(Re)shaping ethical considerations in involuntary admission for inpatient psychiatric care: An empirical ethics inquiry drawing insights from a South African case study

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(Re)shaping ethical considerations in involuntary admission for inpatient psychiatric care: An empirical ethics inquiry drawing insights from a South African case study

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Abstract

Involuntary admission for inpatient psychiatric care, though common in clinical practice, remains a long-standing ethical challenge in mental healthcare. Continued disagreement over when, if ever, involuntary admission can be ethically justified (in the psychiatric ethics literature) sits against the backdrop of calls for increased access to mental healthcare in low- and middle-income countries (in the global mental health discourse). My thesis takes this normative tension as a starting point for inquiry. I first review scholarship in psychiatric ethics and global mental health to identify ethical principles relevant to involuntary admission. I argue that the principles identified diverge along normative ideologies: psychiatric ethics is rooted in a negative rights framework while global mental health is rooted in a positive entitlements framework. In light of this divergence, I adopt an empirical ethics approach to 1) explore the normative commitments that *do* impact decision-making for involuntary admission in practice—drawing insights from a South African case study—in order to 2) understand the normative commitments that *should* impact decision-making for involuntary admission in practice. Using semi-structured interviews with mental healthcare practitioners and mental health advocates, my empirical data analysis demonstrates that practitioners' decisions are influenced by a number of extra-legal considerations. These considerations focus not only on the individual being assessed, but also on their family availability, facility-based and broader resource constraints, and the health system structure. I focus my ethical analysis on the normative value of incorporating resource- and system-focused considerations in decision-making, especially given their relevance to the provision of mental healthcare in low- and middle-income country contexts. I argue that resource-focused considerations—though essential to the proper application of a positive entitlements framework—should not be incorporated into decision-making for involuntary admission, while system-focused considerations should—in order to better meet the demands of a negative rights framework. My work offers a novel contribution to the 'intractable' debate over the ethics of involuntary admission by demonstrating that dominant ethical principles invoked in both psychiatric ethics and global mental health do not fully capture the range of considerations that should be taken into account in decision-making in practice.

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Introduction

Background

Psychiatric inpatient admission without consent (or 'involuntary admission'), though common in clinical practice, remains a long-standing ethical challenge in mental healthcare. As conceptualized in psychiatric ethics and the wider medical ethics scholarship, this challenge stems from disagreement about when, if ever, the state (via the mental healthcare system) should be permitted to infringe on an individual's right to liberty (Livermore, Malmquist and Meehl, 1968; Morse, 1982; Rosenbaum, 2016). Though widely contested, involuntary admission is broadly justified in the psychiatric ethics literature by appeals to *parens patriae*, or paternalism, on the basis of best interests of the individual, or by appeals to police power, or the harm principle, on the basis of (risk of) harm to others (Mill, 1859; Addington v. Texas, 1979; Levenson, 1986). Other justifications of involuntary admission focus on nuanced interpretations and applications of autonomy and capacity (Saks, 2002c; Craigie, 2015).

These ethical justifications for involuntary admission have been translated into core legal rationales, codified in relevant mental health legislation across jurisdictions, to govern the use of involuntary admission. These legal rationales—developed at least in part to guard against historical (and present-day) abuses of psychiatry as a form of political and social control—are largely consistent across contexts. Generally, involuntary admission is considered to be justified by some combination of a) presence of mental disorder, b) risk of harm to self or others, c) need for

treatment, and d) incapacity in some instances (Fistein *et al.*, 2009; Pathare and Sagade, 2013; Wickremsinhe, 2018).

Despite this semblance of a 'settled view' across jurisdictions, disagreement over the underpinning ethical justifications of these legal rationales has intensified in recent years following the 2008 ratification and entry into force of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) (United Nations, 2006b). The CRPD enshrined the right to universal legal capacity for all individuals living with disabilities, including psychosocial disabilities (widely interpreted to include any mental illness or disorder included in mental health legislation) (United Nations Treaty Collection, 2008). The right to universal legal capacity—i.e. the right of all persons, irrespective of disability status, to exercise full legal control over their lives with equal recognition under law—renders involuntary admission (and, of course, involuntary treatment) impermissible in all cases (United Nations, 2006a). This position was also confirmed by the General Comment No. 1, authored by the Committee on the Rights of Persons with Disabilities, in 2014 (Committee on the Rights of Persons with Disabilities, 2014).

However, the UN CRPD's prohibition of involuntary admission was renounced in several interpretive declarations and reservations submitted by various national governments prior to ratification (United Nations Treaty Collection, 2008) and has been sharply criticized in the literature (Dawson, 2015; Freeman *et al.*, 2015; Scholten and Gather, 2018; Appelbaum, 2019). Critics argue that involuntary

admission is ethically justifiable in at least some circumstances, contravening a strict interpretation of the UN CRPD (United Nations, 2006a; Committee on the Rights of Persons with Disabilities, 2014). In this vein, several proposals for alternative routes to justify admission without consent have been put forth. One example is a 'fusion law' to regulate involuntary admission and treatment decisions for *any* health condition (physical or mental) on the basis of capacity (Dawson and Szmukler, 2006); another is the use of advanced directives to guide treatment decisions for individuals living with mental illness under specific circumstances (Committee on the Rights of Persons with Disabilities, 2014; Pathare and Kapoor, 2020).

While a handful of jurisdictions have revised mental health legislation in order to comply with the UN CRPD (e.g. Northern Ireland, India), even these countries retain the power of the state, via the health system, to involuntarily admit individuals under at least some (emergency) circumstances (Lynch, Taggart and Campbell, 2017; Parliament of India, 2017). The fact remains that involuntary admission is nonetheless *legally* permissible across all jurisdictions (Davidson, 2021).

Not only is involuntary admission still legally permissible across jurisdictions—available evidence suggests that involuntary admission is often utilized. The World Health Organization (WHO) estimates rates of involuntary admission (relative to

all admissions to psychiatric hospitals) at a median percentage of 39% globally[1] (World Health Organization, 2018).

The legal permissibility and routine use of involuntary admission is likely to persist in practice, despite the mandates of the UN CRPD, for three key reasons. Firstly, most health systems rely on inpatient hospital settings—often accessed involuntarily (World Health Organization, 2018)—to provide mental healthcare (World Health Organization, 2003b, 2008a, 2021a; Funk *et al.*, 2004; Thornicroft and Tansella, 2013). Secondly, though the UN CRPD was ratified in 2008, interpretive declarations and reservations submitted by several countries suggest that the legal permissibility of the practice is unlikely to change drastically for the foreseeable future (United Nations Treaty Collection, 2008). Thirdly, involuntary admission is understood by many, including individuals living with mental illness, to be a necessary tool for mental healthcare under specific circumstances (Plumb, 2015; Bhugra *et al.*, 2017); however, *which* specific circumstances remains a matter of strong disagreement.

[1]At first, this figure might not seem astounding, but, beyond the number itself, this data indicates that in *half* of the countries surveyed (though the total number of reporting countries is not provided by the WHO for this indicator), more than 40% of inpatient admissions to psychiatric hospitals are involuntary (World Health Organization, 2018). In October 2021, the WHO published the Mental Health Atlas 2020, which reported that 15% of admissions to psychiatric hospitals are involuntary (World Health Organization, 2021b). The shift from reporting the *median* rate of involuntary admissions in 2017 to the *mean* rate of involuntary admissions in 2020 makes comparison difficult, and the Mental Health Atlas 2020 does not offer any analysis of why the reporting strategy changed (or any analysis of why the figure has shifted). While these figures cannot be compared, a 15% average rate of involuntary admissions in 2020 looks to be an improvement on involuntary admission rates since 2017. However, this picture is complicated by reports of *increasing*, not decreasing rates of involuntary admissions in some regions (Sheridan Rains *et al.*, 2019).

The continued disagreement in the psychiatric ethics literature over ethical justifications of involuntary admission sits against the backdrop of growing calls for increased access to mental healthcare. The field of global mental health, a subdomain of the broader global health field (Patel and Prince, 2010), has prominently voiced these calls, focused specifically on the need to increase access to mental healthcare in low-resource settings, especially low- and middle-income countries. Global mental health has already made a considerable impact in raising the profile of mental health and in improving access to mental healthcare in low- and middle-income countries, including through its advocacy efforts to include mental health indicators in the Sustainable Development Goals (which drive much of the global health and development agenda) and through its implementation of cost-effective interventions to promote mental health and to treat mental ill-health (Patel *et al.*, 2018).

An "evolving field of research and practice" (Collins, 2020, p. 265), global mental health seeks to promote mental health through the prevention, care, and treatment of mental disorders[2] to achieve equitable access to mental healthcare, especially in low- and middle-income settings (Patel and Prince, 2010; Collins, 2020). The field has focused much of its effort on improving access to mental healthcare in low- and middle-income countries because "the attainment of human rights to care and

[2]Terminology is important, and my use of 'mental disorder' in this instance, and when speaking about global mental health generally, is deliberate. Broadly, 'mental disorder' is indicative of a biomedical model of mental ill-health, which aligns with the dominant narrative of global mental health (as I will demonstrate in Chapter 2). Conversely, proponents of a social model of mental ill-health use the term 'psychosocial disability' to describe "mental, intellectual or sensory impairments" (United Nations, 2006b) that interact with social barriers.

dignity were most seriously compromised" in these contexts (Patel *et al.*, 2018, p. 1556). Global mental health's motivation to increase access to mental healthcare cites a large 'treatment gap', where individuals who experience symptoms of mental illness do not access mental healthcare to address those symptoms (Kohn *et al.*, 2004). Available estimates of the treatment gap in low- and middle-income countries suggest that four in five individuals living with mental disorders do not receive care to address their disorder (World Health Organization, 2013). Prominent voices in the field argue that closing this treatment gap is a matter of human rights, aligning with a broader claim that mental health is itself a "fundamental human right" (Patel *et al.*, 2018, p. 1553). To respect this right, the argument goes, governments and health systems must drastically increase access to mental healthcare, including inpatient care.

Given that, at present, a significant proportion of inpatient admissions are involuntary admissions (World Health Organization, 2018) (true even in well-resourced mental healthcare systems with adequate provision of community-based care (Perera, 2020)), the ethical challenge of involuntary admission is unlikely to be eliminated through the development of robust health systems, even with increased funding. That is, if even the optimal model of mental health service provision includes the significant possibility of involuntary admission, as available evidence suggests, further scrutiny as to *when*, if at all, involuntary admission is ethically permissible is paramount.

Yet, the extent to which global mental health, despite being a key driver of this community-based service delivery model that explicitly includes inpatient care, has adequately addressed how its own agenda might intersect with this long-standing ethical challenge in psychiatric practice is unclear (Wickremsinhe, 2021). Moreover, the ways in which the normative underpinnings of the field of global mental health may influence understandings of the ethics of involuntary admission have not been adequately investigated.

There is an apparent tension between calls advanced in global mental health to increase access to care in low- and middle-income countries, including inpatient care accessed involuntarily, on the one hand and continuing debate over the ethics of involuntary admission in psychiatric ethics on the other. Put simply, the normative commitments of these two fields appear to be in conflict: where global mental health advocates for increased access to care, including inpatient services which are often 'accessed' involuntarily, psychiatric ethics wrestles with the broader question of when, if ever, involuntary admission can be justified.

Research aim and overarching approach

Against this background, my research aims to explore how the normative commitments of global mental health and psychiatric ethics intersect with respect to involuntary admission, specifically in low- and middle-income country settings where they are particularly in tension. I aim to understand how these commitments arise and should be managed in practice.

To address this aim, I situate my project within the realm of bioethics research, given its focus on the ethical aspects of clinical practice in psychiatric care. To scaffold my inquiry, I adopt the 'mapping-framing-shaping' framework, proposed by Huxtable and Ives, for bioethics research. This framework gives shape to the research project while providing a flexible approach that can be adapted to the specific research aim. The framework does not prescribe any particular methodology or discrete methods, but offers an "overarching shape" to the thesis that is broadly familiar across disciplines (Huxtable and Ives, 2019, p. 6 of 8). My thesis is organized into three phases of inquiry according to this framework.

The first phase—'mapping'—seeks to "get a sense of the general terrain" (Huxtable and Ives, 2019, p. 2 of 8). In my project, the 'mapping' phase applies a literature review method of critical interpretative review to investigate the nature of the tension between the ethical principles and normative underpinnings of psychiatric ethics and global mental health as they relate to involuntary admission. This first phase corresponds to Part I of my thesis: *Mapping ethical principles in involuntary admission—psychiatric ethics and global mental health*.

Using the outputs of this first phase of the thesis, I go on to develop the project's specific research questions—one empirical and one normative, highlighting the need for an empirical ethics approach. These research questions guide the second and third phases of the research, respectively. The second phase—'framing'—aims to "explore specific areas of the mapped terrain that have been identified as either

being in need of deeper exploration or unmappable from our current vantage point" (Huxtable and Ives, 2019, p. 3 of 8). In my project, this 'framing' phase seeks to empirically explore how the normative commitments of psychiatric ethics and global mental health are encountered and navigated in practice.

The third phase—'shaping'—aims to "(re)shape the terrain, informed by the findings and analyses generated while mapping and framing" (Huxtable and Ives, 2019, p. 3 of 8). In this 'shaping' phase of the project, I address the project's normative research question by bringing together the outputs of the first two phases of the thesis. I reflect on how we might make practical normative progress in our understanding of the ethics of involuntary admission in light of the conflicting ethical principles identified in psychiatric ethics and global mental health.

Thesis overview

Having set out the challenge in this Introduction, I begin Part I of the thesis, *Mapping ethical principles in involuntary admission—psychiatric ethics and global mental health*. In Part I, I explore ethical principles broadly relevant to involuntary admission—first as explicated in the psychiatric ethics literature (Chapter 1), and then as described in the broader global mental health discourse (Chapter 2). To analyse these two distinct bodies of scholarship as I have characterised them, I adopt the literature review method of critical interpretive review (McDougall, 2015) in order to understand if there is, indeed, a tension between the normative commitments of psychiatric ethics and global mental health, and if there is, the

nature and scope of this tension. I conclude that there is a tension, and I characterise the nature of that tension as follows: while the ethical principles described within the dominant narrative of the global mental health discourse are broadly focused on a positive entitlements framework that sees access to healthcare as the core right by which all other rights can be realized, the ethical principles explicated in psychiatric ethics are broadly focused on a negative rights framework that seeks to protect the right to freedom from interference by the state.

In Part II, *Framing involuntary admission in context—insights from a South African model of decision-making*, I develop two research questions—one empirical and one normative—informed by my analysis of the tension uncovered and investigated in Part I. I show why an empirical ethics approach is best-suited to addressing these two research questions. I go on to argue for the value of understanding how this tension is encountered (and managed) in a context where these ethical principles intersect—South Africa (Chapter 3). I then justify the specific methodology and methods I used to pursue this work. I justify my application of the empirical ethics methodology of reflexive balancing and I justify my adoption of the qualitative research method of semi-structured interviews with practitioners and mental health advocates (Chapter 4). In the subsequent chapters, Chapters 5 and 6, I present the findings of my empirical research by exploring two overarching themes identified in my analysis. The first theme centres on *pathways to decision-making*, identifying the ways in which distinct 'micro-decisions' (all of which *precede* the decision to admit involuntarily) impact how and whether a range of considerations can be taken into account in decision-making (Chapter 5). The

second theme centres on four discrete categories of *considerations in decision-making*—individual-, family-, resource-, and system-focused—that practitioners incorporate in their decision-making (Chapter 6). These considerations sit beyond the narrowly prescribed legal criteria, and practitioners' accounts of decision-making often incorporated multiple considerations within and across categories. I explore how various pathways to decision-making influence the extent to which these considerations can be meaningfully incorporated in decision-making.

In Part III, *(Re)shaping ethical considerations in decision-making for involuntary admission*, I seek to integrate the empirical and normative components of my thesis, i.e. connect Parts I and II of the project in order to explore how the tension between the normative commitments of global mental health and psychiatric ethics *should* be navigated (Chapter 7). Using the specific method of reflexive balancing within a reflexive balancing methodology, I explore the normative value of non-individual-focused considerations in decision-making (specifically resource- and system-focused considerations). I show how the empirical picture shapes our understandings of positive entitlements and negative rights as they relate to involuntary admission, and I propose a resolution to the tension between these two frameworks. I suggest that any application of a positive entitlements framework, specifically in terms of the 'right to health', demands the incorporation of resource-focused considerations in decision-making; however, resource-focused considerations cannot be 'distilled' to the level of the individual in an ethically justifiable way. I therefore argue that a positive entitlements framework is inappropriate for understanding the ethics of involuntary admission as its demands

cannot be defensibly applied in a single clinical encounter. I turn then to a negative rights framework, and suggest that system-focused considerations should be considered in decision-making to ensure that the criteria used to justify admission align with a realistic assessment of what the service can actually provide.

In the Conclusion, I reflect on the insights gained by my thesis as a whole. By integrating conceptual and empirical analysis, my thesis offers a novel contribution to the "intractable" debate over the ethics of involuntary admission (Galderisi *et al.*, 2020, p. 7); I suggest that our understandings of the ethics of involuntary admission should adopt a negative rights framework, not a positive entitlements one, and that the incorporation of considerations beyond the individual may be permissible in order to ensure that the justificatory criteria for involuntary admission align with a realistic assessment of what admission can provide given the health system structure. I also review the limitations of the work and suggest key areas of further research.

Chapter 1. Psychiatric ethics and involuntary admission

1.1. Introduction

This chapter begins Part I of my thesis, *Mapping ethical principles in involuntary admission—psychiatric ethics and global mental health*. In Part I, I seek to characterise the nature of the tension between key ethical principles in psychiatric ethics (Chapter 1) and the normative commitments of global mental health (Chapter 2).

In this chapter, I explore the normative principles that underpin (and challenge) discussions of involuntary admission in the psychiatric ethics scholarship. The debate over the normative principles that can ethically justify involuntary admission is primarily located in scholarship in psychiatric ethics, a branch of medical ethics. A matter of longstanding disagreement, the ethics of involuntary admission is still widely debated and, arguably, unsettled (and even fraught, by some accounts (Martin and Gurbai, 2019; Galderisi *et al.*, 2020)). However, some consensus emerges in the dominant normative principles cited in the psychiatric ethics scholarship and enshrined in mental health law across settings. These legal rationales are 1) presence of mental disorder, 2) risk of harm to others, 3) risk of harm to self, 4) need for treatment, and 5) mental incapacity. That said, much scholarship in psychiatric ethics argues that alternative criteria—or, indeed, no criterion—can ethically justify involuntary admission.

1.2. Method: critical interpretive review

In Part I of the thesis (Chapters 1 and 2), I apply the method of critical interpretive review to explore two distinct bodies of scholarship. Critical interpretive review is well-suited for bioethics research projects seeking to "capture and analyse the key ideas relevant to a research question" (McDougall, 2015, p. 523). In this method, reviewing the literature aims not necessarily to identify a gap in the existing scholarship but rather to critically analyse the literature in light of a particular research question and in order to meet a particular aim (McDougall, 2015). In my thesis, the aim is to understand whether there is a tension between the normative commitments of global mental health and psychiatric ethics, and if so, how that tension might be characterised. Notably, the method of critical interpretive review is *not* a method of systematically reviewing the literature on the topic; the goal of a critical interpretive review is not comprehensiveness (i.e. "[identification of] *all* literature on a topic") but rather the identification of key ideas (McDougall, 2015, p. 524). The core requirement of the method is to make clear the search strategy for identifying literature cited in order to characterise key ideas relevant to the topic of interest, but not to gather *all* literature published on the topic of interest.

In light of the research aim, a critical interpretive review is particularly appealing in this project. Not only does a critical interpretive review allow for evaluation of the literature as a whole, it also allows for consideration of empirical *and* normative literature together (McDougall, 2015). In bioethics research, this feature of a critical interpretive review represents a clear advantage on a systematic review,

which primarily focuses narrowly on *either* normative or empirical literature, but rarely both combined (McDougall, 2014, 2015).

I anchor my discussion of psychiatric ethics principles in an analysis of dominant legal criteria, drawing from the search strategy applied in the exemplar paper (Kass *et al.*, 2013) cited in McDougall's exposition of the method (McDougall, 2015). This strategy, while useful from the perspective of managing the literature, is not sufficient to capture the range of relevant key ideas; in Section 1.5, I move beyond analysing domestic law to exploring mandates in international law, specifically the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). I then explore a range of laws and proposals for alternative criteria to govern involuntary admission.

1.2.1. The relationship between law and bioethics

My choice to pin my exploration of ethical principles in psychiatric ethics to law tracks a broader conversation about the relationship between law and bioethics, and is specifically relevant to the particular topic of involuntary admission, which is governed by legal frameworks across settings.

Huxtable describes the relationship between law and bioethics as follows:

> Law will sometimes appear to get things ethically 'wrong', according to some theory or other. But perhaps law can teach the ethical theorists something too, about the sorts of practical resolutions to which particular moral problems are most—or least—amenable. (Huxtable, 2016, p. 93)

As Huxtable implies, law is not necessarily morally 'right' in any way—and the criteria presented in the law should not be taken at face value without sound ethical analysis. However, pinning discussion of the ethical debate to the law is helpful in light of the very explicit and dominant role the law plays in governing involuntary admission. Moreover, the place of law—as opposed to, say, policy guidance or clinical practice guidelines—in governing the ethics of involuntary admission is well-established and widely considered to be necessary: at its root, involuntary admission strips an individual of basic rights guaranteed by other legal frameworks. Understandably, then, any justification of its use must stand up to *legal* scrutiny; therefore, the law plays a prominent role in our understanding of the ethics of involuntary admission.

Of course, domestic law does not capture the range of ethical principles that might be relevant to involuntary admission; in fact, this inadequacy is exactly the problem much of the recent debate has sought to remedy. The strongest challenge to the core ethical justifications of involuntary admission found in law has been posed by the UN CRPD, a binding international human rights treaty, which I use to further my exploration of relevant ethical principles per the method of critical interpretive review.

1.2.2. Managing disparate literatures

In pinning my exploration of relevant ethical principles to law as a strategy for managing the (vast) literature on the topic, I also seek to overcome a critical

challenge posed by conducting a literature review on a topic of this nature: a search of all relevant literature would be impractical given the breadth of relevant scholarship across multiple disciplines. The literature on the ethics of involuntary admission is incredibly disparate: some aspects of the ethical debate sit in the philosophical literature, others in the legal literature, and still others in the bioethics, psychology, and psychiatry literatures.[3] The debate also suffers from overlapping use of key terms but with distinctive definitions and applications depending on the field (e.g. 'capacity' as having different legal, philosophical, and psychiatric meanings (Owen *et al.*, 2009)), making the literature difficult to parse.

To navigate the challenges posed by this disparate literature on the ethics of involuntary admission, framed as an "interdisciplinary challenge" (Owen *et al.*, 2009, p. 79) with footing in multiple fields, I analysed dominant legal frameworks as a scaffolding to explore relevant ethical principles, in line with a critical interpretive review. I gathered supplementary literature to further explore ethical arguments related to legal criteria through keyword searches in Google Scholar, Web of Science, and HeinOnline, applying terms related to the specific legal criterion being investigated. I also used reference lists to identify additional relevant papers. My search was guided in part by my previous work on and familiarity with this topic (Wickremsinhe, 2016, 2018). Because I sought to surface the key ethical rationales that underpin various legal criteria, I was interested not in collecting *every* paper on the topic of a particular criterion, but rather in locating

[3]For the purposes of this thesis, I have characterised this range of relevant literatures as falling within the bounds of 'psychiatric ethics scholarship'.

papers that clearly elucidated the argument for the criterion's utility from an ethical perspective.[4]

1.3. Definitions of key terms

In the next section, I provide definitions of two key terms used throughout the thesis—'mental illness' and 'involuntary admission'.

1.3.1. Mental illness

Language is important in conversations about mental health, and choices in terminology tend to underlie a particular ideological approach to and understanding of mental illness (if 'mental illness' even really exists) (Russo and Wallcraft, 2011; Russo and Wooley, 2020). For some, adopting a biomedical model of mental illness makes 'mental disorder' the correct term, while for others, adopting a social model of disability makes 'psychosocial disability' the correct term. Because use of these terms differs along ideological lines, I use 'mental illness' in general to discuss the contested 'thing' under scrutiny in this thesis.[5] However, I adopt 'psychosocial disability' when describing arguments rooted in the ideological position of a social model of disability, and 'mental disorder' when describing

[4]I should also note that I was not particularly interested in capturing ethical arguments for specific considerations that are so far off the beaten path that their strength is thrown into question *at this stage* of the research project. For example, in my research, I identified a paper arguing that involuntary admission should be permissible under the premise that it would reduce the stigma about associations between violence and mental ill-health (Torrey, 2011). This is not a common or necessarily widely endorsed argument, and Torrey's claims are not suitably defended or evidenced. Therefore, I have set this defence of involuntary admission aside for now.
[5]A choice which will, of course, be completely objectionable to some.

arguments rooted in the ideological position of a biomedical model of mental health. These disagreements also run parallel to critiques of the medicalization of distress and the importation of a Western model of 'mental disorder' into non-Western cultural contexts (Summerfield, 2012).

1.3.2. Involuntary admission

'Involuntary admission' is the term I use in this thesis, but 'involuntary admission' is also called many other things, including 'detention', 'compulsion', and 'coercion'. While the term 'involuntary admission', taken literally, implies *only* admission, and not necessarily treatment, I am using 'involuntary admission' in this thesis to mean admission *and* treatment under the assumption that justifications for admission will align with justifications for treatment (Ryan and Bartels, 2021), though this is not necessarily always the case. For simplicity, however, I use 'involuntary admission' (and, in some cases to avoid confusion when specific legal terminology is in play, 'psychiatric inpatient admission without consent') to describe the process by which an individual is admitted, as an inpatient, to receive psychiatric care without their consent. In this definition of 'involuntary admission', I understand the admission to be 'involuntary' even if proxy consent (e.g. from a family member) is obtained.

In the next section, I review core ethical justifications of involuntary admission, as enshrined in legal frameworks globally.

1.4. Core ethical justifications of involuntary admission

Global reviews of mental health legislation identify a broadly consistent set of criteria, applied in different combinations, to justify the use of involuntary admission (Fistein *et al.*, 2009; Pathare and Sagade, 2013; Zhang *et al.*, 2015; Wickremsinhe, 2018; Dobri *et al.*, 2019). These broadly consistent criteria have been met with challenge since their instatement (e.g. Livermore et al., 1968 (Livermore, Malmquist and Meehl, 1968)), but especially so in light of the mandates of the UN CRPD, of which 164 jurisdictions are signatories[6] (United Nations Department of Economic and Social Affairs, no date). In this section, I describe the legal criteria that govern most involuntary admissions decisions across jurisdictions and explore the ethical rationales that underpin their relevance and force. I also briefly explore challenges to each criterion, on both normative and empirical grounds. The impact of the UN CRPD is discussed more fully in Section 1.5.

1.4.1. Presence of mental disorder

The first of these criteria is 'presence of mental disorder'. While this criterion is considered a necessary but not sufficient criterion to justify the use of involuntary admission (Roth, 1980; Wettstein, 1987), its retention in law is not as widely debated as other criteria. In theory, the ethical argument for including this core criterion is two-fold: firstly, by maintaining this criterion, we ensure that

[6]As of 17 September 2021.

individuals are not involuntarily admitted *without* having a mental disorder[7] and secondly, we ensure that admission offers some prospect of *benefit* (i.e. if there is no mental disorder, then there is no prospect of benefit through treatment of the mental disorder). However, much writing discussing the relevance of this criterion assumes to some extent that 'presence of mental disorder' is a 'given' consideration, with little broader explanation for its ethical relevance:

> Certainly the most central requirement (necessary, but still not sufficient) for involuntarily detaining and committing an individual to a psychiatric institution is the presence of mental illness or mental disease. Generally, the disorder must be severe in degree, usually rising to the level of a psychosis, not too brief in duration, and subject to a reliable determination. (Wettstein, 1987, p. 112)

Broadly, this criterion can be understood as a crude approximation for "some other constellation of circumstances" (Wesson, 1980, p. 150) that indicate the need for substitute decision-making on the form of involuntary admission:

> Why do we tolerate substituted judgment simply because some doctor is willing to describe its subject as mentally ill? The answer must be that we view "mental illness" as a proxy for some other constellation of circumstances, circumstances that justify the state in substituting its judgment or the judgment of a third party for that of the person most directly affected. (Wesson, 1980, p. 150)

However, the uncritical adoption of this particular criterion has been met with challenge, especially on the basis of non-discrimination. Critics argue that this criterion is discriminatory on the basis of disability, and therefore violates the UN CRPD (Bartlett, 2012; Flynn and Arstein-Kerslake, 2017). Moreover, given the

[7]To guard against psychiatry's sordid history of involuntarily admitting individuals who do not have a mental disorder, e.g. political dissidents (Spencer, 2000; Buoli and Giannuli, 2017).

lack of biological markers to determine 'presence of mental disorder' (Wolfers *et al.*, 2018), this criterion can also be critiqued for its susceptibility to bias.

The inclusion of this criterion in mental health legislation—beyond the mere fact that such legislation explicitly sets out to govern 'mental health' (and therefore 'mental disorder')—seems to approximate justification for involuntary admission *through* the presence of mental disorder, as Wesson notes in the previous quote. That is, 'presence of mental disorder' appears to be doing some (un-evidenced) justificatory work as a proxy for incapacity (Wesson, 1980).

1.4.2. Risk of harm to others

The second core criterion present in mental health legislation across most jurisdictions is 'risk of harm to others'. The ethical rationale for this criterion is rooted in the harm principle, which stipulates that the state is only justified in infringing on an individual's liberty to prevent harm to others (Mill, 1859). The notion of 'protecting society' through involuntary admission on the basis of risk of harm to others is a long-standing feature of mental health legislation, and is broadly considered to be justified by the legal doctrine of *police power* (Addington v. Texas, 1979; Levenson, 1986; Wettstein, 1987; Cornwell, 1998; Saks, 2002e).

Despite its longevity in the debate, the 'risk of harm to others' criterion has been met with many challenges on both normative and empirical grounds. Firstly, critics

argue that this criterion is inherently discriminatory when coupled with a 'presence of mental disorder' criterion, as it renders individuals living with a psychosocial disability as the *only* members of society subject to pre-emptive detention on the basis of perceived risk (Szmukler and Holloway, 2000; Szmukler, 2003). Secondly, this criterion has been further critiqued empirically: available evidence indicates that medical practitioners are poor predictors of risk (Lidz, Mulvey and Gardner, 1993; Ryan *et al.*, 2010), suggesting that this kind of criterion may be inappropriately or inaccurately applied in practice. Finally, critics contend that the 'risk of harm to others' criterion is stigmatizing (Ryan *et al.*, 2010; United Nations General Assembly, 2017), encouraging the incorrect assumption that individuals living with a psychosocial disability are more violent than the rest of the population.

1.4.3. Risk of harm to self

The third core criterion present in mental health legislation across most jurisdictions is 'risk of harm to self'. The ethical rationale for this criterion is rooted in soft paternalism, or the legal doctrine of *parens patriae*, where infringement of liberty, on the part of the state, is permissible in order to prevent harm to self, primarily through suicide but also through significant self-harm (Levenson, 1986; Cornwell, 1998; Gordon, 2016).

Some scholars link the *parens patriae* justification of involuntary admission on the basis of 'risk of harm to self' to the broader 'dangerousness' criterion, meant to

capture *both* the risk of harm to self and to others, and thus argue that this criterion is also underpinned by *police power* (Hermann, 1986; Gordon, 2016). For other scholars, risk of harm to self implicitly or explicitly co-travels with incapacity and is therefore justified under paternalism (Wesson, 1980; Morse, 1982).

As with *police power*, the *parens patriae* justification for involuntary admission is not without its critics. Firstly, some argue that, in fact, invoking *parens patriae* to prevent suicide violates the 'right to suicide', or at least ignores the possibility that suicide can be a rational choice (Bonn, 2010). Secondly, some argue that the demands of the broader 'dangerousness' criterion—which is generally understood to include both the 'risk of harm to self' and the 'risk of harm to others' criteria—are, in fact, too *stringent* to adequately meet the needs of individuals living with psychosocial disabilities (Myers, 1983; Gordon, 2016; Miller and Hanson, 2016). Finally, commonly used clinical scales have been demonstrated to be poor predictors of risk of self-harm and suicide (Steeg *et al.*, 2018), and available empirical data suggests that admission to hospital does not itself prevent or otherwise mitigate the risk of suicide after discharge (Chung *et al.*, 2017; Wang and Colucci, 2017; Jordan and McNiel, 2020).

1.4.4. Need for treatment

The fourth core criterion represented in mental health legislation is centred on the 'need for treatment'. This criterion, like the 'risk of harm to self' criterion, is rooted in an interpretation of *parens patriae*, but adopts a primarily medical, as opposed to

legal, definition of 'best interests' by focusing on treatment as opposed to the prevention of physical harm (Ward, 2014). Some arguments in favour of a need for treatment criterion acknowledge that the mental disorder must itself be treatable, and that the appropriate treatment must be available in the hospital where the individual is being admitted (Wettstein, 1987).

The use of this criterion as justification of involuntary admission tracks disagreements between the 'medical model' and the 'civil liberties' model of involuntary admission (Chodoff, 1984; Aviram, 1990; Salize, Dressing and Peitz, 2002; Fischer, 2006). Where the medical model sees 'need for treatment' as the *only* rationale for involuntary admission (Chodoff, 1984; Dressing and Salize, 2004), the civil liberties model sees 'risk of harm to self and others' (Sections 3.2.2 and 3.2.3) as the *only* rationale for involuntary admission (Salize, Dressing and Peitz, 2002). Through analysis of US case law, Ward argues that the blending of the civil liberties and medical models has confused the nature of involuntary admissions decisions in practice:

> Psychiatry and Law have different perspectives, and inherently different roles, with respect to this issue. The contemporary standard for involuntary commitment—requiring both a "mental illness" and "danger to self"—attempts to marry those roles but has succeeded only in confusing the courts, too often causing them to convert what is fundamentally a legal question about legitimate grounds for overruling individual rights into a psychiatric question about the need for treatment. (Ward, 2014, p. 257)

Importantly, while most jurisdictions draw criteria for involuntary admission from both models, others permit involuntary admission *only* on the basis of risk of harm (to self or others) or *only* on the basis of need for treatment (Salize, Dressing and

Peitz, 2002; Fistein *et al.*, 2009; Pathare and Sagade, 2013). The ethical implications of these single-rationale legal models are included in Section 1.6.

Like other criteria, the 'need for treatment' has been critiqued. Firstly, on empirical grounds, available evidence challenges the idea that involuntary admission is beneficial, given poor health outcomes following admission without consent (Katsakou and Priebe, 2006; Priebe *et al.*, 2011). Secondly, the 'need for treatment' criterion can be challenged on the basis of presuming a biomedical model of psychosocial disability which 'requires clinical treatment' instead of adopting a social or even critical model of disability. Lastly, this criterion is also at risk of overstepping human rights by some critics' accounts—the 'need for treatment' criterion is, of course, subject to practitioner discretion (Aviram, 1990; Feiring and Ugstad, 2014), and the idea that involuntary admission is in the best (medical) interests of the individual to restore autonomy relies on a suspect and paternalistic view that mental illness interferes with an individual's 'true' nature (Saks, 2002b).

1.4.5. Mental incapacity

Serving as a guardrail for protecting autonomy (and thus, in theory, avoiding the critique of the 'need for treatment' criterion as unnecessarily paternalistic), evaluation of mental capacity is meant to offer an unbiased assessment of decision-making competence[8] with respect to admission. According to this perspective,

[8]'Competence' and 'capacity' are used interchangeably in the literature.

involuntary admission is ethically permissible if an individual is found to lack mental capacity:

> For the law, mental capacity is an essential ingredient of individual autonomy and is employed to define the line between legally effective and legally ineffective decisions. Those with mental capacity will have the legal capacity to act: their decisions or choices will be respected. In contrast, those who lack mental capacity will also lack legal capacity: their decisions and choices will not be respected and decisions will be made by others on their behalf. (Richardson, 2013, p. 89)

The inclusion of incapacity as a core criterion in involuntary admissions decisions intends to clarify that 'presence of mental disorder' does not itself imply incapacity, as is often assumed in mental health law across jurisdictions. Proponents argue that capacity assessment in decision-making is a step toward a more ethical mental health law (Holloway and Szmukler, 2003).

Despite its original framing as a progressive criterion (and spurring the development of capacity law in many jurisdictions, e.g. the UK's Mental Capacity Act, 2005), mental capacity has since been critiqued, on both normative and empirical grounds. Firstly, capacity assessment is "inherently subjective and value-laden" (Flynn, 2019, p. 50), and debate has ensued over whether a strict functional test of capacity can ever be disability-neutral. Craigie et al. note multiple challenges in justifying involuntary admission on the basis of mental incapacity, including the potentially discriminatory nature of capacity assessments as well as the tendency for incapacity to be determined on the basis of diagnosis in practice (2019).

Secondly, 'insight' as a key component of capacity assessments, tends to prize agreement with a medical understanding of disorder:

> […] There is a circularity problem when 'awareness of illness' is construed as willingness to accept treatment, so only those who are adherent could have insight. (Guidry-Grimes, 2019, p. 179)

Similarly, others have argued that insight is a functionally meaningless concept because it "has no objective reality—it lies in the individual assessment of clinicians" (Brosnan, 2018, p. 9 of 15). Yet, 'insight'—or rather the absence of insight—as a clinical judgement remains stubbornly common as a justification of involuntary admission in practice, in part because a lack of insight is often presumed to indicate a lack of (mental) capacity (Freckelton, 2010). Available evidence suggests that practitioners tend to employ 'lack of insight' as an 'extra-legislative' (Freckelton, 2010, p. 206) or 'catch-all' (Radovic, Eriksson and Dahlin, 2020, p. 601) justificatory factor in decisions about involuntary admission, even though insight remains a poorly defined and highly contested construct, both in general and as a proxy indicator for mental incapacity.

Moreover, some have challenged the notion of (in)capacity on the basis that the legal concept is insufficient to wrestle with moral intuitions on when involuntary admission should be permissible in 'hard cases' like anorexia nervosa. Through their work, Tan and Hope have critiqued the utility of capacity assessments based solely on 'rational' or 'logical' reasoning (Tan and Hope, 2008). Tan and Hope argue that individuals living with anorexia nervosa are, in fact, competent on the standard model of competence, but challenge whether this standard model can be

appropriately applied to involuntary admissions decisions for individuals living with anorexia nervosa (Tan and Hope, 2008).

1.5. Additional principles (UN CRPD)

As suggested in Section 1.4 (page 37), legal criteria governing the use of involuntary admission, however dominant, are still widely contested. The most critical challenges to the dominant criteria have been spurred by the UN CRPD and its interpretation set out in General Comment No. 1, which explicitly prohibits involuntary admission under any circumstance (discussed further in Section 1.5.2) (United Nations, 2006b; Committee on the Rights of Persons with Disabilities, 2014). Furthermore, the UN CRPD proposes two key concepts that challenge the validity of every core ethical justification of involuntary admission dominant in law: non-discrimination and universal legal capacity.

1.5.1. Non-discrimination

As discussed in Sections 1.4.1 (page 37) and 1.4.2 (page 39), dominant criteria in mental health legislation are consistently critiqued on the basis of non-discrimination. Per the UN CRPD, any criterion for involuntary admission that is predicated on 'presence of mental disorder' is inherently discriminatory. Likewise, interpretations of the UN CRPD push back on the uncritical segregation of individuals living with psychosocial disabilities as the sole group which can be

subjected to involuntary admission by advocating that mental health legislation should be abolished wholesale (Minkowitz, 2010).

To accommodate this principle, scholars have developed a 'fusion' law, which is agnostic of type of illness (physical or mental) and instead focuses strictly on a generic requirement for capacity assessment (Dawson and Szmukler, 2006). This approach will be discussed further in Section 1.6.3.1.

1.5.2. Universal legal capacity

In 2014, six years after the UN CRPD's entry into force, the Committee on the Rights of Persons with Disabilities adopted General Comment No. 1, offering further guidance and clarification of key points related to Article 12 of the UN CRPD, 'Equal recognition before the law' (Committee on the Rights of Persons with Disabilities, 2014). General Comment No. 1 reaffirms that *all* individuals have legal (as distinct from mental) capacity:

> The right to equal recognition before the law implies that legal capacity is a universal attribute inherent in all persons by virtue of their humanity and must be upheld for persons with disabilities on an equal basis with others.
> (Committee on the Rights of Persons with Disabilities, 2014, p. 2)

Critically, this standard of universal legal capacity, i.e. that all individuals, regardless of disability or other status, have legal capacity at all times, is independent of mental capacity:

> Under Article 12 of the Convention, perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity. (Committee on the Rights of Persons with Disabilities, 2014, p. 3)

The CRPD's account of universal legal capacity holds that any individual, no matter their present mental capacity, is both a "holder of rights and an actor under the law" (Committee on the Rights of Persons with Disabilities, 2014, p. 3), meaning that the individual should be not only protected by the law but also recognized as a legal agent at all times and under any circumstances. By separating legal capacity from mental capacity, the CRPD's guarantee of the right to universal legal capacity acknowledges the potential need for key supports to be in place to ensure that universal legal capacity can be realised in full, including reasonable accommodation and supported (as opposed to substitute) decision-making. However, the CRPD and General Comment No. 1 make clear that an individual who uses such supports should not be misinterpreted as lacking legal capacity (Committee on the Rights of Persons with Disabilities, 2014).

In pulling apart the concepts of legal and mental capacity, General Comment No. 1 also specifically critiques the construct of mental capacity itself, noting that:

> The concept of mental capacity is highly controversial in and of itself. Mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity. (Committee on the Rights of Persons with Disabilities, 2014, p. 4)

Despite these decisive statements from the Committee on the Rights of Persons with Disabilities, universal legal capacity has been met with resistance. Many argue that it is impossible to meet the demands of General Comment No. 1 with respect

to universal legal capacity, specifically where decision-making is to be aligned with the individual's "will and preferences" in the case of supported decision-making (Committee on the Rights of Persons with Disabilities, 2014, p. 4). Craigie et al. argue:

> Whether one appeals to a best interpretation of "will and preference" or of "best interests," it is a basic fact that either way someone else and not the principal is proposing, adopting, and using the rule of interpretation. The same applies to whether we use substituted or supported decision-making. These rules are made and used by persons (an [*sic*] institutions and committees made up of persons) who are decisionally capable *for* others who are not, *regardless of which rule is used*. [emphasis theirs] (Craigie *et al.*, 2019, pp. 164–165)

That is, even if we are trying to operate on a supported (as opposed to substitute) decision-making model, the inevitable consequence is that some form of 'deciding *for*' is occurring, which suggests that universal legal capacity cannot, at least practically speaking, be universal.

The most significant implication of universal legal capacity, per a strict interpretation of the UN CRPD, is the prohibition of involuntary admission under *any* circumstance (United Nations, 2006b). This position was reaffirmed in 2014, six years after the CRPD's entry into force, in the Committee on the Rights of Persons with Disabilities' General Comment No. 1:

> Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. States parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. (Committee on the Rights of Persons with Disabilities, 2014, p. 11)

It is important to note that arguments for abolition are not new. For example, Szasz voiced an abolition argument decades ago (Szasz, 1960). Myers, writing in 1983, summarises the 'old-school' abolitionist argument as follows:

> […] The abolitionists combine a basic preference for liberty with a pervasive distrust of psychiatry's ability and will to limit treatment to those who are unquestionably in need. (Myers, 1983, p. 413)

The difference between the 'old-school' abolitionist argument and the one expressed in the UN CRPD is in the rationale. While earlier versions of the abolitionist argument focused most prominently on challenging the scope and nature of psychiatry across the board, the UN CRPD's abolitionist stance argues two distinct but interrelated points: firstly, that psychosocial disability is *real*, but is social—rather than medical—in nature, and secondly, that involuntary admission on the basis of disability is fundamentally discriminatory. As such, the UN CRPD does not deny the utility of treatment altogether, like Szasz does, nor does the UN CRPD suggest that distrust of psychiatry is the reason to abolish involuntary admission. Rather, the UN CRPD and General Comment No. 1 adopt the position that involuntary admission on the basis of a social phenomenon—psychosocial disability—is discriminatory and therefore unjustifiable (United Nations, 2006b; Committee on the Rights of Persons with Disabilities, 2014). This abolitionist position is underpinned by the social model of disability endorsed in the UN CRPD.

However, the abolitionist perspective is not without its critics. Many nations submitted interpretive declarations and reservations at the point of signing,

reserving the right to override an individual's legal capacity in specific cases (i.e. according to their mental health law governing criteria for involuntary admission), and the literature is speckled with vehement arguments against a total prohibition on involuntary admission (Dawson, 2015; Freeman *et al.*, 2015; Scholten and Gather, 2018; Appelbaum, 2019). These anti-abolition perspectives adopt the core thesis that:

> [Article 12 of the UN CRPD] will in a considerable range of cases have an adverse effect first on the wellbeing and second on the autonomy of persons with mental disabilities. (Scholten and Gather, 2018, p. 229)

In general, the principle of universal legal capacity has been met with considerable resistance not only in the literature but also in practice (insofar as no national government has committed to abolishing involuntary admission completely (Cratsley, Wickremsinhe and Mackey, 2021; Ryan and Bartels, 2021)).

1.6. Making progress: modifications and new proposals in law

While most jurisdictions adopt a combination of the criteria set out in Section 1.4 (page 37), other legal frameworks have been put forward, both in practice and in theory. In this section, I review a key 'alternative' frameworks—developed both before and after the UN CRPD's entry into force—and the ethical principles that underpin them. The first two legal frameworks presented (Section 1.6.1 and 1.6.2) are single-rationale models, distinct from the dominant legal framework which combines multiple rationales to justify involuntary admission; the second two legal

frameworks presented (Section 1.6.3.1 and 1.6.3.2) are a response to meeting the mandates of the UN CRPD.

1.6.1. 'Need for treatment' only

Some jurisdictions govern involuntary admission through the determination of 'need for treatment' alone (Salize, Dressing and Peitz, 2002; Fistein *et al.*, 2009). Italy is one of these jurisdictions, having enacted Law 180, or 'the Basaglia law' as it is often called, in 1978 (Tansella, 1986). Per this law, involuntary admission is permissible only on the basis of a 'need for treatment' criterion, prohibiting admission on the basis of 'dangerousness', i.e. 'risk of harm to self or others' (Mezzina, 2018; Ferracuti *et al.*, 2021). In this model, involuntary admissions are time-bound (Mezzina, 2018), as "hospital psychiatry is considered complementary to community care and not vice versa" (Tansella, 1986, p. 665).

As discussed in Section 1.4.4 (page 41), the 'need for treatment' criterion draws its ethical force from a model of medical paternalism that applies a broadly biomedical interpretation of 'best interests'. A 'need for treatment' only law, like the Basaglia law, functionally critiques the use of 'dangerousness' as grounds for involuntary admission, which was a key motivation for Italy's mental health law reform more than four decades ago (Lovell and Scheper-Hughes, 1986).

However, Italy's law has been critiqued on empirical grounds. Firstly, there is some evidence to suggest that suicide rates have increased since the law's implementation (Ronchetti *et al.*, 2020). Secondly, a recent analysis suggested that some applications for involuntary admission in Italy are "improperly motivated"—a dangerousness criterion, as opposed to a need for treatment criterion, is sometimes cited as the primary reason for admission, contrary to the legal requirement (Ferracuti *et al.*, 2021, p. 121).

Importantly, Italy's reform of criteria to govern the use of involuntary admission was accompanied by a reform of the mental healthcare system, too, specifically shifting focus to community-based care (Barbui, Papola and Saraceno, 2018). However, some commentators have noted challenges with the system itself, including short-staffing and increasing lengths of stay in community residential facilities (Barbui, Papola and Saraceno, 2018).

1.6.2. 'Risk of harm to self or others' only

Taking the opposite approach, other jurisdictions have introduced legislation to support a 'dangerousness only' criterion to govern the use of involuntary admission (Salize, Dressing and Peitz, 2002; Fistein *et al.*, 2009). Some commentators argue that this model of involuntary admission is more aligned with a human rights model (Salize, Dressing and Peitz, 2002), where a 'dangerousness only' criterion allows for the preservation of core civil liberties (e.g. freedom, self-determination) in all cases except when an individual is likely to infringe on someone *else's* civil

liberties. In fact, the "move toward dangerousness" has been interpreted as a corrective response to the ills of a more permissive 'best interests' stance rooted in medical paternalism (Weissbourd, 1982, p. 83).

Beyond the specific criticisms of the criterion itself, as discussed in Section 1.4.2 (page 39), legislation that permits involuntary admission on the basis of 'dangerousness only' has been critiqued for a) "rephras[ing] and shift[ing]" the state's *police power* function into its *parens patriae* function by sanctioning admission (and treatment) for mental disorder on the basis of 'risk of harm to others' (Shah, 1975, p. 504), and b) causing delays in access to needed treatment, as involuntary admission can only be offered once an individual's mental health has "deteriorated" to the point of (risk of) harm (Copeland and Heilemann, 2008, p. 142).

1.6.3. UN CRPD-inspired shifts

It is important to note that, despite explicit prohibition of involuntary admission in General Comment No. 1, meant to clarify and defend Article 12 ('Equal recognition before the law') of the UN CRPD, many scholars argue that the UN CRPD has left in its wake an irreconcilable debate. Sometimes called 'the Geneva impasse' (Martin and Gurbai, 2019), the debate centres on whether involuntary admission can ever be permissible within a human rights framework. Importantly, this debate has not stymied progress in the development of laws that seek to cohere to principles of the UN CRPD. However, these shifts do not do away with

involuntary admission entirely—emergency admissions are broadly considered to be an exception to the rule. For example, Peru's recently adopted Mental Health Act, widely considered to be a progressive and landmark piece of legislation[9] (Mahomed, Stein and Patel, 2018; Galderisi *et al.*, 2020; Encalada, 2021), still permits involuntary admission in the case of "psychiatric emergencies" (Encalada, 2021, p. 136). In the next sections, I will review two key developments in mental health legislation that specifically address the ethics of involuntary admission.

1.6.3.1. Fusion law ('incapacity' only)

One alternative model put forth to accommodate the UN CRPD's mandate of non-discrimination is a *generic* capacity-based law to justify involuntary admission, where incapacity is the primary criterion used to determine whether involuntary admission is ethically permissible (Dawson and Szmukler, 2006; Szmukler, 2020). Per this model, a version of which has been enacted in Northern Ireland through its Mental Capacity Act (Northern Ireland) 2016:

> […] Involuntary treatment is only permitted when the person (a) has impairment of decision-making capacity and (b) the intervention proposed is in the person's best interests. (Lynch, Taggart and Campbell, 2017, p. 356)

However, this model is not without its critics. Firstly, some contend that a fusion law is still non-compliant with UN CRPD, because it does not guarantee universal legal capacity (permitting substitute decision-making *in cases of incapacity*) and because it retains a discriminatory diagnostic requirement in its application of the

[9]Considered progressive especially for abolishing all guardianship law, but with little attention to the ethics of involuntary admission (Encalada, 2021).

law (Lynch, Taggart and Campbell, 2017; Campbell and Rix, 2018). Secondly, critics contend that fusion legislation may do more harm than good for rights-based protections, as its requirements essentially *broaden* as opposed to *narrow* the range of individuals who might be subject to its requirements, including individuals living with psychosocial disabilities in the community (Kelly, 2016; Campbell and Rix, 2018).

Importantly, fusion law still retains the possibility of involuntary admission in (largely undefined) emergency cases, both in the law as implemented in Northern Ireland (Lynch, Taggart and Campbell, 2017) and in its scholarly development (Dawson and Szmukler, 2006).

1.6.3.2. Advance directives

Another proposed model for justifying involuntary admission centres on the use of advance directives. Advance directives—also called 'Ulysses arrangements' or 'Ulysses contracts'—act as a form of "self-paternalism" (Saks, 2002d, p. 204) to determine the correct course of action a practitioner should take in the event that the individual lacks mental capacity to make a decision themself (Saks, 2002a). While the Committee on the Rights of Persons with Disabilities has proposed advance directives as the ethical 'solution' to the abolition of involuntary admission via substitute decision-making (Committee on the Rights of Persons with Disabilities, 2014), the debate over advance directives is complex. Some

scholars argue that advance directives present their own paradox, where individuals "[avoid] coercion through prearranging for it" (Gremmen, 2008, p. 176).

Though advance directives have been debated in psychiatric ethics for some time, their place in legal frameworks is fairly new. India's recently adopted Mental Healthcare Act (2017) specifically authorizes the use of advanced directives to direct admissions decisions in cases of incapacity, and is considered to be a "highly progressive" piece of legislation (Duffy and Kelly, 2017, p. 48). Per this law, any individual can develop their own advance directive, setting out their wishes for treatment (or non-treatment) should they be both diagnosed with a mental illness and deemed to lack mental capacity (Duffy and Kelly, 2020; Pathare and Kapoor, 2021).

However, while advance directives are specifically acknowledged in General Comment No. 1 to be part of a UN CRPD-complaint supported decision-making regime, their applicability in a given scenario is not to be "based on an assessment that the person lacks mental capacity" (Committee on the Rights of Persons with Disabilities, 2014, p. 5). Therefore, even India's ground-breaking mental health law runs afoul of the UN CRPD, first in hinging the applicability of advanced directives to assessment of capacity, and second, in allowing practitioners or family members to overrule an advanced directive (Pathare and Kapoor, 2021).

Further, through the law's provision of 'nominated representatives'—another strategy to encourage *supported* as opposed to substitute decision-making—a 'supported admission' can be initiated by the nominated representative if admission is the least restrictive alternative and at least one of the following criteria are met, thereby functionally permitting proxy consent:

> "(i) Bodily harm to self: person has recently threatened or attempted or is threatening or attempting to cause bodily harm to self.
>
> (ii) Harm to other: person has recently behaved or is behaving violently towards another person or is causing another person to fear bodily harm.
>
> (iii) Inability to care for self: person has recently shown or is showing inability to care for themself to the degree that the person is a risk to their own self." (Mental Health Care Act of 2017, Section 89 (1) (a), India, as cited in Pathare and Kapoor (2021, p. 163))

This provision may contravene the UN CRPD (Duffy and Kelly, 2019).

Finally, just as with fusion law, India's legislation, which prioritises supported decision-making in line with the UN CRPD, still permits involuntary admission on an emergency basis "to prevent: (i) death or irreversible harm to the person; (ii) the person inflicting serious harm to others or their own self; or (iii) serious damage to property belonging to the person or others due to the person's behaviour flowing from their mental illness" (Pathare and Kapoor, 2021, p. 164).

1.6.4. Summary

While many different legal frameworks have been put forth to govern involuntary admission, all (at least as are currently implemented in any jurisdiction) permit

involuntary admission of some kind under specific circumstances (primarily emergency or ‘urgent’ cases). Continued disagreement over the practical and ethical fallout of abolition of involuntary admission has spurred proposals of a kind of ‘interim’ legislation—even if not UN CRPD-complaint—that can bridge current mental health laws into the possibility of a future without involuntary admission (Davidson, 2020, 2021). However, even this interim legislation, which aims to offer a “practical legal approach towards global abolition of psychiatric coercion” (Davidson, 2021, p. 70), deems involuntary admission ethically permissible under some circumstances:

> Any such legislative justifications [for involuntary admission] must […] be based on objective criteria, and include the procedural protection of at least two professional opinions except in a clearly and tightly defined “emergency”. (Davidson, 2020, pp. 170–171)

Throughout the literature on the ethics of involuntary admission, the need for emergency admissions is often granted but rarely discussed. Of course, the general concern of most commentators is that involuntary admission is initiated far too often and for far too long; however, the ethics of ‘emergency’ provisions for involuntary admission, usually for a period of twenty-four to seventy-two hours are less often interrogated. This is a significant gap in the literature and the law, however, as our determinations of what constitutes an ‘emergency’ in practice are, of course, values-laden, and still subject to bias. Moreover, where ‘emergency’ criteria are specifically delineated, their descriptions are similar to the ‘standard’ ethical justifications for admission described in Section 1.4 (page 37), with focus on ‘dangerousness’ or ‘need for treatment’ in some iteration, e.g. as in India’s Mental Health Care Act, noted in Section 1.6.3.2 (page 56).

