153	6 135	1 361	7 650
6	Calvinia	0	245	16 773	4 345	21 363
7	Cape	2 202	6 582	66 389	116 211	191 384
8	Ceres	7	6 066	36 945	5 695	48 713
9	Clanwilliam	2	866	22 777	5 409	29 054
10	Fraserburg	0	38	3 895	999	4 932
11	George	48	7 715	55 497	24 854	88 114
12	Goodwood	2 906	1 243	195 243	73 250	272 642
13	Heidelberg	1	422	9 935	2 294	12 652
14	Hermanus	12	2 004	11 031	7 938	20 985
15	Hopefield	2	143	6 066	2 386	8 597
16	Knysna	36	8 427	26 333	14 099	48 895
17	Kuilsriver	62	6 210	52 181	24 230	82 683
18	Ladismith	1	462	10 612	1 979	13 054
19	Laingsburg	23	375	5 730	1 289	7 417
20	Malmesbury	67	4 063	90 826	19 422	114 378
21	Montagu	37	2 607	14 831	4 028	21 503
22	Mosselbay	12	5 005	28 095	11 810	44 922
23	Murraysburg	2	901	4 549	826	6 278
24	Namakwaland	10	4 255	56 589	10 875	71 729
25	Oudtshoorn	34	4 582	51 446	15 582	71 644
26	Paarl	107	20 390	95 418	27 358	143 273
27	Piketberg	8	1 046	27 738	8 139	36 931
28	Prince Albert	0	53	7 967	1 540	9 560
29	Riversdale	2	785	18 053	7 481	26 321
30	Robertson	13	3 528	25 307	6 481	35 329
31	Simons Town	156	1 233	15 573	30 623	47 585
32	Somerset West	61	3 942	33 134	23 205	60 342
33	Stellenbosch	68	6 424	46 021	26 580	79 093
34	Strand	113	2 458	18 021	20 421	41 013
35	Sutherland	1	130	3 368	1 022	4 521
36	Swellendam	13	2 486	24 544	7 416	34 459
37	Tulbagh	5	1 596	22 210	3 517	27 328
38	Uniondale	2	599	8 878	1 332	10 811
39	Vanrhynsdorp	4	168	10 358	2 901	13 431
40	Victoria-West	5	1 746	9 253	1 809	12 813
41	Vredenburg	35	1 059	25 996	8 697	35 787
42	Vredendal	1	1 031	23 563	6 275	30 870
43	Wellington	55	773	29 709	8 313	38 850
44	Williston	0	18	3 939	1 038	4 995
45	Worcester	179	21 911	80 016	25 410	127 516
46	Wynberg	15 571	361 074	593 984	159 311	1 129 940
	Walvisbay	8	10 675	5 255	5 918	21 856
	Total	22 660	528 523	2 124 928	892 241	3 568 352

Source: Directorate: Epidemiology, based on the 1985-census

Eastern Cape



Estimated population - 1992 Eastern Cape (Included in development region D)

Map Ref.	District Name	Asian	Black	Coloured	White	Total
1	Aberdeen	4	1 664	6 484	1 288	9 440
2	Adelaide	22	13 469	2 395	1 770	17 656
3	Albany	455	72 830	9 561	16 148	98 994
4	Albert	28	18 166	2 163	2 737	23 094
5	Alexandria	12	30 906	2 981	2 822	36 721
6	Aliwal North	31	21 896	3 172	4 193	29 292
7	Barkly East	1	13 049	618	1 411	15 079
8	Bathurst	36	32 892	1 343	5 002	39 273
9	Bedford	13	12 261	3 346	1 135	16 755
10	Cathcart	5	17 970	389	1 709	20 073
11	Cradock	44	27 975	10 975	6 012	45 006
12	East London	3 226	108 340	27 292	81 623	220 481
13	Elliot	2	16 242	178	1 370	17 792
14	Fort Beaufort	37	27 730	3 387	2 759	33 913
15	Graaff-Reinet	23	8 679	22 959	5 911	37 572
16	Hankey	13	11 518	13 566	2 521	27 618
17	Hofmeyr	2	5 384	1 215	503	7 104
18	Humansdorp	18	10 698	21 922	9 201	41 839
19	Indwe	0	10 447	227	661	11 335
20	Jansenville	1	5 209	5 632	1 626	12 468
21	Joubertina	4	3 618	10 202	2 096	15 920
22	King William's Town	277	15 637	7 300	10 501	33 715
23	Kirkwood	8	30 050	5 940	3 241	39 239
24	Komga	26	17 447	441	1 890	19 804
25	Lady Grey	4	7 513	832	773	9 122
26	Maclear	6	20 998	743	1 851	23 598
27	Middelburg	18	9 585	10 989	3 261	23 853
28	Molteno	6	11 925	642	1 036	13 609
29	Pearston	4	2 190	3 288	520	6 002
30	Port Elizabeth	8 290	358 741	163 304	160 720	691 055
31	Queenstown	246	39 201	6 221	12 525	58 193
32	Somerset East	23	20 769	8 579	3 781	33 152
33	Sterkstroom	4	9 369	293	774	10 440
34	Steynsburg	4	8 039	1 644	1 078	10 765
35	Steytlerville	5	1 830	4 019	812	6 666
36	Stutterheim	20	41 714	695	3 149	45 578
37	Tarka	16	9 105	825	1 116	11 062
38	Uitenhage	518	82 501	42 027	44 382	169 428
39	Venterstad	10	3 659	2 349	566	6 584
40	Willowmore	0	593	9 409	1 343	11 345
41	Wodehouse	20	17 078	483	1 507	19 088
	Total	13 482	1 178 887	420 030	407 324	2 019 723

