Family Support for Schizophrenia

ONLINE SUPPORT GROUP MEETING

29 August 2022 at 19:00

Understanding the Mental Health Care Act and the functions of the Mental Health Review Board

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WESTERN CAPE MENTAL HEALTH REVIEW BOARD

2022

UNDERSTANDING THE MENTAL HEALTH ACT AND THE FUNCTIONS OF THE REVIEW BOARD.

Elsa van der Watt

Powers and Functions of the Review Board

Chapter IV

Section 19 of the Act

Powers and functions of Review Board

19. (1) The Review Board must-

- (a) consider appeals against decisions of the head of a health establishment;
- (b) make decisions with regard to assisted or involuntary mental health care, treatment and rehabilitation services;
- (c) consider reviews and make decisions on assisted or involuntary mental health care users;
- (d) consider 72-hours assessment made by the head of the health establishment and make decisions to provide further involuntary care, treatment and rehabilitation;
- (e) consider applications for transfer of mental health care users to maximum security facilities; and
- f) consider periodic reports on the mental health status of mentally ill prisoners.

The ACT and Admissions

Types of Admissions under the MHCA

- **All restrictions require a degree of risk for the assessment for admission to be processed.**
- **Emergency Admissions** – Section 09, MHCA 01
- **Assisted Admissions** – User is willing to receive care treatment and rehabilitation, but not able to make informed decisions – Section 27 & 28, MHCA 04, MHCA 05's & MHCA 07
- **Involuntary Admissions** – User is unwilling and not able to make informed decisions Section 33 & Section 34, MHCA 04, MHCA 05's, MHCA 07, MHCA 06's & MHCA 08

EMERGENCY ADMISSIONS

- Any person or health establishment that provides care and treatment to a MHCU or admits the user in circumstances **where delay in providing care may result in:**
  - death or irreversible harm to the health of the user
  - user will inflict serious harm to himself or others;
  - user causing serious damage to or loss of property
- This must be reported to the Review Board in the **prescribed manner (MHCA 01)**
- May not continue longer than **24 hours** unless an application in terms of Chapter V is made within the 24-hour period.

INVOLUNTARY ADMISSIONS

- **Section 33** – Applications to obtain involuntary care, treatment and rehabilitation. (MHCA 04; 05 & 07)
- **Section 34** – 72-hour assessment and subsequent provision of further involuntary care, treatment and rehabilitation. (MHCA 06, 08 & 09)