1.7. Analysis of literature more broadly

In this section, I offer a brief summary and analysis of the literature on ethical principles that (should) govern decision-making for involuntary admission.

1.7.1. Differing implicit values

While legislation across jurisdictions tends to centre on broadly consistent criteria, with alternative criteria put forward in light of the mandates of the UN CRPD, a closer analysis of the nature of the debate reveals that much of the disagreement over the ethics of involuntary admission is rooted in differing implicit values. For example, one's perspective on whether a civil liberties framework versus a medical framework is more appropriate for governing involuntary admission will dictate the ethical 'rightness' of a 'dangerousness' criterion as compared with a 'need for treatment' criterion. Likewise, those who believe that legal capacity is necessarily contingent upon mental capacity will likely find a capacity-based framework to be more favourable, where those who believe that legal capacity is independent of mental capacity will likely accept only abolition.

Similarly, various legal stipulations added to these core criteria, e.g. "therapeutic purpose" (Pathare and Sagade, 2013, p. 24), necessarily shift the strength of the ethical rationale for admission; for example, if the primary criterion for admission is 'risk of harm to others', but the admission must also offer a 'therapeutic purpose', then we are faced with a mismatch between the underlying rationale to

justify admission and the added stipulation that the admission itself offer some sort of therapeutic value.[10] That is, the layering of specific criteria to justify admission—criteria that are underpinned by a certain view of scope and permissibility of involuntary admission—alongside other restrictions, e.g. 'treatability', may confuse our understandings of why and how certain criteria are ethically justifiable over others.

Critically, these kinds of disagreements on underlying *values* remain unresolved, and any defence of specific criteria to govern the use of involuntary admission must mount a defence of not only the criteria themselves but also the various underpinnings of those criteria, related to, e.g., understandings of what mental illness or psychosocial disability really 'is', or indeed what the purpose of admission is based on the criteria used to justify admission in the first place.

1.7.2. Negative rights framework

Despite disagreements over not only the specific ethical justifications for involuntary admission but also their underlying assumptions (e.g. about the nature of mental illness), one overarching observation of the nature of the ethical principles described in this chapter is that their focus is broadly rooted in a negative rights framework. A negative rights framework prioritises the right to freedom

[10]Shah makes a related point, as referenced in Section 1.4.2 (page 35): "Issues of dangerousness and the involuntary commitment of the mentally ill exemplify rather strikingly the manner in which public policy and legal questions have been translated in psychiatric and mental health terms. Stated differently, what would appear essentially to be issues relevant to the state's use of its police powers seem to have been rephrased and shifted to the exercise of *parens patriae* functions" (Shah, 1975, p. 504).

from interference by the state—requiring that the state *not* intervene on the lives of citizens except in specified cases. That is, the starting point of the general argument for each of these ethical principles is rooted in an understanding of what the state must *not* do to an individual (i.e. a negative right) as opposed to what the state *must* do for an individual (i.e. a positive entitlement). Even the 'need for treatment' criterion is rooted in a negative rights framework—the *parens patriae* power of the state permits intervention in cases of (potential) harm to self, but not to *enable* access to mental healthcare or even necessarily to *require* that such intervention take place.

1.7.3. The enduring challenge of involuntary admission

Regardless of ethical arguments, most would agree that involuntary admission is vastly over-utilized, and that efforts must be made to reduce the use of coercion in psychiatric care. However, many commentators (legal scholars, medical practitioners, service users, mental health advocates, and family members of service users alike) contend that involuntary admission is still necessary in some cases (Dawson, 2015; Plumb, 2015; Bhugra *et al.*, 2017; Scholten and Gather, 2018). However, and as this chapter has demonstrated, there is continued disagreement over *which* cases. Beyond discussion of involuntary admission in the general case, many scholars (and legal frameworks) also accept the need for involuntary admission in emergencies. However, the specific criteria used to justify admission in 'emergencies' warrant further scrutiny.

My analysis of the literature more broadly suggests that there are three key points to build the case for more considered exploration of this well-trod moral problem.

Firstly, my exploration of the literature has revealed wide disagreement over the ethics of involuntary admission not just between but *within* stakeholder groups. For example, while many service users are vehemently opposed to any form of admission without consent (World Network of Users and Survivors of Psychiatry, 2001; Minkowitz, 2012), some service users argue that, under certain circumstances, admission without consent is necessary (Freeman *et al.*, 2015; Plumb, 2015; Bhugra *et al.*, 2017). Where some ethicists, philosophers, and legal scholars argue that respect for autonomy negates the ethical permissibility of involuntary admission (Livermore, Malmquist and Meehl, 1968; Morse, 1982; Cherry, 2010), others suggest that, in fact, involuntary admission may promote autonomy by restoring mental capacity (Verkerk, 1999; Saks, 2000; Owen, Spencer and Kanaan, 2016). Medical professionals themselves disagree—Torrey (Torrey, 2005) and Szasz (Szasz, 2004) represent polar opposite views on admission without consent, yet both trained in psychiatry. This degree of intra- and inter-group disagreement cannot be resolved even by appealing to the perspective of one stakeholder group over another (e.g. by appealing to some false notion of a 'unified' or otherwise monolithic service user perspective), which suggests that more work is needed to understand when, if ever, involuntary admission is ethically permissible.

Secondly, as I have demonstrated throughout this chapter, no criterion put forth to govern involuntary admission—whether drawn from dominant frameworks or the UN CRPD—is without criticism, often on both normative and empirical grounds. That is, the disagreement that persists over the ethics of involuntary admission is not unfounded—there are legitimate worries not just about how dominant criteria are applied in practice, but also challenges to the normative force of these dominant criteria. The strength of arguments against each of the dominant criteria highlighted in Section 1.4 (page 37) and the additional principles highlighted in Section 1.5 (page 46) suggests that more work is needed to understand whether these arguments sufficiently negate the validity of (some of) these criteria, or whether (some of) these criteria need to be refined in order to withstand the challenges posed to their validity.

Finally, while new legal frameworks have been put forth, in many ways seeking to address challenges to the dominant criteria described in Section 1.4 (page 37), these legal frameworks do not, as I have demonstrated, sufficiently address the core challenge of involuntary admission—emergency cases. While efforts to reduce the use of involuntary admission for long-term stays are important, the ethical contours of *emergency* involuntary admissions, especially in light of how many involuntary admissions proceed (i.e. through emergency centres, often with police involvement), should be more robustly explored.

In light of these three challenges—disagreement both between and within stakeholder groups, empirical and normative critiques of dominant and alternative criteria alike, and the need for further consideration of emergency cases—I suggest that the debate over involuntary admission as it plays out in the psychiatric ethics scholarship, however well-trod, remains unresolved.

1.8. Conclusion

In this chapter, I have explored the dominant criteria to justify the use of involuntary admission in legislation across many jurisdictions. I explored the ethical principles that underpin the force of these justificatory criteria, and I explored normative and empirical challenges to their value, relevance, and applicability. I also introduced key principles of the UN CRPD and related policy guidelines, specifically General Comment No. 1, highlighting the ways in which UN CRPD principles directly challenge the dominant criteria (i.e. by critiquing the permissibility of involuntary admission all together). I described various legal provisions that have sought to make progress on the tensions identified between the dominant criteria as well as in light of UN CRPD-based principles, and I explored normative and empirical challenges to each of these legal frameworks. I characterised the ethical principles explored in this chapter as being rooted in a negative rights framework. I concluded that, in light of wide disagreement and challenges to every principle that has been put forth, the debate over the ethics of involuntary admission remains unresolved. In the next chapter of the thesis, I

explore the ethical principles relevant to involuntary admission in global mental health.

Chapter 2. Global mental health and involuntary admission

2.1. Introduction

In the previous chapter, I explored the nature of the debate on the ethics of involuntary admission as it is broadly conceived in the psychiatric ethics scholarship. I concluded that the debate is still largely unsettled. In this chapter, I explore the debate on the ethics of involuntary admission as it relates to calls for increased access to mental healthcare, championed by the field of global mental health. I compare arguments in psychiatric ethics to arguments in global mental health and characterise the nature of tension between their approaches.

As described in the Introduction, global mental health is a growing field of research and practice whose "ultimate goal" is to "[improve] the lives of individuals living with [mental] disorders in all countries" (Patel and Prince, 2010, p. 1977). In pursuit of this aim, the field of global mental health[11] integrates and harmonizes work across many disciplines—from basic science and public health research to implementation science and clinical practice—in order to prevent, treat, and manage mental disorders globally, and with dedicated focus on low- and middle-income country settings, cultural landscapes, and healthcare systems (Patel *et al.*, 2018; Collins, 2020). With roots in both biological and cultural explanations of mental disorder, the field spans work across domains, including anthropology,

[11]As with many fields, global mental health is rife with debate over what falls in and out (as well as *who* falls in and out) of the 'field' of 'global mental health'. The field is also widely criticized for all kinds of sins—often for its colonial, imperialist, and capitalist tendencies, and for its fairly unquestioning adoption of a biomedical understanding of mental ill-health that draws from Western constructs of psychiatry (Lund, Bemme and Bass, 2020). (For further discussion of these points, see Bemme and D'Sousa (2014)).

medicine and genetics, epidemiology, psychology, sociology, and advocacy (Cohen, Patel and Minas, 2013).

Since "coming of age" in 2010 (Patel and Prince, 2010, p. 1976), the field of global mental health, which also includes advocacy work to "[translate] evidence into actionable policies" (Collins, 2020, p. 265), has had an outsized impact on the landscape for mental healthcare globally. As a field, global mental health has successfully increased the visibility and profile of mental health in global health and development efforts; one of the field's most significant achievements is the inclusion of mental health-related goals and indicators in the United Nations' Sustainable Development Goals (SDGs) (Patel *et al.*, 2018), largely driven by global mental health advocacy (Votruba and Thornicroft, 2016). Beyond international policy, the field is also influential in the development of mental healthcare systems across settings. The work of global mental health as a field is interlinked with much of the WHO's work on mental health (Bemme, 2018), co-championing a community-based model of mental healthcare service provision with the WHO (World Health Organization, 2008a, 2008b, 2009).

In this model—conceptualized first as decentralisation of mental health services (Saraceno *et al.*, 2007; Eaton *et al.*, 2011), and later as the 'balanced care model' (Thornicroft and Tansella, 2013; Patel *et al.*, 2018)—the majority of mental healthcare is provided in primary care and outpatient settings, with a recognized need for at least some inpatient care (Thornicroft and Tansella, 2013; World Health

Organization, 2021a). A key element of community-based care models, then, is the provision of some inpatient mental healthcare in *general* hospitals (as opposed to psychiatric hospitals) (Thornicroft and Tansella, 2013; Patel *et al.*, 2018; World Health Organization, 2021a). While the provision of community-based services intends to align with human rights protections (World Health Organization, 2021a), available evidence suggests that even robust community-based care models in highly resourced settings do not eliminate the need for involuntary admission altogether (Perera, 2020).

Given global mental health's influence, especially in shaping mental healthcare delivery, I analyse a specific element of the field's dominant narrative: its engagement with the ethics of involuntary admission. In this chapter, I first characterise the dominant narrative of global mental health as a field and then identify key arguments made in the field with respect to the ethical justifications of involuntary admission. I analyse connections between these arguments and the dominant narrative's normative underpinnings. Finally, I offer an analysis of the literature more broadly as part of my application of a critical interpretive review method, which seeks to "[put] forth an argument about the literature" (McDougall, 2015, p. 527).

2.2. Method revisited: critical interpretive review

As discussed in Chapter 1, Part I of the thesis (Chapters 1 and 2) applies a method of critical interpretive review to explore the literature. I will not repeat my discussion of the method again in this chapter (for reference, see Chapter 1); instead, I will pick up with discussion of how I approached the literature search.

An initial targeted search of the literature pertinent to global mental health[12] returned few papers of relevance (i.e. that offer robust consideration of reasons for or against involuntary admission under certain circumstances). Furthermore, many papers widely considered to have *influence* in the field of global mental health do not include the phrase 'global mental health' at all (i.e. would not be identified in a search of the 'global mental health' literature). Given the lack of specific demarcations of the field's bounds, no possible combination of search terms could sufficiently identify all relevant literature.

Considering these challenges, I drew from the exemplar paper cited in McDougall's exposition of the method (McDougall, 2015), as in Chapter 1, and hinged my search for key ideas on an analysis of policy documents (Kass *et al.*, 2013) as a strategy to manage the literature. In the case of this chapter, Chapter 2, my literature review strategy looks primarily at key (sets of) agenda-setting papers

[12]Using the search terms ["global mental health" AND (involuntary OR coerc* OR forced OR commitment OR detention)] in Web of Science and in Google Scholar (search last updated on 15 September 2021).

in the field of global mental health, all widely recognized to have significantly impacted the direction of the field (Patel *et al.*, 2008, 2018; Cohen, Patel and Minas, 2013; Bemme, 2018; Vigo *et al.*, 2019). These three documents are:

1. The 2007 *Lancet* series
2. The 2011 *Lancet* series
3. The 2018 *Lancet* Commission

These agenda-setting papers, consistently cited in global mental health research, clearly set out the parameters of the field's work and therefore offer a useful starting point for exploring the literature. Each of these papers outlines various elements of an agenda for global mental health, culminating in the "reframed agenda" set out by the 2018 *Lancet* Commission (Patel *et al.*, 2018, p. 1553). I also used backward chaining (manual search of reference lists) and forward chaining (manual search of 'cited by' lists) (Booth, 2008), as well as key author searches to explore the dominant perspectives presented in discussions (however brief) of the ethics of involuntary admission in the field of global mental health.

Anchoring exploration of the literature to these core papers is intended to stay 'true' to the field's self-imposed demarcations, especially in light of the challenge of searching literature of a field with undefined or diffuse boundaries. That said, and as I will demonstrate, there is a dominant narrative within the field of global mental health, and this narrative is the one I seek to analyse.

2.3. The global mental health agenda: core commitments

The first widely recognized formulation of a global mental health agenda[13], marked by publication of the 2007 *Lancet* series on global mental health, set out two key aims for the field: increasing access to services and protecting human rights (*Lancet* Global Mental Health Group, 2007). Development of these aims was informed by decades of research in epidemiology and clinical medicine as well as transcultural psychiatry and social anthropology[14] (Cohen, Patel and Minas, 2013; Patel *et al.*, 2018).

These twin aims have guided much work in the field since publication of the 2007 *Lancet* series, and have been revisited and refined in key agenda-setting papers published since, most notably, the 2011 *Lancet* series on global mental health (*Executive summary: Global Mental Health 2011*, 2011) and the 2018 *Lancet* Commission on global mental health and sustainable development (Patel *et al.*, 2018). The 2018 *Lancet* Commission on global mental health and sustainable development represents a "reframed agenda" that "broaden[s] the global mental health agenda" to focus on "the improvement of mental health for whole

[13]If the very notion of 'global mental health' is contested, so too is the notion of a singular 'global mental health agenda'. For the purposes of this project, I take the 'global mental health agenda' to be the agenda first outlined by scholars who labelled the field as such and identified themselves as researchers and practitioners of 'global mental health'; that is, I take the 'global mental health agenda' to be the one described "within the frame of its own discourses" (Bemme and D'souza, 2014, p. 853). Of course, there is plenty of room to disagree with this choice; that said, in this thesis, I'm concerned with the *dominant* narrative of global mental health. I am especially concerned with this dominant narrative's recommendations for mental healthcare service delivery as they might pertain to the use of involuntary admission. Critiques aside, most would agree that this dominant narrative does, in fact, dominate work in the field.

[14]For a history of the field of global mental health from within its own discourse, see Cohen, Patel and Minas (2013). History is never neutral, so see also Lund et al. (2020). For a more critical perspective, see Bemme (2018).

populations and reducing the contribution of mental disorders to the global burden of disease" (Patel *et al.*, 2018, p. 1553).

In the next sections, I analyse the core commitments of the global mental health agenda as they are set out in the three key agenda-setting papers—the 2007, 2011, and 2018 *Lancet* series. This agenda (and its subsequent revisions) directs discourse, research, and practice in the field, and in turn impacts mental healthcare delivery globally:

> How global mental health is and has been framed is of vital importance to the construction of global priorities for how global mental health is defined and delivered, and subsequently how human rights can be promoted or undermined. (Special Rapporteur on the right to health, 2020, p. 3)

Broadly speaking, the global mental health agenda as framed within the dominant narrative[15] of the field retains the two key aims first outlined in the 2007 *Lancet* series: 1) increasing access to mental healthcare, and 2) promoting human rights. I will take each in turn.

2.3.1. 'Scaling up' mental healthcare

The first core commitment of the field of global mental health, per the dominant narrative, is to 'scale up' mental healthcare. This commitment has carried through

[15]Though the term 'global mental health' is variably defined and applied in the literature (Rajabzadeh et al., 2021), a dominant narrative (as labelled by promoters and critics alike) has emerged, in part by virtue of the nature of the field's development. Bemme's ethnographic study of 'global mental health' as a field (Bemme, 2018) argued that its work is propelled by a small group of leading scholars who have driven the field since its founding, who "playful refer to themselves as the 'flying circus'" (Bemme and Kirmayer, 2020, p. 5).

revisions to the field's dominant narrative, appearing as a key priority in the 2007, 2011, and 2018 versions of the agenda set forth in the literature (*Lancet* Global Mental Health Group, 2007; Eaton *et al.*, 2011; Patel *et al.*, 2018). Scaling up mental healthcare has long served as the field's driving force. This aim is motivated by the field's goal of closing the 'treatment gap', defined as the "absolute difference between the true prevalence of a disorder and the treated proportion of individuals affected by the disorder" (Kohn *et al.*, 2004, p. 859). Though the global treatment gap for mental illness is difficult to measure (and contested (Roberts *et al.*, 2020)), an oft-cited statistic in the field suggests that "between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries" (World Health Organization, 2013, p. 35). In response to this treatment gap, then, global mental health prioritises the aim of increasing access to services.

To achieve this aim, global mental health puts forth a few key strategies, largely centred around the provision of mental healthcare in primary healthcare settings (Saxena *et al.*, 2007). One such strategy is increasing the provision of effective interventions at the level of primary care, and often through 'task-shifting'—relying on non-specialists (e.g. general practitioners, nurses, lay workers) to provide mental healthcare (Patel *et al.*, 2018). Another is promoting a particular model of service delivery (first 'decentralisation' (Saraceno *et al.*, 2007) and later the 'balanced care' model (Thornicroft and Tansella, 2013; Patel *et al.*, 2018)) which seeks to shift the provision of mental healthcare (including inpatient care) out of specialized psychiatric institutions and into general hospitals and primary

healthcare clinics where possible. The rationale for decentralisation is fairly intuitive: "resources for care need to be geographically decentralised so that care is available and accessible in the community" (Saraceno *et al.*, 2007), instead of concentrated in specialist psychiatric hospitals, most often located in city centres, thereby making mental healthcare more accessible.

The 2018 *Lancet* Commission, in putting forth global mental health's reframed agenda, promotes the adoption of the 'balanced care' model, which advocates for the provision of mental healthcare in community-based settings, including primary care and general hospital settings (Thornicroft and Tansella, 2013). The balanced care model focuses primarily on decentralising the bulk of mental healthcare service provision away from specialized hospital and into community-based settings, including settings for physical healthcare service provision (Thornicroft and Tansella, 2013; Patel *et al.*, 2018). This model of mental healthcare service delivery prioritises the provision of *in*patient psychiatric care at *general* hospitals, even involuntarily (and available data suggests that admissions to general hospital for mental healthcare are involuntary in many cases (World Health Organization, 2018)).

2.3.2. Protecting human rights

The second aim that has fuelled much of the global mental health agenda is protecting human rights, often bolstered by pointing to principles of the UN CRPD (*Lancet* Global Mental Health Group, 2007; Drew *et al.*, 2011; Patel *et al.*, 2018).

Global mental health, as a field, has drawn much-needed attention to chaining, imprisonment, and other gross human rights violations inflicted upon individuals living with mental disorders—in some cases, even as a form of treatment (Kleinman, 2009; Patel and Prince, 2010; Drew *et al.*, 2011). Many scholars in the field have addressed the varied and widespread abuses experienced by individuals living with mental disorders, from being caged outside their family homes to being discharged from hospital-based care into homelessness or even incarceration, and from experiencing workplace discrimination to enduring stigma in social and cultural life (Kleinman, 2009; Drew *et al.*, 2011; Patel, Kleinman and Saraceno, 2012). Human rights violations also occur in care, and are often most egregious in psychiatric hospitals, as documented by Patel, Kleinman, and Saraceno (2012).

Interestingly, the first iteration of the dominant global mental health agenda, put forth in the 2007 Lancet series, spends comparably little time discussing human rights in any robust sense, but maintains its importance as the second of the field's two aims:

> We argue that a basic, evidence-based package of services for core mental disorders should be scaled up, and that protection of the human rights of people with mental disorders and their families should be strengthened. (*Lancet* Global Mental Health Group, 2007, p. 1241)

Despite minimal discussion of human rights in the 2007 *Lancet* series, the field's agenda was founded on these two aims, and was widely referenced as such (see, for example, Patel et al. (2008)).

Offering more dedicated attention to this second aim, the 2011 *Lancet* series includes a paper specifically on human rights and global mental health (Drew *et al.*, 2011), and another paper to strengthen the argument on the importance of human rights in the field (Patel *et al.*, 2011). The protection of human rights as a key goal of the global mental health agenda has now shifted focus to "mental health [as] a fundamental human right" in the 2018 *Lancet* Commission (Patel *et al.*, 2018, p. 1553), retaining (if reformulating) the importance of the human rights-based framework to drive progress in global mental health.

2.3.3. Protecting human rights *by* increasing access to services

While these simple and widely agreeable twin aims have largely driven the field since 2007, as demonstrated in Section 2.3.1 (page 74) and 2.3.2 (page 76), further scrutiny of their relationship to one another reveals a thornier challenge. Broadly, the global mental health agenda implies that protecting human rights is achieved *by* increasing access to services. This kind of logic is evident in much writing within the dominant narrative.

In much of the global mental health literature, characterisations of the human rights crisis faced by people living with mental illness frame a 'lack of access to care' as the primary *cause* of human rights violations. For example, Patel et al. note:

> First and foremost, the issue of the human rights of people with mental health problems should be placed at the foreground of global health— the abuse of even basic entitlements, such as freedom and the *denial of the right to care* (Drew *et al.*, 2011), constitute a global emergency on a par with the worst human rights scandals in the history of global health, one which has rightly been

> called a "failure of humanity" (Kleinman, 2009). [emphasis added] (Patel *et al.*, 2011, p. 1441)

Likewise, much writing on 'increasing access to services' frames the obligation as a human rights priority in and of itself, reinforcing the idea that human rights are best protected *through* the provision of care:

> Our first recommendation therefore supports the call to scale up mental health services (*Lancet* Global Mental Health Group, 2007), not only as a public health and human rights priority, but also, on the basis of evidence from this review, as a development priority. (Lund *et al.*, 2011, p. 1513)

However, many critique this framing as implicitly reliant on (or ignorant of) key assumptions built into the generalized formulation of Western psychiatry. In critiquing the 'scaling up' arm of global mental health's agenda, Saraceno writes:

> We all have enthusiastically endorsed the notion of closing or reducing the gap between untreated and treated and therefore, the urgent need of scaling-up mental health care. However, we have to build the 'content' of the scaling-up: *what actually do we want to scale-up?* If we do not put a clear content to this process, we will certainly get a sort of easy and general consensus about scaling-up and reducing the gap, but this type of consensus may be too generic. Let's be clear: in scaling-up mental health care are we scaling-up outmoded psychiatric hospitals (as many psychiatrists would like)? Compulsive hospitalisation with different rules and rights depending on the gender of the patient (as some countries do)? Unmodified electroshocks 'exceptionally allowed' (as some professionals seem to recommend); finally, are we scaling-up also the unacceptable influence of Big Pharma on psychiatric prescribing practices? Of course, the answer should be: No, we do not want to scale-up all this, but we must say this more clearly and make our efforts to scaling-up care more comprehensive and inclusive of innovative policies and human rights driven mental health service organisations. [emphasis added] (Saraceno, 2019, p. 2)

In fact, Howell, Mills, and Rushton have specifically criticized global mental health's human rights-based arguments in favour of increasing access to care, noting that global mental health frames human rights as "[focusing] on the right to access treatment at the expense of the right to refuse it" (2017, p. 3 of 9). The

authors go on to highlight a key tension in the field's dominant framing of human rights:

> In the case of mental health, the problem may not be lack of access to treatment but quite the reverse: the right to access information about, and to refuse, treatments - including medications that in some cases have been found to be harmful, particularly long-term. There is also evidence of widespread human rights abuses within psychiatric institutions worldwide (see, for example, see [*sic*] the work of Mental Disability Rights International). These rights abuses are sometimes recognized and highlighted by GMH [global mental health] advocates, who argue that (for the most part) care is better delivered within communities not institutions. (Howell, Mills and Rushton, 2017, p. 2 of 9)

Here, Howell, Mills and Rushton highlight the crux of the implicit argument in the field of global mental health. Broadly, the field has framed increasing access to services (where 'services' refers to mental healthcare within a largely biomedical framework) as the primary strategy for promoting human rights, with little acknowledgement of the kinds of human rights violations that can occur *in* care—or in accessing it.

Despite persuasive criticisms like these, even the newest formulation of the global mental health agenda, crafted in 2018, commits to this framing. Critically, though this renewed agenda seeks to expand upon the two aims that had guided global mental health since 2007, the agenda retains much of the same general thrust of the initial twin aims set out in the first-ever *Lancet* series on global mental health, first by committing to mental health as a fundamental human right and then by committing to scaling up mental health services as the first key action needed to make progress toward this reframed agenda (Patel *et al.*, 2018).

Even in adopting its renewed agenda, then, the dominant narrative of global mental health maintains an overarching aim of increasing access to services (Patel *et al.*, 2018). However, narrow focus on this aim may obscure questions of *how* care is accessed. As other commentators have noted, this uncritical view within the field—providing access to biomedical mental healthcare as an alternative to faith healing or other means of 'care'—leads to "little acknowledgement of the potential irony of transferring persons from one form of coercion to another" (Read, 2019, p. 629). The field of global mental health must ensure that its "easy and general consensus" around scaling up mental healthcare and closing the treatment gap does not inadvertently 'scale up' harmful systems (Saraceno, 2019, p. 2). The 2018 *Lancet* Commission was criticized for its laser-sharp focus on 'scaling up' mental healthcare with little consideration of what that 'care' might entail:

> The iatrogenic effects of scaling-up efforts should be taken seriously; caution is needed so that an absence of care is not replaced with coercive medical practices that undermine people's fundamental rights. (Cosgrove *et al.*, 2019, p. 117)

2.4. Exploring explicit positions on involuntary admission

As demonstrated in the previous section, global mental health prioritises increasing access to services as a human rights imperative; however, global mental health has given far less priority to exploring what 'access to services' might entail in practice. As I have argued elsewhere, global mental health, as a field, should engage more deeply with the debate over the ethics of involuntary admission, and for two reasons (Wickremsinhe, 2021). Firstly, the field specifically promotes a model of service delivery that includes inpatient services (especially inpatient services in general hospital settings), a significant proportion of which are

'accessed' involuntarily according to available data (World Health Organization, 2018). Secondly, global mental health roots its commitment to human rights in key principles of the UN CRPD (see, for example, Drew et al. (2011)), thereby "[risking] a piecemeal approach to human rights" by failing to grapple with the mandates of the UN CRPD in full (i.e. abolition of involuntary admission, per a strict reading) (Wickremsinhe, 2021, p. 3 of 4).

In this section, I explore the extent to which the field of global mental health has engaged with the debate over the ethics of involuntary admission. This exploration is sensitive not only to the case for engagement outlined, but also, the field's overarching focus on access to services as part of its human rights framework, as described in Section 2.3.3 (page 78). To ground my exploration of global mental health's engagement with the ethics of involuntary admission, I reviewed the three key sets of agenda-setting papers[16] in the field, as set out in Section 2.2 (page 72), all of which revealed limited engagement with the topic of involuntary admission.

Take first the 2007 *Lancet* series. Across six papers in the series, involuntary admission, by any associated term (e.g. 'detention', 'coercion'), is mentioned in just three instances:

1. The first two instances are in the series' second paper, entitled "Resources for mental health: scarcity, inequity, and inefficiency" by Saxena et al. (2007). 'Involuntary' admission, treatment, or detention is mentioned once

[16]So named *by* the dominant narrative, as indicated in, e.g., Cohen, Patel and Minas (2013) and Patel et al. (2018).

as part of the discussion on mental health policy and legislation[17] and then briefly as part of the discussion on human rights[18] (Saxena *et al.*, 2007).
2. The second instance is in the series' concluding paper, entitled "Scale up services for mental health: A call to action" by the *Lancet* Global Mental Health Group, which references 'involuntary admission' as part of a recommended secondary indicator[19] to monitor health systems after the five core recommended indicators are met (2007).

In either case, the ethics of involuntary admission—on human rights grounds or otherwise—is not discussed.

The 2011 *Lancet* series refers to involuntary admission more robustly, specifically in the sixth and final paper of the series: 'Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis' by Drew et al. In this paper, 'involuntary' admission or treatment[20] is mentioned only twice (2011):

1. In their discussion on protections of legal capacity, the authors note the limited provisions for appealing involuntary admissions decisions.[21]
2. This same point is echoed later in the paper, where the authors call for the establishment of legal and oversight mechanisms.[22]

[17]"A mental health policy framework must include legislation for protection of the basic human and civil rights of people with mental disorders, especially those in receipt of involuntary treatment" (Saxena *et al.*, 2007, p. 878).
[18]"The abuses associated with involuntary detention vary from country to country in both the private and public sectors" (Saxena *et al.*, 2007, p. 885).
[19]"Involuntary admissions as a proportion of all annual admissions" (*Lancet* Global Mental Health Group, 2007, p. 1244).
[20]By content search for not only the word 'involuntary' but also associated terms, e.g. 'detention', 'coercion'.
[21]"Despite the far-reaching powers that can be exercised by guardians, there are very often few or no judicial mechanisms to enable people to appeal their involuntary admission and treatment or protect their right to exercise their legal capacity more generally" (Drew *et al.*, 2011, p. 1668).
[22]"In many low-income and middle-income countries, there is no well-defined independent judicial procedure or mechanism that can be accessed by people admitted involuntarily to mental health facilities to contest their detention" (Drew *et al.*, 2011, p. 1672).

Again, while the 2011 *Lancet* series nods to involuntary admission, there is no explicit discussion of the ethics of involuntary admission, despite the fact that the Drew et al. paper roots its analysis of human rights violations in principles of the UN CRPD (Drew *et al.*, 2011).

The most recent global mental health agenda-setting paper, the 2018 *Lancet* Commission on global mental health and sustainable development (Patel *et al.*, 2018), does offer some substantive discussion of involuntary admission. Ultimately, though, the authors do not take a stand on the ethics of involuntary admission, instead reproducing the various perspectives on the practice without offering a considered view of how the field intends to navigate the debate.[23]

Echoing the framing described in Section 2.3.3 (page 78), where promoting human rights is achieved primarily through increasing access to services, the authors frame a lack of access to care as a critical human rights violation (Patel *et al.*, 2018). For example, the authors write, "In many countries, lack of access to health services, housing and employment, and sometimes extreme violation of basic rights, is common" (Patel *et al.*, 2018, p. 1571), situating 'lack of access to health services' as a key human right the field seeks to protect. In this same discussion, the authors

[23]A recent volume that arguably sits within the frame of the global mental health literature given the makeup of its authors and editors, entitled "Mental Health, Legal Capacity, and Human Rights" (published September 2021), works to further this 'fence-sitting' by including perspectives from UN CRPD defenders as well as critics (Stein *et al.*, 2021). Broadly, the dominant narrative of the field has taken a bystander perspective on involuntary admission, acknowledging the overuse of coercion in psychiatric practice (Mahomed *et al.*, 2021) without wholeheartedly committing to the abolitionist stance.

also assert that "Such violations of human rights occur most frequently at the nexus of poverty, social marginalisation, and *lack of access to mental health care*" [emphasis added] (Patel *et al.*, 2018, p. 1571).

The authors then engage with the debate by summarising the nature of the disagreement[24] without taking a clear position on the ethics of involuntary admission:

> The CRPD states that all people have inherent legal capacity and should always be at the centre of decisions about their own welfare. **In situations in which people need support (supported decision making), states should primarily be guided by the person's will and preference** (Freeman *et al.*, 2015) [sic]. Commentators have referred to guardianship as civil death subject to widespread abuse (Mental Disability Advocacy Center, 2013) and have called for states to develop supported decision-making mechanisms, compatible with their settings, to allow people to exercise their right to decide and make choices about their lives (Perlin, 2013). **Critics of this view suggest that the absolute commitment to the person's will and preference could inadvertently undermine the right to health, freedom, and justice, thereby leading to a backlash including a rise in stigma and discrimination** (Perlin, 2013) [sic]. [emphasis added] (Patel *et al.*, 2018, p. 1572)

Here, the authors describe the nature of the debate but do not take a stance. Interestingly, the authors also nod to a perceived difference in culture in high-income versus middle- and low-income country settings, suggesting that, in the latter contexts, the family may have a more prominent role in decision-making (presumably lending validity to a substituted decision-making model wherein the family decides that an individual should be involuntarily admitted, though the authors do not make this point clear).

[24]Somewhat bizarrely, the quoted passage is incorrectly referenced in several places in the original article. The authors mistakenly cite Freeman et al. (2015) as arguing for a will and preferences model of supported decision-making (the words 'will and preferences' do not even appear in the Freeman et al. article). Likewise, the authors have mistakenly cited Perlin (2013) to represent the 'critics' view', despite the fact that Perlin says nothing to this effect (and is, in fact, a defender of a strict reading of the UN CRPD). The critical view is made by Freeman et al.

Beyond the specific section of the paper dedicated to this discussion, the tangle is referenced in one other instance. Earlier in the article, under discussion of 'threats to mental health', the authors also nod to the disagreement:

> Tension has developed between people who believe that the UN Convention of the Rights of Persons with Disabilities (CRPD) enshrines the right to autonomy in decision making about treatment to all people with mental disorders (or psychosocial disabilities, the term used in the CRPD) in all circumstances, and people who believe that mental health laws provide appropriate guidelines that allow for substituted decision making in the best interests of the individual when the mental disorder profoundly interferes with the person's capacity to make informed decisions (Freeman *et al.*, 2015). (Patel *et al.*, 2018, p. 1560)

The debate over the ethics of involuntary admission is listed under "threats to global mental health" alongside, e.g. minimal financial resources allocated to mental healthcare and social and political contexts such as global income inequality and conflict (Patel *et al.*, 2018, pp. 1559–1560).

In exploring the literature within, as well as adjacent to and explicitly critical of, global mental health, I came across several additional articles that broached the topic of involuntary admission (e.g. Mahomed, Stein, and Patel (2018), Cohen and Minas (2017)). However, most articles offered neither a specific defence of key principles or criteria that might render involuntary admission ethically justifiable, nor endorsement of or agreement with the UN CRPD's ban on involuntary admission. Even Wildeman, who acknowledges and engages with the intersection between global mental health policy and the UN CRPD, still does not address specific justifications, instead highlighting *that* these two narratives stand in tension:

> Going forward, the interaction of global mental health policy and the CRPD—by way of the many social actors brought together through these political mechanisms—will continue to pose challenges running deeper even than the challenge of improving global mental health outcomes or reducing concomitant burdens. […] These challenges reach to the meaning and practical implications of the human rights values of equality, autonomy, and political participation—or the relevance of these fundamental values to our collective efforts to support individual and social well-being in and beyond the policy domain of mental health. (Wildeman, 2013, p. 61)

Given the general lack of in-depth engagement with the ethics of involuntary admission in the global mental health literature, I pin my exploration of the ethical principles in global mental health to the exposition of the debate outlined in agenda-setting papers, specifically the 2018 *Lancet* Commission, which frames involuntary admission as a tension with no immediate resolution.

In the next subsections, I explore key ethical arguments for involuntary admission with influence in the global mental health field as captured in the 2018 *Lancet* Commission's discussion. I focus on the 2018 *Lancet* Commission's framing of the debate because of its intention and force in shaping the direction of the field as an agenda-setting paper.[25] In this chapter, I will focus specifically on defences of involuntary admission, as UN CRPD-based principles that prohibit involuntary admission—also referenced in the 2018 *Lancet* Commission's framing of the debate—were addressed in Chapter 1.

[25]According to PlumX, the paper has been cited in the peer-reviewed literature 569 times as of 14 November 2021 (https://plu.mx/plum/a/?doi=10.1016/S0140-6736(18)31612-X&theme=plum-jbs-theme&hideUsage=true); according to Google Scholar, the paper has been cited 940 times as of 14 November 2021 (https://scholar.google.co.uk/scholar?cites=8819297539307626815&as_sdt=2005&sciodt=0,5&hl=en).

The arguments in defence of involuntary admission as given in the 2018 *Lancet* Commission are originally put forth in a 2015 paper by Freeman et al., the only citation provided for the 'critics' view' in the 2018 *Lancet* Commission (Freeman *et al.*, 2015; Patel *et al.*, 2018).[26] This paper, entitled "Reversing hard won victories in the name of human rights: A critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities" offers a number of defences of involuntary admission rooted in a particular interpretation of a rights-based framework that implicitly prioritises access to care as a human right (Freeman *et al.*, 2015). I will describe the three key rights-based arguments referenced in the *Lancet* Commission and derived from Freeman et al.

2.4.1. 'Right to health'

The primary challenge to an abolitionist stance on involuntary admission as mandated by a strict interpretation of the UN CRPD stems from the idea that *prohibiting* involuntary admission risks a violation of the 'right to health' (Freeman *et al.*, 2015).

Despite the fact that the very definition of the 'right to health' (in full, the 'right to the enjoyment of the highest attainable standard of physical and mental health') put forth by the UN specifically *prohibits* forced treatment (United Nations Office of

[26]Their referencing error aside.

the High Commissioner for Human Rights, 2008)—Freeman et al. assert that in defence of the 'right to health', involuntary admission could be permissible:

> The dilemma of informed consent aside, if a person having a severe exacerbation of affective or psychotic illness is not provided proven, effective treatment, can he or she be said to be receiving the highest attainable standard of health? […] In the example of psychosis, **we might be undermining the right to health to allow a person to stay in a psychotic state and never allow them to get to a point of refusing or accepting treatment in an informed manner**. The question then becomes whether involuntary treatment of a person with psychosis can be given at least to the point at which sufficient recovery has been made to make an informed decision. (Freeman *et al.*, 2015, p. 846)

Here, the 'right to health' is interpreted as a positive entitlement, one that the state via the mental healthcare system is obliged to offer, even if the individual is unable to consent to treatment. This argument also centres on an implicit link between mental disorder (if not generally, then in the specific case of psychosis) and (in)capacity to make an informed decision about treatment.

Critically, this perspective is not rooted in the more common 'need for treatment' rationale (to be discussed in Chapter 3), where the justification for overriding autonomy stems from the presumed benefit of treatment, as is often referenced in the debate over involuntary admission in psychiatric ethics. Rather, this argument is rooted in a rights-based framework that sees providing needed care as the responsibility of the government, via the health system, even if through involuntary admission.

The 'right to health' argument, and its derivative 'right to care' argument[27], are fairly common across the (limited) literature in global mental health that *does* clearly address involuntary admission. For example, Patel defends the "right to care", asserting, e.g., that some commentators who argue against involuntary admission, in line with the UN CRPD, are "conflat[ing] the principle of autonomy for people with disabilities with that of right to healthcare for people with health conditions" (2013, p. 75), and that closer analysis of healthcare access for individuals living with schizophrenia as a global priority "invokes the principle of the right to care for the most disabled and the most disadvantaged" through involuntary admission (2016, p. 889).

This framing conforms to the central aim of the global mental health agenda, where 'increasing access to services' is the primary mechanism for promoting human rights. In summary, the dominant narrative of global mental health endorses the view that the 'right to health' can justify involuntary admission in some cases, thereby fulfilling a positive entitlement.

2.4.2. 'Right to freedom'

The 2018 *Lancet* Commission also paradoxically references a 'right to freedom' argument in defence of involuntary admission, again drawing on Freeman et al.,

[27]Howell, Mills, and Rushton note that the "rhetorical slippage" between the 'right to health' and the 'right to care' (or 'the right to access treatment') runs the risk of centring pharmaceutical interventions in understandings of 'health' (2017, p. 4 of 9).

who suggest that a temporary deprivation of liberty (through involuntary admission) can prevent longer-term losses of freedom:

> However, application of an absolute rule of not admitting a person because of mental disability could in some circumstances result in the long-term deprivation of liberty—possibly in a prison—rather than a potentially much short(er)-term "deprivation" in a hospital. (Freeman *et al.*, 2015, p. 846)

While the right to liberty is broadly framed as a critical consideration in the psychiatric ethics literature, here, Freeman et al. argue for the right to liberty not in an absolute sense, but with respect to future outcomes. Again, this framing coheres with the particular interpretation of a rights-based framework that underpins the global mental health agenda, where access to care is positioned as the foundational right through which other rights are either enabled or sustained.

2.4.3. 'Right to justice'

The final rights-based argument cited in the *Lancet* Commission is the right to justice, which Freeman et al. frame as a comment on legal systems and competency to stand trial:

> […] If a person is assumed to have legal agency and legal standing [per the UN CRPD], then competency to stand trial and criminal responsibility for one's actions follow. […] Convicting a person who committed a crime as a result of serious mental illness and sentencing them to prison rather than diverting them for treatment and possible quick discharge is unlikely to be to their benefit. (Freeman *et al.*, 2015, p. 847)

Because the UN CRPD guarantees the right to universal legal capacity, Freeman et al. suggest that the possibility of an 'insanity defence' is inconsistent with the UN CRPD's principles. Freeman et al. do not offer this particular argument as a

defence of involuntary admission but rather as a general critique of the UN CRPD's guarantee of universal legal capacity. However, a potential implication of this argument is that an individual's 'right to justice' is better served by involuntarily admitting them *to prevent* the possibility of committing a crime.

2.4.4. Summary

Broadly, the arguments in defence of involuntary admission that have influence in global mental health cohere with the broader aims of the field. That is, these defences of involuntary admission presuppose the value of access to services as a critical enabler of individual human rights. By this logic, then, involuntary admission can itself be understood as a 'right'[28] that allows the individual to realize other rights. The ethical principles identified in this chapter are clearly in tension with the ethical principles identified in Chapter 1. Moreover, the underlying frameworks operating beneath these ethical principles are fundamentally distinct, further complicating the nature of this tension.

2.5. Analysis of literature more broadly

In this section, I offer a brief summary and analysis of the literature on ethical principles that (should) govern decision-making for involuntary admission within the global mental health discourse.

[28] However perverse that sounds!

2.5.1. The ‘right to health’ as foundational

As noted in Section 2.3.3 (page 78), critical voices in (and adjacent to) global mental health have criticized the field’s unreflective assumption that ‘access to care’—largely as an implementable policy translation of the ‘right to health’—is the salve to protecting human rights. That is, global mental health’s engagement with involuntary admission, however limited, has overlooked the kinds of human rights violations that may occur *in* care, or even in accessing it (Read, 2019; Saraceno, 2019; Wickremsinhe, 2021). In hinging its normative foundation on the right to health, the global mental health agenda has broadly come to the conclusion that involuntary admission may be required as part of the state’s obligation to enable the right to health.

As described in Section 2.4 (page 81), not only has the global mental health discourse only minimally engaged with this long-standing debate in psychiatric ethics, but the disagreement over the ethics of involuntary admission is explicitly listed in the reframed agenda, captured by the 2018 *Lancet* Commission, as a “threat to global mental health” (Patel *et al.*, 2018, pp. 1559–1560). The authors suggest that the “tension that has developed” between those who advocate for a strict interpretation of the UN CRPD and those who maintain the importance of retaining mental health legislation that permits the use of involuntary admission in specific circumstances is rooted in disagreement over the “biomedical framing of the treatment gap” (Patel *et al.*, 2018, p. 1560); however, they do not offer a solution to overcoming this tension. As in the debate over the ethics of involuntary admission in the psychiatric ethics scholarship, the heart of the disagreement

appears to be rooted in differing views of whether mental ill-health can and should be understood as a biomedical illness or a social disability.

2.5.2. Positive entitlements framework

The tendency in the field to gloss over the human rights violations that might occur *in* care—or in 'accessing' care—in favour of focusing on the human rights violations that occur elsewhere (e.g. chaining), as noted in Section 2.3.3 (page 78) aligns with disagreements that arise in discussions of the tension between negative rights and positive entitlements in relation to mental healthcare. These disagreements centre on whether mental health legislation is intended to protect negative rights to freedom from state intervention or confer positive entitlements to access to mental healthcare (Kelly, 2011, 2014).

Ecks, writing on ethnographic critiques of global mental health, notes this very tension in an analysis of the nature of global mental health's agenda:

> An emphasis on legal protection and on human rights is the most recent component of GMH [global mental health]. The question of rights is as old as the various movements against involuntary confinement and against inhuman treatments in mental asylums, but the paradigm adopted in GMH is more like that of the HIV/AIDS activism since the 1990s, which lobbied for access to life-saving medications. (Ecks, 2016, p. 805)

The tension to which Ecks alludes tracks debates between negative rights and positive entitlements in mental healthcare. The global mental health agenda argues that access to care—even involuntarily—is part of the 'right to health' (generally understood in medical terms). Clearly, then, ethical principles put forward to justify

involuntary admission in the global mental health literature cohere with a positive entitlements framework—the state is in some way obliged to *enable* health, freedom, and justice *through* the provision of mental healthcare, even involuntarily. This kind of positive entitlements framework to govern human rights (related not just to health but also to education, housing, et cetera) is widely considered to be emblematic of the "'North-South' divide" in understandings of human rights—"where developing countries argue for a much higher priority to socio-economic rights in order to further goals of equality" (Fredman, 2008b, p. 1).

That is, global mental health frames involuntary admission as sitting within the realm of a positive entitlement—the right to health—at least in some cases, which contrasts sharply with the negative rights framing of involuntary admission that dominates the debate in psychiatric ethics. In a positive entitlements framework, the provision of social and economic rights, including the right to health, is an obligation of the government (Sunstein, 1993, 2001). However, these entitlements are, in effect, only "qualified" rights (Sunstein, 2001, p. 228)—the obligation is acknowledged to be limited by resource constraints in practice, and positive entitlements can therefore only be *progressively* realized over time, not immediately guaranteed, like negative rights (United Nations Office of the High Commissioner for Human Rights, 1990, 2008; Fredman, 2008c).

While recent scholarship has begun to explore the normative tensions between the dominant rights-based narrative of global mental health and its intersections with

the UN CRPD (e.g. Wildeman (2013)), and to challenge the *kind* of rights-based narrative put forth within the field (e.g. Howell, Mills and Rushton (2017)), more work is needed to understand how—if at all—the normative underpinnings of global mental health *should* shape the debate over the ethics of involuntary admission.

2.6. Conclusion

In this chapter, I explored the normative underpinnings of the dominant view of involuntary admission in global mental health, a subfield of global health that has gained prominence in the past two decades. I showed that the field's limited engagement with the ethics of involuntary admission has centred broadly on a particular understanding of a rights-based framework for human rights. In this framing, much of the focus has centred on the 'right to health' that sees most other rights for individuals living with mental disorders as *enabled* by the right to access mental healthcare. I contrasted the ethical principles identified through my search of the global mental health literature—trained specifically on the dominant narrative of the field—with the ethical principles identified through my search of the psychiatric ethics literature—focused largely on legal rationales and challenges to these rationales, including the challenge posed by the UN CRPD.

There is a clear tension between the normative commitments of global mental health and psychiatric ethics; broadly speaking, this tension is rooted in underlying disagreements about applying a negative rights or positive entitlements framework

to understand the ethics of involuntary admission. This concludes Part I of the thesis, *Mapping ethical principles in involuntary admission—psychiatric ethics and global mental health*. In addressing the research aim (as noted in the Introduction on page 22), I have identified a clear tension between the ethical principles relevant to involuntary admission as argued in psychiatric ethics and global mental health—while the ethical principles drawn from psychiatric ethics broadly cohere with a negative rights framework, the ethical principles drawn from global mental health broadly cohere with a positive entitlements framework. In Part II of my thesis, I pursue two research questions, motivated by my identification of this tension, and in alignment with the research aim.

Chapter 3. Empirical ethics through a South African case study

3.1. Introduction

In Part I of my thesis, *Mapping ethical principles in involuntary admission—psychiatric ethics and global mental health*, I explored whether there is a tension between the normative commitments of psychiatric ethics and global mental health as it relates to involuntary admission. I concluded in Chapter 2, that there is, in fact, a tension. I characterised this tension as a fundamental disagreement in outlook: where global mental health adopts a broadly positive entitlements framework which views mental health(care) as a human right, psychiatric ethics adopts a broadly negative rights framework which views freedom from interference by the state as paramount. That is, the arguments given for when involuntary admission should be permissible (if ever) seem to fall along different orientations to how we ought to understand rights and obligations.

However, comparing these two orientations to the ethics of involuntary admission does not reveal a clear path forward to resolve this tension. Yet, this tension should be addressed, and for the primary reason given in the Introduction of this thesis: calls for increasing access to services in low- and middle-income countries, championed by global mental health, will inevitably collide with this longstanding and still unsettled debate in psychiatric ethics over when involuntary admission is ever permissible.

3.2. Research questions

In Part I, I began to pursue the project's overarching aim—to explore how the normative commitments of global mental health and psychiatric ethics should be managed in practice—through a review of relevant scholarship in psychiatric ethics and global mental health. My analysis of these two literatures—and specifically the clear tension between their normative underpinnings—motivates two key research questions pursued in the next two parts of the thesis, Parts II and III, respectively:

1. How *are* involuntary admissions decisions made in practice, and what normative commitments impact decision-making?
2. How *should* the ethical principles relevant to involuntary admission as well as the normative commitments arising in decision-making be navigated in practice?

The remainder of the thesis proceeds from these two questions—the first empirical and the second normative. In combining empirical and normative inquiry, my work is situated within the realm of empirical ethics.

In this chapter, which begins Part II of the thesis, *Framing involuntary admission in context—insights from a South African model of decision-making*, I explore the rationale for adopting an empirical ethics approach in order to address the research aim and its related research questions. Having justified the need for an empirical ethics approach, I then describe my approach to selecting an appropriate case study to conduct the empirical inquiry. I highlight the need to identify a case study that stands to offer insights into the way this tension is navigated (if at all) in context. I suggest that South Africa offers a particularly rich case study to explore the nature

of the tension between the normative underpinnings of global mental health and psychiatric ethics.

3.3. Justifying an empirical ethics approach

In an empirical ethics approach, ethical theory and empirical data are integrated in some way to draw normative conclusions (Ives and Draper, 2009). Empirical ethics, as a particular form of applied ethics, seeks to bridge the divide between theoretical arguments about a moral problem and lived experience of a moral problem (Ives, Dunn and Cribb, 2016a). I suggest that an empirical ethics approach, allowing for interrogation of theory *and* practice, is best-suited to address my research questions, as set out in Section 3.2 (page 101).

In an empirical ethics approach, normative claims are "richly informed by the empirical world" (Huxtable and Ives, 2019, p. 1 of 8). Empirical ethics is rooted in a fairly uncontroversial claim that "bioethics is neither disconnected from empirical knowledge nor subjugated to it" (Racine, 2008, p. 93), recognizing that the careful and well-reasoned integration of empirical data and ethical theory ensures that our normative claims are "relevant to the world" (Dunn *et al.*, 2012, p. 467).

An empirical ethics approach is well-suited to address the project's research questions primarily because an empirical ethics methodology allows for engagement with the kinds of ethical considerations (whether expressed as ethical

considerations or not) that arise *in practice*. Of course, not all potentially relevant ethical considerations *will* arise in practice, and the moral perspectives of stakeholders (especially practitioners) should not be assumed to carry moral authority. That said, understanding the kinds of considerations that *do* impact decision-making in practice stands to offer critical insights, through integrated empirical and normative analysis, on the kinds of considerations that *should* impact decision-making. In this way, empirical ethics draws on the strengths of both philosophical ethics and empirical inquiry to ensure that normative claims are adequately responsive to the contexts in which they are applied. In my work, adopting an empirical ethics approach allows for engagement with the kinds of stakeholders whose moral perspectives stand to offer insights into how decisions are made in practice.

A key worry with an empirical ethics approach, however, is that considerations that appear in practice—however prominently—will be assumed to be ethically meaningful in some way. Any empirical ethics project must take care not to derive an 'ought' claim from an 'is' claim. While the integration of empirical and normative inquiry is critical to an empirical ethics approach, the method of integration must be clearly documented to ensure that empirical facts are not being used to inform normative values (discussed in depth in Section 3.3.1.2).

In summary, an empirical ethics approach acknowledges that gaining an understanding of how practitioners make admissions decisions in practice may

illuminate the broader range of ethical considerations at stake in admissions decisions, beyond the normative principles implied or explicated in the literature. The value of engaging empirically with the decision-making context is derived from the view that the "judgments and actions" of practitioners "contain moral insights" (Widdershoven and van der Scheer, 2008, p. 24). Practitioners' views are still open to challenge and scrutiny, and are not taken to be moral *truths* in this project, but rather moral perspectives. As such, these moral perspectives are to be understood *in context*, and therefore must be subjected to robust ethical analysis, not simply taken up as moral truths without critique. That said, an empirical ethics project that adequately engages with these epistemological challenges in seeking to draw out ethical considerations in a particular context holds the possibility of reshaping the ethical debate by offering refined understandings of existing considerations or by introducing new ones.

3.3.1. Challenges in empirical ethics

By virtue of its aim to bridge the distinct epistemologies of empirical and normative inquiry, empirical ethics is open to two interrelated challenges.

3.3.1.1. The 'is/ought' problem

The first challenge to empirical ethics stems from the philosophical argument that an 'ought' claim cannot be derived from an 'is' claim" (Hume's law) (Dodd and Stern-Gillet, 1995; Ives, Dunn and Cribb, 2016b). Put simply, just because something *does* happen does not mean it *should* happen. In the context of

involuntary admission, for example, just because the law permits involuntary admission under certain circumstances, and just because practitioners *do* involuntary admit individuals under certain circumstances in practice, does not mean that these specific circumstances are ethically justifiable, (i.e. that involuntary admission *should* occur under these, or indeed any, circumstances).

The 'is/ought' problem creates a challenge for empirical ethics because, the criticism goes, by including any empirical data in the normative calculus at all, we run the risk of unjustifiably deriving an 'ought' from an 'is' (i.e. 'we *should* do [x] because we *do* do [x]'). The empirical ethicist's response to this challenge, however, problematizes not the is/ought problem itself, but rather *how* the 'is/ought' problem is adequately and justifiably attended to in the work (Ives, Dunn and Cribb, 2016b). That is, per Ives, Dunn and Cribb, the *real* challenge for empirical ethics is not the existence of the is/ought problem; rather, the challenge is the *account* any given empirical ethics methodology gives for overcoming the is/ought problem[29] (2016b). That is, the 'problem' for empirical ethics is not whether its key methodological account of navigating the 'is/ought' problem *can* be sufficiently justified at all, but rather *that* its key methodological claims are sufficiently justified in a given piece of research.

[29]Of course, some philosophers argue that the 'is/ought' problem is not a problem at all, and Ives, Dunn, and Cribb suggest that part of the challenge of the 'is/ought' problem is the assumption that "all of 'philosophy' is united" in seeing the is/ought problem as a 'problem' (2016b, p. 7). However, considering the prominence of the 'is/ought' problem in debates over the validity and legitimacy of an empirical ethics approach, I argue that some account for overcoming the 'is/ought' problem should be provided in my thesis.