Source: Directorate: Epidemiology, based on the 1985-census

Northern Cape

B - Bophuthatswana

Estimated population - 1992 Northern Cape (Included in development region B)

Map Ref.	District Name	Asian	Black	Coloured	White	Total
1	Barkly West	40	24 263	11 267	3 253	38 823
2	Britstown	1	1 212	4 667	936	6 816
3	Carnavon	14	58	9 166	1 660	10 898
4	Colesberg	5	11 820	4 694	1 655	18 174
5	De Aar	42	9 067	15 937	6 185	31 231
6	Gordonia	34	19 812	91 663	18 959	130 468
7	Hanover	0	3 143	2 503	395	6 041
8	Hartswater	54	20 396	5 720	6 513	32 683
9	Hay	6	2 430	8 121	1 686	12 243
10	Herbert	7	9 414	12 744	2 447	24 612
11	Hopetown	5	1 613	9 573	1 996	13 187
12	Kenhardt	2	87	9 335	1 961	11 385
13	Kimberley	1 442	95 079	59 880	39 986	196 387
14	Kuruman	7	16 506	6 321	6 712	29 546
15	Noupoort	5	6 327	3 432	1 706	11 470
16	Phillpstown	6	3 178	5 927	1 168	10 279
17	Postmasburg	12	26 278	18 576	14 002	58 868
18	Prieska	14	5 870	16 139	3 336	25 359
19	Richmond	1	2 271	5 007	934	8 213
20	Vryburg	470	82 635	9 132	12 534	104 771
21	Warrenton	53	19 239	4 165	3 994	27 451
	Total	2 220	360 698	313 969	132 018	808 905

Source: Directorate: Epidemiology, based on the 1985-census.

Appendix D

DOCUMENTS USED IN CERTIFICATION PROCESS

D.1 LIST OF DOCUMENTS USED

G2/1	Application for a Reception Order
G2/2	Medical Certificate
G2/3	Reception Order
G2/6	Application for Urgent Admission, without Reception Order
G2/7	Detention Order
G2/8	Periodical Reports
G2/28	Report to the Attorney-General.

D.2 EXAMPLES OF DOCUMENTS

G.P.-S. 021-1328

ADMINISTRASIE: RAAD VAN VERTEENWOORDIGERS
ADMINISTRATION: HOUSE OF REPRESENTATIVES

DEPARTEMENT VAN GESONDHEIDSDIENSTE EN WELSYN
DEPARTMENT OF HEALTH SERVICES AND WELFARE

AANSOEK OM 'N OPNEMINGSBEVEL
APPLICATION FOR A RECEPTION ORDER

(Wet op Geestesgesondheid, 1973, artikel 8)
(Mental Health Act, 1973, section 8)

Aan die landdros te
To the magistrate at.....

Familienaam van pasiënt
Surname of patient.....

Voorname van pasiënt
First names of patient.....

.....

Geboortedatum Date of birth.....	of geskatte ouderdom or estimated age.....	Ras Race.....
Beroep Occupation.....	Huwelikstaat Marital status.....	Nasionaliteit Nationality.....

Woonadres
Residential address.....

.....

.....

.....

Ek, die ondergetekende, is van mening dat bogenoemde aan 'n geestesongesteldheid ly, om die volgende redes:
I, the undersigned, am of the opinion that the above-mentioned person is suffering from a mental illness, for the following reasons:

(i) Algemene gedrag en optrede
General behaviour and conduct.....