MHCA O4

THE APPLICATION also known as FOUNDING ADVIDAVIT

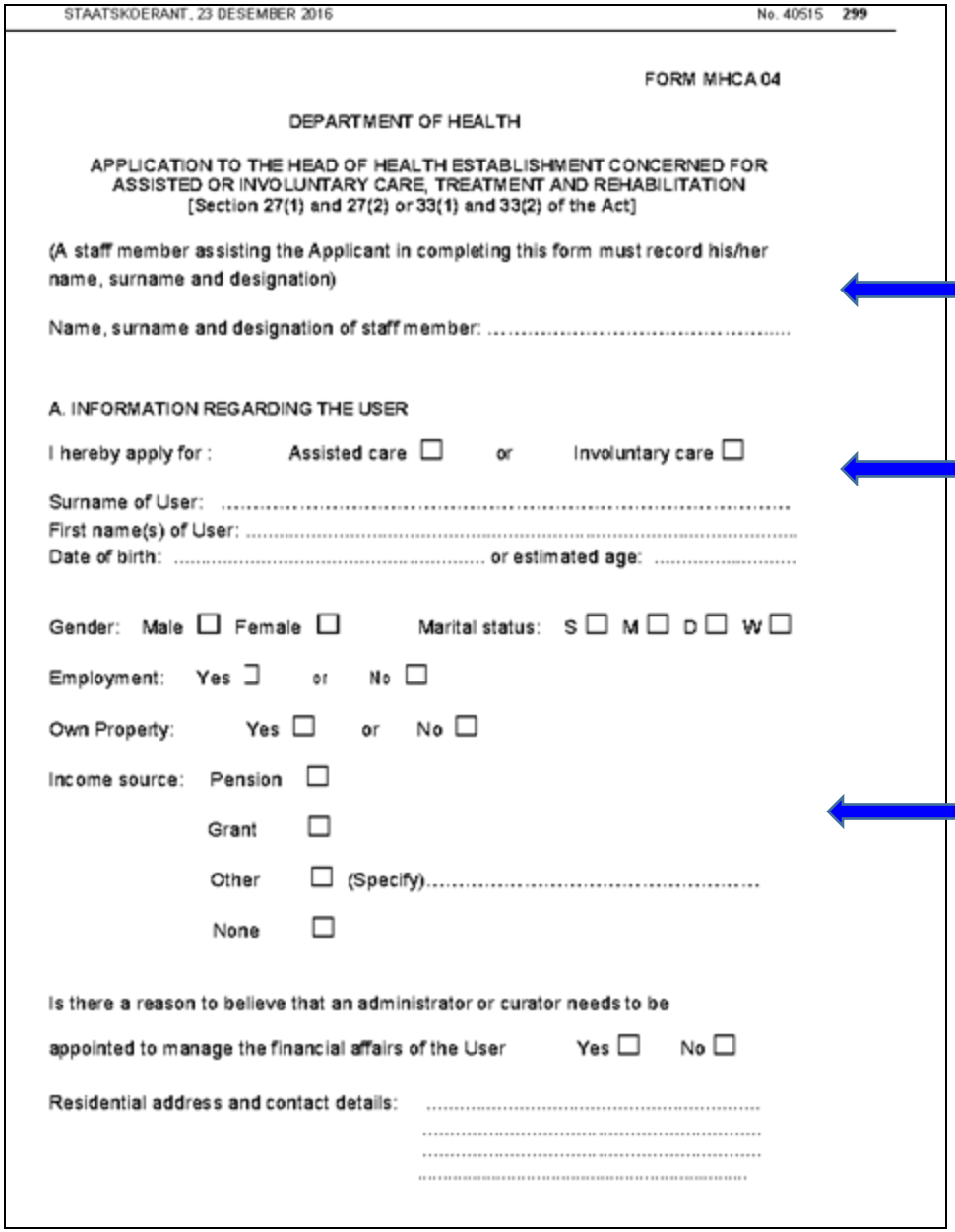
Note – the applicant does need to be included in other **communications – Notice of Decision (MHCA 07) and Outcome of the 72-hour assessment (MHCA 08)**

Ensure that the contact details of the applicant are clear for these further communications.

Rights of the Applicant

- The applicant does have the right to **withdraw** their application at any time.
- The applicant has the right to **appeal** the decision and the outcome of the 72-hour assessment

MHCA 04



STAATSKOERANT, 23 DESEMBER 2016 No. 40515 299

FORM MHCA 04

DEPARTMENT OF HEALTH

APPLICATION TO THE HEAD OF HEALTH ESTABLISHMENT CONCERNED FOR ASSISTED OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION
[Section 27(1) and 27(2) or 33(1) and 33(2) of the Act]

(A staff member assisting the Applicant in completing this form must record his/her name, surname and designation)

Name, surname and designation of staff member: .....

A. INFORMATION REGARDING THE USER

I hereby apply for : Assisted care ☐ or Involuntary care ☐

Surname of User: .....
First name(s) of User: .....
Date of birth: ..... or estimated age: .....

Gender: Male ☐ Female ☐ Marital status: S ☐ M ☐ D ☐ W ☐

Employment: Yes ☐ or No ☐

Own Property: Yes ☐ or No ☐

Income source: Pension ☐
Grant ☐
Other ☐ (Specify).....
None ☐

Is there a reason to believe that an administrator or curator needs to be appointed to manage the financial affairs of the User Yes ☐ No ☐

Residential address and contact details: .....
.....
.....
.....

Who can act as the **scribe**?
Verbal assistance vs written assistance
Scribe & Commissioner of oaths

Note – application for **Assisted/ Involuntary**
Check not covered by sticker
What happens if this request changes on MHCA 05's

Requirement to disclose income and make a recommendation for an **administrator/ curator.**
SASSA beneficiaries without property ownerships cannot have a curator/ administrator appointed
Persons employed may also have employment options restricted if a curator is appointed
Process for appointment of an administrator / curator will be addressed separately.
If indicated, ensure that the MHCA 05's are in agreement & evidence of efforts made recorded.