Here, Ives, Dunn and Cribb call for "an entreaty to embrace diversity" (2016b, p. 14), recognizing that many sufficient justifications for navigating this challenge exist, and so long as some sufficient justification is clearly explicated in an empirical ethics project, diversity in methodology should be welcomed (Davies, Ives and Dunn, 2015; Ives, Dunn and Cribb, 2016b). Such diversity allows for careful consideration of the potential justifications of how a given empirical ethics methodology traverses these kinds of philosophical critiques while recognizing that multiple justifications exist, depending on what the research project seeks to do.

3.3.1.2. The fact/value distinction

The fact/value distinction poses another potential challenge to empirical ethics. Distinct from (but derivative of) the is/ought problem—where "no evaluative statement may be validly derived from any set of non-evaluative statements alone" (Dodd and Stern-Gillet, 1995, p. 729)—the fact/value distinction is concerned with the nature of 'truth'—positing that facts are truth-apt while values are not (McMillan, 2016). That is, while the is/ought problem is concerned with whether an 'ought' can be determined from an 'is', the fact/value distinction is concerned with questions about whether 'facts' are, in fact, 'values-free', and whether 'values' are, in fact, 'fact-free' (Putnam, 1998).

Putnam and Putnam both argue that our understanding of facts is *values*-laden (for example, our factual evaluation of a health intervention that 'improves' health is imbued with implicit and values-laden understandings of 'good health') and that

our understanding of values is *fact*-laden (for example, our value of 'improving health' is imbued with implicit and fact-laden understandings of what 'health' *is*) (Putnam, 1998, 2002). Therefore, Putnam argues that "factual description and valuation can and must be entangled" (Putnam, 2002, p. 27).

While some have criticized empirical ethics for trying to marry the 'incompatible' realms of fact and value, several scholars (including, e.g., Putnam and Putnam) argue that the fact/value distinction is a false dichotomy. McMillian argues that the "traditional empiricist version [of the fact/value distinction], where fact and value are dichotomous, is arguably untenable" (McMillan, 2016, p. 31); McMillian therefore argues in favour of Putnam's entanglement position recognizing the values-laden-ness of scientific knowledge and the fact-laden-ness of 'thick ethical concepts' (McMillan, 2016). Other scholars of empirical ethics share this view (see, for example, Ives (2014)).

Amidst debates over these two challenges, the point stands: so long as an empirical ethics methodology offers a defensible and clearly explicated understanding of the fact/value distinction, the show goes on. In fact, Ives has argued that the precise nature of the fact/value *entanglement*, as opposed to distinction, need not be specified in order to pursue an empirical ethics methodology:

> The precise ontological relationship between the two can remain undefined, and yet we can still accept relatively unproblematically that the two are often mutually informing. (Ives, 2014, p. 303)

In summary, any empirical ethics project can guard itself against these challenges with careful attention to these theoretical concerns in its development and defence of a specific empirical ethics methodology. In my project, I pay particular attention to the risk of deriving 'ought' claims from 'is' claims, and work to ensure that my integrated analysis is transparent and reflexive.

3.3.2. Empirical ethics research in involuntary admission

The justification for the utility of adopting an empirical ethics approach to explore the ethics of involuntary admission is furthered by the lack of empirical inquiry into this particular topic in psychiatric ethics. A search of the literature[30] revealed one study exploring the ethics of involuntary admission using an empirical ethics approach. This study focused specifically on the ethics of involuntary admission for individuals living with anorexia nervosa (Kendall and Hugman, 2014). Though a particular empirical ethics methodology is not discussed in the article (nor in the doctoral thesis on which the article was based (Kendall, 2011)), the authors situate the work within the remit of empirical ethics and conclude that features of the decision-making *context*, specifically in terms of how professional knowledge is constructed, influence multidisciplinary team-based decisions to involuntarily admit individuals living with anorexia nervosa (Kendall and Hugman, 2014). A wider search of the literature, focusing on empirical ethics studies of psychiatry or mental healthcare generally, yielded many papers applying empirical ethics approaches in psychiatry (including the book, *Empirical Ethics in Psychiatry*,

[30]Search strategy included in Appendix A.

2008, eds. Widdershoven, et al. (Widdershoven *et al.*, 2008), but none specifically related to the ethical justifications of involuntary admission. The general lack of empirical ethics inquiry into decision-making for involuntary admission, and specifically in contexts where key features of global mental health and psychiatric ethics meet, motivates my work.

3.4. Identifying an informative case study

Having established the rationale for adopting an empirical ethics approach, I next need to identify and defend an appropriate case study to focus the empirical work.

Given the research aim of Parts II and III of the thesis, and in light of the empirical research question that guides Part II specifically, I am particularly interested in identifying a case study where key facets of the tension between ethical principles in psychiatric ethics and global mental health might be at play—i.e. where efforts in global mental health intersect with the debates in psychiatric ethics. A case study approach is useful for generating in-depth data about a specific phenomenon in a specific context (Flyvbjerg, 2006), and is common in empirical ethics projects (see, for example, McKeown, 2013 (McKeown, 2013) and Mortimer, 2019 (Mortimer, 2019)).

In light of the overarching research aim and the specific research question I seek to address in the empirical work, I suggest that South Africa, an upper-middle income

country (World Bank, 2019), offers a rich case study for exploration of decision-making in practice.

The clear rationale for studying decision-making for involuntary admission in South Africa is attributable to key elements of its legal context and its health system context, each of which underscore facets of interest in psychiatric ethics and global mental health. South Africa is recognized as a leader in the global mental health discourse (Saraceno, 2019), and much research, including implementation research, in global mental health occurs in South Africa (Misra *et al.*, 2019). In these ways, South Africa's mental healthcare system is both an adopter and driver of global mental health's core aims. Likewise, South Africa's health system context adopts several key elements of the broader global mental health agenda, specifically a decentralized mental healthcare system that relies on task-shifting approaches to deliver mental healthcare. South Africa's mental health legislation not only codifies a positive entitlements framework for access to mental healthcare, aligning with the normative commitments of global mental health; the legislation offers two distinct pathways for admission without consent—rooted in the kind of negative rights framework emphasised in psychiatric ethics—each centring different rationales for justification.

To note, my defence of South Africa as a case study for this project is not, in any way, a comment on whether or not this model is 'good' or 'bad'. Rather, South Africa emerges as an informative case study *because of* the unique ways in which it

frames the tension between psychiatric ethics and global mental as exposed in Part I of the thesis. Put simply, a South African model of decision-making offers a rich case study to investigate the empirical research question posed at the beginning of this chapter.

3.4.1. Legal context

Three critical elements of South Africa's legal framework for involuntary admission, governed by the Mental Health Care Act No. 17 of 2002 (MHCA 2002)[31] make South African an important case study for the work.

Firstly, the MHCA 2002 offers unique criteria, beyond the dominant criteria found in legislation across jurisdictions (as set out in Chapter 1) to justify the use of involuntary admission. The MHCA 2002 permits involuntary admission on the basis of three distinctive criteria: protection of financial interests (self), protection of reputation (self), and damage to (or loss of) property (self or others) (Republic of South Africa, 2002).

Secondly, the MHCA 2002 makes provisions for two different routes to inpatient admissions without consent—'assisted' admission and 'involuntary' admission,

[31]The MHCA 2002 (Republic of South Africa, 2002) has been widely heralded as a progressive model of mental health legislation (Lund *et al.*, 2010; Burns, 2011; Ramlall, 2012; Szabo and Kaliski, 2017). While it is important to note that, in the nearly two decades since the MHCA 2002 was enacted, several other highly progressive pieces of mental health legislation have passed in other jurisdictions (e.g. the Mental Capacity Act (Northern Ireland) 2016, India's Mental Healthcare Act 2017), these laws were still in the process of being fully implemented during the study period (Department of Health, no date; Pathare and Kapoor, 2020).

each with distinct criteria. While the criteria for 'assisted' admission align more closely with 'need for treatment' justifications of admission on the basis of incapacity, the criteria for 'involuntary' admission align more closely with risk-based justifications (e.g. risk of harm to others, risk of harm to self), including the additional and distinctive criteria summarised earlier (Republic of South Africa, 2002). That said, the justificatory criteria for both admissions routes acknowledge the interplay of both risk- and need-based rationales for admission without consent (Republic of South Africa, 2002).

Thirdly, the MHCA 2002 adopts a broadly positive entitlements framework to the provision of mental healthcare, aligned with the general legal context of post-apartheid South Africa (Sunstein, 2001). Accordingly, the MHCA 2002 uses rights-based language throughout, e.g. "A mental health care user who submits voluntarily to a health establishment for care, treatment and rehabilitation services, is *entitled to* [services]" [emphasis added] (Republic of South Africa, 2002, p. 24). Likewise, "A mental healthcare user *must be* provided with services without his or her consent [if justificatory criteria are met]" [emphasis added] (Republic of South Africa, 2002, p. 32). Critically, the MHCA 2002, in keeping with a positive entitlements framework, also acknowledges at the outset that mental healthcare must be provided equitably and is limited by available resources:

> The objects of this Act are to—
> regulate the mental health care in a manner that—
> (i) makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources […]
> (Republic of South Africa, 2002, p. 12)

Each of these critical features of a South African model of decision-making for psychiatric inpatient admission without consent—unique justificatory criteria, two routes to admission without consent, a positive entitlements framework —attends to key facets of the tension set out at the end of Part I. The first two features align with a negative rights framework prioritised in psychiatric ethics, while the third feature aligns with a positive entitlements framework prioritised in global mental health.

3.4.2. Health system context

In implementing the MHCA 2002, South Africa's health system has adopted two core strategies of the global mental health agenda[32], both of which have significant theoretical implications for involuntary admissions decisions: 1) decentralising mental healthcare and 2) task-shifting.

A core requirement of the MHCA 2002 is integration of mental healthcare into the general health system. By integrating mental health service provision into primary, secondary, and tertiary hospitals,[33] the MHCA 2002 'decentralises' mental healthcare away from specialist psychiatric hospitals and into general district and

[32]To note: implementation of the MHCA 2002 precedes much of the published development of the global mental health agenda, despite aligning quite closely to global mental health's commitments to decentralised mental health systems and task-shifting as key strategies for increasing access to services. That said, South African researchers and practitioners are considered to be key players in global mental health leadership (Saraceno, 2019).

[33]The initial call for decentralization of the mental healthcare system (and the wider healthcare system, more generally) was laid out in a 1997 White Paper authored by the Department of Health (Department of Health, 1997; Lund *et al.*, 2010; Ramlall, 2012).

regional hospitals (Republic of South Africa, 2002; Burns, 2008; Jack-Ide, Uys and Middleton, 2012; Lund *et al.*, 2012; Ramlall, 2012; Mulutsi, 2017).

As part of this decentralised model, where mental healthcare is integrated into the general health system, acute inpatient admission, including involuntary admission, is provided through a 72-hour assessment period in general hospitals (at the district, regional, or tertiary level) as opposed to psychiatric hospitals (Republic of South Africa, 2002). Admission for a 72-hour assessment period proceeds through the emergency centre (often called 'casualty') of the general hospital. After this 72-hour period, any patient who is deemed to still require involuntary admission should be transferred to a specialist psychiatric hospital (Republic of South Africa, 2002). Assisted admissions also proceed through district hospitals, but assisted admissions do not first require a 72-hour assessment (Republic of South Africa, 2002).

In setting out this decentralised health system, where mental healthcare (including involuntary and assisted admissions) proceeds through general hospitals, the MHCA 2002 also enacts a particular kind of 'task-shifting', as discussed in Chapter 2 (page 75), where involuntary admissions decisions are made largely by non-specialists. The MHCA 2002 redefines a "'mental healthcare practitioner' as 'a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental healthcare, treatment and rehabilitation services" (Republic of South Africa, 2002,

p. 10), thereby task-shifting much of mental healthcare to general—i.e. non-specialist—practitioners.

Both of these features of a South African model of decision-making for psychiatric inpatient admission without consent—decentralising the mental health system and task-shifting key responsibilities—align to core commitments of the global mental health agenda. These features offer a unique backdrop for understanding how a health system that has clearly adopted key strategies in global mental health might impact involuntary admissions decisions. Put simply, these two features attend to certain implications of global mental health's principles, as discussed in Chapter 2.

While the decentralisation of mental healthcare service delivery to acute beds in general hospitals works to increase access to inpatient services, a significant proportion of these beds are 'accessed' involuntarily in South Africa (Ramlall, Chipps and Mars, 2010). In line with the project aim, a South African model of decision-making offers an important opportunity to grapple with the complexities of involuntary admissions decisions made in the context of a broader 'access to mental healthcare' framework within the health system.

Likewise, the task-shifting approach to integrating mental healthcare across the general health system presents several theoretical implications for involuntary admissions decisions. Perhaps most significantly, many non-specialist providers working in district hospitals, who regularly make involuntary admissions decisions,

lack expertise in the diagnosis and management of mental illnesses (Schierenbeck *et al.*, 2013; de Kock and Pillay, 2017). This lack of expertise could in turn impact the interpretation and application of not only legal but extra-legal factors in decision-making for psychiatric inpatient admission without consent. Importantly, while a lack of expertise is, in most cases, *not* a good thing, I take the view that it might be worth exploring how this lack of expertise impacts, if at all, the kinds of considerations that inform practitioner decision-making for psychiatric inpatient admission without consent.

3.4.3. Summary: South Africa as an instructive case study

Taken together, the legal and health system contexts of South Africa offer a rich case study to explore decision-making in practice, specifically in light of the empirical research question and overarching research aim.

Moreover, available evidence suggests that a significant proportion of psychiatric inpatient admissions *do* occur without consent (whether involuntary or assisted) across South Africa[34], further bolstering the rationale for the case study. Practically speaking, South Africa's use of English as the dominant language of medical practice (and medical education and training programmes) minimised the language

[34]Ramlall, Chipps, and Mars found that more than 75% of mental healthcare users admitted to regional and district hospitals in KwaZulu-Natal in 2009 were admitted as assisted or involuntary patients (2010). Likewise, Thomas et al. recorded 487 involuntary admissions (72-hour assessments) at a district hospital in the Western Cape over the course of 2011 (2015). Other studies report similarly high numbers of involuntary and assisted admission in South Africa, though much of the available evidence is outdated (study period or publication date before 2012) (Mayers *et al.*, 2010; Moosa and Jeenah, 2010; Burns, Jhazbhay and Emsley, 2011).

barrier and also avoided the need for an interpreter or fieldworker to conduct the empirical work.

3.5. Conclusion

In this chapter, I have developed two research questions—one empirical and one normative—to understand first how decisions are made in practice and then how decisions should be made in practice. I explained that an empirical ethics approach is best-suited to address both research questions, and I explored various challenges to empirical ethics. I also demonstrated that, while much empirical ethics research focuses on challenges in psychiatric ethics, only one study specifically investigated the *process* of decision-making for involuntary admission.[35]

I then explored the rationale for choosing South Africa as a rich case study to conduct the empirical work. I suggested that key features of the context—specifically in terms of the law and the health system—allow for exploration of the normative commitments arising in decision-making in practice.

[35]Though much empirical ethics research in psychiatry addresses key facets of the broader debate over the ethical principles relevant to involuntary admission, e.g. understandings of capacity for individuals living with anorexia nervosa (Tan and Hope, 2008).

Chapter 4. Methodology and methods: a reflexive balancing methodology and qualitative research methods

4.1. Introduction

As described in Chapter 3, Parts II and III of my thesis seek to answer two inter-related research questions in pursuit of the project's overarching research aim: to explore how the normative commitments of global mental health and psychiatric ethics should be managed in practice. From my review of scholarship in both fields (Part I), I developed one empirical research question and one normative research question:

1. How *are* involuntary admissions decisions made in practice, and what normative commitments impact decision-making?
2. How *should* the ethical principles relevant to involuntary admission as well as the normative commitments arising in decision-making be navigated in practice?

To address these two research questions, my project adopts an empirical ethics approach and draws insights from South Africa as a case study. I have defended taking an empirical ethics approach and investigating South Africa as an informative case study in Chapter 3.

In this chapter, I identify a suitable empirical ethics methodology to guide my inquiry. Then, I defend the specific methods of the empirical work, which aims to address the first of these two research questions.

4.2. Orientation to the empirical ethics methodology

In this section, I focus on identifying a suitable empirical ethics methodology to apply in my work. I describe the theoretical underpinnings of the chosen methodology and its key steps.

In adopting an empirical ethics approach, a wide range of methodologies can be applied (Davies, Ives and Dunn, 2015), all seeking "epistemological harmonisation" of divergent commitments in empirical and normative inquiry (Ives, Dunn and Cribb, 2016b, p. 4). Davies et al. stress the importance of these methodological choices, suggesting that empirical bioethicists must:

> …[Engage] explicitly and meaningfully with questions concerning the kinds of moral claim that [they] want to be able to make, about normative justification and the methodological process, and about the coherence of these different components of their work. (Davies, Ives and Dunn, 2015, p. 12 of 13)

My choice of empirical ethics methodology has therefore paid close attention to these considerations.

4.2.1. Methodologies in empirical ethics

A range of methodologies are included under the umbrella of an empirical ethics approach. Davies et al. systematically reviewed methodologies in empirical ethics to develop a typology of methodologies along a consultative to dialogical continuum, all with differing meta-ethical and epistemological commitments (Davies, Ives and Dunn, 2015). At the dialogical end of the continuum, "the ethical

analysis and reaching of a normative conclusion is part of the research encounter itself" (Davies, Ives and Dunn, 2015, p. 8 of 13). Conversely, at the consultative end of the continuum, the researcher conducts an ethical analysis of stakeholder views "post-engagement" (Davies, Ives and Dunn, 2015, p. 9 of 13). In consultative approaches, moral authority stems not from consensus among research participants (as in dialogical approaches), but rather from the "theoretical soundness" of the arguments presented (Davies, Ives and Dunn, 2015, p. 9 of 13).

Put simply, consultative methodologies retain the central role of theory, thereby avoiding the potential pitfall of being 'led' exclusively or at least predominantly by stakeholders' perspectives—a risk in dialogical methodologies (Davies, Ives and Dunn, 2015). In their description of dialogical approaches, Davies et al., note that "the role of the researcher is less central, and becomes more one of facilitation and process than substantive analytic contribution" (Davies, Ives and Dunn, 2015, p. 10 of 13).

In order to retain the possibility of offering a 'substantive analytic contribution' to the debate, I opted for a consultative methodology—seeking coherence (between ethical principles and empirical facts) rather than consensus (between stakeholders) (Davies, Ives and Dunn, 2015). This choice is also sensitive to the nature of the moral problem itself. That is, a dialogical approach runs the risk of allowing those with decision-making power—practitioners—to dictate the normative direction of travel; I opt instead for a consultative approach to ensure that the central role of

theory—and especially new challenges to existing theory brought by, e.g. the UN CRPD—is not lost.

When identifying a suitable consultative methodology for empirical bioethics—one that effectively marries empirical and normative inquiry through coherence-seeking—wide reflective equilibrium becomes an "obvious candidate" (Ives, 2014, p. 304). In fact, wide reflective equilibrium is widely applied in empirical bioethics research (see, for example, de Vries and van Leeuwan, (2010), Barilan and Brusa (2011), or van Thiel and van Delden (2016)). As put forth by Rawls and Daniels (Rawls, 1974; Daniels, 1979), wide reflective equilibrium can be defined as a "non-foundational constructive method of justification" (Barilan and Brusa, 2011, p. 310), where a broad range of potentially relevant moral judgements, moral principles, and background theories are systematically analysed, accepted, or discarded in pursuit of *coherence*, i.e. consistency (Daniels, 1979).

However, wide reflective equilibrium is not without critique, especially as an empirical ethics methodology. Ives and Strong both argue that wide reflective equilibrium is compromised for two reasons: first, its lack of grounding in any ethical foundation obscures our understanding of *when* sufficient coherence is achieved, and second, its lack of grounding in any ethical foundation challenges

our confidence that the normative conclusions drawn are sufficiently immune to the biases of the thinker (Strong, 2010; Ives, 2014).[36]

Strong especially critiques this coherence-seeking model of analysis, suggesting that even the incorporation of background theories (moral and empirical) cannot sufficiently insulate analysis from the thinker's own prejudice, leading Strong to reject a coherentist model of justification in favour of a foundationalist one (Strong, 2010). Moving away from coherentism, Strong proposes a "modest moral foundationalism", where some key "basic moral propositions", rooted in "common morality", are incorporated into the analysis (Strong, 2010, p. 137). In Strong's approach, the value and relevance of these basic moral propositions are not dependent *solely* on coherence (Strong, 2010). Ives, however, disagrees with Strong's modest moral foundationalism, suggesting that a) this 'common morality' is unspecified and b) the privileging of these basic moral propositions may still be subject to "historical accident and prejudice" (Ives, 2014, p. 306). Put simply, Ives argues that Strong's proposal for modest moral foundationalism does not adequately overcome the very criticism of wide reflective equilibrium it seeks to address (Strong, 2010; Ives, 2014).

[36]Wide reflective equilibrium can also be critiqued for its lack of attention to how 'data' is 'collected', which further compromises its validity as a method of justification. Dunn et al. note that wide reflective equilibrium "[requires] data to be collected in ways that are blind to the methodological and epistemological foundations of the contemporary social sciences" (Dunn *et al.*, 2012, p. 473).

Instead, Ives suggests a 'quasi'-moral foundationalism, where boundary principles are seen *not* as "genuinely foundational", but rather as "necessary posits" to "[make] ethical inquiry possible" (Ives, 2014, p. 307). This 'quasi'-moral foundationalism is, of course, merely 'quasi'—Ives argues for fully coherentist, *not* foundationalist, approach to justification.

Rooted in this 'quasi'-moral foundationalism, Ives goes on to propose a reflexive balancing methodology, which seeks to address the shortcomings of wide reflective equilibrium as an empirical ethics methodology without accepting the modest moral foundationalism proposal stemming from Strong's critique. Ives' reflexive balancing methodology seeks to overcome the persuasive criticisms of both wide reflective equilibrium and a more firmly foundationalism approach (however 'modest') as being subject to bias. The methodology of reflexive balancing instead requires transparency and reflexivity in the gathering and integration of normative values and empirical facts (Ives, 2014).

4.2.2. Reflexive balancing methodology

In light of the proposed topic of study—the ethics of involuntary admission—I sought a methodology that allows the integrated normative and empirical analysis to be sensitive to the idea that both the normative aspects of the problem (what Ives calls 'boundary principles') and the empirical aspects of the problem (what Ives calls 'recalcitrant experience')—as explored, uncovered, and defined in the

project—are open to challenge. To accommodate this perspective, I adopt the empirical ethics methodology of reflexive balancing.

Within a reflexive balancing methodology, the thinker seeks coherence between 'boundary principles' and 'recalcitrant experience'. If the boundary principles and the recalcitrant experience are in genuine conflict, the thinker must work to resolve that conflict in some way. Per Ives:

> "The resolution will require us to either:
> 1) Reject one or more of the 'in tension' boundary principles;
> 2) Develop new ways of understanding one or more of the 'in tension' boundary principles to accommodate the recalcitrant experience;
> 3) Reject the apparently recalcitrant experience outright;
> 4) Develop ways of understanding the recalcitrant experience that render it coherent with our existing boundary." (Ives, 2014, p. 308)

Here, we can see how the methodology of reflexive balancing overcomes a key limitation of wide reflective equilibrium, as well as a core criticism of Strong's modest moral foundationalism. Unlike in wide reflective equilibrium, Ives outlines a clear strategy for seeking (and defending) coherence. Unlike in modest moral foundationalism, Ives allows the boundary principles to be open to revision, requiring retention of any boundary principles to be rooted in *coherence*, as opposed to independent justification. In light of these advantages, I favour a reflexive balancing methodology to maximise transparency in the integrative project—not only with regard to *how* integration happens, but also in gathering and defining the *inputs*, normative and empirical, that feed into the integrative project.

In reflexive balancing, normative propositions are open to revision, but the methodology takes special care to avoid running afoul of the is/ought problem by ensuring that normative recommendations are not informed *solely* by what happens in practice—termed 'recalcitrant experience' in Ives' methodology (Ives, 2014; Austin, 2020). This methodological design is well-suited to addressing involuntary admission for two reasons. Firstly, the ethical terrain of involuntary admission is well-documented and widely debated; any robust empirical ethics project on this topic must engage meaningfully with these conflicting normative values at the outset. Secondly, the empirical landscape of involuntary admission suggests that these decisions are made frequently and routinely, and any robust empirical ethics project on this topic must engage equally meaningfully with the practical contexts in which involuntary admissions decisions take place. Ives' reflective balancing methodology addresses each of these needs of the project (Ives, 2014), allowing for considered reflection of normative principles, which are given "initial weighting" in the analysis, but which have to then be justified through a coherence-seeking model with the empirical landscape of the problem (Davies, Ives and Dunn, 2015, p. 7 of 13).

4.2.2.1. Theoretical assumptions

To allow for this integration, where *both* normative principles and lived experiences are considered to enhance understandings of the ethical complexities of the topic of interest and therefor included in analysis, Ives' reflexive balancing methodology is rooted in Racine's meta-ethical stance of moderate pragmatic naturalism (Racine, 2008; Ives, 2014). Moderate pragmatic naturalism asserts that

"ethical norms derive neither from reason nor from biological observation and experience but rather from the interaction between ethical reasoning and context" (Racine, 2008, p. 100). In this meta-ethical view, fact and value are sufficiently 'entangled' in such a way that, even if the exact nature of the relationship is left undefined, "the two are often mutually informing" (as described in Chapter 3) (Ives, 2014, p. 303). According to Ives, moderate pragmatic naturalism:

> "…Adopts the view that some form of ethical insight may be gleaned from any form of human enquiry, and the job of the 'bioethicist' is to draw together those insights, explore the relationship between them, and offer some way of resolving a given ethical problem." (Ives, 2014, p. 303)

From this meta-ethical view—which guards itself against the core criticisms of empirical ethics described in Chapter 3 by acknowledging the entanglement of fact and value without deriving an 'ought' from an 'is'—Ives develops an account of reflexive balancing as a methodology.

Having set out this meta-ethical view on the nature of normative claims, Ives then describes the epistemological commitments necessary to the reflexive balancing methodology—specifically the adoption of a 'quasi-moral foundationalism'. From this epistemological commitment to quasi-moral foundationalism, Ives posits 'boundary principles' a "null hypothesis" in the ethical calculus—thereby making ethical inquiry *possible* (Ives, 2014, p. 307). However, in line with the 'quasi'-ness of this 'quasi'-moral foundationalism, these boundary principles are nonetheless still open to challenge and revision, just as a null hypothesis is in a statistical analysis. As Ives puts it:

> "…In quasi-moral foundationalism, boundary principles […] have no independent justification—they are merely treated *as though* they are epistemically privileged." [emphasis theirs] (Ives, 2014, p. 307)

Ives contrasts this view of boundary principles to Strong's 'basic propositions', which are epistemically privileged *by virtue of* their root in 'common morality' (Strong, 2010; Ives, 2014). Ives' development of boundary principles is a critical response to these 'basic propositions' rooted in 'common morality'—Ives argues that this 'common morality' is an unspecified one, and therefore subject to bias. In response, Ives proposes the identification of a set of boundary principles, *as part of the research project*, that are "considered useful, resilient, and relatively stable," but are drawn from a wide range of sources (not just 'common morality') (Ives, 2014, p. 307). Critically, and in contrast to Strong's basic propositions, these boundary principles, while 'relatively stable', are still, in theory, revisable (Ives, 2014).

Accepting Ives' criticism of Strong's modest moral foundationalism and adopting instead Ives' proposal for quasi-moral foundationalism is an especially attractive epistemological account for this project. Because the specific moral problem under scrutiny—involuntary admission—is a well-trod but highly contested debate, a wide range of potentially relevant boundary principles ought to be weighed in the analysis, beyond what might be identified through any appeal to 'common morality', as Strong would suggest (Strong, 2010).

4.2.2.2. The role of the thinker

A key component of Ives' methodology—and driven in part by Ives' criticisms of wide reflective equilibrium, discussed in Section 4.2.1 (page 121)—is recognising the place of the thinker in guiding the ethical analysis. Ives' methodology, careful not to run afoul of Hedgecoe's tongue-in-cheek critique (that "thinking hard in a special way" will lead to trustworthy moral insight (Hedgecoe, 2004, p. 138)), roots its ethical starting point not in the personal interests or prejudices of the thinker, but rather in a transparent and documented inquiry into the core values and norms that act upon the moral problem—thereby identifying the key boundary principles at stake. This move ensures that the broadest range of relevant boundary principles, gathered through "disciplinary naïve enquiry", is used to ground the normative analysis (Ives, 2014, p. 310). Furthermore, this move seeks to mitigate any potential biases or prejudices introduced by the thinker themself (Ives, 2014).

Another key component of Ives' methodology is recognising the role of the thinker in the integrative project. Ives' specific account of integration—where 'reflexive balancing' is applied as a discrete method—seeks to ensure a "systematic and transparent" process of integration that is informed by a broader range of inputs (i.e. boundary principles *and* recalcitrant experience) than traditional normative *or* empirical inquiry (Ives, 2014, p. 311).

4.2.2.3. Steps of reflexive balancing

Per Ives' outline of the methodology, three steps are necessary for reflexive balancing (Ives, 2014, p. 311):

1. Identification of a moral problem
2. Disciplinary-naïve inquiry into the problem
    a. Identifying boundary principles
    b. Uncovering recalcitrant experience
3. Reflexive balancing (as a method)

4.2.2.3.1. Identifying a moral problem (Step 1)

The first step of a reflexive balancing methodology is to identify a moral problem. Per Ives, "this problem may be generated from theoretical considerations, practical experience, engagement with empirical literature, or a mixture of all three" (Ives, 2014, p. 311). In my project, the moral problem is the ethics of involuntary admission—a long-standing challenge in psychiatry, and one that is thrown into sharp and urgent focus in light of calls for increased access to services in low- and middle-income countries, championed by scholars and advocates in global mental health.

4.2.2.3.2. Disciplinary-naïve inquiry: Identifying boundary principles (Step 2a)

The second step of a reflexive balancing methodology is 'disciplinary-naïve' inquiry into the identified moral problem. This 'disciplinary-naïve' inquiry encompasses two key sub-steps:1) identifying 'boundary principles' and 2) uncovering 'recalcitrant experience'.

In the first sub-step (Step 2a), the thinker seeks to "uncover and explore, from multiple perspectives, all the values that operate on the problem, and attempt to find some basic value propositions, which can act as quasi-foundational boundary principles" (Ives, 2014, p. 311). Though Ives' methodology does not prescribe a specific method to use in this step of the inquiry, previous research applying a reflexive balancing methodology has utilised a method of critical interpretive review for this step of the process (Austin, 2020). A method of critical interpretive review (as defined in Chapter 1) is particularly applicable to the broader reflexive balancing methodology, as it allows not just for exploration of the broader research context but also *targeted discovery* of the kinds of boundary principles that come to the fore in disciplinary-naïve inquiry into the moral problem.

Ives' description of this step looks broadly comparable to the work I have conducted in Part I. Firstly, in analysing two distinct bodies of scholarship—psychiatric ethics and global mental health—I have engaged in disciplinary naïve inquiry; secondly, in identifying the specific arguments for and against involuntary admission described in each of these two bodies of work, I have, in effect, captured key 'boundary principles' to ground the empirical ethics inquiry. Recasting the work of Part I to align with a reflexive balancing methodology, I have highlighted eleven key boundary principles (Table 1).

Psychiatric ethics	*Global mental health*
1. Presence of mental disorder	1. The right to health
2. Risk of harm to others	2. The right to freedom
3. Risk of harm to self	3. The right to justice
4. Need for treatment	
5. Mental incapacity	
6. Non-discrimination	
7. Universal legal capacity	

Table 1. Boundary principles drawn from psychiatric ethics and global mental health

4.2.2.3.3. Disciplinary-naïve inquiry: Uncovering recalcitrant experience (Step 2b)

The second sub-step of disciplinary-naïve inquiry (Step 2b) involves uncovering recalcitrant experience. Ives defines 'recalcitrant experience' as including "new practices, new understandings of old practices, new technologies, new facts/theories, or recurring challenges from existing and established theories and principles" (Ives, 2014, p. 311). In this step of the process, the thinker aims to explore the broader context of the moral problem, especially "the way it is constructed by stakeholders (broadly defined), lived through and experienced" (Ives, 2014, p. 311).

In this research, my uncovering of recalcitrant experience seeks to understand how involuntary admissions decisions are made *in context*, and specifically in a context where features of global mental health and psychiatric ethics come together. The methods employed to do so are explored in Section 4.3.

4.2.2.3.4. Reflexive balancing (Step 3)

The third and final stage of reflexive balancing as a methodology is reflexive balancing as a distinct method. Ives' description of the method demonstrates the relevance of boundary principles *and* recalcitrant experience in guiding the normative analysis:

> In the balancing process I propose here, the boundary principles are posited as a 'null hypothesis', and then systematically challenged by confronting these principles with the recalcitrant experience that generated the problem, alternative theoretical perspectives, potentially disconfirming data, et cetera. With each new confrontation, an attempt to find coherence with the boundary principles must be made, and the reason for either accepting or rejecting the new addition made explicit and justified in terms of its overall coherence. (Ives, 2014, p. 311)

Ives' compares the method of reflexive balancing to both "the philosopher's method of presenting an argument and defending it against possible criticism" and "the skills a qualitative researcher might employ when analysing a large dataset and reducing it into a set of coherent themes, justifying one interpretation of the data over another" (Ives, 2014, p. 311).

In my project, the method of reflexive balancing (applied in Chapter 7) seeks to transparently document this 'systematic challenge' of boundary principles (drawn from my analysis in Part I of the thesis and recast as such in Section 4.2.2.3.2) with recalcitrant experience (to be explored in the coming chapters comprising Part II of the thesis). By applying the method of reflexive balancing, I aim to offer normative reflections on the tensions and potential resolutions between boundary principles and recalcitrant experience as uncovered in this project.

4.2.2.4. Minor modifications to the methodology

In adopting Ives' reflexive balancing methodology to address the specific moral problem of involuntary admission for psychiatric inpatient care, I've made some small adaptations to better align the methodology with the topic of interest, specifically in light of the nature of the discourse on the topic of involuntary admission itself. In my identification of the moral problem at the outset of the project, I characterised a tension between two critical domains that have some influence on how we might understand the ethics of involuntary admission: global mental health and psychiatric ethics. As such, the key boundary principles (Step 2a), as they have been distilled from Part I and recast in Section 4.2.2.3.1 (page 131), draw specifically from the global mental health and psychiatric ethics scholarship in light of their shared relevance to—but clear tension in—understanding the ethics of involuntary admission.

Additionally—and aligning with Ives' methodology, which explicitly acknowledges the need for reflexivity in both identifying boundary principles and integrating empirical and normative inquiry through reflexive balancing as a discrete method—I have also sought to centre reflexivity in the empirical work (also cohering with Ives' prior work on empirical ethics (Ives and Dunn, 2010)). As such, my account of 'uncovering recalcitrant experience' in this project seeks to pay close attention to how my own position impacts on data collection and analysis (Section 4.6), in line with critiques of the often undertheorised use of social science methods in empirical bioethics research (Dunn and Ives, 2009; Singh, 2016).

4.3. Study procedures—data collection and analysis

Having justified the overarching approach (empirical ethics) and the case study (South Africa) in Chapter 3, and having justified the specific empirical ethics methodology applied (reflexive balancing) in Section 4.2 (page 121), I turn now to describe the discrete methods used to collect and analyse empirical data.

My data collection and analysis is led by my empirical research question, first presented in Chapter 3: How are involuntary admissions decisions made in practice, and what normative commitments impact decision-making?

In order to answer this research question, i.e. to understand how a moral problem looks *in practice*, two key questions arise, drawn from Dunn et al. (Dunn *et al.*, 2012):

- Moving from practice to data: What *kind* of empirical data should I pursue to answer the research question, i.e. to understand how decisions are made in practice, and what normative commitments impact decision-making?
- Moving from data to data analysis: How should I analyse the empirical data I have collected in order to answer the research question?

My answers to these questions lead me to specific methods. These choices of methods, and their justifications, are provided in the following sections. Before describing these specific methods, I set out the epistemological orientation of the

empirical research, and explain how these epistemological commitments connect to the epistemological orientation of the methodology of reflexive balancing.

The empirical work adopts a weak social constructionist perspective, where the research encounter is part of the process of generating empirical knowledge, especially empirical knowledge on ethical issues (and perspectives of ethical issues) (Dunn and Ives, 2009). That is, any data 'collected' is indeed data 'generated' by the research encounter. The research encounter does not yield values-neutral 'facts' that have been extracted or somehow 'discovered' through research, as in a positivist epistemology (Avis, 2005); rather, the researcher and the participant co-construct data within the research encounter (Charmaz, 2008). I take the view that the empirical 'facts' obtained through data collection are values-laden interpretations by participants' responses in conversation with me, as the interviewer.

This epistemological orientation dovetails with the fact-value 'entanglement' position that characterizes the epistemological commitments of the broader reflexive balancing methodology (Racine, 2008; Ives, 2014). Per Racine and Ives, empirical knowledge and ethical norms are not easily cleaved, recognising the values-laden-ness of 'facts' and the fact-laden-ness of 'values'. That is, the fact-value 'entanglement' position that underpins the methodology of reflexive balancing accommodates a weak social constructionist perspective by acknowledging that empirical knowledge can be subject to multiple interpretations

(given the 'entanglement' between facts and values). A social constructionist epistemology also accommodates the view of ethical norms as socially constructed "rules proper to human life" (Racine, 2008, p. 98).

4.3.1. Collecting empirical data

In order to understand how normative commitments in decision-making are encountered and navigated in practice, I have opted to use qualitative research methods. Qualitative research methods are well-suited to the exploratory nature of my inquiry (Silverman, 2020), working to understand perspectives of key stakeholders on how decision-making operates *in context*. The value of qualitative (over quantitative) research methods is clear: my empirical work seeks to understand how involuntary admissions decisions proceed in practice, with special attention to how varied normative commitments impact in decision-making.

To answer the research question, I sought to collect data with mental healthcare practitioners and with mental health advocates working in South Africa.[37] As discussed in Section 3.4.2 (page 114), 'mental healthcare practitioner' is broadly

[37]Mental health advocacy has a strong history in South Africa (World Health Organization, 2003a; Lund *et al.*, 2008; Kleintjes, Lund and Swartz, 2013), with good representation of global and local advocacy movements alike. Advocates perspectives are likely to be informed by a) the amalgamated experiences of many service users (as this is, broadly, the stated aim of many mental health advocacy organisations, including those from which participants were recruited), and b) a robust knowledge of the general landscape of mental healthcare systems in South Africa, including dedicated attention to the law. In South Africa, many mental health advocacy organisations prioritise leadership, staff, and members who have lived experience of mental illness.

defined in a South African context, and the vast majority of these practitioners work in emergency centre settings.

My approach to data collection was explorative and non-directive, seeking to gain a broad understanding of the considerations and contextual features relevant to the ethics of involuntary admission in practice. Through data collection with mental healthcare practitioners, I aimed to understand how involuntary admissions decisions are made, with attention to the range of considerations that might impact or influence decision-making. Through data collection with mental health advocates, I aimed to understand how involuntary admission is perceived and understood by service users and mental health advocates, with attention to the broader landscape of mental healthcare in South Africa.

The research question I seek to address in the empirical work focuses on decision-making itself, exploring how practitioners who make admissions decisions balance different normative commitments. I focus specifically on how decisions are made given the tension between normative commitments in psychiatric ethics and global mental health, as characterized in Chapter 2, and in light of the specific legal and health systems contexts in South Africa that shape practitioners' decision-making, as described in Chapter 3. Therefore, practitioners are the primary object of study in this research.

While I was specifically interested in scrutinizing practitioners' perspectives and experiences in light of the empirical research question, I was also sensitive to the need to triangulate the data collected with practitioner participants. One strategy for triangulation would be to speak directly to mental healthcare users who have experienced involuntary admission. However, I felt that a stronger strategy to understanding the mental healthcare user perspective was to speak with mental health advocates given their particularly unique vantage. Not only might advocates be able to speak to the range of experiences of involuntary admission in South Africa through their work with mental healthcare users, but advocates are also well-positioned to speak to the wider contextual features that characterize these admissions decisions.

4.3.1.1. Interviewing practitioners and mental health advocates

To gather this data, I considered a range of qualitative research methods, including participant observation of practitioners and focus group discussions with mental health advocates.

Participant observation of practitioners could have provided the kind of data I sought to collect in this project. However, in addition to practical constraints (e.g. time available to conduct the research, ethical permissions to access hospitals, et cetera), admissions decisions are difficult to 'observe' in practice. Unless decision-makers are honestly and actively (i.e., in real time) recounting their decision-making process aloud—which runs the risk of being insensitive, distressing, or

aggravating to mental healthcare users about whom a decision is being made, and could be perceived as a burden on practitioners—observing decision-making is nearly impossible.

In determining an appropriate method of data collection with advocates, I considered focus group discussions. However, given the potentially sensitive nature of the topic, as well as the possibility of conflicting views or other disagreement on the topic of involuntary admission, focus group discussions may have proven challenging. Moreover, focus group discussions may have compromised the richness of the data, e.g. if an advocate with lived experience of involuntary admission wanted to share their experiences but felt uncomfortable to do so in front of a larger group (Hennink, 2014).

In light of these various challenges, I decided to conduct semi-structured interviews with both practitioners and advocates. Semi-structured interviews are well-suited to an exploratory study like mine that aims to collect open-ended data about participants' experiences and perspectives (DeJonckheere and Vaughn, 2019).

In interviews with mental healthcare practitioners, I explored their accounts of decision-making for involuntary and assisted admission. In interviews with mental health advocates, I explored their own experiences of and perspectives on mental healthcare delivery in South Africa, as well as their organisational or personal views on which kinds of considerations (if any) should factor into decision-making.

I also explored service users' experiences (whether the advocate's own or second-hand) of involuntary admission.

The aim of conducting interviews with practitioners and advocates was both to explore the process of involuntary and assisted admission in practice, and to tease out the kinds of considerations that *do* shape practitioners' decisions as well as the kinds of considerations that advocates think *should* shape practitioners' decisions.

4.3.1.3. Sampling strategy and recruitment

In line with a qualitative research paradigm, my data collection sought not to be generalisable but rich, obtaining a deeper understanding of *how* decisions are made. Here, the focus is on gathering a wide range of perspectives from relevant stakeholders, not on trying to understand which perspective on decision-making is most common or which one predominates. As such, my sampling strategy looked to gather a range of perspectives that 'have something to say' about the process of decision-making in order to maximise heterogeneity of the sample (Fassinger, 2005) as much as possible according to parameters of interest identified in the literature.[38] I sought to sample a diverse range of roles, hospital levels, and hospital settings in my recruitment of practitioners.

[38]Mulutsi's empirical work on implementation of the MHCA 2002 highlighted the diversity of roles involved in decision-making (Mulutsi, 2017). Other research points to differences between urban and rural settings in mental healthcare (de Kock and Pillay, 2017; Docrat *et al.*, 2019).

In recruiting practitioners, I originally pursued a purposive sampling strategy, supplemented by snowball sampling. Through purposive sampling, I intended to speak to a wide range of practitioners who 'fill out the forms' (i.e. make the decisions)—i.e. not only consultant psychiatrists and psychiatry registrars but also medical officers and interns, who are often involved in making admissions decisions, as well as clinical psychologists and mental health nurses (Mulutsi, 2017).

I originally pursued a snowball sampling strategy with mental health advocates. My sampling strategy for this population was limited by a) the significantly smaller number of advocates in the country (compared to practitioners) and b) the lack of pre-existing relationships with relevant stakeholders.

4.3.1.3.1. Study sites (practitioners)

I approached two hospital sites—a district hospital (which sees most first-time admissions, and especially emergency admissions) as well as a tertiary hospital centre or 'referral hospital' (which sees more 'repeat' patients through the psychiatry department, as well as emergency admissions)—to help capture a wide range of considerations drawn from a wide range of perspectives.

I originally selected a district hospital (i.e. 'general hospital') (Site A) and a tertiary hospital with a specialty psychiatric unit or 'specialised hospital' (Site B) for recruitment. Sites A and B were selected because of access to gatekeepers through

key contacts of the project's external advisors, Prof Doug Wassenaar and Prof Suvira Ramlall, and because of their relative proximity to one another, thereby facilitating face-to-face interviews. I sought to recruit clinical psychologists, medical officers in psychiatry, medical interns, casualty officers (i.e. medical officers working in the emergency centre), and mental health nurses from the district hospital (Site A), and I sought to recruit psychiatrists, registrars, medical officers in psychiatry, and mental health nurses from the tertiary hospital (Site B). Based on available data as to the spread of practitioners who complete the forms prescribed by the MHCA 2002 to authorise involuntary admissions, purposive sampling of each of these kinds of practitioners stood to offer an ideal range for my sample (Mulutsi, 2017).

While I could not travel to South Africa to conduct face-to-face interviews because of the COVID-19 pandemic, I was able to transition to a virtual interview strategy with practitioners based at these two hospitals. However, recruitment proved challenging in the pandemic, and I struggled to recruit enough participants during the height of South Africa's first peak in COVID-19 cases. I was ultimately only able to conduct six interviews with practitioners at these two hospital sites after two months of targeted recruitment; I concluded this first wave of data collection and developed a revised recruitment strategy.

In the second wave of data collection with practitioners, I opted for snowball recruitment across the country through key contacts of Dr Ruth Passchier and Prof

Jantina de Vries. With this revised sampling strategy, I was able to recruit not through hospital sites but through personal connections. I again recruited purposively to maximise heterogeneity of the sample, working with Dr Passchier to identify potential participants with diverse experiences of practicing medicine (primarily as non-specialists) across multiple provinces, and especially in rural settings.

The new recruitment strategy strengthened the study by allowing me to speak with a broader range of practitioners, specifically those with experience practicing in rural hospitals settings (primarily district hospitals). Four of the five participants with rural work experience had just finished their community service year as of one month prior to their interview.

4.3.1.3.2. Study sites (advocates)

I struggled to recruit mental health advocates in this study. I reached out to four advocacy organisations in South Africa and two independent advocates identified in my search for potential participants. I was able to recruit four participants from one organisation [Organisation A], but I was unable to recruit from any of the other organisations or contacts in the study period. One organisation [Organisation B] reported that their work had shifted to focus on COVID-19 relief which therefore limited members' bandwidth for participation in the study. A key contact from another organisation [Organisation C] declined to participate because of a lack of familiarity and expertise with the topic of involuntary admission, as did a key

contact from yet another organisation [Organisation D]. Another key contact from the Organisation D expressed initial interest but did not follow up after subsequent communication. One of the independent advocates responded after the study period had closed, and I did not receive a response from the other independent advocate.

4.3.1.3.3. Process of recruitment

Potential interviewees were approached via email with a short description of the project; if interested in participating, I shared a copy of the relevant participant information sheet to offer detail on what participation would entail (see Appendices B and C for participant information sheets). If, after reading the participant information sheet, a potential interviewee confirmed interest in participating, I arranged a virtual interview and shared a copy of the relevant consent form (see Appendices D and E for consent forms). Only practitioners working in the public sector were approached[39]; advocates were approached whether their advocacy work was paid or volunteer.

All participants were over 18 years of age and spoke English. All interviews were conducted virtually via video or voice-only call, recorded using an encrypted recorder, and transcribed. Participants received a 150 ZAR voucher to an online retail store as compensation for time taken to participate. Interviews generally lasted 60 minutes and ranged in length from 44 to 152 minutes.

[39]I focus specifically on decision-making for psychiatric inpatient admission in the public sector, which serves approximately 85% of South Africa's population (Naidoo, 2012; Docrat, Lund and Chisholm, 2019).

4.3.1.3.4. Topic guide development

To mitigate the risk of bias within the interview itself (e.g. by introducing a particular term in the interview or implying a specific framing of a concept), I structured the topic guides for both practitioners and advocates to be particularly open-ended (see Appendices F and G for topic guides).

In designing the topic guide for practitioner interviews, I opted to not only ask direct questions about what kinds of considerations impact decision-making, but also to invite practitioners to recount their own experiences of decision-making in an attempt to manage any potential social desirability bias. Ensuring as many opportunities (built-in and probed) to tell 'stories of decision-making' as possible allowed for the recounting of experiences—freeing practitioners from reproducing the tick-box exercise of 'filling out the forms' that govern admissions decisions and instead allowing for a less guarded and more honest retelling of the kinds of considerations (sometimes implicit) that impact their decision-making. I piloted the first topic guide for practitioner participants with Dr Passchier, who has extensive experience of making decisions for psychiatric inpatient admission without consent in South Africa.

With advocates, I allowed space to tell their own stories and the stories of those for whom they advocate, probing their perspectives and the perceived perspectives of mental healthcare users generally about how mental healthcare operates in South Africa, both in general and specifically with regard to involuntary admission.

The forced pause and re-routing of the sampling and recruitment strategy, induced by COVID-19, allowed time for an interim analysis of data from the first phase of data collection gathered from six practitioners and three advocates. (I have included a brief statement explaining how my research was affected by the COVID-19 pandemic in Appendix H). In light of this interim analysis, I restructured the topic guide for practitioners to use in the second phase of data collection (see Appendix I for revised topic guide).

4.3.1.3.5. Summary of participants

In total, I spoke with twenty healthcare providers: six in the first phase of interviews and fourteen in the second phase of interviews. These healthcare providers represented a range of expertise, with experience working in varied hospital settings (Table 2).

In total, I spoke with four advocates—three in the first phase of interviews and one in the second phase of interviews. All four advocates were affiliated with the same advocacy organisation based in South Africa ('Organisation A'), and two advocates had personal experience of involuntary admission. Advocate interviews focused on 1) their own engagement, if any, in conversations with mental healthcare users about involuntary admission, 2) experiences, whether their own or the experiences of others, of involuntary admission, with special attention to *how* the admissions decision was made, and 3) their perspectives on the criteria used to justify involuntary admission in the law.

Interview number	Role	Hospital level	Hospital setting	Province	In role?	Mental healthcare specialists in hospital?	Hospital ID
1	Psychiatrist	Tertiary	Urban	KwaZulu-Natal	Current	Yes	A
2	Registrar in psychiatry	Tertiary	Urban	KwaZulu-Natal	Current	Yes	A
3	Registrar in psychiatry	Tertiary	Urban	KwaZulu-Natal	Current	Yes	A
4	Clinical psychologist	District	Urban	KwaZulu-Natal	Current	Yes	B
5	Clinical psychologist	District	Urban	KwaZulu-Natal	Current	Yes	B
6	Registrar in psychiatry	Tertiary	Urban	KwaZulu-Natal	Current	Yes	A
7	Psychiatrist	Regional	Urban	Western Cape	Current	Yes	C
8	Medical intern (Y1)	Tertiary	Urban	Western Cape	Current	Yes	D
9	Community service medical officer	District	Rural	Limpopo	Former (<1 year)	No	E
10	Community service medical officer	District	Rural	Western Cape	Former (<1 year)	No	F
11	Community service medical officer	District	Rural	Mpumalanga	Former (<1 year)	No	G
12	Psychiatrist	District	Urban	Western Cape	Current	Yes	H
13	Casualty officer	District	Urban	Western Cape	Former (<3 years)	Yes	I
14	Registrar in psychiatry	Tertiary	Urban	Western Cape	Current	Yes	D
15	Internal medicine specialist	Tertiary	Urban	Gauteng	Current	Yes	J
16	Community service medical officer	District	Rural	Mpumalanga	Former (<1 year)	No	K
17	Casualty officer	Tertiary	Rural	KwaZulu-Natal	Current	Yes	L
18	Medical officer in psychiatry	Regional	Urban	Western Cape	Current	Yes	C
19	Community service medical officer (casualty)	Regional	Urban	Western Cape	Former (<1 year)	Yes	C
20	Registrar in psychiatry	Tertiary	Urban	Western Cape	Current	Yes	D

Table 2. Recruitment table for healthcare provider participants (July 2020 to February 2021)

4.3.1.4. Closing data collection

After 20 interviews with practitioners and four interviews with advocates, conducted over two phases of data collection, I ended recruitment in the first week of February 2021. I closed data collection based on 'information power' (Malterud, Siersma and Guassora, 2016; Braun and Clarke, 2021b). Determination of whether sufficient information power has been acquired in data collection should be made with respect to the project aim. In my empirical project, I aimed to explore how various normative commitments are encountered and navigated in practice; based on the interim analysis and my initial reflections on the second phase of interviews, I felt that an appropriately rich and highly relevant body of data had been collected.

Data collection was also, of course, constrained by COVID-19. My second phase of data collection coincided with South Africa's largest peak of infections in the second wave of the pandemic in January 2021 (Gray, 2021), which made the recruitment of mental healthcare practitioners working in emergency centres much more challenging.

4.3.2. Analysing empirical data

In the analysis, I was particularly concerned with paying attention to small pieces of data that shed light on more subtle considerations; in order not to miss these small pieces of data, I needed to ensure that my analysis plan was as sensitive to fragments of data as it was to overarching themes. I also wanted to be sure that

my analysis plan was appropriate to my constructivist view of data generation, meaning I wanted to "attempt to become aware of [my] presuppositions and to grapple with how they affect the research" (Charmaz, 2006c, p. 131). In analysing my empirical data, I sought to not only robustly describe patterns across the overall data set but also to capture implicit meaning in participants' responses (Braun and Clarke, 2006; Charmaz, 2006b).

Broadly, then, I adopted an inductive approach to the empirical data analysis. This is consistent both with the general aims of the project (given that a key objective is to elucidate considerations that *are not* necessarily explicated in the law or the literature already), and with my understanding of how knowledge of this kind is produced, which also aligns with my interpretation of the broader reflexive balancing methodology.

My analytic approach is informed by the empirical research question and therefore focused especially on understanding what kind of normative commitments impact decision-making. To do so, I adopted a method of reflexive thematic analysis, which specifically acknowledges a non-positivist view of qualitative research—i.e. that qualitative research is necessarily interpretive, and strengthened, not weakened, by research subjectivity (Braun and Clarke, 2019). Per Braun and Clarke, reflexive thematic analysis "emphasise[s] the inescapable subjectivity of data interpretation" (Braun and Clarke, 2021a, p. 37). In reflexive thematic analysis, analysis proceeds in six phases—a revision of Braun and

Clarke's steps of thematic analysis set out in 2006 (Braun and Clarke, 2006; Braun *et al.*, 2019):

1. Familiarising oneself with the data
2. Generating codes
3. Constructing themes
4. Revising themes
5. Defining themes
6. Producing the final report

In this analysis, I take the view—aligned with the underpinning assumptions of reflexive thematic analysis—that themes do not 'emerge' from the analysis but rather are constructed[40] (Braun *et al.*, 2019). That is, the themes are, themselves, *outputs*, not findings of the data analysis—the themes are created *through* the process of coding (Braun and Clarke, 2019). Therefore, I use the language of generating and constructing themes (in the same way that I used the language of generating and constructing data), which acknowledges my own role in "actively" shaping their content (Braun and Clarke, 2019, p. 594). Of course, leaning into this researcher subjectivity also demands transparency to ensure that constructed themes are demonstrably rooted in the data. In the method of reflexive thematic analysis, then, reflexivity becomes critical to ensure that these constructed themes are, in fact, trustworthy; I discuss this point in Section 4.6.

[40]This is, in fact, a key point made by Braun and Clarke in their shift from 'thematic analysis' to '*reflexive* thematic analysis', and can be observed through their revisions to the steps of the method and their clarifications of the theoretical assumptions underpinning qualitative research of this kind.

Importantly, Braun et al. suggest that these steps of reflexive thematic analysis are "reflexive and recursive, rather than strictly linear" (Braun *et al.*, 2019, p. 852). While I present the steps in order here, the process of analysis was much 'messier' in reality, with initial codes and memos revisited, many candidate themes developed and scrapped, and multiple attempts to clearly frame the analytic story made.