.....

.....

.....

.....

.....

(ii) Die volgende spesifieke bykomende probleme toon:
Displays the following specific additional problems:

(a) Dwelmmiddelverslaafdheid Drug addiction.....	Ja/Nee Yes/No.....
(b) Misbruik van alkohol Abuse of alcohol.....	Ja/Nee Yes/No.....
(c) Selfmoordneigings Suicidal tendencies.....	Ja/Nee Yes/No.....
(d) Gevaarlik vir ander Dangerous to others.....	Ja/Nee Yes/No.....
(e) Vorige aanvalle van geestesongesteldheid Previous attacks of mental illness.....	Ja/Nee Yes/No.....

Indien antwoord "Ja" is, gee verdere besonderhede
If the answer is "Yes", give further particulars.....

.....

.....

.....

.....

.....

.....

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.....

.....

.....

Ek kan ook die volgende redes meld wat daarop dui dat die pasiënt so ongesteld is en dat hy nie as 'n vrywil-
I can also furnish the following reasons which indicate that the patient is so ill that he will not accept treatment
lige pasiënt behandeling sal aanvaar of as 'n pasiënt met toestemming vir behandeling opgeneem kan word nie
as a voluntary patient or cannot be admitted for treatment as a patient by consent.....

.....

.....

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.....

.....

*Ek bevestig dat ek die is van die pasiënt/ek is nie 'n familielid nie
I confirm that I am the .....of the patient/I am not a family member and
en doen aansoek omdat
am applying because .....

.....

.....

.....

.....

* Indien die vorm nie deur die eggenoot of eggenote of 'n naasbestaande van die pasiënt onderteken is nie moet die rede genoem word waarom dit nie aldus onderteken is nie.
* If the form is not signed by the husband or wife or a near relative of the patient the reason shall be stated why it is not so signed.

Ek heg ook 'n mediese sertifikaat aan van dr.
I also attach a medical certificate by Dr .....

en dr. , gedateer die dag van
and Dr ....., dated the ..... day of

..... 19.....

Op grond van bogenoemde feite ten opsigte van
On the grounds of the above-mentioned facts in respect of.....
(naam van pasiënt/name of patient)

doen ek aansoek dat 'n opnemingsbevel uitgereik word vir sy/haar aanhouding en behandeling in 'n inrigting.
I apply for a reception order to be issued for his/her detention and treatment in an institution.

Datum/Date ....
Handtekening/Signature

Plek/Place.....

VERKLARING/AFFIDAVIT

Ek, die ondergetekende en applikant, bevestig hierby dat:
I, the undersigned and applicant, hereby affirm that:

*(a) Ek ouer is as 18 jaar.
I am older than 18 years.

*(b) Ek die pasiënt binne sewe dae van die datum van die aansoek gesien het.
I have seen the patient within seven days of the date of this application.

*(c) Ek 'n familielid is, naamlik
I am a relative, being .....

*(d) Ek nie verwant is nie, naamlik
I am not related, being .....

Handtekening
Signature of applicant.....

Bostaande verklaring is voor my plegtig bevestig of beëdig te
The above statement was solemnly declared or sworn to before me at.....

.....

Die verklaarder erken dat *hy/sy ten volle op hoogte is van die inhoud van hierdie verklaring en dit begryp.
The dependent has acknowledged that *he/she knows and understands the contents of this affidavit which

Hierdie verklaring is *beëdig/bevestig voor my.
was *sworn to/affirmed before me.

.....
Vrederegter of Kommissaris van Ede
Justice of the Peace or Commissioner of Oaths

Datum
Date.....

* Skrap wat nie van toepassing is nie.
Delete whichever is not applicable.

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

MEDIESE SERTIFIKAAT KRAGTENS DIE WET OP GEESTESGESONDHEID, 1973

Ingevolge artikels 8, 12 en 22, soos gewysig

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

MEDICAL CERTIFICATE UNDER THE MENTAL HEALTH ACT, 1973

In terms of sections 8, 12 and 22, as amended

Volle naam van pasiënt
Full name of patient.....

.....

Geboortedatum
Date of birth ☐☐ ☐☐ ☐☐ (J/Y M D)

of geskatte ouderdom
or estimated age ☐☐ Jaar / Years

Huwelikstaat
Marital status

Ongetroud / Unmarried ☐
Getroud / Married ☐
Weduwee/Wewenaar / Widow/Widower ☐
Geskei / Divorced ☐

Woonadres
Residential address.....

