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The role of 'micro-decisions' in involuntary admissions decision-making for inpatient psychiatric care in general hospitals in South Africa

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ABSTRACT

While the ethics of involuntary admission for psychiatric inpatient care is widely contested, the practice is legally permissible across most jurisdictions. In many countries, laws governing the use of involuntary admission set out core criteria under which involuntary admission is permitted; these parameters broadly related to either risk of harm to self or others, need for treatment, or both. In South Africa, the use of involuntary admission is governed by the Mental Health Care Act no. 17 of 2002 (MHCA 2002), which sets out clear criteria to direct mental healthcare practitioners' decision-making and delineates a process by which decision-making should occur. However, recent research suggests that, in practice, the process of decision-making differs from the procedure prescribed in the MHCA 2002. To further explore how decision-making for involuntary admission occurs in practice, we interviewed 20 mental healthcare practitioners, all with extensive experience of making involuntary admission decisions, working in district, regional, and tertiary hospitals across five provinces. We also interviewed four mental health advocates to explore patient-centered insights. Our analysis suggests that the final decision to involuntarily admit individuals for a 72-h assessment period under the MHCA 2002 was preceded by a series of 'micro-decisions' made by a range of stakeholders: 1) the family's or police's decision to bring the individual into hospital, 2) a triage nurse's decision to prioritise the individual along a mental healthcare pathway in the emergency centre, and 3) a medical officer's decision to sedate the individual. Practitioners reported that the outcomes of each of these 'micro-decisions' informed aspects of their final decision to admit an individual involuntarily. Our analysis therefore suggests that the final decision to admit involuntarily cannot be understood in isolation because practitioners draw on a range of additional information, gleaned from these prior 'micro-decisions', to inform the final decision to admit.

1. Introduction

Involuntary admission for psychiatric inpatient care, while common in clinical practice, remains ethically contested. Disagreement over when—if ever—involuntary admission may be ethically permissible continues in the scholarly literature and in legal and policy debates. However, involuntary admission is legally permissible across most national jurisdictions, including in South Africa. In South Africa, the criteria for involuntary admission are legislated by the Mental Health Care Act no. 17 of 2002 (MHCA 2002). The MHCA 2002 outlines a clear procedure through which an individual can be admitted without consent for a 72-h assessment period, after which point a subsequent decision to continue the admission can be made. Critically, the decision to involuntarily admit an individual for a longer hospital stay can only be made *after* the individual has been admitted and assessed during this 72-h period. In this study, we sought to understand how practitioners make the decision to admit an individual for the 72-h involuntary assessment period.

Per the MHCA 2002, involuntary admission for the 72-h assessment period is permissible when the following criteria are met:

"(b) […] There is reasonable belief that the mental healthcare user has a mental illness of such a nature that—

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(i) the user is likely to inflict serious harm to himself or herself or others;
(ii) or care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user; and

(c) at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services and is unwilling to receive the care, treatment and rehabilitation required" (Republic of South Africa, 2002, p. 32)

The MHCA 2002 also outlines the *process* by which the admission decision (whether to admit or not) should be made. Per the MHCA 2002, an application for involuntary admission should be initiated by the "spouse, next of kin, partner, associate, parent or guardian of a mental health care user", unless this person is "unwilling, incapable, or not available", in which case a healthcare provider should initiate the application (Republic of South Africa, 2002, p. 26). Following this initial application, two mental healthcare practitioners (different to the initial applicant, if also a healthcare provider) must independently assess whether the individual meets the requisite criteria for involuntary admission. Should their assessments disagree on whether the criteria for involuntary admission are met, a third mental healthcare practitioner must assess the individual. For the purposes of the MHCA 2002, 'mental healthcare practitioner' is defined 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).