4.3.2.1. Familiarising oneself with the data (and transcribing interviews)

To familiarise myself with the data, I transcribed ten of the 24 interviews by hand; the remaining 14 of 24 audio files were sent to two secure transcription services (Way with Words and Appen). After receiving the written transcripts, I listened back to the audio files and corrected mistakes, captured relevant aspects of field notes (e.g. in two cases, participant use of air quotes as noted by timestamp in my field notes), and inserted specific notation on pauses, repeated speech, et cetera. Though I did not transcribe all of my interviews by hand, I gained much from the experience of spending many hours with each transcript, either by transcribing myself or by combing through to ensure alignment between the original audio file and the document generated by the transcription service. Throughout the transcription/checking process, I kept memos and recorded key insights as they arose as part of the data familiarisation process. All transcripts were anonymised during the transcription process (either as I transcribed or after receiving the transcription).

4.3.2.2. Generating codes

I first used open coding to engage with the minute considerations affecting decision-making. In open coding, codes are developed inductively; I moved through the data line-by-line and coded for action as much as was feasible, focusing on semantic meaning. I used this open coding technique with eight interviews (two with advocates, six with practitioners) of the nine interviews conducted in the first phase of data collection. Inductive coding means that coding is "open and organic" (Braun and Clarke, 2020, p. 334), but, at the same time, inductive coding is not ignorant of relevant literatures and concepts. Per Braun et al.:

> Coding inductively does not mean that we assume the researcher is a "blank state," but, instead, that the starting point of the analysis is with the data, rather than existing concepts or theories (Terry *et al.*, 2017). (Braun *et al.*, 2019, p. 853)

An inductive approach appealed to me because of the nature of the data itself; that is, considerations in decision-making were unlikely to appear pre-labelled. Rather, in describing cases and their own experiences, practitioners tended to expose a set (or tangle) of considerations—framed as observations, 'facts' about the individual, patterns of mental illness in their catchment area, et cetera—that led them to a certain decision. Likewise, advocate interviews similarly benefitted from this kind of treatment in analysis, allowing initial codes to develop from advocates' own words.

After generating these initial codes through the interim analysis and then including the initial codes generated from line-by-line coding of two additional practitioner interviews conducted in the second phase of the data analysis, I noticed that the line-by-line codes were focusing on the same clusters of concepts. I then worked to group and categorise these initial codes[41], refining as necessary and maintaining a flexible and expansive approach to viewing the data. This process of moving from initial codes to aggregate codes substantially improved the quality of the analysis, transitioning from primarily descriptive labels to primarily conceptual labels (Charmaz, 2006a). For example, 'excluding physical health conditions' or some variation of this phrase appeared in several instances in the line-by-line coding; this descriptive code was combined with other codes that focused on the inconsistencies in access to physical and mental healthcare for service users, and was eventually developed into an aggregate code called 'mental health(care) versus physical health(care)', highlighting the ways in which interviewees described these two concepts as being pitted against one another. Over time, this code was further refined to be called 'Entrenching the mental-physical healthcare divide' to better capture the way in which practitioners and advocates described the process of accessing mental healthcare and physical healthcare in context.

[41]This list comprised more than 1,350 initial codes!

After developing a list of aggregate codes, I returned to the data and coded each interview one at a time according to these codes, modifying names and adding nuanced sub-codes as necessary.

4.3.2.3. Constructing themes

With the support of my supervisor, Prof Michael Dunn, I began to develop initial themes around these aggregated and mostly conceptual codes. Braun et al. intentionally use the term 'constructing' to describe this stage of reflexive thematic analysis:

> Because themes *do not emerge* fully-formed from the data, the process of constructing them is akin to processes of engineering or design. [emphasis theirs] (Braun *et al.*, 2019, p. 854)

Candidate themes were initially developed in the interim analysis and revisited after the second phase of data collection. These candidate themes were substantially refined after the second phase of data collection, as the second phase opened up a much more diverse and far-ranging set of experiences to be incorporated into the analysis. Many of these candidate themes folded into other themes, and in some cases, these candidate sub-themes ended up taking on new meaning once the rest of the dataset was included in analysis.

4.3.2.4. Revising themes

Retaining candidate themes developed early in the process of data analysis—described as "prototypes" by Braun et al. (2019, p. 854)—does not, in most cases, serve the analysis. As Braun et al. note:

> […] Holding too tightly to a candidate theme can potentially result in analytic "thinness" or conceptual overlap. The story being told about the data risks being diminished in richness, or conceptually confused, by inclusion of weak or overlapping themes. (Braun *et al.*, 2019, p. 855)

Through conversations with my supervisors, I was able to hone in on how different candidate themes seemed to confuse the analysis (for example, 'Understanding the patient's context' as a theme seemed to overlap with 'Individualising admissions criteria' as a theme). Moreover, in comparing candidate themes both between one another and with the overall picture of the data itself, I was able to see which candidate themes were 'analytically thin' and in need of revision, either by removing or combining candidate themes. That said, rich descriptions of specific considerations, even if not mirrored across most or even many interview transcripts, were not dismissed at this stage, cohering with my strategy to maximise heterogeneity of the sample.

4.3.2.5. Defining themes

At this stage of the analysis, the themes start to take clear shape, both in terms of their standalone meaning and their relationship to other themes. Per Terry et al.:

> […] The researcher should have started to move away from a summative position (thinking about these themes as lists of codes and collated data) to an

> interpretative orientation. This involves telling a story that is based on, and about, the data, that makes sense of the patterning and diversity of meaning. (Terry *et al.*, 2017, p. 30)

It became clear in this stage of the method that many of the candidate themes could be folded into two overarching themes that described the data: first, a theme that captures *pathways to decision-making*—exploring the key actors and steps and contexts that shape how the final decision to admit 'looks'—and second, a theme that captures key *considerations in decision-making*—exploring the key considerations that are weighed up, explicitly and implicitly, in the final decision to admit. Of note is that not every practitioner endorsed every consideration; that said, if a practitioner's description of a consideration was sufficiently detailed, I included it in the analysis, in line with my objective to seek out the *range* of considerations that impact practitioners' decision-making in at least some cases. Per Braun and Clarke, the "keyness" of a theme (or subtheme) is not dependent on the *prevalence* of the theme within the data set but rather "whether it captures something important in relation to the overall research question" (Braun and Clarke, 2006, p. 82).

The two overarching themes—*pathways to decision-making* and *considerations in decision-making*—captured different sub-themes constructed in the analysis that work to explain or further contextualise the overarching theme. The observed relationship between the various pathways to decision-making and the considerations in decision-making also relates to the specific aim of this part of the project.

4.3.2.6. Producing the final report

This final stage of reflexive thematic analysis is not merely an exercise in summarising, but rather a constitutive part of the analytic process. Per Braun et al.:

> […] We urge researchers to view this phase as the final stage of analysis, and be open to making further revisions to the themes' content, structure, and names. (Braun *et al.*, 2019, p. 857)

Throughout the process of writing, themes were open to minute revision in accordance with the dataset; the names of the themes did, in fact, subtly shift over the course of several drafts. The order in which subthemes were presented also shifted in this time. Through conversation with my supervisors about the themes and their organising structure, I was able to refine the final presentation of the analysis in terms of both clarity with respect to explanation of themes and fidelity with respect to the dataset.

The presentation of the empirical analysis is organised according to theme—each of the two overarching themes has their own dedicated chapter (Chapters 5 and 6), with key sub-themes specified in each.

In presenting participant quotes, I have redacted the names of hospital(s) and listed only the province as opposed to the specific city or town to ensure sufficient anonymity of participants. In my analysis, participant quotes are presented both

illustratively and analytically, meaning that their inclusion is, in some cases, intended to richly exemplify a point made, and in other cases, intended to be further dissected and studied for latent meaning, assumptions, and links to other concepts (Terry *et al.*, 2017). Throughout my presentation of the data, I have added emphasis (in bold) to key lines of text that highlight the specific element of the theme being described.

To contextualize practitioners' responses, I list their role title, hospital type, hospital setting, and province of work after every quote. This contextualizing information was not only of theoretical interest at the outset of the study but also proved essential to understanding the analytic story of the emerging data as interviews progressed. That is, practitioners' accounts of decision-making differed according to their own training and the wider context in which they were practicing.

Recognizing the need, then, to include this level of detail to contextualize practitioners' perspectives, I was concerned that reporting demographic information, such as self-reported racial identity or gender identity, alongside critical information about role and hospital context could compromise anonymity. Ensuring anonymity was of particular concern when I first designed the study, as I planned to recruit from only two hospital sites. Given the small numbers of specialists in these hospitals, including both essential context about role title and the participant's demographic information could have compromised anonymity.

For example, only two clinical psychologists are on staff at one of these hospital sites; both would be identifiable if their demographic information was reported alongside their title and hospital context. I therefore chose not to ask practitioners to share personal data of that kind in the interview.

My choice to exclude demographic information in my presentation of participant quotes is not to say that race or gender (or age or sexual orientation or any other kind of identity marker) are irrelevant to mental healthcare provision generally or to involuntary admissions decisions specifically. Indeed, in some cases, references to an individual's race did arise in practitioners' accounts of decision-making (though not to the level of constituting a theme or sub-theme). This choice is attributable to the lack of a clear analytic justification for including demographic information in my presentation of the data, either theoretically or empirically (i.e. through analysis of the data itself). This reasoning is consistent with other recent qualitative research conducted with mental healthcare practitioners and other allied mental healthcare professionals on a range of topics (e.g. Jacobs et al. (2021), Mabala, van der Wath and Moagi (2019), and Goldstone, Bantjes, and Dannatt (2018)), which do not report demographic information when presenting participant quotes.

4.4. Practical considerations

Because I was unable to travel to South Africa to conduct interviews face-to-face due to the COVID-9 pandemic, I collected data virtually. Virtual interviewing has many benefits as well as some limitations.

One key benefit is increased participant control over the research environment, and an inherent flexibility in scheduling and extending the interview as needed (Hanna and Mwale, 2017). However, virtual interviewing limits participants to those who have access to a stable internet connection which can introduce bias; in one case, I was unable to interview an interested advocate due to internet accessibility challenges. My study was, in many ways, strengthened by the forced move to virtual interviews as a result of the COVID-19 pandemic: I was able to sample a much wider and more diverse group of practitioners as a result, which has undoubtedly contributed to a richer and more nuanced analysis of how decisions are made. Furthermore, this diversity of participants ensured that my data analysis was not only sensitive to potential correlations between hospital type and decision-making practices, but also not merely reproducing the policies and cultures of a specific hospital or province.

4.5. Ethical approvals

The study protocol was approved by the University of Oxford's Tropical Research Ethics Committee (OxTREC), reference 545-19, in August 2019, and was approved by the University of KwaZulu-Natal's Biomedical Research Ethics

Committee (BREC), reference BREC/00000947/2020, in May 2020. Revisions to the protocol, necessitated by COVID-19, were approved from both OxTREC and BREC in November 2020. An annual report was submitted to OXTREC in August 2020, and the ethics approval from BREC was renewed in June 2021. Per the original design, only two hospital sites were to be included in the study, and site permission to recruit practitioner participants through these two hospital sites was sought and obtained from the medical managers at each healthcare establishment. The study also received approval from the KwaZulu-Natal Department of Health. See Appendices J through P for copies of all relevant ethical approvals.

4.6. Reflexivity

In choosing my methodology for this project, I was careful to reflect on my own role, not only in actively co-producing the empirical data, but also in how I might be perceived by participants. For example, some participants were (reasonably!) sceptical about an American conducting research in South Africa via a British institution that prides itself on having educated Cecil Rhodes (and were perhaps more guarded than they would have been had I been South African or some other nationality, or had I been affiliated with a different university); others seemed to perceived my age and/or student status as necessitating a certain kind of response to my questions (e.g. that as a student, I was interested in 'being taught' in response to my interview questions).

Further, the kind of data generated is also impacted by the fact that I do not identify as a mental healthcare user. While my non-user identity did not necessarily come up explicitly in interviews, my lack of lived experience in accessing medicalised mental healthcare services likely influenced how I conducted interviews, what kinds of questions I followed up on, and potentially, how participants (both practitioners and advocates) related to me.

Reflexivity is relevant to data collection—and the ways in which the data created is shaped not only by the encounter but also by my own identity and role in that encounter—as well as the process of data analysis. As described in Section 4.3.2 (page 150), a requirement of reflexive thematic analysis is reflexivity on the part of the researcher in the analytic work. Per Braun and Clarke, the hallmark of 'good' reflexive thematic analysis is not determined through 'reliability', as in coding or consensus-based models of data analysis, but rather through "reflective and thoughtful engagement" with the data and the analytic process (Braun and Clarke, 2019, p. 594).

Therefore, I have endeavoured to clearly explicate my process of data analysis. I took care throughout the analytic process to document my own emerging thoughts as memos that I could revisit and check against the final analysis to ensure that I was not being led by an early or unfounded insight. In exercising reflexivity in the data collection process, I have also confronted some of my own preconceived

values and beliefs, which has certainly strengthened not only the empirical data analysis but also the normative analysis pursued in Chapter 7.

Finally, I recognise that active listening techniques delivered over video or especially voice-only calls can disrupt the flow of the interview. In a face-to-face interview, nodding or giving subtle verbal feedback while participants speak positively impacts the quality of the interview in my experience. However, I found use of these techniques to be somewhat disruptive in virtual interviewing, especially because the minor delays in sound, and automatic shifts in how sound is foregrounded or backgrounded depending on who is speaking, can interrupt the interview's flow. While building rapport and trust during the interviews through the use of active listening techniques is important, I recognise that the unanticipated consequences of using these techniques in a virtual interview format may have impacted the interviews.

4.7. Conclusion

Having justified the adoption of an empirical ethics approach in Chapter 3, in this chapter, I have justified my choice of a specific methodology within empirical ethics—a reflexive balancing methodology—given its merits and its relevance to addressing the project aim. I explicated the theoretical commitments of the project, and I described the discrete steps of work necessitated by the methodology: identifying a moral problem, enumerating the boundary principles

relevant to the moral problem, uncovering recalcitrant experience of the moral problem, and then 'reflexive(ly) balancing' that recalcitrant experience against the identified boundary principles (Ives, 2014). I have recast my work in Part I as identifying a moral problem and enumerating the boundary principles.

Having justified the utility of conducting the empirical work in South Africa, highlighting the utility of South Africa as a case study based on specific features of the legal and health system contexts, I then explained and justified the empirical project's discrete methods. I described my data collection processes—semi-structured interviews, conducted with mental health practitioners and mental health advocates—and analytic strategies—reflexive thematic analysis. I also discussed reflexivity in analysis and practical constraints (largely induced by COVID-19).

I summarised the two overarching themes in my empirical analysis; these two themes orient the content of Chapters 5 and 6. I closed this chapter with a reflection on reflexivity in data collection and analysis, as necessitated not only by the specific method of reflexive thematic analysis but also the broader empirical ethics methodology of reflexive balancing employed in this thesis.

In the next two chapters, I describe the outputs of my analysis, organized around two key themes: pathways to decision-making (Chapter 5) and considerations in decision-making (Chapter 6).

Chapter 5. Pathways to decision-making: 'micro-decisions' and their consequences

5.1. Introduction

In this chapter, I build an account of four 'micro-decisions' that sit along key *pathways to decision-making* and precede the final decision to admit. I explain how each of these four micro-decisions can shape the informational 'inputs' that factor into the final decision. I also explore how these four micro-decisions play a central role in shaping the final decision, as characterised by interviewees.

In their accounts of decision-making, the practitioners I interviewed revealed that admissions decisions are made with highly disparate amounts of information. In some cases, the lack of information available to guide an admissions decision in a particular case is exacerbated by a prior micro-decision. As a consequence, practitioners sometimes rely on 'substitute' information—gleaned from the outcomes of prior micro-decisions—to guide their final decision to admit. I close this chapter by exploring the implications of making admissions decisions with disparate amounts of information. The key takeaway here is twofold: 1) many decisions are made in the absence of 'direct' information (i.e. the kind of information practitioners deem helpful to decision-making, beyond immediately observable clinical presentation), and 2) the quantity and quality of information available to guide the decision is, in many cases, influenced by various pathways to decision-making.

Before exploring the data, I briefly summarise the process of decision-making as prescribed in South Africa's Mental Health Care Act no. 17 of 2002 (MHCA 2002). The MHCA 2002 outlines not only the justificatory criteria for involuntary (and 'assisted') admission (as presented in Chapter 3), but also the specific *process* of admission, including the corresponding forms to be completed at each stage (Figure 1):

- One Form 04, to be completed by the individual's next of kin, or where the individual is brought to hospital by police, by a healthcare provider;
- Two Form 05s, to be completed by two different healthcare providers (neither of whom can be the same as the provider who completed the Form 04 in relevant cases); and
- One Form 07, to be completed by the head of hospital.

In South Africa, the 'emergency centre' is also referred to as 'casualty'. I use these terms interchangeably throughout the thesis (as do interviewees).

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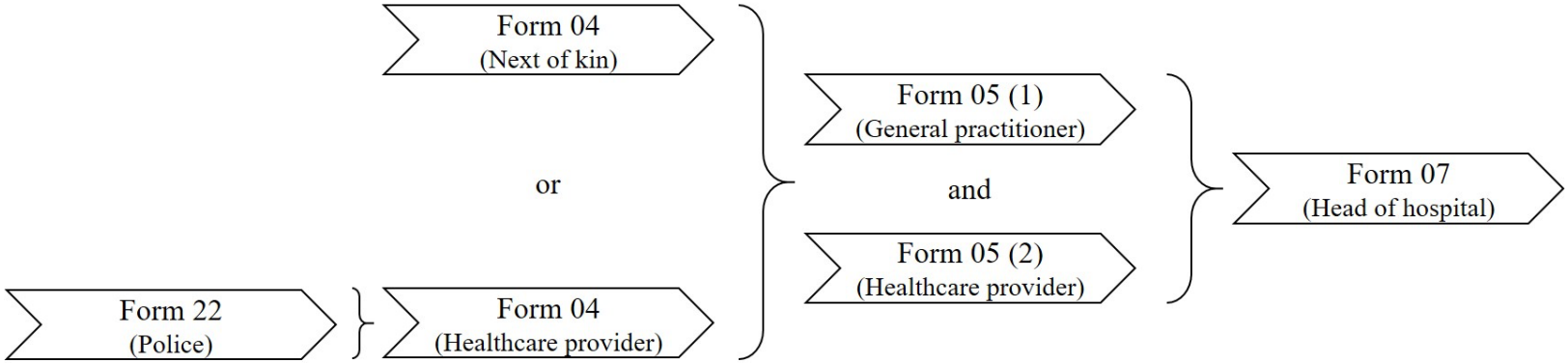


Figure 1. Forms required for assisted and involuntary admission, per the MHCA 2002, where 'healthcare provider' includes both practitioners and non-practitioners (e.g. nurses, social workers), and 'general practitioner' refers to general medical officers working in casualty

Though the legal requirements may appear straightforward as presented here, the process of decision-making for involuntary admission, as explained by interviewees, is far more complex in practice. Perhaps most significantly, and most divergent from what a straightforward reading of the MHCA 2002 implies, the 'final' decision to admit is not made by two practitioners simultaneously. Instead, depending on the hospital setting, the 'final' decision to admit is made by *one* practitioner, who is functionally designated as the *sole* decision-maker based on the range of practitioner expertise available within the hospital (Figures 2 and 3).

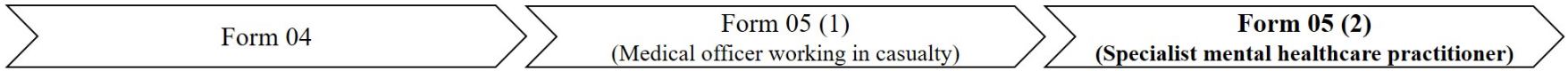


Figure 2. Decision-making process in hospitals with specialist mental healthcare practitioners on staff, where completion of the *second* Form 05 by a specialist mental healthcare practitioner operates as the 'final' decision

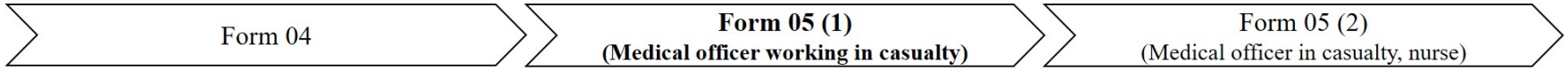


Figure 3. Decision-making process in hospitals without specialist mental healthcare practitioners on staff, where completion of the *first* Form 05 by a medical officer working in casualty operates as the 'final' decision

Practitioners' reflections on making the final decision to admit revealed that this final decision is, in practice, impacted by the various pathways to decision-making. That is, the final decision to admit is preceded by a series of 'micro-decisions' made about the individual. These micro-decisions sit along a pathway to decision-making and impact how and whether a range of considerations can be incorporated into the final decision to admit, per practitioners' accounts. In this chapter, I explore the inputs of decision-making for psychiatric inpatient admission without consent in a South African decision-making model.

5.2. 'Micro-decisions' that precede the final decision to admit

As implied in the MHCA 2002, the broader admissions pathway entails multiple steps, with involvement from multiple key actors (Figure 1). Explained one specialist mental healthcare practitioner:

> Very basically, so-- so, you know, usually **a family member brings the patient in**, um… who they are worried about. Um, it can also be a-- a random person, you know, a random, kind of, bystander who saw someone acting very strangely and called the police, or it can be an ambulance or whatever. Um… they… **then get seen by the EC [emergency centre] team**, um, who-- who do, kind of a… a-- a-- quite a basic medical screen, to make sure that there's no-- no medical issues. Um… **the Form 04 then gets filled in by-- if the family member or a friend or someone brought the patient in**, they do the Form 04, otherwise, one of the psychi-- agh, one of the-- the nurses in EC would usually do the Form 04. Um, the-- **one of the EC doctors, or if the patient is sent from the clinic, one of the clinic doctors, does one Form 05 after they assess the patient and they find that, you know, they are psychiatrically unwell**, and then the patient gets referred to us. Um, so basically, we have a nice little box in the EC and there's-- the file gets put in the box, and I get there in the morning and I see the file in the box and then-- and then I see the patient. Um… yeah, and **then I'll assess the patient, um… and-- and, you know, assess whether I think they need admission or not, and then I do the-- the second Form 05 and from there they're admitted**… (*M: Right, okay*.) To the ward.
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

In the next sections, I will explore how each of these routine steps of the admissions process, as outlined by this practitioner, constitutes a micro-decision that impacts the final decision to admit. I term these decisions as 'micro'-decisions—even though each is arguably a major decision (especially in terms of the individual's experience)—because these decisions are not *directly* part of the final decision to admit. These decisions are, in practice, 'micro' in relation to the 'macro' involuntary admissions decision (i.e. the final decision to admit); however, these 'micro'-decisions shape how that final decision is made, as I will demonstrate in this chapter. The term 'micro' here is not meant to imply that the decisions are *themselves* small, but rather that they are smaller decisions in comparison to the final decision to admit.

5.2.1. 'Micro-decision' 1: Bringing the individual to hospital

The initial decision to bring an individual in for psychiatric assessment is the first of these micro-decisions. The decision to initiate a potential admission is almost always made by someone other than a practitioner, or, indeed the individual themself. This point was underscored by practitioners and advocates alike:

> Okay, and then after that, you know, I-- I kept relapsing-- (*M: Mm*.) Um, but I had a few involuntary admissions, so I have specific issues around how it's done. (*M: Absolutely*.) Um… so, typically… **I was always tricked. I still worked i-- at some point, I was always tricked by either colleagues from work, or from a relative saying they'd take me home… but then they locked the car at the back, and next thing I know we're at the hospital**.
>
> Advocate (Interview 1)

> I mean if a family is like, 'Look, this guy is speaking to himself'. And I'm like, 'Oh, he's speaking to himself, okay'. Um… we take bloods, and we say, 'Look, cheers'. And the family's going to be like, 'Well, what's his problem?' And I'm going to be like, 'I don't know'. **So what I'd rather then do is just admit the patient, keep him, and then when**

> **they come back, I'll be like, 'Okay, cool, I've actually interviewed him for these past couple days, and I've got a better impression.'**
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

That is, non-practitioners *initiate* the decision-making process for involuntary admission in almost all cases, in line with the process set out by the MHCA 2002, wherein a non-practitioner makes the initial application for admission in almost all cases. That said, in many cases, practitioners saw the fact that the individual had been brought to hospital at all as critical information to guide the decision itself—practitioners explicitly or implicitly endorsed the view that decision-making inputs could be gleaned from the circumstances of the individual's arrival, as demonstrated in the next sections.

5.2.1.1. Arriving with family

The MHCA 2002's requirements leave the family to initiate the decision-making process in a significant proportion of cases. Practitioners trusted the family's report of the potential patient's behaviour, even if those symptoms were not present at the time of assessment:

> But if the family are telling me-- even if that's not what I'm seeing in front of me, if the family are telling me, 'Listen, when he's home, you know, he threatens us and we're scared of him and, you know, he's trying to strangle me'. **Um, you know… w-- even if that's not what I'm seeing in the EC [emergency centre], if the family is telling me that, then I would admit the patient.**
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

> So, for example, I had a patient yesterday, and **when you talk to him you can't pick up any delusions, doesn't say he's aggressive-- like, he denies aggression, denies defaulting his medication, just denies everything**. And I was thinking to myself, 'Why

> on earth would this family bring this man in at three o'clock in the morning if he's completely fine?' So, in that case, I called his sister and I asked, like, 'What's going on?' And she said, He's using drugs, he's not using his medication, he's breaking windows at home, he's not sleeping, he's threatening to kill them, um, and he's walking around with a knife'. For example. So in that way… collateral information is important**. So then, I would admit him based on what the family is saying, just because… he-- he-- yeah, he's guarded at the moment and he's-- it's not safe to send him home.**
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

Practitioners also relied heavily on the family's report because they presumed the family would not bring the individual into hospital *unless* admission was needed:

> But for me, when they're admitted, um, when they get brought in, I re-- I rely heavily on what the family tells us. So, if-- like, 'cause, as I said, when it comes to Black families, they have a very poor health-seeking behaviour in general. **So, a lot of the times when they bring someone to hospital you know that they're bringing them in for a reason. So, I rely heavily on what the family says**.
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

> Because it's like, whoever's taking them in will either be the family member, um, or will be the police. Okay**. So it's-- it has to be quite escalated, quite a lot, like, for them to bring them after hours and do that, and, like, they're usually pretty clearly, like-- um, like, they're acting crazy**. Like, there's no-- there's very rarely, like, there's nothing wrong with them, whereas compared to, like, a lot of medical patients who come in with lower back pain, who just, like, I don't know. **With psych patients, it's not really like that, because it's someone else who has to bring them in**. And psych patients are very much less likely to bring themselves in.
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

Practitioners implied or explicitly reported their reliance on this rationale—that families would not bring someone to be assessed for admission without having 'a reason' (as noted in the first quote presented above). However, several practitioners were also quick to point out that, even though the *standard* case is that the family brings an individual in for a (good) reason, there are always cases

in which the family is not trustworthy, per practitioners' accounts. Laughed one interviewee:

> As mentioned, like… as I said, ad-- admitting is the easy part. **So, regardless of-- mm-- so, re-- regardless of where the-- whether there's-- um, how the circumstances are, the fact that they were brought to hospital--** (*M: Yeah*.**) Is-- is reason enough to make that consideration of admitting**. […] **And at the end of this I want to tell you a story which completely contradicts what I said**. [*chuckle*]
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

The story was one in which the family member was lying about the individual's behaviour to try to get him admitted to hospital. Other practitioners reported similar concerns regarding the amount of pressure placed on them *by* families to admit an individual:

> Patients come with the police-- well, **patients that come with family, especially during the end of the month or December times where the family wants to go out for holiday. And then you can hear from the story that they're trying to make up a story to have the patient sleep in hospital for the next week or two**. And they're begging you, and begging you, and begging you to please admit the patient. Um, and the patient is fine. Um, of course they've got this psychiatric condition and of course they need their treatment. But when you interview the patient, he's fine. He's not aggressive, he's not a risk to himself, or anyone, and there's no reason for me to book the patient. **But you get this huge amount of pressure from the family to admit the patient, you know?** And I think at the beginning when you start off, you-- you-- I think you cave into the pressure.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

> Um, but also, and you know, I feel so sad to say this about my… like, people in my country. But also, like, family ulterior motives, is this older person with, you know, known schizophrenia, that, you know, they've been sent home ages ago. Does this family just want to go away for the weekend, or have, like, a party? **And they're just dropping off their family member, to get him out of the way for the weekend.** (*M: Oh, right, of course. How do you suss that out? How do you tell?*) [*sigh*] I mean… maybe the patient-- I mean, you'd look at the previous, like, files, you know? (*M: Okay. Okay*.) **Also, it's called the Friday drop-off!** (*M: Right*.) **Or… or, like, a Friday, like, older, more chronic patients, with very, like-- little to no acute issues, will get dropped off by their family on a Friday. And then the family won't answer their phones until the Monday to pick them up.** (*M: Right*.) Yeah, that's a common occurrence.
>
> Casualty officer, district hospital [I], urban, Western Cape (13)

Lying or not, in a majority of cases, the mere fact of a family's decision to initiate assessment for admission plays at least some role in practitioners' final decisions to admit. Put simply, *that* the family brought the individual in becomes a factor in practitioners' decision-making. As initiators of the process, the family's report of the individual's behaviour and mental state is generally taken to be true at least most of the time.

5.2.1.2. Arriving with police

Practitioners also reported erring on the side caution—i.e. erring on the side of admission—for an individual arriving with police, even if the police were being relied on primarily for transport, especially in rural settings:

> But you do have to admit them because… can't-- they've been-- come in with the police. There's no way around that. **If they come in with the police, then… like-- like, nobody's gonna really accept the fact that you didn't… admit that patient**. Like, um… (*M: Yeah--*) I don't know-- (*M: And why do you say that?*) [*sigh*] I guess in your head, you're like… Like I said, okay, as an intern in there, like the-- if they've come with police, they've definitely done something wrong. They've probably hurt someone. (*M: Okay*.) **But besides-- yeah, I've just said that that's not always the case, and it isn't, because they do-- are just using it as form of transport. Um, I guess it's not gonna be acceptable to whoever's called the police [*chuckle*] that you sent them back**. [*laughter*]
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

> And, um, obviously **if they were brought by the police and stuff, that's clear-cut admissions, like, that's quite obvious**.
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

However, the dominant role of police in the admissions process was criticised by advocates and practitioners alike:

> It should be the ambulance. [*pause*] (*M: Right*.) Because there's-- **sick people go in an ambulance, they don't go in a cop van.**
>
> Advocate (Interview 2)

> Um, you know, legally, it should be the ambulance that is accompanying the police-- or the police that's accompanying the ambulance-- (*M: Yeah*.) Uh, to bring in this-- this-- this patient. (*M: Yeah*.) But it's just the police, and they're at the back of a van, which angers them more, and you know, when they come to the hospital, they're obviously in-- in a-- in a fit of rage, not receptive to anything or anyone because the people closest to them have betrayed them, in inverted commas. (*M: Right*.) **So you know, it's almost a very inhumane way, and then that makes our work more difficult--**
>
> Clinical psychologist, district hospital [B], urban, KwaZulu-Natal (5)

One advocate expressed the view that the police should not be involved in admission at all:

> […] because in South Africa, when you, um… [*pause*] li-- later, when you're violent and aggressive, and you refuse to go to-- okay, they say I refuse to go to hospital, there's never that conversation, but anyway, so-- (*M: Right*.) The procedure is actually to phone the police. (*M: Yeah*.) So, then the police arrives-- okay, that's a whole… different… drama on its own-- *(M: Yeah*.) With the police. (*M: Right*.) So the police arrive. According to the law-- so the police arrive… and then they must also called the ambulance. [*pause*] Um, and the police are not really allowed to transport the person, in the police vehicle-- (*M: Okay*.) They may escort the ambulance… kind of, help the-- (*M: Huh*.) Get the patient into the ambulance, and then the ambulance… (*M: Okay*.) And then, the police, kind of, hand over the person at the hospital. […] **For me, first of all, I do not believe the police should pay-- play a role in involuntary admission, unless a crime has been committed.**
>
> Advocate (Interview 1)

Building on this point, one practitioner commented on suspected mistreatment of patients by police:

> **Um… yeah, other challenges that I've had before was when patients come in with police, and you suspect that the police were manhandling the patient in a-- in a-- in a bad way**. But there aren't any documentable injuries that I can look at. But you can see that, you know, this patient was hit a couple times. Um, that's also a very difficult situation. Because again, you're in a village which is very, very small, and, um, as soon as you now start asking this question to the police, then they-- they-- they sort of think that you're viewing them as the enemy. And there aren't any channels to… I don't know, it was just really tricky, this sort of thing.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

Likewise, one practitioner suggested that police involvement in the admission process can make clinical assessment more challenging with regard to both limiting access to information about the individual and upsetting the individual:

> **And so, the police will end up bringing the patient in. Um, so, in that case a lot of the time it can be difficult to actually get hold of collateral [information]**. (*M: Yeah.*) Um… um, and if we are unable to, we, sort of, have to go based on just, um, having the patient in front of us, um… and, um… well, we-- we-- we speak to the police as well, how was the patient, you know, en route and-- and a lot of the time the patient… **I mean, most of them are aggressive and are not cooperative but that could also be because they're now being picked up by the police.** [*chuckle*] So, it's difficult to say-- so, **I mean, none of them are cooperative, because they're being picked up by the police**.
>
> Community service medical officer, regional hospital [C], urban, Western Cape (19)

5.2.1.3. Self-presenting

Just as practitioners used information about the circumstances of an individual's arrival—as initiated by family or police—in their final decision to admit, so too do practitioners weigh up the fact that someone self-presented in their decision.

Several practitioners reported that individuals who self-presented for admission were *less* likely to be admitted:

> (*M: Could you tell me about a case when someone, and I don't know if this would have even happened necessarily, but when someone arrived at casualty without family and/or without family having called the police to help. Does that happen, or did that happen?*) Yeah, yeah, it happens quite a bit. But those are often patients that are well-controlled, that understand that their treatment is finishing, and they need more treatment. **(*M: Oh, fascinating! So would you admit them?*) No, we'd just give them the treatment, and they would go.**
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

> (*M: …I'm wondering if you can tell me about a case where a patient arrives to casualty [emergency centre] without any family members.*) Yeah, that happens quite often. (*M: Oh, okay.*) So, um… so, in that case, usually they can tell us what's wrong with them, because they brought themselves to hospital, so we can get history from them. […] **A lot of the time when patients bring themselves they can be discharged, i-- I find.**
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

Several practitioners made this point, suggesting that inpatient services are, in a South African decision-making model, broadly 'reserved' for involuntary patients, and for two reasons.

Firstly, in the public sector, an individual is not charged for an assisted or involuntary psychiatric inpatient admission; an individual is 'liable for payment' only if admitted voluntarily (South African Government, 2021). One practitioner expressed scepticism at an individual's desire to be admitted voluntarily and pay for services, and cited this line of reasoning as justification for not admitting someone who asks for admission:

> Yeah, so, and the other thing is that, um, in South Africa, uh, you know, a-- uh… so-- **so a-- voluntary patients, you-- they get charged, involuntary patients don't get charged anything**, because, you know, the-- it's against their will, it's-- (*M: Right.*) Protects-- largely about protecting society and also from them… the minute you're voluntary, you get charged. […] So we get very few patients who present saying, "Hey, um--" or-- or, like, they'll say, "Hey, admit me." (*M: Yeah.*) **But often those that present, saying, "Hey, admit me," there's no reason to, you know?** Sometimes it's just that they're-- they're-- things are very rough. They've been doing-- taking loads of drugs, they're out of home for a bit. Um… uh… a few weeks' stay in the hospital is going to be good-- better than being out in the streets, you know?
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

Secondly, not only does the fee schedule discourage voluntary admission, so does the health system structure. That is, because all initial psychiatric admissions must

proceed through general district or regional hospitals (or tertiary hospitals if the individual lives within the catchment area), the ward facilities are not well-suited to attending to the needs of mental healthcare users. Because of the lack of 'therapeutic' spaces in these general hospitals, (attempted) voluntary admissions warranted further scepticism in the view of some practitioners.[42] Said this same practitioner:

> Yeah, if someone-- generally in our context, if someone self-presents, we are a bit more sceptical, yeah? (*M: Okay*.) Just the nature of the work and the patients we see because it's-- **we don't have large-scale therapeutic units at these hospitals, you know**.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

While the decision of *others* to bring an individual to hospital warranted at least some consideration in decision-making, the decision of the *individual* to bring themself to hospital was considered grounds *not* to (voluntarily) admit in most cases.

One advocate commented specifically on the fraught nature of voluntary admissions, noting that the power to declare something 'serious' (enough to warrant intervention) rested not with the individual but with someone—anyone—else:

> Even with the-- the current situation that's happening in the world, this-- this COVID pandemic, you'll only be admitted if you are serious. (*M: Yeah*.) Um, you know what I mean? So-- it's-- (*M: Yeah*.) **It's-- it's-- it's almost how-- how it works in a way, is… it's only regarded as serious if it's-- if somebody else is saying it's serious**, but if-- if you're going, 'Hey, man, I demand it'-- (*M: Yeah!*) It's serious. [*chuckle*]
>
> Advocate (Interview 3)

[42]Why this logic does not also implicate *in*voluntary admissions is unclear.

This advocate was recounting their story of seeking voluntary admission—actually demanding admission at the hospital—after having been involuntarily admitted on several occasions. They noted the irony of how difficult it was to be admitted voluntarily as opposed to how easy it was to be admitted involuntarily in their own experience.

In their accounts of making the final decision, practitioners reported being influenced by the assumption that *other* people, no matter who, had good reason to set the individual along the involuntary admission route, specifically in terms of a non-practitioner's decision to bring someone to hospital. By virtue of the admission's involuntariness, the reasoning goes, the initial decision to deem an individual as 'in need of' assessment *must* be made by someone else, and specifically someone outside the mental healthcare system.[43] However, this logic seems to have imbued through practitioners' interpretations of *all* admissions, rather than just involuntary admissions. Of course, a *voluntary* admission, i.e. where an individual has self-presented, should also be accommodated by the system. However, practitioners and advocates alike reported that voluntary admissions for psychiatric inpatient care are fairly uncommon in a South African decision-making model.

[43]Even where an individual has been referred from a clinic, the initial decision to bring the individual to the clinic was made by family members or other supporters.

5.2.1.4. Summary

My analysis of the interview data suggests that, given practitioners' reliance on micro-decisions in many cases, key informational inputs that influence the final decision to admit originate *outside* the hospital—family members, friends, and police are often the starting point of decision-making. While decision-making for involuntary admission is often described, in the literature and in the law, as a single, time-stamped clinical encounter, analysis of participants' interviews indicates that the informational inputs of the process are being developed well before practitioners are even involved. The facts of the individual's arrival to hospital—whether self-presenting or brought by family or police—inform and shape the final decision about whether or not to admit.

However, there are important implications for this initial 'micro-decision' being made by non-practitioners outside a healthcare setting. For one, there are legitimate concerns that family and police are, intentionally or not, misinterpreting or misusing the law—a concern expressed by advocates and practitioners alike. Speaking about an individual who had been brought to hospital multiple times by her partner, one practitioner noted:

> So after I think the third or fourth time that the guy brought the wife to casualty [emergency centre], we told them, um… 'Maybe you guys should, like, have marital counselling, and…' you know, because now, you're starting to infringe on the health system, and you're using that as, sort of, punishment. **So, getting someone admitted under the Mental Health Care Act shouldn't be, um… a punitive measure**--
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (3)

Secondly, there are implications for who is *missed*. Whose family members are decidedly *not* bringing them into hospital for assessment? Practitioners and advocates noted the impact of poor mental health literacy on the mental healthcare system in general, suggesting that low mental health literacy contributes to two opposing outcomes: on the one hand, some worried that poor mental health literacy leads family members to make inappropriate or unnecessary applications for involuntary admission; on the other hand, some suggested that poor mental health literacy leads family members to significantly delay making applications for involuntary admission, with negative consequences for the individual's overall health.

On balance, though, this initial micro-decision is arguably the most important one—only through this micro-decision can any subsequent micro-decisions be made, and only through this micro-decision can an individual even come into contact with the *possibility* of an involuntary admission. And yet, this critical 'micro-decision' is left to individual interpretation on the part of family and the police. In fact, the system relies on people in the community flagging others for psychiatric assessment:

> **And-- and, you know, people get brought to hospital; we're not out their checking how mentally ill people are.** So-- so, usually people are unsubtly unwell [*chuckle*] l by the time they get to us-- (*M: Right*.) Which makes assessment a little bit more easy in some ways, but it-- it doesn't-- it worsens prognosis and a bunch of other problems.
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

Though, of course, the final decision to admit is made by a practitioner, the circumstances of an individual's arrival—as indicated in the participant quotes presented in this section—offer a specific kind of informational input into the practitioner's final decision.

5.2.2. 'Micro-decision' 2: Prioritising the individual in the emergency centre

After arriving to hospital, the individual must be managed in the emergency centre in order to be assessed (and eventually admitted, if assessed to be in need of admission). Practitioners described a kind of teamwork (or, arguably, patchwork) approach to making admissions decisions, largely in response to the challenges of managing individuals in the emergency centre. One part of this teamwork approach includes the triage nurse's identification of an individual to be prioritised for psychiatric assessment. For example, one interviewee commented that nursing staff may specifically prioritise an individual for assessment based on their own observations of the individual upon arrival to the hospital:

> Usually like the-- the nurses and, um… that work in OPD [outpatient department] and stuff, also usually, they-- sometimes they pick out patients from, like, the crowd, or, like even when people enter and say, "You should prioritise this patient--" (*M: Sure*.) "…because I think that they're going to need admission" so… [*chuckle*] (*M: Right, right*.) **So… usually it's--um… usually it's a couple of people, like, uh, that would… um… also guide it [the admissions decision], I guess, so…**
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (2)

In my analysis of practitioners' interviews, triage nurses appear to have a particularly significant role in the broader admissions pathway: even though nurses rarely complete the first Form 05,[44] nurses in the emergency centre can elevate certain individuals to be seen sooner than others, and can accelerate the decision-making process by ensuring that a Form 04 is already filled. The specific decision to prioritise an individual for psychiatric assessment often includes the provision of certain information, e.g. noting down the family's contact details and reason for bringing the individual to hospital.

Further, in many cases, nurses may be more familiar with mental healthcare users than the medical officers:

> Whereas I'll, say, for example, get called at two in the morning, where I was working now, and say there's a psych patient. And often, um, the patients… **But the nurses will be like, no, we know, he-- he-- he's a known, like, you know, they know him, or he-- he uses drugs, and, like-- even though they say he's not or whatever**. So like, a-- I mean, that can be a bit helpful, I guess. But, um, they'll say, we have-- you know, we need you-- and, like, **when you arrive there, the forms are laid out for you already**. **They've probably already got the family to do the Form 4.**
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

Regardless of hospital setting, several practitioners commented on the role of other healthcare providers, e.g. triage nurses, in building the case for the final decision. That is, the 'micro-decision' by another practitioner to 'refer' an individual along the *psychiatric* assessment route as oppose to the *'medical'* assessment route (where 'medical' was the term used by nearly all practitioners,

[44]Practitioners reported that, although nurses with some form of psychiatric training are legally permitted to assess the individual and complete the first Form 05, few were willing to do so.

specialist and general alike, to describe *physical* health-related parameters) acts as an informational input into the final decision.

The role of these other healthcare providers, especially triage nurses, in prioritising individuals for assessments leaves open questions about *how* nurses make these decisions. Is prioritisation based on clinical presentation, on nurses' interpretation of fit for legal criteria, on family persistence or distress, or even on the individual's disruptiveness in the waiting room? A study of nurses' triaging in a tertiary hospital in Gauteng found that individuals presenting with "psychosis/aggression"—even if these individuals were not actively psychotic but rather had a *history* of psychosis—were consistently coded 'orange', suggesting that nurses may expedite an individual along the 'psychiatric' pathway through triaging (Goldstein *et al.*, 2017).

In this sense, a key micro-decision that precedes the final decision to admit centres around the triage nurse's decision on how to handle intake of an individual brought to the emergency centre by police or family. The outcome of this micro-decision can shape the practitioner's perception of the individual, which in turn acts as a key informational input in the final decision.

5.2.3. 'Micro-decision' 3: Sedating the individual in the emergency centre

Another key 'micro-decision' that influences the final decision to admit revolves around *how* an individual is managed in the emergency centre. To clarify, an individual is not considered to be formally 'admitted' while they are waiting to be assessed in the emergency centre; however, medications and other interventions, e.g. sedation, can be administered during this period. As such, decisions made in the emergency centre, though not part of a formal 'admission' to hospital per se, play a critical role in driving the outcome of the final decision. The 'micro-decision' to sedate an individual in the emergency centre, prior to formal assessment for admission, plays a critical role in driving the decision:

> So… **we tend to admit the people who are heavily sedated because w--** [*chuckle*] [*pause*] **because what that means is that they've been very difficult in the EC**. (*M: Yeah*.) So if people are super, super sedated, they'll come to me [psychiatry]. (*M: Right*.) Almost certainly. I'm always like, 'Well, we have to put them in the ward.'
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

Several practitioners—especially specialist mental healthcare practitioners who are responsible for making the final decision to admit not upon the individual's arrival to hospital but *after* the casualty officer has completed the first Form 05 and run basic blood tests—indicated that, in some ways, the final decision to admit was functionally already made if the individual had been sedated prior to assessment. Of course, sedation makes assessment difficult (if not impossible in many cases), which means that practitioners who are in the position of assessing a sedated individual are left with little information about the clinical presentation.

Their decision therefore must rely on other sources of information (beyond clinical presentation). For example, one practitioner described their 'luck' in being able to rely on the notes made by the casualty officer and the referring clinic doctor when assessing an individual who had been sedated:

> So, um… you know, uh, I got to the EC this morning. **He was very sedated because he was difficult in the EC. So I couldn't even really assess him properly, um… but luckily, you know, the-- the notes from the clinic where he was referred from and-- and from the EC team were quite clear**, and, you know, it was, kind of, his usual… mania. So-- so then it's an easy-- it's an easy admission.
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

In other cases, practitioners drew a straight line between 'being aggressive' and 'needing sedation', and then between 'needing sedation' and 'needing admission':

> So then, um, he then… was taken into hospital […], there was the police there, then the family met them there, then, obviously the casualty doctors were all there, **then he was held down with the securities and then he had to be sedated because he was very aggressive at that point in time**. (*M: Okay…*) **And then the 72-hour process was started**.
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (3)

> (*M: […] But in thinking about what you're looking at in terms of considering the patient for admission, what are the main things that you consider?*) [*sigh*] **Okay, patients who are aggressive, that's a big deal. Because a lot of patients come in, like, they're so aggressive.** There's like, three police guards on top of them, three security and **we, like, nail them to the bed just to try and sedate them because they are very, very disruptive and aggressive**. So that's one thing.
>
> Community service medical officer, district hospital [F], rural, Western Cape (11)

These practitioners—who, notably, sit on opposite ends of the spectrum of specialization and time in practice—both imply a link between 'needing sedation' in the emergency centre and 'needing (involuntary) admission' for inpatient care,

rendering the *fact* of sedation to be a key piece of information that informs the final decision.

Whatever the mechanism (whether because of the lack of information or because sedation is taken as a proxy for aggression, which is sufficient justification for admission in practitioners' views), the micro-decision to sedate in the emergency centre plays a key role in determining the information inputs—or lack thereof—that guide the final decision to admit.

On this basis, advocates expressed serious concern over sedation in the emergency centre, especially with regard to how sedation compromises comprehensive assessment—the stated aim of the 72-hour assessment period:

> You now have to go the route through a general hospital with a psychiatric ward. (*M: Right*.) And there are forms that need to be completed. So you start off there, and the-- their idea is to stabilize you while you're there and assess you. And then you are moved to the-- can be transferred to the specialized psychiatric hospital. (*M: Right*.) But, I have an issue with-- with that process at the moment-- (*M: Mm.*) And still, actually, do, and even psychiatrists complain about it… that those-- when you're psychotic, you go to the general… hospital with a psych ward-- (*M: Mm*.) And you're admitted there. **They, kind of, sedate you so heavily, and my question is, 'How do you assess someone if you are sedated out of your mind?' How-- how can you? It's just not possible**. (*M: Right, right*.) So that is a-- one of the issues that's currently happening in South Africa-- (*M: Okay*.) Around that process. (*M: Right*.) I can understand I need to sedate someone who's aggressive and agitated and all that, but, isn't the point of assessment to, kind of… assess what this is all about? (*M: Right!*) **This-- this-- they sedate the person 24/7**.
>
> Advocate (Interview 1)

Advocates also questioned the value of an admission where the individual is sedated for the vast majority of their hospital stay. Reflecting on stories of mental healthcare users' experiences in hospitals, one advocate noted:

> (*M: […] And… i-- in those conversations and in that time, would you hear-- would people, kind of, tell you about their experiences of having been taken to hospital? Um… like, what do you hear about… people's experiences that way?*) **That they… are really sedated**. (*M: [sigh]*) **Um… like completely sedated, they don't know whether they're coming or going, whether they're Arthur or Martha**, um, just… basically, they say that 'You put me in a bed, you sedate me so that I can't do anything, and then when it's over you'll phone a family member and then I can go home'. […] **After a couple of days, you're sedated, you're tranquillized… they feed you, now you can go home. That doesn't say to me that there's treatment happening.**
>
> Advocate (Interview 2)

This point was also echoed by a psychiatrist:

> The treatment doesn't work, if you use anti-psychotics or-- for patients, but-- **but you restrain and sedate them severely all the time, they just don't get better**.
>
> Psychiatrist, district hospital, urban, Western Cape (12)

While these quotes focus more on the consequences of *being sedated* on the ward during the admission, I want to highlight that, in most cases, the initial decision to sedate *precedes* the final decision to admit (involuntarily) for the 72-hour assessment period. Here, I seek to illustrate the multiple consequences of the decision to sedate. Not only does the decision to sedate have implications for the outcome of the admissions decision itself (which may then be either *rationalized* by the fact that the individual has been sedated, or *complicated* by the fact that the individual had been sedated and therefore cannot communicate)—the decision to sedate also compromises the potential benefit of being on the ward.

Critically, the decision to sedate the individual in the emergency centre has consequences not only for *how* subsequent decisions are made but also *whether* subsequent decisions can be made. That is, not only are practitioners unable to properly assess someone who has been heavily sedated, they may also defer assessment and miss important symptoms, including physical symptoms:

> Because as soon you see the psych form [Form 05] has been filled in, it's someone saying, 'Okay, cool, it's a psychiatric condition, we're just observing him for the 72 hours'. **And I had seen him, to me it just looked like he was heavily sedated. It's tough to wake those guys up**. And he was breathing comfortably, saturating well. **So I was just like, 'Well, I'll examine him when I get a chance'**. The second day, still the same thing. I was like, 'No, something's going on'. And I can't remember how I figured out he was hit. I think a family member said something. And then I was like, 'Oh shucks, this is something else'.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

Broadly, the use of sedation—a tool for *managing* individuals in the emergency centre—was understood by practitioners as an indicator of the need for admission in some cases, whether because practitioners felt they had to admit a sedated individual because they could not properly assess them, or because practitioners assumed that the individual was sedated *because* at least one legal criterion for admission ('risk of harm to others' as approximated by 'aggression') had already been met.

5.2.4. 'Micro-decision' 4: Referring the individual to a specialist mental healthcare practitioner

In hospitals with specialist mental healthcare practitioners—psychiatrists, registrars in psychiatry, and medical officers in psychiatry—on staff, the decision

of a casualty officer to refer the individual on to a specialist mental healthcare practitioner constitutes another key 'micro-decision' that precedes the final decision (in this case, *of* the specialist mental healthcare practitioner) to admit the individual involuntarily.

Even though specialists saw themselves as the final decision-makers[45], many suggested that, especially given the fact that individuals tend to arrive to the emergency centre very unwell, they generally agree with the casualty officer's assessment of the individual:

> **Then, usually it's-- it's m-- myself, I make the decision**-- (*M: Right*.) **Whether the patient gets admitted or not, and then, like, a nurse… or sometimes the casualty officer--** (*M: Right*.) Uh, or the primary care physician will then, um, fill in the other Form 05, also based on their assessment of-- of the patient. (*M: Right, okay*.) **Um… then if we are in agreement, which we usually are, because when they come to us, they're usually really sick, so we usually are in agreement**.
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (6)

Even if specialist mental healthcare practitioners were likely to agree with the assessment of the general practitioners, specialists still saw themselves as the final decision-makers, noting that casualty officers might disagree but ultimately have to respect their decision as the 'last port of call' for psychiatric assessments and admissions decisions:

> So, I decide, if I'm on call, if the patient gets admitted or not. But we have cases where the emergency medicine doctor will say, this patient needs admission, and I would say, 'No, the patient can go home'. […] Um, so, I discharged her home. And then the

[45]Per Figures 2 and 3, specialist mental healthcare practitioners make the 'final' decision to admit in hospital settings with specialists on staff, while general practitioners make the 'final' decision to admit in hospital settings with*out* specialists on staff.

> emergency medicine colleagues, they said, 'Are you sure? It's the second time she's here, and she's cutting herself, and she's behaving, like, so psychotically', essentially. 'She's so disruptive'. Um, I was like, 'No, we've got to discharge her'. **So in that case they will listen to me, because I'm, I guess, the last port of call for psychiatry. Even if they disagree with me.**
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

In this way, general medical officers and specialist mental health practitioners[46] alike described a kind of checks-and-balances system afforded by having specialist mental healthcare practitioners on staff. In this checks-and-balances system, the 'low threshold' of general medical officers in determining whether an individual should be considered for involuntary admission could then be verified (and course-corrected, as necessary) by specialists:

> You can make the decision to decertify somebody any-- even an hour after they've been certified, and this actually often happens, **'cause I think, um, our colleagues in EC, would-- um, they've got a bit of a lower threshold for certifying patients, um, which is probably a good thing, 'cause, if they're worried enough, and then the psych-- the psych team sees the patients and then we of-- we often decertify the patients** and treat them as outpatients.
>
> Psychiatrist, district hospital, urban, Western Cape (12)

However, some specialist mental healthcare practitioners described this tendency for general medical officers to 'consult' on the admissions decision (which, by law, does *not* need to be made by a specialist mental healthcare practitioner) as a waste of time and expertise in some cases. This point was made by one specialist

[46]Of note is that my use of the term 'specialist mental healthcare practitioners' includes psychiatrists and registrars in psychiatry, who have, of course, received specific training in psychiatry, but also medical officers in psychiatry, who have not necessarily had any specific training in psychiatry.

mental healthcare practitioner working in a tertiary hospital setting who expressed, frankly, some exasperation about standard protocol for referring to psychiatry, where available, to make the final decision to admit:

> In-- at tertiary hospitals, people are very cautious, and very academic, and, you know, they don't wanna make mistakes and, you know, it-- it's a bit-- they're a bit more anxious, and they always call the psychiatrist, you know? (*M: Okay*.) **They call us-- like, um, whereas in a district hospital, they make the call. (*M: Yeah*.) There's no psychiatrist on call**. […] Uh, whereas, with us in [tertiary hospital], some-- sometimes depending on [*muffled*] you often get called from your meeting. I mean, if someone is depressed-- um, the role of the cas-- **I mean, we're a specialist service-- (*M: Yeah!*) Right? (*M: Right.*) As a--as a casualty doctor, if someone is presenting with depression, you can assess and treat that because you're a primary [*muffled*] physician, you know what I mean?** (*M: Right*.) You can be like, "There is no risk here." I can actually then start treatment and refer-- (*M: Right*.) But they're used to having a psychiatrist, so they'll often call you, you know?
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

Perhaps (much to the previously quoted registrar's exasperation) the reassurance of this checks-and-balances system meant that, to some general practitioners operating in hospital settings with specialist mental healthcare practitioners on staff, referring the individual along the path toward involuntary admission was not seen as being a 'big' decision:

> So, if I think that there is a risk, I don't, kind of, go, 'Ooh, should I? Because then maybe it's unnecessary and they get an involuntary admission for no reason.' I kind of go, 'Okay cool, this person has got some red flags, let me get psych involved since they're right here.' […] **Um, so, yeah, I think the decision to make that referral where they may be involuntarily-- involuntarily admitted is not something I stress about too much.**
>
> Medical intern (Y1), tertiary hospital [D], urban, Western Cape (8)

> But, yeah, I think, like, um, psychosis is easy, obviously [*chuckle*] and generally the-- the majority of the psychiatric patients I see I do find it easy to decide, 'Listen, let's just admit'. **If there's any doubt, uh, we still just consult psychiatry** and ask them, 'Listen, this patient is known with this problem, um, probably needs follow-up with you soon, you might just come and see this patient in any case [*chuckle*] and, um-- and come and decide whether this patient needs admission or not.'

Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

In contrast, though, some specialists relied, at least in some cases, on an assumption of good 'reason' for the general practitioner to elevate the individual for evaluation by psychiatry (in hospitals with dedicated psychiatry staff). When asked how an admission decision might be made about someone who is clinically not showing any symptoms of mental illness, and about whom little information can be accessed, one registrar in psychiatry cited trust in the casualty officer's prior decision to complete the first Form 05 as warranting consideration in decision-making:

> (*M: Right. Right, okay. And what would you do if that same... And I'm sure you have these cases, but if that same person arrives to casualty but you couldn't get in touch with family to-- you know, so they seem perfectly fine, but they've arrived somehow?*) Um, I would hang on for a bit. I wouldn't-- I would hang on, and we have a social worker, so I'd refer to the social worker to just help me track down family, or track down anyone that could help me. **Because there should be a reason why he was admitted to hospital in the first place. Otherwise they wouldn't admit him**.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

In saying, "otherwise they wouldn't admit[47] him", the registrar is referring to the casualty officer's decision to refer the individual to psychiatry. This registrar is suggesting that the micro-decisions that have led to the individual's referral to psychiatry are themselves employed as a rationale in decision-making—the fact that the individual has already 'made it this far' in the admissions process may

[47] 'Admit' is being used here not in the formal sense, but to the extent that the individual has been given a bed in the emergency centre (as part of 'micro-decision' 2) along the pathway to decision-making.

itself warrant consideration in making the 'final' decision to admit involuntarily, per this practitioner's view.

In general, then, specialist practitioners trusted that there was some rationale for the referral to psychiatry for assessment. Even if that rationale was not apparent in the notes or in the individual's clinical presentation, the specialist would at least 'hold off' and wait to understand why the casualty officer had made the decision to refer to psychiatry. This perspective may borrow from the belief that, because the casualty officer is legally permitted and clinically skilled to assess the individual's need for involuntary admission, their decision will necessarily be legally and clinically justifiable. That said, some specialist mental healthcare practitioners explicitly or implicitly suggested that casualty officers tend to have a low threshold of admission, and that, given this lower threshold for admission, the specialist would consider discharging the individual to outpatient management.

The mere fact that a specialist is being called to assess an individual does, in many respects, influence the way that practitioners—specialists and generalists alike—view the individual. That is, by the time the individual is being referred to a specialist mental healthcare practitioner, the 'mental healthcare user' label has already been applied in some sense. Specialists can, of course, reverse the admission process—and the label—in the particular instance; that said, the label is already there, or at least hovering over the individual, simply by virtue of the casualty officer's decision to refer to psychiatry.

In summary, this specific 'micro-decision'—referring to psychiatry—played a key role in shaping the information inputs to guide the outcome of the final decision to admit. Specialists trusted that general practitioners would not begin the involuntary admission process unless warranted, and general practitioners felt reassured that the admission decision would be reviewed by a specialist and reversed should the specialist disagree.

5.2.5. Summary

The final decision to involuntarily admit the individual is influenced by the informational inputs gleaned from prior micro-decisions (Figure 4). Each of these micro-decisions—bringing the individual to hospital, prioritising the individual in the emergency centre, sedating the individual in the emergency centre, and referring the individual to a specialist mental healthcare practitioner—plays a role in shaping the informational inputs available to guide the final decision to admit. Practitioners reported that various aspects of the final decision are directly or indirectly influenced by the outcomes of these micro-decisions.

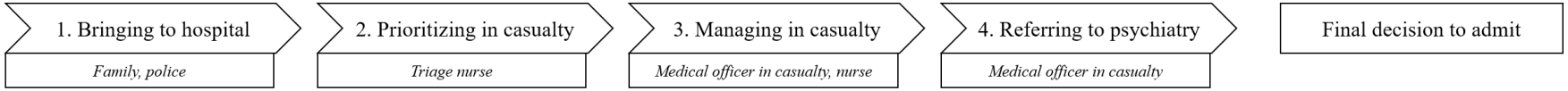


Figure 4. 'Micro-decisions' along the path toward an admissions decision, each of which influence the informational inputs available to guide the final decision to admit

5.3. The cumulative force of micro-decisions and their implications for decision-making

In some ways, then, the final decision to admit can be seen as somewhat cumulative—influenced by preceding micro-decisions made by the family, police, and other healthcare providers. This is not to say that the final decision is a foregone conclusion, or even the sum total of the micro-decisions that preceded it. Rather, in many cases—and especially in the absence of information about the individual—practitioners rely on the presumed validity of a prior micro-decision to inform their final decision to admit.

As described in Section 5.2.4 (page 194), the 'mental healthcare user' label is increasingly hovering over the individual with every micro-decision made, bringing the cumulative force of each micro-decision into view. Each micro-decision influences the way that practitioners proceed in their reasoning about whether or not to admit an individual for psychiatric inpatient admission.

One of the most compelling (and alarming) reasons practitioners cited as justifying their decision to admit was the simple fact that the individual had been brought to hospital by family members, friends, or police. Practitioners cited a number of rationales for this reasoning, including low mental health literacy in some families and communities, as well as difficulty in accessing the hospital itself, especially rurally:

> You're rural. It's not easy to get to a hospital. Okay? So it-- it's transport. It's money. Like, even if you think about COVID, are things in Limpopo? Are our borders closed? Like-- like, things got complicated! (*M: Right!*) Yeah! Like, yeah, things got really complicated. **Um, and, so, there were all these obstacles people had, to come. So, like, it's very rare that they were bringing you in-- the patient in, if they weren't-- be like, 'Oh, this patient needs to be here', I'm not going to argue with that and say, 'By the way, maybe you should come back to clinic tomorrow and we'll work from there.'** So, then there's that factor.
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

In most cases, the final decision to admit gleaned at least some meaning from the outcomes of the prior 'micro-decisions' leading up to it. Again, this is not to say that admissions decisions are formulaic, or prescribed by a decision tree of sorts where the result of each 'micro-decision' sets the admissions process onto a particular (and predefined) course. Rather, the key takeaway is that the outcomes of micro-decisions made prior to the point of admission impact the informational inputs available to guide that final decision to admit. As implied in their accounts of decision-making, practitioners often presume that prior micro-decisions are valid, which then leads practitioners to reason using the specific outcomes or details of these micro-decisions themselves.

5.3.1. Presumed validity of prior micro-decisions

In recounting their experiences of decision-making, practitioners described a certain degree of reliance on the presumed validity of prior micro-decisions made. That is, practitioners expressed some trust that a prior micro-decision will have been made for a reason: 'the family must have brought the individual in for a reason', 'the nurse must have prioritised this individual for a reason', 'the patient must be sedated for a reason', 'the first Form 05 must have been filled in for a

reason'. Even if, then, the practitioner lacks the information needed to make an admissions decision in that moment, the presumed validity of these prior micro-decisions—where the outcomes of each of these micro-decisions serve as pieces of information themselves—becomes at least part of the rationale for practitioners' decision-making. The presumption that a prior micro-decision was justifiably made can play a role in the final decision, whether intentionally or by default.

5.3.1.1. 'You know that they are bringing them in for a reason'

One of the most common rationales practitioners gave to justify their final admissions decision was that there must be some reason the individual had been brought to the emergency centre at that particular moment. As discussed in Section 5.2.1.1 (page 176), even where practitioners were quick to acknowledge that some family members are dishonest and just trying to get the individual admitted to hospital for the weekend—the 'Friday drop-off'—the belief that there must be some explanation of the individual's arrival to hospital that would in turn justify admission was fairly common. Again, this points to the dominant role that non-practitioners play in the admissions decision: the admissions process can only begin if someone outside the hospital brings the individual to hospital, so practitioners tended to assume that the family's reason for bringing the individual to hospital was a valid one, or at least one that warranted further scrutiny (even if the individual seemed 'completely fine').

Overall, practitioners presumed that preceding micro-decisions—especially the micro-decision of a non-practitioner to bring the individual to hospital for assessment—were valid in some way.

5.3.1.2. The place of 'substitute' information in decision-making

By presuming the validity of prior micro-decisions, practitioners gleaned meaning from this kind of 'substitute' information—i.e. the *fact* that a micro-decision had been made—and used that information as part of their own reasoning in decision-making. While this 'substitute' information consists mainly of inferences derived from how the individual arrived to hospital and how practitioners managed the individual in the emergency centre, substitute information nonetheless guided the final decision in many cases, even if these inferences provided little knowledge beyond the mere fact *that* a micro-decision had been made.

Substitute information was also employed in decision-making because many admissions decisions are made *without* sufficient information. Practitioners implied that, in the absence of direct information, the default position is often to admit involuntarily, based on substitute information, in order to gather *more* information over the 72-hour assessment period:

> But, like, when I assess the patient and I see that, like, they're not that psychotic at the moment, as I said, I will still assess. […] But, in that case, I would still admit them to observe. […] I feel that assessing a patient for the first time in, like, ten minutes isn't really enough time to actually see how they are. **So, I most-- I generally give the family the benefit of the doubt. And then I just, you know, admit them to observe.**
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

> And sometimes, if you then-- if you're faced with something on history that you can't quantify, or that's not quantified, so, say for instance, "aggression", just-- or "sexually disinhibited", on the Mental Health Care Act forms, you don't know… what that means, exactly. **And you can't confirm-- confirm it with-- corroborate it with collateral information. It's something as simple as that, we-- we'd possibly-- we'd prob-- probably keep a patient like that, until you can get-- make contact with the… with the next of kin.** And then, sometimes, social workers help us with that, as well, if we really don't have a telephone number… To go to the address or send out the police, um, so those would be some practical things… around making decisions.
>
> Psychiatrist, district hospital [H], urban, Western Cape (12)

In some cases, the absence of information was cited as a reason to keep the individual in hospital even *beyond* the 72-hour assessment period:

> So, where we were, sometimes we would delay discharging the patient after 72 hours, since they will have to stay a bit longer, just so that social issues can be addressed. **'Cause sometimes they will-- we'll have to ask the social worker to try and find someone in the family that could take responsibility for the patient.** Um, they might not need admission for long-term but they need supervision at home, so it's important to have that knowledge of who the patient is going home to, who's going to take responsibility for the patient…
>
> Community service medical officer, district hospital [F], rural, Western Cape (10)

When faced with the outcomes of a prior micro-decisions—e.g. a family member's micro-decision to bring the individual to hospital—practitioners often felt that they *should* admit involuntarily, and then use the 72-hour assessment period to gather further information. Practitioners use substitute information to justify their decision either because of the persuasiveness of a particular piece of 'substitute' information itself (i.e. the 'clear-cut' admission when an individual is brought to hospital by police) or, more often, because of a lack of other information available to guide the final decision to admit.

5.3.2. The importance of ‘direct’ information

Though substitute information plays a key role in guiding decision-making when direct information is unavailable, direct information—when available—is prioritised in decision-making.

My use of the term ‘direct’ information—as a contrast to ‘substitute’ information—encompasses any kind of information about the individual (or their broader context) that goes beyond clinical presentation. Direct information includes any ‘collateral information’ provided by the individual themself or their family member(s) or supporters. Another influential piece of direct information comes from within the hospital itself—patient records and practitioner familiarity. For individuals who are well-known to services, practitioners have a lot of background information on the mental healthcare user—either through their own previous experience with the individual, or through reference to information about the individual on file. In these instances, practitioners are able to rely on and use background and historical information, including details about the individual’s past admissions as well as any personal details included in the file (or already known to the practitioner), in their decision-making.

When practitioners have more information to guide their final decision to admit, they are able to refine the considerations weighed up in their decision-making in terms of the individual’s specific context:

> Um… if I kn-- if I… **if I know that the patient, especially if it's a well-known patient and-- and you know that they tend to not usually be aggressive. Um, if I know that they have… a… very… good family support**, there's someone at home with them all the time, and if the patient tells me, 'Yes, I'm willing to take the medication', and I know that there's someone at home who's going to make sure that this patient is taking their medication and if things go wrong at home, there's someone to make sure that they'll get back to hospital, **then I'm more willing to-- to try outpatient management**.
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

Notably, this refinement of considerations was often positioned by practitioners as a route to justifying *non*-admission, especially if practitioners felt that some element of the individual's specific context—e.g. baseline presentation, support from family—allowed for outpatient management.

In general, admissions decisions fell into one of two camps: on the one hand, practitioners described a range of cases in which the admission was 'clear-cut' based on clinical presentation or other (direct *or* substitute) information that was perceived to justify admission, e.g. direct information from a family member reporting that the individual was being violent at home, or substitute information (that the individual was brought to hospital by police). In cases where practitioners could clearly 'see'—literally or otherwise—the rationale for admission, the admissions decision was made fairly immediately. Note, though, that these 'clear-cut' cases span a wide range, including decisions made *solely* on the basis of substitute information.

On the other hand, practitioners described a range of cases in which direct information was available, but decisions were *not* clear-cut. In these cases, other

factors—that is, factors that sit outside of standard clinical presentation as defined in context—would come into play in decision-making, and additional 'direct' information was needed to guide the final decision to admit.

5.4. Making admissions decisions with limited information

In the previous section, I described the place of 'substitute' and 'direct' information in decision-making. I showed how the presumed validity of prior micro-decisions functioned as 'substitute' information in some cases, and I showed how the availability of 'direct' information sometimes worked to justify *non*-admission. In this section, I explore practitioners' accounts of making decisions with disparate—and often very limited—amounts of information. I show how, in the absence of direct information, practitioners tend to rely on 'substitute' information to make (and justify) their decisions.

Though an obvious point, it's worth noting just *how* information-dependent an involuntary admissions decision is (or, at least, should be). That said, in many cases, practitioners' accounts revealed that their decision-making relies on information that *simply is not available* in so many cases, meaning that admissions decisions are made and justified using *disparate* amounts of information. In the absence of direct information, practitioners lean on substitute information gleaned from various micro-decisions that proceed the final decision to admit.

The variability in information availability is caused in part by the disjointedness of the broader admissions pathway—an individual arrives to hospital, waits to be seen in the emergency centre, is kept in a bed (or a chair) while physical health conditions are excluded, and then, where relevant, seen by a specialist mental healthcare practitioner. The entire process takes hours if not days, and there are plenty of opportunities between each of these moments to lose information (or access to it).

For example, if families are unable to wait in the emergency centre with the individual (e.g. because of COVID-19 precautions), and especially if the family member does not leave contact details or have access to a telephone, practitioners are unable to gather collateral information to even understand why the individual was brought to hospital in the first place:

> So… you know, there's just a very little sense of what the major complaint is, how long it's been like this for… You know, **having a telephone number to get some collateral is, you know, like, a miracle**. Um… (*M: Right.*) Then people's phones are off…
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

Likewise, if the individual has been heavily sedated in the emergency centre, the practitioners cannot converse with the individual or adequately assess them, which also reduces the amount of information available to guide the decision-making:

> Like, um… if the police bring in this patient, um, and you can barely talk to him, he's completely, like, talking different things, he's hitting people in casualty, we just put him down, you know. And I sometimes feel so bad but, yeah, it's just like, 'Okay, let's get a drip up on this guy, give him some Lorazepam and let's just calm things down.' And then, sometimes you get a relative or somebody who came with to give you history, but

> sometimes not, even. **Sometimes you've got zero history and a sedated patient, then it's just like, 'What are we doing?!', I feel so bad**. […] **Yeah, so ack, unfortunately we get patients like that who we just try and see if we can get a history from but otherwise, I mean, we-- we just tell the family medicine department, 'Listen, this patient came in, we had to sedate him… he needs a 72-hour assessment, um, now it's your problem, unfortunately'.**
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

While there are many causes of this variability in information availability—not least of which is to do with the general chaos of the emergency centre context—the casualty officer's quote also demonstrates how micro-decisions themselves can exacerbate the lack of information available. In these cases, then, practitioners generally relied on the outcomes of micro-decisions—that the individual was brought to hospital, that the individual was sedated—as a part of their rationale in making the final decision to admit.

The utility of substitute information in decision-making may also be attributed to the fact that clinical presentation alone was rarely reported by practitioners to offer sufficient information to make a decision. Practitioners advocated for taking as much information as is available into account in decision-making:

> (*M: I'm wondering, uh… would anything, sort of, about the patient… other than the present, sort of, clinical presentation… for example, history of past admissions, inform the decision?*) Yeah… it-- it-- so, **everything informs the decision. Everything you've taken in your history, everything you've seen in the patient, all of those things inform your decision.**
>
> Psychiatrist, tertiary hospital [A], urban, KwaZulu-Natal (1)

In fact, the idea of 'going clinically'—assessing the individual based on their presentation in that moment (assuming they are not sedated) and with no other informational inputs—was often framed as a 'last resort' for decision-making:

> **Um… usually we would hope that there is some history…** um, if the patient… denies everything or is not in a state to give you that information… (*M: Mhm*.) **Um, but otherwise, sometimes, we just go clinically**, so the patient can be very confused or aggressive there at that time, or actively hallucinating or has already attempted suicide… so sometimes we don't have to have a history, as well. (*M: Right*.) Um… but it just depends.
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (2)

> (*M: Okay, so maybe in contrast then, can you tell me about a case where an individual arrives to casualty without any family members, like, you don't have any… collateral to potentially pull on… How do you go about making that decision?*) So, um, it might be by the police-- (*M: Yeah*.) That they'll bring in-- the police might say that, you know, "This person-- patient was wandering across the street." (*M: Yeah*.) "They're very confused." (*M: Yeah*.) "They're disorganised," so you-- they have the-- you know, so the-- the-- there will-- there will be some sort of history like that. (*M: Okay*.) **If there is nothing at all, then it's based on my assessment.** I mean, [*muffled*] you talk to the patient, yeah. (*M: Yeah*.) Yeah. "Are they're psychotic? What's--" you know… yeah.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

I was especially struck by this point, because it seems like the easy solution to the challenge of making decisions with such variable amounts of information is to *exclusively* 'go clinically', i.e. admit only if symptoms are overt. Then we might feel more confident that decisions are being made according to at least some sort of measurable 'clinical' (however values-laden) criteria instead of relying on the view of the family or the notes scribbled in the patient file.

However, and as many practitioners and advocates reported, low mental health literacy and other structural barriers to *getting* an individual to hospital (e.g. distance from clinic, costs of transport) are also at play in a South African

decision-making context. Practitioners were sensitive to these challenges and saw gathering further information as a critical strategy for understanding whether an individual who was not *visibly* in need of admission was *in fact* in need of admission. That is, practitioners would still consider an individual for admission even if symptoms were not clearly visible at the point of assessment, emphasizing their reliance on additional information (whether direct or substitute) to make their decision. This bias toward considering admission, even when symptoms could not be observed, also relies in part on the presumed validity of prior micro-decisions, e.g. the decision of the family to bring the individual to hospital at all, as demonstrated in Section 5.2.1.1 (page 176), and the use of 'substitute' information to guide the final decision to admit.

5.5. Conclusion

While the literature and the law tend to imply that an involuntary admissions decision begins and ends with a single clinical encounter, my data analysis highlighted that several key micro-decisions sit along *pathways to decision-making*. These micro-decisions precede the final decision to admit and can significantly influence its outcome. That is, the decision to admit cannot be understood in isolation.

Based on my analysis, these micro-decisions can bring a cumulative force to the final decision to admit, where at least some informational inputs that guide the

final decision are drawn from prior micro-decisions. These micro-decisions include the initial decision to bring the individual to hospital, the decision to prioritise the individual in the emergency centre (as a potential mental healthcare user), the decision to sedate the individual in the emergency centre, and the decision to refer the individual to a specialist mental healthcare practitioner where available.

These micro-decisions impact the informational inputs available to make the 'final' decision—whether that final decision is made by the casualty officer completing the first Form 05 in settings without specialists on staff, or by the specialist mental healthcare practitioner completing the second Form 05 in settings with specialists on staff. In both cases, practitioners assume that prior micro-decisions made are *valid*, i.e. reasonable or justifiable in some way. Relying on this validity, then, practitioners sometimes use 'substitute' information in their final decision to admit, for example citing *that* the individual was brought into hospital by their family as part of their rationale in decision-making.

The reason 'substitute' information slips into decision-making—and therefore the reason that these micro-decisions *matter*, at least in some cases, to the final decision to admit—is attributable to the variability in information availability at the point of making the 'final' decision to admit. In the absence of direct information, practitioners draw on 'substitute' information gleaned from the outcomes of prior micro-decisions to support their final decision to admit.

In this chapter, I have described the place of micro-decisions along the pathways to decision-making, and I have established how the outcomes of these micro-decisions can influence the final decision to admit. I've explored the role that 'substitute' information can play in practitioners' decision-making and I've shown how information loss can be compounded by certain micro-decisions—being brought to hospital with police, for example, or being sedated upon arrival to hospital. I demonstrated that decision-making is, in many instances, information-dependent (beyond clinical presentation), and that, as a result, practitioners are often forced to rely on 'substitute' information to justify their decisions where 'direct' information is not available.

Chapter 6: Considerations in decision-making: taking individual-, family-, resource-, and system-focused considerations into account

6.1. Introduction

In Chapter 5, I presented the first analytic theme of the empirical analysis, focusing on *pathways to decision-making*. I highlighted the various 'micro-decisions' that sit along key pathways to decision-making and *precede* the final decision to admit. In tracing the role these micro-decisions play in the lead-up to the final decision to admit, I demonstrated how their outcomes can significantly influence the admissions decision. Primarily, these 'micro-decisions' have two effects on decision-making: 1) these micro-decisions can shape the quantity and quality of information available to guide the final decision to admit, and 2) the outcomes of these micro-decisions can themselves be used to justify the admissions decision in certain cases (e.g. making the decision to admit involuntarily *because* the individual was sedated in casualty). To that end, I described the role that *substitute* information can plan in guiding the decision, especially when *direct* information is unavailable. As demonstrated through interviewees' accounts, practitioners sometimes rely on information gleaned from the outcome of a prior micro-decision (e.g. the fact *that* the individual was sedated) to justify their admissions decision in the absence of direct information.

In this chapter, I look more closely at how practitioners make the final decision to admit, especially when *direct* information is available. I developed the theme *considerations in decision-making* to represent the distinct categories of considerations that practitioners reported as relevant to their decision-making. This theme is divided into four sub-themes: individual-focused considerations,

family-focused considerations, resource-focused considerations, and system-focused considerations. The first two categories of considerations—individual- and family-focused considerations—are taken to be information-*dependent* in decision-making. These kinds of considerations can only be used to guide decision-making *when direct information is available* (i.e. when the pathway to decision-making allows for direct information to be gathered). The second two categories of considerations—resource- and system-focused considerations—are taken to be information-*independent* (i.e. applicable regardless of the pathway to decision-making).

The empirical data presented in this chapter demonstrates that many of the considerations included in practitioners' accounts of decision-making sit *outside* the narrow scope of legal criteria prescribed in the MHCA 2002. While most practitioners recited key legal criteria (as approximated specifically by terms like 'aggressive', 'homicidal', 'suicidal') in their accounts, a range of additional considerations—many of which focus not on the individual themself—were central to practitioners' decision-making.

In this chapter, I explore each of the four subthemes in my analysis of *considerations in decision-making*: individual-focused considerations (Section 6.1), family-focused considerations (Section 6.2), resource-focused considerations (Section 6.3), and system-focused considerations (Section 6.4). I also explore the

implications of information-dependent and information-independent considerations in decision-making.

6.2. Individual-focused considerations in decision-making

Practitioners reported that individual-focused considerations are critical to their decision-making. These kinds of considerations attend to practitioners' own interpretations of key elements of the individual's context or social circumstance (critically distinct from incorporating the individual's own preferences, which was not discussed by participating practitioners). Through individual-focused considerations, practitioners refine or move beyond the core legal criteria to best meet the perceived needs of the individual. That said, individual-focused considerations are information-*dependent* per practitioners' accounts, meaning that the extent to which these considerations can be adequately incorporated in decision-making is at least in part influenced by prior 'micro-decisions' along the pathways to decision-making.

When adequate information is available, practitioners reported that their inclusion of individual-focused considerations in decision-making sought to tailor admissions criteria to the particular individual's particular needs. This implicit sense of shaping the decision to the features of the particular individual's context also extended to practitioners' inclusion of family-focused considerations in decision-making (as explored in Section 6.3).

Within the broad subtheme of 'individual-focused considerations', four component considerations were especially prominent:

1) Understanding the root of 'aggression' (Section 6.2.1),
2) Preserving reputation with respect to employment (Section 6.2.2),
3) Avoiding or entrenching stigma (Section 6.2.3), and
4) Indexing 'need' for admission to the individual's baseline (Section 6.2.4).

6.2.1. Understanding the root of 'aggression'

The first consideration in practitioners' accounts of weighing up individual-focused considerations is understanding the root of 'aggression'. To note, 'aggression' as a trait (or behaviour or symptom) was broadly understood by practitioners as an approximation of the 'risk of harm to others' criterion and therefore sufficient justification for involuntary admission. However, several practitioners noted that closer analysis of this 'aggression' is necessary in some cases.

6.2.1.1. Description of the consideration

Several practitioners were sensitive to the potential circumstances under which other emotions may be misconstrued as 'aggression', or when perceived aggression—physical or verbal—may even be justifiable.

As discussed in Chapter 5, some practitioners worried that what may be perceived as 'aggression' is, in fact, an appropriate reaction to a prior experience, e.g. having been picked up by police. Advocates also highlighted that perceived

'aggression' on the part of a mental healthcare service user may be legitimate. The mere fact of being forced into something—the very nature of an involuntary admission—can understandably lead to expressions of frustration or outrage, which may then be perceived as 'aggression'. Noted one advocate:

> Like, that's, kind of, the harsh reality about… involunt-- because **whenever somebody is forced to do something, or-- or gets pushed to do something, inevitably, they react**. (*M: Yeah*.) So it's not fair to judge on that person at that moment, because if you told me 'You have to go in', I probably would've fought back also.
>
> Advocate (Interview 2)

Similarly, practitioners worried that reported 'aggression' may be a justified response to some kind of provocation:

> He came in because this family had reported that he had broken something at home. I think he'd broken the window or something. Um, and that he-- he did something to someone's father. Slapped him or something. **Um, and when I interviewed the guy, he said to me that, "No, I slapped him because he was being disrespectful"**. […] **And it sounds like that particular father was trying to hit someone else, so that's why he slapped that father, to try to protect someone else.**
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

In this quote, the practitioner is justifying the 'aggressive' act as rational. This kind of worry—that any perceived 'aggression' used to justify admission is, in fact, 'legitimate' anger or violence—was of considerable concern to some practitioners. Some practitioners were especially invested in further understanding the root of the individual's 'aggression'. One practitioner noted that 'aggression' may be caused by the family's mistreatment of the individual (in this case, a known mental healthcare user):

> There was this patient who came in, his fam-- okay, so, I think he was a substance-- um, he-- he-- I think he smoked quite a lot of marijuana. (*M: Okay*.) **But now his family brought him in saying, no, he's aggressive**. So-- so-- the-- so, it looked like he was

> having persecutory delusions against family, saying that, no, the family keeps stealing his money. […] But the family would say that, no, the reason they kept taking the money was because, um, all he wanted to do was to go out and buy weed. (*M: Okay…*) So, that's why they wouldn't give him his money**. But when we spoke to the patient, literally, the patient-- he was like, no, literally, all he wants is to buy himself a packet of chips**. **Just once in a while. 'Cause the food they were feeding him at home, it-- it sucks**. Like he just wants one nice thing for himself. **And he was a very aggressive guy, but you could reason with him**. So, whenever he would shout, you-- you could de-escalate and you could reason with the things he was saying.
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

In this quote, the practitioner is noting the disparity between the family's report of aggression and the individual's self-report of justified frustration.

In assessing aggression, practitioners also differentiated between aggression linked to different kinds of conditions[48]:

> Um… first of all, what's the risk? Um… so if the patient is aggressive, to what extent are they aggressive, with weapons, without weapons? Um… **what's the history of aggression, um, but, then also how that is linked to the psychosis, because you also get patients with anti-social personality disorders, always aggressive, and it's not necessarily linked to that, to any mental-- other mental pathology.**
>
> Psychiatrist, district hospital [H], urban, Western Cape (12)

Some practitioners worried about individuals justifying violent or aggressive behaviour by 'pulling the psychotic card', presumably with an eye toward avoiding police involvement or the criminal justice system:

> Or also a lot's accompanied by the police, because, yeah, the-- um, the neighbour called because of a commotion or whatever, and they call the police, and the police came and assessed the guy, and was, like "No, no, this guy needs, you know, medical help. He's not a-- a criminal", you know? (*M: Right, okay*.) Although that line is so thin, but anyway.

[48]There is a long and lively debate about which conditions should or should not be considered 'mental illnesses' (or 'psychiatric disorders' or 'psychosocial disabilities'), which I will not get into here. The point I seek to emphasize here is that practitioners are making a distinction between aggression perceived to be linked to, e.g. psychosis versus a personality disorder. Of course, these kinds of views are in and of themselves stigmatizing and warrant further normative scrutiny.

> Yeah. (*M: Say a bit more*?) **Like, I mean, I-- I've seen some people that maybe pull the-- the psychotic card, when actually-- actually, they're like, just violent or, you know, aggressive, by nature**. Yeah.
>
> Casualty officer, district hospital [I], urban, Western Cape (13)

6.2.1.2. Force of the consideration in decision-making

While practitioners generally cited 'aggression' as a key rationale for involuntary admission, practitioners were, also, in many instances, wary of using 'aggression' to justify admission, as indicated in Section 6.2.1 (page 220). Part of this wariness stemmed from the recognition that 'aggression'—even as an operationalization of the 'risk to others' criterion—is not a 'watertight' rationale: some aggression is normal, or even warranted, and therefore should not be used to justify admission (in general, of course, but especially for known mental healthcare users). Though 'aggression' was still a strong and often overriding consideration in practitioners' accounts of decision-making, many practitioners acknowledged that there is often much more to aggression than the mere *presence* of aggressive behaviour. That is, practitioners were sensitive to avoiding the assumption that visible "aggression" was indicative of mental illness:

> So, literally, everything I saw in this guy, you could justify it. And it wasn't just myself. The nurses saw it as well. We were like, 'No, this guy isn't psychotic. He's just aggressive.' No-- no-- no, sorry, sorry, no-- **he's just angry. He's just frustrated. And he's just scared of needles**. […] And- and-- and, initially, our clinical manager was like, 'No, ah, how-- how else can you explain someone being aggressive?' **But I'm like, no, but being aggressive doesn't always mean, ah, you know, being-- having a mental illness**. You-- you-- you're are allowed to be angry. You're allowed to be frustrated.
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

In light of this perspective, a unilateral definition of 'aggression' was not necessarily applied to all individuals (especially known mental healthcare users) across the board.

6.2.2. Preserving reputation with respect to employment

Another key individual-focused consideration cited by practitioners was preserving reputation, specifically with respect to employment. That is, practitioners were especially sensitive to guarding individuals against perceived reputational risk *with regard to* their employment status, which operated as a key interpretations of the 'risk to reputation' legal criterion. Notably, practitioners reported that 'risk to reputation' would rarely suffice as a justification for involuntary admission in practice, even though legally permissible per the MHCA 2002.

6.2.2.1. Description of the consideration

While some practitioners cited other concerns about reputation (largely dignity-based concerns around, e.g., being naked in public), employment—and specifically *preserving* employment—was especially prominent in practitioners' reasoning:

> (*M: […] Can you give me a sense of […] how you would go about understanding whether or not someone's a risk to their reputation, what kinds of things you're looking for in that category? […]*) Yeah. Yeah, look, um… I just-- you know, with the context of [muffled] we were in, you don't-- you don't really spend a lot of time, um, you know, trying to be comprehensive in that kind of situation-- (*M: Sure*.) Because of time constraints. **Just generally I would ask what kind of job they have, and whether… I mean obviously,**

> **if someone has got a job, you can't now, you know, let them go back into a place that could, you know, tarnish their reputation**.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

> So I had a patient who was… 26? Started on antidepressants by a GP, and then became completely manic. So, um…like, elevated mood, talking fast, breaking things at home. Um, had grandiose delusions. Walking up and down in the emergency department coughing on people. Like, you-- you can imagine**. So, also caused a lot of problems at work, because, I mean, being manic at work is really damaging to your reputation, as well.**
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

Though practitioners were clear that 'risk to reputation' rarely sufficed as the *sole* justification for an admissions decision, assessment of the individual's risk to their reputation can be a driving factor in the decision to admit in some cases:

> (*M: So, I have a quick question for you that you haven't actually brought up. But, obviously, on the MHCA 05 form, right, you're looking through and it says 'risk to self', 'risk to others'. There's also 'risk to reputation'.*) Yeah. (*M: And I'm-- I'm wondering how you interpret that. Or how that's come up, and if you can give me an example of when you admitted someone for being a risk to their reputation.*) To be honest, in a lot of cases, it's never really been that alone. (*M: Okay.*) So, yeah. So-- except for this-- so, for example-- **I think the best example, or rather the case that where risk to reputation was the biggest factor was with the patient-- the-- the bipolar teacher that I told you about.** (*M: Okay. And why?*) **Because of the fact that obvi-- he's a lecturer, so he's seen very highly. And for that to occur… at work.**
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

One practitioner suggested that the primary aim of assessing risk to reputation with respect to employment is linked to longer-term outcomes for the individual:

> Um… so, often reputation actually, um… **I think we probably never admit patients for reputation alone, unless they are… employed, and earning money**, or… It's almost like… it doesn't hold for poor patients as much, kind of-- (*M: Huh.*) Really the-- ad-- admitting patients only to protect their reputation… Um… [*pause*] well, and also finances, which-- so it's obviously… if you're very poor, there's-- there's not a lot to protect. […] **It is, it's very much about employment, I would-- such an important thing in terms of… just, outcomes,** how people are gonna […] Um, and we, like-- this is something I always tell the interns or the young doctors… Are they working,

> have you sent the sick certificate, have you contacted the family? Are they gonna keep the job? **Let us keep the job, let's do our best to-- to, kind of, keep the job, so that's definitely the number one thing.**
>
> Psychiatrist, district hospital [H], urban, Western Cape (12)

This practitioner implicitly expresses concern that, without admission, the individual may lose their job, in turn jeopardizing their longer-term outcomes. However, this practitioner's application and interpretation of the 'risk to reputation' criterion, while clearly tailored to the individual's context, also betrays an arguably discriminatory attitude: the practitioner notes that, "if you're very poor", i.e. unemployed, there is "not a lot to protect".

6.2.2.2. Force of the consideration in decision-making

Broadly, practitioners' assessments of reputation focused on the critical place of employment (and financial stability) in the individual's life. Practitioners' accounts of decision-making highlighted the role that employment plays in not only defining risk to reputation but also in justifying admission under the 'risk to reputation' criterion. Of note here is that behaviour displayed by an *employed* individual might be considered damaging to their reputation *at work*—thereby warranting admission—while the same behaviour displayed by an *unemployed* individual might not necessitate admission, according to some practitioners' accounts. Interestingly, practitioners did not see involuntary admission *itself* as a risk to reputation (e.g., where admission may in turn negatively impact employment status); rather, practitioners viewed involuntary admission as a key strategy for preserving an individual's reputation in their place of work.

6.2.3. Avoiding (or entrenching) stigma

Per practitioners' accounts of decision-making, another individual-focused consideration is avoiding (or entrenching) stigma. Broadly, practitioners were sensitive to the weight of the 'mental healthcare user' label. Practitioners reported that being labelled could impact the individual's personal life as well as their trajectory in hospital on future visits.

6.2.3.1. Description of the consideration

Some practitioners wanted to avoid stigma in decision-making, worrying that a diagnosis of mental illness or an admission for the 72-hour assessment period might impact how the individual is perceived by family:

> And you don't want to subject the patient to, you know, a diagnosis of schizophrenia when, in fact it was just a brief, sort of, episode. Um, so that was one of the-- that was one of the major things. […] I-- I was a little bit different in that I wasn't always keen to admit patients just for the sake of admitting patients. Um, mainly because, you know-- you-- you-- **if you admit them, you're going to be labelling them in some way or form with a particular disease, you know, from the perspective of a family member.**
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

However, worries about stigma extended beyond stigma from family members or members of the community. Practitioners also worried about stigma from healthcare providers themselves: several practitioners suggested that their colleagues might, upon seeing the 'mental healthcare user' label in an individual's medical record, react differently to the individual. Worry about stigma from other healthcare providers was especially prominent in accounts of decision-making from practitioners working rurally:

> **Once you've got that 'MHCU' ['mental health care user'] in your file, guarantee is there for life**… […] **So, but it [the 'MHCU' label] really is it's-- like, sticks to you like glue**, and, um, it happens a lot, you know, when people-- 'cause people just make these bizarre-- just decided, like, today, that's their thing. **And because people are busy or they're lazy or whatever, you flip back in the file, see what the diagnosis is, re-board whatever meds they were on. That is just a generic way of management. Specifically in a rural setting like where I was, where there is no psychiatric input.**
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

Citing worries of improper management by other healthcare providers, some practitioners clearly felt the weight of giving someone the 'mental healthcare user' label. That is, some practitioners were reluctant to label the individual as a 'mental healthcare user' by admitting involuntarily, specifically *because* the label makes practitioners more likely to admit the individual in the future:

> So to me it's more like, um… maybe there's some ethical problems then coming in for me there, where **if I admit this patient as an acute-onset psychosis, he's gonna be labelled like that**. You know? And… if it's-- it's not that clear for me, then I don't want to label that patient like that, um, because in a year or two's time, he's maybe going to come in with a similar problem or just an aggression issue or whatever, and people are gonna see his file and see, 'Oh, he's been admitted for, like, acute psychosis before, it's just another psych patient. We're not going to bother with this, just gonna sedate him'. You know? Like, I know how the people will manage him in the future, and to me, then, that-- that's a bit like… yeah. So-- so in the more subtle cases, **I find it very difficult because I know, once I label this patient like that, how he's going to be treated**. Um... so that-- that would be the one challenge for me, deciding to admit this patient as a psychosis.
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

Another consequence of this stigma was echoed by specialist practitioners, several of whom reported that known mental healthcare users often receive inadequate physical healthcare, simply because mental healthcare users' physical health needs are written off as manifestations of mental ill-health.

Likewise, some practitioners reported that colleagues might hold dismissive attitudes toward mental healthcare users:

> Um, the other thing I would like to mention is that **often our casualty colleagues are very impatient and can have a complete disregard for mentally ill patients**. Uh… so it's either like, "We need to get them out of there quickly," or, "Oh, oh, it's another psycho. Oh, the psychs over there on that side," you know?
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

> […] Despite the fact that there is not much-- the-- despite the fact that the stigma towards mental healthcare patients has sort of improved, I sort of feel as if, in healthcare, they are still labelled. **So, they're like, 'Okay, he's a known mental healthcare user'. So, if there's any issue that-- that-- that occurs, it's always thought to be attributed to the-- to the illness rather than the patient as a whole.**
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

6.2.3.2. Force of the consideration in decision-making

In some cases, practitioners weighed up the impact that the label—and subsequent admission—might have on the individual. Where possible, practitioners sought to avoid stigma through admission, as one practitioner noted:

> […] [I would] try and safety net the patient and speak to the family and say 'Listen, maybe-- I think, maybe-- do you think maybe this was the issue? Like, **do you think maybe we can try this or that, um, before we just jump into admission?**' You know? Um… maybe safety net him with follow-up at the local clinic or, um, a follow-up with a social worker, or even psychologist. **And then see if we can maybe-- maybe it's just-- maybe it's just some other issue that there is, and that he doesn't need to be labelled with, um, yeah, psychosis.**
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

Here, the practitioner suggests that opting for outpatient care of some kind could better serve the individual in order to avoid the 'mental healthcare user' label.

While practitioners generally gave attention to *avoiding* stigma in decision-making, it's worth noting that several practitioners reported that *other* healthcare providers held stigmatizing views which in turn impacted admissions decisions. In this way, avoiding *or entrenching* stigma operated as a consideration in practitioners' decision-making. Critically, avoiding (or entrenching) stigma was rarely the main driver of decision-making; practitioners were simply attentive to the potential consequence of labelling an individual through an admissions decision, or lambasted others for being all too willing to ignore that consequence.

6.2.4. Indexing 'need' for admission to the individual's baseline

Yet another individual-focused consideration is indexing 'need' for admission to the individual's baseline. While this consideration was not an overriding concern across admissions decisions, many practitioners noted that understanding an individual's baseline was critical to decision-making.

6.2.4.1. Description of the consideration

In indexing 'need' for admission to the individual's baseline, practitioners focus not on symptoms and symptom severity, per se, but on the relative difference between the current presentation and the individual's (known or reported) baseline presentation in some cases:

> **So, if I know-- if I know a patient and I know that when they were discharged they were psychotic, 'cause some people have these delusions at baseline that we can't get rid of**. And if I saw that patient again, either in my clinic or in the outpatient-- or, sorry, inpatient emergency department and I can tell that, okay, they're kind of the same as

> previously, or they're a bit better, **then I probably wouldn't admit them**. So [familiarity with the patient] could influence [decision-making] in that way.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

Indexing 'need' for admission to the individual's baseline was seen as a helpful in two ways in practitioners' accounts. Firstly, having a sense of the individual's baseline can allow for a more accurate assessment. Secondly, having a sense of the individual's baseline can operate as justification for admission in order to 'restore' that baseline. Speaking about a known mental healthcare user who had returned to hospital, one practitioner elaborated on both points:

> Um, and… yeah, I mean… seeing him then in casualty, you're sort of, like-- obviously know, like-- he's a resistant schizophrenic, so **he sort of has a baseline of psy-- of psychosis, which I luckily was aware about**. But, um, to me, at that time it was difficult to see now, okay, yes, the relatives are saying he's a problem at home so he needs to come in, and he's not taking his treatment. So that probably. okay, alludes-- or, like-- make us lean towards admission. Um, but I was also like, 'Yo, this guy, actually, like, he's calm, he's cooperative, he's just not making any sense'. **But I remembered this and I remembered his neologisms and stuff, like, I remember, like, his way of talking**. […] **I think if somebody didn't know him, they knew-- like, they would immediately see the way-- like, his thought form, his thought processes are completely deranged, and, like, the words he's using it doesn't make sense**. Um, but, when I was with him in the ward he did-- he would sit and make eye contact with me and sometimes repeat what I tell-- what I ask him or whatever. But he would never be, um, poorly kept, he would never, like, mess himself, or, like, he would be… bit more cooperative and so on. Whereas, when he came in again, I-- **I knew, sort of, what his baseline was, so I wouldn't immediately jump to conclusions just hearing him talk**. But seeing him, um, actually not, like, acknowledging people around him even, seeing him, like, being so messy and seeing him, like, completely non-orientated or anything, pointed me towards 'Okay, he's worse than before'. So at least, even though he's [treatment-] resistant, even though he's sometimes not gonna make sense, he-- this time, now, **maybe we can get back to that baseline. That was, sort of, my idea**-- (*M: Yeah, okay*.) Knowledge as to, like, yes, we can probably-- **he probably needs admission and we, sort of, can aim to at least get to that baseline again.**
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

Here, indexing to baseline ensured, from this practitioner's perspective, that the admissions decision was not an over-reaction (i.e. justified only by the

individual's baseline symptoms) but also that the admission was able to attend to the individual's demonstrable need relative to their baseline.

Indexing 'need' for admission to the individual's reported baseline also proved critical to decision-making for first-time presentations, as practitioners would rely on the family's report on how the individual 'usually' behaves to understand whether the current symptoms are, indeed, a departure from the individual's usual context:

> I mean, so, you know everything from… I mean it's-- if some people are really unintelligent, [*chuckle*] you need to know that! So how far did they get with school? But, you know, it's everything from, like, 'How well were they functioning before they came in?' […] Um… **so it's about everything, from about, like, what is their baseline functioning like, when did that change?**
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

6.2.4.2. Force of the consideration in decision-making

In many cases, indexing 'need' for admission to an individual's baseline was a key consideration in practitioners' decision-making. Here, practitioners moved beyond the legal criteria prescribed in the MHCA 2002 to ensure that their admissions decisions were adequately contextualized to the individual's specific need (at least as determined from the practitioner's perspective).

That said, indexing to baseline does not always override a clear rationale to admit. If an individual is ill enough to warrant admission outright, practitioners did not waste time checking medical records. That said, for admissions that are less

'clear-cut', practitioners relied on their own knowledge of the individual's baseline or their reported baseline in medical records (or from family) to justify their decision. Most notably, then, while a significant departure from known or reported baseline was sufficient to justify admission, having high symptom severity at baseline was not. That is, if current symptoms, no matter how severe, were more or less comparable to the baseline presentation, then the individual would not be admitted:

> Like, there've been some patients that come in, sort of, repeatedly, um… and we always look through the folder just to see, you know, what is the previous presentation, when last were they admitted. (*M: Yeah*.) Um, and then just get the history from the family again, why are they here. (*M: Right.*) **Um… and, I mean, we always-- 'cause sometimes these patients are actually at their baseline and, um, they don't need admission really**. So, we do have to make those types of decisions with the patients that are very well-known.
>
> Community service medical officer, regional hospital [C], urban, Western Cape (19)

6.2.5. Summary

Each of these individual-focused considerations held at least some weight in at least some cases of decision-making, per practitioners' accounts. In their explanations of how these considerations factored into decision-making, as illustrated, practitioners suggested that their aim was to attend to the particular individual in front of them—practitioners tailor their applications and understandings of individual-focused considerations to make admissions decisions.

In tailoring their assessment to the individual (whether by refining specific legal criteria or by moving beyond the realm of legal criteria), practitioners seek to

ensure that they understand the individual's context and are making the decision to admit with respect to that context:

> I mean… deciding to admit someone… eh-- [*pause*] Sometimes you will worry about, maybe their work or whatever, but then also you think that… if they are not well, then they won't be performing well at work. […] usually people will say, 'I'm going to lose my job, there's no one that's going to watch my kids'… and things like that. So… That's when you must look at the risk. So you being at home with the kids, think… that's worse than the kids going to the granny, or… you know? (*M: Right*.) So-- it-- it-- so… **I think it just speaks to how we see patients as a whole. So, the patient is not just a mental illness but it's a mother, you know, of a… young child, and stuff like that… so that speaks to how you would manage the patient.**
>
> Psychiatrist, tertiary hospital [A], urban, KwaZulu-Natal (1)

Here, the practitioner describes an assessment not just of *symptoms*, but also of the individual's broader social context. The practitioners suggests that this 'contextualized' information would be used to guide decision-making (however reasonable or problematic that 'contextualization' may be).

Critically, each of these individual-focused considerations can only be meaningfully incorporated into decision-making when *direct* information is available. That is, practitioners rely on some sort of 'direct' information source[49] (e.g. conversations with the individual, their family members or other supporters, medical records, or consultation with colleagues) to allow these individual-focused considerations to enter into the decision-making calculus in any way.

[49]Recognizing, of course, that this 'direct' information may be at best imperfect and at worst untrue (as discussed in Chapter 5).

As discussed in Chapter 5, depending on the pathway to decision-making—whether the family can be contacted, whether the individual was sedated—this information may be unavailable. Of course, in other cases, e.g. if the police brought the individual in for assessment, these kinds of individual-focused considerations may never come near practitioners' decision-making calculus (not only because of the lack of direct information, but also because practitioners noted that being brought to hospital by the police almost always lead to an involuntary admission). That said, when direct information is available, practitioners sought to weigh up these individual-focused considerations to guide decision-making.

6.3. Family-focused considerations in decision-making

In addition to individual-focused considerations, practitioners also incorporated family-focused considerations in decision-making. Here, practitioners juggled the role of the family in supporting individuals with mental illnesses, and ultimately took a stand on the place of the family as part of the healthcare system. Practitioners' accounts of incorporating family-focused considerations highlighted the ways in which the mental healthcare system in South Africa relies on families to care for and support mental healthcare users. Like individual-focused considerations, family-focused considerations are information-dependent—practitioners can only adequately incorporate family-focused considerations if direct information is available. These family-focused considerations rely on more than just practitioners' knowledge *that* the family has brought the individual in for

assessment (a form of substitute information gleaned from a prior 'micro-decision', as explored in Chapter 5).

Within this broad subtheme of family-focused considerations, four considerations were especially prominent:

1) Assessing the availability of family support (Section 6.3.1),
2) Keeping the family 'on board' (Section 6.3.2),
3) Handing over responsibility to the family (Section 6.3.3), and
4) Gauging trustworthiness (Section 6.3.4).

6.3.1. Assessing the availability of family support

A key family-focused consideration in practitioners' accounts of decision-making is assessing the availability of family support. Though this consideration is not represented in legal criteria pertaining to involuntary admission, practitioners reported that the availability of family support considerably influenced their admissions decisions.

6.3.1.1. Description of the consideration

Practitioners routinely reported that the availability of family support is a key consideration in decision-making:

> (*M: Yeah, what are the things that you would consider about the situation, or the context, when you're making an admissions decision?*) **Okay. I mean, definitely-- I mean, besides the actual diagnosis, besides the patient being, like, acutely psychotic or whatever, um… probably their family situation**. […] A young girl, for example. And she… is suicidal, and you think, maybe she's got some depressive features, or whatever, but she-- she says that she-- she says that she's not suicidal anymore. And she's got a good support system. Like, you'd feel-- you'd feel okay to send somebody home like that, you know? But if she's-- **if there's nobody there with her, and she's going to take a**

> **taxi to go back home, then you would probably reconsider that situation. But definitely family support.**
>
> Casualty officer, district hospital [I], urban, Western Cape (13)

> […] If there's a patient that comes in, and they are high risk, for example high risk for suicide, but they have a father or a mother who says, 'I will watch this child like a hawk', you know 'and take them to the clinic tomorrow', then I will discharge them home. If there is no one at home, if they live alone, for example, I would have more of a reason to want to admit them. So, basically, if they have a supportive family-- and you can tell that quite early on, either they show up with the patient and be very willing to give collateral. Um, you can tell very early on. **So, if they're willing to take care of the patient, even if the patient is psychotic but not disruptive, and the family can… sort of, um, manage them for a day or two, I'm happy to discharge them home. But like I said, if there's no-one, if the family is unreliable, you've gotta admit them**.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

6.3.1.2. Force of the consideration in decision-making

As suggested in the above quotes, practitioners' admissions decisions were influenced by the availability of family support, such that individuals with*out* family support were more likely to be admitted:

> So… sometimes, the patients, actually… because of their condition and their years of, um, mental illness and stuff, have like, kind of estranged relationships with their families and stuff… (*M: Sure*.) So you also can look at social support… (*M: Okay*.) Um… So, like, if this patient goes home or whatever, who is going to supervise them, who is going to bring them back, are they going to, um… be safe? So… **somebody that ha-- doesn't have any of that would be more likely to be admitted, as well.**
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (2)

Conversely, then, practitioners reported that they were generally *less* likely to admit an individual with good support at home. Noted one practitioner:

> Um, alternatively, like sometimes you know, it-- it's a long-term patient, you know your patient, you know the threats, you know when they will make right of those threats and not-- [*chuckle*] (*M: Yeah!*) Um, there has been one or two times where-- where I've discharged back to the next of kin-- (*M: Okay*.) Um, and almost had very frequent follow-ups. (*M: Okay*.) **You know, where they have a good support structure, somebody at**

> **home all the time, somebody watching them all the time**. And had very frequent um, uh, follow-up appointments.
>
> Clinical psychologist, district hospital [B], urban, KwaZulu-Natal (5)

This practitioner is speaking about making an admissions decision for an individual with suicidal ideation, and notes that their decision *not* to admit is influenced by the availability of a 'good support structure' at home. In many cases, meeting a specified legal criterion (in this case, risk of harm to self) for involuntary admission was not sufficient to warrant admission, especially where family support was available.

6.3.2. Keeping the family 'on board'

Another family-focused consideration per practitioners' accounts of decision-making is keeping the family 'on board'. Here, practitioners considered the longer-term effects of a short-term admission with respect to keeping the *family* engaged in the individual's care.

6.3.2.1. Description of the consideration

Primarily, keeping the family 'on board' centred on respite admissions. In these cases, practitioners made admissions decisions to 'give the family a break', especially in the interest of ensuring that the family would be willing to support the individual longer-term:

> (*M: On-- on those repeat, kind of, instances [repeat admissions], what do you see as-- as being the purpose of the admission in that-- in that case? How do*

> *you... yeah, how do you conceptualize that?*) Well, once again it's only if they've been very aggressive and they're not taking meds. (*M: Okay*.) **So my job <u>there</u> is to just keep the family safe--** (*M: Yeah*.) **Often to keep them on board, that they'll take this person [*chuckle*] when I want to discharge them--** (*M: Yeah*.) And… reinitiate medication.
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

Because the family was seen as a partner in providing care in many cases, especially given the implicit role of the family in the admissions process and broader ethos of mental healthcare provision in South Africa[50], this idea of 'keeping the family on board' was incorporated into some admissions decisions, per practitioners' accounts:

> **Sometimes we do do compassionate admissions--** (*M: Okay.*) Like, say, like… you can see that there's a daughter who's got three kids, mother's got dementia, she hasn't slept in days, everything is frustrating for her, so then you just, basically… 'cause… **you just take the load off of her, for that week or two, try to sort out her life, and actually, um… then she can come fetch her mother when everything is fine**, and then try to get her controlled on medication at that point in time and then, um, send her home after that, because, like, things like dementia, patients will be up and down all the time, there's no treatment for it, you know, so, **but sometimes you actually need to be compassionate about how… um, you-- you deal with certain situations…**
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (3)

6.3.2.2. Force of the consideration in decision-making

In many instances, practitioners relied on the family by ensuring that the family was able and willing to carry on with caring for the individual in the long-term. Some practitioners expressed sympathy for the families, especially given the extent to which the system relies on families to provide care. As such,

[50] For further discussion of family caregivers' perceptions, see Mokgothu et al. (2015) and Mokwena and Ngoveni (2020).

practitioners reported admitting individuals at least in part because of that sympathy:

> Yes, so… you know… sometimes… the-- the family's-- and-- and I completely understand, I think the-- the-- sometimes, the- the-- **the, kind of, burden of taking care of a patient with a mental illness is… it's a difficult thing to do**, um… so-- so… **I'm not always very harsh with family members**. [*chuckle*] […] So sometimes it might be a patient who-- I can see the patient-- the patient is psychotic, but they're not aggressive. You know, they're, kind of, willing to take medication, um… but-- but the family-- **I can see that the family is not coping. Then, you know, it's not-- I don't see that's wrong to admit the patient 'cause they are actually unwell**, they are [muffled] and they-- you know, it's-- **it's not gonna be bad for them to be in hospital** but, if the family was willing to look after them at home, then that is potentially someone we would-- if there was lots of bed pressure, you know, that's [muffled] one that I would-- would not admit.
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

However, other practitioners suggested that the role of the service was *not* to offer respite admissions. In fact, while some practitioners' accounts of decision-making highlighted their attempts to use the mental healthcare system—and involuntary admission specifically—as a bandage for other social issues, other practitioners' accounts of decision-making were much more judicious about the scope of the mental healthcare system (especially among specialist practitioners). While some practitioners were persuaded by the need to offer respite admissions in some cases, especially with an eye toward securing the family's engagement with longer-term care, others felt that, especially in cases of drug use, families needed to take *more* responsibility for care.

6.3.3. Handing over responsibility to the family

Another family-focused consideration practitioners cited is handing over responsibility (of care) to the family. In weighing up this consideration, practitioners either opined on the specific responsibilities that families should take on in caring for a family member living with mental illness, or took a stand on the limits of what the mental healthcare system can be expected to provide.