.....

.....

.....Tel. No.....

Datum van ondersoek
Date of examination ☐☐ ☐☐ ☐☐ (J/Y M D)

Plek van ondersoek
Place of examination.....

1. Faktore wat na u oordeel tot die geestesongesteldheid aanleiding gegee het:

(1) Persoonlikheidsteurnis/Verstandelike vertraagdheid	JA	NEE
(2) Epilepsie	JA	NEE
(3) Ernstige hoofbesering	JA	NEE
(4) Alkohol-/Dwelmmiddelmisbruik	JA	NEE
(5) Familieneiging	JA	NEE
(6) Ander	JA	NEE

Indien die antwoord JA is op enige van bogenoemde, gee meer besonderhede.

1. Factors which in your opinion gave rise to the mental illness:

(1) Personality disorder/Mentally retarded	YES	NO
(2) Epilepsy	YES	NO
(3) Severe head injury	YES	NO
(4) Alcohol/Drug abuse	YES	NO
(5) Family tendency	YES	NO
(6) Other	YES	NO

If the answer to any of the above is YES, give further particulars.

.....

.....

.....

.....

2. Inligting verskaf deur ander persone wat op geestesongesteldheid dui. (Noem ook name en adresse van die persone wat inligting verskaf.)

.....

.....

.....

.....

2. Information furnished by other persons, indicating mental illness. (State the names and addresses of the persons furnishing information.)

3. Algemene liggaamlike gesondheid:

(1) Tekens van fisiese siekte	JA	NEE
(2) Tekens van beserings	JA	NEE
(3) Tekens van oordraagbare siekte	JA	NEE

Indien die antwoord JA is op enige van bogenoemde, gee meer besonderhede.

3. General physical health:

(1) Signs of physical illness	YES	NO
(2) Signs of injuries	YES	NO
(3) Signs of communicable disease	YES	NO

If the answer to any of the above is YES, give further particulars.

.....

.....

.....

.....

4. Feite aangaande die geestestoestand van die pasiënt, wat by vorige geleenthede waargeneem is. (Meld datums en plekke.)

4. Personal observations with regard to the mental condition and behaviour of the patient made on previous occasions. (State dates and places.)

5. Geestestoestand van die pasiënt ten tyde van huidige ondersoek.

5. Mental condition of the patient at the time of the present examination.

6. Behandeling toegepas vir geestestoestand.

6. Treatment given for mental condition.

7. Diagnose van geestestoestand.

7. Diagnosis of mental illness.

Indien die diagnose 'n psigopatiese steurnis is, moet die persoon na 'n psigiater, maatskaplike werker en kliniese sielkundige verwys word vir ondersoek en verkryging van addisionele verslae vir die landdros.

If the diagnosis is a psychopathic disorder, then the person must be referred to a psychiatrist, social worker and clinical psychologist for examination to provide additional information for the magistrate.

8. Volgens my oordeel is genoemde persoon—

(1) geneig tot mansslag..... JA | NEE

(2) geneig tot selfmoord..... JA | NEE

(3) gevaarlik..... JA | NEE

Indien JA, lig toe.

8. In my opinion the above-mentioned person—

(1) has homicidal tendencies..... YES | NO

(2) has suicidal tendencies..... YES | NO

(3) is dangerous..... YES | NO

If the answer is YES, elucidate.

Indien die antwoord op aldrie die bogenoemde stellings NEE is, is daar enige bewys deur die persoon se gedrag of wat hy sê, wat aandui dat hy nie as 'n vrywillige pasiënt of 'n pasiënt met toestemming opgeneem kan word nie?

If the answer is NO to all three of the above-named statements, is there any evidence from the person's behaviour, or what he says, that indicates why the patient cannot be admitted as a voluntary patient or patient by consent?

9. In die lig van die inligting hierbo voorsien beveel ek, die ondergetekende aan:

*(1) Aangesien ek geen geestesafwyking by die persoon vind nie, hy vrygelaat word.

*(2) Dat hy wel tekens van 'n geestesongesteldheid toon, en dat hy in 'n inrigting opgeneem word—

(a) as vrywillige pasiënt onder artikel 3;

(b) as pasiënt met toestemming onder artikel 4.

*(3) Dat hy kragtens artikel 9 in 'n inrigting opgeneem word omdat hy behandeling teenstaan.

*(4) Dat hy dringend en onmiddellik opgeneem word vir sy/samelewing se veiligheid ingevolge artikel 12.