As described in the law, this process of decision-making is structured and linear. However, available empirical evidence (and practitioners' anecdotal reports) suggests that the process of decision-making on the ground differs to the process of decision-making as described in the MHCA 2002. For example, Mulutsi's study exploring the implementation of the MHCA 2002 found that some sets of assessment reports, intended to be completed independently by two different practitioners by law, were identical (Mulutsi, 2017). In some cases, the limited experience of and training for mental healthcare practitioners—specifically general medical practitioners—can impact the degree to which the decision-making process complies with the mandates of the MHCA 2002 (Schierenbeck, Johansson, & Andersson, 2013). Several studies also report that financial and human resource constraints within the public sector can impact practitioners' ability to properly enact the statutes of the MHCA 2002 (Moosa & Jeenah, 2008; Petersen et al., 2009; Ramlall, Chipps, & Mars, 2010).

In this study, we sought to explore how the *process* of decision-making occurs in practice, including the degree to which the decision-making process conforms to or deviates from the procedure set out in the MHCA 2002. This study offers an analysis of the ways in which the circumstances and conditions of an individual's arrival to and management in the emergency centre may influence practitioners' final decision to admit.

2. Methodology

To explore how the decision-making process proceeds in practice, we conducted in-depth interviews with a diverse group of South African healthcare practitioners who had experience of making involuntary admission decisions in a range of hospital settings (including district, regional, and tertiary hospitals) across five provinces. We also conducted in-depth interviews with mental health advocates to triangulate the accounts given by practitioners. Interviews with mental health advocates also sought to ensure that our data collection was appropriately sensitive to the range of perspectives service users may hold, as mental health advocates work closely with service users and, in some cases, are service users themselves.

Using snowball sampling methods, we interviewed mental healthcare practitioners with a range of expertise and mental health advocates affiliated with a mental health advocacy organization based in South Africa. The topic guide for practitioners sought to elicit specific experiences of decision-making, focusing especially on exploring practitioners' own perceptions of how admission decisions are made in practice. The topic guide for advocates sought to explore experiences of involuntary admission (either the advocate's own or as known through their own advocacy work) and to understand their views on how admission decisions proceed in practice, from the perspective of both patients and family members.

All participants were over 18 years of age and spoke English. Interviews generally lasted 60 min but ranged in length from 44 to 152 min. Due to the impact of the COVID-19 pandemic, interviews were conducted virtually via video or voice-only call. Participants received a 150 ZAR voucher to an online retail store as an acknowledgement of the time taken to participate.

All interviews were recorded using an encrypted recorder and transcribed verbatim by the lead author and by two confidential transcription services. Transcripts were anonymized at the point of transcription. Interviews were conducted in two phases, first between July and September 2020, and then between January and February 2021. We ended data collection on the basis of 'information power' (Malterud, Siersma, & Guassora, 2016). Given the narrowness of the project aim and the specificity of participants' experience and knowledge relative to that aim, we closed data collection after completing 20 interviews with practitioners and 4 interviews with advocates (Malterud et al., 2016). In this study, the project aim was to understand clinicians' decision-making processes for admission without consent in practice. The practitioners interviewed had extensive experience of making admission decisions, and the advocates interviewed had diverse knowledge of patient and family member perspectives.

Of the 20 practitioners interviewed, 9 worked in Western Cape, 7 in KwaZulu-Natal, 2 in Mpumalanga, 1 in Limpopo, and 1 in Gauteng. We spoke with 9 general practitioners—1 internal medicine specialist, 2 casualty officers, 5 community service medical officers, 1 medical intern—and 11 specialist mental healthcare practitioners—3 psychiatrists, 5 registrars in psychiatry, 1 medical officer in psychiatry, and 2 clinical psychologists. Fourteen practitioners were currently working in a hospital setting where involuntary admission decisions are made, while six practitioners interviewed spoke about their past work experience. Nine practitioners interviewed worked in a tertiary hospital setting, and 11 worked in a district or regional hospital setting. Fifteen practitioners worked in urban hospital settings while five worked in rural hospital settings (see Table 1). The 20 practitioners interviewed in this study worked across 12 different hospital settings.

