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**A CRITICAL ANALYSIS OF SOUTH AFRICAN MENTAL HEALTH LAW:
A SELECTION OF HUMAN RIGHTS AND CRIMINAL JUSTICE ISSUES**

by

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DECLARATION OF ORIGINALITY

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ABSTRACT

This thesis is concerned with determining whether South African mental health law and its application in practice is in need of reform. In order to reach its objectives, the thesis measures mental health legislation and criminal law that affect the mentally ill individual or offender against international and local human rights standards, and generally accepted principles and scientific principles applicable in the mental health profession. Particular focus is placed on the admission of a mentally ill person as a voluntary, assisted or involuntary mental health care user, State Patient or mentally disordered prisoner in terms of the Mental Health Care Act 17 of 2002 ('MHCA'), as well a critical review of the MHCA forms used to translate the Act's provisions into practice. The thesis critically discusses the regulation of mental health care practitioners in terms of the Health Professions Act 56 of 1974, including psychology and psychiatry and the expert witness, and the new Traditional Health Practitioners Act 22 of 2007 and its regulations. An outline of the role of the National Health Act 61 of 2003 in the administration of the health system is provided. The thesis analyses the manners in which mental health affects criminal liability, and Chapter 13 of the Criminal Procedure Act 51 of 1977. Finally a desktop study into the current state of mental health care provision and the implementation of legislation in practice is conducted, followed by conclusions and recommendations for reform to legislation, policy, and the MHCA forms where anomalies have been identified.

KEYWORDS

Mental health law; human rights; mental health and criminal law; criminal procedure; disability rights; right to access to health care; international human rights; voluntary mental health care user; assisted mental health care user; involuntary mental health care user; State Patient; mentally ill prisoner; criminal liability; criminal incapacity; MHCA forms; mental health law in practice; judicial deference in the right to access to healthcare; Mental Health Review Boards; Psychology; Psychiatry; Forensic Expert Witness; DSM-5; classification of mental disorders; Mental Health Care Act 17 of 2002; Health Professions Act 56 of 1974; Traditional Health Practitioners Act 22 of 2007; National Health Act 61 of 2003; Criminal Procedure Act 51 of 1977.

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CHAPTER 1: INTRODUCTION

1.1. Introduction

“No health without mental health” has become a unifying call for the World Health Organisation (WHO), service providers, training institutions, health researchers, and advocacy groups around the world.¹ This statement captures several issues: the growing contribution of mental disorders to the global burden of disease, the availability of efficacious and cost-effective treatments, the high level of comorbidity between “physical” and “mental” illness, and the need to achieve equality for mental health services as a basic human right for people living with mental illness.² Mental health is defined by the World Health Organization (WHO) as a state of well-being in which every individual realizes their potential, can cope with the normal stresses of life, can work productively, and is able to make a contribution to their community.³ Mental health problems affect the functioning processes of the individual, diminishing their social role and productivity in the community.⁴

There has been an alarming increase in the incidence of mental illness across the globe,⁵ and both developing and developed countries are struggling to address the issue in terms of available resources.⁶ Mental health and mental illnesses are determined by multiple and interacting social, psychological and biological factors, just as health and illness in general.⁷ The clearest evidence for this relates to the risk of mental illness, which is associated with indicators of poverty, including low levels of education, and in some studies with poor

¹ Sohrsdahl, K., Stein, DJ., and Lund, C. (2012) 'Mental Health Services in South Africa: Scaling up and future directions' *Afr J Psychiatry* 15 168-171 168; Herrman, Shekwar and Moody (eds) xviii.

² Sohrsdahl, Stein and Lund (2012) *Afr J Psychiatry* 168.

³ World Health Organization (2007) 'Mental health definition' Available at www.who.int/features/factfiles/mental_health/en/index.html (Accessed 20 July 2016); Shah, AA. And Beinecke, RH. (2009) 'Global Mental Health Needs, Services, Barriers, and Challenges' 38 *International Journal of Mental Health* 1 14-29 14; Vigo, D., Thornicraft, G., Atun, R (2016) 'Estimating the true global burden of mental illness' *Lancet Psychiatry* 3 171-78 171; Herrman, H., Shekwar, S., Moody, R (eds) 'Promoting Mental Health: Concepts, emerging evidence, practice' (2005) World Health Organisation, Geneva xviii.

⁴ Shah and Beinecke (2009) *International Journal of Mental Health* 15; Herrman, Shekwar and Moody (eds) xviii.

⁵ This is discussed at length in Chapter 6 of this thesis.

⁶ World Health Organization (2003) 'The mental health context' Available at www.who.int/mental_health/policy/services/3_context_WEB_07.pdf (Accessed 20 July 2016); Shah and Beinecke (2009) *International Journal of Mental Health* 14.

⁷ Herrman, Shekwar and Moody (eds) xviii.

housing and low income.⁸ Poor mental health is associated with social disadvantage, humanrights abuses, and poor health and productivity, as well as increased risk of mental disorders.⁹ In light of the economic, health, and social consequences of high rates of mental disorder, its proper management and treatment has never been more important for the welfare of communities and the country as a whole.

In recent years, the human rights of persons with mental disabilities have attracted increasing attention.¹⁰ Attention has been focused on the civil and political rights of persons with mental disabilities in the past, though recently the economic, social, and cultural rights of mentally ill persons, including the right to health, are also beginning to attract greater attention and concern.¹¹ The main goal of this thesis is to investigate whether human rights infringements and the miscarriage of justice can be prevented by a South African legislative and policy framework that effectively regulates all aspects of mental health care, including instances where the mentally ill person is accused of a crime or is dealt with by the police.

The existence of a mental health policy is an integral tool in the promotion of mental health, though a policy can have significant impact only when it is formulated and implemented correctly.¹² Legislation helps to consolidate and strengthen the objectives, aims, values, and principles of mental health policies.¹³ For this reason this thesis focuses mainly on the content and formulation of legislation regarding mental health in South Africa. It is submitted that the effectiveness of legislation and policy can be measured by striking an acceptable balance

⁸ *Ibid.*

⁹ Herrman H., Swartz, L. (2007) 'Promotion of mental health in poorly resourced countries' *Lancet* 1195-1197 1195.

¹⁰ Hunt and Mesquita (2006) "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" *Human Rights Quarterly* 332-356 334.

¹¹ Hunt and Mesquita (2006) *Human Rights Quarterly* 334; Gostin, L. and Gable, L. (2004) "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" 63 *Md. L. Rev.* 20 98; Purohit and Moore v. Gambia, *African Comm'n. on Hum. and Peoples' Rts.*, Comm. No. 241/2001 (2003).

¹² World Health Organization (2005) 'Mental health policy, plans and program' Available at www.who.int/mental_health/policy/en/policy_plans_revision.pdf (Accessed 20 July 2016); Shah and Beinecke (2009) *International Journal of Mental Health* 24.

¹³ Shah and Beinecke (2009) *International Journal of Mental Health* 24. The World Health Organization has created guiding principles for mental health, human rights, and legislation to help the patients suffering from mental illness and to preserve their rights to live a normal life (World Health Organization (1996) 'Guidelines for the promotion of human rights of persons with mental disorders' Geneva. Available at www.who.int/mental_health/policy/legislation/guidelines_promotion.pdf (Accessed 20 July 2016)).

between the competing interests of the state, the community, and the individual regarding compliance with constitutionally guaranteed human rights standards, science-based medicine and legal provisions and procedure; psychiatric and psychological principles; criminal law principles; and satisfactory practical implementation considering resource constraints. The issues inherent in mental health and law can only be addressed effectively by innovative and original thinking due to its multidisciplinary nature and the variety of roleplayers involved. The presence of mental health legislation in itself does not guarantee respect and protection of human rights,¹⁴ therefore the thesis will also consider the application of mental health legislation in practice.

The purpose, overview, hypotheses, research questions, value contribution and methodology of the study is discussed in this chapter. A brief outline of the history of mental health care practice and regulation, and criminal law and procedure is also given. A discussion of important terminology applied throughout the thesis is included. Reference is made to the problems that exist in the interface between the legal system and the mental health care system, and branches of government responsible for the regulation and implementation of mental health matters. Some of the issues mentioned are the fact that mental health care legislation is not properly implemented in practice, that MHCA forms used are not correctly completed by mental health care practitioners; that practitioners are insufficiently trained in the provisions of the MHCA; that there is disparity in the legal and mental health professions approach to and definition of mental disorder; and that deep-seated stigma and cultural beliefs that prevents some mentally ill persons from seeking treatment, leads to subpar care, treatment and rehabilitation, and prevents the fulfillment of the full potential of persons with mental disorder as participants in and contributors to public life. The study is conducted in the interest of seeking solutions to these broad issues in order to prevent the abuse and further marginalization of mentally ill persons, who are a vulnerable and traditionally stigmatised group of persons worthy of the protection and advancement the law may offer.¹⁵

¹⁴ Shah and Beinecke (2009) *International Journal of Mental Health* 24.

¹⁵ Spammers, M. "A critical analysis of the psycholegal assessment of suspected criminally incapacitated accused persons as regulated by the Criminal Procedure Act" (LLM dissertation, 2010, University of Pretoria) 2; Swanepoel, M. (2011) "Human rights that influence the mentally ill patient in South African medical law: a discussion of Sections 9; 27; 30 and 31 of the Constitution" 14 *Potchefstroom Electronic Law Journal* 7 126-152 126.

1.2. A brief history of mental health care practice and regulation in South Africa

This section briefly outlines the history of legislation regarding mentally disordered persons in South Africa.¹⁶ By reviewing the historical development of mental health laws, context and background is provided that assist in explaining the content and structure of the current framework. It is also helpful to consider the pace of legal development, the historical and political context in which legal reform has taken place, and the constantly evolving nature of medicine and advancements in science and the mental health profession that drive legislative change in order to understand current laws and anticipate possible future changes.¹⁷ It is important to note the history and development of psychiatry, psychology and law, as the uncertainties of the present are invariably a result of decisions made in the past.¹⁸ The current status of legal and health care systems cannot be viewed in a vacuum, but must be analysed with regard to the social, political and cultural context of the regime in which they are implemented and in which they originated, as all of those factors play a role in establishing the *status quo*. Human rights instruments as well as developments in medical knowledge have prompted a revisit of the current state of affairs in mental health laws and an understanding of how the *status quo* came to be is therefore imperative.¹⁹

South African medical practice has come a long way from its origins in the seventeenth century. The medical science is in a state of constant evolution. Psychiatric, psychological and legal approaches towards the mentally ill have changed over time and can undoubtedly also

¹⁶ It is outside the scope of this thesis to fully detail the fascinating history and development of mental health laws, the mental health professions or criminal law and mental health. For more detailed discussion see: Swanepoel Law, psychiatry and psychology: A selection of constitutional, medico-legal and liability issues (LLD Dissertation UNISA 2009); Stevens ‘The role of expert evidence in support of the defence of criminal incapacity’ (LLD Dissertation 2011 UP); Gillis, L. (2012) “The historical development of psychiatry in South Africa since 1652” 18 South African Journal of Psychiatry 3 78-82; Minde, M. (1974) “History of mental health services in South Africa” South African Medical Journal 48; Minde, M. (1977) “History of mental health services in South Africa: Part XIV. Psychiatric Education” South African Medical Journal 21 210; Ure, GB. “A hermeneutical analysis of the impact of socio-political and legislative developments on South African institutional mental healthcare from 1904 to 2004” (PhD thesis, 2015, University of the Witwatersrand).

¹⁷ Meintjes-Van der Walt, L. (2011) “Tracing trends: The impact of science and technology on the law of criminal evidence and procedure” 128 SALJ 1 147-171 147.

¹⁸ Swanepoel 25.

¹⁹ Chapter 2 of this thesis details the international human rights instruments applicable to South African mental health laws, as well as the constitutionally entrenched rights in the Bill of Rights.

be changed in future.²⁰ Our understanding of human rights standards and their interpretation may also change over time. An understanding of how knowledge accrues and knowledge of the mistakes of the past is of prime importance in preventing similar mistakes in present and future work.²¹ The key issue is that while it is tempting to experience current psychiatric, psychological and legal approaches towards the mentally ill as natural and permanent, an understanding of the past helps mental health and legal practitioners to see things in a different perspective.²² It is therefore important to make provision when legislating on mental health that law needs to be flexible to allow for growth and change while protecting the rights of persons involved.

In the nineteenth century several legislative developments to protect the insane were introduced in South Africa, including the Ordinances of 1833, 1837, 1879 and 1891 that culminated in the Mental Disorders Act 38 of 1916.²³ The Mental Disorders Act of 1916 was the first attempt to legislate for the care of people with mental health problems.²⁴ This Act unified the control of mental hospitals under a Commissioner of Mental Hygiene.²⁵ The main thrust of mental health services in the period following this was the provision of hospital beds to accommodate the growing number of patients and the focus was on custodial care.²⁶ The focus of mental health services in South Africa prior to 2002 was on the welfare and safety of the community and this was given priority over the human rights of people with mental health problems.²⁷ Legislation prior to 2002 tended to reinforce the alienation, stigmatisation and disempowerment of mentally ill patients in South Africa.²⁸ Institutions for mentally ill persons in South Africa served more to remove patients from society and to contain them in a secure environment rather than providing them with medical care.²⁹ The Mental Disorders Act of 1916 also provided for medico-legal procedures and the observation of criminals, the

²⁰ Swanepoel 28.

²¹ Swanepoel 25.

²² Swanepoel 28.

²³ Swanepoel 67.

²⁴ Simpson, B.; Chipps, J. (2012) 'Mental Health Legislation: Does it protect the rights of people with mental health problems?' 1 Social Work 48 47-57 48.

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ *Ibid.*; Burns, J. K. (2008) "Implementation of the Mental Health Care Act (2002) at District Hospitals in South Africa: Translating Principles into Practice" 98 South African Medical Journal 1 46-51 46.

²⁸ Burns (2008) South African Medical Journal 46.

²⁹ Swanepoel (2011) Potchefstroom Electronic Law Journal 129.

provision of a report for the court and the fundamentals of expert testimony.³⁰ The Mental Disorders Act of 1916 was later repealed by the Mental Health Act 18 of 1973.³¹ It was seen as an improvement, but the rights of people with mental health problems were still seriously compromised.³² This was exacerbated by the apartheid policies introduced by the Nationalist government in 1948.³³

The South African health care system, prior to 1994, resembled the fragmented and failed system of Apartheid itself, characterised by abject discrimination, unequal distribution of resources, unethical execution of responsibilities by health practitioners, a lack of coordination and accountability, structural deficiencies.³⁴ Social, economic and political barriers interacted to create conditions of underdevelopment, marginalisation and unequal access to resources that persist to this day, including a failure to recognise the rights of mentally disordered patients as being equal to those of other patients.³⁵ The policies and practices adopted by the apartheid government served not only to ignore these rights, but also to set up and maintain mechanisms which contributed to further abuse and discrimination.³⁶ The health system bequeathed to the first democratically elected government in 1994 was simply unable to serve the needs of broader society.³⁷

A policy-orientated workshop held in 1993 identified the following prevalent challenges in mental health care before the MHCA: "...fragmentation, lack of inter-sectoral collaboration, lack of co-ordination of funding, inaccessibility of services in both urban and rural areas, inadequate emphasis on psycho-social problems, almost no prevention and promotion or early identification of problems, too much emphasis on institutional care, shortage of mental health

³⁰ Swanepoel 67 – 68.

³¹ Simpson and Chipps (2012) *Social Work* 48; Swanepoel 68; Freeman, M. (2002) "New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health" 5 *S Afr Psychiatry Rev* 3 4-8 4.

³² Simpson and Chipps (2012) *Social Work* 48.

³³ *Ibid.*

³⁴ Pieterse, M. 'Can rights cure?: The Impact of human rights litigation on South Africa's health system' *PULP* 2014 5; Swanepoel (2011) *Potchefstroom Electronic Law Journal* 129; Simpson and Chipps (2012) *Social Work* 48; Burns (2008) *South African Medical Journal* 46.

³⁵ Swanepoel (2011) *Potchefstroom Electronic Law Journal* 129.

³⁶ Swanepoel (2011) *Potchefstroom Electronic Law Journal* 129.

³⁷ Pieterse 5; Swanepoel (2011) *Potchefstroom Electronic Law Journal* 129; Simpson and Chipps (2012) *Social Work* 48; Burns (2008) *South African Medical Journal* 46.

workers and too much emphasis on one-to-one care at the expense of groups and community care.”³⁸ The Minister of Health published the White Paper on the Transformation of the Health in South Africa in Government Gazette on the 16 of April 1997. This White Paper presents the policies, objectives and principles upon which a unified health system of South Africa will be based.³⁹ It aims to unify the fragmented health services at all levels into a comprehensive and integrated National Health System, to reduce disparities and inequities in health services delivery and increase access to improved integrated services based on primary health care principles,⁴⁰ to give priority to maternal, children’s and women’s health, and to mobilise all partners, including the private sector, Non-Governmental Organisations (NGO’s) and communities.⁴¹

With the new Constitutional dispensation, the introduction of the Bill of Rights and the Constitutional Court, and the establishment of the Human Rights Commission an infrastructure has been put in place to address the inequalities of the past and ensure the rights of all people, including mentally ill patients, are protected.⁴² These changes on a national level, as well as the enactment of human rights instruments on an international level are integral to the further development of mental health laws that have the best interest of the patient at heart. Most of the Mental Health Act of 1973 was recently repealed by Section 73(1) of the Mental Health Care Act 17 of 2002 (the ‘MHCA’).⁴³ The Mental Health Care Amendment Act 12 of 2014 repeals the Mental Health Act 18 of 1973 in its entirety. The Amendment Act came into operation on a 1 July 2016.⁴⁴ Burns describes the that the core principles of the MHCA (human rights for users; decentralisation and integration of mental health care at primary, secondary and tertiary levels of care; and a focus on care, treatment and rehabilitation) as progressive and laudable.⁴⁵

³⁸ Ramllal, S. (2012) 'The Mental Health Care Act No 17 – South Africa. Trials and triumphs:2002-2012' African Journal of Psychiatry 15 407-410 407.

³⁹ Nevondwe, L.; Odeku, KO. (2013) 'The Right of Access to Health Care Services: Pitfalls and Prospects' 4 Mediterranean Journal of Social Sciences 13 837-845 844.

⁴⁰ Simpson and Chipps (2012) Social Work 48.

⁴¹ Nevondwe and Odeku (2013) Mediterranean Journal of Social Sciences 844.

⁴² Swanepoel 69; Swanepoel (2011) Potchefstroom Electronic Law Journal 130.

⁴³ Simpson and Chipps (2012) Social Work 48; Swanepoel 68; Freeman (2002) S Afr Psychiatry Rev 4; Landman, A.A. and Landman, W.J. 'A Practitioner’s Guide to the Mental Health Care Act' (Cape Town; Juta & Co) 2014 288.

⁴⁴ Proclamation 37 of 2016 GG 40107, 30 Jun 2016, Notice 37, page 4.

⁴⁵ Burns (2008) South African Medical Journal 46.

1.3. A brief history of criminal law and procedure regarding mental health in South Africa

In Roman times it was already recognized that a person could not be held criminally liable for their unlawful conduct if they suffered from defective mental capacity that could either stem from youthfulness or insanity.⁴⁶ South Africa has a Roman-Dutch common law that has been influenced by English and other law, as well as an uncodified criminal law that relies on general principles of liability. The courts progressively started to rely on English law in cases of mental incapacity, and the rules set out in the English *M'Naghten* case were adopted.⁴⁷

The M'Naghten Rules can briefly be summarised as including: the rebuttable presumption that a person is sane and responsible for their criminal conduct; that in order to establish the defence of insanity, it must be proven that a person suffers from a defect of reason that rendered them incapable of knowing the nature and quality of their act, or knowing that the act was wrong; and making provision for persons suffering from partial delusions.⁴⁸ The Rules were developed from an essential 'right' and 'wrong' test by adding a further test that entailed proving that the criminal conduct was committed even though the perpetrator realised the quality and nature of the act and its wrongfulness, if he was unable to control himself due to an 'irresistible impulse' stemming from the mental disease.⁴⁹ Different valid criticism were levelled against the Rules and they were ultimately rejected and developed through the years into current South African criminal law. The inadequacy of the M'Naghten Rules as the basis for a finding of insanity was recognised by the Royal Commission on Capital Punishment in 1953, the Butler Commission on Mentally Abnormal Offenders in 1975, and in the Law Commission's draft Criminal Code 1989.⁵⁰

⁴⁶ Burchell, J.M. and Milton, J. "South African Criminal Law and Procedure Volume I: General Principles of Criminal Law" 4th Edition 2011 370; Stevens 462.

⁴⁷ *R v M'Naghten* (1843) 10 Cl and Fin 200, 8 ER 718; Stevens 463; Burchell and Milton 370-402; Ladikos, A. (2012) "Historiese oorsig oor die hantering van psigiatriese pasiënte met misdadigeneigings" 18 *Fundamina: A Journal of Legal History* 1 32-54 52.

⁴⁸ *R v M'Naghten* (1843) 10 Cl and Fin 200, 8 ER 718 722-723; Stevens 428.

⁴⁹ Stevens 429.

⁵⁰ Emmerson, Q.C, Ashworth, A. and Macdonald, A. *et al.* 'Human rights and criminal justice' 2012 737.

It is important to briefly detail the reasons for rejection and development of the M’Naghten rules here in order to demonstrate the reasons and process behind legal development when the judiciary and legislature take cognisance of relevant up to date medical science. Criticisms include, among others:⁵¹

- The fact that there is no scientific method of testing whether a person possessed a certain knowledge;
- Modern science recognises that reason is only one of many facets of personality (cognitive, conative, as well as affective functions play a role);
- The rules do not provide for adequate testimony; and
- The psychiatric expert takes on the role of judge rather than witness.

The acceptance of the Rules into South African law also lead to courts more heavily relying on expert evidence,⁵² illustrating the positive aspects of legal development and highlighting the need for additional debate and refinement.

The Rumpff Commission of Inquiry into the Responsibility of Mentally Disordered Persons was established and delivered its Report in 1967.⁵³ The Report had a profound effect on current South African law relating to mental disorder and crime and illustrates once more the importance of scientific and medical considerations in the development of legislation and common law. The Rumpff Commission Report, among other things, suggests the correct legal test for criminal capacity, which differs from the M’Naghten Rules and is discussed in detail in Chapter 5.⁵⁴ The Report also submits that the personality is made up of more than just reason, suggests changes to the manner in which expert evidence is collected and resented, among other issues relating to the disconnect between scientific fact and the formulation of legal definitions and rules that are discussed in Chapter 3. Since 1977 criminal law relating to mental disorder has been codified in Section 77 to 79 of the Criminal Procedure Act, taking

⁵¹ Stevens 429430; Ladikos (2012) *Fundamina: A Journal of Legal History* 52; Slovenko ‘Psychiatry and Criminal Culpability’ 1995 22.

⁵² Stevens 431.

⁵³ The Rumpff Commission of Inquiry “Responsibility of Mentally Deranged Persons and Related Matters” RP 78/1967.

⁵⁴ Ladikos (2012) *Fundamina: A Journal of Legal History* 52.

into account the recommendations in the Rumpff Commission Report.⁵⁵The South African Law Commission made several recommendations regarding the State Patients, of which some were addressed in the MHCA.⁵⁶

The special verdict regarding State Patients in the current Criminal Procedure Act 21 of 1977 (the “CPA”),⁵⁷ has its origins in Section 29(1) of the Mental Disorders Act 38 of 1916 which relied on Section 2 of the Trial of the Lunatics Act, 1883 of England and Wales.⁵⁸ Section 31 of the Mental Disorders Act of 1916 provided that an accused was to be held in a mental institution until he ceased to be a Governor-General's patient, in later times state patients were detained pending the decision of the State President and today release of a state patient depends on the decision of a judge.⁵⁹ The rationale for the special verdict is to protect society from the dangerous behavior of persons of unsound mind.⁶⁰ The Mental Disorders Act provided for a verdict and the subsequent detention of an accused in a mental hospital, but today the CPA provides for the special verdict as State Patient and the MHCA regulates the admission and detention of the state patient and their involuntary treatment, care and rehabilitation.⁶¹

1.4. The current legislative framework for mental health law

Legislation is an important tool in ensuring that rights are protected. The MHCA seeks to ensure that the care, treatment and rehabilitation of persons who are mentally ill conform to the constitution and in particular, the right to equality and dignity. The current legislative framework of laws effecting mentally disordered persons is quite extensive and covers a diverse range of issues.⁶² The issues regulated in mental health legislation include the

⁵⁵ Act 51 of 1977; Ladikos (2012) *Fundamina: A Journal of Legal History* 53.

⁵⁶ Ladikos (2012) *Fundamina: A Journal of Legal History* 54; South African Law Commission “The Declaration and Detention of Persons as State Patients under the Criminal Procedure Act, Act 51 of 1977, and the Discharge of Such Persons under the Mental Health Act, Act 18 of 1973, including the Burden of Proof with regard to the Mental State of an Accused or Convicted Person” Working Paper (1995) 52-53.

⁵⁷ Contained in Chapter 13 of the CPA and discussed at length in Chapter 5 of the thesis.

⁵⁸ Landman and Landman 171.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ Landman and Landman 172.

⁶² Legislation relevant to current mental health care practice in South Africa include, among others: The Constitution of the RSA, 1996; Criminal Procedure Act 51 of 1977; Basic Conditions of Employment Act 75 of

voluntary and involuntary commitment to mental health institutions of mental health care users, mentally disordered prisoners, mental health practitioners, the forms used by practitioners, procedure to be followed in specific circumstances, living conditions and standards of care, and many other matters pertaining to mental health care. Although the legislation and policy currently enacted in South Africa is progressive and seems at first glance reasonably comprehensive, there are major gaps and loopholes in regulation that translate into inconsistent treatment of mental health care users, lack of transparency in mental health care and lack of accountability under professionals involved in the mental health care system.