10. Waar die persoon ooreenkomstig my aanbeveling (3) of (4) hierbo hanteer word, hy in 'n maksimum sekuriteitsinrigting aangehou moet word ingevolge artikel 27.

*(Skrap wat nie van toepassing is nie)

9. In the light of the above information, I the undersigned, recommend:

*(1) As I find no mental illness with the person, that he be released.

*(2) That he shows signs of a mental illness, and that he should be admitted to an institution—

(a) as a voluntary patient under section 3;

(b) as a patient by consent under section 4.

*(3) That he must be received in an institution under section 9, because he resists treatment.

*(4) That he must urgently and immediately be received in an institution for his/community's safety in terms of section 12.

10. Where the person is managed according to my above-mentioned recommendation (3) or (4) he must be received in a maximum security institution in terms of section 27.

*(Delete whichever is not applicable)

....
Handtekening/Signature Naam in blokletters/Name in blockletters Datum/Date

Adres
Address.....

.....

.....

.....Tel. No.....

VERKLARING/STATEMENT

Hierby verklaar ek, die ondergetekende, dat ek

I, the undersigned, hereby declare that I have examined

Volle naam van pasiënt
Full name of patient.....

.....

ingevolge artikel 22 van die Wet op Geestesgesondheid, 1973, ondersoek het en dat ek nie ingevolge artikel 23 van genoemde Wet verbied word om so 'n ondersoek uit te voer en 'n mediese sertifikaat te verstrek nie.

under section 22 of the Mental Health Act, 1973, and that I am not prohibited under section 23 of the said Act from making such an examination and giving a medical certificate.

....
Handtekening/Signature Plek/Place Datum/Date

.....
Kwalifikasies/Qualifications

Adres
Address.....

.....

.....

.....

81/300859
(Z 609)

OPNEMINGSBEVEL • RECEPTION ORDER

Ingevolge artikel 9 van die Wet op Geestesgesondheid, 1973, soos gewysig
In terms of section 9 of the Mental Health Act, 1973, as amended

Nademaal daar aan my, / Whereas it has been made to appear to me,

Volle naam van Landdros / Full name of Magistrate

.....

Landdros van die distrik / Magistrate of the district of

te kenne gegee is dat / that

Volle naam van pasiënt / Full name of patient

.....

geestesongesteld is, en nademaal / is deemed mentally ill, and whereas

Dr .....

en / and

Dr .....

genoemde / have examined the said

Naam van pasiënt / Name of patient

.....

ondersoek en sertifikaat(e) (wat hoogstens 14 dae voor die bevel uitgereik is deur die geneeshere, wat die pasiënt ondersoek het) omtrent sy/haar geestestoestand aan my verskaf het, en nademaal ek na oorweging van die sertifikate van genoemde geneeshere/geneesheer en na behoorlike ondersoek bevind dat genoemde

and has/have furnished me with certificate(s) (which has/have been issued not more than 14 days before the date of the order) as to his/her mental condition, and whereas upon consideration of the certificates of the said medical practitioner(s) and after due inquiry I am satisfied that the said

Naam van pasiënt / Name of patient

.....

geestesongesteld is, en dat die volgende op die pasiënt van toepassing is: / is mentally ill, and that the following applies to the patient:

1. Onbehoorlike beheer	Ja Yes	Nee No	1. Inadequate control.
2. Gevaarlik vir homself/haarself	Ja Yes	Nee No	2. Dangerous to himself/herself.
3. Gevaarlik vir ander	Ja Yes	Nee No	3. Dangerous to others.
4. Selfmoordneigings	Ja Yes	Nee No	4. Suicidal tendencies.
5. Weier alle redelike samewerking tot behandeling	Ja Yes	Nee No	5. Refuses all reasonable co-operation for treatment.
6. Onwelvoeglike openbare gedrag	Ja Yes	Nee No	6. Indecent behaviour in public.

7. Abnormale aggressiewe gedrag weens 'n psigopatiese neiging soos bevestig deur meegaande addisionele psigiatriese, maatskaplike en kliniese sielkundige verslae	Ja / Yes	Nee / No

7. Abnormally aggressive behaviour as a result of a psychopathic disorder as confirmed by the accompanying additional psychiatric, social and clinical reports

Indien 7 [Ja] is, verwys na algemene opmerkings 1 (a) en 1 (b) in die Regulasies, in verband met psigopate.

If [Yes] to 7, refer to general remarks 1 (a) and 1 (b) in the Regulations related to psychopaths.

gelas ek u

do I hereby direct you

.....