Data were analyzed using reflexive thematic analysis (Braun & Clarke, 2021). Reflexive thematic analysis specifically acknowledges the interpretative nature of qualitative research, suggesting that researcher subjectivity strengthens, not weakens, data analysis. Data analysis was conducted primarily by MW. Data were coded inductively, first using line-by-line coding across ten transcripts (eight interviews with practitioners and two interviews with advocates). From these initial codes, a set of aggregate codes were developed. All transcripts were then coded according to these aggregate codes. MW then developed candidate themes which were later refined and revised through consultation with MD. This paper presents the content of the overall theme 'pathways to decision-making', which includes subthemes to capture each of the three distinct 'micro-decisions' characterized through the data analysis. In this paper, participant quotes are used both illustratively (i.e. to demonstrate a key point through the quoted text) and analytically (i.e. to ground an analytic claim) (Terry et al., 2017).

Ethics approvals to conduct the study were obtained from the University of Oxford (OxTREC 545–19) in August 2019 and from the University of KwaZulu-Natal (BREC/00000947/2020) in May 2020. Revisions to the protocol, necessitated by the COVID-19 pandemic, were

Table 1
Recruitment table for healthcare provider participants (July 2020 to February 2021).

Interview number	Role	Hospital level	Hospital setting	In role?
1	Psychiatrist	Tertiary	Urban	Current
2	Registrar in psychiatry	Tertiary	Urban	Current
3	Registrar in psychiatry	Tertiary	Urban	Current
4	Clinical psychologist	District	Urban	Current
5	Clinical psychologist	District	Urban	Current
6	Registrar in psychiatry	Tertiary	Urban	Current
7	Psychiatrist	Regional	Urban	Current
8	Medical intern (Y1)	Tertiary	Urban	Current
9	Community service medical officer	District	Rural	Former (<1 year)
10	Community service medical officer	District	Rural	Former (<1 year)
11	Community service medical officer	District	Rural	Former (<1 year)
12	Psychiatrist	District	Urban	Current
13	Casualty officer	District	Urban	Former (<3 years)
14	Registrar in psychiatry	Tertiary	Urban	Current
15	Internal medicine specialist	Tertiary	Urban	Current
16	Community service medical officer	District	Rural	Former (<1 year)
17	Casualty officer	Tertiary	Rural	Current
18	Medical officer in psychiatry	Regional	Urban	Current
19	Community service medical officer (casualty)	Regional	Urban	Former (<1 year)
20	Registrar in psychiatry	Tertiary	Urban	Current

approved from both institutions in November 2020. The study also received approval from the KwaZulu-Natal Department of Health (KZ_202004_004).

The qualitative data collection and analysis reported in this article were part of a broader empirical ethics doctoral project which sought to explore ethical considerations in decision-making for involuntary admission in a South African context (Wickremsinhe, 2021).

3. Results

Through data analysis, we characterized the decision-making process as a series of interrelated 'micro-decisions', each of which shaped the quantity and quality of information available to justify the final decision to admit. That is, the various pathways to decision-making, and the specific events that precede the final 'decision point', as described in the MHCA 2002, appeared to influence how the final decision to admit is made.

As implied in the MHCA 2002, the broader admissions process entails multiple steps, with involvement from multiple stakeholders. However, counter to a straightforward interpretation of the law's outline of the decision-making process, practitioners indicated that various contextual features, specifically related to the individual's arrival to and management in the emergency centre, also significantly impacted their decision-making. In their accounts, practitioners revealed how circumstances of the individual's arrival at and management in hospital impacted the quantity and quality of information available to inform the final admission decision.