MHCA 04 – Page 2

B. INFORMATION REGARDING THE APPLICANT:

Surname of applicant: .....

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

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

Residential address and contact details: .....

.....

.....

C. Relationship between applicant and mental health care User: (mark with a cross)

Spouse ☐ Partner ☐ Associate ☐ Parent ☐ Guardian ☐

Heath care provider ☐ Other ☐.....(specify)

(If User is under 18 this application must be made by the parent, caregiver, guardian or person with parental right and responsibilities)

I last saw the User on..... at .....

(date) (time) (place)

(The applicant must have seen the User within seven days of making this application)

D. Why is the applicant the health care provider?:

The spouse, next of kin, partner, associate, parent or guardian of the User is:

(i) Unwilling (State reasons for this conclusion):

.....

.....

.....

.....

or

(ii) Incapable (State Reasons for this conclusions for this conclusion):

.....

.....

.....

.....

or

(iii) Unknown/Untraceable (state efforts made to trace)

.....

.....

.....

.....

Residential address and **contact details** for the Applicant. Efforts to be made to include telephone number and indication how they could best be communicated with.

These are NOT the details of the scribe.

Note the changes **for applicants of Users under the age of 18 years** - parent, caregiver, guardian or person with parental rights and responsibilities.

This needs to be completed (frequently left blank

When a Health Care provider completes the application the Act requires – ***"state steps taken to locate relatives in order to determine their capability or availability to make the application"***

When Health care provider **is the scribe** – this does not mean the Health Care provider is the applicant. Applicants have certain rights, including the right to appeal or withdraw an application. Applicants may also be required to be present at Appeal Hearings. Scribes do not have similar rights and responsibilities.

MHCA 04 Page 3

E. Reasons for the Application:
I, the undersigned, am of the opinion that the above-mentioned person is suffering from a mental illness / intellectual disability for the following reasons(e.g, what did he/she do or say?):

.....

.....

.....

F. In the case of an application for involuntary care:

In your opinion:

(i) Is the User a risk to self and others due to his/her mental illness?

Yes ☐ No ☐

(ii) Is the User willing to receive care, treatment and rehabilitation if needed?

Yes ☐ No ☐

(iii) Is the User able to make an informed decision?

Yes ☐ No ☐

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

Medical certificates ☐

History of past mental illness ☐ / intellectual disability ☐

Other ☐ .....

I wish to have representation/Legal representation/Legal Aid

for myself: Yes ☐ No ☐

Or on behalf of the User: Yes ☐ No ☐

Print initials and surname (Applicant).....
Signature (Applicant):.....
Date: .....
Place: .....
Note: Applicant must sign under oath

This cannot be left blank – some clear indication of mental health symptoms – not violent/ aggression

Please include the reports if they have been attached

Accessing Legal Representation
Reasons that an applicant may require representation.

These are NOT the details of the scribe.

MHCA 04 – Page 4

F. OATH/AFFIRMATION

I certify that:

i. The deponent acknowledged to me that:

a. He/she knows and understands the contents of this declaration;

b. He/she has no objection to taking the prescribed oath;

c. He/she considers the prescribed oath to be binding on his/her conscience;

ii. The deponent signed this declaration in my presence at ……
on this …… day of …… 20……

Signature: Commissioner of Oath: Ex-Officio

Full Name: ……

Rank / Designation: ……

- **PLEASE DO NOT LEAVE THIS PAGE BLANK**
- This must be done in the presence of the applicant
- The original version does not have a place for a stamp/ address, this is still a requirement.
- It is the responsibility of the Commissioner to understand the process and requirements.
- When the form is commissioned at a health establishment vs elsewhere and the impact this has on timeframes and validity of the form.