6.3.3.1. Description of the consideration

Many practitioners felt that, in some very specific cases, family responsibility needed to be factored into decision-making. For example, one clinical psychologist told the story of an outlier case in which the individual was constantly being involuntarily readmitted to hospital:

> Um, and, you know, it-- it makes me angry because I feel like, to a certain degree, um, the parents are enablers, you know. […] Um… he's-- he's-- he's… he's there at least every third or fourth month-- (*M: [sigh]*) So I would expect that, even though he is a-- twenty-- twenty-one-- (*M: Yeah*.) With somebody of that nature, I would expect that parents would, even now, sort of, introduce some sort of behaviour modification… I know it sounds ridiculous for an adult, but, um, rehab facilities have not worked-- (*M: Okay*.) […] And we've reached the point where, you know, even though he's an adult, and one would expect him to eventually come to the party, um, **we've ultimately handed over responsibility to the parents, because I feel like that's probably the only people that have some sort of leverage**, that can say, 'Listen, if you don't do this, then we're taking away that,' or… (*M: Yeah*.) Or, you know, that-- but, we just can't seem to buy them in.
>
> Clinical psychologist, district hospital [B], urban, KwaZulu-Natal (5)

Similarly, another practitioner worried that over-admitting individuals ran the risk of alleviating the family of their responsibility to care for the individual entirely:

> And a lot of the times, you know, the family took this… They just weren't bothered, you know? And I don't know, you try to get social workers involved,

> and families aren't interested in these kinds of people. **And at the end of the day, the more we admitted the patient, it felt like we took away the family's responsibility**. So sometimes you just have to make the call, and be like, 'Look, we're not admitting this patient. We know why the patient has psychosis. We've extensively investigated him many times. He's came here-- he's been admitted four times during the year. Um, and we're not going to admit the patient', you know?
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

Other practitioners did not necessarily argue that the family should take on *more* responsibility, but were clear that the mental healthcare system should *not* take responsibility for certain kinds of individuals brought to hospital for assessment:

> But I'll say, "Look, you have brought the patient in three times this year. Uh, he only stays the day because often he's apsychotic [*sic*]-- he's not ..." you know, "he's not behaviourally disturbed the next day." (*M: Yeah*.) Um… "It's-- it's quite obvious he's tested positive for substances. On each admission, he re-- his intoxication resolves, um… but we-- **we are short of resources here. This is not the kind of work that we do. It's not respite so my-- my advice to you is if-- if someone is behaving badly in the context of intoxication like this, then, you know, you-- you're probably better calling the police**."
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

6.3.3.2. Force of the consideration in decision-making

In handing over responsibility to the family (whether because practitioners perceived the particular kind of care needed to be the family's responsibility, or because practitioners perceived the particular kind of care needed *not* to be the mental healthcare system's responsibility), practitioners were often implicitly commenting on what the service intends to offer or what the service has *capacity* to offer. Several practitioners suggested that, regardless of their own opinion on the role of the family in providing care, the system itself is not built to provide certain kinds of services, especially with an eye toward long-term management of mental healthcare users. In these cases, then, practitioners would therefore *not*

admit the individual involuntarily, as illustrated in Section 6.3.3.1 (page 241). Importantly, whether or not practitioners suggested that the *family should* take responsibility for a particular kind of care, or whether the *service should not* take responsibility for a particular kind of care, the outcome is the same: the family de facto becomes responsible for care of the individual.

6.3.4. Gauging trustworthiness

Yet another family-focused consideration is gauging trustworthiness. Several practitioners noted that, in some cases, family members would lie to try to get their family member admitted to hospital.

6.3.4.1. Description of the consideration

Some individuals are brought in by family members who are lying about the individual's behaviour in the hopes of securing admission for at least 72 hours:

> **Sometimes you have to distinguish, is the family trying to just get rid of the patient, you know, because they don't like dealing with the patient or is the family actually telling the truth**. We have a lot of those patients who are called revolving-door patients that just come in and out, like they're there regularly. So, **sometimes their families just don't like dealing with them because their behaviour is just not very cooperative**. **Even though they may be taking their treatment, their psychiatric symptoms are controlled, but their behaviour is just not cooperative with family to deal with**. So, you know, they're moody and irritable towards their family, so then sometimes their family will just dump them at the hospital and be like, no, they don't want this patient and they don't want to take care of him.
>
> Community service medical officer, district hospital [F], rural, Western Cape (10)

Another practitioner referred to this practice as the 'Friday night drop-off', as noted in Chapter 5.

6.3.4.2. Force of the consideration in decision-making

While practitioners were, in many cases, wary of the possibility that family members were lying about why an individual required involuntary admission, many also conceded that they would still give the family—as opposed to the individual being assessed—the benefit of the doubt (as discussed in Chapter 5). Though practitioners expressed concern that the family might not be trustworthy, and specifically noted that gauging trustworthiness is a key consideration in decision-making in some cases, the force of this consideration rarely resulted in non-admission. Also, because practitioners have to assess the veracity of any information given to them quickly (and often while managing a number of other individuals in the emergency centre), practitioners' accounts of decision-making revealed a general assumption that the information provided to them was true. In their retellings of cases where the family's story was untrue, practitioners suggested that, in the vast majority of cases, they only realized that the story was untrue *after* the individual had been involuntarily admitted (on the basis of that false information).

6.3.5. Summary

Each of these family-focused considerations held at least some weight in at least some cases of decision-making, per practitioners' accounts. In some specific instances, these family-focused considerations drew their force from the belief that the family is or should be the locus of care for individuals living with mental

illnesses.[51] However, this belief was sometimes modified by other factors. For example, practitioners worried about the tension between keeping the family on board and handing over responsibility to the family:

> But, you know, i-- **sometimes we-- we-- we get family members who… don't want to take any responsibility, um, and that gets difficult**. We then have to fight with the family and say, 'Look, we can only keep the patient here while there is, um, grounds for involuntary admission. We can't keep the patient here to make sure that they're taking their medication or to prevent them from using substances, that's where the family has to help'. **Um, but obviously, you know, if the family-- if I-- if I… get the feeling that, you know, this patient is very ill and the family is overwhelmed and they, kind of… you know, they just-- [*sigh*] they just need a break for a few days, then-- then I'd be-- you know, I-- I get that**. So I'll admit the patient, um… [*chuckle*] until the family is feeling a bit more ready for the patient to come home, obviously if the patient is unwell.
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

In this account, the practitioner is weighing two key considerations *within* the broader category of family-focused considerations. Their decision seeks to be sensitive to the family's responsibility—and need to *take* responsibility—while also recognizing that, if the family *is* overwhelmed, then admission might be valuable in the long-run by offering the family a "break for a few days".

While these kinds of deliberations were reported by some practitioners, highlighting, for example, tensions between keeping the family on board (Section 6.3.2) and handing over responsibility to the family (Section 6.3.3), most accounts of incorporating family-focused considerations focused on something else entirely. The importance of these family-focused considerations in practitioners'

[51]Interestingly, versions of this point come up a lot in broader discussions of how mental healthcare should be provided in 'non-Western' settings, i.e. the settings where global mental health, as a field, tends to focus its efforts, as part of arguments about service delivery in more 'communal' as opposed to 'individualistic' societies.

accounts was often *not* about the role of the family in providing care, but rather about the need to manage resource constraints:

> So, we put a lot of pressure and responsibility on the families, because we didn't have the facilities to actually look after them [the patients].
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

That is, in many cases, as demonstrated in Section 6.3.1 (page 236), practitioners chose not to admit an individual who would otherwise be considered for admission *because* the family was available to care for the individual. Practitioners' incorporation of family-focused considerations, especially in assessing the availability of family support, aimed to avoid admission (and thus strain on available resources) in some cases.

6.4. Resource-focused considerations in decision-making

In addition to individual- and family-focused considerations, practitioners also weigh up the force of resource-focused considerations in decision-making. By incorporating resource-focused considerations, practitioners serve as not just care providers but also stewards or protectors of the system itself, including its resource constraints. Unlike individual- and family-focused considerations, these resource-focused considerations were not subject to the provision of 'direct' information *about the individual or their context*; rather, practitioners assumed knowledge of resource-focused considerations at the point of decision-making, regardless of how much direct information was available to guide the decision.

That is, practitioners perceived resource-focused considerations to be information-*independent*, and therefore not influenced in any way by the outcomes of prior micro-decisions along the various pathways to the final decision to admit.

Within this broad subtheme of resource-focused considerations, three considerations were especially prominent:

1) Negotiating the bed crisis (Section 6.4.1),
2) Justifying the use of a rare resource (Section 6.4.2), and
3) Offering the possibility of referral (Section 6.4.3).

6.4.1. Negotiating the bed crisis

The primary resource-focused consideration in practitioners' accounts of decision-making is negotiating the bed crisis. Per practitioners' accounts, the simple fact that beds were not always available played a role in decision-making. However, the force of this consideration differed in urban hospital settings as compared to rural hospital settings (as explored in Section 6.4.1.2).

6.4.1.1. Description of the consideration

Practitioners working in urban settings were clear that 'bed pressure' was a key consideration in decision-making, and that non-admissions (or 'crisis discharges') were regularly made with respect to negotiating the bed crisis:

> So, sometimes if you-- if I come on the ward and I know that this-- there are-- there are no beds. (*M: Yeah*.) There's, like, three waiting for beds. This patient's not so sick, could probably manage if we just re-initiate treatment, so sometimes that comes into play. [...] **Even though they may benefit from an inpatient admission, and you're like, if the ward's really full, I'm actually on-- on that count, I'm gonna discharge, yeah.**

Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

> […] Another factor that we have to weigh up, um, when it comes to 'do we admit or do we not admit', um, unfortunately is also, you know, bed pressure. **So-- so, very often we'll be very, very pressed for beds, um, and then we would-- we probably discharge people who we would-- or we'd probably treat people as… as outpatients who we would usually, kind of, admit to the ward.** But that's kind of a-- you know, just distribution of resources thing. So, um… and if we do have lots of beds, then… we, kind of, you know, we have beds, so we can admit someone… who other times we would feel more pressed to-- to discharge.
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

The COVID-19 pandemic also impacted bed availability. Noted one practitioner:

> **And there was a time, especially during the COVID pandemic, where we had political pressure to keep the beds at a minimal. I have-- I was forced to only keep four or five patients, you know? So you are definitely making decisions to not admit patients who should be admitted**. But the whole healthcare system was saturated with COVID suspects, and this, and that. So there were definitely some patients that you were supposed to admit, but you couldn't. And all we could do medically was write on the file: 'no bed space due to COVID'.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

Most practitioners[52] commented on bed availability as a key consideration in decision-making, and one that ultimately worked to alter the force of other considerations in decision-making:

> Um, so, **if I know that there're no beds available, my threshold for admission goes higher**. So I will only admit if you really need to be admitted, for example.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

[52]The code "Managing resource constraints | citing resource constraints in decision-making" includes quotes from 17 of the 20 practitioner interviews.

6.4.1.2. Force of the consideration in decision-making

Practitioners did indicate that certain considerations, specifically related to risk of physical harm (as represented in core legal criteria)—aggression and suicidality—would supersede any worry about resources. However, for an individual whose symptoms fell outside of that narrow range, weighing up space in the hospital was of top concern in practitioners' decision-making.

In some cases, practitioners reported that having *more* beds available increased their likelihood of admitting. Describing their experience working at a different hospital, one practitioner noted:

> So, the hospital that I work in, i-- **we don't have that many beds available for psychiatry patients. So we have quite a-- a high threshold for admission**. Um… so, with that, I need to-- when I'm-- when I'm admitting the patient, I need to make sure that the patient needs to be admitted. Um… if they can be managed at a clinic as an outpatient, they-- they-- they should go home. […] When I was a medical officer in psychiatry, I would really struggle and **I'd admit everyone, because, um, I was working in a much bigger hospital with beds, like, lots of beds**, and we-- like, our consultants would say, 'If you're unsure, rather admit, so we can discharge in the morning.' Um… but, now, because I'm at the end of my second year, I can… kind of see the patients and I know which ones to admit and which ones to discharge. I think, sort of, that comes with experience. **As well, it's also knowing the facility that you work at, and whether or not you have beds available or not.**
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

This practitioner is making two points: firstly, because there were more beds available at the hospital where they previously worked as a medical officer in psychiatry, they were able to admit individuals even if they were unsure whether admission was necessary. Secondly, because this practitioner was less experienced in their former role as a medical officer in psychiatry, they were more likely to admit individuals across the board, where now, two years into psychiatry

training *and* with far fewer beds, this practitioner felt much more able to determine who 'needs' admission.

Another practitioner spoke directly to this point by contrasting their practice during internship in an urban area to their practice during their community service year in a rural hospital:

> And then another factor is that generally, your approach to admissions in general, not just psychiatry, are very, very different [in urban versus rural areas]. Okay? **Because you don't-- we didn't have a scarcity of beds.** Okay? **So there was never really that issue**. […] Like, so your whole process to admitting is really different, **whereas you are so strict with admissions where I was working in these busy [urban] hospitals**. Like, if you're not, like, dead and dying-- like, you had to. You had to be like, 'Who needs the bed more?' We had patients waiting for beds, lying in the passages-- like, we used to have, in our casualties, many ward rounds while we were doing that. And that included psych patients.
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

This practitioner is noting that, when practicing in a rural setting, where more beds tend to be more available, the bed crisis is less present as a key consideration. However, in urban areas, where beds are scarce, decision-making for involuntary admission was sensitive to bed availability. In several instances, an individual who might have otherwise been admitted involuntarily was *not* admitted, despite meeting the legal criteria for admission, as practitioners navigated the bed crisis.

6.4.2. Justifying the use of a rare resource

Another key resource-focused consideration, which follows on from navigating the bed crisis, is justifying the use of a rare resource—inpatient beds. In incorporating this consideration in decision-making, practitioners are not only attending to resource constraints (perceived or actual), but also operating from their own perspective on who is or is not 'deserving' of admission in a particular case.

6.4.2.1. Description of the consideration in decision-making

Justifying the use of a rare resource was a key consideration in several practitioners' accounts of decision-making for involuntary admission:

> So… for me the most important thing is do-- **do you warrant the use of this very rare resource**. And you don't even have to be particularly mentally unwell. Like some people with very severe symptoms… (*M: Mm*.) I will not admit, because they're not aggressive, they're gonna take their pills and their families are with them.
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

This practitioner suggests that, in some cases, even consideration of the severity of illness can be overshadowed by resource limitations. This quote also demonstrates the way in which family-focused considerations can be incorporated to manage resource-focused considerations.

Conversely, several practitioners expressed their dissatisfaction with individuals who use drugs and become 'revolving door' admissions:

> And there's this idiot, like fif-- 16-year-old, that you saw last week, that is now coming in. I mean, it's-- **it's taxing**. (*M: Yeah. And when you say 'taxing', you mean, like, on you, as the admitting officer?*) Yes, but I mean, also on the-- **on the system, the health system.**
>
> Casualty officer, district hospital [I], urban, Western Cape (13)

Some practitioners felt that known mental healthcare users, especially those with co-morbid substance use (or with substance use-induced psychosis), who were routinely brought to hospital were 'wasting' resources by taking up bed space:

> Sometimes I might say, "Okay, I know this guy. He comes in with recurrent intoxications," and what I will also do is I will look at his discharges. So say his last three discharges have been like, "Admitted but-- but it was an intoxication, he resolved within 24 hours". **It's a waste of resources admitting him. So what I will do is I won't admit him to the ward that night.** (*M: Okay*.) I'll keep him there [in casualty], wake up-- he'll wake up, I'll go see him the next morning. We sedate him often… often the next morning they're like, orientated, no hallucinating, you know, they're off [muffled] you know, the-- they're not high any longer, they're not intoxicated. (*M: Right. Right*.) You know, they, yeah, and then, so then I'll be like, "Okay, yeah, n-- not-- not for admission, discharge," yeah? […] It's a lot of comorbid substance use, and sometimes-- often patients are-- fare a bit better-- (*M: Okay*.) Then, uh-- you know, within two days when they're in the absence of substances, assuming they've got the other medication, th-- their depot or whatever, yeah.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (20)

This practitioner's account also points to the prominence of substance use-induced psychosis in the mental healthcare system. Several practitioners commented that a considerable portion of the mental healthcare system—specifically for involuntary admissions—caters toward substance use-induced psychosis. Some practitioners felt that admitting individuals recurrently, specifically those individuals with substance use-induced psychosis, might also constitute a waste of resources:

> (*M: Can you tell me-- you've mentioned a few examples, but can you tell me about a time, if any, that a patient was considered for inpatient admission, but ultimately you chose not to admit?*) Um… [*pause*] Yeah… [*sigh*] It was-- it was probably more of your substance-induced psychosis patients. Who generally, if it wasn't for the substance-induced part, I would probably admit. **But because they came for the fifth or sixth time, I was just like, 'What are we doing, actually?'**

Community service medical officer, district hospital [E], rural, Limpopo (9)

6.4.2.2. Force of the consideration in decision-making

Practitioners' perspectives on whose admission 'warrants' or 'wastes' resources played a role in some admissions decisions. That is, justifying the use of a rare resource, though not a constant consideration across cases, carried some weight in decision-making, especially when practitioners felt that a particular admission might constitute a 'waste' of resources. In some cases, practitioners' determinations of which admissions were wasteful had roots in (stigmatizing) views of substance use (because individuals with comorbid substance use or substance use-induced psychosis were perceived to be 'wasting' resources in some cases). However, this perspective was also sensitive to the availability of other services, e.g. rehabilitation services, and practitioners were attentive to the ways that resource constraints within the broader health and social care systems influenced their determination of whether or not a specific admission constituted a justifiable use of a rare resource (to be explored further in Section 6.4.3.1).

6.4.3. Offering the possibility of referral

Another key resource-focused consideration was offering the possibility of referral (beyond the initial admission). Here, practitioners sought to ensure that their admissions decisions were sensitive to resource constraints not only within the particular hospital or ward, but across the wider health and social care system.

6.4.3.1. Description of the consideration

The practitioner's account of decision-making for an individual with substance use-induced psychosis, quoted in Section 6.4.2.1 (page 251), leads on to consideration of offering the possibility of referral:

> […] And I mean it's not to say that if-- if say, this guy is back for the second time, it's not to say that I won't admit him. I definitely will admit him in that particular case. It's those that are coming for the seventh time. Yeah? I mean I'm going to treat him, he's going to come back because he's smoking weed, and the family doesn't care about the guy. And the social worker's exhausted every kind of possible option. **You know, at the end of the day, sometimes you've got to realise where the system is failing. Because we're definitely failing him. Because we're not providing the option of a rehabilitation centre, you know?** (*M: Sure, okay*.) There used to be one, and apparently it wasn't functional.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

Here, the practitioner express a critical challenge in justifying recurrent admissions: resource constraints within the system *at large* mean that an acute involuntary admission does not necessarily provide the kind of care that is needed in this particular case. That is, even if the practitioner admits this individual for the 72-hour assessment period, there is no possibility of referring the individual on for further care, which contributed to the practitioner's decision-making process, at least in this case.

Other practitioners also lamented the lack of support for individuals, especially individual who use substances, in health and social care systems, implying that the lack of 'outside support' can compromise the individual's health outcomes:

> […] **It's not so much the resources in the hospital facility, it's more the community resources that are lacking, like the social support for families who are affected**. The, you know, the other social support systems, like dealing with drugs being a big issue

> among people with psychiatric illnesses. […] And I think that is really lacking in our country as a whole, um, from what I've seen in my work, it's-- it's more the outside support that's-- that's really lacking. **'Cause we can do our best in the facility, but once you send the patient out of the doors, like, they go back to that same setting**. And it's very difficult for them to change their lives when they have to go back to the same place that they came from.
>
> Community service medical officer, district hospital [F], rural, Western Cape (10)

Similarly, practitioners were sensitive to the limited possibilities for referral, especially in rural settings:

> **But now the issue was the hospitals we'd wanna refer to were always full**, because they have to serve such a great-- um, such a large state, and they're the only hospitals available. And even within these hospitals, I think there was only about one specialist psychia-- psychiatrist in the entire province. […] **And-- and in most cases we didn't even refer. So, we had to weigh up the, you know, the risks and benefits. For example, if a patient was still psychotic, we pretty much had to assess exactly whether their psychosis would cause harm to them or their families**. If not, then we would maybe try to speak to the family members to see if they would be able to handle um-- um, [*muffled*] from home.
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

Though this practitioner is referring to how decisions are made at the *end* of the 72-hour assessment period, offering the possibility of referral played into some practitioners' decision-making processes from the start of the admissions process, especially for individuals who were known mental healthcare users and especially in rural settings.

6.4.3.2. Force of the consideration in decision-making

Broadly, practitioners reported that the possibility of referral is limited across the system in general, regardless of whether practitioners were working rurally or in an urban hospital setting with much greater proximity to specialized psychiatric

hospitals. Several practitioners noted that only a small percentage of inpatients would be transferred on to a specialized psychiatric hospital, with reported estimates ranging from zero or one per year in some rural settings, to close to 40% of inpatients in some urban settings. While offering the possibility of referral influenced decision-making more so at the end of the 72-hour assessment period, admissions decisions for known mental healthcare users, especially known mental healthcare users for whom referral services were unavailable (either because the service simply does not exist or because the referral service had too few resources to provide needed care) were also influenced by this consideration. Moreover, because the waiting period for referral to a specialist psychiatric hospital was so long in many cases, some practitioners reported that symptoms would actually resolve while waiting to be transferred:

> Yeah, so, after 72 hours, then we-- if the patient requires further admission, then we will go through the process of trying to find them, um, a place in a specialised psychiatric hospital. So, in our region, there are two-- two-- three psychiatric facilities, basically draining the patients from the whole Western Cape. **So, that's quite a lot of patients, so they end up being on a waiting list**. Um… so the waiting list can be from a few weeks before the patient gets a place in that facility-- (*M: Right*.) Um, which is quite a challenge, **because then we end up keeping those patients until such a time that they actually have, um, they reached a state where they can be discharged home before they even get sent to the psychiatric facility.**
>
> Community service medical officer, district hospital [F], rural, Western Cape (10)

One practitioner also noted that the process of intake from the perspective of a specialist hospital was more focused on clearing space in the crowded urban hospitals than the sparsely populated rural hospitals. Speaking about their experience working in a different role—visiting district hospitals to determine which admitted individuals should be referred up to a specialized psychiatric hospital—one practitioner noted:

> (*M: And does that-- in your prior job, where you were doing a lot of driving, did you see a difference there, in terms of how people referred? Like, does it matter how far away people are from the specialist hospital, or…?*) [*pause*] Um… Ooh… Does that make a-- did that make a difference… For once, yes, because all of those smaller hospitals, um, they don't have the patient numbers, um, that the-- the metro district hospitals have. So, they'd definitely be-- um, **the specialist hospitals would rather take patients from the busy, metro hospitals than the two patients, sitting up-- sitting up, you know, 300 km from Cape Town, in one hospital**. Um, but then it can go both ways. I've also been on the other side of the coin, where I've had to do the receiving end. And if I got the sense that the doctor that I'm talking to, actually just don't… know, and I don't trust them… their diagnosis, or their treatment of the patients, then sometimes I would just, like, take that one, just because… yeah.
>
> Psychiatrist, district hospital [H], urban, Western Cape (12)

This practitioner confirms the experiences reported by practitioners working rurally, who indicated that transfer to a specialized hospital was nearly impossible.

Even practitioners working in urban settings described difficulty in getting involuntarily admitted individuals from general hospitals to specialist psychiatric hospitals. Especially in the case of substance use-induced psychosis, and especially for *known* mental healthcare users with substance use-induced psychosis, general practitioners suggested that their decision-making process weighed up the relative 'value' of the admission given the limited scope of the service provided, and recognizing that further referral may not be possible. As one practitioner noted in describing their own interactions with psychiatrists at specialist psychiatric hospitals in their attempts to refer individuals along for care:

> I feel like it's probably the most common thing that psychiatrists say, is **"We are not a rehab facility."**
>
> Casualty officer, district hospital [I], urban, Western Cape (13)

Earlier in the interview, this practitioner acknowledged that a significant proportion of individuals who are involuntarily admitted for the initial 72-hour assessment period are not adequately managed in general hospital settings—in part because the system itself is built toward focusing on short-term management (and not maximizing the possibility of referral):

> I mean, you know, like, from the-- from an emergency point of view, we see-- for example, we'll see a psychotic patient, and we'll make a diagnosis, he's got drug-induced psychosis, and we'll-- and we'll sedate him, and we'll send him-- we'll get a story from his family, and we'll send him to, like, the actual psychiatry department. **And because they're so full, that guy is going to get discharged, maybe before he's actually properly… cured**. […] I-- I want to say there's just, like, a bad cycle, over and over and over again. **So, he's not fully cured, he's sent home with medicine, and then he goes home, he does drugs, comes back to the hospital**. […] I mean, the acute male ward is only supposed to have patients that, um, are there for their 72-hour observation. And then once they-- once they have made a decision about what's happening from there, they're supposed to move to the, um, psychiatric facility**. I mean, there's guys that are staying in the acute care for weeks**. (*M: Right. Right.*) **Yeah, <u>way</u> past their 72 hours. And that's the-- that's the screw up of the facility, that they-- that's the screw up of the public sector…** […] And… and it's just because there are so many patients and not enough healthcare workers.
>
> Casualty officer, district hospital [I], urban, Western Cape (13)

In many cases, then, practitioners were sensitive to the ways in which admission might (or might not) offer the possibility of referral, specifically as a consequence of a lack of resources, including human resources.

6.4.4. Summary

Practitioners' accounts of decision-making emphasized the importance of resource-focused considerations. Practitioners' decisions were influenced in large part by perceived resource limitations within the hospital itself and across the broader health and social care systems. Because practitioners saw inpatient beds

as ‘rare’ resources, their admissions decisions were sensitive to ‘who needs it most’, as demonstrated in Section 6.4.1 (page 247). For example, decision-making was in some cases influenced by practitioners’ perceptions of whether or not a particular admission would constitute a ‘waste’ of resources.

This logic also influenced the general attitude toward *voluntary* patients; self-presenting individuals *asking* to be admitted are rarely considered to be in true ‘need’ or admission, as confirmed by practitioner and advocate interviews. Describing their frustration with the lack of access to care for voluntary patients, one practitioner commented that the mental healthcare system is not well-resourced enough to care for individuals who are actually *asking* for help:

> **Another issue is that the resources and the beds are saturated by people with the least hope, like, the worst prognosis in terms of benefitting from it, okay, from the care**. So the acute psychosis, substance-induced psychosis, where they really just knocked someone out and tried to stab them, who, like-- they are the full-on involuntary admission, I don't have to think twice about it. […] And where it becomes a little iffy is these people who aren't blatantly psychotic, okay? Who aren’t-- who are more likely-- their baseline isn't so poor that they-- that they might really be able to improve their level of functioning, who are more-- less resistant to getting the help. They are saying, ‘I'm not okay. Help me.’ […] And-- and now you really wanna help them, um, but they're going to say […] ‘**If it's voluntary, you're not sick enough to take out a bed**’.
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

While this practitioner was criticizing the idea that voluntary patients should not ‘take up’ a bed, other practitioners actively endorsed it—even suggesting that voluntary patients do not require resource-intensive inpatient care (as discussed in Chapter 5). One advocate commented on this point, as well, reporting that they struggled to convince practitioners to admit them in an instance where they

voluntarily sought care, even though they had been involuntarily admitted previously.

Broadly, practitioners explicitly acknowledged that resource-focused considerations—most often *limitations* in resources—are incorporated in their decision-making process, especially in urban settings where admitted patients may wait for days in casualty until a bed is available on the dedicated psychiatry ward. Conversely, in rural settings, practitioners were less concerned about bed availability, and therefore were less concerned about 'wasting' a bed on an individual who might not need inpatient admission. However, practitioners working rurally were also especially sensitive to resource-focused considerations with respect to offering possibility of referral. In some instances, these practitioners were particularly attentive to the broader resource implications of recurrent admission of an individual for whom the possibility of referral is unavailable, as demonstrated in Section 6.4.3 (page 253).

Overall, then, resource-focused considerations held at least some weight in practitioners' accounts of decision-making. Unlike individual- and family-focused considerations, which can only be incorporated into decision-making when sufficient direct information is available, practitioners did not express concern over a lack of *information* to guide their incorporation of resource-focused considerations in decision-making. Unlike individual- and family-focused considerations, resource-focused considerations were broadly perceived to be

standard across all individuals being assessed. As demonstrated in Section 6.4.1.1 (page 247), resource-focused considerations would sometimes even serve to override individual-focused considerations, as in the case of the practitioner who noted that the same individual might or might not be admitted depending on bed availability. However, resource-focused considerations—despite being taken to be 'known' across all cases—were not necessarily incorporated into *every* decision.

Even though practitioners' applications of resource-focused considerations were, in practice, specific to the individual being assessed (including because of stigmatizing attitudes toward individuals with certain conditions, e.g. comorbid substance use), these resource-focused considerations were generally taken to be information-independent.

6.5. System-focused considerations

In addition to individual-, family-, and resource-focused considerations, practitioners also weigh up system-focused considerations in decision-making. That is, in some cases, practitioners' decisions are sensitive to particular in-built features of the health system itself. By incorporating these considerations, practitioners work to co-opt or work within the bounds of the health system structure. In general, practitioners' descriptions of system-focused considerations stemmed from the fact that all involuntary admissions proceed through general hospitals. While some general hospitals do also have a dedicated psychiatry ward,

with specialist mental healthcare practitioners on staff, limitations in the post-admission pathway and limitations of the general hospital environment itself factored into some decisions, per practitioners' accounts. Two system-focused considerations were especially prominent in practitioners' accounts decision-making:

1. Fast-tracking the provision of specialist care (Section 6.5.1) and
2. Weighing up the benefit of being on the ward (Section 6.5.2).

6.5.1. Fast-tracking the provision of specialist care

Some accounts of decision-making suggested that, depending on the specifics of the hospital setting, practitioners might also take into account the provision of specialist care, and specifically the option of fast-tracking the provision of specialist care *through* admission. Here, practitioners' accounts of decision-making seemed to 'co-opt' the admissions process in certain cases, with attention to limits within the healthcare system, both in terms of its structure and its resource constraints (including human resource constraints).

6.5.1.1. Description of the consideration

Some practitioners' accounts of decision-making take fast-tracking the provision of specialist care into account, especially when admitting through a hospital without a specialist mental healthcare practitioner on staff. In describing their previous experience working at a rural district hospital, one practitioner noted:

> So they-- luckily what they did a-- they've been sending somebody from the psychiatric department, flying them through maybe once every two weeks to come to our hospitals,

> do a round, and so on. So, um, that-- they sort of alleviate-- tried to alleviate with, like, sending somebody to-- to our hospital to come and do a ward round and so on. So if-- if I know-- okay, **so maybe that would have influenced-- like if I knew that doctor was going to come soon, I was like, 'Yeah, let's just admit this patient so that they can see the doctor if they come,' you know?** [*chuckle*] **So that might have actually influenced the admission a bit more**. Um, you want the patient to be there when that doctor is there, but then we always knew that the do-- doctor's gonna come.
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

In light of generally low rates of referral from district hospitals to specialist hospitals, especially in rural hospitals, this practitioner is alluding to the way in which they might 'co-opt' the system to offer some kind of specialist care.

Another practitioner describing their internship experience working at an urban district hospital with specialist mental healthcare practitioners on staff in KwaZulu-Natal recounted how their rationale for admitting worked in this busy hospital setting:

> **And I know that they've got a better chance of receiving treatment, maybe getting lucky enough to see the specialist while they're-- as an inpatient** [in urban district hospital in KwaZulu-Natal]. They're actually getting sorted out. So, like, yeah, I guess from my perspective, **I'm manipulating the system, too, to try and help people**. […] But these, kind of, in-between people who're like, 'I had a suicide attempt. I didn't really want to kill myself, but I'm severely depressed and this is what's going on in my life.' Um, and you, kind of-- like, **if I admit you [to urban district hospital in KwaZulu-Natal], you're going to get a social work and psychology appointment in hopefully the next 72 hours**. **If I get you an outpatient appointment, it's going to be in two months**. Are you gonna come to it? Are you gonna be-- like, are you gonna default? Are you gonna be able to get transport?
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

This practitioner's account of decision-making zeroes in on how admissions decisions might be made in a way that 'co-opts' the system—by involuntarily

admitting an individual who is not severely ill, the practitioner argues that individual will receive specialist input more quickly than through outpatient care.

Building on this broader ethos within the mental healthcare system to attempt to fast-track the provision of specialist care, some general practitioners working in hospitals with mental healthcare practitioners on staff also suggested that, because psychiatry is "right there", the process of referring an individual for a psychiatric assessment, e.g. individuals who are already in the hospital on a general care ward, is fairly straight-forward:

> So, for patients who have been with us for a long time, you might establish that their mood has changed over time and that being in hospital, which is obviously not a great place to be, and especially if they're getting all these horrible diagnoses, has caused significant changes in their mood and their responsiveness or whatever. **Then you make a psych referral and they can just get them. I mean, they're right there as well**, so I guess it would be different if I was in a clinic, I might not have such easy access.
>
> Medical intern (Y1), tertiary hospital [D], urban, Western Cape (8)

This practitioner re-emphasized the same point later in the interview, a point also echoed by the internal medicine specialist I interviewed:

> If we have a slight suspicion that the patient [on a general medical ward] might be depressed and should see a psychiatrist or something, we would want to get them… **I mean, they're in hospital already, um, might as well have them assessed. If they need to be on medication, get them on medication. If they need therapy, get them on therapy, or at least get them into the system, into the mental health clinic system.**
>
> Medical intern (Y1), tertiary hospital [D], urban, Western Cape (8)

6.5.1.2. Force of the consideration in decision-making

Practitioners' accounts of decision-making—especially *general* practitioners' accounts of decision-making—considered the possibility of fast-tracking the provision of specialist care in navigating a decentralised mental healthcare system.

However, the extent to which this fast-tracking was possible varied according to setting. As quoted in Section 6.5.1.1 (page 263), having described how decision-making might go in an urban setting—where access to specialist care offered *through* involuntary admission would be considered in an involuntary admissions decision—the practitioner went on to compare how decision-making looks in a rural setting:

> Now I'm a community service officer and it's a very different ball. […] **I was so much more comfortable, even if I had a patient-- like, patients with mild psychosis, um, to not admit them. Because, the access, like, despite all the million challenges and the flaws, is-- the issues you deal with are different [in a rural setting]**. Okay. So, I have someone who I know I'm going to manage it properly, even if it's me or [colleague]. We'll chat about it to each other. We have a psychiatrist that we can phone. The social worker and psychologist are next to my offices. They're not that busy. I will phone them and be like, 'Hey, come in here. Let's sit down and talk to this patient.' Like, that is what we had. **And we could actually do multidisciplinary stuff and sort out patients way better from an outpatient perspective.**
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

In the quote presented in Section 6.5.1.1 (page 263), this practitioner notes that, in urban areas, their decision-making might take into account the fast-tracking of specialist care *through* admission; in this quote, however, the practitioner notes that, in rural areas, their decision-making might take into account the fast-tracking of specialist (or at least comparably more specialist) care through *non*-admission.

This practitioner points to how regional differences in the health system structure, and its attendant resource constraints, impact the relevant considerations for decision-making, at least in their view.

This practitioner is also commenting on the nature of resource constraints as they appear in different regions and contexts, in part as a product of the health system structure. That is, in densely populated urban areas, where resource constraints in hospitals are more to do with bed availability as opposed to workforce, this practitioner was more likely to admit individuals as inpatients in an attempt to secure access to specialist care within the hospital. However, in rural areas, where resource constraints in hospitals are more to do with workforce as opposed to bed availability, this practitioner reported that they were *less* likely to admit individuals as *in*patients because the kind of care they could provide in an outpatient setting was better, in their perspective:

> ‘Cause even though I had-- the resources weren't really there, **you are the resource and you can use yourself in that [rural] setting**.
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

Practitioners implicitly defended this consideration of fast-tracking the possibility of specialist care by citing the structure of the system itself: given that the initial admission for the 72-hour assessment period was not, itself, a guarantee of the provision of specialist care, and especially in light of challenges in guaranteeing referral to a specialized psychiatric hospital (as part of the decentralised mental healthcare system outlined in the MHCA 2002), practitioners’ accounts of

decision-making sought to fact-track the provision of specialist care where possible. Of course, in many cases, specialist care is not available, and is unlikely to be made available, across contexts. As noted, only a minority of individuals involuntarily admitted to general hospitals for the 72-hour assessment period are (able to be) referred on for specialist care, largely owning to limited bed availability in specialist psychiatric hospitals.

6.5.2. Weighing up the benefit of being on the ward

Another key system-focused consideration present in practitioners' accounts of decision-making is weighing up the benefit of being on the ward, primarily stemming from the fact that all involuntary admissions proceed through a general hospital. That is, practitioners were concerned with the extent to which the ward environment of a general hospital—even a dedicated psychiatry ward in a general hospital—would be beneficial to an individual admitted involuntarily.

6.5.2.1. Description of the consideration

Practitioners' accounts of decision-making were sensitive to their perception of the ward environment itself as 'not pleasant':

> I don't know if you've ever been inside a big government hospital in South Africa […] Especially in most hospitals **the psychiatric wards really are not pleasant places to be, um… so-- so I always, kind of, feel bad having to admit someone there, it's not nice to be there.**
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

Several practitioners acknowledged this point, noting that the ward environment is 'not luxurious':

> I think sometimes a lot of their resistance comes from the fact, um, that **they don't want to be admitted to a district-level hospital because of the conditions at the hospital**, you know? (*M: Okay*.) **It's not luxurious!** You have to share a bathroom, um, you know-- (*M: Right*.)
>
> Clinical psychologist, district hospital [B], urban, KwaZulu-Natal (5)

Conversely, practitioners reported that admitting known mental healthcare users involuntarily can be easier because the experience would *not* be a "shock":

> But also i-- it's probably not a g-- it's probably a bad thing, it's probably not a good thing, but, you know, once a patient is-- is-- [*sigh*] he's been in our ward a million times before, so I know that he knows the ward and he knows the system, everyone there knows him. So I know it's not-- it's not gonna be as horrible as-- and a shock to him to be in that ward, as it is for other people. So it makes it almost a bit easier. I'm like, you know-- you know how the system works. You've been here before. You know… so**… it's not a good thing, but [*sigh*] it is-- it's the truth. I feel a little bit less bad about admitting him because he's been there so many times**, so he knows [*muffled*].
>
> Medical officer in psychiatry, regional hospital [C], urban, Western Cape (18)

That is, practitioners felt that it was 'easier' to admit known mental healthcare users—whether because the individual themself is more amenable to admission or because the practitioner finds it easier to make the decision—because they are already 'institutionalized' within the system itself, so to speak:

> Um, but look**, I think because she's so, uh, well-institutionalized, if I can put it that way, you know, she knows the ins and outs of it--** (*M: Right*.) **Um, very happy to get admitted, very happy to go through the whole process again**-- (*M: Huh!*) Um… you know, see the psychologist, see the psychiatrist, go through the whole process, very readily went home, came back immediately with clothes, you know-- (*M: Right!*) Just a normal day. No drama, no fight, no struggle.
>
> Clinical psychologist, district hospital [B], urban, KwaZulu-Natal (5)

> (*M: Is there-- do you see a difference in how you go about making decisions betw-- for a known patient versus an-- an index case, or how-- how does that influence the way that your decision making goes?*) So… [*pause*] Often with the known cases it's a bit easier, because there's much more of a paper trail. Um, so we know the last time you got your meds, we know what you look like when you're sick, we know what medication to put you on, it just-- it just feels easier for you to be in the system. **And, of course, shame,**

> **our patients are a bit institutionalized, they often know what's coming, so they don't fight as hard**-- (*M: Right*.) Um… [*pause*] So it's just that because there's-- **we know more, it's easier.**
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

Some practitioners expressed worry that the process of admission (waiting in the emergency centre and then being transferred to the ward) would not benefit some individuals, specifically those with symptoms of depression:

> **I think I would often treat, uh, depressive patients as outpatients, also knowing that, um, their journey in the hospital, um… is gonna be in EC [emergency centre], then it's gonna be in a ward full of psychotic patients**, and also depending on what they're used to at home, now they're going to be sharing a room with six, seven other patients, there's no privacy. **Um, there's not gonna be a psychologist-- our-- our-- our psychologist in our team's probably gonna… see them to evaluate them, but if they're gonna follow-up at a different clinic, she's not going to start the therapeutic process**.
>
> Psychiatrist, district hospital [H], urban, Western Cape (12)

This practitioner is not only implying that consideration of the ward environment itself may be factored into decision-making, but also that consideration of what would be offered *on* the ward, given the health system structure for providing follow-up care, may be factored into decision-making.

Beyond the quality of the ward, then, practitioners suggested that the ward environment itself might not be sufficiently therapeutic for most mental healthcare users, largely because general hospitals are unable to provide the kind of therapeutic services needed to address mental ill-health:

> […] Because at the-- at the, um, psychiatric hospital, they'll get a multidisciplinary approach, they'll get occupational therapists, and psychologists, blah, blah, blah. **Whereas, um, they're getting acute care only, sedation, maybe a clerk once in a**

> **while, see a-- a psychiatrist, not even every day, maybe every second day, or every third day**.
>
> Casualty officer, district hospital [I], urban, Western Cape (13)

This practitioner is pointing to the nature of what can be provided in general hospitals at all. That is, these general hospital settings are meant to provide *acute* care.

6.5.2.2. Force of the consideration in decision-making

Practitioners voiced concern that the ward environment was not particularly conducive to improving individuals' mental health in many cases, especially because inpatient care is largely provided in 'standard' general medical wards (i.e. wards originally set up to provide *physical*, not mental, healthcare). Practitioners worried that inpatient admission to general hospitals primarily entailed just lying in a bed, without provision of other kinds of therapeutic interventions that would better support recovery. This worry was true even if an involuntarily admitted individual had been referred on to the specialized hospital but were waiting to be transferred, simply because practitioners were limited in what they were able to provide on the general hospital ward:

> […] How-- how it works is that [*specialist hospital*], which is the specific psych hospital, is meant to take patients from my hospital for longer-term admission, 'cause my hospital's meant to be short term. But we have patients that are there for months. Um, so I say [*specialist hospital*] but there are also other psychiatric hospitals in the drainage area, like [*another specialist hospital*] or hospitals for-- specifically for adolescents. Um, so they are-- so they're put on waiting lists and they just sit there. So that's really difficult. Because they-- they need, like, they should go to other psychiatric hospitals because it's better for them, better for their recovery**. Um… because our-- our ward is a room with windows that don't open, so the patients can't go outside. And it's, um, not a great place to be for anyone.**

Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

While we might worry that rural hospitals would fare *even* worse in this regard, some practitioners working rurally suggested that, actually, because the hospital grounds are quite large (and probably also because these hospitals do not have a dedicated psychiatric ward which can be locked), mental healthcare users admitted to hospital were able to more freely move about the hospital and spend time outside:

> And 'cause the thing is our-- our hospital, because it's in a rural setting, there was-- it was-- even though the hospital was small but the-- the area was large. There was, like-- I wouldn't exactly say gardens, but there was a large area of grass. **So, they would-- they would allow patients-- you know, psych patients to go to lie outside in the sun, relax, knowing that they wouldn't-- they wouldn't really risk them absconding**.
>
> Community service medical officer, district hospital [F], rural, Western Cape (10)

Broadly, practitioners' accounts of decision-making, at least in some cases, weighed up the benefit of *being* on the ward for the particular individual, with attention to the kinds of services provided on the ward and the hospital's particular context, thereby incorporating system-focused considerations into decision-making in at least some cases. One practitioner working rurally underscored this point by opting for *non*-admission in some cases, specifically where the potential benefit (or lack thereof) of being on the ward was outweighed by the practitioner's own perception of what could be offered via outpatient services:

> Because… the-- the management-- like, **the inpatient management, for me, I saw it as a bed to sleep on, where you might get your medication and you might be seen by a doctor that day**. So, like, a lot of the time, for me, if you weren't sick enough, like, you

> send them home, because they could be managed better by me as an outpatient basis. So I avoided admitting patients, unless I had to.
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

6.5.3. Summary

Practitioners' accounts of decision-making were sensitive to their own determinations of what admission itself could or could not provide—i.e. whether admission would or would not be beneficial to the individual. This assessment sits against the backdrop of practitioners' perceptions that access to mental healthcare is, in fact, fairly limited in South Africa, by virtue of both the system structure and its resource constraints:

> […] Because for me, I definitely have-- mental healthcare is quite personal to me and, um, access to it, in like-- and I used to even have an interest in it, until I saw the reality of what it was in our public health setting. […] And I hated it. Everything I'm saying that happens, I hate. It upsets me the way that in the-- in the wards and things like that. Like, although we had a referring facility in [KwaZulu-Natal], people would wait for months to get there. Months. But they couldn't be discharged because once you're discharged, you're off the waiting list. […] **But I also really, kind of, resent the fact that the access is restricted, and even, like, some access, like, some kind of consult or care is better than nothing.**
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

> For a lot of South Africa, I don't think, especially outside of the Western Cape-- (*M: Right.*) Mental healthcare really isn't that accessible and often isn't really thought of because I think for most of these more rural and-- and, uh, less well-developed, um, municipalities, I guess, the primary objective is, like, just make-- let's have mothers not die in childbirth. You know? (*M: Yeah.*) […] **People won't get access to the care they need because it's not available, because it's too full and it's-- it's, um, flooded, the system is flooded**.
>
> Medical intern (Y1), tertiary hospital [D], urban, Western Cape (8)

In light of this 'restricted' access, then, practitioners' accounts of decision-making included consideration of whether admission might fast-track the possibility of

access to specialist care. In some cases, practitioners felt that admission *would* amount to better access to needed care, especially if some kind of comparatively greater expertise in psychiatric management might be made available upon admission. This point is evidenced by the example of the casualty officer working rurally, who reported being more likely to admit an individual if the specialist (even a medical officer in psychiatry with no formal psychiatric training) was coming to visit the hospital in the coming days.

Broadly, decision-making is, in part, informed by the health system structure: because all initial admissions are made to general hospitals in accordance with the decentralised mental healthcare system specifically instituted by the MHCA 2002, practitioners consider what kinds of services can be provided in general hospital contexts. While this capacity is, of course, also constrained by resources in some respects, the problem persists even in more highly resourced hospitals, e.g. tertiary hospitals which also conduct 72-hour assessments as part of their general hospital services. That is, practitioners observed that involuntary admission to a general hospital—even one with a dedicated psychiatry ward—does not necessarily best support the provision of adequate mental healthcare.

Practitioners working rurally reported that some individuals were ‘treated’ through a specialist practitioner *via* the general practitioner:

> Yeah so, you know, the way the system is supposed to work is that we are an acute, sort of, centre. So they'll stay for the 72 hours. And after that, then we-- we generally have to now contact someone to refer. [...] And if they don't go home, I've had a patient stay there

> for I think probably four months. I just couldn't-- I couldn't refer him. Each time I would refer him to the guys, they'd be like, 'look, start him on this'. And I do that. And then they say, 'Start him on that'. Um… then I do that. Then they'll say, 'Look, that's--'… Maybe then he develops any [*unclear*] side effects, stop that. **So basically they were supposed to be in that facility, but now they're just-- they're treating him via me.**
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

Practitioners also reported difficulties in providing adequate mental healthcare to individuals admitted in rural district hospitals, noting especially limitations in training and expertise. Describing their own experience of working in a rural district hospital, one practitioner noted:

> I think it's just… after the 72-hour assessment, if… they remain really… really a problem and they're not really responding to treatment that you've-- and, like you probably know, we've only got a limited variety of drugs to try out. [*chuckle*] Um… I think it's just, um… yeah, I think there's not enough, like, skilled doctors to manage, like, more resistant psychiatric problems, and, um, seeing them every day [wifi cut] getting nowhere. […] We would see them every day, um, and it feels like you're getting nowhere with your management. Sort of feel-- like, I easily felt a bit stuck, that I'm not sure where we're going with this. **But I also feel like we're not doing them full justice because we can't investigate everything we need to or we're just trying to cover up with whatever history we've got to, sort of, um, yeah, make a diagnosis**. […] I just think I-- I obviously also didn't feel very competent, and I think that's why, um… we do, like, during our F1/F2 [medical training], we do like, a psychiatric rotation of three or four months, but, I mean, um, that's also usually really advanced cases with consultant supervision. **And now if you're alone, you've got some haloperidol and risperidone to play around with, you know?** [*chuckle*] **You just try that and see**. [*chuckle*] And then, referring a patient… like, who's not that severe but also not completely well, like, it's very difficult. And, it's sort of-- **people just, like, try and, like, brush it off with some haloperidol and just make sure things are fine.**
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

As this quote demonstrates, practitioners were aware of and sensitive to the limitations of the system, specifically in terms of admitting and managing individuals in general hospitals in rural settings.

Even in urban hospital settings, the health system structure can complicate access to specialized care. That is, in addition to the lack of space at specialist psychiatric hospitals, as discussed in Section 6.4.3 (page 253), any admission, even for a known mental healthcare user, must proceed through a general hospital, in accordance with the health system structure prescribed in the MHCA 2002. Lamented one practitioner discussing an individual who is routinely brought to the emergency centre:

> Um… he's-- he's-- he's… he's there at least every third or fourth month-- […] **Because we're district level, he has to come to us first.** (*M: Right*.) He's been to [specialized psychiatric hospital] many a times. (*M: Okay. Okay*.) And things haven't worked out so well. [*chuckle*] (*M: Sure, sure*.) **Um... he comes back out and it's back to square one**. (*M: Back to square one*.) And I think also they've learned to prioritise their patients-- (*M: Right*.) If I can put it that way. (*M: Right, yeah*.) Right now, I think their substance-induced wards are inundated-- (*M: Sure*.) So that could be one reason why he's not getting in-- (*M: Right*.) Over and above the fact that he's been there a few times.
>
> Clinical psychologist, district hospital [B], urban, KwaZulu-Natal (5)

This practitioner is pointing to the way the system structure can also impede access to specialist care, even if a specialist psychiatric hospital is located nearby.

Overall, practitioners' incorporation of system-focused considerations in decision-making took into account key features of the health system structure, contextualized to the particular hospital setting, in an effort to provide access to (the 'right' kind of) care. Though practitioners did not necessarily include system-focused considerations in every case of decision-making, practitioners took system-focused considerations, as with resource-focused considerations, to be information-independent.

6.6. Incorporating multiple considerations into decision-making

Practitioners' accounts of decision-making suggested the importance of individual-, family-, resource-, and system-focused considerations in decision-making. While the quotes used throughout this chapter narrow in on one specific component consideration within these four broader categories, practitioners' accounts of decision-making often shifted between each category of consideration with ease in many cases. Practitioners generally incorporated multiple considerations across any number of categories in their accounts of decision-making. While there was no clear prioritisation or weighting of categories in decision-making, practitioners' accounts highlighted the unique combinations of considerations relevant to each case that together influenced the admissions decision.

For example, this practitioner's general account of approaching admissions decisions runs through the relevance of specific considerations at every level, ranging from individual- to system-focused considerations:

> (*M: Have you ever been unsure about admissions decision one way or the other whether that was, you admitted and you were unsure or you*--) Oh, yeah! Often! All the time! (*M: Okay. Okay*.) Yeah, no! Completely! Completely. Um… and I do-- **I do tend to err on the side of discharging--** [*chuckle*] (*M: Okay*.) Um… **partly because I know that it works in terms of my beds**, but… I mean, I still have that old idea which is that, I mean, can you imagine putting somebody into a psychiatric ward who's not mentally ill?! I mean, it's just possibly the worst flipping thing I could imagine-- (*M: Yeah*.) So… Um… Yeah, I mean I know that I'm-- I'm allowed to use the assessment period for that, to decide-- (*M: Sure.*) But **knowing how awful my ward is-- and, I-- I mean… no,**

> **another reason why I'm just very interested in history, because by and large, if you can get a story from the family, you can-- you can get a better sense of what's going on.**
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

Likewise, some practitioners' accounts of decision-making weighed the perceived lengths to which families had gone to bring an individual in for assessment, specifically in rural areas:

> And now we've got another factor in the situation. You're rural. It's not easy to get to a hospital. Okay? So it-- it's transport. It's money. […] Um, and, so, there were all these obstacles people had, to come. **So, like, it's very rare that they were bringing you in-- the patient in, if they weren't-- be like, 'Oh, this patient needs to be here', I'm not going to argue with that and say, 'By the way, maybe you should come back to clinic tomorrow and we'll work from there.'** So, then there's that factor.
>
> Community service medical officer, district hospital [K], rural, Mpumalanga (16)

This practitioner is alluding to the fact that system-focused considerations—specifically motivated by the aim of providing access to care, as discussed in Section 6.5.1 (page 262)—could influence interpretations of family-focused considerations in some cases. For example, in this case, the practitioner assumed that the family-focused consideration of gauging trustworthiness was either met by or made irrelevant by the system-focused consideration of fast-tracking the provision of specialist care (or, indeed, any care at all).

Practitioners' accounts of decision-making often highlighted the relevance of multiple categories of considerations to the decision, and practitioners suggested that their interpretation of a certain consideration may be shaped by their interpretation of another consideration. For example, practitioners often suggested

that the importance of family-focused considerations was derived at least in part from the importance of resource-focused considerations.

Practitioners' accounts of decision-making revealed a complex decision-making calculus, where even 'like' cases (from the perspective of the initial presentation, say) might be managed completely differently based on these categories of considerations. While practitioners were clear that certain key considerations—especially evidence of aggression or serious self-harm—would make for a 'clear-cut' admissions decision, in general, practitioners' accounts of decision-making were sensitive to a range of individual-, family-, resource-, and system-focused considerations.

In many of these cases, the provision of direct information, e.g. knowing that the individual was already at their baseline, or having a sense of the family's capacity to provide care, allowed practitioners to manage resource- or system-focused considerations.

6.7. The critical place of information in decision-making

While practitioners did not suggest any consistent prioritisation of categories of considerations, one element of the broader context played a critical role in practitioners' accounts of decision-making: information availability. Influenced at least in part by micro-decisions preceding the final decision to admit, as explored

in Chapter 5, information availability significantly impacts how and when practitioners can adequately incorporate certain considerations in decision-making.

Decision-making—and especially 'good' decision-making—is of course aided by having information to guide understanding of considerations at every level: individual-, family- resource-, and system-focused. As explained in Chapter 5, practitioners relied on the provision of direct information when available—and substitute information otherwise—to make decisions.

6.7.1. Information-*dependent* considerations

Information availability—specifically the provision of direct information—influences *how* or *to what degree* certain considerations can be assessed. Individual- and family-focused considerations are highly dependent on the quantity and quality of information available to guide decision-making; practitioners cannot know about, say, the nature of the individual's aggression, or the availability of family support, without having some kind of additional information beyond clinical presentation (whether through conversations with the individual themself, conversation with the family or other supporters, medical records, prior knowledge of the individual, or discussion with colleagues who are familiar with the individual).

By practitioners' accounts, individual- and family-focused considerations are taken to be information-*dependent*; that is, their incorporation into decision-making is dependent on the provision of direct information:

> So we don't have good medical workups often, and **we don't have good information**. **And then contacting families is very difficult**, so, by and large, a clinical-- I mean, a mental state exam is the best evidence you have of something going on. (*M: Okay*.) And so… yeah, I have to decide, there and then, how super-sick you are, and if I can discharge you. So-- so that-- that's very, very tricky. […] So… but one thing that does work for us is that we've got very good electronic care system, and if we've got the old folder, then that is often very useful-- (*M: Okay*.) **So it's-- it's the new info that's difficult**, but, you know, people are in the system, then we can get discharge summaries or what medications they're on. […] **So… yeah, so there are some useful information, but the actual, like, now information is very bad.**
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

This practitioner refers to a kind of direct information—medical records—but this direct information is, of course, only available for known mental healthcare users. In general, practitioners suggested that acquiring information that would allow for the adequate incorporation of individual- and family-focused considerations was often quite difficult. Acquiring this information was complicated not only by the outcomes of various micro-decisions, as described in Chapter 5, but also by other circumstances, e.g. COVID-19 precautions:

> **So-- so there's very severe restrictions on who's allowed to come into the hospital, um… which is what has made it very difficult to get collateral [information].** (*M: Right*.) And sometimes the patients show up and they have no family around them, they've been pulled off the street by-- by police or something. And the police provide you with a very meagre, kind of... 'The patient was on the side of the road looking scary', and you're like, 'Okay, fine.' […] Um… so, uh, but yeah, so, sometimes they are brought in by their family or-- or they're brought in by a paramedic and then you only have the paramedic's history to go by. **Or… um, you-- you have, like, the history that the triage sister took from the-- from the family when they arrived which is a one-liner saying, uh, 'Family brought patient in, saying patient behaving strangely.'** (*M: Right.*) **And that's what you've got, that's what you've gotta work with.** (*M: Right, okay*.) Um… so then-- so yeah, so that's-- I mean, that's-- that's not nearly enough. And then you ask them what happened and they're like, 'I don't know what you're talking about, why am I here?' And then you're like, 'Okay, well.'
>
> Medical intern (Y1), tertiary hospital [D], urban, Western Cape (8)

As explored in Chapter 5, the absence of direct information (often a consequence of a prior micro-decision, e.g. the triage sister's prioritisation of the individual *as a potential mental healthcare user* in casualty, as noted in the quote) often led practitioners to rely on *substitute* information, gleaned from the fact that a prior micro-decision had been made.