In our analysis, we term these discrete events as 'micro-decisions', meant to capture their deliberative nature as well as their relative significance in comparison to the final decision to admit. Importantly, the *consequences* of these 'micro-decisions' are not 'micro' at all with respect to the mental healthcare user's own experience; rather, these 'micro-decisions' are smaller in relation to the 'macro'-decision to admit an individual without consent. Critically, practitioners' accounts did not explicitly identify these micro-decisions as 'micro-decisions', or even as *decisions* at all. Rather, the key 'micro-decisions' characterized in this analysis have been drawn out through the analytic process, which paid close attention to subtleties in practitioners' and advocates' descriptions of the broader context and process of decision-making. These subthemes, termed as 'micro-decisions' in the analysis, highlight various ways in which the circumstances of the individual's arrival at and management in the emergency centre impacted practitioners' accounts of the final decision to admit involuntarily.

Each key 'micro-decision'—bringing the individual to hospital, prioritising the individual in the emergency centre, and sedating the individual in the emergency centre—is embedded in routine steps of the admissions process. In the following sections, we describe the decision-making process as it was characterized by participants. First, we define each of the three key 'micro-decisions' that preceded the final decision to admit and illustrate the various complexities and limitations associated with each of these key points along the decision-making pathway. Second, in explicating how these three micro-decisions were considered and enacted, we explain how, together and independently, their outcomes shaped practitioners' final decision to admit, especially by influencing the amount and kind of information available to inform that decision.

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

Per participants' reports, the decision to initiate an involuntary admission is made by someone other than a practitioner, and, by definition, by someone other than the individual. This point was emphasized by practitioners and advocates alike:

> Okay, and then after that, you know, I—I kept relapsing—(*Interviewer: Mm.*) Um, but I had a few involuntary admissions, so I have specific issues around how it's done. (*Interviewer: 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)

> 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, rural district hospital (Interview 16).

Put simply, non-practitioners almost always initiated the decision-making process for involuntary admission. The role of non-practitioners in initiating the admissions process is in line with the process set out by the MHCA 2002, wherein a non-practitioner must make the initial application for involuntary admission in most cases.

Indeed, practitioners and advocates both reported that an individual was *less* likely to be admitted (involuntarily *or* voluntarily) if self-presenting:

> (*Interviewer: …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. (*Interviewer: 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, urban tertiary hospital (Interview 14)

One advocate commented specifically on the 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. (*Interviewer: Yeah.*) Um, you know what I mean? So– it's– (*Interviewer*: *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'– (*Interviewer: Yeah!*) It's serious.
> Advocate (Interview 3)

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.

Practitioners suggested two reasons why self-presenting individuals are rarely admitted to hospital. Firstly, *voluntary* patients are charged according to the public hospital fee schedule (and self-presenting patients were broadly described as voluntary patients by virtue of their willingness to seek care). Secondly, 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 were not considered by some practitioners to be well-suited to attending to the specific needs of mental healthcare users. That is, because of the lack of 'therapeutic' spaces in these general hospitals, self-presenting individuals evoked scepticism from some practitioners:

> Yeah, if someone– generally in our context, if someone self-presents, we are a bit more sceptical, yeah? (*Interviewer: 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, urban tertiary hospital, (Interview 20)

Conversely, practitioners interpreted the fact that the individual had been brought to hospital *by someone else* as critical information to guide the final admissions decision itself. Practitioners explicitly or implicitly endorsed the view that decision-making inputs could be gleaned from the circumstances of the individual's arrival. For example, practitioners suggested that an individual who was brought to hospital by police would nearly always be admitted involuntarily, even while acknowledging that, in some cases, especially rurally, the police are called purely to provide transport to hospital:

> 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… (*Interviewer: Yeah*–) I don't know– (*Interviewer: And why do you say that?*) 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. (*Interviewer: 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 that you sent them back.
> Community service medical officer, rural district hospital (Interview 16)

Though some practitioners and advocates expressed the view that the police should not be involved in the admissions process, and some interviewees pointed to the risks of police violence against individuals being brought to hospital, practitioners nonetheless gleaned certain information from police involvement in the process. Specifically, practitioners tended to assume that the police had been called to manage the risk of harm (to self or others)—a core criterion for admission per the MHCA 2002.