Getting SAPS assistance

MHCA 22 – SAPS Custody

FORM MHCA 22

DEPARTMENT OF HEALTH

HANDING OVER CUSTODY BY THE SOUTH AFRICAN POLICE SERVICES (SAPS) OF A PERSON SUSPECTED OF BEING MENTALLY ILL AND LIKELY TO INFLICT SERIOUS HARM TO HIM/HERSELF OR OTHERS
[Section 40(1) of the Act]

A. I .....
(print rank, initials and surname of member of SAPS)

have reason to believe from personal observation ☐

or from information obtained from a mental health care practitioner ☐

that .....
.....
.....
.....
(User's name or description if no name is available)

is suffering from a mental illness and is likely to inflict serious harm to him/herself or others.
I have apprehended the person and have brought him / her to .....
.....(name of health establishment)
for an assessment by a mental health care practitioner.

Name and address of next of kin (where possible)
.....
.....
.....
.....

I hereby hand over custody of the said person to the Head of the Health Establishment or his / her designate.

Signature: ..... Force No: .....
(Member of SAPS)

Date: .....
Time: .....
Place: .....

B. I .....accept
(Name of Head of Health Establishment or Acting Head)
custody of .....
(Name of User or description if no name is available)
at the .....
(Name of health establishment)

The User's physical condition is as follows (describe any bruises, lacerations etc):
.....
.....
.....
.....
.....

The mental status of the person will be assessed and an application will be made in terms of section 33 if applicable

Signature: .....
(Head of health establishment or Acting Head)

Date: .....
Time: .....
Place: .....

Note that this is meant to be signed by HHE

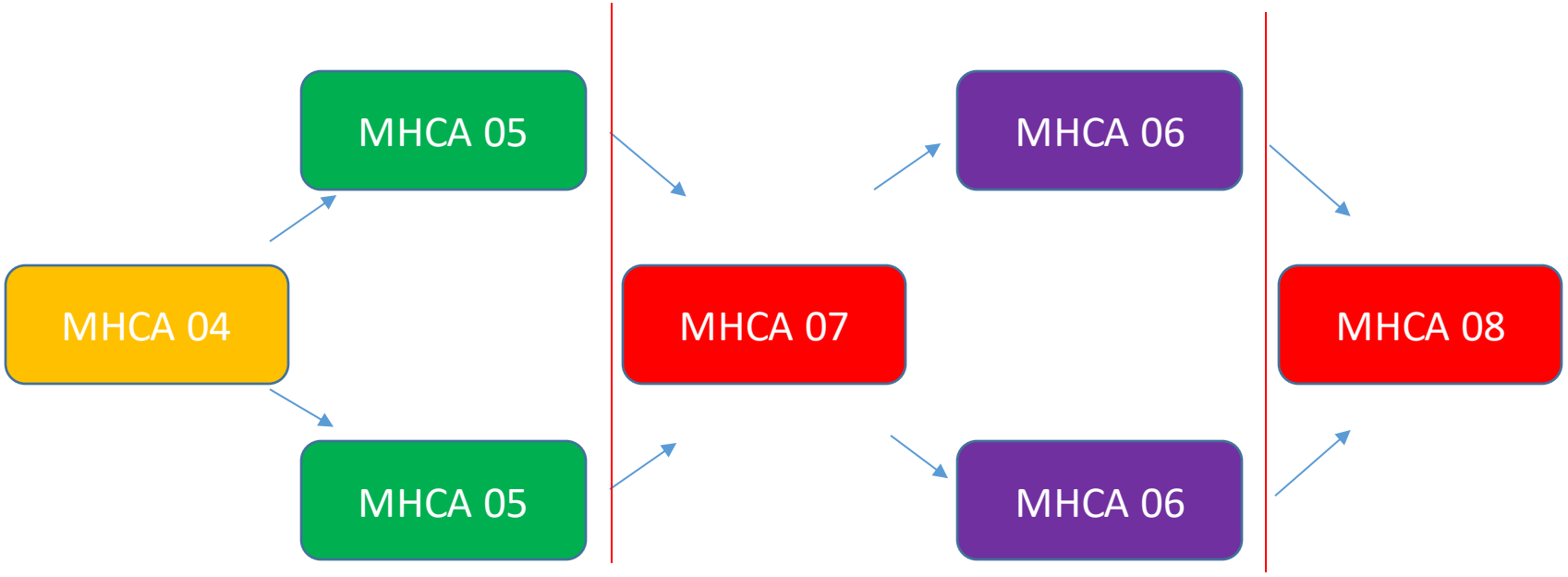
[Copy to be sent to SAPS to confirm in writing the physical condition as stated above during handing over of custody]

C. The SAPS hereby confirms that the physical condition as stated above was present during the handing over the User in terms of section 40(1) of the Act.