Given the importance of direct information in decision-making, practitioners sometimes struggled to make decisions in the absence of direct information, and would try to enlist other healthcare professionals to aid in the procurement of relevant information:

> First, we thought that it was an index presentation. But then we-- we didn't get much information about the family. 'Cause for some reason-- like, I-- I don't know. So, a lot of family members, it's like they ask the person who knows the least about her to accompany the patient. **So, you get such little information. And she didn't even leave her phone number. So, now, we had to get the social worker to assist, so the social worker had to-- I don't know how the social worker got it, but then she ended up getting hold of the family**. And the family was like, 'Okay, no, she was diagnosed. She was seen before. She's on this medication.' So, yeah. […] And sometimes, if you then-- if you're faced with something on history that you can't quantify, or that's not quantified, so, say for instance, "aggression", just-- or "sexually disinhibited", on the Mental Health Care Act forms [i.e. Form 04, completed by the family], you don't know… what that means, exactly. And you can't confirm-- confirm it with-- corroborate it with collateral information. **It's something as simple as that, we-- we'd possibly-- we'd prob-- probably keep a patient like that, until you can get-- make contact with the… with the next of kin**.
>
> Community service medical officer, district hospital [G], rural, Mpumalanga (11)

The final point this practitioner makes—that, in the absence of direct information, the 'default' response would be to keep the individual—also relates to the way that individual- and family-focused considerations are used in decision-making.

Broadly, practitioners suggested that their decision-making calculus would generally lean toward admission in the absence of direct information, and especially as a consequence of key micro-decisions, as discussed in Chapter 5. However, where direct information was available to guide decision-making, its incorporation in decision-making often functioned to justify *non*-admission.

6.7.2. Information-*independent* considerations

Conversely, resource- and system-focused considerations were taken to be 'true' and known for all individuals arriving to a particular hospital (whether or not practitioners' assessments of these considerations were, in fact, accurate). That is, practitioners' accounts of having *insufficient* information to make an admissions decision did not affect their ability to incorporate resource- or system-focused considerations.

In describing resource- and system-focused considerations, practitioners expressed with relative certainty that these structural considerations were, in fact, *always* present; resource- and system-focused considerations were simply standard features of the decision. Of course, practitioners did not explicitly interpret the resource- and system-focused considerations as 'information-independent'; however, their descriptions of resource- and system-focused considerations were resolute and certain, and practitioners consistently cited these

resource- and system-focused considerations across their accounts of decision-making. Often, resource- and system-focused considerations were 'learned' in the particular context—once practitioners knew how a particular region or hospital setting 'worked', their understandings of resource- and system-focused considerations were generally constant across cases (even if inconsistently incorporated into decision-making for each case).

The clearest examples of this are in practitioners' contrasting accounts of practice in different settings. For example, as noted in Section 6.5.1 (page 262), one practitioner perceived 'fast-tracking the provision of specialist care' as being achieved through involuntary admission in an urban setting, but through outpatient management in a rural setting, owing to the system structure. Here, interpretation of this system-focused consideration was 'fixed' in the practitioner's mind *based on* the setting in which they operated.

Perhaps *because* practitioners broadly perceived resource- and system-focused considerations to be information-independent, the force of these considerations was prominent in many accounts of decision-making. That is, these resource- and system-focused considerations, which were generally understood to be 'known' in decision-making, frequently featured in practitioners' accounts.

6.7.3. Using information-dependent considerations to manage information-independent considerations

However, the importance of incorporating individual- and family-focused considerations in decision-making—where direct information is available—is sometimes underpinned by the need to manage resource- and system-focused considerations.

The strongest example of practitioners using information-*dependent* considerations (individual- and family-focused considerations) to manage considerations taken to be information-*independent* (resource- and system-focused considerations) is in practitioners' accounts of the importance of assessing the availability of family support, as well as handing over responsibility to the family, as a way of negotiating the bed crisis:

> So… it's one thing for me or the nurses to do our part in diagnosing and treating the patient. Um... and it's another if the family is sort of, 'Look, we want nothing to do with him'. You know? Um, because I'm-- I'm operating in the context-- within a hospital. And I do have the social worker to help me, um, you know... and the community healthcare worker to help me manage the patient, you know, at home, and to-- and to-- and to sort of see. **But we need the family to also partake in that management**. You know? And unfortunately, if the family has a hands-off approach, and we've exhausted our social and psychological support, and community healthcare support, then the reality is that… **And it's especially true in our resource constrained setting**. **You know, with-- with beds, bed space is a big deal.** Yeah, so we've got to make hard decisions like that, you know? We've got to make very hard decisions.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

While this quote speaks in general terms, practitioners' accounts explicitly and implicitly opined on the role of the family, not as a matter of principle but more so as a mechanism of managing resource constraints. In many cases, practitioners

often chose not to admit *because* the family was available to care for the individual, as demonstrated in Section 6.3.1 (page 236).

Here, practitioners' incorporation of family-focused considerations was rooted in avoiding admission (and thus strain on the resources of the health system). Whether by assessing the availability of family support or by handing over responsibility to the family, practitioners relied on the family to provide care that they felt the service could not or should not provide.

One practitioner was particularly animated about this point, suggesting that their assessment of the availability of family support would include even a 'well-meaning neighbour':

> And-- and you know, ideally, that would be a family member who cares about you, but, you know, **I'm not picky, like, if your neighbour is a well-meaning neighbour, and they don't know what they're getting themselves into, then I'm going to milk that poor neighbour for all their worth**. So it's just really about, like, who is gonna supervise, do you have a stable place, um… is someone gonna make sure you come to your follow-up appointment and take your pills. (*M: Right*.) Um… it's that simple.
>
> Psychiatrist, regional hospital [C], urban, Western Cape (7)

As such, practitioners implicitly justified the force of family-focused considerations as a way of managing resource- and system-focused considerations.

Likewise, practitioners' accounts of decision-making were also sensitive to the system-focused consideration of fast-tracking the provision of specialist care—and in some cases, any care at all. Practitioners weighed up whether or not an individual had had *prior* meaningful access to care—relevant especially in more rural settings—in their decision-making:

> Um… ack, yeah, generally, any-- like, like, un-- undifferentiated patients that comes with, like, psychosis or severe mood issues, um… yeah, I think the family history to me is usually a big thing. Like, if the family is saying 'Listen, we can't manage this patient at home, like, we just can't', I believe them, because I know the home setting is really bad, usually. And, um, I-- if I feel I can trust the family, then I just admit them, because generally people have, like, a high threshold before they come to hospital. And by the time they get to hospital, **by the time they've spent the amount of money that is probably all the money they have for the week for food or everything**, or by the [wifi cut]. **Like, if you're saying this patient-- like, you can't cope with this patient at home, then it's fine, let's make a plan and admit, just, at least for a few days and see what we can do.**
>
> Casualty officer, tertiary hospital [L], rural, KwaZulu-Natal (17)

This practitioner's account, and others like it, weighs up the potential challenges the family (or the individual) has faced in even *arriving* to hospital, and uses this logic to justify involuntary admission as a way of providing care that is perceived to have been inaccessible prior to the point of admission. Again, practitioners cited an individual-focused consideration, but explained its relevance through system-focused considerations. That is, practitioners' accounts of decision-making implicitly weighed the possibility of providing access to care while also considering features of the particular case, especially in terms of the individual's prior access to care. Practitioners often made decisions with respect to their perception of whether the individual had *already* been offered access to services (i.e. for whom admission would constitute 'over-utilization' of the health system).

Here, practitioners attempted to manage system-focused considerations *through* individual-focused considerations.

In some cases, indexing 'need' for admission to the individual's baseline, an individual-focused consideration, allowed practitioners to negotiate the bed crisis, a resource-focused consideration:

> Even, like, with our psychotic patients and things… (*M: Mhm.*) **Like, we don't admit everybody that's still having psychotic features--** (*M: Sure.*) …**because you can't…** […] so we wouldn't necessarily admit somebody that's-- that's… symptomatic all the time… (*M: Right. And when you-- when you first, kind of, started talking about this you said, you wouldn't admit, um… you said, 'Because-- because we can't'… And did you mean… **in what way did you mean, 'We can't'?***) [*chuckle*] Well… Um… Again, **because of our bed crisis.** (*M: Okay, okay.*) We always have a bed crisis. (*M: Oh.*) So… um… um… there's-- the-- **unfortunately, we have to prioritise**. […] So, there may be times where we just have accept, unfortunately, that the patient is going to have some of these symptoms that come up now and again… (*M: Sure…*) That… Um… that they nev-- that they may not ever be asymptomatic, completely… um… so…
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (2)

In this quote, the practitioner makes clear that indexing the 'need' for admission to the individual's baseline is helpful not only for knowing when to admit an individual, especially when residual symptoms are present, but also for knowing when to prioritise or, indeed, *de*prioritise an individual for admission in light of resource-focused considerations.

In several practitioner accounts of decision-making, this appeal to individual- and family-focused considerations in order to manage resource- and system-focused considerations appeared:

> So… it might-- in-- in-- it might, in some instances, be better to… have them be at home because at least they're more comfortable at home and they're-- (*M: Yeah*.) They're less depressed. **Hospital can be a des-- a depressing place**. (*M: Mm*.) **So ultimately it's-- we-- you know, when I decided against an admission, it's when I can find a very supportive family member**. (*M: Okay*.) Who is willing to-- to do the suicide, um, observation at home and they know what to do when the patient is-- is actively suicidal-- (*M: Right*.) Then I will then m-- decide, look, **maybe it's better to send the patient home.**
>
> Registrar in psychiatry, tertiary hospital [A], urban, KwaZulu-Natal (6)

Here, the practitioner is weighing up the benefit of being on the ward, and suggesting that, given the "depressing" nature of the ward, and considering the potential comfort of being home, the practitioner's decision might be again swayed by the presence of "a very supportive family member". This quote offers another vivid example of the subtle ways in which system-focused considerations are, in effect, managed by an appeal to individual-focused considerations.

Because practitioners perceived resource- and system-focused considerations to be information-independent—i.e. constant across all assessments (whether for that particular shift, for example with respect to bed availability, or whether for that particular hospital setting, for example with respect to access to specialist care)—these considerations were critical to decision-making in many cases, and often seemed forefront on practitioners' minds. For example, one practitioner explained that navigating the bed crisis—a resource-focused consideration—could directly shape assessment of an individual-focused consideration:

> If it's the first time [index presentation], we admit. Especially if we've got enough beds, we will admit. Um, I don't know, I think it's-- it's-- it's a thing of, how will I now discharge this man not knowing what he's got, you know? […] But if-- if you're pressed for beds, you might then just, again, call the social worker, call the psychologists, um, and

> then bring him back in three days' time for the blood results. Sometimes if there's a first-time presentation, you'll do that.
>
> Community service medical officer, district hospital [E], rural, Limpopo (9)

Likewise, another practitioner suggested that resource-focused considerations influenced assessment of individual-focused considerations such that an individual who might otherwise be admitted (per the practitioner's account) would be treated as an outpatient:

> **So, look, if I had beds-- so she's an example**. She's, essentially, a borderline in crisis. **I would admit her because whatever the crisis is, the crisis needs to pass. Um… but I don't have beds.** So, um, for her, I discharged her home, **I called her mother to make sure that her mom knows she's going home, but she needs a safe environment**. And she was going to see a psychologist the following day. So, she had a good discharge plan.
>
> Registrar in psychiatry, tertiary hospital [D], urban, Western Cape (14)

Again, we can see the dominant role that resource-focused considerations play in some decisions. While the relationship between information-dependent and information-independent considerations was not fully fleshed out through the interviews, the tendency to use information-dependent considerations in order to manage information-independent considerations was prominent in decision-making.

6.7. Conclusion

In this chapter, I have explored discrete categories of considerations relevant to practitioners' decision-making, per their own accounts. Within each of these categories—individual-, family-, resource-, and system-focused—practitioners

operationalise certain considerations to justify their decisions. As described, many of the considerations that impact practitioners' decision-making sit *beyond* the individual, focusing not on features of the individual's particular circumstances but rather on an assessment of the availability of family (or other) support, resource constraints, and the structure of the health system.

In general, practitioners' accounts of decision-making included considerations across multiple categories; for example, practitioners might weigh up family-focused considerations *in light of* resource-focused considerations, or individual-focused considerations *because of* system-focused considerations. Critically, individual- and family-focused considerations can only be meaningfully incorporated in decision-making when direct information is available; that is, individual- and family-focused considerations are information-*dependent*. Incorporation of these kinds of considerations in decision-making is impacted at least in part by the pathways to decision-making discussed in Chapter 5, specifically in terms of how outcomes of micro-decisions may foreclose access to information or may even be used as information themselves. Implicit in practitioners' accounts of decision-making is the idea that resource- and system-focused considerations are information-*independent* (i.e. known across the board, and not dependent on a particular individual's presentation or context). Broadly, practitioners' accounts of decision-making focused not on legal criteria, but rather on a number of extra-legal factors relating to the individual, the family, available resources, or the health system. In the next chapter, which begins Part III of the

thesis, I explore the implications of the empirical picture of decision-making described in this part of the thesis, Part II, as it relates to the boundary principles identified in Part I of the thesis.

Chapter 7: Re-examining normative commitments in involuntary admission

7.1. Introduction

In this part of the thesis, Part III—*(Re)shaping ethical considerations in decision-making for involuntary admission*—I seek to bring together the outputs of Parts I and II, where Part I focused on understanding the normative landscape of involuntary admission and Part II focused on exploring how tensions between various normative values are worked out in practice. By applying the method of reflexive balancing, I seek to answer my project's normative research question: How should the ethical principles relevant to involuntary admission as well as the normative commitments arising in decision-making be navigated in practice?

The integration of normative and empirical inquiry, as required by the method of reflexive balancing, situates my project within the remit of empirical ethics. The integrative project I embark on corresponds with the '(re)shaping' phase of the overarching mapping-framing-shaping framework applied in my thesis (Huxtable and Ives, 2019), as described in the Introduction.

In this chapter, I use the specific method of reflexive balancing to seek coherence between key ethical principles identified in Part I *in light of* the empirical picture I described in Part II. I first review the requirements of Ives' method of reflexive balancing and revisit the relevant ethical principles identified in Part I of the thesis (and recast as boundary principles in Chapter 4). I then apply the method of reflexive balancing to argue for a particular resolution of the conflict between the

normative frameworks of the ethical principles identified in Part I and specific elements of the empirical picture described in Part II.

7.2. Reflexive balancing (the method)

Per Ives' methodology, Part I of my thesis focused on identifying key ethical principles relevant to the ethics of involuntary admission; Part II of my thesis focused on gaining an understanding of how these ethical principles are encountered and navigated in practice. After identifying these ethical principles or 'boundary principles' (Part I) and after uncovering the empirical picture of decision-making in practice or 'recalcitrant experience' (Part II), the final step in Ives' methodology is to engage with reflexive balancing *as a method* (Part III), where:

> […] The boundary principles are posited as a 'null hypothesis' […], and then systematically challenged by confronting these principles with the recalcitrant experience that generated the problem, alternative theoretical perspectives, potentially disconfirming data, et cetera. (Ives, 2014, p. 311)

This process of "systematically challenging" the boundary principles with the recalcitrant experience seeks coherence—where "the reason for either accepting or rejecting the new addition [is] made explicit and justified in terms of its overall coherence" (Ives, 2014, p. 311).

In light of the outputs of my empirical analysis in Part II, I seek to understand how the incorporation of considerations that sit beyond the individual—

specifically resource- and system-focused considerations—should (if at all) shape our understanding of the boundary principles outlined in Part I (and framed as such in Chapter 4). This analysis pays specific attention to how resource- and system-focused considerations might, if at all, (re)shape our understandings of the negative rights and positive entitlements frameworks that underpin boundary principles in psychiatric ethics and global mental health, respectively.

My engagement with reflexive balancing focuses on exploring how tensions *between* boundary principles—especially the tensions between the underlying negative rights framing of principles drawn from psychiatric ethics on the one hand and the underlying positive entitlements framing of principles drawn from global mental health on the other—ought to be navigated. In fact, much of the *reason* for the debate in the literature being so "intractable" (Galderisi *et al.*, 2020, p. 7) is in part related to the simple fact that the boundary principles—both within and across the fields analysed—are themselves *already* in tension with one another. This apparent irreconcilability of the boundary principles is precisely *why* involuntary admission remains an ethical challenge, thereby motivating the work.

My application of reflexive balancing seeks coherence between practitioners' accounts of decision-making and the ethical principles identified in the literature review. I root my application of reflexive balancing in a critical tension between the boundary principles and the recalcitrant experience: while practitioners' accounts of decision-making included a range of considerations beyond the

individual themself, explications of the boundary principles are focused entirely on the individual.

7.2.1. Revisiting boundary principles

Per Ives' methodology, and continuing on from Ives' previous quote (page 294), boundary principles *make analysis possible* by acting as a 'null hypothesis' for inquiry:

> Such posits act as null hypotheses about morality, which we can treat as though they were true and justified for the purpose of starting inquiry, but which must then cohere with the wider system of beliefs if they are to be considered justified. (Ives, 2014, p. 307)

As explored in Part I (and then enumerated as such in Chapter 4), I identified a core set of boundary principles by exploring arguments for and against involuntary admission drawn from both psychiatric ethics and global mental health. I noted that, while psychiatric ethics has historically been the site of much of the debate over involuntary admission, global mental health too has relevance for how we might think about involuntary admission. The field of global mental health calls for increased access to mental healthcare and promotion of a specific model of healthcare delivery that includes inpatient care, often accessed involuntarily (World Health Organization, 2018, 2021b), suggesting that a deeper understanding of its key tenants and normative underpinnings is necessary to understanding the moral problem of involuntary admission. Boundary principles from each field are included in Table 3 (a reproduction of Table 1).

Psychiatric ethics	*Global mental health*
1. Presence of disorder	1. The right to health
2. Risk of harm to others	2. The right to freedom
3. Risk of harm to self	3. The right to justice
4. Need for treatment	
5. Mental incapacity	
6. Non-discrimination	
7. Universal legal capacity	

Table 3. Boundary principles drawn from psychiatric ethics and global mental health, reproduced from original presentation in Chapter 4 (page 132)

In comparing and contrasting these two literatures—psychiatric ethics and global mental health—I identified an overarching tension between their underlying normative position on involuntary admission, as presented in Chapter 2. Where psychiatric ethics prioritises a negative rights framework, in which coercion can be imposed only in specific cases to *limit* freedom, global mental health prioritises a positive entitlements framework, in which coercion may be considered beneficial in specific cases to *enable* freedom.[53]

7.2.2. Summarising 'recalcitrant experience'

The empirical work conducted in Part II of the thesis highlighted just how many of the considerations incorporated in decision-making, as described by practitioners, lie decidedly *outside* the MHCA 2002's legal rationales and their underpinning ethical principles, as presented in the literature. Broadly,

[53]The fundamental distinction between a negative rights framework and a positive entitlements framework turns on a "conception of freedom which entails not just absence of interference with rights, but genuine ability to exercise these rights; a recognition of the role of society and the State in enhancing freedom; and a substantive view of equality which insists that everyone be able to exercise their rights" (Fredman, 2008a, p. 30).

practitioners' accounts of decision-making implied that applying *only* legal criteria was insufficient to guide their decision-making.

Based on the empirical picture presented in my analysis of participant interviews, practitioners' accounts of decision-making incorporate a number of considerations that sit beyond the individual themself. That is, practitioners' accounts of decision-making incorporated not just individual-focused considerations, but also family-, resource-, and system-focused considerations, as described in Chapter 6. A core rationale for including these '*non*-individual-focused' considerations is rooted in practitioners' perceived roles as stewards or guardians of the system *itself*, seeking to ensure that beds were allocated only to those most 'in need' or those most likely to benefit (e.g. from expedited access to specialist care).

Importantly, practitioners' accounts of decision-making were also explicitly and implicitly impacted by key features of the *process* of decision-making, as enacted in practice. Practitioners noted that, in many cases, decisions are made with limited information—a consequence, in part, of the 'micro-decisions' leading up to the final decision to admit, as described in Chapter 5. Overall, the empirical picture suggests that, contrary to the law (and even contrary to much of the debate over the ethics of involuntary admission in the literature), the decision to admit involuntarily cannot be neatly understood as a single, isolated decision. Rather, the decision to admit is, in practice, influenced by the processes leading up to the decision-making point itself, as well as the broader forces that press upon the

health system—specifically its resource constraints and its organisational structure. Practitioners' clear accounts of and justifications for incorporating resource- and system-focused considerations underscore this view.

Moreover, practitioners took resource- and system-focused considerations to be 'known' across all decisions, implying that these considerations are applicable to any case, regardless of the pathway to decision-making. While, in practice, resource- and system-focused considerations were not necessarily incorporated into all decisions, direct information, when available, was often used to justify *non*-admission with an explicit or implicit appeal to the need to manage resource- or system-focused considerations (e.g. indexing 'need' for admission to baseline to avoid admitting an individual who is in need of care but might not warrant the use of a bed, or assessing the availability of family support to avoid admitting an individual who is in need of care but might not benefit from being on the ward).

In my thesis, I take these resource- and system-focused considerations to constitute 'recalcitrant experience' per Ives' methodology of reflexive balancing given their prominence in practitioners' accounts of decision-making (Ives, 2014).

7.3. Integrating boundary principles and recalcitrant experience: reflexive balancing applied

Using the method of reflexive balancing, I analyse the normative value—if any—of incorporating resource- and system-focused considerations in decision-making. I approach the analysis by exploring the implications of these considerations in the context of the tensions between a positive entitlements framework (as adopted in the debate over the ethics of involuntary admission within the global mental health scholarship) as compared with a negative rights framework (as adopted in the debate over the ethics of involuntary admission within the psychiatric ethics scholarship). I explore the implications of the 'recalcitrant experience' of incorporating resource- and system-focused considerations in decision-making in relation to a relevant boundary principle within each—the right to health within the realm of positive entitlements and the need for treatment within the realm of negative rights.

Though I focus specifically on understanding the ethically justified place, if any, of the incorporation of resource- and system-focused considerations in decision-making, it is important to note that many other critical challenges highlighted in my empirical work could be addressed through the method of reflexive balancing. For example, another question raised by my empirical analysis relates to the role that family availability should play in decision-making, if any. Likewise, there are also important questions to be asked about how decision-making should proceed

(if at all) in the absence of needed information. Moreover, the lack of appeals to autonomy, liberty, or even dignity in any real sense—all key concepts that underpin much of the debate on the ethics of involuntary admission in the literature—in the empirical work could be further explored.

That said, I take the prominent place of resource- and system-focused considerations, as presented in Chapter 6, to be of particular interest in my thesis for two reasons. Firstly, the incorporation of resource- and system-focused considerations in decision-making in practice is especially striking because considerations of this type do not explicitly feature in the identified boundary principles, at least at first glance, and secondly, the incorporation of resource- and system-focused considerations is especially relevant to the provision of mental healthcare in any resource-constrained setting, of course, but especially in low- and middle-income country contexts. By focusing on the place of resource- and system-focused considerations in my application of reflexive balancing, I am not suggesting that these various other questions listed are unimportant (or even remotely resolved). These challenges—especially related to the place of key ethical concepts like autonomy and dignity—are of concern and should be pursued in further research.

I have also prioritised exploration of the place of resource- and system-focused considerations in this thesis because of their specific relevance to the overarching research aim, seeking to understand how the normative commitments of global

mental health and psychiatric ethics arise in practice and should be managed in practice (and focusing specifically on low- and middle-income country settings where these commitments are particularly in tension). Of course, in *not* addressing these other challenges, my application of reflexive balancing is incomplete: I am not able to consider coherence across *all* boundary principles identified in the literature review. Rather, I focus on seeking coherence between the overarching normative frameworks put forth in psychiatric ethics and global mental health in general by systematically challenging their applications in light of key elements of the empirical picture.

To understand how—if at all—the recalcitrant experience gathered in Part II of the thesis (specifically the incorporation of resource- and system-focused considerations in decision-making in practice) should shape understandings of the boundary principles gathered in Part I of the thesis (specifically in terms of the tension between the underlying normative frameworks in psychiatric ethics and global mental health), I pose two key questions to orient my application of the method of reflexive balancing:

1. Should we enact a positive entitlements framework in involuntary admissions decisions, and if so, how? (Section 7.3.1), and
2. What kinds of considerations beyond the individual, if any, does enacting a negative rights framework necessitate? (Section 7.3.2).

I address each of these question in light of the recalcitrant experience of incorporating resource- and system-focused considerations in decision-making.

7.3.1. Should we enact a positive entitlements framework in involuntary admissions decisions, and if so, how?

As described in Chapter 2, the boundary principles drawn from global mental health are broadly rooted in a positive entitlements framework. In context, this positive entitlements framework prioritises the 'right to health' as a critical right through which all other rights can be attained.[54] Some commentators in global mental health suggest that the right to health can be invoked as justification of involuntary admission, as discussed in Chapter 2.

I argue that practitioners' incorporation of resource-focused considerations in decision-making is of particular relevance to our understandings of the right to health as it relates to involuntary admission. Although the boundary principles do not speak explicitly to resource-focused considerations, such considerations are broadly considered to be *relevant* to the pursuit of positive entitlements (Fredman, 2008d). That is, the realisation of any positive entitlement, including the 'right to health', is dependent on available resources (Fredman, 2008d). Therefore, resource-focused considerations should have a place in decision-making where a positive entitlements framework is applied.[55]

[54]In this thesis, I do not address whether involuntary admission should be seen as a positive entitlement in and of itself (i.e. to enable the 'right to health'), as this question is already assumed to be 'answered' by the dominant narrative of global mental health (i.e. that involuntary admission can be understood as a positive entitlement in some cases).

[55]While a positive entitlements framework is, of course, limited by resource constraints, the force behind positive entitlements is not immediate; positive entitlements can only be achieved over time ("progressive realization") (United Nations Office of the High Commissioner for Human

Taking this understanding of positive entitlements seriously, then, the rationale for keeping resource-focused considerations 'on the table' in involuntary admissions decisions is clear: in order to effectively enable a 'right to health', specifically as it is applied in the dominant narrative of global mental health,[56] a realistic assessment of available resources is necessary. Therefore, the incorporation of resource-focused considerations is not only relevant to a positive entitlements framework, but, in fact, *essential*. That is, in order to effectively appeal to any sense of a 'right to health' in practice, decision-making must take available resources into account in order to offer an equitable service.

Of course, the right to health does not guarantee some infinite standard of health, but rather 'health' within the parameters of what is scientifically and environmentally possible, and within the bounds of available resources, as described in Section 2.5.2 (page 95). Therefore, justifying involuntary admission on the basis of the 'right to health' necessarily needs to take into account available resources *while* ensuring that resource use is justly distributed across the population.

Rights, 1990, p. 3). Progressive realization acknowledges that such entitlements are, of course, limited by resource constraints, but also requires that concerted effort should be made to increase the resources available to enable access to the entitlement (United Nations Office of the High Commissioner for Human Rights, 1990).

[56]As explained in Chapter 2, the 'right to health' as it is defined by the UN (United Nations Office of the High Commissioner for Human Rights, 2008) does not permit involuntary admission under any circumstance.

While the incorporation of resource-focused considerations is, as I have suggested, essential to the proper application of a positive entitlements framework, the extent to which resource-focused considerations can be ethically interpreted and applied in practice is severely limited. That is, resource-focused considerations cannot, in fact, be incorporated into decision-making *because* they cannot be ethically 'distilled' to individual cases. Therefore, not only are resource-focused considerations unethical to include in decision-making, but so is a positive entitlements framework at all (insofar as its proper application necessitates the incorporation of resource-focused considerations).

As made clear in practitioners' accounts of decision-making, the kind of 'resource'-focused consideration predominantly factored into decisions centres not on wider resource constraints (though these wider constraints are, of course, relevant to practitioners' decisions), but rather on bed availability within the admitting hospital. In weighing the ethical force of resource-focused considerations in practitioners' decision-making, I therefore focus my argument on the discrete 'resource'-focused consideration of available beds in the admitting hospital itself.

The primary reason to reject the incorporation of resource-focused considerations, as defined, is because their inclusion inevitably entails rationing at the bedside, where practitioners make decisions "about how those absolutely scarce resources will be allocated among all the patients who have serious medical needs for those

resources" (Fleck, 2014, p. 173). My analysis of the empirical data indicated that practitioners' incorporation of resource-focused considerations often functioned as an overlay for practitioners' own perceptions of who 'deserved' admission, as opposed to a different (albeit values-laden) judgement about, say, who 'needed' admission. This kind of rationing at the bedside is broadly critiqued for compromising the individual's best interests.[57] Rationing at the bedside also necessarily entails comparison between individuals, as practitioners determine who 'needs' admission, thus acting as "both a Samaritan and a gatekeeper" (Wyller, 2014, p. 257). As was also evident in practitioners' accounts of decision-making, the incorporation of resource-focused considerations is inherently comparative not just in the present moment, but also with respect to the future: the needs of the individual being assessed in the present are compared to, and in some cases eclipsed by, the hypothetical needs of a potential individual being assessed in the future.

Overall, then, incorporation of resource-focused considerations in decision-making for involuntary admission unethically allows for "a third party—be it the next patient in the corridor or some anonymous person or undertaking in society—[to be] included in the doctor–patient relationship" (Wyller, 2014, p. 256). The incorporation of resource-focused considerations, in attempting to

[57]In the debate over involuntary admission, 'best interests' is itself a contentious topic, as General Comment No. 1 contend that assessments of an individual's 'best interests' (as invoked in substitute decision-making) should be replaced with determinations of an individual's 'will and preferences' to promote supported decision-making (Committee on the Rights of Persons with Disabilities, 2014).

ensure equitable distribution of available resources across the population, inevitably runs afoul of the practitioner's basic duty of care to the individual in front of them—the practitioner's focus should be on the particular individual, not the wider population of individuals who *might* warrant involuntary admission later in the shift, or indeed at any future point.

That said, while practitioners took resource-focused considerations to be information-independent—i.e. constantly knowable—this is not, in fact, *true* in case in practice. While practitioners rooted some decisions in a comparative judgement of 'who needs the bed more' (where the individual being assessed is compared to a potential individual being assessed in the future), this judgment cannot be known or adequately assessed at the bedside (and certainly not with respect to future predictions of who might turn up at the hospital).

Practitioners' own assessments of whether a future case might be 'more' or 'less' worthy of taking up a bed on the ward is not only vulnerable to discriminatory or stigmatising attitudes[58], but also to the mere fact that this kind of hypothetical comparison is too infused with uncertainty to be defensible. That is, a particular

[58]As demonstrated in Chapter 6, practitioners' decisions can trade on stigmatizing attitudes toward mental healthcare users, and practitioners' understandings of when an admission is a 'waste' of resources run the risk of not only being simply wrong but also completely overlooking the nature of the individual's need for admission (thereby defeating the possibility of involuntary admission in enabling an individual's right to health).

admissions decision should not be influenced by appeals to the needs of some future individual, currently unknown, who may arrive to hospital later.

Therefore, resource-focused considerations should *not* be incorporated into decision-making—despite their prominence in practitioners' accounts—which in turn means that a positive entitlements framework cannot and should not be applied to understanding the ethics of involuntary admission.

7.3.1.1. Counterargument: responding to reasons in favour of incorporating resource-focused considerations in decision-making

The objection to my argument—i.e. the argument in *favour* of including resource-focused considerations in decision-making in order to enact a positive entitlements framework—seeks to ensure that the system is not 'saturated' by only certain individuals. As practitioners noted, without due attention to resource-focused considerations, decision-making could inadvertently lead to the provision of mental healthcare for only a select few. This potential bias toward only admitting certain kinds of individuals would, in theory, compromise efforts to enact a positive entitlements framework that offers equitable access to inpatient mental healthcare, including inpatient mental healthcare accessed involuntarily. Therefore, as the argument goes, the incorporation of resource-focused considerations in decision-making is essential, recognising that practitioners have a duty to the entire population, not *just* the individual in front of them (Danis *et al.*, 2014). On this basis, then, some argue that resource-focused considerations

are not only inevitable in medical practice, but also may not "morally objectionable" (Fleck, 2014, p. 171).

Proponents of incorporating resource-focused considerations in decision-making might suggest that, in fact, the health system—especially the public health system—has an equal responsibility to care for an individual being assessed in the present as for any potential individual being assessed in the future. To do so, resource-focused considerations *must* be taken into account to ensure that those most in need of a bed—where 'need' is based on severity or, indeed, some other consideration entirely—are admitted. Moreover, without adequate attention to (and evaluation of) an individual's specific resource use (especially in terms of frequency of admissions), those in most need may be unjustifiably overlooked because available beds are already occupied.

Therefore, the overriding objection to *not* taking resource-focused considerations into account in decision-making stems from this appeal to the need to ensure that the 'rare' resource of inpatient beds are used equitably.

However, I contend that this objection misses the *trees* for the *forest*. That is, the inclusion of resource-focused considerations seems to obscure the nature of what is at stake in a decision of this kind. While positive entitlements can be understood as reasonably applying at the level of the population, the extent to which any application of positive entitlements can be actualised at the level of the

individual remains unclear. As demonstrated in the empirical picture, the resource-focused considerations that need to be incorporated into decision-making in order to realise a positive entitlements framework cannot be clearly 'mapped' onto the particular individual about whom a decision is being made. Put simply, there is no clear way to distil a resource-focused consideration into a justifiable principle at the level of the individual case, even if a positive entitlements framework necessarily entails the incorporation of resource-focused considerations in decision-making.

While I agree with a key premise of the counterargument—that any instantiation of a 'right to health' argument in favour of involuntary admission *should* include resource-focused considerations in its calculus in order to cohere to the demands of a positive entitlements framework—I do not agree that that these resource-focused considerations can, and therefore *should*, be taken into account in practice. The lack of clarity around how (if at all) resource-focused considerations—specifically as a function of enabling a positive entitlement to the demands of a 'right to health'—can be distilled and applied at the level of the individual poses a clear challenge to the ethical force of a 'right to health' argument in favour of involuntary admission.

Some proponents of the counterargument would concede that any incorporation of resource-focused considerations left up to the whims of individual practitioners is unethical, subject to unexamined or unacknowledged biases. However, proposals

to govern decision-making according to a defined framework for rationing on the basis of clinical judgment, e.g. Hurst and Danis (2007), would nonetheless run a similar risk in practice—especially given the apparent variability in 'clinical judgement' across practitioners (i.e. when practitioners spoke about their colleagues' decision-making). While other proposed protocols for rationing, e.g. a democratically agreed one (Fleck, 2014), successfully overcome this kind of critique, such proposals still do not adequately address the key aim of incorporating resource-focused considerations with a positive entitlements framework. That is, the inclusion of resource-focused considerations according to a predefined protocol still cannot guarantee that individual positive entitlements are indeed fulfilled to the extent that resources allow. Such rationing protocols draw their moral defensibility from their democratic and therefore "freely chosen, self-imposed" rationing (Fleck, 2014, p. 177), but democratically determined rationing is unlikely to sufficiently attend to the question of how positive entitlements can and should be enabled in practice—as part of the state's obligation—*in light of* available resources. That is, democratically determined rationing is a suitable strategy for cost-containment as a component of fair resource allocation, but falls short in determining who is in need of a bed (and when).

Thus, I have shown that the counterargument in favour of including resource-focused considerations in decision-making cannot overcome a key challenge. Specifically, the inclusion of resource-focused considerations, regardless of the

rationing proposal adopted, cannot adequately accommodate evaluation of fair resource use as it relates to involuntary admission *across* the entire population (as a positive entitlements framework demands). Hurst et al. (2009) allude to this challenge, calling for further work to understand how fair resource allocation can be understood where positive entitlements are concerned. Moreover, while practitioners' accounts demonstrated that the incorporation of resource-focused considerations is especially subject to discriminatory or stigmatising attitudes toward mental healthcare users, a further challenge arises in citing resource-focused considerations in decision-making. How should we ensure that appeals to fair resource use adequately address inequity? While Dankwa-Mullan et al., have recommended prioritising service provision for individuals who are impacted by social inequities, they also contend "fair allocation of resources in resource-poor settings (i.e., developing countries) may be more challenging" (Dankwa-Mullan, Goodwin and Wynia, 2014, p. 347).

For these reasons, the incorporation of resource-focused considerations—while essential to the application of a positive entitlements framework—is not ethically justifiable in practice. Therefore, not only should resource-focused considerations be excluded from decision-making, but a positive entitlements framework for understanding the ethics of involuntary admission should be abandoned.

7.3.2. Does a negative rights framework necessitate the incorporation of considerations beyond the individual?

Accepting, then, that a positive entitlements framework cannot be justifiably applied to involuntary admissions decisions—despite its promotion in the global mental health discourse—we then must address the boundary principles arising in a negative rights framework, drawn from psychiatric ethics. I analyse the boundary principle of 'need for treatment', as part of a broader negative rights framework, in light of the recalcitrant experience identified in Part II of the thesis.

To do so, I address the incorporation of system-focused considerations in decision-making. Per practitioners' accounts, the incorporation of system-focused considerations was sensitive to the nature of what could reasonably be provided through admission. In some cases, practitioners focused on providing access to care, specifically specialist care; in other cases, practitioners focused on a realistic assessment of the nature of the ward environment itself.

I suggest that, even in a negative rights framework, our understanding of which specific considerations are most justifiable *should* attend to these kinds of system-focused considerations. That is, any decision to admit should be adequately sensitive to the nature of healthcare delivery in the particular context, and should therefore ensure that the decision to admit (or, indeed, *not* to admit) is

appropriately grounded in a realistic understanding of what the service can provide to the individual upon admission.

Meaningfully applying the boundary principle of 'need for treatment', turns on our understanding of beneficence of this kind. Put simply, 'need for treatment' assumes that admission (and subsequent treatment) is in some way beneficial to the individual. To effectively apply the boundary principle of 'need for treatment' in practice, then, attention must be paid to system-focused considerations.

Of course, many would contest that involuntary admission is ever beneficial, especially in light of empirical evidence to suggest that individuals do not perceive involuntary admission to be beneficial after discharge (Katsakou and Priebe, 2006) and that involuntary admission fundamentally erodes the clinical relationship (Borecky, Thomsen and Dubov, 2019). Moreover, and as evidenced by the empirical picture developed in this analysis, questions of what can actually be offered on admission are also relevant to how practitioners' understand an individual's 'need for treatment' in practice.

In the case of South Africa, the nature of the decentralised system of mental healthcare delivery *should* be part of the decision-making calculus. In this system, involuntary admissions specifically proceed through general hospitals with limited capacity to provide appropriate care (again, not only because of resource

constraints but also because of the set-up of the wards—and even admission through the emergency centre). The extent to which any boundary principle, but especially the 'need for treatment' boundary principle, can be justifiably cited in decision-making should turn on the nature of what the admission can provide.

An involuntary admission determined on the basis of 'need'—variably defined—that intends to 'provide treatment' but instead provides compromised medical care (e.g. near constant sedation) is not justifiable. If the admission itself does not stand to benefit the individual in line with what a 'need for treatment' criterion implies, then the admission is unethical. That is, if the admission itself does not adequately consider limitations (or, indeed, access points) within the system, then the admission may not be justifiable, even if the specific criteria used to justify admission are themselves defensible on some account. Any admissions decision must consider not just justificatory criteria at the point of admission but also a realistic view of what admission could reasonably provide in the context of the health system by incorporating system-focused considerations in decision-making.

7.3.2.1. Counterargument: responding to reasons against the incorporation of system-focused considerations

An obvious objection to my argument—i.e. the argument *against* including system-focused considerations in decision-making—has two components: firstly, as with resource-focused considerations, practitioners may still not be well-positioned to actually *know* how system-focused considerations might impact a

particular case, and secondly, practitioners may be overlooking their responsibility to the individual by weighing up elements of the health system structure in decision-making. These arguments together would suggest that the incorporation of system-focused considerations is, like resource-focused considerations, both impossible to distil to the level of the individual and subject to bias.

Proponents of the argument *against* incorporating system-focused considerations may also suggest that the inclusion of system-focused considerations could lead to inequitable treatment, based on both the individual and the hospital setting (urban or rural). That is, some individuals who could benefit from inpatient care might be managed as an outpatient, while a 'like' presentation in a different hospital setting might be admitted as an inpatient because of the potential access to services that admission might bring. By taking system-focused considerations into account, we risk inconsistently differentiating 'like' cases on the basis of an external characteristic—the health system structure.

My response to this objection is focused predominantly on the need to ensure some degree of correlation between the justification for admission and a realistic assessment of what admission can actually provide. Take the case of an individual who could (in theory) benefit from inpatient care, but isn't admitted because of the practitioner's assessment of the ward environment. In this example, involuntary inpatient admission (for a 72-hour assessment period), justified on the

basis of a 'need for treatment' criterion, is unethical simply because the 'need for treatment' justification of involuntary admission cannot be sufficiently met within the bounds of the health system structure as is.

While I concede that evaluation of system-focused considerations may be vulnerable to a certain degree of bias—based both on their 'knowable-ness' as well as their potential to lead to different decisions about 'like' cases according to hospital setting—I suggest that practitioners are still *better* placed than other relevant stakeholders (e.g. policymakers or even hospital administrators) to consider and predict how system-focused considerations might work to benefit (or, indeed, harm) the individual upon admission. This is because practitioners have, if not perfect knowledge, at least *adequate* knowledge of key aspects of the system itself—e.g. conditions on the ward, the visiting mental healthcare specialists' schedule, knowledge of how quickly key services might be provided based on ample past evidence, what kind of care can be feasibly delivered in the context of a general district hospital (especially in a rural setting), et cetera. By applying this knowledge—even if imperfect—to decision-making, practitioners are better able to ensure that their decisions are appropriately sensitive to meeting the individual's needs *in context*, i.e. by weighing up whether admission or, indeed, *non*-admission stands to offer greater benefit to the individual.

Unlike with resource-focused considerations—where making decisions *without* perfect knowledge cannot be justified—the ethical defence of incorporating

system-focused considerations is less contingent on their 'knowable'-ness for one key reason. While the incorporation of resource-focused considerations is inherently comparative across individuals, and therefore subject to greater scrutiny (and thus a much higher demand on how much information is needed to justify the comparison), system-focused considerations are *not* comparative—that is, the incorporation of system-focused considerations allows for a realistic assessment of what the service can provide the individual *in relation to the individual*, not in comparison to other potential individuals who might be brought for assessment.

As such, the argument in favour of incorporating system-focused considerations in decision-making avoids the pitfall of the argument in favour of incorporating resource-focused considerations: while system-focused considerations inherently factor in wider concerns about resource limitations that impact how the system itself operates, their inclusion does not unjustly allow for a comparative evaluation of one individual over another. Instead, the inclusion of system-focused considerations in decision-making focuses on a practitioner's clinical (though, again, values-laden) determination of potential beneficence with respect to what the admitting hospital or wider network of referral services can reasonably provide.

However, I concede that the incorporation of system-focused considerations in decision-making necessarily entails some degree of differentiation across settings

(given the limits of the system as is)—the admissions decision made for each of two individuals with 'like' characteristics on every other parameter of interest might vary according to hospital setting. While, on its face, this inconsistency may look unjust, I argue that this variation is necessary requirement of ensuring that the individual's needs are met *in practice* and not just in theory.

Accepting this variation or apparent inconsistency *across* the system (i.e. different admissions decisions for 'like' cases in different hospital settings) allows the incorporation of system-focused considerations to ensure that the individual actually *benefits* from admission—not just that the individual fits the criteria for admission. For these reasons, the incorporation of system-focused considerations in decision-making for involuntary admission is ethically justifiable in practice.

7.4. Conclusion

Based on my engagement with the method of reflexive balancing, I have argued for (re)shaped framings of two key boundary principles.

Firstly, I suggested that a positive entitlements framework to guide involuntary admissions decisions, as adopted within the global mental health discourse and especially enacted in 'right to health' arguments, should *not* be applied in practice. I demonstrated that any appeal to a positive entitlements framework to root understandings of the ethics of involuntary admission ought to include resource-

focused considerations. However, resource-focused considerations cannot, I contend, be defensibly applied at the level of the individual. That is, 'right to health' arguments cannot be applied in practice because the relevant resource-focused considerations are not only unknown in many cases but also nearly impossible to distil down to the level of the individual. In any specific decision-making moment, practitioners are unable to justifiably decide whether admission (or, indeed, non-admission) is aligned with the broader demands of the 'right to health'—not at the level of the individual but population-wide.

Secondly, having rejected the incorporation of resource-focused considerations in decision-making and therefore a positive entitlements framework, I turned to analyse the contours of applying a negative rights framework to understand the ethics of involuntary admissions decisions. I argued that applications of ethical principles within a negative rights framework should include a realistic assessment of the health system, including its limitations, to ensure that the criteria for admission align to the expected outcome of admission. In the case of a South African decision-making context, we have good reason to believe that the decentralised model—where involuntary admissions proceed through emergency centres in general hospitals—is likely to stay, especially considering its staunch defences not only within South Africa (Burns, 2008) (not to mention its immortalization in the MHCA 2002 itself (Republic of South Africa, 2002)) but across settings, promoted specifically by leading voices in global mental health (Patel *et al.*, 2018) as well as the WHO's Department of Mental Health and

Substance Use (World Health Organization, 2021a). To the extent that the health system continues to be structured in this way, practitioners must ensure that the criteria for involuntary admission—especially the 'need for treatment' criterion—align to the scope of what the admission itself can reasonably provide. These kinds of system-focused considerations challenge our understanding of how involuntary admission—especially for a 72-hour assessment period, like in South Africa—can meaningfully meet the purpose of admission implied by the legal justificatory criterion itself.

Broadly, then, the incorporation of considerations beyond the individual—as is common in accounts of decision-making drawn from the empirical work but not clearly acknowledged in the ethical principles drawn from the literature—can be ethically justified in some cases.

Conclusion

Thesis summary

In my thesis, I sought to address the moral problem of involuntary admission, a long-standing ethical challenge in mental healthcare. The ethics of involuntary admission is widely contested, and is further challenged by the UN CRPD's entry into force in 2008, as well as calls for increased access to mental healthcare through a model of service delivery that permits involuntary admission. I rooted my inquiry in this apparent conflict between shifts in the debate over the ethics of involuntary admission in psychiatric ethics and the stated aim of the global mental health agenda to increase access to mental healthcare especially in low- and middle-income countries.

In Part I, *Mapping ethical principles in involuntary admission—psychiatric ethics and global mental health*, I sought to characterise the nature of this apparent tension. To do so, I applied a critical interpretive review method to explore relevant literature in psychiatric ethics (Chapter 1) and in global mental health (Chapter 2). In these two chapters, I identified key ethical principles pertaining to involuntary admission, as positioned in each of these two areas of scholarship. In analysing the literature broadly, I exposed a key conflict between the normative ideologies of these two fields: while psychiatric ethics is rooted in a negative rights framework, global mental health is rooted in a positive entitlements framework.

In Part II, *Framing involuntary admission in context—insights from a South African model of decision-making*, I sought to understand how we should navigate normative commitments in decision-making in practice by first understanding how normative commitments shape decision-making in practice. To do so, I adopted an empirical ethics approach, seeking to understand decision-making in practice through a South African case study, where the legal and health system contexts underscore key normative commitments drawn from both psychiatric ethics and global mental health. By applying a method of reflexive balancing, my analysis sought to integrate key ethical principles identified in Part I of the thesis with the empirical picture of decision-making as gathered through semi-structured interviews with mental healthcare practitioners and mental health advocates. My empirical data analysis demonstrated that practitioners' decisions are influenced by extra-legal considerations focused not only on the individual themself but also family availability, resource constraints, and the structure of the health system. Practitioners' decisions are also influenced by the process of decision-making itself, specifically because of the ways in which decisions made prior to the final decision to admit operate to foreclose access to key pieces of information, or operate as pieces of information themselves.

In Part III, *(Re)shaping ethical considerations in decision-making for involuntary admission*, I integrated the outputs of Parts I and II of the thesis in order to explore how the ethical principles relevant to involuntary admission as well as the normative commitments arising in decision-making should be navigated in

practice. I explored the normative value of incorporating resource- and system-focused considerations in decision-making, not only because their place in decision-making (if any) is unaccounted for in the boundary principles but also because their place in decision-making is especially relevant to the provision of mental healthcare in low- and middle-income country contexts. I argued that resource-focused considerations, though essential to the proper application of a positive entitlements framework (especially in terms of a 'right to health' argument), should not be incorporated into decision-making for involuntary admission. I argued that system-focused considerations *should* be incorporated into decision-making for involuntary admission in order to better meet the demands of a negative rights framework (especially in terms of a 'need for treatment' criterion).

Implications of the work

My thesis offers a novel contribution to the 'intractable' debate over the ethics of involuntary admission. Overall, my inquiry has suggested that the ethical principled cited in debates over the ethics of involuntary admission in both psychiatric ethics and in global mental health do not sufficiently capture the range of considerations that *should* be taken into account in decision-making.

My empirical work shows that practitioners' accounts of decision-making incorporate a range of considerations that sit beyond the individual themself. I

have examined the normative value of including these *non*-individual-focused considerations—specifically resource- and system-focused considerations—in decision-making. I have argued that resource-focused considerations cannot be justifiably incorporated in decision-making, which in turn negates practitioners' ability to enact a positive entitlements framework in understanding the ethics of involuntary admission. Put simply, appeals to positive entitlements, like the right to health', inevitably fail to sufficiently enact what a positive entitlements framework demands—attention to fair use of available resources *at the level of the individual* as it relates to involuntary admissions decisions.

In turning to explore how a negative rights framework should be enacted, I have argued that there is still a need to look beyond the individual themself. I have demonstrated that any application of a 'need for treatment' criterion within a negative rights framework should also incorporate system-focused considerations in order to determine whether involuntary admission can, in practice, offer 'treatment' of a suitable standard (with due consideration to the limitations of admission to general hospitals). Therefore, I conclude that the incorporation of system-focused considerations can be ethical in practice. The logic behind this particular argument—that the criteria for admission (in this case 'need for treatment') should match the purpose of admission (in this case 'to provide beneficial treatment')—also applies to other ethical principles within a negative rights framework, e.g. 'risk of harm to others'. That is, if an admission is justified

on the basis of 'risk of harm to others', than the admission should, in theory, adequately mitigate that risk (and perhaps *not* do much more than that).

By failing to take system-focused considerations into account, practitioners run the risk of doubly harming the individual—not only is the individual subject to detention and the loss of liberty (even for 72 hours), but that detention may not, itself, offer any substantive benefit to the individual. Conversely, by failing to take system-focused considerations into account, practitioners may unjustifiably deny inpatient care—even if accessed involuntarily—to an individual who stands to greatly benefit (e.g. where specialist care might be made available on the ward, especially in rural settings).

My project has demonstrated that the debate over the ethics of involuntary admission in the psychiatric ethics scholarship is too narrow to adequately capture the nuances and complexities of decision-making in context. As the empirical work revealed, decision-making in practice often includes a wide range of considerations beyond the individual. Some of this inclusion of considerations beyond the individual is, I argue, ethical—specifically system-focused considerations concerned with the kind and quality of care being provided by virtue of the health system structure. Through the integrated normative and empirical analysis, I have concluded that considerations that sit beyond the individual—specifically a realistic assessment of what kind and quality of care can be provided given the health system structure—should also impact decision-

making. Acknowledging the ethically justified place of system-focused considerations in decision-making stands to offer a more nuanced application of the ethical principle of 'need for treatment' within a negative rights framework.

In my thesis, I have also demonstrated that global mental health's adoption of a positive entitlements framework to drive its key rights-based arguments for increasing access to services cannot be neatly applied to the ethics of involuntary admission. I have also demonstrated that the primary model of mental healthcare delivery promoted by the dominant narrative of global mental health—specifically the delivery of inpatient mental healthcare in general hospitals, with admissions proceeding through general emergency centres—brings certain implications for involuntary admissions decisions. Given the strong arguments for retaining this model of service delivery to achieve other key aims (e.g. destigmatizing mental healthcare, achieving parity between mental and physical health), global mental health must grapple with the consequences of the model for involuntary admission.

Strengths and limitations of my analysis

I have sought to offer a robust defence of each of my methodological choices across the project; however, there are key limitations in each part of the thesis that must be acknowledged when considering the force of the analysis.

Strengths and limitations in Part I

In Part I of the project, my choice to anchor the search for boundary principles in key agenda-setting papers, policy documents, and the law necessarily limits the *kinds* of principles identified. McDougall acknowledges the limitations of a critical interpretive review in "permitting individual judgement" in the selection of literature included, thereby potentially introducing bias (McDougall, 2015, p. 527), and my work is, of course, no exception. To mitigate this risk, especially in Chapter 1, I supplemented my excavation of boundary principles by tracking the active debate over the ethics of involuntary admission in the psychiatric ethics literature; that said, by rooting my inquiry in the law, I am inevitably privileging the law's place in the debate to some extent. However, given the importance of law in governing involuntary admission, and given the slow progress being made toward revising legislation, I felt it important to ensure that my analysis was sensitive to the kinds of ethical principles that currently govern practice, as opposed to more broadly idealist conditions (however defensible) discussed in the literature. Furthermore, and as discussed in Chapter 1, the challenge with involuntary admission remains in *emergency* cases, like the ones described in practitioners' accounts of decision-making. These emergency cases, like the 72-hour assessment period for involuntary admission (broadly understood to be an 'emergency' provision (Petersen and Lund, 2011)), are governed by dominant legal criteria in most jurisdictions. As such, the project sought to understand how core features of legal rationales operated in practice. The project is strengthened by the 'disciplinary naïve' inquiry in two key domains, which ensures that a broad range of potentially relevant ethical principles are brought into the analysis.

Strengths and limitations in Part II

The empirical work is also subject to a few key limitations. Firstly, the pandemic-induced reliance on snowball sampling for practitioners, as well as an exclusively snowball sampling strategy for advocates, shaped who participated and in turn what kind of data was collected. Given the practical constraints, snowball sampling was the best option available to me. While snowball sampling as a form of convenience sampling may be prone to some bias, I believe that the strategy also afforded some strengths—specifically by increasing sample heterogeneity in practitioner recruitment. That is, because I relied on snowball sampling to overcome recruitment challenges induced by COVID-19, I was actually better able to sample practitioners with a wide range of practical experiences, specifically those working rurally, which has improved the force of the analysis.

Secondly, the nature of the topic guide used in interviews with practitioners is not sensitive enough to determine clearly whether perspectives shared are rooted in hospital culture, regional culture, or the practitioners' personal values. To combat this limitation, I have striven to stay sensitive to the possibility of patterns in the data based on hospital setting, and have transparently included data labels to indicate *which* specific hospital setting practitioners described. In this vein, the data collection is also limited by the lack of attention to broader sociocultural forces, e.g. racism, poverty, and other important social determinants of health that undoubtedly impact the health system itself, and even the clinical encounter. While these kinds of considerations were briefly referenced in some interviews,

far more research is needed to understand how such social determinants of health (historical and present-day) might specifically weigh upon our understandings of the ethics of involuntary admission.[59]

Finally, the low number and lack of organizational diversity of advocates is a limitation of the study. That said, the advocate interviews illuminated a key aspect of the analysis, which also furthered refinement of the topic guide in practitioner interviews: critically, advocates highlighted the limits in the system, especially in terms of what admission *looks like* after the decision is made, which facilitated the opportunity to challenge assumptions in practitioner interviews about what actually *happens* for individuals after admission. Though limited in number, the advocate interviews allowed for nuanced understanding of how constraints within the system do (and should) influence admissions decisions. That said, while advocates were interviewed to represent and service user voices and though some advocates had lived experience of involuntary admission, the missing explicitly service user or survivor perspective (not combined with an advocacy role) is a key limitation of this study.