Likewise, practitioners reported that, in general, their decision-making was influenced by the mere fact that an individual was brought to hospital by their family:

> 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 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, rural district hospital (Interview 9).

Practitioners relied heavily on the family's report in part because they often presumed the family would not bring the individual into hospital *unless* admission was needed, even while acknowledging that, in some cases, family might lie about symptoms in an attempt to get their family member admitted:

> 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, rural district hospital (Interview 9).

> …It's called the Friday drop-off! (*Interviewer*: *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. (*Interviewer: Right.*) Yeah, that's a common occurrence.
> Casualty officer, urban district hospital (Interview 13).

That said, in general, practitioners suggested that the *final* decision to admit draws, at least in part, on some interpretation of the circumstances of an individual's arrival to hospital—specifically whether the individual was brought to hospital by family members or police. In their accounts of decision-making, practitioners reported being influenced by the assumption that other people, no matter who, likely had good reason to set the individual along the involuntary admission route. 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.

Our analysis suggests that this initial micro-decision is arguably the most important one. Only through this micro-decision can 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. Yet, this critical initial 'micro-decision' is typically left to interpretation on the part of family and the police. Indeed, one practitioner suggested that the system specifically 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 by the time they get to us– (*Interviewer: 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, urban regional hospital (Interview 7).

As demonstrated in the quotes presented, practitioners and advocates alike acknowledged that this first 'micro-decision', i.e. the decision to *initiate* the process of assessment for admission, is usually made by someone without medical training—often family members or police officers—and often without clearly defined parameters.

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

After arriving at the hospital—usually brought in by family or police—the individual must be managed in the emergency centre while waiting to be assessed (and eventually admitted, if assessed as needing admission). Practitioners described a multi-faceted approach to making admission decisions, informed by multiple actors, largely in response to challenges of managing individuals in the emergency centre. One part of this multi-faceted approach includes the triage nurse's identification of an individual to be prioritized for psychiatric assessment. For example, one interviewee commented that nursing staff may specifically prioritise a patient 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–" (*Interviewer: Sure.*) "… because I think that they're going to need admission" so… (*Interviewer: Right, right.*) So… usually it's–um… usually it's a couple of people, like, uh, that would… um… also guide it [the admission decision], I guess, so…
Registrar in psychiatry, urban tertiary hospital (Interview 2).

Triage nurses play a significant role in the broader admissions pathway: while practitioners suggested that nurses rarely complete the first Form 05 (though legally permitted to do so), nurses in the emergency centre can accelerate the decision-making process by prioritising certain individuals to be seen more quickly and by ensuring that the initial Form 04 is already completed (most often by family). Per practitioners' reports, a triage nurse's specific decision to prioritise an individual for psychiatric assessment often included gathering specific pieces of information (e.g. family contact details, reported reason for bringing the individual to hospital). Further, in many cases, nurses may be more familiar with mental healthcare users than 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." […] 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 04.
Community service medical officer, rural district hospital (Interview 16).

Regardless of hospital setting, several practitioners commented on the role of other healthcare providers, especially triage nurses, in building the case for the final decision. That is, another practitioner's 'micro-decision' to set an individual along the mental health assessment route (as opposed to an exclusively physical health assessment route) acted as a credible informational input into the final decision to admit in practitioners' accounts of decision-making.

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

The decision to sedate an individual in the emergency centre—a decision taken prior to formal assessment for admission—played a critical role in driving the final decision to admit:

So… we tend to admit the people who are heavily sedated because w– because what that means is that they've been very difficult in the EC [emergency centre].
Psychiatrist, urban regional hospital (Interview 7).