(Ampstitel of naam van persoon aan wie pasiënt oorgegee word in geval van 'n enkelsorg pasiënt),

(Designation or name of person in whose care patient is placed in case of single care),

om genoemde

to receive the said

Volle naam van pasiënt

Full name of patient

.....

op te neem in die

and to detain him/her in

.....

(Vul naam van hospitaal of ander plek van aanhouding in.)

1. Staats-psigiatriese Hospitaal.
2. Rehabilitasie- en Opleidingsentrum, bedryf ingevolge artikel 1 (xiv) van die Wet op Geestesgesondheid, 1973.
3. Gelisensieerde tehuis.
4. Gevangenis.

L.W.—Ingevolge artikel 9 (6) mag 'n pasiënt nie na 'n gevangenis gestuur word, tensy dit onmoontlik is om hom onmiddellik na 'n inrigting te stuur, en die Landdros oortuig is dat beheer op geen ander manier op hom uitgevoer kan word nie en vir 'n tydperk van hoogstens ses weke, aan te hou behoudens sodanige verdere bevel wat ten aansien van hom/haar uitgereik mag word.

(Insert name of hospital or other place of detention.)

1. State Psychiatric Hospital.
2. Rehabilitation and Training Centre run in accordance with section 1 (v) of the Mental Health Act, 1973.
3. Licenced home.
4. Prison.

N.B.—In terms of section 9 (6) no patient shall be committed to a prison unless it is impossible to remove him immediately to an institution and the Magistrate is satisfied that he cannot be otherwise controlled, for a period not exceeding six weeks, subject to such further order as may be made in regard to him/her.

Gegee onder my Hand te .....

op hede die .....

dag van.....19.....

Given under my Hand at .....

this.....

day of.....19.....

.....

Landdros/Magistrate

DEPARTEMENT VAN GESONDHEID EN WELSYN
DEPARTMENT OF HEALTH AND WELFARE

DRINGENDE AANSOEK OM OPNEMING IN 'N INRIGTING VAN 'N PERSOON WAT VOLGENS BEWERING GEESTESONGESTELD IS, VOORDAT 'N OPNEMINGSBEVEL VERKRY KAN WORD

URGENT APPLICATION FOR RECEPTION IN AN INSTITUTION OF A PERSON ALLEGED TO BE MENTALLY ILL, BEFORE A RECEPTION ORDER CAN BE OBTAINED

Ingevolge artikel 12 van die Wet op Geestesgesondheid, 1973, soos gewysig

In terms of section 12 of the Mental Health Act, 1973, as amended

Aan die Superintendent van/To the Superintendent of

.....

Familienaam van pasiënt
Surname of patient .....

Voorname van pasiënt
First names of patient .....

.....

Geboortedatum
Date of birth | | | | | | J/Y M D

of geskatte ouderdom
or estimated age | | | Jaar Years

Beroep
Occupation .....

Huwelikstaat
Marital status | Getroud Married | Ongetroud Unmarried | Weduwee/Wewenaar Widow/Widower | Geskei Divorced |

Woonadres
Residential address .....

.....

.....

..... Tel. No. .....

Ek, die ondergetekende, is van mening dat bogenoemde aan 'n geestesongesteldheid ly, om die volgende redes:

I, the undersigned, am of the opinion that the above-named person is suffering from a mental illness, for the following reasons:

(i) Algemene gedrag en optrede

(i) General behaviour and conduct

.....

.....

.....

(ii) Die volgende spesifieke bykomende probleme toon:

(ii) Displays the following specific additional problems:

(a) Dwelmmiddelverslaafdheid	Ja Yes / Nee No	(a) Drug addiction
(b) Misbruik van alkohol	Ja Yes / Nee No	(b) Abuse of alcohol
(c) Selfmoordneigings	Ja Yes / Nee No	(c) Suicidal tendencies
(d) Gevaarlik vir ander	Ja Yes / Nee No	(d) Dangerous to others
(e) Vorige aanvalle van geestesongesteldheid	Ja Yes / Nee No	(e) Previous attacks of mental illness

Indien antwoord [Ja] is, gee verdere besonderhede

If the answer is [Yes], give further particulars

.....

.....

.....

.....

Ek kan ook die volgende redes meld wat daarop dui dat die pasiënt so ongesteld is dat hy dringend behandeling moet ontvang, wat nie kan wag totdat die gewone roetine vir opneming afgehandel is nie.

I can also furnish the following reasons which indicate that the patient is so ill that he is in urgent need of treatment, which should not be delayed by formalities.

.....

.....

.....

.....