Only a selection of issues that affect the mental health care user in their progression through the health care and criminal justice system is covered in depth in this thesis, particularly: Admission, treatment and discharge as a mental health care user (as a voluntary, involuntary, or assisted user, or as a State Patient); the regulation of the mental health profession; regulation of mental health care infrastructure; MHCA forms; and mentally disordered prisoners. The main pieces of legislation discussed in this thesis are the Mental Health Care Act 17 of 2002 and its General Regulations; the Criminal Procedure Act 51 of 1977; the National Health Act 61 of 2003; the Health Professions Act 56 of 1974, and the new Traditional Health Practitioners Act 35 of 2004. The influence of the Constitution and Bill of Rights, as well as the influence of international human rights instruments are also considered in Chapter 2, and throughout the thesis.

1997; Labour Relations Act 66 of 1995; Promotion of Access to Information Act 2 of 2000; Employment Equity Act 55 of 1998; National Health Act 61 of 2003; Mental Health Care Act 17 of 2002; Health Professions Act 56 of 1974; Allied Health Professions Act 63 of 1982; Nursing Act 50 of 1978; Pharmacy Act 53 of 1974; Dental Technicians Act 19 of 1979; Medical, Dental and Supplementary Health Services Professions Amendment Acts 18 of 1995 and 89 of 1997; Chiropractors, Homeopaths and Allied Health Service Professions Amendment Acts 40 of 1995 and 91 of 1997; and the Traditional Health Practitioners Act 35 of 2004. Janse van Rensburg, ABR (2007) 'A framework for current public mental health care practice in South Africa' Afr J Psychiatry 10: 205-209 206.

1.5. Factors considered in the interface between law and the mental health profession

Department of Health in its ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ has identified several ongoing challenges that face mental health in South Africa, namely:⁶³

- Until the development of the present document, there has been no officially endorsed national Mental Health Policy for South Africa;
- Mental health care continues to be under-funded and under-resourced compared to other health priorities in the country, despite the fact that neuropsychiatric disorders are ranked third in their contribution to the burden of disease in South Africa, after HIV&AIDS and other infectious diseases;
- There is enormous inequity between provinces in the distribution of mental health services and resources;
- There is a lack of public awareness of mental health and widespread stigma against those who suffer from mental illness;
- There is a lack of accurate routinely collected data regarding mental health service provision;
- Mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on psychiatric hospitals; and
- While the integration of mental health into primary health care is enshrined in the White Paper and the Mental Health Care Act, in practice mental health care is usually confined to management of medication for those with severe mental disorders, and does not include detection and treatment of other mental disorders, such as depression and anxiety disorders

Many problems exist that affect the successful collaboration between law and mental health, both practical problems in implementation of existing legislation and policy, as well as problems inherent in interpretation, terminology and deficient regulations. Some of the issues

⁶³ Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 9.

that are relevant to the discussion of mental health and law serve to illustrate the importance of the subject and research on the topic include:

- Mental health legislation and the common law does not reflect the values and obligations enshrined in the Bill of Rights in all instances and are in need of appropriate reform.⁶⁴
- The clinical and legal definitions of ‘mental illness’ that differ significantly, as well as the vastly different and sometimes contradictory conceptual boundaries and measurement in law and the mental health profession. Legal principles that are vague or poorly understood by experts compound the issue, and the reverse is also true that legal practitioners in turn do not adequately understand clinical diagnoses and terminology.⁶⁵
- The weight that different mental health experts attach to the degree that certain mental disorders affect capacity and the weight, understanding and application of expert mental health testimony in legal proceedings is not always consistent or satisfactory. The courts are the final arbiters in all decisions before them, but their decisions must be based on sound foundations. If a sound psychological basis for a concept is absent, the question as to the basis on which it is justified should be raised.⁶⁶
- Mental health care professionals base their presumptions, diagnoses and conclusions on very different bases than legal professionals. This serves to further complicate the mutual understanding that must exist between the professions in order to ensure that the interface of mental health and law is as effective and fair as possible. Furthermore psychology and psychiatry also are vastly different disciplines with varied schools of thought and methods of assessment. This impacts the foundation and coherence of legal assessments and concepts.⁶⁷
- In South Africa there exists no system of registration and training of forensic mental health experts;⁶⁸ there is no definition of what an expert is; and there is no system of

⁶⁴ The Bill of Rights and legislation protecting the rights of mentally ill persons is discussed in Chapter 2.

⁶⁵ This is discussed in Chapter 3.

⁶⁶ This is discussed in Chapter 3.

⁶⁷ Swanepoel 2010 THRHR 181. These issues are dealt with in Chapter 3 and 5.

⁶⁸ Kaliski, S. “Introduction” in Kaliski, S. (ed.) “Psycholegal assessment in South Africa” 20063.

record keeping that could assist researchers in determining the effectiveness of the current policy and implementation thereof.⁶⁹

- In South Africa, police often decide whether the person with mental illness enters the mental health system or the criminal justice system, though they are not trained in psychiatric care and intervention.⁷⁰
- There is a lack of clarity as to when mentally ill patients should be held responsible for their criminal behaviour or considered legally capacitated or not.⁷¹ Although procedures are clear, implementation is inadequate.⁷²
- Shortage of facilities and psychiatrists to assess the competence of offenders under the CPA is a cause for concern,⁷³ as well as the high levels of mentally disordered prisoners.⁷⁴

Problems that arise from the practical implementation of the legislation that require investigation and possible steps to rectify shortcomings are as follows:⁷⁵

- Standard forms that are prescribed for use by mental health legislation are deficient in that information required for the legal process is not adequate, mental health professionals are not adequately trained in how to complete these forms, or complete them in insufficient detail with general terms used across the bank for patients instead of individual reports. The terminology used in these forms, and to complete them, is also confusing and inconsistent.
- Mental health professionals required to deliver reports on a mental health care user's capacity in terms of legislation that require three psychiatrists and one psychologist, for example, make a habit of signing off on one expert's diagnosis in the report without also consulting with the user or discussing possible different diagnoses with their colleagues.

⁶⁹ This is discussed in Chapter 3.

⁷⁰ This is discussed in Chapter 4.

⁷¹ This is discussed in Chapter 5; Jonnson, G., Moosa, MYH., Jeenah, FH. (2009) "The Mental Health Care Act: Stakeholder compliance with Section 40 of the Act" 15 SAJP 2 37-42 37.

⁷² *Ibid.*

⁷³ This is discussed in Chapter 6.

⁷⁴ This is discussed in Chapter 5.

⁷⁵ These issues are discussed in Chapter 4 and 5.

- The regulations in mental health care legislation make provision for time periods in assessments and the detention of mental health care users, but do so inadequately, leaving confusion and causing possible injustices where mental health care users are detained for periods longer or shorter than required.

1.6. Thesis Statement, Hypotheses and Research Objectives

1.6.1 General Statement of the Thesis

Human rights infringements and the miscarriage of justice can be prevented by a South African legislative and policy framework that effectively regulates all aspects of mental health care.

1.6.2 Hypotheses

The hypotheses the thesis will depart from are as follows:

- South African mental health legislation may be in conflict with the Constitution and human rights standards.
- An analysis of applicable human rights instruments and Constitutionally protected fundamental rights will indicate both the importance of protecting vulnerable members of society, as well as the direction that legislative reform should take.
- Legislation and legal terminology dealing with mental health issues might not accurately reflect modern, accepted medical science, or clinical psychiatric and psychological schools of thought.
- Criminal law and procedure affecting mentally ill offenders and prisoners are deficient in their formulation and requirements, do not reflect accurately the aims of the legislator, and may lead to human rights abuses.
- A desktop study of the practical implementation of mental health law and policy in South Africa will bring to light problems in the fundamental fabric of the current regulatory system.
- The thesis will find that South African mental health legislation is in need of reform and indicate the path that must be taken to avoid human rights abuses and the miscarriage of justice.

1.6.3 Research Objectives

Specific research aims are:

- a) Compiling a comprehensive and detailed discussion of selected current mental health legislation and policy in South Africa, as well as an account of criminal law and procedure that apply to mentally disordered persons.
- b) Determining the clinical psychological, psychiatric and medical bases that inform legislation on mental health issues in order to ascertain whether current mental health law and policy is rooted in accepted science.
- c) Identify problems in the interpretation and implementation of mental health legislation.
- d) Detailing a framework of national and international human rights standards, and criminal law principles against which regulations should be measured.
- e) Presenting findings as to the efficacy of the current system regulating mental health and law in South Africa and recommending of steps to be taken where reform is needed.

1.7. Research Methodology

The approach taken in this thesis is holistic, critical, and mainly rights-based as it advocates that respect for human rights should be an aim of the legal process instead of a marginal consideration. A rights-based approach to mental disorder and disability means acknowledging the social, economic, and political forces that result in the disability experienced by people with mental health problems.⁷⁶

Data was gathered by systematic keyword searches relating to mental health, mental disorder and disability, criminal capacity, criminal justice, criminal procedure, and human rights. The search produced journal articles, textbooks, dissertations and theses, local and foreign legislation, international law instruments, policy documents, and government publications and

⁷⁶ Burns J. K. (2009) "Mental health and inequity: a human rights approach to inequality, discrimination and mental disability" 11 Health and Human Rights: An International Journal 2 19-31 21.

reports that are all analysed in the thesis. Due to the fact that an analysis of legislation on its own does not portray an accurate picture of the lived experience of a mentally ill person in the mental health care and legal system, a desktop study of the practical implementation of mental health legislation and the state of affairs of the mental health care system is undertaken. Of particular significance is the review and critique of the MHCA forms, as they can be viewed as the bridge between the provisions and requirements contained in the MHCA and the practical implementation of those provisions. Where the MHCA forms are lacking in the information required to complete them, clarity, or other deficiencies, the goals of the legislator cannot be reached and the possibility of human rights abuses emerges. Similarly where mental health practitioners, Review Boards, and the SAPS are unaware of the implications of the MHCA, or insufficiently trained in completing the MHCA forms, and where there is a lack of accountability, the rights of mental health care users are compromised.

Mental health affects a broad range of legal issues in private and public law, though the focus of this study is on selected human rights and criminal liability issues specifically pertaining to the Mental Health Care Act 17 of 2002 and its General Regulations; the Criminal Procedure Act 51 of 1977; the National Health Act 61 of 2003; the Health Professions Act 56 of 1974, and the new Traditional Health Practitioners Act 35 of 2004 and its regulations. The scope of this thesis is limited to discussing the public health care system, and excludes the private sector. The thesis is also limited to discussion pathological criminal incapacity, or conditions of an internal nature. Incapacity due to non-pathological states or external factors are excluded from the discussion.

1.8. Overview and Structure of Chapters

1.7.1 Chapter 1 – Introduction

In this introductory chapter the thesis statement, background, reasons for the research, research questions, the structure of the thesis, the scope of the study and the methodology are discussed. A brief history of mental health care practice and criminal law and procedure in South Africa is given, along with a discussion of key issues in the interface between law and mental health to contextualise the importance of the study. The original contribution the thesis brings to the literature is articulated against this backdrop.

1.7.2 Chapter 2 - Human Rights Principles applicable to South African Mental Health Law

This chapter discusses the human rights guaranteed to mentally disordered persons in the Bill of Rights in order to establish their content and scope as a means against which to measure the mental health legislation discussed in the following chapters. International human rights as contained in international customary law, conventions and soft law instruments is analysed in order to determine whether the rights entrenched in the Bill of Rights are sufficient in their content and correct in their interpretation as measured against global and regional standards. Specific rights discussed include the rights to equality; privacy; access to health care; freedom and security of the person; and freedom of religion, belief and culture.

1.7.3 Chapter 3 - Mental Health Care Practice: Context, Concepts, Classification and Regulation in South Africa

This chapter discusses the conceptual differences between the legal and mental health care professions, with regard to free will and determinism, capacity and competence, legitimacy and purpose, and mental disorder in legal and clinical settings. Further the psychology and psychiatry that underlie legal concepts are explored pertaining to the classification and categories of mental disorders, and the use of clinical assessment and diagnosis in forensic settings. The purpose of this discussion is to ascertain whether current mental health law and policy is rooted in accepted science. The chapter also deals with the influence of culture on the diagnosis and treatment of mental disorder and the Traditional Health Practitioners Act 22 of 2007; the regulation and training of mental health care practitioners in terms of the Health Professions Act 56 of 1974; and mental health care institutions and their administration in terms of the National Health Act 61 of 2003 and the Mental Health Care Act 17 of 2002.

1.7.4 Chapter 4 - A Critical Discussion of the Mental Health Care Act: Provisions, Regulations, and Forms

In this Chapter the Mental Health Care Act 17 of 2002 and its General Regulations are discussed. Particular focus is placed on the admission and discharge as a voluntary, involuntary and assisted mental health care user in terms of the Act. Issues dealt with include consent to treatment, the role of the South African Police Service, and mechanisms for

accountability and transparency such as the Mental Health Review Boards, the judiciary and administrative law. Importantly, an analysis of the MHCA forms used in these processes is conducted. The human rights principles and psychiatric and psychological terminology as discussed in Chapter 2 and Chapter 3 are utilised as a measure against which the suitability and effectiveness of the Act and forms are evaluated.

1.7.5 Chapter 5 - Mentally Disordered Persons in Criminal Law, Criminal Procedure and Corrective Services

This chapter discusses criminal justice principles and the theories of punishment as backdrop against which the criminal law and procedure affecting the mentally ill offender and prisoner should be viewed. Mental health in criminal law is analysed regarding the different ways in which mental disorder might affect criminal liability (either affecting the voluntariness of conduct, unlawfulness, criminal capacity or fault) or might affect sentencing where diminished criminal capacity is present. Chapter 13 of the Criminal Procedure Act 51 of 1977 is discussed as it pertains to the capacity of the accused to understand proceedings in terms of Section 77, the criminal capacity of the accused in terms of Section 78 of the Act, and the panel for purposes of enquiry and report in terms of Section 79 of the Act. The Mental Health Care Act 17 of 2002 is also discussed in this chapter regarding State Patients and mentally ill prisoners, as well as the MHCA forms utilised. The constitutional validity and internal logical consistency of these provisions are debated.

1.7.6 Chapter 6 - The Application of Mental Health Law in Practice

Chapter 6 contains a discussion of the current state of the mental health care system in South Africa and the practical application of mental health legislation. The prevalence of mental disorder and barriers to the effective implementation of existing policies are discussed to highlight the importance of not only legislative reform, but also of the necessary steps to be taken to ensure legislation is translated into the lived experience of mentally ill persons. Issues discussed include human resources and infrastructure, the efficiency of the Mental Health Review Boards, the administrative burden imposed on mental health care practitioners by the MHCA, and human rights abuses perpetrated in the provision of mental health care.

1.7.7 Chapter 7 – Recommendations and Conclusion

This chapter summarises the findings in the previous chapters of the thesis and makes recommendations for reform of mental health law and legislation. Recommendations are also made regarding the proposed amendment of the MHCA forms and avenues for future research. Recommendations take the form of suggested issues, arguments and perspectives to be considered by the legislator in conjunction with all relevant stakeholders when composing legislation and policy to reform the current state of affairs.

1.9. Value Contribution and Motivation of Thesis

The point of departure in the research is that if legislation and policy concerning mental health care falls short of human rights standards and is not in line with accepted principles in the mental health care profession, then its legitimacy must be questioned and the *status quo* reformed. This thesis is primarily concerned with the mental health laws, criminal law and procedure as it applies to the mentally disordered individual in South Africa. The goal is to critically present the current position in South Africa, therefore an in depth comparison of foreign jurisdictions is outside the scope of the discussion, and foreign law is only mentioned incidentally where it is of interpretative value or where a particular aspect of regulation is referred to. International law and international human rights law is discussed in as far as it is directly applicable to South African law or where it has an indirect influence on the interpretation of legal provisions.

The original contribution of this thesis is that it is the first study to comprehensively analyse, from a human rights and criminal justice perspective, South African mental health legislation against the backdrop of accepted science and universally accepted human rights standards; recommend amendments where necessary; and review the MHCA forms prescribed for use in practice to establish their coherence with the aims of the legislator and suggest amendment and other measures to ensure the prevention of human rights abuses. The research fills a gap in current knowledge regarding the compliance with human rights principles and medical expertise of current South African mental health law and its implementation. The study has never before been attempted in this specific format and contributes to a new and original understanding of the law as it relates to mental health in a more comprehensive manner that does not just pay attention to theorising, but also to the law in practice.

1.10. Note on terminology used in the thesis

Throughout this thesis the terminology employed is defined in context of the relevant legislation under discussion. When discussing mental health and mental disabilities, a complicating factor is the absence of agreement on the most appropriate terminology.⁷⁷ Mental illness, mental disorder, mental incapacity, psychiatric disability, mental disability, psychosocial disability, intellectual disability, and several other terms are all used with different connotations and meaning.⁷⁸ Terminology has evolved significantly in recent years, for example, intellectual disability, mental retardation or handicap, is now sometimes referred to as developmental disability.⁷⁹ When the term 'mental disability' is used in this thesis it includes disabilities arising from mental illness and psychiatric disorders, as well as intellectual disabilities,⁸⁰ unless the contrary is made plain. Mental ill health is defined as a disability in Article 1 of the Convention on the Rights of Persons with Disabilities, therefore mentally disordered persons fall under the ambit of disability rights and protections in local and international human rights instruments in addition to mental health specific provisions. Current approaches to mental health draw on the philosophies of social inclusion and non-stigmatisation developed by the disability rights movement.⁸¹ Reconceptualising mental health rights as disability rights is important for the protection of individual dignity, because it lays a greater emphasis on the duty on a state to act to ensure rights are realised instead of on negative rights.⁸²

1.11. Conclusion

South African law, procedure and policy and the existing legal, philosophical and political framework cannot be divorced from a 'global', professional, psychological and psychiatric science, or principles underlying international human rights instruments. Reform and the prevention of human rights violations can only be achieved through research to challenge the

⁷⁷ Hunt and Mesquita (2006) *Human Rights Quarterly* 335-336.

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ Fennel, P. 'Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights Based Approaches' in McSherry, B.; Weller, P. (eds) 'Rethinking rights-based mental health laws' 2010 20.

⁸² Fennel 21.

validity of existing structures. The South African system needs refinement in terms of regulation and critical attention to the implementation of existing legislation and policy. This thesis is the first of its kind and has the potential to affect positive change and legal reform through pointing out the necessary amendments to be made and steps to be taken in practice to prevent human rights abuses, taking the above considerations into account.

CHAPTER 2: HUMAN RIGHTS PRINCIPLES APPLICABLE TO SOUTH AFRICAN MENTAL HEALTH LAW

2.1 Introduction

In this chapter the international human rights standards applicable to mental health laws, and criminal law and procedure that impact the mentally disordered person, is discussed as a framework against which the current system of regulation and rights in South Africa can be measured. International human rights law and the South African Bill of Rights, and other enabling legislation, are discussed to establish whether the South African State is theoretically complying with its duties regarding the protection of mentally ill persons. The substantive and procedural aspects of law affecting mentally disordered persons regarding their treatment as mental health care users and in the criminal justice system are discussed in Chapter 4 and 5, and the framework of human rights set out in this chapter is used to analyse whether the legislation is up to standard and where and how they can be improved upon if not. The practical implementation of mental health law in practice and whether it is in line with the human rights protections offered in the Constitution is discussed in Chapter 6. This chapter is aligned to the research objective of detailing a framework of national and international human rights standards and policy considerations against which regulations should be measured.

A central concept in human rights is that every person has inherent value, worth and dignity and that every person should be protected from infringements and abuses of fundamental rights from any source.¹ Generally, human rights are understood as rights that belong to a person solely as a consequence of being human.² The United Nations states that the denial of human rights and fundamental freedoms is not only an individual tragedy, but it creates conditions of social and political unrest.³ The Universal Declaration of Human Rights

¹ Section 7(1) of the Constitution affirms the democratic values of human dignity, equality and freedom in South Africa. In *S v Makwanyane and another* 1995 (6) BCLR 665 (CC) at par 111 the court stated that respect for life and dignity are values of the highest order in the Constitution. Section 8(1) and (2) of the Constitution indicates that the Bill of Rights applies to all law and binds the State, as well as natural and juristic persons, taking into account the nature of the right and the nature of the duty imposed by the right.

² Swanepoel, M. (2011) 'A selection of constitutional aspects that impact on the mentally disordered patient in South Africa' *Obiter*, Vol 32, Issue 2: 282-303 285.

³ Swanepoel (2011) *Obiter* 286.

provides that the foundation of freedom, justice and peace in the world is respect for human rights and human dignity.⁴ Implementing effective policies to ensure that the protection of the mentally disordered person becomes a reality is an ongoing prerogative of nations around the globe.⁵

The Constitution is the supreme law in South Africa and all other laws, executive, administrative, legislative and judicial conduct is subject to the values enshrined in the Constitution. The Constitution contains a Bill of Rights that sets out the rights and fundamental freedoms, accorded all citizens and the corresponding duties of the State. The Constitution also provides in section 39, the Interpretation Clause, that when interpreting and developing law the courts must consider international law, and may consider foreign law. Section 39(2) determines that when interpreting any legislation to promote the spirit, purport and objects of the Bill of Rights.

The treatment of people with mental health problems worldwide has been marked by abuse and neglect.⁶ Issues of concern include a lack of access to essential health care and treatment, inappropriate or forced admission to psychiatric facilities without protective measures in place, poor living conditions in psychiatric institutions, unnecessary or inhumane treatment, inappropriate use of seclusion and restraints, abuse from personnel or fellow patients during treatment, isolation from family and society, discrimination, and the loss of basic civil rights.⁷ Gostin and Gable,⁸ in their article, examine the important relationship between mental health and human rights, contending that coercive mental health policies can infringe on human rights, that invasions of human rights can harm mental health and that the positive promotion of mental health and human rights can have mutually reinforcing and positive results. Mental health care and human rights protections are complementary approaches to improving the lives of human beings, and some measure of mental health is indispensable for human rights,

⁴ *Ibid.*

⁵ Swanepoel (2011) *Obiter* 303.

⁶ Simpson, B.; Chipps, J. (2012) 'Mental Health Legislation: Does it protect the rights of people with mental health problems?' 1 *Social Work* 48: 47-57 47.

⁷ Simpson, Chipps (2012) *Social Work* 47.

⁸ Gostin, LO.; Gable, L. (2004) 'The Human Rights of Persons With Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health Wayne State University Law School Legal Studies Research Paper Series No. 08-31' 63 *Maryland Law Review* 20: 22-121 28.

as only those who possess a reasonable level of functioning can engage in political and social life.⁹ Government authority by its nature affects a variety of personal interests, including autonomy, physical integrity, privacy and liberty. These interests give rise to human rights violations where the government exercises its powers regarding mentally disabled persons arbitrarily, in a discriminatory manner, or in the absence of a fair process.¹⁰

Pieterse describes human rights as a powerful instrument through which marginalised persons or groups can demand accountability from those responsible for service delivery, and change how society views the delivery of services such as mental health care.¹¹ Gradually enforcement of rights have the power to change the way social delivery systems function, although the enforcement through the judiciary of these rights are controversial in the sense that tension is caused between the branches of government.¹² The use of judicial enforcement of human rights has the potential to deepen democracy and give citizens a voice, but factors such as unequal access to courts, the power of social movements and interest groups which make use of the judicial process, and judges' individual perspectives and value systems, may distort democratic processes and disrupt the pursuit of democratic projects.¹³

Rights-based legalism is the dominant model for contemporary mental health law indicating the complex nature between human rights and mental health law reform if visualised as a pendulum swinging between the exclusive concepts of patient rights and medical welfare paternalism.¹⁴ In current mental health rights discourse, traditional welfare principles are incorporated into this framework, illustrating that rights are interconnected, interdependent and indivisible.¹⁵ The effectiveness of rights-based approaches to mental health legislation in

⁹ *Ibid.*

¹⁰ Gostin and Gable (2004) *Maryland Law Review* 27.

¹¹ Pieterse, M. 'Can rights cure?: The Impact of human rights litigation on South Africa's health system' 2014 *PULP* 1; Mubangizi, JC, Twinomugisha, BK. (2010) 'The right to health care in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?' *African Human Rights Law Journal* Vol 101:105 128-129

¹² Pieterse 2.

¹³ *Ibid.*

¹⁴ Weller, P 'Lost in translation: Human rights and mental health law' in McSherry, B.; Weller, P. (eds.) 'Rethinking rights-based mental health laws' 2010 51.

¹⁵ *Ibid.*

achieving social inclusion and protection of rights depends on the social context.¹⁶ A balance must be struck between the risk of human rights infringements to the mentally disordered person and the risk posed by the mentally disordered person to the community.¹⁷

When rights are enforced through the judiciary the doctrine of separation of powers becomes an important consideration in preventing tensions between the branches of government and disrupting the democratic process.¹⁸ Courts are thought of as being ineffective in reforming socio-economic policy as they lack the technical and financial expertise to decide on the content of intricate matters of social policy, and do not have the institutional influence or manpower to ensure that their judgments are heeded.¹⁹ It is often pointed out in relation to the right to health that courts lack the medical and scientific knowledge to decide on diagnosis, suitable treatment options, and on whether particular treatment is necessary in a specific case.²⁰ Although there are distinct advantages to the justiciability of socio-economic rights, litigation is limited by its nature, and the judiciary might be an inappropriate forum for taking such decisions as they are not in a position to fully consider the multidimensional effects of decisions on whether or not to enforce rights.²¹ Courts are however expert legal interpreters and therefore well placed to flesh out the content of socio-economic rights and their application in real-life contexts.²² Additionally, courts are independent, impartial, even-handed, and deliberative, and have expertise in solving disputes and balancing competing interests.²³ Through judicial review, courts enhance deliberative and participatory democracy by holding the legislature and executive accountable for meeting their constitutional commitments and by forcing them to engage with claims regarding protected rights.²⁴ Judicial deference, by which a court defers to the other branches of government instead of taking a

¹⁶ Fennel, P. 'Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Bases Approaches' in McSherry, B.; Weller, P. (eds.) 'Rethinking rights-based mental health laws' 2010 14.