Several practitioners 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 clinical assessment difficult (if not impossible in many cases), which means that practitioners tasked with clinical assessment of a sedated individual are left with little information about the individual's actual clinical presentation prior to being sedated. Their decision therefore must rely on sources other than direct medical observation. For example, one practitioner described their 'luck' in being able to rely on 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, urban regional hospital (Interview 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. (*Interviewer: Okay…*) And then the 72-h process was started.
Registrar in psychiatry, urban tertiary hospital (Interview 3).

Practitioners implied a link between 'needing sedation' in the emergency centre and 'needing (involuntary) admission' for inpatient care, thereby positioning the fact that an individual was sedated in the emergency centre as a key piece of information that informs the final decision.

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, rural district hospital (Interview 9).

On this basis, advocates expressed serious concern about the use of sedation in the emergency centre, considering how sedation compromises comprehensive assessment—the stated aim of the 72-h assessment

period:

> When you're psychotic, you go to the general… hospital with a psych ward– (*Interviewer: 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. (*Interviewer: Right, 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?
> 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:

> (*Interviewer: 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. 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).

The decision to sedate —a decision made to 'manage' individuals in the emergency centre—was often understood by practitioners as an indicator of the need for admission. In some cases, practitioners felt they had to admit a sedated individual because they could not properly assess them. In other cases, practitioners assumed that the individual was sedated because at least one legal criterion for involuntary admission ('risk of harm to others' as approximated by 'aggression') had already been met.

3.4. Making admission decisions with limited information

Each of these micro-decisions—bringing the individual to hospital, prioritising the individual in the emergency centre, and sedating the individual in the emergency centre—appeared to play a role in shaping the informational inputs available to guide the final decision to admit. Practitioners reported that various aspects of the final decision were directly or indirectly influenced by the outcomes of these micro-decisions. Indeed, in many cases—and especially in the absence of information about the individual—practitioners relied on the presumed validity of a prior micro-decision to inform their final decision to admit.

As demonstrated through participants' reports, the outcomes of micro-decisions made prior to the point of admission work to shape the informational inputs available to guide that final decision to admit. Practitioners often presumed that these prior micro-decisions were valid, which then led practitioners to reason using the specific outcomes or details of these micro-decisions themselves. For example, and as illustrated in the data, 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:

> 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, rural district hospital (Interview 11).

Practitioners cited several 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, 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, rural district hospital (Interview 16).

Indeed, practitioners tended to rely on the outcomes of a prior micro-decisions—e.g. a family member's micro-decision to bring the individual to hospital—as sufficient rationale, even where needed information may be unavailable:

> 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, urban district hospital (Interview 12).

Likewise, practitioners noted that their colleagues' decision to prioritise the individual as a potential mental healthcare user (including, in some cases, by referring the patient on to a mental healthcare practitioner specifically, where available), may be taken into account when making the final decision to admit. Practitioners also reported using the mere fact that an individual had been sedated in the emergency centre as sufficient justification to involuntary admit the individual for the 72-h assessment period. As one practitioner commented, having clinical notes available to support in 'assessing' an individual who had been sedated in hospital was viewed as a lucky break, as sedation in the emergency centre compromises the final decision-maker's ability to properly assess the patient clinically.

4. Discussion

As has been reported elsewhere, the process of decision-making for involuntary admission in practice differs from the procedure outlined in the MHCA 2002 in some cases (Mulutsi, 2017; Ramlall et al., 2010; Schierenbeck et al., 2013). Our analysis highlights another way in which the process of decision-making differs from the procedure outlined in the MHCA 2002—specifically, how 'micro-decisions' that precede the final decision to admit can influence decision-making for involuntary admission. Though none of these micro-decisions are explicitly governed by criteria set out in the MHCA 2002, specific outcomes of each of these micro-decisions appeared to influence how the final decision to admit was made.

In the next sections, we discuss the implications of each micro-decision in practice. We conclude with a broader reflection on how these micro-decisions may impact practitioners' decision-making, especially in the absence of information required to make the final admission decision according to legal criteria.