Ek heg ook 'n mediese sertifikaat aan van

I also attach a medical certificate by

Dr

Gedateer
Dated

J/Y M D

Op grond van bogenoemde feite doen ek hierby aansoek om die dringende opneming van

On the ground of the above-mentioned facts, I hereby apply for the urgent admission of

Volle naam van pasiënt
Full name of patient.....

.....

.....

in die
in the

Naam van die inrigting
Name of institution

vir die geestesongesteldheid wat hom 'n gevaar vir homself/die gemeenskap maak, sodat hy onder behandeling en versorging geplaas moet word totdat 'n opnemingsbevel uitgereik kan word.

for the mental illness which causes him to be a danger to himself/the community, so that he must be placed under care and treatment until a reception order can be issued.

....

Handtekening/Signature Plek/Place Datum/Date

VERKLARING/AFFIDAVIT

Ek is ouer as agtien jaar en het bogenoemde pasiënt gedurende die afgelope twee dae persoonlik gesien, naamlik op

I am older than eighteen years and have seen the above-named patient during the past two days, namely on the

J/Y M D

Gedateer te....., Dated at.....

op hede die..... this.....

dag van.....19..... day of.....19.....

.....

Handtekening/Signature

Bostaande verklaring is in my teenwoordigheid plegtig bevestig/beëdig te..... The above statement was solemnly declared/sworn to before me at.....

.....

Datum/Date

.....

Vrederegter of Kommissaris van Ede
Justice of the Peace or Commissioner of Oaths

DEPARTEMENT VAN GESONDHEID EN WELSYN
DEPARTMENT OF HEALTH AND WELFARE

BEVEL VIR DIE VERDERE AANHOUDING VAN 'N PASIËNT
ORDER FOR FURTHER DETENTION OF PATIENT

(Artikel 19 van die Wet op Geestesgesondheid, 1973, soos gewysig)
(Section 19 of the Mental Health Act, 1973, as amended)

In die Hooggeregshof van Suid-Afrika

(.....Afdeling).

In die geval van (volle naam).....

.....

.....

wat op die oomblik as 'n pasiënt aangehou word in die

.....

.....

kragtens 'n bevel van die landdros,.....

.....

gedateer die.....dag van

.....19.....

en uitgereik ingevolge artikel.....

van die Wet op Geestesgesondheid, 1973, soos gewysig,

WORD HIERBY GELAS

dat genoemde.....

.....

verder as 'n pasiënt aangehou word in 'n inrigting soos omskryf in Wet 18 van 1973, soos gewysig, totdat genoemde pasiënt herstel is of wettig ontslaan word.

Op las van Sy Edele Regter.....

.....

gedateer in kamers op hede die.....

dag van.....19.....

.....

Griffier

In the Supreme Court of South Africa

(.....Division).

In the matter of (name in full).....

.....

.....

at present being detained as a patient in the.....

.....

.....

by order of the magistrate,.....

.....

dated the.....day of

.....19.....

and issued in terms of section 9

of the Mental Health Act, 1973, as amended,

IT IS HEREBY ORDERED

that the said.....

.....

be further detained as a patient in an institution as defined by Act 18 of 1973, as amended, until the said patient be recovered or shall be otherwise legally discharged.

By order of the Honourable Mr Justice.....

.....

bearing date in chambers this.....

.....day of.....19.....

.....

Registrar

DEPARTMENT OF HEALTH AND WELFARE

FIRST PERIODICAL REPORT ON A MENTALLY ILL PATIENT

(Mental Health Act, 1973, sections 25 and 35)

Institution or other place .....

Full name of patient.....

.....

Age..... File number .....

Date of first admission to an institution or place under proceedings which terminated in the issue of the existing authority for detention:

Y		M		D	

Date of admission to this institution .....

Section of Mental Health Act under which detained .....

Charge in case of President's patient .....

Mental state: A condensed summary of the course of the case before and since admission and the present mental condition, with special reference to any symptoms indicating homicidal, suicidal or other dangerous behaviour as described by .....

.....and verified by me.

Before admission.....

.....

.....

.....

On admission .....

.....

.....

.....

Since admission .....

.....

.....

.....

Present mental state.....

.....

.....

.....

Present psycho-pharmacological treatment.....

Present physical condition .....

Diagnosis at present .....

Family contacts:

PERSONAL	CORRESPONDENCE	REGULAR	SELDOM	NEVER

Indicate with "X".

In the case of "NEVER" submit a separate report to indicate what has been done in this respect to trace the family.

Recommendation .....

.....