¹⁷ *Ibid.*

¹⁸ Brand, D 'Socio-economic rights and courts in South Africa: Justiciability on a sliding scale' in Coomans, F (ed.) *Justiciability of economic and social rights: Experiences from domestic systems* (2006) 207, 225-227; Gloppen, S. 'Social rights litigation as transformation: South African perspectives' in P Jones & K Stokke (eds.) *Democratising development: The politics of socio-economic rights in South Africa* (2005) 153, 158-160.

¹⁹ Pieterse 25; Brand 225.

²⁰ *Ibid.*

²¹ Pieterse 25; Mbazira, C. (2008) 'Confronting the problem of polycentricity in enforcing the socioeconomic rights in the South African Constitution' 23 SA Public Law 30.

²² Pieterse 25.

²³ *Ibid.*

²⁴ *Ibid.*

decision regarding the issue at hand,²⁵ is discussed and critiqued regarding socio-economic rights in Chapter 6.

The judiciary is an indispensable tool in shaping the body of law and rights regarding mentally disordered persons and other vulnerable groups, although it may not always be the best or only option for reform. Case law is discussed regarding the right to access to health care and Section 27 of the Constitution in this Chapter at 2.4.10. Legislative change must take place through law reform commissions and the legislature, and through the commitment of all spheres of government to being truly transformatory. Law might not always be the best tool through which to correct and prevent wrongs, but given that legislation is paramount to the functioning of the mental health system, it is important that mental health laws are workable and conform to international human rights documents.²⁶ The health system in South Africa direly needs reform and raises concerns of human rights violations.²⁷ It is submitted that a study of the human rights guaranteed to all in the Bill of Rights, including those with mental disorders, is the obvious starting point into an enquiry whether human rights violations are taking place, the extent of the violations considering the content of the right concerned, and eventually to establish which form reforms in the health system should take to prevent continued and possible future rights abuses.

2.2 International human rights law

2.2.1 Introduction

In this section international human rights instruments applicable to mentally disordered persons in South Africa is discussed to determine whether the existing human rights framework in the Constitution, Bill of Rights, and other legislation conforms to international standards. This lays the groundwork for the analysis of mental health laws and their

²⁵ See Brand, D (2011) 'Judicial deference and democracy in socio-economic rights cases in South Africa' 22 Stellenbosch Law Review 614.

²⁶ McSherry and Weller 'Introduction' in McSherry, B.; Weller, P. (eds.) 'Rethinking rights-based mental health laws' 2010.

²⁷ Pieterse 3.

implementation, the mental health professions, and the criminal justice system in the following chapters.

The United Nations appointed three Special Rapporteurs on Human Rights and Disability who found that people with mental disabilities experience some of the harshest conditions of living that exist in any society.²⁸ Much of the hardship experienced by people with mental disabilities is caused by discrimination.²⁹ People with mental disabilities are often deprived of liberty for prolonged periods of time without legal process and are often:³⁰

- Subjected to peonage and forced labour in institutions;
- Subjected to neglect in harsh institutional environments;
- Deprived of basic health care;
- Victimised by physical abuse and sexual exploitation; and
- Exposed to cruel, inhuman or degrading treatment.

An international system of human rights with universal application has accordingly been developed under the auspices of the United Nations, and regional human rights systems that apply geographically and provide additional protection. Both the international and regional systems have addressed the human rights of persons with mental disabilities through treaties, declarations and thematic resolutions.³¹ The international human rights movement has recognised the rights of individuals under international law and in so doing has pierced the veil of national sovereignty.³² International human rights law places the onus on the State to safeguard the human rights of all people, including persons with mental disabilities.³³ The human rights duties of a government includes the state's obligation to not infringe upon human rights (e.g. no arbitrary confinement), to prevent private violations (e.g. anti-discrimination laws), and to promote human rights (e.g. through education and services).³⁴

²⁸ *Ibid.*

²⁹ Rosenthal, E.; Sundram, CJ. 'The Role of International Human Rights in National Mental Health Legislation' Department of Mental Health and Substance Dependence, World Health Organization 20042.

³⁰ *Ibid.*

³¹ Gostin and Gable (2004) Maryland Law Review 23.

³² Gostin and Gable (2004) Maryland Law Review 22.

³³ Gostin and Gable (2004) Maryland Law Review 23.

³⁴ *Ibid.*

South Africa has acceded to most of the international treaties being discussed in this chapter, but beyond specific treaty obligations, the understanding of the rights of mentally ill persons in international law must influence the manner in which the right and its accompanying obligations are understood in the context of the Constitution.³⁵ According to Section 39(1) of the Constitution, when interpreting the Bill of Rights, a court, tribunal or forum must promote the underlying values of an open and democratic society based on human dignity, equality and freedom, **must** take international law into account and **may** also have regard to foreign law when interpreting rights in the Bill of Rights. Section 233 of the Constitution further determines that “when interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law”.³⁶

Conventions fall into the category of “hard” international law and General Assembly resolutions fall into the category of “soft” law.³⁷ Soft law instruments in the human rights field are also referred to as international human rights “standards”.³⁸ Soft law is considered non-binding and hard law is considered binding.³⁹ The two main sources of binding international human rights law are customary international law and conventions.⁴⁰ Customary international law comprises legal principles so widely accepted by governments and legal scholars as binding that they need not even be written legal principles, such as the concept that a government must protect against torture or inhuman and degrading treatment.⁴¹ Gradually soft law principles that become widely accepted can “harden” into binding international law.⁴²

The adoption of domestic legislation conforming to the requirements of international standards is one of the most important ways governments can meet their obligations to people

³⁵ Pieterse 16.

³⁶ *Ibid.*

³⁷ Rosenthal and Sundram 10.

³⁸ *Ibid.*

³⁹ *Ibid*; Currie, I. and De Waal, J. ‘The Bill of Rights Handbook’ 2013 117, 146-147.

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

⁴² *Ibid.*

with mental disabilities under existing international human rights law.⁴³ The South African government should review its domestic legislation against the standards articulated in international human rights law, especially to the extent that such legislation affects the exercise of power and discretion by each government and its agents regarding people with mental disabilities.⁴⁴

International human rights law provides a powerful and often underutilised tool to advance and protect the human rights of persons with disabilities.⁴⁵ International human rights law is important regarding mental health due to two fundamental ideas unique to global protection of rights and freedoms, namely:⁴⁶ Firstly, human rights law is the only source of law that legitimises international scrutiny of mental health policies and practises in a sovereign country; Secondly, international human rights law provides fundamental protections that cannot be taken away by the political process. Each country's mental health policies and practices are susceptible to international monitoring and control, as human rights are a matter of international law enforceable against a state on behalf of persons living in and under control of the state.⁴⁷

Even where no international enforcement mechanism is available, many human rights conventions create a system for international monitoring, including the major UN conventions, like the ICCPR and the ICESCR, that create treaty-based supervisory bodies.⁴⁸ Governments that ratify conventions agree to report regularly on the steps that they have taken to implement the convention through changes in legislation, policy, or practice.⁴⁹ Non-governmental organisations may submit information for review by oversight bodies.⁵⁰ Oversight bodies review both the official and non-governmental reports and publish their findings, which may include a determination that governments have not met their

⁴³ Rosenthal and Sundram 1.

⁴⁴ *Ibid.*

⁴⁵ Gostin and Gable (2004) Maryland Law Review 20.

⁴⁶ Gostin and Gable (2004) Maryland Law Review 21.

⁴⁷ Gostin and Gable (2004) Maryland Law Review 22.

⁴⁸ Rosenthal and Sundram 13.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

international obligations under the convention.⁵¹ The international oversight and reporting process thus provides an opportunity to educate the public on a specialised area of rights and the process can also be a powerful way to pressure governments to realise convention-based rights.⁵²

The guidelines, known as General Comments, produced by human rights oversight bodies to guide governments, preparing their official reports is one of the most important sources of interpretation of human rights conventions.⁵³ General comments are non-binding, but they represent the official view concerning the proper interpretation of the convention by the human rights oversight body.⁵⁴ In 1996, the Committee on Economic, Social, and Cultural Rights adopted General Comment 5, which details the application of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) regarding people with mental and physical disabilities.⁵⁵ As part of General Comment 5, the Committee recognised the MI Principles, the Standard Rules, and the UN's Guidelines for National Coordinating Committees as instruments established by the international community to "ensure the full range of human rights for persons with disabilities."⁵⁶ General Comment 5 singles out the Standard Rules as "a particularly valuable reference guide in identifying more precisely the relevant obligations of States under the Covenant."⁵⁷

2.2.2 International Customary Law

International customary law already forms part of South African law and need not be ratified the way that treaties need to be. International customary law is law that has so often been accepted as international law by the global community with the intention of it being binding, that it has become common practice to adhere to it willingly. Section 232 of the Constitution of South Africa determines that customary international law is law in the Republic, unless it is inconsistent with the Constitution or an Act of Parliament.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ Rosenthal and Sundram 14.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*

2.2.1.1 The Universal Declaration of Human Rights (UDHR)

The main sources of human rights law protecting mentally disabled persons in the United Nations system comprises the International Bill of Human Rights, which contains the United Nations Charter, The Universal Declaration of Human Rights, and the two International Covenants of Human Rights.⁵⁸ The International Bill of Human Rights forms the foundation of international human rights law, though its provisions do not explicitly focus on the rights of persons with mental disabilities, and the UN has adopted additional declarations, resolutions and guidance documents specifically addressing those rights.⁵⁹

The Universal Declaration of Human Rights was adopted by the UN in 1948 and built upon the UN Charter by identifying specific rights and freedoms deserving protection.⁶⁰ The preamble to the Universal Declaration of Human Rights states that it is meant to be “a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance”.⁶¹ The UDHR was the international community's first attempt to establish a common standard for human rights being achieved by all nations, establishing that people with mental disabilities are protected by human rights law by virtue of their basic humanity.⁶²

The principles of the Universal Declaration of Human Rights are considered to be international customary law and do not require signature or ratification by the state in order to be recognised as a legal standard.⁶³ Countries have so often applied and accepted its key provisions that the principles have obtained the status of customary international law,

⁵⁸ Gostin and Gable (2004) Maryland Law Review 29.

⁵⁹ *Ibid.*

⁶⁰ Gostin and Gable (2004) Maryland Law Review 31; Rosenthal and Sundram 3.

⁶¹ Rosenthal and Sundram 18.

⁶² Gostin and Gable (2004) Maryland Law Review 31; Rosenthal and Sundram 3; Article 1 of the Universal Declaration of Human Rights provides that “all people are free and equal in rights and dignity”.

⁶³ Swanepoel (2011) Obiter 285.

although the UN did not promulgate the UDHR to legally bind member states.⁶⁴ The rights contained in the UDHR include the right to life; liberty; security of the person; the prohibition of cruel, inhuman, or degrading treatment; the right to effective judicial remedy; the prohibition of arbitrary arrest, detention and exile; freedom from arbitrary interference with privacy, family or home; freedom of movement; and freedom of conscience, religion, expression and association.⁶⁵ The UDHR does not distinguish between civil and political rights, and economic, social or cultural rights and characterises socio-economic and cultural rights as indispensable to a person's dignity in Article 22.⁶⁶ It is similar to the South African Bill of Rights in this way. Among the socio-economic rights included in the UDHR, The UDHR does not specify the enumerated human rights beyond their most general application and therefore has a minimal application to the rights of persons with disabilities.⁶⁷

2.2.3 International instruments

South Africa follows a dual system between international and national law, meaning that international treaties and conventions are not automatically binding, unless the requirements of Section 231(2) of the Constitution are met.⁶⁸ Section 231(2) of the Constitution provides that an international agreement is only binding on South Africa after it has been approved by resolution in the National Assembly and the National Council of Provinces. Section 231(3) provides that South Africa is bound to international agreements that were in force when the Constitution took effect. A treaty of this nature becomes domestic law in South Africa when it has been enacted by national legislation. An international agreement of technical, administrative or executive nature, or an agreement not requiring ratification or accession, entered into by the national executive, is binding on the country (Section 231(4)). This agreement must be tabled in the National Assembly and National Council of Provinces within a reasonable time (Section 231(2)). A self-executing provision of an agreement that has been approved by Parliament becomes law automatically, unless it is inconsistent with the

⁶⁴ Gostin and Gable (2004) Maryland Law Review 32.

⁶⁵ Gostin and Gable (2004) Maryland Law Review 31.

⁶⁶ Gostin and Gable (2004) Maryland Law Review 32.

⁶⁷ Gostin and Gable (2004) Maryland Law Review 33.

⁶⁸ Dugard, J. 'International Law: A South African Perspective' 4th Edition 2011:43; Buchner-Eveleigh and Nienaber 'Gesondheidsorg vir kinders: Voldoen Suid-Afrika se wetgewing aan die land se verpligtinge ingevolge die Konvensie oor die regte van the Kind en die Grondwet?' (2012) 15 PER/PELJ 1103-146 106.

Constitution or other legislation. (Section 231(4)).⁶⁹ Treaties relating to mental health are mainly UN treaties, some of a general nature and others of narrower scope.⁷⁰ Normally a treaty does not automatically form part of a country's domestic law, even if signed and ratified.⁷¹

Specialised treaties dealing with mental health or general health are:⁷²

- UN Convention on the Rights of Persons with Disabilities, 2006 (signed on 30 March 2007 and ratified on 30 November 2007);
- Optional Protocol to UN Convention on the Rights of Persons with Disabilities, 2006 (accepted on 30 November 2007);
- International Covenant on Economic, Social and Cultural Rights (2008) (signed 3 October 1994 and ratified on 12 December 2015);
- International Covenant on Civil and Political Rights, 1966 (signed on 3 October 1994 and ratified on 10 December 1998);
- Convention on the Rights of the Child, 1989 (signed 29 January 1993 and ratified on 16 June 1995);
- Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment, 1984 (signed on 29 January 1993 and ratified on 10 December 1998);
- Convention on the Elimination of all Forms of Discrimination against Women, 1979 (signed on 29 January 1993 and ratified 15 December 1995);
- International Convention on the Elimination of all Forms of Racial Discrimination, 1966 (signed on 3 October 1994 and ratified 10 December 1998);

These instruments offer mandatory as well as optional guidelines that the human rights standards in South Africa must comply with. The UN has promulgated conventions on the

⁶⁹ Kanter, A.S. 'The Development of Disability Rights Under International Law: From Charity to human rights' 2015 1.

⁷⁰ Landman, A.A. and Landman, W.J. 'A Practitioner's Guide to the Mental Health Care Act' (Cape Town; Juta & Co) 2014 21.

⁷¹ *Ibid.*

⁷² Landman and Landman 23; The United Nations Human Rights Office of the High Commissioner webpage http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=162&Lang=EN (accessed 10 February 2016).

rights of women, children and racial minorities to establish specific protections for these vulnerable groups.⁷³ These treaties also recognise the rights of mentally disordered individuals, and have established their own monitoring bodies.⁷⁴ These monitoring bodies can offer additional mechanisms for oversight where a mentally disordered person's rights have been violated while falling under the ambit of an already vulnerable group.⁷⁵

2.2.3.1 The United Nations Charter (UN Charter)

The UN Charter of 1945 in its preamble sets out the undertaking of the international community to reaffirm faith in fundamental human rights and in the dignity and worth of the person. Article 1(d) states that one of the central purposes of the Charter is to achieve international cooperation in the promotion and encouragement of respect for human rights and freedoms for all persons, without distinction.⁷⁶ Articles 55(a) and (c) states that the UN shall promote higher standards of living, full employment and conditions of economic and social progress and development, and universal respect for and observance of human rights for all.⁷⁷

2.2.3.2 The International Covenants on Human Rights

While the Universal Declaration of Human Rights establishes a fundamental set of human rights applying to all nations, the UN drafted two international human rights conventions to promote the implementation and oversight of the rights it established.⁷⁸ The two core UN human rights conventions are the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR). Together with the Universal Declaration of Human Rights, they make up what is known as the “International Bill of Rights”.⁷⁹

⁷³ Gostin and Gable (2004) Maryland Law Review 35-36.

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

⁷⁶ Gostin and Gable (2004) Maryland Law Review 31.

⁷⁷ *Ibid.*

⁷⁸ Rosenthal and Sundram 3-4.

⁷⁹ Rosenthal and Sundram 4.

The International Covenants on Human Rights are a binding, treaty based scheme to protect human rights and include the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESR) adopted in 1966, and entered into force in 1976.⁸⁰ Like the UDHR, the covenants do not focus explicitly on the rights of persons with mental disabilities and adopt broad principles of safeguarding and promotion of the rights.⁸¹ The ICCPR in article 6(1) qualifies the right to life as follows: “Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.” The ICCPR was adopted and opened for signature, ratification and accession by the General Assembly Resolution 2200A (XXI) on 16 December 1966.⁸² It was entered into force on 23 March 1976 in accordance with Article 4. The International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the central international protection of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.⁸³

The covenants also separate civil and political rights from socio-economic and cultural rights and diverge in their treatment of different rights, acknowledging in the ICCPR that some are absolute and non-derogable and, such as the right to life, freedom from torture and cruel, inhumane and degrading treatment or punishment, the right to recognition as a person before the law and the right to freedom of thought, conscience and religion (Articles 6, 7, 16, 18, 999).⁸⁴ The ICCPR states that other rights may justifiably be limited under certain conditions to the extent required by the situation, provided such measures are not inconsistent with other obligations under international law and do not amount to discrimination solely on the grounds of such as race, colour, sex, language, religion or social origin (Article 4.1, 999).⁸⁵ Persons with mental disabilities have frequently invoked the civil and political rights in the ICCPR,

⁸⁰ Gostin and Gable (2004) Maryland Law Review 33.

⁸¹ *Ibid.*

⁸² Swanepoel, M ‘Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues’ (LLD thesis, 2009 Unisa) 203.

⁸³ Hunt and Mesquita (2006) “Mental Disabilities and the Human Right to the Highest Attainable Standard of Health” Human Rights Quarterly 332-356 340.

⁸⁴ Gostin and Gable (2004) Maryland Law Review 34.

⁸⁵ *Ibid.*

for example the prohibition on cruel, inhumane, and degrading treatment to argue for more humane conditions of confinement and treatment.⁸⁶

Freedom of movement may be limited where restrictions provided by law, are necessary to protect public health or the rights and freedoms of others (among other factors).⁸⁷ The ICESCR permits the limitation of rights as are determined by law only where compatible with the nature of the right and solely to promote the general welfare in a democratic society (Article 4, 993).⁸⁸ The ICESCR forms the foundation for rights that impose positive duties of the state to provide services (see Article 2, 993 that requires signatory states to guarantee the rights articulated in the ICESCR).⁸⁹ Article 12 of the ICESCR requires states to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.⁹⁰ The socio-economic and cultural rights in the ICESCR have been used to advance access of mentally disabled persons to more effective and humane treatment for mental illness, and to increase the availability of educational and vocational programs targeting individuals with mental disabilities.⁹¹

2.2.3.3 United Nations Convention on the Rights of Persons with Disabilities (CRPD)

On 30 March 2007, South Africa became a signatory to the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol, which was ratified on 30 November 2007, and came into force internationally on 3 May 2008.⁹² The CRPD was agreed upon unanimously by the member states of the UN, signifying a shift to a new understanding of disability.⁹³ The South African Government committed itself to a new

⁸⁶ Gostin and Gable (2004) Maryland Law Review 34.

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

⁹¹ Gostin and Gable (2004) Maryland Law Review 35.

⁹² Burns, J.K. (2011) 'The mental health gap in South Africa – A human rights issue' The Equal Rights Review, Vol. 6 99; Kanter 1.

⁹³ Lewis, O. 'The Expressive, Educational and Proactive Roles of Human Rights: An Analysis of the United Nations Convention on the Rights of People with Disabilities' in McSherry, B.; Weller, P. (eds.) 'Rethinking rights-based mental health laws' 2010 101; Kanter 1; Burns J. K. (2009) "Mental health and inequity: A human rights approach to inequality, discrimination and mental disability", Health and Human Rights: An International Journal, Vol. 11, No. 2 19-31 20.

approach to persons with disabilities in aligning itself to the CRPD, premised on an acceptance that persons with disabilities are legal subjects with rights worthy of protection.⁹⁴ Mental health conditions are conceptualised as disabilities under the CRPD.⁹⁵ The CRPD was ratified after the MHCA came into effect in 2004. The Act is discussed in this chapter and the following chapters and its implementation is analysed to determine whether it is in line with the CRPD and other international instruments and customary law, and the Bill of Rights in the South African Constitution.

“Mental illness” and “unsoundness of mind” are defined in the CRPD as generic concepts embracing all disabilities and disorders of mind, including mental illness, learning disability, and personality disorders.⁹⁶ The CRPD in its preamble recognises that all rights are universal, indivisible, interdependent and interrelated and adopts the social model of disability rather than the medical model, which views persons with disabilities as rights holders with inherent dignity.⁹⁷ The social model of disability holds that disabled persons are disabled by society's failure to provide the means to promote their social inclusion.⁹⁸ The CRPD also recalls various international instruments in the rights contained therein, namely:

- The International Covenant on Economic, Social and Cultural Rights;
- The International Covenant on Civil and Political Rights;
- The International Convention on the elimination of all forms of racial discrimination;
- The Convention on the elimination of all forms of discrimination against women;
- The Convention against torture and other cruel, inhuman or degrading treatment or punishment;
- The convention on the rights of the child; and
- The International Convention on the Protection of the rights of all migrant workers and members of their families.⁹⁹

⁹⁴ Burns (2011) *The Equal Rights Review* 99; Weller 68; Lewis 101.

⁹⁵ *Ibid.*

⁹⁶ Fennel 14; Burns (2009) *Health and Human Rights: An International Journal* 20.

⁹⁷ Fennel 13; Kanter 8; Burns (2009) *Health and Human Rights: An International Journal* 21.

⁹⁸ Fennel 13; Kanter 8; Burns (2009) *Health and Human Rights: An International Journal* 21.

⁹⁹ The CRPD Preamble.

The goals of the CRPD invite a re-evaluation of the broader role of the law in providing the social infrastructure and mental health services that allow mentally disabled persons to participate fully in social life as a legal subject.¹⁰⁰ The preamble to the CRPD also recognises the importance of the principles and policy guidelines in the World Programme of Action Concerning Disabled Persons and in the Standard Rules on the Equalization of Opportunities for Persons with Disabilities in influencing the promotion, formulation and evaluation of the policies, plans, programmes and actions at the national, regional and international levels to further equalise opportunities for persons with disabilities.¹⁰¹ These policies and rules are discussed in this chapter as they are important tools to through which to interpret human rights guaranteed in treaties.

The establishment of the International Committee on the Rights of Persons with Disabilities, which has oversight and monitoring functions, means that citizens of signatory states have a means of reporting local violations and obtaining redress.¹⁰² There is widespread ignorance in the public and private health sectors, and among the general public, regarding the CRPD and its implications.¹⁰³ The South African Government is not carrying out its obligations as signatory to the CRPD, health and social services for mentally ill persons remain grossly underfunded, and mentally ill persons are isolated and stigmatised, and their rights routinely violated still.¹⁰⁴

The CRPD sets out a framework for a rights-based approach to disability and in doing so “calls for changes that go beyond quality of care to include both legal and services reforms” and “demands that we develop policies and take actions to end discrimination in the overall society that has a direct effect on the health and well-being of the mentally disabled”.¹⁰⁵ The CRPD removes the distinction between political and civil rights, and socio-economic and

¹⁰⁰ Weller 69.

¹⁰¹ The CRPD Preamble.

¹⁰² Burns (2011) The Equal Rights Review 99; CRPD Article 34.

¹⁰³ Burns (2011) The Equal Rights Review 99.

¹⁰⁴ *Ibid.*

¹⁰⁵ Burns (2011) The Equal Rights Review 107; Yamin, A. E. and Rosenthal, E.(2005) “Out of the shadows: Using human rights approaches to secure dignity and well-being for people with mental disabilities”, PLOS Medicine, Vol. 2(4) 296–298; Kanter 3.

cultural rights across all of its provisions.¹⁰⁶ The CRPD prescribes several guiding principles representing its moral basis, and providing guidance for national authorities and courts on its interpretation, namely:¹⁰⁷

- a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- b) Non-discrimination;
- c) Full and effective participation and inclusion in society;
- d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- e) Equality of opportunity;
- f) Accessibility;
- g) Equality between men and women; and
- h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

State parties to the CRPD under Article 4(1) undertake, among other things, to take all appropriate measures (including legislation) to modify or abolish discriminatory laws and policies, to refrain from acts inconsistent with the CRPD, to provide accessible information to persons with disabilities regarding support services and facilities, and to promote the training of professionals and staff working with persons with disabilities. Article 4(2) of the CRPD provides that “With regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realisation of these rights, without prejudice to those obligations in the present Convention immediately applicable according to international law”.

The CRPD highlights the importance of several related rights. These include:¹⁰⁸

¹⁰⁶ Kanter 3.

¹⁰⁷ The CRPD Article 3; Lewis 103.

¹⁰⁸ Burns (2011) The Equal Rights Review 106.

1. Equal recognition before the law, access to justice, and legislative reform to abolish discrimination in society;
2. Awareness-raising to educate society, combat prejudices and promote awareness of the capabilities of persons with disabilities;
3. The right to life, liberty and security of person including freedom from degrading treatment, abuse, exploitation and violence;
4. The right to movement, mobility, independent living and full inclusion within the community including full access to and participation in cultural life, recreation, leisure and sport;
5. Freedom of expression and opinion, access to information and full participation in political and public life;
6. Respect for privacy, for the home and the family, including the freedom to make decisions related to marriage and parenthood;
7. The right to equal education, work and employment including the full accommodation of individual requirements;
8. The right to health and rehabilitation; and
9. The right to an adequate standard of living, suitable accommodation and social protection.

Article 31, regarding statistics and data collection, determines that States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:

- a) Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities; and
- b) Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.