Importantly, and as conveyed through practitioner and advocate interviews, the outcomes of these micro-decisions are not categorically prescriptive; that is, practitioners still, in all cases, evaluate the individual and make a final, formal decision to involuntarily admit the individual for the 72-h assessment period, as prescribed by the MHCA 2002. That said, this final decision is, per practitioners' reports, clearly also influenced by certain outcomes of prior micro-decisions related to the circumstances of the individual's arrival to and management in the emergency centre.

4.1. 'Micro-decision' 1: bringing the individual to hospital

As expressed in participant interviews, key informational inputs that influenced the final decision to admit originated *outside* the hospital: that is, family members, friends, and police made the initial decision to even begin the involuntary admissions process. The broader context of the individual's arrival to hospital—whether brought by family or police, or self-presenting—informs and shapes the final decision about whether to admit.

However, there are important implications for this initial 'micro-decision' being made by non-practitioners outside a healthcare setting. Firstly, practitioners and advocates expressed concern that family and police are, intentionally or not, misinterpreting or misusing the law in seeking involuntary admission for others. Secondly, there are implications for which individuals are never brought to hospital: it stands to reason that some, if not many, families would never choose to bring an individual into contact with healthcare services to be assessed at all.

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.

Moreover, and as suggested by practitioners and advocates alike, limited access to hospital—especially due to distance, lack of transport, or both—plays a role in which individuals are ever brought into hospital to be assessed for inpatient psychiatric care.

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

The role of other healthcare providers, especially triage nurses, in prioritising individuals for assessment along the involuntary admission pathway leaves open questions about how nurses make these decisions. Is prioritisation based on clinical presentation, on nurses' interpretation of 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 the individual was 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 may centre 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 for the final decision.

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

The micro-decision to sedate in the emergency centre also plays a key role in determining the information inputs—or lack thereof—to guide the final decision to admit. Practitioners reported incorporating the fact that an individual was sedated into their decision-making, either because sedation compromised a proper assessment of the individual's clinical presentation, or because sedation was taken as a proxy for demonstrated aggression—considered to be sufficient justification for involuntary admission according to practitioners' accounts.

In most cases, the decision to sedate an individual preceded the final decision to admit (involuntarily) for the 72-h assessment period. On this basis, advocates expressed serious concern over sedation in the emergency centre, especially noting how sedation compromises comprehensive assessment—the stated aim of the 72-h assessment period.

Thus, the decision to sedate has multiple consequences. Sedation brings implications for the outcome of the admission 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). Sedation can also compromise any potential benefit of being admitted to hospital, a point highlighted by advocates and echoed by a psychiatrist.

4.4. Making the final decision: Information availability

By presuming the validity of prior micro-decisions, practitioners derived meaning from this kind of 'substitute' information—i.e., by drawing certain informational inputs based on the fact that a micro-decision had been made in a particular way. Practitioners then used the outcomes of these micro-decisions, e.g. *that* an individual was brought to hospital, *that* an individual was prioritized in the emergency centre, *that* an individual was sedated, to inform their own reasoning in decision-making. This 'substitute' information consists mainly of inferences, as made clear in practitioners' own accounts of decision-making. Nonetheless, this 'substitute' information was used to guide the final decision in many cases. Practitioners incorporated information gleaned from prior micro-decisions into their final decision to admit, even where this information offered little knowledge beyond the mere fact that a micro-decision had been made.

Substitute information was also employed in decision-making because some involuntary admission decisions were made without sufficient information according to practitioners' reports. 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 during the 72-h assessment period. In several cases, practitioners' accounts suggested that decision-making would have ideally incorporated information that simply is not available, meaning that, in practice, admission decisions are made and justified using disparate amounts of information. In the absence of direct information, practitioners based their decision-making on substitute information gleaned from various micro-decisions that proceed the final decision to admit.