Remarks: (Give reasons if the "present mental state" reflects a normal picture and further detention is recommended.)

.....

.....

.....

.....

Date ..... 19..... .....

Psychiatrist/Medical Superintendent

Instructions and remarks .....

.....

.....

.....

Date ..... 19..... .....

Director-General for Health and Welfare/Medical Superintendent

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

PERIODICAL REPORT ON A MENTALLY ILL PATIENT

(MENTAL HEALTH ACT, 1973, SECTIONS 25 AND 35)

No.

Institution or other place.....

Full name of patient.....

.....

Age..... File Number.....

Date of first admission to an institution or place under proceedings which terminated in the issue of the existing authority for detention:

Y		M		D	

Date of admission to this institution.....

Section of Mental Health Act under which detained.....

Mental state.—A condensed summary of the course of the case since the previous report, and the present mental condition, with special reference to any symptoms indicating homocidal, suicidal or other dangerous behaviour as described by.....

.....and verified by me.

Charge in case of President's patient.....

Instructions at previous report.....

.....

.....

.....

Since previous report.....

.....

.....

.....

.....

Present mental state.....

.....

.....

.....

.....

Present psyco-pharmaceutical treatment.....

Present physical condition.....

Diagnosis at present.....

Family contacts..... | Personal | Correspondence | Regular | Seldom | Never | Indicate with "X"

In the case of "Never" submit a separate report to indicate what has been done in this respect to trace the family.

Recommendation.....

.....

Remarks (Give reasons if the "present mental state" reflects a normal picture and further detention is recommended).....

.....

.....

.....

.....

.....

Date..... .....

Psychiatrist/Medical Superintendent

Instructions and remarks.....

.....

.....

.....

Date.....19..... .....

Director-General: National Health and Population Development
Medical Superintendent

G.P.-S.

GW 2/28

DEPARTEMENT VAN GESONDHEID EN WELSYN • DEPARTMENT OF HEALTH AND WELFARE

MEDIESE VERSLAG • MEDICAL REPORT

* Skrap woorde nie van toepassing
Delete words not applicable

Die Prokureur-generaal
The Attorney-General

Die Direkteur-generaal van Gesondheid en Welsyn
The Director-General for Health and Welfare

.....

.....

Adres
Address.....

.....

.....

Datum
Date.....

1. Ek....., sertifiseer hiermee:

(a) dat ek 'n behoorlike geregistreerde Mediese Praktisyn is;

(b) dat (naam voluit).....

.....

wat tans in die.....

.....

aangehou word ingevolge 'n bevel uitgereik op .....19..... deur die landdros.....

kragtens artikel..... van die Wet op Geestesgesondheid, 1973 (soos gewysig), deur my gesien en ondersoek is;

*(c) dat die bogenoemde persoon, wat skynbaar .....jaar oud is, na my mening ly aan/nie ly aan 'n geestesongesteldheid (nie);

*(d) dat die bogenoemde persoon onbevoeg is om sy eie sake te behartig en/of 'n bedreiging is vir homself en vir die samelewing;

*(e) dat bogenoemde persoon as 'n pasiënt aangehou moet word/nie aangehou word nie; en

(f) dat hierdie bevindinge gegrond is op die volgende feite:

1. I....., hereby certify:

(a) that I am a duly registered Medical Practitioner;

(b) that I have seen and examined (name in full)

.....

.....

who is at present detained at.....

.....

by virtue of an order in terms of section..... of the Mental Health Act, 1973 (as amended),

and issued on .....19.....

by the magistrate.....

*(c) that the above-mentioned person appears to be .....years of age and in my opinion is suffering/not suffering from a mental illness;

*(d) that the above-mentioned person is not capable of handling his own affairs and/or is a threat to himself and to the community;

*(e) that the above-mentioned person be detained as a patient/not be detained; and

(f) that these findings are based on the following facts:

.....

.....

.....

.....

.....

2. Afskrifte van die mediese sertifikaat(e) waarop die opnemingsbevel uitgereik is, is hierby aangeheg.

3. Slegs een Mediese Praktisyn was beskikbaar tydens die ondersoek.

Onderteken te....., op hede die.....dag van.....19.....

2. Copies of the medical certificate(s) on which the reception order was issued, is attached.

3. Only one Medical Practitioner was available during the examination.

Dated at.....,

this.....day of.....19.....

.....

Superintendent/Distriksgeneesheer/Mediese Praktisyn
Superintendent/District Surgeon/Medical Practitioner

.....

Naam in blokletters/Name in block letters