The information collected under Article 31(2) shall be disaggregated, as appropriate, and used to help assess the implementation of State Parties' obligations under the present Convention. The information shall also identify and address the barriers faced by persons with disabilities

in exercising their rights.¹⁰⁹ State Parties shall assume responsibility for the dissemination of these statistics and ensure accessibility to persons with disabilities and others.¹¹⁰

Article 35 of the CRPD determines that each State Party shall submit to the Committee, a comprehensive report on measures taken to give effect to its obligations under the present Convention and on the progress made through the Secretary-General of the United Nations within two years after the entry into force of the present Convention for the State Party concerned. Thereafter it shall submit subsequent reports at least every four years and further whenever the Committee so requests. South Africa was supposed to submit its first comprehensive Country Report on the Convention on the Rights of Persons with Disabilities by 3 May 2010, but missed the deadline and the report was submitted on 26 November 2014 instead.¹¹¹

The United Nations Committee on the Rights of Persons with Disabilities makes several observations and recommendations in its consideration of the report submitted by South Africa, namely:¹¹²

- Regarding Disability statistics, the lack of adequate, reliable, relevant and recent information on the nature and prevalence of disability in South Africa remains a challenge. Issues include the non-comparability of the 2011 census with previous census statistics due to changes in criteria, and no data on children younger than five years.¹¹³
- While significant time and resources were devoted to raising awareness of the need to prioritise universal access and design, to disaggregate statistics and data collection, to put participatory institutional arrangements in place, to build capacity of both Government and civil society and to conduct a legislative audit, the awareness created did not

¹⁰⁹ CRPD Article 31(2).

¹¹⁰ CRPD Article 31(3).

¹¹¹ The United Nations Human Rights Office of the High Commissioner webpage http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/countries.aspx?CountryCode=ZAF&Lang=EN (accessed 10 February 2016).

¹¹² United Nations Committee on the Rights of Persons with Disabilities 'Consideration of reports submitted by States Parties under article 35 of the Convention: South Africa' (2015).

¹¹³ United Nations Committee on the Rights of Persons with Disabilities 'Consideration of reports submitted by States Parties under article 35 of the Convention: South Africa' (2015) 6.

necessarily translate into access, partly due to the lack of an effective monitoring and evaluation system to track implementation of the CRPD in the country.¹¹⁴

- The notion of “informed consent”, which features in several laws (Choice on Termination of Pregnancy Act, 1996; Sterilisation Act, 1998; National Health Act, 2003; and Children’s Act, 2005) will have to be re-examined in the light of article 12(3) and the obligation of states parties to provide persons with disabilities with the support they require to make decisions.¹¹⁵
- Evidence produced by civil society during the consultative processes during the drafting of this report indicate that policy has largely not translated into implementation, and that very few children with disabilities, and in particular children with intellectual, communication and mental disabilities, have equal access to justice due to lack of reasonable accommodation measures.¹¹⁶
- The MHCA requires review to bring it in line with the CRPD, especially pertaining to involuntary detention.¹¹⁷

Burns suggests an action plan to apply the principles of the CRPD to the South African context as follows:¹¹⁸

1. The development of a strong advocacy movement, led by persons with mental disabilities.
2. Legislative reforms to abolish discrimination, outlaw abuse and exploitation, and protect personal freedom, dignity, and autonomy. As mentally disabled persons may not be in a position to safeguard their personal rights while unwell, there should be a mechanism for active monitoring and enforcement of such rights (for example through Mental Health Review Boards).

¹¹⁴ United Nations Committee on the Rights of Persons with Disabilities 'Consideration of reports submitted by States Parties under article 35 of the Convention: South Africa' (2015) 16.

¹¹⁵ United Nations Committee on the Rights of Persons with Disabilities 'Consideration of reports submitted by States Parties under article 35 of the Convention: South Africa' (2015) 28.

¹¹⁶ United Nations Committee on the Rights of Persons with Disabilities 'Consideration of reports submitted by States Parties under article 35 of the Convention: South Africa' (2015) 29.

¹¹⁷ United Nations Committee on the Rights of Persons with Disabilities 'Consideration of reports submitted by States Parties under article 35 of the Convention: South Africa' (2015) 35-36.

¹¹⁸ Burns (2011) *The Equal Rights Review* 108.

3. Legislative reform to enforce equality of opportunity, access, and participation in all aspects of life. Substantive equality requires attention to the social context that contributes to the origin of mental disabilities as well.
4. Inclusion of mental disability on the agenda of development programs and targets such as the Millennium Development Goals.
5. Mental health and social services reform with equitable funding for resources, infrastructure, and programmes development.
6. Removal of barriers to access to health services encountered by persons with mental disabilities (including financial barriers and education campaigns and programs on mental disability and the rights of mentally disabled persons).
7. Removal of barriers to access to social, family-related, accommodation, educational, occupational and recreational opportunities, and full participation for persons with mental disabilities.
8. Service systems reform to move away from institutional care toward providing treatment, care, rehabilitation, and reintegration within the community.

A rights-based approach to mental disability means domesticating such treaties as the CRPD. Using the framework of this convention and others like it, it is possible to formulate an active plan of response to the multiple inequalities and discrimination that exist in relation to mental disability, both in South Africa and in other nations.¹¹⁹ The White Paper of the Rights of Persons with Disabilities published on 9 March 2016,¹²⁰ is another step forward in ensuring that South African law is brought in line with the provisions of the CRPD.

2.2.3.4 Optional Protocol to UN Convention on the Rights of Persons with Disabilities, 2006

The Optional Protocol in Article 1 confirms that State Parties recognise the competence of the Committee on the Rights of Person with Disabilities (the Committee) to receive and consider communications from individuals and groups subject to its jurisdiction who claim to be

¹¹⁹ Burns (2011) The Equal Rights Review 101.

¹²⁰ No 230/39792.

victims of a violation by the State Party of the CRPD. The Optional Protocol deals further with the procedure of receiving and considering such communications. In Article 6 it provides that a State Party will be invited by the Committee to cooperate in the examination of a reliable complaint. The Committee can also make recommendations and invite submissions from State Parties to report on their compliance.

2.2.3.5 Convention on the Rights of the Child, 1989

The Convention on the Rights of the Child (hereafter the CRC) in its preamble recognises that childhood is entitled to special care and assistance by reason of physical and mental immaturity, and children need special safeguards and care, including appropriate legal protection, before and after birth. Children with mental disorders are a doubly vulnerable group and thus entitled to greater protections. The need to extend particular care to the child was stated in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child, adopted by the General Assembly on 20 November 1959. This was also recognised in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in Articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialised agencies and international organisations concerned with the welfare of children.¹²¹ South Africa ratified the CRC on 16 June 1995, and included in its Constitution Section 28 protecting the rights of Children.¹²² South Africa has also enacted legislation to give effect to the rights of children protected in the CRC and Constitution, namely the National Health Act 61 of 2003, the MHCA and the Children's Act 38 of 2005.¹²³ Although South Africa ratified the CRC, it has not incorporated the CRC into national law by a decision in terms of Section 231 of the Constitution as discussed above, still Section 233 of the Constitution, regarding interpretation of legislation, requires a reasonable interpretation in line with international law as opposed to an interpretation contrary to it.¹²⁴

¹²¹ The CRC Preamble.

¹²² Buchner and Nienaber (2012) 'Gesondheidsorg vir kinders: Voldoen Suid-Afrika se wetgewing aan die land se verpligtinge ingevolge die Konvensie oor die regte van the Kind en die Grondwet?' 15 PER/PELJ 1 103-146 104.

¹²³ Buchner and Nienaber (2012) PER/PELJ 104.

¹²⁴ Buchner and Nienaber (2012) PER/PELJ 106.

The Convention on the Rights of the Child provides in Article 23 that “a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community“. Article 24(1) asserts the rights of the child “to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. The African Charter on the Rights and Welfare of the Child share the values of the CRC and provide for roughly the same rights and freedoms of children, and it has been ratified by South Africa.

2.2.3.6 Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment, 1984

The Convention against torture and other cruel, inhuman or degrading Treatment or Punishment is also notable as persons with mental disabilities may be subject to such treatment, though the convention does not explicitly mention mentally disabled persons.¹²⁵ The content of this right and its application to South African law is discussed below.

2.2.3.7 Convention on the Elimination of all Forms of Discrimination against Women, 1979

The Convention in Article 12(1) calls for the elimination of discrimination against women in the field of health care in order to ensure on a basis of equality of men and women, and access to health care services.

2.2.3.8 International Convention on the Elimination of all Forms of Racial Discrimination, 1966

The Convention includes in Article 5(e)(iv) “the right to public health, medical care, social security and social services” to all persons of all races.

¹²⁵ Gostin and Gable (2004) Maryland Law p 35.

2.2.4 Regional instruments

Besides the UN instruments, regional human rights have been drafted and widely ratified by countries globally.¹²⁶ Regional treaties develop concurrently with the human rights instruments of the UN and share many UN system values and goals.¹²⁷ In Africa the African Charter on Human and Peoples' Rights, was adopted on 27 June 1981 and entered into force on 21 Oct. 1986.¹²⁸ The African Charter Human and Peoples' Rights (the African Charter) is the centrepiece of the African Human Rights system.¹²⁹ South Africa has ratified the African Charter on Human and Peoples' Rights; Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (1996); African Charter on the Rights and Welfare of the Child (1990); African Union Convention Governing the Specific Aspects of Refugee Problems in Africa (1969).¹³⁰

The African Charter promotes civil and political rights and establishes the African Commission on Human and Peoples' Rights (the African Commission) to promote, protect and interpret those rights.¹³¹ The Charter contains not only the rights granted, but also a list of individual duties.¹³² Article 18(4) of the African Charter states that “the disabled also have the right to special measures of protection in keeping with their physical and moral needs.” The Charter contains no derogation clause and refuses States to derogate rights even in emergency situations, though it does contain general limitations clauses, internal limitation clauses and “claw-back” clauses that a state might interpret to allow it to claim any act as an exception if it is mandated by national law, though the African Commission has interpreted such clauses to refer to international law to prevent governments from undermining the universality and effectiveness of the Charter.¹³³ The Charter has a weakness in that it grants states more latitude in their compliance with Charter rights.

¹²⁶ Rosenthal and Sundram 4.

¹²⁷ Gostin and Gable (2004) Maryland Law Review 47.

¹²⁸ *Ibid.*

¹²⁹ Gostin and Gable (2004) Maryland Law Review 53.

¹³⁰ Landman and Landman 24.

¹³¹ Gostin and Gable (2004) Maryland Law Review 53.

¹³² *Ibid.*

¹³³ *Ibid.*

The African Commission has the power to investigate violations of the rights in the African Charter and collect reports from states detailing compliance (Articles 46, 62 and 21).¹³⁴ Individuals, groups, and NGO's can file complaints, regardless of their geographical location and whether they were themselves a victim of the alleged violation.¹³⁵ The African Commission issues recommendations, but the enforcement of substantive remedies has been problematic.¹³⁶

The African Court on Human and Peoples' Rights was established in 1998 to complement and reinforce the functions of the African Commission on Human and Peoples' Rights.¹³⁷ The Court can make binding decisions, including orders of compensation or reparation, while the Commission can only make recommendations. The court has jurisdiction over all cases and disputes submitted to it concerning the interpretation and application of the:¹³⁸

- African Charter on Human and Peoples' Rights, being the main African human rights instrument;
- Protocol that established the Court; and
- Any other relevant human rights instrument ratified by the State Party concerned.

Under Article 5 of the 1998 Protocol establishing the Court, the Commission, States Parties to the Protocol and African inter-governmental organisations may submit cases to the Court, as well as non-governmental organisations with observer status before the Commission, and individuals from States Parties that have made a declaration accepting the jurisdiction of the Court can also institute cases directly under Article 34(6).¹³⁹

Besides the general protections under the convention, the African Charter is the only one of the three regional conventions that explicitly creates special protections for people with

¹³⁴ Gostin and Gable (2004) Maryland Law Review 54.

¹³⁵ *Ibid*; Viljoen, F. 'Admissibility under the African Charter' in Evans, M. and Murray, R. The African Charter on Human and Peoples' Rights: The System in Practice 1986-2000' 2002 61, 74-76.

¹³⁶ Gostin and Gable (2004) Maryland Law Review 54; Viljoen 54.

¹³⁷ African Union Website <http://www.au.int/en/organs/cj> (accessed 11 February 2016).

¹³⁸ *Ibid*.

¹³⁹ *Ibid*.

disabilities.¹⁴⁰In the Americas, the American Convention on Human Rights was adopted 22 Nov. 1969, and entered into force on 3 Sept. 1953.¹⁴¹ In Europe, the European Convention for the Protection of Human Rights and Fundamental Freedoms entered into force on 3 Sept 1953 (hereinafter ECHR).¹⁴² The ECHR is a convention of the Council of Europe, made up of 43 countries in Eastern and Western Europe.¹⁴³ The Council of Europe recently adopted the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, on 4 April 1997. This convention includes a right to informed consent for people with mental disabilities stronger than the MI Principles adopted by the UN General Assembly.¹⁴⁴

The influence of the ECHR is not limited to European legal systems, and the Convention forms the basis of many of the independence constitutions adopted in Commonwealth Africa and the African Convention on Human and People's Rights.¹⁴⁵ The text in the South African Bill of Rights is similar to the ECHR, and South African courts have cited with approval judgements of the European Court of Human Rights (the ECtHR).¹⁴⁶ The ECHR and ECtHR judgements are therefore helpful interpretive tools when determining the content and scope of South African human rights guarantees. For this reason throughout this chapter, and the rest of the thesis, ECtHR judgements are discussed in context of the relevant rights they pertain to in the South African Bill of Rights.

2.2.5 Soft law

The following documents are not binding but serve a useful purpose in the interpretation of human rights guaranteed to mentally ill persons in international instruments, and their content

¹⁴⁰ Gostin and Gable (2004) Maryland Law Review 54; Viljoen 102.

¹⁴¹ Gostin and Gable (2004) Maryland Law Review 54.

¹⁴² *Ibid*; Bartlett, P.; Lewis, O.; Thorold, O. 'Mental Disability and the European Convention on Human Rights' 2007 15.

¹⁴³ Gostin and Gable (2004) Maryland Law Review 54; Bartlett, Lewis, and Thorold 15.

¹⁴⁴ Gostin and Gable (2004) Maryland Law Review 54.

¹⁴⁵ Emmerson, Q.C, Ashworth, A. and Macdonald, A. *et al.* 'Human rights and criminal justice' 2012 5-6.

¹⁴⁶ Emmerson, Ashworth and Macdonald *et al.* 6.

is discussed in this chapter to aid in interpreting the content of rights guaranteed in the South African Constitution:¹⁴⁷

- UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991(the MI Principles);
- UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, 1993(the Standard Rules);¹⁴⁸
- WHO Mental Health Care Law: Ten Basic Principles, 1996;
- Declaration of the Rights of Mentally Retarded Persons¹⁴⁹
- The Declaration of the Rights of Disabled Persons (the Disability Declaration).¹⁵⁰

The Principles for the Protection of Persons with mental illness and the improvement of mental health care (the MI Principles) and the Standard Rules on the equalisation of opportunities for Persons with disabilities (the Standard Rules) are complementary to each other and although they do not systematically address all human rights issues regarding disabled persons, they do provide guidance and should apply to mentally disabled persons as well.¹⁵¹ Even though international resolutions do not bind states, international principles such as the MI Principles and Standard Rules have significant practical importance as they help establish international rights norms and are useful interpretive guides in relation to the binding, treaty based right to health.¹⁵² The guidance in the Principles provides a standard against which States can evaluate their compliance, and enables fair and more effective monitoring as countries use resolutions as interpretive guides to international treaty obligations.¹⁵³ International human rights principles may be invoked by domestic courts or

¹⁴⁷ Landman and Landman 23; Gostin and Gable (2004) Maryland Law Review 40.

¹⁴⁸ GA Resolution 96.

¹⁴⁹ GA Resolution 2856.

¹⁵⁰ GA Resolution 3447.

¹⁵¹ Gostin and Gable (2004) Maryland Law Review 43; Rosenthal and Sundram 6; Hunt and Mesquita (2006) Human Rights Quarterly 332-356 337.

¹⁵² Gostin and Gable (2004) Maryland Law Review 43; Hunt and Mesquita (2006) Human Rights 337-339.

¹⁵³ Gostin and Gable (2004) Maryland Law Review 43.

incorporated into domestic legislation.¹⁵⁴ Gradually, the increased acknowledgement and adherence to such norms advance them towards recognition as customary international law.¹⁵⁵

The MI Principles contain a “general limitation clause” stating “The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise protect public safety, order, health or morals or the fundamental rights and freedoms of others”.¹⁵⁶ Thus, limitations upon these principles cannot be arbitrary, or applied by practices of clinicians on the front lines of the service system, or as part of culture and tradition, but need to be carefully thought out and enacted in legislation, and even then, they are limited to narrow justifications.¹⁵⁷

The Standard Rules is a revolutionary international instrument because it establishes citizen participation by people with disabilities as a globally recognised human right.¹⁵⁸ To realise this right, governments “are under an obligation” to provide opportunities for people with disabilities, and organisations consisting of people with disabilities, to be involved in drafting new legislation on matters that affect them.¹⁵⁹ The Standard Rules calls on every country to engage in a national planning process to bring legislation, policies, and programs into conformity with international human rights standards.¹⁶⁰ The Standard Rules states in Article 1 that States should endeavour to raise awareness on disability issues and reduce stigma.¹⁶¹ Article 19 provides that States should ensure adequate training of personnel.¹⁶²

The Disability Declaration sets out an extensive list of civil and socio-economic rights, including the right to medical, psychological and functional treatment (Article 6), whilst also endorsing community integration (Article 9).¹⁶³ WHO Mental Health Care Law: Ten Basic

¹⁵⁴ Gostin and Gable (2004) Maryland Law Review 43.

¹⁵⁵ Gostin and Gable (2004) Maryland Law Review 44.

¹⁵⁶ Rosenthal and Sundram 18.

¹⁵⁷ *Ibid.*

¹⁵⁸ Rosenthal and Sundram 7; Hunt and Mesquita (2006) Human Rights Quarterly 332-356 337.

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.*

¹⁶¹ Gostin and Gable (2004) Maryland Law Review 42.

¹⁶² Gostin and Gable (2004) Maryland Law Review 42.

¹⁶³ Gostin and Gable (2004) Maryland Law Review 40.

Principles describes ten basic principles of mental health care law and provides annotations for their implementation in practice.¹⁶⁴ The instrument aims to depict basic legal principles for mental health with as little influence as possible from given cultures or legal traditions.¹⁶⁵

The WHO¹⁶⁶ recommends that if domestic legislation is to be compliant with international human rights standards for persons with mental disorders a set of safeguards need to be employed, including:

- Empowering mental health care users in mental health institutions by equipping them with knowledge of their rights. The content of the rights should be included as part of the orientation for newly admitted patients.
- Supporting the formation of NGO's of consumers, families and other advocates and empowering them to participate in the development of public policy, drafting legislation and regulations, and in monitoring the implementation of the public policy and legislation.
- Encouraging open access to institutions by families and friends and NGO's involved in advocacy on behalf of people with mental disabilities. Specifically, the observation of institutional conditions by such groups should be incorporated into the process of periodic monitoring of the health and safety of residents by qualified professionals.
- Building connections to community resources through rehabilitation and work programs help preserve pre-existing skills of patients or develop the skills needed for community living.
- Developing a process for professional and thorough investigations of reports of physical and sexual abuse and for monitoring and following up on serious injuries, including injuries of unknown origin, illnesses, and all deaths.
- Creating a grievance or complaint process for patients and their families to protect them against reprisals while assuring them fair and impartial investigations into their complaints. One model is to create an independent Ombudsman office with the responsibility for managing the grievance or complaint function also having access to all institutions and to any information needed to carry out oversight responsibilities.

¹⁶⁴WHO Mental Health Care Law: Ten Basic Principles 1996 Foreword.

¹⁶⁵*Ibid.*

¹⁶⁶Rosenthal and Sundram 69.

- Providing institutional residents with access to legal and non-legal advocates, to assist them when other means of resolving their problems, have proved unsuccessful.

2.3 South African legislation protecting the rights of mentally disordered persons

In this section the MHCA and the National Health Act are discussed, as they offer protection for the human rights of mentally disordered persons in the health system. This discussion is prior to the analysis of the Constitution of South Africa and the content of the rights protected therein to enable the reader to understand the rationale for the existence of the two mentioned Acts and to have a clearer picture of their position in the legal system. The rights provided in the MHCA and National Health Act are elaborated on in this chapter in context of the Bill of Rights and its corresponding provisions below.

The National Health Act and MHCA came after the White Paper for the transformation of the Health system in South Africa produced by the Department of Health in 1997, which acknowledged in Chapter 12 the promotion of mental health and the provision of services fragmented in the past under Apartheid. It proposed a comprehensive and community-based mental health and related service at national, provincial, district and community levels, and the integration of mental health care into primary health care services.

2.3.1 The Mental Health Care Act 17 of 2002, Chapter III - Rights and Duties Relating to Mental Health Care Users

The MHCA was widely lauded as one of the most progressive pieces of mental health legislation in the world, though unfortunately it was an unfunded mandate and little preparation and training has occurred, facilities have not been developed at district and regional level, and no budget has been allocated by the government for the implementation of the Act.¹⁶⁷ The result is a list of chronic problems encountered by health care services nationwide.¹⁶⁸ Burns states that there is a substantial gap that exists between current resources

¹⁶⁷ Burns (2011) The Equal Rights Review 100.

¹⁶⁸ *Ibid.*

for mental health care in South Africa and the huge burden of suffering and disability due to mental illness.¹⁶⁹ This is further discussed in Chapter 6 regarding the implementation of mental health laws in practice.

The MHCA emphasises rights and devotes Chapter III to the rights and duties relating to mental health care users.¹⁷⁰ Section 7(1) of the MHCA states that the rights and duties of persons, bodies or institutions set out therein are in addition to any rights and duties they may have in terms of any other law, and in Section 7(2) emphasises that in exercising the rights and in performing the duties set out in Chapter III, regard must be had for what is in the best interests of the mental health care user. The provisions in Chapter III of the MHCA cover:

- Respect, dignity and privacy;
- Consent to care, treatment and rehabilitation services and admission to health establishments;
- Unfair discrimination;
- Exploitation and abuse;
- Determinations concerning mental health status;
- Disclosure of information;
- Limitation on intimate adult relationships;
- Right to representation;
- Discharge reports; and
- Knowledge of rights.

The Mental Health Care Act makes provision for the rights and treatment of mental health care users who are prisoners, receive care either as voluntary, involuntary or assisted users or as State Patients admitted under the Criminal Procedure Act.¹⁷¹ The MHCA is adamant that services rendered to mental health care users must be proportionate to their mental health status and may intrude as little as possible.¹⁷² The practitioner must use the least restrictive

¹⁶⁹*Ibid.*

¹⁷⁰ Simpson, Chipps (2012) Social Work 49.

¹⁷¹ Act 61 of 2003.

¹⁷² Landman and Landman 5.

means possible to not infringe too much on the user's rights.¹⁷³ Drastic measures that must be used in unfortunate cases, such as electroconvulsive therapy and chemical restraints are strictly regulated.¹⁷⁴ When interpreting legislation such as the MHCA, the Constitution is the essential starting point.¹⁷⁵ The *Bato Star Fishing* case¹⁷⁶ determines that the statute must be interpreted to advance an identifiable value in the Bill of Rights and be reasonably capable of such interpretation.¹⁷⁷ The rights contained in the MHCA are in accordance with international standards as stated in MI Principles.¹⁷⁸ The guiding principles ensure that decisions are taken in “the best interests” of users and in the “least restrictive environment”.¹⁷⁹

2.3.2 The National Health Act

National Health Act 61 of 2003 (the NHA) provides a rights-based framework for the structure and functioning of the entire health system.¹⁸⁰ Referred to as ‘arguably the most important Act passed by Parliament to give effect to the right of everyone to have access to health care services’,¹⁸¹ the Act aims, in its Preamble, to give effect to the rights in Sections 27(2); 27(3); 28(1)(c) and 24(a) of the Constitution, to:¹⁸²

“Unite the various elements of the national health system in a common goal to actively promote and improve the national health system in South Africa; provide for a system of co-operative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality health care services; establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation; promote a spirit of cooperation and shared responsibility among public and private health professionals and providers

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*

¹⁷⁵ Landman and Landman 17.

¹⁷⁶ *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs and Tourism and Others* 2004 (4) SA 490 (CC) par 72.

¹⁷⁷ Landman and Landman 17.

¹⁷⁸ Simpson, Chipps (2012) *Social Work* 49.

¹⁷⁹ *Ibid.*

¹⁸⁰ Pieterse 42.

¹⁸¹ Hassim, A., *et al.* (eds.) *The National Health Act 61 of 2003: A Guide* (2008) xi.

¹⁸² Pieterse 43.

and other relevant sectors within the context of national, provincial and district health plans”.

The Act contains provisions on the manner in which health care must be rendered, that flesh outpatients’ rights to autonomy and bodily integrity, which are discussed in this chapter regarding the right to freedom and security of the person. Importantly, Section 6 requires patients to be informed in a language and manner that they can understand, of their health status and available treatment options.¹⁸³ Section 12 mandates the wide dissemination of information on, amongst other things, the type of health services available, the extent of their availability, procedures through which available health services may be accessed, procedures for complaining about the manner in which available services have been rendered, and the rights and obligations of patients.¹⁸⁴

Legislative provisions such as the NHA and MHCA require significant translation through supporting policy and regulations to be effective.¹⁸⁵ Such supporting policy and regulations need to clarify the exact parameters of entitlements to specific services, the obligations of different health care establishments in delivering such services and the processes through which patients can access their entitlements and insist on compliance with such obligations and in the case of the NHA, such clarification has not been forthcoming.¹⁸⁶ In particular, the Act’s definitions of concepts central to the enjoyment of the entitlements that it awards are often vague, non-descript or non-existent.¹⁸⁷ The definition of “health services”, for instance, simply refers back to the relevant constitutional provisions, none of which provide any clarity on the content of the concept.¹⁸⁸ The Ministry of Health has further failed to define concepts such as “essential health services”, “primary health care services” and “emergency medical services and treatment” by way of regulations, as envisaged by the Act.¹⁸⁹ It is submitted that these aspects of the NHA require amendment to create legal certainty.

¹⁸³ Pieterse 44.