Our analysis furthers existing research on the "'hard to reach' phenomena" of decision-making for involuntary admission, specifically Fistein et al.'s study of tensions between policy and practice in involuntary admissions decision-making (Fistein, Clare, Redley, & Holland, 2016, p. 56). While Fistein et al. identify and describe various 'practical criteria' that influence practitioners' decision-making for involuntary admission, we outline various 'procedural criteria' in decision-making, each of which can also influence the outcome of the final decision to admit.

4.5. Limitations

Given practical constraints, we used snowball sampling to recruit practitioners and advocates; as a form of convenience sampling, snowball sampling may be prone to some bias. Further, 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 cultures, regional cultures, or the practitioners' personal values. To combat these limitations, our analysis strove to stay sensitive to nuance

in participants' responses, coding for action as much as was feasible and focusing on semantic meaning in generating initial codes.

The study is also limited by the low number and lack of organizational diversity of advocates recruited, complicated especially by the practical constraints introduced by COVID-19 prevention measures. Though limited in number, the advocate interviews allowed for nuanced understanding of how the various micro-decisions characterized in this analysis impact the mental healthcare user's experience of the admission itself, especially with respect to the decision to sedate the individual in the emergency centre.

As a qualitative research study, this analysis aims not to be generalizable but rather to offer an in-depth exploration of a range of stakeholders' accounts of how decision-making proceeds in practice. Our inductive analysis of participant interviews highlighted some ways in which the various 'pathways to decision-making', and three distinct micro-decisions that sit along those pathways, appear to influence the final decision to admit involuntarily.

5. Conclusion

While the literature and the law tend to imply that an involuntary admission decision begins and ends with a single clinical encounter, guided by predefined and discrete legal criteria, our data analysis highlighted that several key micro-decisions occur prior to the final decision to admit an individual without consent. These micro-decisions are, in general, made based on the subjective assessments of various stakeholders, including family members, police, and hospital staff. Practitioners' accounts of their own decision-making—and advocates' accounts of practitioners' decision-making—suggest that the final decision to admit can be influenced by a series of events, or 'micro-decisions', that precede the final 'decision point' for involuntary admission as described in the MHCA 2002. As explained in practitioners' and advocates' accounts, the outcomes of these micro-decisions can influence the outcome of the final decision to admit; therefore, involuntary admission decisions cannot be understood in isolation. Our analysis highlights that the concordance of practitioners' decision-making with the statutes of the MHCA 2002 is dependent on the quantity and quality of information available to guide the decision, which is in turn impacted by three preceding micro-decisions.

Based on our analysis, these micro-decisions can bring a cumulative force to the final decision to admit, specifically by impacting the available informational inputs that guide the final decision, many of which are drawn from these 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), and the decision to sedate the individual in the emergency centre.

Practitioners tended to assume that micro-decisions made earlier along the pathway to decision were valid, i.e., reasonable or justifiable in some way. Relying on this validity, then, practitioners sometimes used '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 clear information, practitioners draw on 'substitute' information gleaned from the outcomes of prior micro-decisions to support their final decision to admit.

Our analysis suggests that the final decision to admit involuntarily is not based solely on legal criteria set out in the MHCA 2002. Practitioners' and advocates' accounts of decision-making point to the influence of three key 'micro-decisions'—all of which precede the final decision to admit—whose outcomes impact how the final decision is made.

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Availability of data and materials

The transcribed interviews are not publicly available to respect participant confidentiality; anonymized transcripts can be made available from the corresponding author on reasonable request.

Declaration of competing interest

Prof Wassenaar is the chair of the Biomedical Research Ethics Committee (University of KwaZulu-Natal) that reviewed and approved this application. Given his involvement in the project, Prof Wassenaar recused himself from all decisions on this study and the review process was fully managed by a deputy-chair. Otherwise, the authors declare that no competing interests exist.

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