[59]For example, while many high-income countries report disproportionately high rates of involuntary admission for Black individuals compared to white individuals (Barnett *et al.*, 2019), a key argument *in favour* of South Africa's MHCA 2002, including its provisions for involuntary admission, was to improve access to care for non-White and especially Black South Africans, who could not access mental healthcare on an equal basis with white South Africans under apartheid (McCrea, 2010; Mulutsi, 2017, pp. 25–26). Limited empirical data is available to determine whether rates of involuntary admission in South Africa are, at present, (dis)proportionate by race.

Strengths and limitations in Part III

A major limitation of the study is that my application of the method of reflexive balancing has only sought coherence between one element of the empirical picture and its relationship to relevant ethical principles drawn from the literature. Instead of seeking coherence across all of the boundary principles, I have analysed the implications of including resource- and system-focused considerations in decision-making as it relates to the tension between a positive entitlements framework and a negative rights framework. As such, my adoption of a reflexive balancing methodology is incomplete, and further work is needed to understand how the empirical picture intersects with the full normative picture of decision-making.

Another critical limitation of this work is that neither the normative analysis nor the empirical analysis has put forth any strong indication of how (if at all) individual boundary principles should be weighted in decision-making. Moreover, because the boundary principles identified in Part I of the thesis were already in tension, I have not been able to defend a specific formulation of coherence between boundary principles and recalcitrant experience. Despite these limitations, my study has successfully defended a coherent and justifiable resolution to the tension identified between the psychiatric ethics and global mental health literatures, thereby addressing the normative research question set out in Chapter 3.

Further research

By focusing on understanding the ethical place of resource- and system-focused considerations in decision-making, I left open some challenges, specifically in terms of understanding how each boundary principle (especially those drawn from the psychiatric ethics scholarship) might be managed in practice. Having worked through how we should think about the tension between boundary principles—those rooted in positive entitlements and those rooted in negative rights—and then how we should think about two key facets of the empirical picture of decision-making—resource- and system-focused considerations—as they relate to these two frameworks, the next step is to address the conflicts between key boundary principles (e.g. the conflict between the 'risk of harm to others' and the 'need for treatment' criteria) rooted in a negative rights framework themselves, as described in Section 1.7.1 (page 60).

Additional work in this area might take carefully designed vignettes to practitioners in an attempt to understand more clearly *how* practitioners explicitly or implicitly value certain kinds of considerations over and above others. Further reflection is needed to explore how this weighing of considerations might shape our understandings of which ethical principles should govern decision-making in practice. The method of reflexive balancing could also be applied, using the data collected in this project, to address other aspects of the tensions between ethical principles and the empirical picture, e.g. the normative value, if any, of the place of family-focused considerations in decision-making.

Final reflections

A critical voice might challenge not only the arguments made in this thesis but also the general orientation of the work, taking issue with my minimal engagement with the prior question of whether involuntary admission is ever ethical (i.e. the abolitionist's argument). Though this argument is of critical importance, my thesis has demonstrated that the practical contexts of decision-making complicate the very nature of the question: while the abolition argument is suitable for an ideal world (and one toward which health systems should arguably strive), it does not adequately attend to the various complexities of the moral problem as it plays out in the very non-ideal world in which we live. This, I contend, is especially the case considering health systems as they are structured at present.[60] That is, the push for abolition should not be rooted in a *reaction* to the challenges of involuntary admission—it is clear that the contexts in which these decisions are made are far more difficult and nuanced than the standard description of the case lets on.

Broadly, my reflections suggest that there is a need to connect the criteria used to justify admission with a realistic acknowledgement of what the system intends to and can actually provide to the individual in that case—thereby taking the health system structure into account in decision-making. This latter point is, of course, a

[60]This perspective, and the specific focus on the health system structure, aligns with a key point made by Prof Diana Rose in the WPA-*Lancet* Commission on the future of psychiatry: "[…] I believe that there is a place for involuntary admission in very particular circumstances and *given the current configuration of services in many countries*" [emphasis added] (Bhugra *et al.*, 2017, p. 794).

moving target—and one that can absolutely improve with policy change and substantial investment in the health system (and other social systems of care). However, it is important to recognize how hard-line commitments in health policy and systems—e.g. parity between mental and physical health, the value of integrating mental healthcare into primary healthcare settings, and especially endorsing the provision of inpatient care through general hospitals—might meaningfully shift our understandings of when, if ever, involuntary admission should be justified.

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Appendices

Appendix A: Search strategy (empirical ethics and involuntary admission)

Web of Science (search last updated on 9 October 2021)

Field tag	Search terms	Boolean operator
TOPIC	(compulsory OR involuntary OR forced OR civil OR coerced OR coercive) NEAR/2 (treatment OR detention OR commitment OR admission OR hospitalisation OR institutionalization OR care OR intervention OR confinement))	AND
TOPIC	(psychiat* OR psycho* OR 'mentally ill' OR 'mental health' OR mental*)	AND
TOPIC	(“empirical bioethics” OR “evidence based bioethics” OR “interdisciplinary bioethics” OR “empirical ethics” OR “social sciences perspectives on bioethics” OR “empirical research in bioethics” OR “empirical-ethical research” OR “ethics-related empirical research”)	

Appendix B: Participant information sheet (practitioners)

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

RESEARCH STUDY on DECISION-MAKING FOR PSYCHIARIC INPATIENT ADMISSION

Participant Information Sheet (PIS)

[for mental healthcare practitioners]

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

OxTREC reference number: 545-19 | **BREC reference number**: BREC/00000947/2020

Dear mental healthcare practitioner,

Thank you for taking time to learn about this study. My name is Marisha Wickremsinhe and I am a doctoral researcher in ethics and population health from the University of Oxford, working in partnership with expert advisors from the University of KwaZulu-Natal. This study is being undertaken as part of my DPhil thesis.

You are being invited to consider participating in a study about decision-making for psychiatric inpatient admission.

1. What is the purpose of this research?

With increased attention on the importance of mental health comes an opportunity to better understand how we can improve access to critical mental health services in different types of health systems. The purpose of this research is to better understand hospital admissions decisions for psychiatric inpatients. In particular, I am interested in the array of factors and considerations that might inform the decisions of experts such as yourself. This includes not only clinical, but ethical, sociocultural, economic, and legal considerations. South Africa offers an important ethical-legal model for guiding psychiatric admissions, particularly with the Mental Health Care Act 17 of 2002 (MHCA 2002). The idea is to learn from this model when considering the wider, international context of mental health services and delivery. As a study in ethics and population health, the main focus of the research is to understand the full range of considerations relevant to ethical reasoning and decision-making for psychiatric inpatient admission without consent. I expect to recruit approximately 15 mental healthcare practitioners with experience of making decisions about psychiatric inpatient admission without consent, and approximately 10 mental health advocates with specialized knowledge of the ways in which various considerations are understood and weighed by the user community.

2. Why have I been invited to take part?

As a healthcare practitioner with mental health work experience, you have important insights to offer on this topic. You have been asked to participate because of your experience in initiating admissions and treatment decisions for psychiatric inpatient care.

3. What's involved for me?

Your participation in this interview is entirely voluntary. You are absolutely free to choose not to participate or, even if you choose to participate now, to later change your mind.

If you decide to take part in this study, you will be invited to participate in an interview. The interview will last for no more than 90 minutes. Interviews will take place over voice or video call via Skype or Zoom, based on your preference.

In the interview, you will be asked to describe the kinds of considerations you have used to inform your decision-making for psychiatric inpatient admission, including admissions without consent. You are under no obligation to answer any of the questions; if you wish to skip a question, you can tell the interviewer to move onto the next question. You can stop or leave the interview at any time and without giving any explanation.

You may be contacted again over the course of the next 14 months to take part in a follow-up interview of no longer than 60 minutes. You are free to decline taking part in the follow-up interview.

As compensation for time taken to participate, you will receive a 150 ZAR voucher. If you would like to hear about the findings of this study, you are very welcome to give contact details so that any study reports or dissemination materials can be shared with you.

4. What will happen to my data?

The content of your interview—recordings and transcripts—will be kept securely. Any personal details, including name and contact information, will not be shared with anybody else and will not be included in any study reports. Your personal data will not be shared or made available to anyone outside of the study team at the University of Oxford. Neither your colleagues nor your supervisors will have any access to the full content of your interview, even after the transcript is pseudonymised (for individuals' names as well as the names of any institutions or similarly identifying information). There are very rare circumstances in which, as a researcher, I may have an obligation to breach confidentiality if safeguarding concerns are raised about a particular person, but this is very unlikely to occur in this project.

The findings drawn from this research will be shared in the form of a written doctoral thesis, as peer-reviewed journal articles, and in presentations made at conferences or to partner sites. Any direct quotes from your interview that might be used in these dissemination materials will be fully anonymized.

5. Are there any risks in taking part?

There is a small risk that you might find some of the questions uncomfortable or distressing. You are not required to respond to any questions you do not wish to answer, and if you want to skip a question or stop the interview at any time, please say so; we can end the interview or continue at a later time.

Because our discussion will include legal considerations, you might feel concerned about liability for your responses to some questions. To ease this worry, we will not link your name to your responses *or* the study itself when we share findings from this study in writing or presentations. Also, as mentioned under 'What will happen to my data?' above, the data will be pseudonymised at the point of transcription.

6. What are the benefits of taking part?

There are no direct benefits of taking part in this study. However, you might find it beneficial to have the opportunity to share your views and experiences of this kind of decision-making. You might also value contributing to this research, which seeks to better understand and characterize the kinds of ethical considerations that inform decision-making for psychiatric inpatient admission without consent.

7. Do I have to take part?

Your participation in this interview is entirely voluntary. You are invited and encouraged to ask any questions you have about the study, the interview, or any other aspect of the research before deciding whether to take part. It is absolutely your choice to agree or decline to participate. There are no penalties for declining to participate or withdrawing from the study (during or after the interview).

8. Has the study been reviewed by an ethics committee?

The study has been reviewed and approved by the following research ethics committees:

1. Oxford Tropical Research Ethics Committee (OxTREC), University of Oxford, Oxford, United Kingdom

2. Biomedical Research Ethics Committee (BREC), University of KwaZulu-Natal, Durban, South Africa

9. What if I have any questions or want to raise a concern?

You may ask any questions about the nature and content of the interview and/or the research project itself at any time before, during, or following your participation in the study. If you have questions or concerns about the interview, please ask the principal investigator:

Marisha Wickremsinhe, Ethox Centre, Nuffield Department of Population Health, University of Oxford

marisha.wickremsinhe@ethox.ox.ac.uk

Alternatively, you may contact the research supervisor:

Prof. Michael Dunn, University of Oxford: michael.dunn@ethox.ox.ac.uk

You can also contact the ethics review committees who have approved this study:

Oxford Tropical Research Ethics Committee, University of Oxford: oxtrec@admin.ox.ac.uk

Biomedical Research Ethics Committee, University of KwaZulu-Natal: BREC@ukzn.ac.za

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, South Africa
Tel: 27 31 2604769
Fax: 27 31 2604609

10. Data protection

The University of Oxford is responsible for ensuring the safe and proper use of any personal information you provide, solely for research purposes. There is some risk to confidentiality because personal data will be collected for research purposes; however, because data will be pseudonymised at the point of transcription and audio recordings kept safely in an encrypted file on the University of Oxford secure server, the likelihood of this risk is extremely small.

Appendix C: Participant information sheet (advocates)

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

RESEARCH STUDY on DECISION-MAKING FOR PSYCHIARIC INPATIENT ADMISSION

Participant Information Sheet (PIS)

[for mental health advocates]

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

OxTREC reference number: 545-19 | **BREC reference number**: BREC/00000947/2020

Dear mental health advocate,

My name is Marisha Wickremsinhe and I am a doctoral researcher in ethics and population health from the University of Oxford, working in partnership with expert advisors from the University of KwaZulu-Natal. Thank you for taking time to learn about this study, which focuses on the kinds of considerations that matter to decision-making for psychiatric inpatient admission without consent. This study is being undertaken as part of my DPhil thesis.

1. What is the purpose of this research?

With increased attention on the importance of mental health comes an opportunity to better understand how we can improve access to critical mental health services in different types of health systems. The purpose of this research is to better understand hospital admissions decisions for psychiatric inpatients. In particular, I am interested in the way in which factors and considerations that might inform admissions decisions are understood by members of the mental health care user community. This includes not only clinical, but ethical, sociocultural, economic, and legal considerations. South Africa offers an important ethical-legal model for guiding psychiatric admissions, particularly with the Mental Health Care Act 17 of 2002 (MHCA 2002). The idea is to learn from this model when considering the wider, international context of mental health services and delivery. As a study in ethics and population health, the main focus of the research is to understand the full range of considerations relevant to ethical reasoning and decision-making for psychiatric inpatient admission without consent. I expect to recruit approximately 10 mental health advocates with knowledge of the ways in which various considerations are understood and weighed by the user community, like you, and approximately 15 mental healthcare practitioners with experience of making decisions about psychiatric inpatient admission without consent.

2. Why have I been invited to take part?

You have been asked to participate because you have specialized knowledge about the ways in which these considerations are understood, justified, or critiqued by members of the mental health care user community.

3. What's involved for me?

Your participation in this interview is entirely voluntary. You are absolutely free to choose not to participate or, even if you choose to participate now, to later change your mind.

If you decide to take part in this study, you will be invited to participate in an interview. The interview will last for no more than 90 minutes. Interviews will take place over voice or video call via Skype or Zoom, based on your preference.

In the interview, you will be asked to describe the kinds of considerations you perceive to be important to decision-making for psychiatric inpatient admission, including admissions without consent, especially based on your knowledge and experience as a mental health advocate. You are under no obligation to answer any of the questions; if you wish to skip a question, you can tell the interviewer to move onto the next question. You can stop or leave the interview at any time and without giving any explanation.

As compensation for time taken to participate, you will receive a 150 ZAR voucher. If you would like to hear about the findings of this study, you are very welcome to give contact details so that any study reports or dissemination materials can be shared with you.

4. What will happen to my data?

The content of your interview—recordings and transcripts—will be kept securely. Any personal details, including name and contact information, will not be shared with anybody else and will not be included in any study reports. Your personal data will not be shared or made available to anyone outside of the study team at the University of Oxford. Neither your colleagues nor your supervisors will have any access to the full content of your interview, even after the transcript is pseudonymised (for individuals' names as well as the names of any institutions or similarly identifying information). There are very rare circumstances in which, as a researcher, I may have an obligation to breach confidentiality if safeguarding concerns are raised about a particular person, but this is very unlikely to occur in this project.

The findings drawn from this research will be shared in the form of a written doctoral thesis, as peer-reviewed journal articles, and in presentations made at conferences or to partner sites. Any direct quotes from your interview that might be used in these dissemination materials will be fully anonymized.

5. Are there any risks in taking part?

There is a small risk that you might find some of the questions uncomfortable or distressing. You are not required to respond to any questions you do not wish to answer, and if you want to skip a question or stop the interview at any time, please say so; we can end the interview or continue at a later time.

6. What are the benefits of taking part?

There are no direct benefits of taking part in this study. However, you might find it beneficial to have the opportunity to discuss user views on psychiatric inpatient admission without consent. You might also value contributing to this research, which seeks to better understand and characterize the kinds of ethical considerations that inform decision-making for psychiatric inpatient admission without consent.

7. Do I have to take part?

Your participation in this interview is entirely voluntary. You are invited and encouraged to ask any questions you have about the study, the interview, or any other aspect of the research before deciding whether to take part. It is absolutely your choice to agree or decline to participate. There are no penalties for declining to participate or withdrawing from the study (during or after the interview).

8. Has the study been reviewed by an ethics committee?

The study has been reviewed and approved by the following research ethics committees:

1. Oxford Tropical Research Ethics Committee (OxTREC), University of Oxford, Oxford, United Kingdom
2. Biomedical Research Ethics Committee (BREC), University of KwaZulu-Natal, Durban, South Africa

9. What if I have any questions or want to raise a concern?

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

You may ask any questions about the nature and content of the interview and/or the research project itself at any time before, during, or following your participation in the study. If you have questions or concerns about the interview, please ask the principal investigator:

Marisha Wickremsinhe, Ethox Centre, Nuffield Department of Population Health, University of Oxford

marisha.wickremsinhe@ethox.ox.ac.uk

Alternatively, you may contact the research supervisor:

Prof. Michael Dunn, University of Oxford: michael.dunn@ethox.ox.ac.uk

You can also contact the ethics review committees who have approved this study:

Oxford Tropical Research Ethics Committee, University of Oxford: oxtrec@admin.ox.ac.uk

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Research Office, Westville Campus
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Fax: 27 31 2604609

10. Data protection

The University of Oxford is responsible for ensuring the safe and proper use of any personal information you provide, solely for research purposes. There is some risk to confidentiality because personal data will be collected for research purposes; however, because data will be pseudonymised at the point of transcription and audio recordings kept safely in an encrypted file on the University of Oxford secure server, the likelihood of this risk is extremely small.

Appendix D: Consent form (practitioners)

Title of Study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

UNIVERSITY OF OXFORD

RESEARCH STUDY on DECISON-MAKING FOR PSYCHIATRIC INPATIENT ADMISSION

Consent Form

[for mental healthcare practitioners]

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

OxTREC reference number: 545-19 | **BREC reference number**: BREC/00000947/2020

If you agree, please initial box

1. I have been informed about the study 'Decision-making for psychiatric inpatient admission without consent in South Africa' by Marisha Wickremsinhe. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information and ask questions, and have had these questions answered satisfactorily.	
2. I understand the purpose of the study, and I understand that participation in the study consists of an interview with the researcher, Marisha Wickremsinhe, on the topic of psychiatric inpatient admission without consent.	
3. I understand that my participation in this study is voluntary. I also understand that I am free to withdraw from the study at any time for any reason, and that my withdrawal will not lead to any penalty.	
4. I understand that data collected during the study will be looked at by the study team. I give permission for these individuals to have access to the content of my interview.	
5. I understand that content of the interview will be anonymized in any dissemination of findings so that it will not be possible for me to be directly identified. I agree to the use of the information I provide for this purpose.	
6. I consent to being audio-recorded during this interview.	
7. I consent to being re-contacted to participate in a follow-up interview.	
8. I agree to take part in this study.	

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

Appendix E: Consent form (advocates)

Consent Form (mental health advocates), version 2.2 5 June 2020
OxTREC reference number: 545-19 | BREC reference number: BREC/00000947/2020

Title of Study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

UNIVERSITY OF OXFORD

RESEARCH STUDY on DECISION-MAKING FOR PSYCHIATRIC INPATIENT ADMISSION

Consent Form

[for mental health advocates]

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

OxTREC reference number: 545-19 | **BREC reference number**: BREC/00000947/2020

If you agree, please initial box

1. I have been informed about the study 'Decision-making for psychiatric inpatient admission without consent in South Africa' by Marisha Wickremsinhe. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information and ask questions, and have had these questions answered satisfactorily.	
2. I understand the purpose of the study, and I understand that participation in the study consists of an interview with the researcher, Marisha Wickremsinhe, on the topic of psychiatric inpatient admission without consent.	
3. I understand that my participation in this study is voluntary. I also understand that I am free to withdraw from the study at any time for any reason, and that my withdrawal will not lead to any penalty.	
4. I understand that data collected during the study will be looked at by the study team. I give permission for these individuals to have access to the content of my interview.	
5. I understand that content of the interview will be anonymized in any dissemination of findings so that it will not be possible for me to be directly identified. I agree to the use of the information I provide for this purpose.	
6. I consent to being audio-recorded during this interview.	
7. I agree to take part in this study.	

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

Appendix F: Topic guide (practitioners)

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

RESEARCH STUDY on DECISION-MAKING FOR PSYCHIATRIC INPATIENT ADMISSION

Topic guide

[for mental healthcare practitioners]

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

OxTREC reference number: 545-19 | **BREC reference number**: BREC/00000947/2020

{INTRODUCTION AND GENERAL CONTENT}

Thank you so much for agreeing to share your own thoughts and reflections with me today! As you know, I'm conducting this interview as part of my doctoral research project. Just to give some background on the project: My research aims to better understand hospital admissions decisions for inpatient psychiatric care. I'm especially interested in exploring the full range of considerations relevant to your clinical decision-making to admit inpatients, focusing especially on how these admissions decisions are made on the ground. So, all that said, I'll be asking you to think about your own experiences of decision-making, maybe calling on a memorable case from years ago or more recent cases from your last shift, even, to help illustrate your perspective. Of course, it's absolutely fine if you can't remember a specific example on the spot or if you can't recollect anything in the moment, but I'm most interested in your own reflections on your own experiences. Does that sound okay to you?

Great, let's get started!

1. Maybe we could begin with a question more broadly about why you do the kind of work you do. What drew you into mental healthcare?
    - Probe: What drew you into your current role?
2. [That was really moving/inspiring/fascinating.] Thank you so much for sharing a little about your own story. I'm just thinking about your journey and wondering if you could share any reflections you might have on how the landscape for mental healthcare has changed, if at all, in the time you've worked in the field?
3. Thank you so much for sharing that. Perhaps now we could shift to talking a bit more about psychiatric inpatient admission generally. Could you tell me a little bit about the process for admitting a patient for psychiatric care on your ward?
    - Probe: How do staff determine whether someone is in need of psychiatric care?
    - Probe: What kind of clinician would assess the patient first?
    - Probe: Who is involved in the admissions decision for inpatient psychiatric care?
4. What are the main things you consider about the patient themself when making admissions decisions?
5. What are the main things you consider about the situation or context when making admissions decisions?
    - Probe: Is there anything about the patient's family circumstances that might impact your decision?
    - Probe: Is there anything about the patient's personal circumstances that might impact your decision?
    - Is there anything challenging about the process?

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

{ADMISSION WITHOUT CONSENT}

Thank you for talking to me about the admissions process generally. Now, I'd like to shift to talking about admission without consent—that is involuntary or assisted admission—more specifically.

6. Can you tell me how often you would admit patients without their consent versus with their consent in, say, a given shift?
    - Probe: How often would a voluntary patient come to hospital?
    - Probe: How often would a patient be admitted as an assisted patient? As an involuntary patient?

7. [Does the process for admission without consent differ from the process you described earlier?]

8. I'm wondering about who brings patients in to be assessed for admission without consent. Who tends to bring a patient in for assessment in your experience?
    - Probe: Are family involved? Can you give me an example?
    - Probe: Are police involved? Can you give me an example?
    - Probe: How do these cases differ, if at all?

9. What considerations would go into a decision to admit without consent?
    - Probe: Could you give an example?
    - Probe: Would that be typical?
    - **Probe: How would you assess [criterion]?**

10. Would anything about the patient inform your decision, for example, history of past admissions?
    - Probe: Could you give an example?
    - Probe: Would that be typical?

11. Would any non-clinical factors inform your decision?
    - Probe: Could you give an example?
    - Probe: Would that be typical?

12. How do you distinguish a patient for 'assisted' versus 'involuntary' care? How do you differentiate these two categories of admission in your experience and practice?

13. Can you tell me about a time, if any, that an individual was considered for inpatient admission, but your team ultimately chose not to admit?
    - Probe: Why did you make this decision? In what way or ways did this patient not fit the criteria for admission?

14. What kinds of challenges come up for the team when making an admissions decision?
    - Probe: Could you give an example?
    - Would that be a typical kind of situation?

15. Have you ever disagreed with a colleague about an admissions decision?

16. Have you, or a colleague at your facility or elsewhere, had to make any especially difficult admissions decision for psychiatric inpatient care without consent? Could you tell me about that?

{CLOSE}

Thank you so much for talking to me in such detail about the process for involuntary and assisted admissions.

17. Is there anything else you would like to share about this topic? Do you have other reflections you want to share about mental healthcare in South Africa?

18. Is there anything on your mind that you haven't had the chance to share yet?

19. Do you have any colleagues who you think I should speak with?

Appendix G: Topic guide (advocates)

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

RESEARCH STUDY on DECISION-MAKING FOR PSYCHIARIC INPATIENT ADMISSION

Topic guide

[for mental health advocates]

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

OxTREC reference number: 545-19 | **BREC reference number**: BREC/00000947/2020

{INTRODUCTION AND GENERAL QUESTIONS}

Thank you so much for agreeing to speak with me today! As you know, I'm conducting this interview as part of my doctoral research project. Just to give some background on the project: My research aims to better understand hospital admissions decisions for psychiatric inpatient care. I'm hoping to explore with you the way in which factors and considerations that might inform admissions decisions are understood by members of the mental health advocacy communities. In our conversation today, I'll ask you to reflect on the experiences of individuals with lived experience in relation to involuntary or assisted admission in South Africa, whether they're the anonymized experiences of members of your organization , or whether those are your own personal experiences, if you have any and wish to share. We will also speak about your own perspective on admission without consent generally, and what you make of the way in which those admissions generally proceed. Lastly, we can speak about the degree to which admission without consent is an area of focus for the work of your organization, or your own advocacy work. If that all sounds okay, then we can get started!

- Just to begin, I'm wondering if you could share a bit about what drew you into mental health advocacy work and how you got into this kind of work.
- How long have you been involved in mental health advocacy? I'm wondering if you could share any reflections you might have on how the landscape for mental healthcare has changed, if at all, in the time you've spent doing mental health advocacy work.

{EXPERIENCES OF ADMISSION WITHOUT CONSENT}

- Thank you so much for sharing you story and perspectives with me. I wondered if we could now speak a bit about experiences of admissions. Is admission without consent a prominent topic of discussion among members in your organization?
- I'm wondering if you might tell me a bit about experiences of psychiatric inpatient admission without consent, whether those experiences are members' experiences, or experiences you've heard of or witnessed, or even your own experiences, if you have any and would feel comfortable to share. You are, of course, absolutely welcome to either skip this question or answer in more general terms if you prefer.
- What do people tend to think about their admission after they've been discharged?
- What do you hear about patients' experiences of being admitted to hospital for mental healthcare, if anything?
    - Probe: Do those experiences differ based on whether the hospital is private or public?

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

{GENERAL PERCEPTIONS OF ADMISSION WITHOUT CONSENT}

- How is admission without consent generally viewed by mental healthcare users and individuals with lived experience?
- How is the Mental Health Care Act viewed by users and advocates?
- How do you and other advocates view human rights in relation to admission without consent?
- What changes would you and other advocates like to see in the process for hospital admissions decisions, especially admissions decisions without consent?
    - Probe: What changes would you and other advocates like to see in the process for voluntary hospital admissions decisions?

{WORK OF ORGANZATION}

- Again, thank you so much for sharing your perspective with me. I'm wondering if we could now transition to speaking more generally about the work of your organization. What are the most important issues for your advocacy work?
- To what extent is admission without consent an important area of focus for your organization, if at all?
- Does your organisation have a dominant perspective on admission without consent?
- What are the most pressing mental health-related issues in South Africa now? How do these issues direct the work of your organization?

{CLOSING}

- Thank you so much for speaking with me and for sharing your perspectives with me! Just before we close, is there anything else you would like to share about this topic, or something on your mind that you haven't had the chance to share yet?

Appendix H: COVID-19 impact

My research was significantly impacted by COVID-19. I planned to travel to South Africa to conduct fieldwork for my qualitative research project in June 2020. I intended to conduct in-depth interviews with mental health advocates and mental health practitioners (specialists and non-specialists) working primarily in emergency medicine. When travelling to South Africa became an impossibility, I redesigned my study to pursue a virtual interviewing strategy.

After reconfiguring recruitment procedures, I was able to begin virtual interviews in the last week of July 2020, nearly two months behind schedule. However, I encountered considerable difficulties in recruiting participants as a direct result of the pandemic: only a small number of clinicians working in emergency medicine were available to participate in in-depth interviews due to work demands placed on them by COVID-19 (South Africa experienced its first COVID-19 peak between July and August 2020).

With recruitment numbers significantly lower than expected in the first phase of my data collection, I was forced to pause further recruitment in early September 2020 and to adapt my study once more. I revised my study protocol to sample (again virtually) from a wider range of physicians, including physicians who were not currently working in emergency settings, but who had relevant experience.

This substantive change to the study protocol, necessitated by the COVID-19 pandemic, required amendment and re-approval from the research ethics committees at both University of Oxford and the University of KwaZulu-Natal. After receiving both approvals and again reengineering my recruitment procedures, I was able to begin an extended second round of data collection in mid-January 2021, and closed data collection in early February 2021. South Africa experienced the height of its second wave of COVID-19 in January 2021.

Appendix I: Revised topic guide (practitioners)

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

RESEARCH STUDY on DECISION-MAKING FOR PSYCHIATRIC INPATIENT ADMISSION

Topic guide

[for mental healthcare practitioners]

Title of study: *Decision-making for psychiatric inpatient admission without consent in South Africa*

OxTREC reference number: 545-19 | **BREC reference number**: BREC/00000947/2020

{INTRODUCTION AND GENERAL CONTENT}

Thank you so much for agreeing to share your own thoughts and reflections with me today! As you know, I'm conducting this interview as part of my doctoral research project. Just to give some background on the project: My research aims to better understand hospital admissions decisions for inpatient psychiatric care. I'm especially interested in exploring the full range of considerations relevant to your clinical decision-making to admit inpatients, focusing especially on how these admissions decisions are made on the ground. So, all that said, I'll be asking you to think about your own experiences of decision-making, maybe calling on a memorable case from years ago or more recent cases from your last shift, even, to help illustrate your perspective. Of course, it's absolutely fine if you can't remember a specific example on the spot or if you can't recollect anything in the moment, but I'm most interested in your own reflections on your own experiences. Does that sound okay to you?

And just a note to say I will be taking notes in addition to having the recording on, so if I'm not saying anything, it's because I'm frantically writing! Just forgive me if there's a delay every so often. If that sounds okay, then we can get started!

[*FOR NON-SPECIALISTS*]

1. To start, could you tell me a bit more about what kind of settings you've worked in, and in what capacity related to mental healthcare?
    - Probe: What drew you into that role and/or setting?
    - Probe: And just to clarify, what kind of setting or settings have you worked in where admissions decisions are made?

2. Based on your experiences in [x], how would you characterize the landscape for mental healthcare in the public sector?
    - Probe: In your experience, does practicing mental healthcare differ from practicing physical healthcare at all in your setting/context? In what ways?

{MAKING DECISIONS}

1. Thank you so much for sharing that. Perhaps now we could shift to talking a bit more about psychiatric inpatient admission generally. Can you tell me a bit about a typical case for a 72-hour admission? How does the admissions process usually go?
    - Probe: And how would the patient usually arrive to the hospital?
    - Probe: And what would you normally consider when making an admissions decision?
    - Probe (mentions of collateral information/patient history): And how would you use collateral information in your decision-making process?
    - Probe: Does it feel easy to make inpatient decisions, or is it a difficult process? Why?

2. What are the main things you consider about the patient themself when making admissions decisions?
    - Probe: Can you give me an example of how you would consider [x] in decision-making?

3. What are the main things you consider about the situation or context when making admissions decisions?
    - Probe: Is there anything about the patient's family circumstances that might impact your decision?
    - Probe: Is there anything about the patient's personal circumstances that might impact your decision?

4. At the end of the 72-hour window, what do you consider when making a decision to discharge or refer on for further care?
    - Probe: How would prior knowledge of the patient play a role in decision-making, if at all?
    - Probe: How would knowledge of the patient's personal or family circumstances play a role in decision-making, if at all?

5. It's clear that the process of decision-making can be difficult and complex. Could you outline some of the practical challenges you have faced in this work?
    - Probe: Could you say a bit more about why that particular case was challenging?

{EXPLORING SPECIFIC CASES}

Thank you for talking to me about the admissions process generally. Now, I'd like to shift to talking about specific cases or types of cases you would generally encounter. So here, I'll ask you if you can tell me about certain kinds of instances of decision-making, for example, an instance of decision-making for a 72-hour admission with a known patient, and then I'll ask a few follow up questions about that case. Does that sound okay?

6. So first, maybe we could take that example I just gave. Could you tell me about a case you've had of decision-making with a known patient? How did that admissions process go?
    - Probe: What did you consider when making that decision?
    - Probe: And what did you see as being the purpose of admitting that patient in that moment?
    - Probe: Did your familiarity with the patient impact your decision-making? How?
        - Probe: How did the patient's history of past admissions impact your decision-making?
    - Probe: How did you assess [key criterion]?

7. Let's speak now about an index case. Could you tell me about a case where the patient was unknown to services prior to coming in? How did that admissions process go?
    - Probe: What did you consider when making that decision?
    - Probe: And what did you see as being the purpose of admitting that patient in that moment?
        - Probe: And how did that purpose relate to the kinds of considerations you took into account in your decision-making?
    - Probe: How did you assess [key criterion]?

8. Can you tell me about a case where an individual arrived to casualty without any family members?
    - Probe: What did you consider when making that decision?
    - Probe: And what did you see as being the purpose of admitting that patient in that moment?
    - Probe: How did you assess [key criterion]?
    - Probe: How did this case differ to a case where a patient arrived *with* a family member?

9. Can you tell me about a time, if any, that an individual was considered for inpatient admission, but you ultimately chose not to admit?
    - Probe: Why did you make this decision? In what way or ways did this patient not fit the criteria for admission?

{QUESTIONS ABOUT EXPERIENCES}

10. I asked you earlier about the challenges associated with admissions decisions. Now that we've spoken about a few different cases from your experiences, do you have any additional thoughts about challenges that come up for you when making admissions decisions?

2. What are the main things you consider about the patient themself when making admissions decisions?
    - Probe: Can you give me an example of how you would consider [x] in decision-making?

3. What are the main things you consider about the situation or context when making admissions decisions?
    - Probe: Is there anything about the patient's family circumstances that might impact your decision?
    - Probe: Is there anything about the patient's personal circumstances that might impact your decision?

4. At the end of the 72-hour window, what do you consider when making a decision to discharge or refer on for further care?
    - Probe: How would prior knowledge of the patient play a role in decision-making, if at all?
    - Probe: How would knowledge of the patient's personal or family circumstances play a role in decision-making, if at all?

5. It's clear that the process of decision-making can be difficult and complex. Could you outline some of the practical challenges you have faced in this work?
    - Probe: Could you say a bit more about why that particular case was challenging?

{EXPLORING SPECIFIC CASES}

Thank you for talking to me about the admissions process generally. Now, I'd like to shift to talking about specific cases or types of cases you would generally encounter. So here, I'll ask you if you can tell me about certain kinds of instances of decision-making, for example, an instance of decision-making for a 72-hour admission with a known patient, and then I'll ask a few follow up questions about that case. Does that sound okay?

6. So first, maybe we could take that example I just gave. Could you tell me about a case you've had of decision-making with a known patient? How did that admissions process go?
    - Probe: What did you consider when making that decision?
    - Probe: And what did you see as being the purpose of admitting that patient in that moment?
    - Probe: Did your familiarity with the patient impact your decision-making? How?
        - Probe: How did the patient's history of past admissions impact your decision-making?
    - Probe: How did you assess [key criterion]?

7. Let's speak now about an index case. Could you tell me about a case where the patient was unknown to services prior to coming in? How did that admissions process go?
    - Probe: What did you consider when making that decision?
    - Probe: And what did you see as being the purpose of admitting that patient in that moment?
        - Probe: And how did that purpose relate to the kinds of considerations you took into account in your decision-making?
    - Probe: How did you assess [key criterion]?

8. Can you tell me about a case where an individual arrived to casualty without any family members?
    - Probe: What did you consider when making that decision?
    - Probe: And what did you see as being the purpose of admitting that patient in that moment?
    - Probe: How did you assess [key criterion]?
    - Probe: How did this case differ to a case where a patient arrived *with* a family member?

9. Can you tell me about a time, if any, that an individual was considered for inpatient admission, but you ultimately chose not to admit?
    - Probe: Why did you make this decision? In what way or ways did this patient not fit the criteria for admission?

{QUESTIONS ABOUT EXPERIENCES}

10. I asked you earlier about the challenges associated with admissions decisions. Now that we've spoken about a few different cases from your experiences, do you have any additional thoughts about challenges that come up for you when making admissions decisions?

Appendix J: Ethics approval (University of Oxford)

Oxford Tropical Research Ethics Committee

University of Oxford
Research Services, University Offices
Wellington Square, Oxford OX1 2JD
Tel. +44 (0)1865 (2)82106
E-mail: oxtrec@admin.ox.ac.uk

Ms Marisha Wickremsinhe

02 August 2019

[redacted]

Dear Ms Wickremsinhe

Full Title of Study: Ethical considerations in decision-making for psychiatric inpatient admission without consent: insights from the South African legal, clinical, and sociocultural model

OxTREC Reference: 545-19

Thank you for your email of the 1 August 2019, and for your minimal risk application form.

I am pleased to confirm that approval has now been granted for this study. This is valid for the first five years and is subject to receiving the local ethical approval (if this approval has not yet been received).

The documents approved for this study are as follows:

Documents:	Version:	Date:
Participant information sheet	2	1/8/19
Consent form	2	1/8/19
Topic guide	1.1	16/7/19

Any subsequent changes to the application must be submitted to the Committee as an Amendment. This should include a letter to give the reasons for the proposed modifications and all revised documents with changes tracked.

Please ensure that you submit a completed Annual Report form on every anniversary of this approval and a final End of Study Report. The relevant forms can be found on the OxTREC website: https://researchsupport.admin.ox.ac.uk/governance/ethics/apply/oxtrec.

Finally, please note the following **important information**:

Data safety—all studies
It is the responsibility of the PI to ensure that all data collected during the course of the study is stored and transferred safely and securely. Further guidance and advice is available from the Research Data Team.

Studies that will involve storing human tissue samples in Oxford
As you are planning to import the samples into England, you will need to make arrangements before the samples are transferred to store them under the governance of a Human Tissue

Tel: +44 (0)1865 (2)82106
Email: oxtrec@admin.ox.ac.uk
Web: https://researchsupport.admin.ox.ac.uk/governance/ethics

Authority (HTA) licence. It is a legal requirement that any tissue or fluid made up of or containing human cells to be used for the purpose of research is stored on premises licensed by the HTA unless covered by an exemption. OxTREC approval is not a recognised exemption. Further information may be found on the University's human tissue governance web pages: https://researchsupport.admin.ox.ac.uk/governance/human-tissue.

Yours sincerely

Dr Rebecca Bryant
Research Ethics Manager, OxTREC

Appendix K: Ethics approval (University of KwaZulu-Natal)

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

01 June 2020

Miss Marisha Nimeishi Wickremsinhe (T20190223)
University of Oxford

Dear Miss Wickremsinhe,

Protocol reference number: BREC/00000947/2020
Project title: Ethical considerations in decision-making for psychiatric inpatient admission without consent: insights from a South African legal, clinical, and sociocultural model
Degree Purposes: DPhil (Population Health - University of Oxford))

EXPEDITED APPLICATION: APPROVAL LETTER

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application.

The conditions have been met and the study is given full ethics approval and may begin as from 01 June 2020. Please ensure that outstanding site permissions are obtained and forwarded to BREC for approval before commencing research at a site.

This approval is subject to national and UKZN lockdown regulations and the general BREC circular emailed by the Research Office on 23rd March 2020 and repeatedly since.

This approval is valid for one year from 01 June 2020. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be noted by a full Committee at its next meeting taking place on 14 July 2020.

Yours sincerely

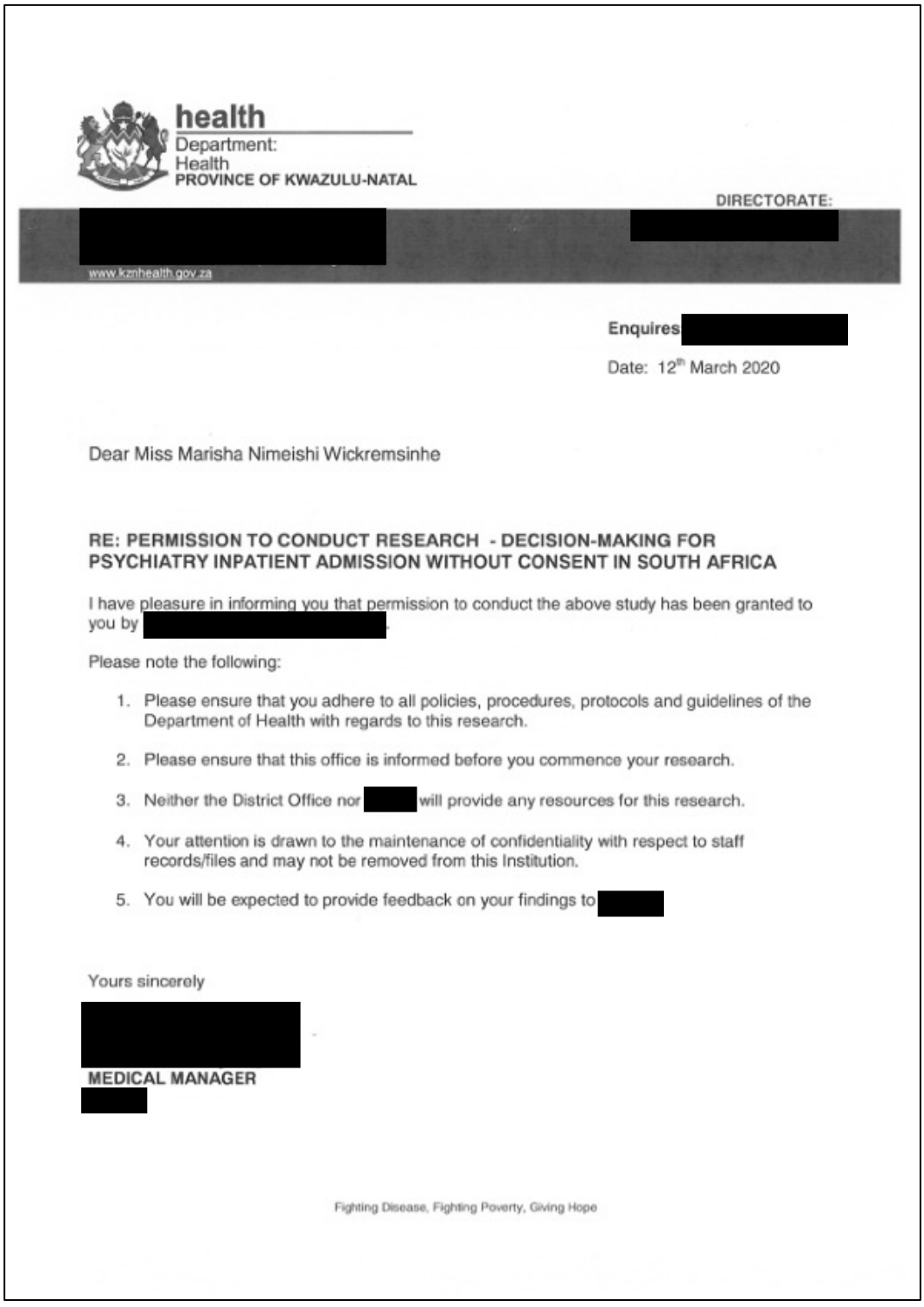
Prof R Bhimma
Deputy Chair: Biomedical Research Ethics Committee

Biomedical Research Ethics Committee
Chair: Professor D R Wassenaar
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

Appendix L: Site permissions (Hospital A)



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE: [redacted]

[redacted]
www.kznhealth.gov.za

Enquires [redacted]

Date: 12th March 2020

Dear Miss Marisha Nimeishi Wickremsinhe

RE: PERMISSION TO CONDUCT RESEARCH - DECISION-MAKING FOR PSYCHIATRY INPATIENT ADMISSION WITHOUT CONSENT IN SOUTH AFRICA

I have pleasure in informing you that permission to conduct the above study has been granted to you by [redacted].

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. Please ensure that this office is informed before you commence your research.
3. Neither the District Office nor [redacted] will provide any resources for this research.
4. Your attention is drawn to the maintenance of confidentiality with respect to staff records/files and may not be removed from this Institution.
5. You will be expected to provide feedback on your findings to [redacted]

Yours sincerely

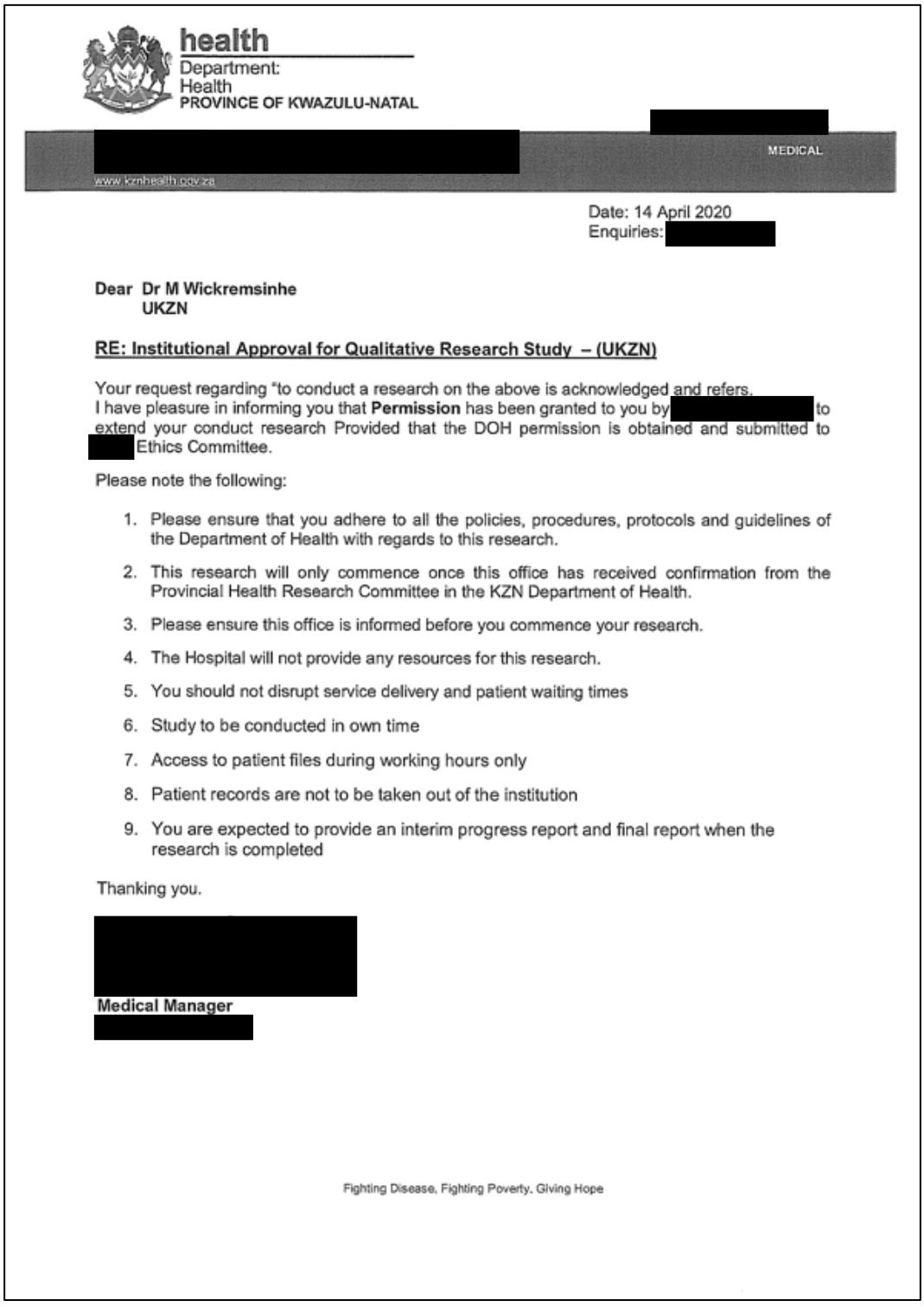
[redacted]

MEDICAL MANAGER

[redacted]

Fighting Disease, Fighting Poverty, Giving Hope

Appendix M: Site permissions (Hospital B)



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

[redacted]

MEDICAL

www.kznhealth.gov.za

Date: 14 April 2020
Enquiries: [redacted]

Dear Dr M Wickremsinhe
UKZN

RE: Institutional Approval for Qualitative Research Study – (UKZN)

Your request regarding "to conduct a research on the above is acknowledged and refers.
I have pleasure in informing you that **Permission** has been granted to you by [redacted] to extend your conduct research Provided that the DOH permission is obtained and submitted to [redacted] Ethics Committee.

Please note the following:

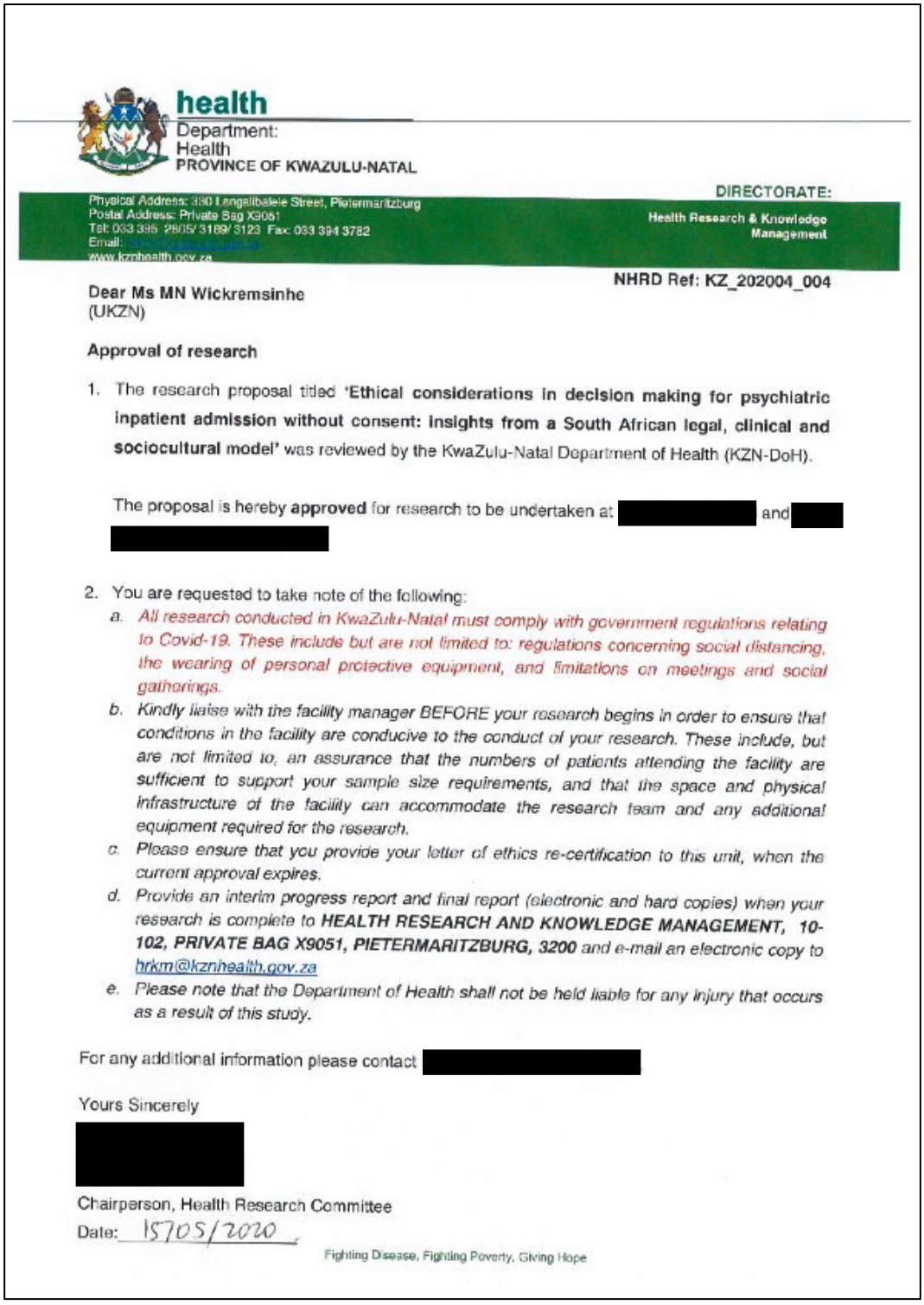
1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The Hospital will not provide any resources for this research.
5. You should not disrupt service delivery and patient waiting times
6. Study to be conducted in own time
7. Access to patient files during working hours only
8. Patient records are not to be taken out of the institution
9. You are expected to provide an interim progress report and final report when the research is completed

Thanking you.

[redacted]
Medical Manager
[redacted]

Fighting Disease, Fighting Poverty, Giving Hope

Appendix N: Ethics approval (Department of Health, KwaZulu-Natal)



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2605/ 3189/ 3123 Fax: 033 394 3782
Email: [redacted]
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_202004_004

Dear Ms MN Wickremsinhe
(UKZN)

Approval of research

1. The research proposal titled '**Ethical considerations in decision making for psychiatric inpatient admission without consent: insights from a South African legal, clinical and sociocultural model**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at [redacted] and [redacted]

2. You are requested to take note of the following:
   a. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
   b. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to* ***HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200*** *and e-mail an electronic copy to* hrkm@kznhealth.gov.za
   e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact [redacted]

Yours Sincerely

[redacted]

Chairperson, Health Research Committee
Date: 15/05/2020

Fighting Disease, Fighting Poverty, Giving Hope

Appendix O: Amended ethics approval (University of Oxford)

Oxford Tropical Research Ethics Committee

University of Oxford
Research Services, University Offices
Wellington Square, Oxford OX1 2JD
Tel. +44 (0)1865 (2)82106
E-mail: oxtrec@admin.ox.ac.uk

UNIVERSITY OF OXFORD

Ms. Marisha Wickremsinhe [redacted]

24 November 2020

Dear Ms. Wickremsinhe,

Full Title of Study: Ethical considerations in decision-making for psychiatric inpatient admission without consent: insights from the South African legal, clinical, and sociocultural model.

OxTREC Reference: 545-19

Thank you for your letter of the 20 November 2020 requesting an amendment to the above study. The revised documents that you have submitted for consideration are as follows:

Documentation:	Version:	Date:
PIS – advocates	V3.0	19/10/20
PIS – practitioners	V3.0	19/10/20

I am pleased to inform you that this amendment has been approved.

Yours sincerely

Ms. Sami Kelsh
Research Ethics Administrator, OxTREC

Direct Line Tel: +44 (0)1865 (2)82106
Email: oxtrec@admin.ox.ac.uk Web: https://researchsupport.admin.ox.ac.uk/governance/ethics

Appendix P: Amended ethics approval (University of KwaZulu-Natal)

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

05 November 2020

Miss Marisha Nimeishi Wickremsinhe (T20190223)
University of Oxford

Dear Miss Wickremsinhe,

Protocol reference number: BREC/00000947/2020
Project title: Ethical considerations in decision-making for psychiatric inpatient admission without consent: insights from a South African legal, clinical, and sociocultural model
Degree: PhD (University of Oxford)

We wish to advise you that your correspondence received on 19 October 2020 submitting an application for amendments listed below for the above study has been **noted and approved** by a subcommittee of the Biomedical Research Ethics Committee.

1. 7.2 Inclusion criteria (practitioners) : Change to "Healthcare practitioners who have experience working as a mental healthcare practitioner in a psychiatric or designated public hospital in any province"
2. 8.2. Interview procedures: Add "The revised topic guide will include vignettes (anonymized composites of cases shared in data collection thus far) to assess the ways in which various considerations impact practitioners' decision-making."

The committee will be notified of the above at its next meeting to be held on 08 December 2020.

Yours sincerely

Ms A Marimuthu
(for) Prof R Bhimma
Deputy Chair: Biomedical Research Ethics Committee

Biomedical Research Ethics Committee
Chair: Professor D R Wassenaar
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

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