Print initials and surname: .....
Signature: .....
(Member of SAPS who handed over custody)

Date: .....
Place: .....

WHAT HAPPENS AFTER THE MHCA 04 HAS BEEN COMPLETED



Last seen Within 7 days	2 Mental Health Care practitioners are to assess the patient and determine if admission for 72-hour assessment is needed or discharge	Permission for 72-hour assessment Signed by the Head of the Health Care establishment	To be completed by 2 mental health care practitioners after permission to assess is received within a time frame of 72 hours. Recommends discharge or ongoing care and treatment	Ongoing admission/treatment after 72 Hours and possible transfer to specialist hospital Signed by the Head of the Health care establishment

Involuntary Inpatient care vs Involuntary Outpatient care

Inpatient

- The User remains in hospital for care and treatment
  - Risk: high levels of risk
  - Unwilling
  - Unable to make informed decisions

Outpatient

- The User is discharged into the care of a specific person willing to ensure compliance to treatment and care
  - Risk: level of risk has decreased but is still present
  - User remains unwilling to adhere to treatment
  - Poor insight and judgement remains.

MHCA 10 CONDITIONS FOR INVOL OUT-PT

FORM MHCA 10

DEPARTMENT OF HEALTH

TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER - SCHEDULE OF CONDITIONS RELATING TO HIS OR HER INVOLUNTARY OUTPATIENT CARE, TREATMENT AND REHABILITATION SERVICES
[Section 34(3)(b) or (5) of the Act]

Surname of User: .....
First name(s) of User: .....
Date of birth: ..... or estimated age: .....

Occupation: ..... Marital status: S ☐ M ☐ D ☐ W ☐
Residential address: .....
.....
.....
.....

Name of custodian into whose charge the User is discharged:

.....

Address of custodian: .....
.....
.....
.....
.....

i. The User's mental health status will be monitored and reviewed at
..... (name of health establishment)

ii. The User is to present him / herself to this health establishment every ..... week/ month to have his or her mental health status reviewed.

iii. Name of health establishment(s) where involuntary mental health care, treatment and rehabilitation will be provided on an outpatient basis if different from preceding health establishment:

.....

iv. Conditions of behaviour which must be adhered to by the User:
.....
.....
.....
.....
.....
.....

Name of psychiatric hospital and/or care and rehabilitation centre where the User is to be admitted if he / she relapses to the extent of being a risk to him / herself or others if he / she remains an involuntary outpatient, or to which he / she is to be admitted if the conditions of outpatient care are violated:

.....
(name of health establishment)

Print initials and surname: .....

Signature: ..... (Head of Health Establishment)

Date: .....

Place: .....

.....
Signature of User (understands and accepts the stipulated conditions)

.....
Signature of custodian (understands and accepts the stipulated conditions)

Note: User and Custodian must sign and both must receive copy.
This must be signed by the HHE – or authorisation attached

Appealing an Admission

MHCA 15

FORM MHCA 15

DEPARTMENT OF HEALTH

APPEAL TO REVIEW BOARD AGAINST DECISION OF HEAD OF HEALTH ESTABLISHMENT ON ASSISTED- OR INVOLUNTARY MENTAL HEALTH CARE, TREATMENT AND REHABILITATION
[Sections 29(1) and 36(1) of the Act]

etails of User

urname of User: .....
irst name(s) of User: .....
ate of birth: ..... or estimated age: .....

ender: Male ☐ Female: ☐

ccupation: ..... Marital status: S ☐ M ☐ D ☐ W ☐

esidential Address: .....
.....
.....
.....
.....

the User the appellant? Yes ☐ No ☐

No to the above:
urname of appellant: .....
irst name(s) of appellant: .....
ontact number of appellant: .....
esidential address: .....
.....
.....
.....