¹⁸⁴ *Ibid.*

¹⁸⁵ Pieterse 45.

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid.*

¹⁸⁹ *Ibid.*

2.4 The constitution of South Africa and the Bill of Rights

2.4.1 Introduction

In this section the content of selected human rights applicable to mentally disordered persons as contained in the Bill of Rights is discussed. The discussion of each right will consider the content of the right in terms of current South African legal precedent and interpretation, along with a discussion on how the right is further guaranteed in legislation (notably the Mental Health Care Act and the National Health Act), followed by international law considerations. The implementation of these guaranteed rights in practice is discussed in Chapter 6. The provisions of the Mental Health Care Act and National Health Act that do not specifically address the protection of rights of mental health care users are discussed in Chapter 3, 4 and 5 along with an analysis of whether their provisions are in line with the Constitutional rights and their implementation in line with the aims of the legislator.

Section 2 of the Constitution states that it is the supreme law of the Republic that law or conduct inconsistent with it, is invalid to the extent of the conflict, and that the obligations imposed by it must be fulfilled. Section 7(2) of the Constitution requires the state to “respect, promote, and fulfil” the rights in the Bill of Rights.¹⁹⁰ The exact nature and scope of this obligation depends on the wording of the right and its relationship with other fundamental rights.¹⁹¹ “Respect” in this context requires negative action on behalf of the state, as it may not unjustly interfere with a person's fundamental rights.¹⁹² The duty to “promote” means that the state must take positive steps to guarantee that relevant executive and legislative frameworks are in place to ensure protection of its citizens, in particular the vulnerable groups in society.¹⁹³ The term “fulfil” implies that the state must provide for the realisation of the right by directly providing in the need, for example by making necessary resources available.¹⁹⁴

¹⁹⁰ This was confirmed by the court in *Rail Commuter Action Group v Transnet LTD t/a Metrorail* (2001) 311 SA 741 at par 20.

¹⁹¹ *Swanepoel* 291.

¹⁹² *Ibid.*

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

Section 8(1) of the Constitution of South Africa (1996) declares that: “The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.”¹⁹⁵ This section provides for the direct vertical application of the Bill of Rights.¹⁹⁶ Section 239 of the Constitution defines “organ of state” as:

- a) any department of state or administration in the national, provincial or local sphere of government; or
- b) any other functionary or institution-
 - i. exercising a power or performing a function in terms of the Constitution or a provincial constitution; or
 - ii. exercising a public power or performing a public function in terms of any legislation, but does not include a court or a judicial officer.

Section 8(2) of the Constitution provides for the direct horizontal application of the Bill of Rights between natural and juridical persons, taking into account the nature of the right and the duty imposed by it.¹⁹⁷ Section 8(3) of the Constitution provides that the court, when applying a provision in the Bill of Rights to a natural or juristic person, must apply or develop the common law to the extent that legislation does not give effect to a right in the Bill of Rights, and the court may develop the common law to limit a right in accordance with the limitation clause (as discussed below).¹⁹⁸ Section 8 refers to the direct application of the Bill of Rights in which case the Bill of Rights overrides ordinary law, and subject to justiciability and constitutional jurisdiction, generates its own set of remedies.¹⁹⁹ According to Section 39(2) of the Constitution every court, tribunal or forum must promote the spirit and objects of the Bill of Rights in the interpretation of legislation and the development of the common law. Section 39 refers to the indirect application of the Bill of Rights where ordinary law is

¹⁹⁵ Carmichele v Minister of Safety and Security and Another 2001 (10) BCLR 995 (CC); Currie, I. and De Waal, J. 'The Bill of Rights Handbook' 6th Edition 2013 30; Cheadle, H. Davis, D. and Haysom, N. 'South African Constitutional Law: The Bill of Rights' 2002 33.

¹⁹⁶ Currie and De Waal 31, 41-42.

¹⁹⁷ Currie and De Waal 31-32, 34, 56; Cheadle, Davis and Haysom (2002) 20-23

¹⁹⁸ Currie and De Waal 150; Barkhuizen v Napier 2007 (5) SA 323 (CC) par 29.

¹⁹⁹ Currie and De Waal 24; Carmichele v Minister of Safety and Security 2001 (A) SA 938 (CC) par 56.

interpreted and developed in line with the values that underlie the Bill of Rights, before direct application of the Bill of Rights is considered.²⁰⁰

In terms of challenges to the constitutionality of legislation, the court in *Govender v Minister of Safety and Security*²⁰¹ held that the following must be considered:

- The objects and purport of the Act or section;
- The ambit and meaning of the rights protected by the Constitution;
- Whether it is reasonably possible to interpret the Act of section in such a manner that it conforms with the Constitution;
- If such interpretation is possible, to give effect to it; and
- If it is not possible, to initiate steps leading to a declaration of invalidity.

In this chapter and the totality of this thesis, the direct or indirect application of the supreme Constitution is considered regarding all legislation, law and conduct, as well as the different actors, featuring in matters relating to mentally ill persons. Throughout the thesis the object and purport of the Act or section under consideration is examined, regarding the ambit of the rights protected in the Constitution (as discussed in this chapter), in order to determine whether an interpretation in conformity with the Constitution is possible. Where such an interpretation is impossible, amendments to the provisions are suggested that would ensure constitutional validity. Where conduct or common law is considered in the thesis, the same approach is followed, along with suggested amendment or action to be taken.

2.4.2 The limitation clause

The limitations clause (Section 36) is discussed here prior to the substantive content of the rights in the Bill of Rights, as it applies to all rights in the Bill of Rights and influences the application of the right involved. The Constitutional Court in *Walters*²⁰² set out the two-stage

²⁰⁰ Currie and De Waal 24; Carmichele v Minister of Safety and Security 2001 (A) SA 938 (CC) par 56; S v Thebus 2003 (6) SA 505 (CC), 2003 (2) SACR 319 (CC); S v Mhlungu 1995 (3) SA 867 (CC).

²⁰¹ 2001 (4) SA 273 (SCA); Stevens 98.

²⁰² Ex Parte Minister of Safety and Security: In re S v Walters 2002 (4) SA 613 (CC); Currie and De Waal 153.

approach to the limitation of rights, namely the threshold stage and justification stage.²⁰³ In the threshold stage it must be determined whether a right in the Bill of Rights has been infringed by law or conduct.²⁰⁴ To establish this, requires an examination of the content and ambit of the right in question, as well as the meaning and effect of the maligned provision or conduct.²⁰⁵ Section 39(2) of the Constitution requires both aspects to be interpreted to promote the value system underlying the Bill of Rights. The justification stage ensues when it has been established that a right has been infringed upon and entails an examination of the requirements of the limitation clause.²⁰⁶ The rights in the Bill of Rights may be limited, according to Section 36 of the Constitution, only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:²⁰⁷

- The nature of the right (entails the weighing up of the infringement of a right against the benefits sought by the limiting provision);²⁰⁸
- The importance of the purpose of the limitation (reasonableness requires a worthwhile purpose);²⁰⁹
- The nature and extent of the limitation (the effect of the limitation on the right is considered rather than the effect on the individual);²¹⁰
- The relation between the limitation and its purpose (the purpose must be reasonable and justifiable);²¹¹ and
- Less restrictive means to achieve the purpose.²¹²

According to the decision in *Khala v Minister of Safety and Security*²¹³ the word “law” includes legislation, common law and customary law.²¹⁴ If a court determines that law or

²⁰³ Currie and De Waal 153.

²⁰⁴ *Ibid.*

²⁰⁵ *Ex Parte Minister of Safety and Security: In re S v Walters* 2002 (4) SA 613 (CC).

²⁰⁶ *Ibid*; Currie and De Waal 153.

²⁰⁷ Currie and De Waal 155-171.

²⁰⁸ *S v Makwanyane* 1995 3 SA 391 (CC).

²⁰⁹ *Pharmaceutical Manufacturers Association of SA: In re President of the Republic of South Africa* 2000 (2) SA 674 (CC); *Harksen v Lane* NO 1998 (1) SA 300 (CC); *Ferreira v Levin* NO 1996 (1) SA 984 (CC).

²¹⁰ *S v Manamela* 2000 (3) SA 1 (CC); Currie and De Waal 168.

²¹¹ *S v Makwanyane* 1995 3 SA 391 (CC).

²¹² *S v Makwanyane* 1995 3 SA 391 (CC).

conduct impairs a fundamental right, it must be considered whether the infringement is nevertheless a justifiable limitation of the right in question.²¹⁵ In *S v Makwanyane*²¹⁶ the court held that an assessment based on proportionality is required where competing values are weighed against each other in terms of the limitation of a right for a reasonable and necessary purpose.

2.4.2.1 International law considerations

Article 29 of the UDHR determines that:

“In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.”

2.4.3 The right to equality

According to Section 9 of the Constitution:

- (1) Everyone is equal before the law and has the right to equal protection and benefit of the law.
- (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.
- (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

²¹³ (1994) 2 BCLR 89 (W).

²¹⁴ Swanepoel 198.

²¹⁵ Swanepoel (2011) Obiter 283.

²¹⁶ *S v Makwanyane* 1995 3 SA 391 (CC).

- (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
- (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

Section 10(2) of MHCA determines that mental health care users have the right to receive services according to standards equivalent to those applicable to any other health care user. The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 contains provisions on ensuring that the right to equality is observed in health care service provision. In the case of *Western Cape Forum for Intellectual Disability*, the court found that children with severe intellectual disabilities were not treated equally to children with normal intellectual functions.²¹⁷ Intellectually disabled children received far less subsidies and access to education than other children; the needs of intellectually disabled children were inadequately catered for and were only truly available when provided by non-government institutions.²¹⁸ The court held that this policy and practice by the state infringed the rights of the children regarding their rights to education, equality and right to be protected from degradation and neglect.²¹⁹ It is submitted that the principles in this case may be applied to the provision of services to mental health care users as well.

The case of *Harksen v Lane*²²⁰ demonstrates the two step inquiry in terms of the limitation clause that must be followed where unfair discrimination is suspected. Firstly the determination of whether the equality clause may be invoked in this case required an inquiry into whether there was differentiation between people or categories of people, and if such a differentiation exists whether there was a rational connection to a legitimate government purpose.²²¹ Even if there is such a rational connection, it might still amount to

²¹⁷ *Western Cape Forum for Intellectual Disability v Government of the Republic of South Africa and Another* 2011 (5) SA 87 (WCC); Landman and Landman 40.

²¹⁸ *Ibid.*

²¹⁹ *Ibid.*

²²⁰ 1998 1 SA 300 (CC).

²²¹ Currie and De Waal 216; Swanepoel, M. (2011) "Human rights that influence the mentally ill patient in South African medical law: a discussion of Sections 9; 27; 30 and 31 of the Constitution" Potchefstroom Electronic Law Journal Vol 14 Issue 7: 126-152 132.

discrimination.²²² Secondly, the court needs to establish whether the differentiation amounts to unfair discrimination, requiring a three-stage analysis.²²³

Firstly, it must be established if the differentiation amounts to discrimination.²²⁴ The court was of the opinion that, if the differentiation is not based on a listed ground, it must be resolved objectively if the ground is based on “attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably adverse manner.”²²⁵ Secondly, it must be determined that if the differentiation it amounts to discrimination, whether such discrimination is unfair.²²⁶ If the differentiation is on a listed ground, the court will presume unfairness.²²⁷ However, if it is found to be on an unspecified ground, the test of unfairness primarily focuses on the impact of the discrimination on the complainant and other people in the same situation. Thirdly, if the discrimination is found to be unfair, it must be determined if it can be justified under the limitation clause.²²⁸

Discrimination must be proven on balance of probabilities and the burden rests on the complainant.²²⁹ The complainant must show that the offender was aware of their mental health status.²³⁰ The complainant must show they were less favourably treated than another person “comparator” and a causal connection exists between act or omission and the discrimination.²³¹ Differentiation on a specified or unspecified ground is a requisite and the court then decides whether it was unfair (refer to the two stages of enquiry discussed above regarding the limitations clause).²³² Discrimination may be direct or indirect, for example not

²²² Swanepoel (2011) Potchefstroom Electronic Law Journal 132.

²²³ *Ibid.*

²²⁴ Currie and De Waal 218.

²²⁵ *Ibid.*

²²⁶ Currie and De Waal 219-220.

²²⁷ *Ibid.*

²²⁸ *Ibid.*

²²⁹ Landman and Landman 40.

²³⁰ Landman and Landman 41.

²³¹ *Ibid.*

²³² Landman and Landman 42.

admitting mental health care users.²³³ Complainant must prove that the offender could reasonably have accommodated their mental illness.²³⁴

The development of mental health policy and legislation within countries that have not established formal equality for mental disability is a priority, and there are several global institutions actively engaged in this task.²³⁵ These efforts to achieve formal equality should not stand alone, without similar advocacy focused on the achievement of substantive equality for persons with mental disabilities, and factors such as poverty; illiteracy; income inequality; homelessness; war and displacement; discrimination based on ethnicity, race, and gender; social exclusion; stigma; and abuse all impact the mentally ill individual's ability to access services and realise full personhood within their communities.²³⁶ These factors also play a role in enhancing individual risk for mental disabilities, and act to hinder recovery and reintegration into social and occupational life.²³⁷

In Chapter 6, the practical implementation of mental health laws and policy is discussed, also regarding the resources allocated towards mental health care and whether the State is fulfilling their Constitutional duty to provide health services to mental health care users on an equal basis to other health care users.

2.4.3.1 Stigma

Stigma plays a major role in the persistent suffering, disability and economic loss associated with mental illnesses.²³⁸ To some, mental illness suggests not a legitimate medical condition but rather something that results from an individual's own actions and choices.²³⁹ People may

²³³ *Ibid.*

²³⁴ *Ibid.*; Dawood and Another v Minister of Home Affairs and Others; Shalabi and Another v Minister of Home Affairs and Others; Thomas and Another v Minister of Home Affairs and Others (CCT35/99) (2000) ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837.

²³⁵ Burns (2009) Health and Human Rights: An International Journal 27.

²³⁶ Burns (2009) Health and Human Rights: An International Journal 27.

²³⁷ *Ibid.*

²³⁸ Kakuma, R., Kleintjes, S., Lund, C., Drew, N., Green, A., Flisher, AJ., MHaPP Research Programme Consortium (2010) 'Mental Health Stigma: What is being done to raise awareness and reduce stigma in South Africa?' *Afr J Psychiatry* 13:116-124 116.

²³⁹ Shah, AA. and Beinecke, RH. (2009) 'Global Mental Health Needs, Services, Barriers, and Challenges' 38 *International Journal of Mental Health* 1 14-29 23.

blame the individual and even believe that the condition is all in his or her head, or think that mental illness is an indication of weakness or laziness, that such an individual is a moral failure or simply cannot cut it, that he or she should just “get over it.”²⁴⁰ This stigmatization has four components:²⁴¹

1. Labeling someone with a condition;
2. Stereotyping people with that condition;
3. Creating a division through a superior “us” group and a devalued “them” group, resulting in loss of status in the community; and
4. Discriminating against someone on the basis of the applied label.

The term stigma is applied when elements of labelling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold.²⁴² People diagnosed with certain diseases are often discriminated against due to the “unfavourable” nature of their diagnosis, leading to those persons concealing their mental health status and not seeking help voluntarily.²⁴³ Stigma also affects policy decisions, access to health care and prioritisation.²⁴⁴ Stigmatisation is a form of discrimination and has negative consequences for the mental health and social standing of mentally ill persons when they realise others view them as less trustworthy and intelligent, and more dangerous.²⁴⁵ Acknowledging that mental illness can be associated with violent acts, that research and knowledge is the greatest destigmatiser, and that open communication about the nature of mental illness is important is recommended to assist in understanding why stigma exists as silence creates fear and more stigma.²⁴⁶ The unhelpful stereotypes that exist regarding mentally ill persons have their roots

²⁴⁰*Ibid.*

²⁴¹*Ibid.*

²⁴² Swanepoel (2011) Potchefstroom Electronic Law Journal 135.

²⁴³ Kakuma, Kleintjes, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) Afr J Psychiatry 116-117.

²⁴⁴ Thornicroft, G. 'Shunned: discrimination against people with mental illness' 2006; Swanepoel (2011) Potchefstroom Electronic Law Journal 127; Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, *et al.* Mental health policy development and implementation in South Africa: a situation analysis. Phase 1. Country Report. Cape Town, South Africa 2008; Kakuma, Kleintjes, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) Afr J Psychiatry 117.

²⁴⁵ Swanepoel (2011) Potchefstroom Electronic Law Journal 133; Kakuma, Kleintjes, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) Afr J Psychiatry 117.

²⁴⁶*Ibid.*

in the past and understanding of this might help to appreciate that current efforts to address issues such as stigma must be well planned, sustained and systematic to make an impression on the layers of prejudice that have built up over time.²⁴⁷

Both outside and within the health system, mental health care users encounter discrimination and prejudice in the form of reduced work and social opportunities, the restriction of civil liberties, inferior treatment of co-morbid physical illnesses, and as social stigma.²⁴⁸ This is reflected, as seen, in the state's failure to close the mental health gap through providing resources and it means that people with mental disabilities experience a fundamental violation of their basic right to care by the state.²⁴⁹ The allocation of resources is further discussed in Chapter 6 of this thesis, as well as measures that are in place to reduce stigma in mental health, in order to determine whether the state is meeting its constitutional obligation to ensure the human rights of persons suffering from mental disorder, such as the right to equality.

The new terminology in the MHCA referring to mentally ill patients as “mental health care users” and all professional designations of persons working in the mental health sector as “mental health practitioners”, while some might say this is purely a matter of semantics, it was an attempt to move away from the hurtful labels that set apart people with mental health problems.²⁵⁰ Language can separate people by defining the needs of people with a particular label as fundamentally different from those of other citizens. It was also hoped that by widening the definition of who could assist people with mental health problems, greater access to services would be facilitated.²⁵¹

Education among mental health practitioners and in the community is the only way to attack stigma and enable mentally ill persons to seek and receive the treatment they need. If persons in communities feel that they are not free to seek treatment due to stigma or cultural beliefs or religious beliefs, it impacts their right to equality and right to access to health care. If

²⁴⁷ Swanepoel 27.

²⁴⁸ Burns (2011) The Equal Rights Review 107.

²⁴⁹ Burns (2011) The Equal Rights Review 27.

²⁵⁰ Simpson, Chipps (2012) Social Work 51.

²⁵¹ *Ibid.*

communities and traditional healers disagree with medical science this also jeopardises effective treatment. The standardisation of teaching practises according to science, is a major factor in the fight against discrimination and stigma, this impacts traditional health care practitioners, community clinics, and western mental health care practitioners and this is discussed in Chapter 3.

The MHCA provides in Section 10 that a mental health care user may not be unfairly discriminated against on the grounds of their her mental health status. Every mental health care user must receive care, treatment and rehabilitation services according to standards equivalent to those applicable to any other health care user.²⁵²

2.4.3.2 International law considerations

Article 1 of the UDHR determines that “All human beings are born free and equal in dignity and rights”. Article 2 of the UDHR determines that “Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. Article 7 of the UDHR determines that “All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination”.

Article (3) of the African Charter determines that every individual shall be equal before the law and every individual shall be entitled to equal protection of the law. Article 12 of the CRPD reaffirms that persons with disabilities have the right to recognition everywhere as persons before the law, that persons with disabilities enjoy legal capacity equally with others in all aspects of life, and that States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity. State Parties to the CRPD shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with

²⁵² Section 10 of the MHCA.

international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.

Article 13 of the UN Convention on the Rights of Persons with Disabilities regarding access to justice requires that State Parties must ensure effective access to justice for persons with disabilities on an equal basis with others and facilitate their effective role as participants in legal proceedings. In order to facilitate effective access to justice for persons with disabilities, States must promote appropriate training for those working in the field of administration of justice, including police and prison staff.

2.4.4 The right to dignity

Section 10 of the Constitution states that everyone has inherent dignity and the right to have their dignity respected and protected. This right has a wide scope of application and is often infringed in conjunction with other rights, such as the right to privacy, bodily integrity and to an environment that is not harmful to health or well-being. The strong link between human dignity and equality is also conceptualised in the value of *ubuntu*, and although not expressly mentioned in the Constitution, it was nevertheless recognised as a constitutional value in *S v Makwanyane*.²⁵³ In *Carmichele v Minister of Safety and Security* it was said that human dignity is a central value of the objective, normative value system.²⁵⁴ Dignity informs the content of all the concrete rights and plays a role in the balancing process necessary to bring different rights and values into harmony.²⁵⁵ The court in *Makwanyane* states that recognising a right to dignity is an acknowledgment of the intrinsic worth of human beings: Human beings

²⁵³ *S v Makwanyane* 1995 3 SA 391 (CC); Swanepoel (2011) Potchefstroom Electronic Law Journal 133.

²⁵⁴ *Carmichele v Minister of Safety and Security* 2001 (4) SA 938 (CC).

²⁵⁵ Cornell, D. and Fuller, F. "Introduction" in Cornell, D., Woolman, S., Fuller, S. *et al.* (eds.) "The dignity jurisprudence of the Constitutional Court of South Africa, Volume 1" 2013 7; Swanepoel (2011) *Obiter* 286.

are entitled to be treated as worthy of respect and concern.²⁵⁶ This right is therefore the foundation of many of the other rights that are specifically entrenched in the Bill of Rights.

Dignity has been established in the Constitution as inherent to human beings, therefore even though a person with a mental disorder might not be sufficiently capacitated to be aware that their dignity is being infringed, they still retain the right to have it respected. It is submitted that the delictual or private law concept that subjective infringement of dignity is required to establish *crimen iniuria* must be rejected regarding the constitutionally protected right to dignity of mentally disordered persons. The perceived or objective dignity accorded to a human by other humans must be rejected just by dint of their humanity. The fact that dignity is not subjectively infringed in some instances is not exculpatory or grants leniency in the treatment of mentally ill persons in a manner inconsistent with the law. If anything the vulnerability of patients and the paternalistic protective function of law would be adamant to have the dignity of such persons protected.

The question that arises, is whether the wishes of persons who do not want to be treated, should be respected.²⁵⁷ Sometimes physical restraint and seclusion are the safest option for confused, mentally unstable patients who are at risk of hurting themselves or others, though a full range of alternatives should be considered for preventing harm and respecting dignity in the face of clinical and legal risks in inappropriately using restraints and it should be a last resort.²⁵⁸ Seclusion can be therapeutic, for example where a patient is removed from stressful interpersonal relations and where it provides for destimulation in patients prone to overstimulation as they have lost their ability to filter out unnecessary detail. Swanepoel submits that seclusion is not justified where other less restrictive means are available to achieve the same putative ends.²⁵⁹

Section 8(1) and (2) of the MHCA provides that the person and dignity of a mental health care user must be respected, and every mental health care user must be provided with care,

²⁵⁶ *S v Makwanyane* 1995 3 SA 391 (CC); Swanepoel (2011) Potchefstroom Electronic Law Journal 133.

²⁵⁷ Swanepoel (2011) *Obiter* 287.

²⁵⁸ *Ibid*; Saks 'Refusing care: Forced treatment and the Rights of the Mentally ill' 2002 1-3.

²⁵⁹ *Ibid*.

treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life. The care, treatment and rehabilitation services administered to mental health care users must be proportionate to their mental status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation. Section 12 of the MHCA determines that any determination concerning the mental health status of any person must be based on factors exclusively relevant to that person's mental health status or, for the purposes of giving effect to the Criminal Procedure Act, and not on socio-political or economic status, cultural or religious background or affinity. A determination concerning the mental health status of a user may only be made or referred to for purposes directly relevant to the mental health status of that user. The right of physical and mental integrity contained in section 12 of the Constitution is discussed below, as well as the issues surrounding autonomy and capacity.

2.4.4.1 International law considerations

Article 5 of the African Charter determines that “Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status.”

2.4.5 The right to life

Section 11 of the Constitution provides that everyone has the right to life. The right to life is the most basic human right on which all other rights are premised.²⁶⁰ In *S v Makwanyane* the Constitutional Court described the rights to life and dignity as the “most important of all human rights, and the source of all other personal rights in the Bill of Rights”.²⁶¹ The court in *Makwanyane* stated that the right to life is antecedent to all other rights in the Constitution and incorporates the right to dignity.”²⁶²

²⁶⁰ *S v Makwanyane* 1995 3 SA 391 (CC); Carstens and Pearmain Foundational Principles of South African Medical law (2007) 27; Swanepoel 203.

²⁶¹ *Ibid.*

²⁶² *S v Makwanyane* 1995 3 SA 391 (CC); Swanepoel 222.

The right to life as it relates to the death penalty that was abolished in *S v Makwanyane* is outside the scope of this thesis. The full discussion on whether the right to life includes the right to death and the recognition of active voluntary euthanasia fall outside the scope of this thesis. Instead the focus will be on discussing the content of the right to life and the right to die, as it pertains to mental health care users. This discussion is limited to impact of the right to life on the mentally disordered person and whether there are special considerations to take into account should active voluntary euthanasia be an option open to them in future. Quality of life is considered and is also an important consideration and precursor to the discussion of other rights, such as the right to an environment that is not harmful to their health, forced treatment or detention of a person, the right to access health care services in the community or in prisons.

2.4.5.1 Euthanasia and the right to die

The discussion in this thesis will not go in-depth into whether the right to die includes the right to legal active voluntary euthanasia, as this is covered extensively in other writings.²⁶³ Instead this discussion will focus on the capacity of a mentally disordered person to make valid decisions to end their life. This begs the question that if a person is in a state where they have the necessary capacity, that translates to them suffering from “severe enough” mental illness as to impair their lives to such an extent that justifies euthanasia, as well as other questions regarding the autonomy and dignity of a person on the other hand.

Supporters and opponents of euthanasia and assisted suicide have been highly critical of extending suicide rights to psychiatric patients.²⁶⁴ One set of objections is directed against the practice of assisted suicide itself - for a host of reasons ranging from a belief in the inherent sanctity of human life to a fear of sliding down a slippery slope toward involuntary euthanasia.²⁶⁵ Another set of objections are from those who support a basic right to assisted

²⁶³See Carstens and Pearmain 200-209; Swanepoel (2011) 'End of life decisions and the mentally ill patient' THRHR 74: 402-417; Burchell, J.M., Milton, J. “South African Criminal Law and Procedure Volume I: General Principles of Criminal Law” 4th Edition 2011 210–213. See also Labuschagne JMT "Aktiewe eutanisie en professionele hulpverlening by selfdoding van 'n psigiatriese pasiënt" 1995 112 SALJ 2 227-230.