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

Spouse ☐ Partner ☐ Associate ☐ Next of kin ☐ Parent ☐ Guardian ☐

Caregiver ☐ Other ☐ ..... (specify)

Grounds for the appeal:
.....
.....
.....
.....
.....
.....

Facts on which the appeal is based:
.....
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.....

I, the undersigned wish to have:

Representation: Yes ☐ No ☐

Legal Representation: Yes ☐ No ☐

Legal Aid: Yes ☐ No ☐

for myself or on behalf of .....

Signature: .....
(Appellant)

Date: .....
Place: .....

Representation?

Timeframes for appeal
It is important that written confirmation of advising Users of their rights is given on admission MHCA forms

Reports on exploitation and abuse

MHCA 02

Regulation 7 of the Regulations is hereby substituted for the following regulation: "(1) A victim to abuse or a person witnessing any form of abuse, exploitation or degrading treatment against a mental health care user as contemplated in section1(1) of the Act—

(a) may report this fact to the Review Board concerned in the form of Form MHCA 02 of the Annexure; or

(b) may lay a charge with the South African Police Service who shall investigate the matter and take appropriate action, and thereafter in writing notify the Review Board concerned of that charge.

(2) When a Review Board receives a report contemplated in subregulation (1)(a) that Board must investigate that report and if necessary, lay a charge with the South African Police Service and may decide to hold a complaint hearing.

(3) Should the Review Board decide to hold a complaint hearing, the secretariat of the Review Board must in writing and by registered post inform—

(a) the person who witnessed the abuse, exploitation or degrading treatment of a mental health care user;

(b) the relevant mental health care practitioners;

(c) the head of the health establishment concerned;

(d) the mental health care user concerned; and

(e) any other person whom the Review Board considers to be relevant to the hearing,

of the complaint, the date of hearing and whether written or oral representation, as appropriate, must be made to the Review Board and advise of the right of representation as required.

(4) The Review Board must give notice of the hearing contemplated in subregulation (3) at least two weeks before the date of such hearing.

(5) The Review Board may issue a summons in the form of Form MHCA 18 of the Annexure to any person to appear before it as a witness to give evidence or to produce any book, record, document or other item, which in the opinion of the Review Board is relevant to the hearing."

MHCA 02

FORM MHCA 02

DEPARTMENT OF HEALTH

REPORT ON EXPLOITATION, PHYSICAL OR OTHER ABUSE, NEGLECT OR DEGRADING TREATMENT OF A MENTAL HEALTH CARE USER
[Section 11(2) of the Act]

(All the information contained in this Form will be held strictly confidential).

I.....
(name/s)

.....
(address)

☐ hereby declare that I have witnessed exploitation, physical or other abuse, neglect or degrading treatment of the following mental health care user:

☐ hereby declare that I have been through exploitation, physical or other abuse, neglect or degrading treatment

A. Details of User (where known)

First Name and Surname of User: .....

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

Gender: Male ☐ Female ☐

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

Residential address: .....
.....
.....
.....

B. Name of health establishment or other place where the alleged incident occurred
.....
Address: .....
.....
.....
.....

C. Date of incident .....

D. Brief description of the User:
.....
.....
.....
.....

D. Description of the alleged incident:

.....
.....
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.....

Print initials and surname: .....
Contact number: .....
Signature under oath: .....
(person who witnessed alleged incident)
Date: .....

Signed under oath

OATH/AFFIRMATION

I certify that:

i. The deponent acknowledged to me that:
   a. He/she knows and understands the contents of this declaration;
   b. He/she has no objection to taking the prescribed oath;
   c. He/she considers the prescribed oath to be binding on his/her conscience;

ii. The deponent signed this declaration in my presence at .....
on this ..... day of ..... 20.....

_____
Signature: Commissioner of Oath: Ex-Officio
Name: .....
Rank / Designation: .....

[Original to be submitted to the relevant Review Board]

QUESTIONS