²⁶⁴ Swanepoel 223; Swanepoel (2011) THRHR 402.

²⁶⁵ Swanepoel 223.

suicide in certain situations, such as those of terminal disease, but do not wish to extend it to cases of severe and incurable mental disorders.²⁶⁶ Pivotal to the euthanasia debate is the content being afforded to the right to life, in context of what is to be regarded as the “quality of life” and to what extent patient autonomy and the right to self-determination may be influential to request a physician to end a life “not worth living” on account of terminal illness.²⁶⁷

In the case of *Clarke v Hurst*,²⁶⁸ the decision whether the discontinuance of the artificial feeding of the patient and his resultant death would be wrongful, depends on whether the legal convictions of society would find it reasonable.²⁶⁹ The decision of the issue depends on the quality of life remaining to the patient, for example, the physical and mental status of that life. The evaluation has to be made in relation to the medical procedures that would have to be instituted or maintained to sustain the patient's life. To make such a decision, the quality of life left to a patient must be considered, keeping in mind the medical procedures necessary to maintain that life.²⁷⁰ In the *Clarke* case the court was unfortunately not prepared to give recognition to the patient's right of autonomy.²⁷¹

An important concern in cases of mental disorder is the competence of the decision-maker.²⁷² The principle of autonomy, integral to a free society, requires that a person's decisions regarding their own life should be respected wherever possible, though only the products of the “sound mind” of an adult are generally considered competent and given the status of autonomous decisions.²⁷³ Patients who experience psychosis or are incapable of making general medical decisions should not be able to take their own lives until they can think

²⁶⁶ *Ibid*; Appel, JM.(2007) "A suicide right for the mentally ill? A Swiss case opens a new debate" 37 Hastings Center Report 3 21.

²⁶⁷ Swanepoel 222.

²⁶⁸ 1992 4 SA 630 (D).

²⁶⁹ Swanepoel 203; Swanepoel (2011) THRHR 409.

²⁷⁰ Swanepoel 229.

²⁷¹ *Ibid*; Strauss 1993 *S Afr J Criminal Justice* 196 at 208.

²⁷² Swanepoel 230; Taitz, J. "Euthanasia and the legal convictions of society in a South African Context" 1993 110 *SALJ* 3: 440.

²⁷³ Swanepoel 231.

rationality.²⁷⁴ But one can be both deeply depressed or otherwise mentally ill and capable of making rational decisions.²⁷⁵

Where mental health care users suffer from neurodegenerative diseases such as Alzheimer's and dementia, the question of competence and capacity to consent arises especially regarding the possibility of the *lucidum intervallum* (lucid interval) and the factual enquiry concerning when a decision can validly be made by the user and if can be overturned when they are no longer lucid. Capacity to consent is further discussed in Chapter 3 that deals with, among other issues, mental disorders and the degree to which they impact decision-making ability.

Burchell and Milton, and Carstens and Pearmain,²⁷⁶ in light of the emphasis in the Constitution on human dignity and patient autonomy, concur with the South African Law Reform Commission's recommendation that a so-called "Living Will" should be legally recognised where it requests a passive form of cessation of life and is drafted by a competent person who foresees the possibility that they may, due to physical or mental disability, be unable to make rational decisions concerning his or her medical treatment and care.²⁷⁷

The Draft Bill (To Regulate End-Of-Life Decisions and to Provide for Matters Incidental Thereto), proposed by the South African Law Reform Commission proposes three options relating to active voluntary euthanasia, namely:²⁷⁸

- a) Confirming the present legal position that sanctions active voluntary euthanasia;
- b) Regulating the practice of active voluntary euthanasia by legislation, permitting a medical practitioner to give effect to the request of a terminally ill person, but mentally competent person to end unbearable suffering; or
- c) Regulating the practice of active euthanasia by legislation conferring the final decision on a panel or committee to decide on set criteria.

²⁷⁴ *Ibid.*

²⁷⁵ *Ibid*; Labuschagne (1995) SALJ 228.

²⁷⁶ See Carstens and Pearmain 209; Burchell and Milton 328.

²⁷⁷ Swanepoel 230.

²⁷⁸ *Ibid.*

At present there is little guidance for practicing psychiatrists and psychologists faced with ethical dilemmas regarding a patient's wish to die.²⁷⁹ Psychiatrists and psychologists are trained to prevent suicide, leading to a conflict of interest and placing the practitioner in the unpleasant scenario of choosing between a patient's wishes and the standard of care.²⁸⁰ Swanepoel argues that from a psychiatric perspective, competency is fundamental to decision-making, therefore respect for autonomy should guide actions.²⁸¹ It is imperative that in cases of medical intervention, including active voluntary euthanasia, informed consent is obtained from the patient. Informed consent is discussed in-depth in this chapter below.

2.4.5.2 International considerations

The Universal Declaration of Human Rights reads: “Everyone has the right to life, liberty, and security of the person.” The International Convention on Civil and Political Rights also qualifies the right to life as follows: “Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.” The CRPD in Article 10 reaffirms that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities equally with others.

2.4.6 The right to freedom and security of the person

Section 12 of the Constitution regarding freedom and security of the person states that:

- 1) Everyone has the right to freedom and security of the person, which includes the right-
 - a) not to be deprived of freedom arbitrarily or without just cause;
 - b) not to be detained without trial;
 - c) to be free from all forms of violence from either public or private sources;
 - d) not to be tortured in any way; and
 - e) not to be treated or punished in a cruel, inhuman or degrading way.

²⁷⁹ Swanepoel 232; Appel, (2007) Hastings Center Report 23.

²⁸⁰ *Ibid.*

²⁸¹ *Ibid.*

- 2) Everyone has the right to bodily and psychological integrity, which includes the right-
 - a) to make decisions concerning reproduction;
 - b) to security in and control over their body; and
 - c) not to be subjected to medical or scientific experiments without their informed consent.

The rights contained in Sections 12 apply to legislation and common law pertaining to the treatment of persons with mental disorders, including the procedures under the Mental Health Care Act and in Criminal law. In Chapter 4 and 5 these laws are discussed and analysed to determine whether the legal framework is meeting the Constitutional rights standards. Chapter 6 deals with the practical implementation of mental health laws and an analysis of whether the right to freedom and security of the person and right to bodily and psychological integrity is sufficiently respected and protected. In this section the content and extent of the rights contained in section 12 is discussed to provide clarity on the concepts of competency, autonomy and informed consent pertaining thereto.

2.4.6.1 *Autonomy*

Section 12(2)(b) has two components: “security in” and “control over” one’s body.²⁸² “Security in” refers to the protection of physical integrity against intrusion by others and is a component of the right to be left alone and unmolested.²⁸³ “Control over” refers to the protection of what could be called physical autonomy or self-determination against interference and is a component of the right to be left alone and allowed to live the life one chooses.²⁸⁴ Personal autonomy refers to the personal rule of self free from interference by others and from personal limitations that prevent meaningful choice.²⁸⁵ A person can however only be autonomous to the extent to which they are able to reason rationally, are free of external constraints and have access to relevant information and options.²⁸⁶ The four basic

²⁸² Currie and De Waal 287; Swanepoel (2011) *Obiter* 289.

²⁸³ Currie and De Waal 287; Swanepoel (2011) *Obiter* 289; Strauss, SA. 'Doctor, patient and the law' 2004/30-31.

²⁸⁴ Currie and De Waal 287.

²⁸⁵ Van der Reyden, D (2008) 'The right to respect for autonomy: Part 1 - What is autonomy all about?' 38 *South African Journal of Occupational Therapy* 1: 27-31 27; Currie and De Waal 286.

²⁸⁶ Van der Reyden 27.

tenets that govern medical bioethics are usually considered to be autonomy, nonmaleficence, beneficence and justice.²⁸⁷ The principle of respect for autonomy from a bioethical perspective is articulated as requiring the health professional not to interfere with the effective exercise of the autonomy of the patient and presupposes an acknowledgment of the patient's capacity and right to make decisions about their life and to act accordingly, as well as enabling persons to act autonomously.²⁸⁸ Autonomy pertains to the right to make a decision regarding medical intervention even if mentally ill at the time, provided that person is mentally competent to make decision.²⁸⁹ The only purpose for which power can lawfully be exercised over any person against his will is to prevent harm to others, but the individual is sovereign over their own body and mind if they are competent to do so.²⁹⁰

The tension between autonomy and paternalism is evident in relation to the treatment of mentally disordered patients, balancing the need to limit the power of mental health professionals to protect the patient's mental and physical integrity and autonomy.²⁹¹ As well as the concept of "medicalism" which stresses the need to ensure that the safeguards for patients' individual rights are not so cumbersome that they impede medical interventions aimed at serving those same patients' best interests.²⁹² Personal autonomy is not without limits and should a state demonstrate a narrowly defined interest it may be able to supersede an individual's right to autonomy.²⁹³ The state may act under its *parens patriae* powers to protect the innocent and vulnerable, including from medically-acknowledged and bona fide health risks and treatments, but it cannot exclude due process.²⁹⁴

²⁸⁷ Dhai, A.; McQuoid-Mason, D.; and Knapp van Bogaert, D. 'Ethical concepts, theories and principles and their application in healthcare' in Dhai, A. and McQuoid-Mason, D. 'Bioethics, Human Rights and Health law: Principles and Practice' (2011) 14-15; Segal, J; Thom, R. (2006) 'Consent procedures and electroconvulsive therapy in South Africa: impact of the Mental Health Care Act' South African Psychiatry Review 9:206-215 206; Fennel 13.

²⁸⁸ Van der Reyden 27; Beauchamp T.L, Childress J.F. 'Principles of Biomedical Ethics' 1994.

²⁸⁹ Landman and Landman 26.

²⁹⁰ Swanepoel (2011) Obiter 289; Fennel 14.

²⁹¹ Swanepoel (2011) Obiter 290; Weller 59; Fennell, P. (1990) "Inscribing paternalism in the law: Consent to treatment and mental disorder" 17 *J L & Soc* 1: 29.

²⁹² Swanepoel (2011) Obiter 290; Weller 59; Fennell (1990) *J L & Soc* 29.

²⁹³ *Ibid.*

²⁹⁴ *Ibid.*

Forcible detention in a hospital can be a distressing, difficult, and an embarrassing process. Patients treated involuntarily generally protest and may be difficult to diagnose if they do not cooperate.²⁹⁵ This impact of coercion may be mitigated if patients feel “respectfully included in a fair decision-making process” and their autonomy is respected as far as possible. Patient advocacy also reduces the antagonism between staff members and patients. It is justified on the grounds of ethics, justice, and rights.²⁹⁶ The understanding of the regulations and principles governing involuntary treatment is important for physicians wherever they practice. When it is done sensitively, respectfully and conservatively, the users’ and societies’ interests can be protected whilst at the same time complying with the principles of the MHCA.²⁹⁷

2.4.6.2 Competency

Consulting psychiatrists are frequently asked to assess a patient’s competency, but the definition of competency varies widely depending on the circumstances.²⁹⁸ Adults are presumed competent in law until proved otherwise, and the determination of incompetency requires a court’s decision.²⁹⁹ The term “competency” is widely used in the clinical settings, though practitioners make a determination regarding a lack of decisional capacity.³⁰⁰ Competency depends on the situation, but includes the awareness and understanding of the illness and proposed intervention, appreciation of available alternatives, the ability to communicate a choice regarding intervention, and a rational process for deciding.³⁰¹ Cognitive disorders can reduce these elements, while other psychiatric disorders primarily affect rational decision-making.³⁰² Mental disability, whether in mentally impaired psychiatric patients or psychiatrically impaired medically ill patients, does not automatically render a person incompetent to all decisions.³⁰³ If a person suffers incapacity to make medical

²⁹⁵ Moosa, Jeena (2008) ‘Involuntary treatment of psychiatric patients in South Africa: review’ *African Journal of Psychiatry* 109-112 111.

²⁹⁶ Moosa, Jeena (2008) *African Journal of Psychiatry* 111.

²⁹⁷ *Ibid.*

²⁹⁸ Swanepoel (2011) *Obiter* 290.

²⁹⁹ *Ibid.*

³⁰⁰ *Ibid.*

³⁰¹ *Ibid.*; Moodley, K. ‘Respect for patient autonomy’ in Moodley, K. (ed.) ‘Medical ethics, law and human rights: A South African Perspective’ (2011) 44.

³⁰² *Ibid.*

³⁰³ *Ibid.*

decisions, the person's rights are protected by using proxies and substitute judgment in terms of the MHCA.³⁰⁴

Chapter 3 of this thesis investigates the different categories of mental disorders and the degree to which they may affect decision-making capacity from a medical viewpoint. The fact that in the MHCA forms “competency” is often used as a diagnostic term though it has no legal or clinical value is a problem that puts into question whether the rights of mental health care users are adequately protected. In Chapter 4 this aspect is discussed regarding the relevant provisions of the MHCA and MHCA forms, also proposing guidelines for the completion of MHCA forms in consideration of clinically accepted terminology that is legally informative, and suggesting that training and accountability must be enforced.

2.4.6.3 Informed consent

The right to bodily and psychological integrity as enshrined in section 12(2)(c) of the Constitution includes the right not to be subjected to medical or scientific experiments without the informed consent of the patient.³⁰⁵ Obtaining informed consent is imperative before treatment is administered, as the ramifications of a failure to obtain consent may include liability for the health care practitioner based on breach of contract, delictual liability, criminal liability, professional censure, or disciplinary action in terms of the Health Professions Act 56 of 1974.³⁰⁶ It is important to consider this when consent to admission as a mental health care user is discussed in Chapter 4, as well as the ability and right to consent to treatment while admitted as a mental health care user.

Section 6 of the National Health Act³⁰⁷ provides that a health care user is to have full knowledge of their health status, the treatment and diagnostic options available to them, the benefits, risks, costs and consequences associated with each option, and their right to refuse

³⁰⁴ Swanepoel (2011) Potchefstroom Electronic Law Journal 144. The MHCA is discussed in Chapter 4 of this thesis.

³⁰⁵ This is reinforced by Section 7(1)(c) of the National Health Act 61 of 2003.

³⁰⁶ Zwart, L. “An analysis of informed consent and clinical aspects regarding mental capacity in context of the Mental Health Care Act 17 of 2002” (Unpublished LLM dissertation, University of Pretoria, 2015)64; Van Oosten (2000) THRHR 12; Stoffberg v Elliott 1923 CPD 148; Carstens and Pearmain 872.

³⁰⁷ Act 61 of 2003.

health services and the implications of such a refusal. Section 7(1) of the National Health Act³⁰⁸ determines that a health service may not be provided to a user without the user's informed consent, unless:

- f) the user is unable to give informed consent and such consent is given by a person
 - i. mandated by the user in writing to grant consent on his or her behalf; or
 - ii. authorised to give such consent in terms of any law or court order;
- g) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order listed;
- h) the provision of a health service without informed consent is authorised in terms of any law or a court order;
- i) failure to treat the user, or group of people that includes the user, will cause a serious risk to public health; or
- j) any delay in providing the health service to the user might cause his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.

Section 7(2) of the National Health Act³⁰⁹ provides that a health care provider must take all reasonable steps to obtain the user's informed consent. In the context of court ordered forensic assessment, assessment can proceed without informed consent although it is advisable to try and obtain it, while Section 7(3) determines that "informed consent" means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in Section 6 (of the National Health Act). This may not be possible in most cases, due to the nature of informed consent requiring participation in decision-making, capacity and voluntariness.³¹⁰ For consent to be valid, the person must have

³⁰⁸ *Ibid.*

³⁰⁹ *Ibid.*

³¹⁰ Zabow, T.; Kaliski, S. "Ethical considerations" in Kaliski, S. (ed.) "Psycholegal assessment in South Africa" 2006370. According to the Guide to the National Health Act, for a patient in a hospital or clinic to give informed consent, they must know about and understand what health service will be given to him or her. They must also know about and understand the risks of that service. This well recognised principle of our law was first set out in

the legal capacity to consent (or competency as discussed above), and the consent must be informed and free.³¹¹ McQuoid-Mason and Dhali state the legal and ethical elements of valid consent as disclosure, understanding, capacity, and voluntariness.³¹²

Section 8 of the National Health Act³¹³ determines that a user has the right to participate in decisions affecting their personal health and treatment; if the informed consent is given by another person authorised to do so, the person must consult the user before giving consent if possible; a user capable of understanding must be informed as contemplated in Section 6, even if they lack capacity to give informed consent; and if a user cannot participate in a decision affecting his or her personal health and treatment, they must be informed as contemplated in Section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interests.

The legal consequences of the absence of consent, apart from infringing upon a user's human rights, include that the hospital or healthcare provider may incur liability for an breach of contract, civil or criminal assault, civil or criminal *iniuria* (a violation of dignity or privacy), or negligence, depending on the particular case.³¹⁴ An in-depth discussion of these consequences and their critique falls outside the scope of this thesis.³¹⁵

The Ethical Code for Psychologists also determines that: "A psychologist shall recognise the inalienable human right to bodily and psychological integrity, including security in and control over his or her body and person, and the right not to be subjected to any procedure or experiment without his or her informed consent which shall be in a language that is easily understood by him or her."³¹⁶

Stoffberg v Elliott 1923 CPD 12 and was confirmed by the Supreme Court of Appeal in Louwrens v Oldwage 2006 2 SA 161 SCA.

³¹¹ Nienaber, A (2010) 'The regulation of informed consent to participation in clinical research by mentally ill persons in South Africa: An overview' SAJP 16: 4 118-124 119.

³¹² McQuoid-Mason, D, Dhali, A, and Gardner, J. 'Consent' in in Dhali, A. and McQuoid-Mason, D. 'Bioethics, Human Rights and Health law: Principles and Practice' (2011) 71.

³¹³ Act 61 of 2003.

³¹⁴ Carstens and Pearman 890.

³¹⁵ For more on the topic, see Van Oosten, FFW "The doctrine of informed consent in Medical Law" (unpublished LL.D thesis, Unisa, 1989) ; Carstens and Pearman "Foundational Principles of South African Medical Law" 2007.

³¹⁶ Swanepoel (2011) Obiter.

Section 9(1) of the MHCA provides that a health care provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if:

- a) the user has consented to the care, treatment and rehabilitation services or to admission;
- b) authorised by a court order or a Review Board; or
- c) due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the-
 - i. death or irreversible harm to the user;
 - ii. user inflicting serious harm to himself or others; or
 - iii. user causing serious damage or loss to property belonging to themselves or others.

Section 9(2) provides that any person or health establishment that provides care, treatment and rehabilitation services to a mental health care user or admits the user under circumstances referred to in subsection (1)(c):

- a) must report this fact in writing in the prescribed manner to the relevant review board; and
- b) may not continue to provide care, treatment and rehabilitation services to the user concerned for longer than 24-hours unless an application in terms of Chapter V is made within the 2-4-hour period (Chapter V deals with the admission of voluntary, assisted and involuntary mental health care users and is discussed in Chapter 4).

The issues pertaining to children and consent to voluntary admission is discussed below. Chapter 4 includes a discussion on whether informed consent is properly understood and documented by mental health care practitioners and mental health care users. The MHCA forms pertaining to situations where informed consent is required are analysed to determine whether the requisite information to prove informed consent can be notes there and whether these forms are completed in a way that complies with legal requirements.

The requirements of informed consent as stated by Claassen and Verschoor are:³¹⁷

1. The user must be of an age considered by law to be capable of giving consent (Section 129 of the Children's Act sets the age at 12 years taking into account the maturity and level of development of the child.³¹⁸ Mental illness or disability might negate capacity to consent. A person may be able to consent to some forms of treatment but not to others);
2. Consent must be given prior to the administration of treatment (a person may ratify the decision afterwards, but it is not recommended);
3. The person required to consent must be informed sufficiently about their diagnosis, prognosis and treatment options to make a knowledgeable decision, including information regarding the scope of the treatment, consequences, risks and implications, available alternative treatments, and the results of not receiving treatment must be understood and explained in a language the person understands.³¹⁹ Essential knowledge of the procedure must be gained by the user to be properly “informed”.³²⁰ Receiving all this information may come at some psychological cost; namely anxiety and perhaps psychiatric decompensation³²¹ can occur when patients feel overburdened, placing mental health professionals in a unique and paradoxical position regarding informed consent.³²²

*Castell v De Greef*³²³ is the cardinal case regarding informed consent and states that the following requirements must be satisfied that:³²⁴

³¹⁷Claassen, N. J. B., and Verschoor, T. (1992) 'Medical Negligence in South Africa' Digma 57-71; Landman and Landman 85-89.

³¹⁸ Buchner and Nienaber (2012) PER/PELJ 116.

³¹⁹ Zwart46; Van Oosten (2000) THRHR 25.

³²⁰ Swanepoel 162.

³²¹ The inability to maintain defence mechanisms in response to stress, resulting in personality disturbance or psychiatric / psychological imbalance.

³²² Swanepoel 162.

³²³ 1994 (4) 408 (C) 426.

³²⁴ Claassen and Verschoor57-71; Landman and Landman 85-89.

- a. the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk,
 - b. the consenting party must have appreciated and understood the nature and extent of the harm or risk,
 - c. the consenting party must have consented to the harm or assumed the risk,
 - d. the consent must be comprehensive, that is extend to the entire transaction, inclusive of all its consequences.);
4. Consent must be given freely and voluntarily (no duress, undue influence or misrepresentation. Sound and sober senses, e.g. no intoxication);
 5. The person consenting must subjectively consent to the intervention (inferred from facts and circumstances. Writing is proof of consent, but may not be sufficient if it was not explained before signing the form);
 6. The consent must be permitted by law and not be *contra boni mores* (experimental procedures might fall into this category. Sleep therapy is prohibited);
 7. Generally no formalities are required (may be express or tacit, orally or in writing. Preferable to obtain consent in writing);
 8. Consent may be provided in advance of treatment by a user capable of making such a decision. The question is whether consent remains valid if the user becomes incapable of consenting any time after consent was given. Landman states that there are no clear answers to these questions³²⁵ The author submits that until there is evidence that consent has been revoked it should be considered valid and binding;
 9. Consent may be revoked at any time, though it might be unethical to heed such revocation where the user would suffer greater harm if treatment were immediately terminated than if it were phased out gradually. Mental health care practitioners should

³²⁵ Landman 85-89.

ask for withdrawal of consent to be set out in writing. The author submits that if a voluntary user were to withdraw consent for treatment, that treatment should be ceased if they have the capacity to make decisions, or they should be admitted as an assisted or involuntary user if the circumstances allow, if they are incapable of making decisions regarding their health;

10. Consent may be withheld even if it is not in the user's best interests (*Stoffberg v Elliot*³²⁶)

The The Professional Board For Psychology Health Professions Council Of South Africa Ethical Code Of Professional Conduct (hereafter the 'Ethical Code for Psychologists') in Section 11(1) regulates informed consent to professional procedures as follows: “When a psychologist conducts research or provides assessment, psychotherapy, counselling, or consulting services in person or via electronic transmission or other forms of communication, they shall obtain the written informed consent of a client, using a language that is reasonably understandable to such client.”³²⁷ Section 11(2) of the Ethical Code states that informed consent ordinarily requires that a client:³²⁸

- Has the capacity to consent;
- has been provided with information concerning participation in the activity that reasonably might affect his or her willingness to participate, including limits of confidentiality and monetary or other costs or reimbursements;
- is aware of the voluntary nature of participation and has freely and without undue influence expressed consent; and
- has had the opportunity to ask questions and receive answers regarding those activities.

³²⁶ *Stoffberg v Elliott* 1923 CPD 148.

³²⁷ *Swanepoel* 163.

³²⁸ *Ibid.*

Provided that, in the case of a client who is legally incapable of giving informed consent, a psychologist shall nevertheless:³²⁹

- i. provide an appropriate explanation;
- ii. seek the client's assent;
- iii. consider such client's preferences and best interests; and
- iv. obtain appropriate permission from a legally authorised person, if such substitute consent is permitted or required by law, but if consent by a legally authorised person is not permitted or required by law, a psychologist shall take reasonable steps to protect the client's rights and welfare. (Section 11(2)).

It is important to note that when psychological services are court ordered or administratively decreed or ordered through mediation or arbitration, a psychologist shall:³³⁰

- inform the individual of the nature of the anticipated services, including whether the services were ordered and any limits of confidentiality, before proceeding; and
- appropriately document written or oral consent, permission or assent.

Van Oosten³³¹ states that any medical intervention undertaken without the patient's consent or the consent of a person acting on his or her behalf is in principle unlawful or wrongful unless some other ground of justification exists.³³² Consent by a patient to medical treatment in South African law is regarded as falling under the defence of *volenti non fit iniuria*, a ground of justification which excludes the unlawfulness or wrongfulness element of a crime or delict.³³³ If a medical intervention is performed without the patient's lawful consent, the doctor or hospital is exposed to liability for civil or criminal assault, civil or criminal iniuria,

³²⁹ Section 11(2) of the The Professional Board For Psychology Health Professions Council Of South Africa Ethical Code Of Professional Conduct of 2002 (hereafter the 'Ethical Code for Psychologists'); Swanepoel 162.

³³⁰ Section 11(3)(a-b) of the Ethical Code for Psychologists; Swanepoel 162.

³³¹ Van Oosten, FWW. (1995) "Castell v De Greeff and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy" 28 De Jure 1:164-179.

³³² Swanepoel 316.

³³³ *Ibid*; Zwart 33-34.

breach of contract or negligence.³³⁴ The leading case on compliance with the consent requisite is *Stoffberg v Elliott* in which the court held that “Any bodily interference with or restraint of a man's person which is not justified in law, or excused in law, or consented to, is a wrong, and for that wrong the person whose body has been interfered with has a right to claim such damages as he can prove he has suffered owing to that interference”.³³⁵

In the case of *Castell v De Greef* regarding informed consent the court determined that:³³⁶

- Medical paternalism is ousted in favour of patient autonomy;
- the decision to undergo or refuse a medical intervention is that of the patient and not that of the doctor;
- The important question is whether the reasonable patient would have regarded the risk as significant, or whether the doctor was or could have been aware that the individual patient would regard the risk as significant. The appropriate legal defence if therapeutic privilege is raised would be necessity as a justification;
- the court prefers to place the doctor's duty of disclosure and the patient's informed consent within the framework of the wrongfulness element rather than the fault element;
- the court remarks that the doctor is also under a contractual obligation to furnish the patient with information.

In the case of *Oldwage v Louwrens*³³⁷ the court a quo held that a medical practitioner is bound to employ reasonable skill and care and is liable for the consequences if he does not. Regarding *Castell v De Greef*, the plaintiff had not been properly counselled before the operation, other options had not been properly discussed with him, and he had not been advised of the material risks associated with the operation.³³⁸ It was concluded that the plaintiff had not given an informed consent to the operation. The defendant's conduct had

³³⁴*Ibid*

³³⁵Swanepoel 274; *Stoffberg v Elliott* 1923 CPD 148.

³³⁶ Swanepoel 280; *Castell v De Greef* 1994 (4) SA 408 (C).

³³⁷ (2004) 1 All SA 532 (C).

³³⁸ Zwart 49.

amounted to an assault upon the plaintiff. The Supreme Court of Appeal³³⁹ found that a remote risk need not have been disclosed, however, in its judgment, the court did not consider exactly what was meant by “remote”.³⁴⁰ While the court did not apply the subjective patient-centred approach, it did not overrule it.³⁴¹ There is, therefore, as yet no binding judgment by the Supreme Court of Appeal concerning what the correct approach to determining the boundaries of a material risk to medical treatment may be.³⁴² In the absence of such a judgment, courts are still free to follow the patient-centred approach, which was extensively and cogently argued in *Castell v de Greef*.³⁴³

To avoid a claim of negligence, information disclosed to patients when obtaining consent about risks must be “reasonable”.³⁴⁴ Reasonableness has traditionally been determined by the *Bolam* test.³⁴⁵ The *Bolam* test applies where expert witnesses confirm the appropriateness of an aspect of medical care, which is then regarded as appropriate if a relevant, reasonable body of professional opinion would endorse the course of action taken.³⁴⁶ The *Bolam* test can be applied to consent, where the question would be whether the information disclosed by a doctor and contested by a patient would have been reasonable in the circumstances.³⁴⁷ The appropriateness of the information would be irrespective of the claimant’s believe they were morally entitled to specific information; the degree of harm suffered as a result; and the extent to which the patient’s claim for a financial remedy may be supported by the public’s opinion.³⁴⁸

The doctrine of informed consent takes full account of the probability that a patient is untrained in medical science, and therefore completely depends on and trusts in the skill of their physician for the information on which a decision is based.³⁴⁹ The patient’s consent or

³³⁹ Louwrens v Oldwage (2006) 1 All SA 197 (SCA).

³⁴⁰ Swanepoel 281.

³⁴¹ *Ibid.*

³⁴² *Ibid.*

³⁴³ *Ibid.*

³⁴⁴ Swanepoel 317.

³⁴⁵ As established in the English case of *Bolam v Friern Hospital Management Committee* [1957] 2 ALL ER 118 (QB); Swanepoel 317.

³⁴⁶ Swanepoel 317.

³⁴⁷ *Ibid.*

³⁴⁸ *Ibid.*

³⁴⁹ Swanepoel 273.

the consent of a person acting on their behalf is essential to establish a proper doctor-patient relationship.³⁵⁰ The so-called “therapeutic privilege”, in terms of which the harm caused by the disclosure of information will be greater than the harm caused by non-disclosure of information, can denote a professional privilege on the side of the doctor to withhold certain information from a patient, or it can signify a legal defence in terms of which the doctor can justifiably withhold certain information from the patient.³⁵¹

The WHO maintains that informed consent is required before any interference with a person can occur.³⁵² A medical intervention without the required informed consent amounts to a violation of a person’s physical integrity, and may amount to criminal assault, civil or criminal injuria, or result in an action for damages based on negligence.³⁵³ The MHCA expressly provides that services are to be delivered only where for consent has been obtained, although the MHCA acknowledges that in certain situations (Section 9(1) of the MHCA) it is not possible to obtain consent.³⁵⁴ In certain circumstances a surrogate decision maker may authorise care, treatment and rehabilitation services.³⁵⁵

Landman and Landman are of the opinion that the regulations promulgated in the MHCA do not provide for cases where a mentally disordered person is incapable of giving informed consent to treatment or an operation and in case of an emergency, the common law would dictate when medical practitioners may intervene.³⁵⁶ The author submits that the provisions regarding informed consent in the National Health Act read with the MHCA, makes sufficient provision for obtaining informed consent from mental health care users or their proxies as discussed hereafter.

³⁵⁰ *Ibid.*

³⁵¹ Swanepoel 316; Steyn, CR The law of malpractice liability in clinical psychiatry: Methodology, foundations and applications (unpublished LLM dissertation, Unisa, 2002) 93ff. For an in depth discussion of grounds of justification for medical interventions and other defences in medical law, see Carstens & Pearmain 871ff.

³⁵² Landman and Landman 6.

³⁵³ Swanepoel (2011) Obiter 291.

³⁵⁴ Landman and Landman 6.

³⁵⁵ *Ibid.*

³⁵⁶ Landman and Landman 166.

Section 6(1) of the NHA provides that every health care provider must inform a user (where possible in a language the user understands and in a manner that takes into account the user's level of literacy) of:

- a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;
- b) the range of diagnostic procedures and treatment options generally available to the user;
- c) the benefits, risks, costs and consequences generally associated with each option; and
- d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.

A health care provider must take all reasonable steps to obtain the user's informed consent.³⁵⁷ "Informed consent" means consent for the provision of a specified health service given by a person with legal capacity and who has been informed as contemplated in Section 6.³⁵⁸ Section 7(1)(a) and (b) of the NHA also provides that informed consent must be obtained before a health service is provided to a user, unless the user is unable to give informed consent and consent is given by a person mandated to give such consent by the user on their behalf, or authorised to give consent in terms of a law or court order. If the user is unable to give consent and no other person is mandated to do so, a spouse or partner, or in the absence of one, a parent, grandparent or adult child or a sibling may give consent in the order listed.³⁵⁹ If the provision of a health service without informed consent is authorised by law or court order the health service may be provided; or if a delay in the provision of the health service might result in their death of the user and they have not refused the service.³⁶⁰

Section 8(1) of the NHA determines that a user has the right to participate in any decision affecting his or her personal health and treatment. If the informed consent required by Section

³⁵⁷ Section 7(2) of the NHA.

³⁵⁸ Section 7(3) of the NHA.

³⁵⁹ Section 7(1)(b) of the NHA.

³⁶⁰ Section 7(1)(c) and (e).

7 is given by a person other than the user: such person must, if possible, consult the user before giving the required consent.³⁶¹ A user who is capable of understanding must be informed as contemplated in Section 6 even if they lack the legal capacity to give informed consent required by Section 7.³⁶² If a user is unable to participate in a decision affecting his or her personal health and treatment, they must be informed as contemplated in Section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.³⁶³

The informed consent of a patient to treatment for mental disorders (including electroconvulsive therapy) is discussed in Chapter 4 in relation to the MHCA provisions and forms pertaining to such matters, as well as the consent of a mental health care user to treatment for illness and injury other than mental illness.

2.4.6.4 Medical research and experimentation

Section 12(2)(c) of the Constitution reads: "Everyone has the right to bodily and psychological integrity, which includes the right not to be subjected to medical or scientific experiments without their informed consent." An analysis of this right can be broken down into the question of what constitutes medical or scientific experiments should be examined, and what counts as informed consent should be defined.³⁶⁴ Currie and De Waal indicate that when doctors prescribe approved drugs or engage in accepted practices on their patients, they are still experimenting, because no two patients react exactly alike to the same drug or procedure.³⁶⁵ Van Oosten submits that therapeutic research could sometimes be allowed without the informed consent of the research subject.³⁶⁶ Without subjecting the Mental Health Care Act to constitutional scrutiny in terms of section 36, it is concluded that therapeutic

³⁶¹ Section 8(2)(a) of the NHA.

³⁶² Section 8(2)(b) of the NHA.

³⁶³ Section 8(3) of the NHA.

³⁶⁴ Swanepoel 270. See also Van Staden, CW. "Can involuntary admitted patients give informed consent to participation in research?" 2007 13 S Afr J of Psychiatry 1: 10-12.

³⁶⁵ Currie and De Waal 288-289; Swanepoel 270.

³⁶⁶ Van Oosten, FFW. (2000) "The law and ethics of information and consent in medical research" 63 THRHR 1:5 9; Swanepoel 272.

research seems to be included under the notion of “medical treatment or operation on” mentally disordered patients, for which proxy consent can be given.³⁶⁷

2.4.6.5 Decisions concerning reproduction (section 12(2)(a))

The specific inclusion of the right to make decisions concerning reproduction is the recognition that the power to make decisions about reproduction is a crucial aspect of control over one's body.³⁶⁸ The main concern of this thesis lies with the particular questions need to be posed regarding mentally disordered persons, therefore an in-depth analysis covering aspects of reproductive rights fall outside the scope of this section. Instead this study focuses in particular to the aspect of consent and the capacity of mentally disordered persons to make decisions on their reproductive rights, including sterilisation, abortion, and consent to sexual acts. Section 14 of the MHCA determines that subject to conditions applicable to providing care, treatment and rehabilitation services in health establishments, the head of a health establishment may limit intimate relationships of adult mental health care users only if due to mental illness, the ability of the user to consent is diminished.

The Sterilisation Act 44 of 1998 is currently being amended to clarify that while the reproductive rights of mentally disordered persons under the age of eighteen years must be respected and protected, their other constitutional rights, such as the right to human dignity and psychological integrity must also be taken into consideration when the question of their sterilisation arises.³⁶⁹ One of the primary concerns of the Sterilisation Act when it was first passed was to ensure that unnecessary sterilisation of mentally disordered persons was prohibited since they also have reproductive rights.³⁷⁰

Regarding abortion, the Choice on Termination of Pregnancy Act 92 of 1996 also deals with situations where a woman is severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a

³⁶⁷*Ibid.*

³⁶⁸ Swanepoel 237.

³⁶⁹*Ibid.*

³⁷⁰ Swanepoel 242. A full discussion of the Sterilisation Act falls outside the scope of this thesis. For more on the topic, see Swanepoel 237-242.

termination of her pregnancy in terms of Section 2.³⁷¹ Such a pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto (Section 5(4))³⁷² in the following circumstances: During the period up to and including the twentieth week of the gestation period if the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or after the twentieth week of the gestation period if the continued pregnancy would endanger the woman's life; would result in a severe malformation of the foetus; or would pose a risk of injury to the foetus. This may only be done after consulting her natural guardian, spouse, legal guardian or *curator personae*, as the case may be; provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian, or *curator personae*, as the case may be, refuses to consent thereto.³⁷³ The court in the second *Christian Lawyers* case stated that regarding the capacity to consent in this context, valid consent can only be given by someone with the intellectual and emotional capacity for the required knowledge, appreciation and consent.³⁷⁴

The MHCA provides in section 11 that every person, body, organisation or health establishment providing care, treatment and rehabilitation services to a mental health care user must take steps to ensure that users are protected from exploitation, abuse and any degrading treatment; and that care, treatment and rehabilitation services are not used as punishment or for the convenience of other people. Cruel, inhuman or degrading treatment may take the form of indefinite detention, seclusion from others, being subjected to unhygienic and inhumane living situations, and generally violating a person's autonomy and physical or mental integrity through abuse. The right to an environment that is not harmful to health is discussed below.

³⁷¹ Currie and De Waal 286; Swanepoel 243.

³⁷² Choice on Termination of Pregnancy Act 92 of 1996.

³⁷³ Swanepoel 244.

³⁷⁴ *Christian Lawyers' Association v National Minister of Health* 2004 (1) BCLR 1086 (T)1093I-1094C, 1095A-J, 1096C, 1103 F-J, 1104G-1105J, 1106A-D; Pieterse 41; Currie and De Waal 286; Swanepoel 244.

2.4.6.6 International law considerations

Article 9 of the ICCPR establishes that “everyone has the right to liberty and security of the person. No one shall be subjected to arbitrary detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.” The Universal Declaration of Human Rights, Article 3 states that “Everyone has the right to life, liberty and security of person.” This concept is captured more specifically in the MI Principles. Principle 8(2) provides that “Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.”

Article 14 of the CRPD determines that State Parties shall ensure that persons with disabilities, on an equal basis with others, enjoy the right to liberty and security of the person and are not deprived of their liberty unlawfully or arbitrarily. Article 14 does not ban the involuntary detention of persons outright, but requires State Parties to ensure that the existence of a disability must in itself never be the justification of depriving a person of their liberty.³⁷⁵ Any deprivation of liberty must be in conformity with the law and therefore due process protections or safeguards must be employed.³⁷⁶ Article 23 of the CRPD further states that State Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, to ensure that: The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognised, and the means necessary to enable them to exercise these rights are provided; and that persons with disabilities, including children, retain their fertility on an equal basis with others.

The CRPD in Article 17 determines that every person with a mental disability has the right to respect for their physical en mental integrity on an equal basis with others. This provision can

³⁷⁵ Kanter 133.

³⁷⁶ Kanter 134.

be taken to imply that a mentally disordered person must be assumed to have mental capacity to give informed consent until the contrary is determined. Also the CRPD's Reporting Guidelines for Article 17 state that the provision of medical intervention or treatment without free and informed consent constitutes an infringement of mental and physical integrity.³⁷⁷

Article 9 of the UDHR determines that “No one shall be subjected to arbitrary arrest, detention or exile.” Article 6 of the African Charter states that “Every individual shall have the right to liberty and to the security of his person. No one may be deprived of his freedom except for reasons and conditions previously laid down by law. In particular, no one may be arbitrarily arrested or detained”. The MI Principles state that “physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facilities and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose.”

Article 5 of the ECHR prohibits arbitrary detention of persons to protect the right to liberty and security of the person.³⁷⁸ Article 5(4) determines that everyone deprived of their liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful. Article 5(1) provides that no one is to be deprived of their liberty save in the narrow closed list of circumstances set out as follows, as other reasons for detention would amount to arbitrary detention:³⁷⁹

- a) the lawful detention of a person after conviction by a competent court;
- b) the lawful arrest or detention of a person for noncompliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;
- c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed

³⁷⁷ Kanter 211.

³⁷⁸ Emmerson, Ashworth and Macdonald 261.

³⁷⁹ Emmerson, Ashworth and Macdonald 263.

an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;

- d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
- e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
- f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition

The case of *Winterwerp v The Netherlands*³⁸⁰ before the European Court of Human Rights dealt with the issue around arbitrariness in the detention of persons with mental disorder. The court held that three conditions are necessary to warrant lawful detention. Firstly, apart from in emergency situations, the person must reliably be shown to be of unsound mind, meaning that a true mental disorder must be established before an independent authority on the basis of objective expertise.³⁸¹ Secondly, the mental disorder must be of a type or degree warranting compulsory confinement.³⁸² And thirdly, the validity of continued confinement depends on the persistence of such a mental disorder, established at reasonable intervals.³⁸³ Detention may also be arbitrary if it is disproportionate to the attainment of its purpose.³⁸⁴ This means that persons detained on grounds of dangerousness by reference to characteristics susceptible to change over time will become unlawful and arbitrary once the characteristics are no longer present.³⁸⁵ In *Varbanov v Bulgaria* the court stated that “medical assessments must be based on the

³⁸⁰ (1979) 2 EHRR 387.

³⁸¹ Fennel 16; Claydon, L. (2012) 'Are there lessons to be learned from a more scientific approach to mental condition defences?' *International Journal of Law and Psychiatry* 35 88-98 90; Emmerson, Ashworth and Macdonald 261.

³⁸² Fennel 17.

³⁸³ *Ibid.*

³⁸⁴ *Winterwerp v The Netherlands* (1979) 2 EHRR 387; Emmerson, Ashworth and Macdonald 263.

³⁸⁵ *Abed Hussain v United Kingdom* (1996) 22 EHRR 1; Emmerson, Ashworth and Macdonald 264. The aspect of risk and dangerousness as a factor to consider when imposing detention is discussed in Chapter 4 relating to involuntary mental health care users, and in Chapter 5 regarding criminal procedure and the MHCA pertaining to State Patients.

actual state of health of the person concerned and not solely on past events.³⁸⁶ A medical opinion cannot be seen as sufficient to justify deprivation of liberty if a significant time period has elapsed”.³⁸⁷

The MI Principles protect the patient's autonomy by creating a due process procedure before a patient can be determined to lack legal capacity, thus empowering a personal representative to represent the patient's interest or exercise the patient's rights. Principle 1(6) provides: “Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by the person to the extent that they do not have sufficient means to pay for it. The counsel shall not in the same proceeding represent a mental health facility or its personnel and shall not represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest.”³⁸⁸

Principle 11 of the MI Principles addresses consent to treatment, and strikes a compromise between autonomy and paternalism.³⁸⁹ The right to informed consent includes the right to information about treatment “in a form and language understood by the patient.” Rights to privacy and confidentiality, freedom of communication and access to information are also protected in the MI Principles 6, 13 and 19.³⁹⁰ Socio-economic rights such as the right to health and social services appropriate to health needs, an individualised treatment plan (Principles 8-10), and resources for mental health facilities comparable to other health facilities (Principle 14) are also protected.³⁹¹ The civil and political rights in the MI Principles apply to all mentally disabled persons, regardless of whether they are in a mental health care

³⁸⁶ Application No 00031365/96 (Judgment given 5.10.2000); Claydon (2012) International Journal of Law and Psychiatry 90.

³⁸⁷ *Ibid.*

³⁸⁸ Rosenthal and Sundram 35.

³⁸⁹ Gostin and Gable (2004) Maryland Law Review 39.

³⁹⁰ *Ibid.*

³⁹¹ *Ibid.*

facility, whilst the socio-economic rights only apply to those patients in a mental health facility (whether they have a mental illness or not).³⁹²

Principle 5 of the WHO's Ten Basic Principles regarding self-determination suggests that to promote a patient's autonomy the following should be done:

1. Presuming that patients are capable of making their own decision unless proven otherwise;
2. Making sure that mental health care providers do not systematically consider that patients with a mental disorder are unable to make their own decisions;
3. Not systematically considering a patient to be unable to exercise self-determination regarding all components (e.g. integrity, liberty) because the patient was found to be unable regarding one (e.g. authority for involuntary hospitalization does not automatically include authority for involuntary treatment, especially if the treatment is invasive);
4. Giving verbal and written information (in an accessible language) to patients about the treatment; detailed verbal explanations should be provided to patients unable to read;
5. Calling for the patient's opinion regardless of his or her ability to consent and giving it careful consideration prior to carrying out actions affecting his/her integrity or liberty; asking someone deemed unable to decide about his/her own good to explain the motives behind an given opinion may unveil legitimate concerns for consideration and promotes the exercise of self-determination;
6. Abiding by any wishes expressed by a patient prior to becoming unable to consent.

2.4.6.6.1 *Inhuman and degrading treatment*

Article 5 of the UDHR determines that “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.” Article 5 of the African Charter determines that “All forms of exploitation and degradation of man particularly slavery, slave trade,

³⁹² *Ibid.*

torture, cruel, inhuman or degrading punishment and treatment shall be prohibited”. Article 15 of the CRPD regarding freedom from torture or cruel, inhuman or degrading treatment or punishment determines that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation, and that State Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.³⁹³

The Article 7 protection in the ICCPR against “inhuman and degrading treatment” is one of the most important protections under international human rights law for people with mental disabilities.³⁹⁴ Article 7 reads in full: “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation”. Article 7 is such an important part of the ICCPR, it is designated as one of the provisions that are “non-derogable”, and therefore it can never be limited even under conditions of national emergency. It is notable that the first sentence of Article 7 is a verbatim repetition of Article 5 of the UDHR, which is widely considered to be binding, customary international law.³⁹⁵ Thus, the protection against torture or inhuman and degrading treatment is applicable even to countries that have not ratified the ICCPR. Article 7 of the ICCPR requires governments to establish protections that would prevent unnecessary physical or mental suffering.³⁹⁶ Article 7 protects not only detainees from ill-treatment by public authorities or by persons acting outside or without any official authority but also in general any person, including patients in medical institutions.³⁹⁷

General Comment 20(44) states that “States Parties should indicate how their legal system effectively guarantees the immediate termination of all acts prohibited by Article 7 as well as

³⁹³ Kanter 153.

³⁹⁴ Rosenthal and Sundram 47.

³⁹⁵ Rosenthal and Sundram 47.

³⁹⁶ *Ibid.*

³⁹⁷ Rosenthal and Sundram 49.

appropriate redress”.³⁹⁸ By calling on governments to report on conditions in psychiatric facilities, appeals processes, and complaint procedures, the UN Human Rights Committee makes clear that government legislation and practice in these matters raise fundamental human rights concerns protected by Article 7 of the Covenant.³⁹⁹ Legislation is needed to define the expected standard of care and to protect against mistreatment. In order to protect these rights, governments must not only establish legislation that prohibits abuses but also must ensure the enforcement of these laws.⁴⁰⁰ Legislation may need to be enacted to create safeguards, such as systems for inspection or independent monitoring.⁴⁰¹ Systems for investigating complaints must also be established as part of domestic legislation.⁴⁰² When the violation of human rights standards for mentally ill persons causes great suffering or personal degradation, these practices should also be seen as a violation of Article 7 of the ICCPR and Article 5 of the UDHR.⁴⁰³

Rosenthal and Sundram for the WHO state authoritatively that:⁴⁰⁴ “When individuals detained in institutions are kept in unhygienic conditions, for example, such treatment is not only unhealthy but also causes physical and mental suffering and degradation.” The threshold of suffering required to prove an Article 7 violation is high, and so not every violation of the MI Principles will constitute a violation of the ICCPR. The obligation on the part of governments to prevent inhuman and degrading treatment is much greater than the obligation to protect the right to health –whether or not or not a State has ratified the ICCPR, it is bound by the identical language of Article 5 of the UDHR. Whereas the ICESCR recognises that governments have constraints on their budgets and that “progressive realisation” of the right to health may take place gradually, the ICCPR requires immediate enforcement for every person. The lack of financial or professional resources is not an excuse for inhuman and degrading treatment. Governments are thus required to provide adequate funding for the basics needed to protect against suffering that can be caused by a lack of food, clothing, proper staffing at an institution, protection of basic hygiene, and provision of an environment

³⁹⁸ *Ibid.*

³⁹⁹ Rosenthal and Sundram 50.

⁴⁰⁰ *Ibid.*

⁴⁰¹ *Ibid.*

⁴⁰² *Ibid.*

⁴⁰³ Rosenthal and Sundram 54.

⁴⁰⁴ Rosenthal and Sundram 60.

that is respectful of individual dignity.” The exact contours of Article 7 requirements regarding basic conditions of living in institutions have not been fully tested yet and, consequently, it is not clear to what extent the MI Principles would have to be violated before they could be considered to cause inhuman or degrading treatment.⁴⁰⁵

2.4.7 The right to privacy

Privacy is a right enshrined by Section 14 of the Constitution, which includes the concept of confidentiality. The right to privacy impacts on physical privacy, communications, and the right of a person to have control over the use of personal information.⁴⁰⁶ Should a medical practitioner reveal information that is privileged, the right to physical and psychological integrity and right to dignity may be breached as well as the right to privacy, as the disclosure of such information could adversely affect a person’s dignity and psychological integrity.⁴⁰⁷

The right to privacy enshrined in Section 14 of the Constitution includes the right not to have one’s person searched.⁴⁰⁸ The physical examination of a person in the health care context is an invasion of privacy and can only be lawfully done if the person waives the right for the purpose of the examination,⁴⁰⁹ though it is not an absolute right and may be limited in terms of Section 36 of the Constitution for the purpose of a court mandated psycholegal en medical examination. The court in *Bernstein v Bester*⁴¹⁰ held that the right to privacy extends to only those aspects regarding which a legitimate expectation of privacy can be harboured.

Section 13(1) of the MHCA states that a person or health establishment may not disclose any information that a mental health care user is entitled to keep confidential in terms of any other law, but the head of the national department, the head of the provincial department or the head of a health establishment concerned may disclose such information if failure to do so would

⁴⁰⁵ *Ibid.*

⁴⁰⁶ Currie and De Waal 294; Swanepoel (2011) *Obiter* 297.

⁴⁰⁷ Spammers, M 'A critical analysis of the psycholegal assessment of suspected pathologically incapacitated accused persons in terms of the Criminal Procedure Act' (Unpublished LLM Dissertation, UP 2010) 38.

⁴⁰⁸ Currie and De Waal 304.

⁴⁰⁹ Carstens and Pearmain 943-944.

⁴¹⁰ NO 1996 (2) SA 751 (CC); Currie and De Waal 298.

seriously prejudice the health of the mental health care user or of other people.⁴¹¹ A mental health care provider may temporarily deny mental health care users access to information contained in their health records, if disclosure of that information is likely to seriously prejudice the user; or cause the user to conduct their self in a manner that may seriously prejudice him or her or the health of other people.⁴¹²

2.4.7.1 Confidentiality

Section 14 of The National Health Act⁴¹³ stipulates that all information regarding a patient is confidential, unless the health care user consents to disclosure in writing, if non-disclosure represents a serious threat to public health or a court order or any law requires disclosure.⁴¹⁴ The Promotion of Access to Information Act 2 of 2000 regulates the mandatory protection of privacy of a third party who is a natural person in Section 34.⁴¹⁵ According to Section 34(1), the information officer of a public body must refuse a request of access to a record of the body if its disclosure would involve the unreasonable disclosure of personal information about a third party, including a deceased person.

In the usual clinical relationship, confidentiality is an implied agreement that the clinician not disclose any privileged information received from the patient to third parties unless legally required to do so.⁴¹⁶ This duty is not absolute, and in some circumstances breaching confidentiality is appropriate and may even be legally required.⁴¹⁷ Psychiatrists must balance patient confidentiality with the need to provide adequate information to other medical providers, and where there is a duty upon them to warn.⁴¹⁸ Documentation in the medical record, and verbal communication to others providing patient care, requires careful

⁴¹¹ Section 13(2) of the MHCA.

⁴¹² Section 13(3) of the MHCA.

⁴¹³ Act 61 of 2003.

⁴¹⁴ Moodley, K. 'Respect for patient autonomy' in Moodley, K (ed.) 'Medical ethics, law and human rights: A South African Perspective' 2011 48.

⁴¹⁵ McQuoid-Mason, D, and Dhali, A, 'Confidentiality' in Dhali, A. and McQuoid-Mason, D. 'Bioethics, Human Rights and Health law: Principles and Practice' 2011 87.

⁴¹⁶ Zabow and Kaliski 362; Swanepoel (2011) *Obiter* 299.

⁴¹⁷ Steyn, CR. (2006) "Breach of confidentiality and the duty to warn in medical law: Examples from clinical psychiatry" 31 *TRW* 1: 134-142; Swanepoel (2011) *Obiter* 299.

⁴¹⁸ Steyn (2006) *TRW* 135; Swanepoel (2011) *Obiter* 299.

consideration of what to communicate and what to keep confidential.⁴¹⁹ Radden submits that, because the psychiatric patient's vulnerability is increased due to being at least temporarily and partially deprived of those traits most useful in combating exploitation, this vulnerability imposes a special burden on the clinician, who must adhere to stricter standards of awareness and good conduct.⁴²⁰ This also holds true for the forensic mental health assessor who enquires into criminal capacity in terms of Section 78 and 79, even though the relationship between assessor and accused is not conventionally therapeutic.

The Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act stipulates that a practitioner shall divulge information verbally or in writing regarding a patient, they ought to divulge only:⁴²¹

- In terms of a statutory provision;
- at the instruction of a court of law; or
- where justified in the public interest (s13(1) (a-c)). Any information other than the information referred to in sub rule (1) shall be divulged by a practitioner only:
 - With the expressed consent of the patient;
 - in the case of a minor under the age of 14 years, with the written consent of his or her parent or guardian; or
 - in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate. (s13(1) (a-c)). p 159:

Section 8 of the MHCA provides that the privacy of a mental health care user must be respected. The Ethical Code for Psychologists provides that a psychologist shall safeguard the confidential information obtained in the course of practice, teaching, research or other professional duties, subject only to the exceptions set forth as limits to confidentiality and that psychologist shall only disclose confidential information to others with the written informed

⁴¹⁹ *Ibid.*

⁴²⁰ Radden (2004) 'The nature and scope of psychiatric ethics: review article' South African Psychiatry Review 7.

⁴²¹ McQuoid-Mason and Dhali 'Confidentiality' 88-89; Swanepoel 158.

consent of a client.⁴²² Rule 27(1) of the Ethical Code determines that a psychologist may disclose confidential information:

- a) only with the permission of a client;
- b) as mandated by law;
- c) when permitted by law for a valid purpose such as to provide needed professional services to a client;
- d) to obtain appropriate professional consultations;
- e) to protect a client or others from harm; or
- f) to obtain payment for a psychological service, in which instance disclosure is limited to the minimum necessary to achieve that purpose.

In Rule 33 of the Ethical Code, a psychologist is required to protect the privacy of a patient by disguising confidential information used for didactic or other purposes.

Where a mental health practitioner is called on to observe and report on the mental status of a person in forensic settings, the report should be unbiased and objective, without regard to the interest of either party concerned. The boundaries in the psycholegal relationship is more formal and rigid than in most other clinical relationships.⁴²³ The accused must clearly be informed before and during the observation that he does not enjoy the usual fiduciary relationship with the assessor where the treating clinician must always act in the best interests of the patient.⁴²⁴ The mental health practitioner must inform the client that a forensic relationship does not carry a confidentiality clause and that all clinical and other information can be communicated to the court and to the lawyers in a written report.⁴²⁵ There is still a duty on the assessor to not disclose any information that is not relevant to the evaluation.⁴²⁶ With this in mind, the Health Professions Council has declared it unethical for a treating clinician to

⁴²² *Ibid.*

⁴²³ Zabow and Kaliski 361.

⁴²⁴ Zabow and Kaliski 361, 363; Tredoux, C.; Foster, D.; Allan, A.; Cohen, A.; Wassenaar, D. "Introduction" in Tredoux, C. *et al.* "Psychology and the law" (Lansdowne, South Africa: Juta) 200873.

⁴²⁵ Swanepoel 178.

⁴²⁶ Zabow and Kaliski 363.

conduct psycholegal assessments on their patients.⁴²⁷ In psycholegal evaluations, the relationship is best described as one of “examiner-examinee”, and the greater needs of the community or justice may come before those of the examinee, contrary to a usual doctor-patient relationship, so it is possible for the assessor to report in a way that may be harmful to the interests of the accused, and accountability to third parties may be involved.⁴²⁸ This needs to be explained to the patient being assessed and the clinician must take care not to reveal privileged information in the report that is not relevant.⁴²⁹

Section 79(7) of the Criminal Procedure Act determines that statements made to a forensic assessor of mental health by an accused during observation relevant to the enquiry into mental health are admissible in court and not subject to confidentiality, but only serve to establish mental state and not to prove any other facts relating to the case at hand.⁴³⁰ The Promotion of Access to Information Act is not applicable to such statements after criminal or civil proceedings have commenced.⁴³¹ The accused must be informed of his right to remain silent and to presumed innocent until proven guilty⁴³² and the right against self-incrimination, but also that this failure to speak or cooperate during the observation will be noted and may be detrimental to the accused in court.⁴³³ In terms of Regulation 6(4) of the Mental Health Act⁴³⁴ the accused, when referred for observation, must be informed that he is under no obligation to disclose any information. The referral for observation in terms of Section 79 is for the purpose of determining criminal capacity, not to gain additional evidence. Only information regarding the enquiry may be disclosed. Anything else is subject to confidentiality.

The court in *Forbes*⁴³⁵ held that it was undesirable that statements made by the accused during enquiries into the accused’s mental state should be allowed to be put before the court in evidence for the purpose of establishing the truth of any facts referred to in such statements,

⁴²⁷ Kaliski, S.; Allan, A.; Meintjes-van der Walt, L. “Writing a psycholegal report” in Kaliski, S. (ed.). “Psycholegal assessment in South Africa” 2006 339.

⁴²⁸ Zabow and Kaliski 359-360.

⁴²⁹ Kaliski, Allan and Meintjes-van der Walt 339-340.

⁴³⁰ Act 51 of 1977.

⁴³¹ Section 7 of Act 2 of 2000.

⁴³² As set out in Section 35 of the Constitution.

⁴³³ Joubert Strafprosesreg Handboek (2009) 20.

⁴³⁴ Act 19 of 1973.

⁴³⁵ 1970 2 SA 594 K 599.

save those having direct bearing on the mental condition of the accused. In the case of *Webb*⁴³⁶ the defence called an expert to testify that the accused was criminally incapacitated during the alleged murder he was charged for and the defence objected to the admissibility of statements made to the forensic assessor during the observation.⁴³⁷ The court held in this instance that the statements were admissible. The court in the case of *Leaner*⁴³⁸ also held that, on proper interpretation of Section 79(7),⁴³⁹ there was no reason why the expert witness could not be questioned regarding a statement made during an enquiry into the mental state of the accused that was relevant to such an enquiry.⁴⁴⁰

Obtaining informed consent regarding disclosures of patient information in the public interest where health care practitioners have considered all the available means of obtaining consent, where that patients are not competent to give consent, or in cases where patients withhold consent, personal information may be disclosed in the public interest where the benefits to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential.⁴⁴¹ Examples of such situations include where third parties such as the spouse or partner of a patient who is HIV positive are endangered where the patient refuses to disclose of their HIV status to such spouse or partner; or reporting a notifiable disease.⁴⁴² In all such cases the health care practitioner must weigh the possible harm to the patient, and the overall trust between practitioners and patients, against the benefits that will arise from the release of information.⁴⁴³ Swanepoel also discusses the issue around confidentiality in online communications where therapeutic sessions conducted via the internet are inherently unsecure and files containing sensitive information could be accessed by persons other than those authorised to do so.⁴⁴⁴

⁴³⁶ 1971 2 SA 340 T.

⁴³⁷ *Spamers* 2010 40.

⁴³⁸ 1996 2 SACR 347 C.

⁴³⁹ Act 51 of 1977.

⁴⁴⁰ *Spamers* 2010 40.

⁴⁴¹ Swanepoel 163.

⁴⁴² *Ibid.*

⁴⁴³ *Ibid.*

⁴⁴⁴ A comprehensive discussion of the issues surrounding confidentiality and other issues around online communications, the online storage of medical records, confidential emails and other issues surrounding technology and the mental health care profession are outside the scope of this thesis. For more on this topic, see Swanepoel, M. (2011) 'A selection of constitutional aspects that impact on the mentally disordered patient in South Africa' *Obiter*, Vol 32, Issue 2: 282-303.

Respect for autonomy demands that informed consent should always be obtained before a procedure or examination is contemplated.⁴⁴⁵ In many forensic settings, such as court ordered evaluations of an accused's competence, an assessment can proceed without the examinee's consent, though the psychologist should at least attempt at obtaining it.⁴⁴⁶ It is generally accepted that to achieve informed consent the elements of voluntariness, competency, disclosure of information and the dynamic nature of the process have to be fulfilled.⁴⁴⁷ The psychologist may specifically be required to assess an individual's ability to provide informed consent in the following situations:⁴⁴⁸

- A mentally ill person refuses to be admitted to hospital and an involuntary admission is being contemplated;
- there is doubt whether a person is able to provide consent for a medical or legal procedure;
- a retrospective analysis is needed of whether an individual who was subjected to a procedure or intervention actually did provide informed consent; and
- whether a person who has been referred for a psychological assessment, for example, for determination of child custody, provided informed consent.

The “wrongfulness” of an infringement of privacy is determined by means of the criteria of reasonableness or the *boni mores* (the legal convictions of society).⁴⁴⁹ In the case of *Jansen van Vuuren v Kruger*⁴⁵⁰ the court held that a patient is entitled to doctor-patient confidentiality and rejected the argument that the disclosure of a defendant's HIV status was justified because it was true, that it was in the public interest or that it was made on a privileged occasion to other doctors who were not at risk during a social occasion.⁴⁵¹ This signifies that doctor-patient privilege is protected and that the limits of that confidentiality are strictly enforced.

⁴⁴⁵ Swanepoel 179.

⁴⁴⁶ *Ibid.*

⁴⁴⁷ Zabow and Kaliski 370; Swanepoel 180.

⁴⁴⁸ Swanepoel 180.

⁴⁴⁹ Swanepoel (2011) *Obiter* 297.

⁴⁵⁰ 1993 4 SA 842 (A).

⁴⁵¹ Swanepoel (2011) *Obiter* 297.

2.4.7.2 *International law considerations*

MI Principle 13(1) protects the right to privacy, freedom of communication, and private visits. The right to privacy is also protected as a right under Article 12 of the UDHR and Article 17 of the ICCPR, which states that “No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence”.

2.4.8 Religion, belief and culture

2.4.8.1 *The right to freedom of religion, thought, belief and opinion*

Section 15(1) of the Constitution determines that everyone has the right to freedom of conscience, religion, thought, belief and opinion. Section 15(3)(a)(ii) provides that Section 15 does not prevent legislation recognising systems of personal and family law under any tradition, or adhered to by persons professing a particular religion, though this recognition must be consistent with this section and the other provisions of the Constitution.

In the *Christian Education South Africa* case,⁴⁵² the court held that a court will in the first place consider whether the belief relied upon in fact forms part of the religious doctrine of the religion practised by the person concerned.⁴⁵³ Then the court will not embark upon an evaluation of the acceptability, logic, consistency, or comprehensibility of the belief but rather inquire into the sincerity of the person's claim that a conflict exists between the legislation and the belief which is indeed burdensome to the person.⁴⁵⁴ The right to freedom of religion and thought is contained in most human-rights treaties, though the possibility exists that members of religious communities may seek to use the freedom of religion as a shield to fend off attacks on constitutionally offensive group practices.⁴⁵⁵

⁴⁵² *Christian Education South Africa v Minister of Education* 2000 (4) SA 757 (CC) 958E.

⁴⁵³ *Currie and De Waal* 320-321; *Swanepoel* 267.

⁴⁵⁴ *Currie and De Waal* 3319.

⁴⁵⁵ *Currie and De Waal* 320-322; *Swanepoel* 267.

In *Phillips v de Klerk* the applicant was a confirmed Jehovah's Witness and an adult of sound mind who refused a blood transfusion on religious grounds and the court set aside, on the basis of section 15 of the Constitution, a previous order it had granted to the applicant's doctor to authorise blood transfusion.⁴⁵⁶ Conversely in the case of *Hay v B* the applicant was a doctor applying to the court for an order authorising a blood transfusion to an infant child of Jehovah's Witness parents.⁴⁵⁷ The court held that in terms of section 28(2) of the Constitution, a child's best interests were of paramount importance in every matter concerning the child and was the single most important factor to be considered when balancing or weighing competing rights and interests concerning children.⁴⁵⁸ The court further held that the infant's right to life was an inviolable one and was capable of protection, which could be achieved by allowing the blood transfusion in the face of the infant's imminent death.⁴⁵⁹ While the first and second respondents' concerns were understandable, they were neither reasonable nor justifiable and their private beliefs could not override the infant's right to life.⁴⁶⁰ Carstens⁴⁶¹ and Swanepoel⁴⁶² submit that a distinction was drawn in these two cases concerning Jehovah's Witnesses between an adult who is *compos mentis* and an infant and that the same distinction should be drawn regarding the mentally disordered patient who is not competent to make an informed decision. The outcome might be different where the adult mentally disordered Jehovah's Witness patient had a "living will" or other directive not to receive any blood, even in a life-saving situation.⁴⁶³

It is submitted that cases such as these two are indicative of the manner in which courts will deal with other cultural and religious groups as well. If a particular group's culture or religion prevents the proper care of a person with a mental disorder who is incapable of making informed decisions, then the courts and legislature must ensure that their duty of care is discharged by providing for the proper procedure in such circumstances. If consent to mental health care is denied by way of a proxy on cultural or religious grounds that medically will be

⁴⁵⁶ *Phillips v De Klerk* 1983 TPD (unreported); Swanepoel 267.

⁴⁵⁷ *Hay v B* 2003 (3) SA 492 (W); Swanepoel 268.

⁴⁵⁸ Swanepoel 268.

⁴⁵⁹ *Ibid.*

⁴⁶⁰ Swanepoel 268.

⁴⁶¹ Carstens and Pearmain.

⁴⁶² Swanepoel 268.

⁴⁶³ *Ibid.*

to the detriment of a mentally ill person's mental health, courts should consider placing the vulnerable party's right to access to healthcare and the highest attainable standard of health above other considerations. The situation would be different in cases where advance directives are given by mentally ill persons while they have capacity to consent that their particular beliefs must be honoured.

Section 11 (3) of the Children's Act⁴⁶⁴ states that a child with disability or chronic illness has the right not to be subjected to medical, social, cultural or religious practices that are detrimental to their health, well-being or dignity. Therefore in cases involving a child with mental disorder, the situation is clearer. It is submitted that the distinction between children and adults with mental disorder is arbitrary as both belong to vulnerable and similar population groups. Adults with mental disorder who are incapable of making informed decisions should be afforded the same protection as children.

2.4.8.2 The rights of cultural, religious and linguistic communities

In terms of Section 30 of the Constitution everyone has the right to use the language and to participate in the cultural life of their choice. In terms of Section 31(1) of the Constitution persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community to enjoy their culture, practise their religion and use their language;⁴⁶⁵ and to form, join and maintain cultural, religious and linguistic associations and other organs of civil society.⁴⁶⁶ The rights in subsection 31(1) may not be exercised in a manner inconsistent with any provision of the Bill of Rights.⁴⁶⁷ The Ethical Code for Psychologists stipulates that: "A psychologist shall respect the right of a client to hold values, attitudes, beliefs and opinions that differ from their own."

⁴⁶⁴ 38 of 2005.

⁴⁶⁵ Section 31(1)(a) of the Constitution.

⁴⁶⁶ Section 31(1)(b) of the Constitution.

⁴⁶⁷ Section 31(2) of the Constitution.

The relevance of these procedures lies therein that culture can have a strong influence on how individuals experience psychiatric disabilities and on care and support preferences.⁴⁶⁸ Every patient should have the right to treatment suited to his or her cultural background. For example, mental healthcare and support services for indigenous peoples or racial and ethnic minorities must be respectful of their cultures and traditions.⁴⁶⁹

Culture and religion should accordingly be considered and respected when decisions regarding the treatment of a mental health care user is made. This can have an impact on the type of treatment or medical intervention prohibited or preferred by the particular group, as well as the capacity to make decisions regarding the patient's own best interests. The influence on culture in the diagnosis and treatment of mentally ill persons are discussed further in Chapter 3, taking into consideration widely held beliefs of cultural groups in South Africa pertaining to mental disorder and the treatment of those disorders by traditional healers.

2.4.8.3 International law considerations

Article 8 of the African Charter determines that freedom of conscience, the profession and free practice of religion shall be guaranteed, and that no one may, subject to law and order, be submitted to measures restricting the exercise of these freedoms. The MI Principles recognise the right of every person receiving mental health care “to treatment suited to his or her cultural background (Principle 7(3)). One of the most powerful protections for community and culture is the respect for self-determination and individual choice embodied in the MI Principles and the Standard Rules.⁴⁷⁰

2.4.9 The right to an environment that is not harmful to health and well-being

According to Section 24 of the Constitution, everyone has the right to an environment that is not harmful to their health or well-being. This may be read with the rights to health, dignity,

⁴⁶⁸ Swanepoel (2011) Potchefstroom Electronic Law Journal 145.

⁴⁶⁹ *Ibid.*

⁴⁷⁰ Rosenthal and Sundram 18.

and equality. This open-ended right guarantees environmental health and is phrased broadly enough to serve as a constitutional basis for a right to occupational health, including a working environment not harmful to health or well-being, and for rights to a variety of other non-medicinal, health-conducive social goods.⁴⁷¹

The *Volkman* case⁴⁷² illustrates the right contained in Section 24. In this case the accused was charged with murder and raised the offence of non-pathological criminal incapacity. The state applied for him to be admitted to Pollsmoor psychiatric hospital for observation in terms of the Criminal Procedure Act. The defence requested that the observation take place during the day only so that the accused would not have to be locked up in the hospital at night. Evidence placed before the court showed that the conditions in the hospital were inhumane. The state requested that the accused be admitted for observation on a full-time basis. The court agreed to the defence's request. One of the reasons given for this order, was that the accused had not yet been convicted and had a constitutional right to be detained under conditions consistent with human dignity under Section 35(2)(e) of the Constitution.⁴⁷³ In spite of the fact that Section 36 of the Constitution permits rights to be limited if it is justifiable and reasonable to do so, and in spite of the fact that Section 78(2) gives the court a discretion whether to refer the accused for observation or not, the court held that given the “extremely unpleasant and degrading conditions” that the accused would face, it could not exercise its discretion in the state's favour.⁴⁷⁴

2.4.9.1 International law considerations

The international law understanding of the right to health includes entitlements to environmental and occupational health as well as to several non-medicinal, health-conducive social goods.⁴⁷⁵ Under MI Principle 13, “the environment and living conditions in mental health facilities shall be as close as possible to those of normal life of persons of similar age.” This includes facilities for leisure, education, and vocational rehabilitation. The MI Principles

⁴⁷¹ Pieterse 19.

⁴⁷² *S v Volkman* 2005 (2) SACR 402 (C).

⁴⁷³ Deane (2006) ‘Criminal procedure: from the law reports’ *Codicillus* 91-93 91.

⁴⁷⁴ Deane (2006) *Codicillus* 92.

⁴⁷⁵ Pieterse 19.

recognise a right to freedom of communication, a right to receive visitors in private, “and freedom of access to postal and telephone services and to newspapers, radio, and television.” MI Principle 8(1) requires that “Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs and is entitled to care and treatment in accordance with the same standards as other ill persons.” To make this possible, Principle 14(1) requires that resources should be provided to ensure “qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy.”⁴⁷⁶

2.4.10 The right to access to healthcare services

Section 27 (1)(a) of the Constitution determines that everyone has the right to access to health care services, including reproductive health care. The term “health services” is defined in Section 1 of the National Health Act 61 of 2003 as:

- a) health care services, including reproductive health care and emergency medical treatment , contemplated in Section 27 of the Constitution;
- b) basic nutrition and basic health care services contemplated in Section 28(1)(c) of the Constitution (regarding the rights of children);
- c) medical treatment contemplated in Section 35(2)(e) of the Constitution (regarding the rights of arrested, detained and accused persons); and municipal health services.

Section 27(2) imposes specific obligations on the state and determines that the state must adopt legal measures to achieve the progressive realisation of the right of access to health care, and that these measures must be reasonable.⁴⁷⁷ The obligations generated by Section 27 must further be understood in conjunction with Section 7(2) of the Constitution, which mirrors international law by determining that “the state must respect, protect, promote and fulfil the rights in the Bill of Rights”.⁴⁷⁸ Conventional wisdom indicates that only the obligation to fulfil the right of access to health care services is subject to the limiting effect of

⁴⁷⁶ Rosenthal and Sundram 55.7

⁴⁷⁷ Pieterse 21.

⁴⁷⁸ *Ibid.*

the progressive realisation standard and resource limitation in Section 27(2) of the Constitution, while the obligation to respect the right, and most aspects of the obligation to protect it, are more immediately enforceable.⁴⁷⁹

Section 27(3) determines that no one may be refused emergency medical treatment. Section 5 of the National Health Act also states that a health care provider, health worker or health establishment may not refuse a person emergency medical treatment. In terms of mental illness this can be regarded in relation the 72 hour observation period provided for in the MHCA in specific circumstances which are further discussed in Chapter 4. By virtue of the textual separation of Section 27(3) from Section 27(1)(a) and the strong negative language it employs, it may be argued that Section 27(3) operates free from the constraints posed by Section 27(2) and that it may thus be immediately enforced against all entities able and qualified to render emergency care.⁴⁸⁰ Non-provision of emergency medical treatment would thus be constitutionally justifiable only in narrowly defined circumstances, in accordance with the general limitation clause in Section 36 of the Constitution.⁴⁸¹ Section 27(3) appears to imply a positive obligation on the state, to ensure that relevant medical services are available and are adequate to cope with the demands of medical emergencies.⁴⁸² In South Africa the provision of emergency services for mentally disordered patients are woefully insufficient regarding the number of available facilities and mental health professionals.⁴⁸³

Persons with mental illness, especially those who are institutionalised but also those living in the community, are often unable to access independent and effective accountability mechanisms when their human rights have been violated.⁴⁸⁴ This may arise for various reasons, including the severity of a condition; the absence of effective procedural safeguards, such as the provision of a personal representative for those deemed to lack legal capacity; a lack of access to legal aid; and a lack of awareness of their human rights and other entitlements. In some cases, there is no independent accountability mechanism in the first

⁴⁷⁹ *Ibid.*

⁴⁸⁰ *Ibid.*

⁴⁸¹ *Ibid.*

⁴⁸² *Ibid.*

⁴⁸³ Chapter 6 deals with the practical implementation of

⁴⁸⁴ Swanepoel (2011) Potchefstroom Electronic Law Journal 143.

place.⁴⁸⁵ Swanepoel submits that because South Africa acknowledges access to health care services in its Constitution, it includes adequate treatment services for mentally disordered patients, including adequate treatment in psychiatric institutions, especially if these are the only treatments recognised as appropriate for the purpose and treatment.⁴⁸⁶

The Constitution does not guarantee a right to health, but only the qualified right of access to health care services.⁴⁸⁷ A further question of importance in understanding the right of access to health care services is the nature and level of care to which people are entitled.⁴⁸⁸ In the *Soobramoney* case⁴⁸⁹ the Constitutional Court had to interpret the scope and content of the right of access to health care services guaranteed under Sections 27(1)(b) and 27(3).⁴⁹⁰ The Constitutional Court was called upon to decide on the constitutionality of a resource rationing policy of a state hospital, when an indigent kidney-failure patient who was denied life sustaining dialysis treatment because of the policy, claimed that it violated his rights to life, to not be refused emergency medical treatment and to have access to health care services.⁴⁹¹ The court in that case held that obligations imposed on the state under Section 27 of the Constitution depended upon the resources available for such purposes, and the corresponding rights themselves were limited by the lack of resources.⁴⁹² The words “emergency medical treatment” in Section 27(3) seems to be to ensure that treatment is given in an emergency, and is not frustrated by bureaucratic requirements or other formalities.⁴⁹³

The ordinary meaning of “emergency treatment” does not include ongoing treatment for chronic illness and it is not expressed in the Constitution in specific terms.⁴⁹⁴ The word “everyone” in Section 27 also cannot be interpreted in line with Section 11 entrenching the

⁴⁸⁵ *Ibid.*

⁴⁸⁶ *Ibid.*

⁴⁸⁷ Carstens and Pearmain 41; Nevondwe, L.; Odeku, KO. (2013) 'The Right of Access to Health Care Services: Pitfalls and Prospects' 4 Mediterranean Journal of Social Sciences 13: 837-845 839; Swanepoel (2011) Potchefstroom Electronic Law Journal 139.

⁴⁸⁸ Swanepoel (2011) Potchefstroom Electronic Law Journal 139.

⁴⁸⁹ *Soobramoney v Minister of Health Kwazulu-Natal* 1998 1 SA 765 (CC).

⁴⁹⁰ Pieterse 27. Swanepoel (2011) Potchefstroom Electronic Law Journal 139.

⁴⁹¹ Pieterse 27.

⁴⁹² *Soobramoney v Minister of Health Kwazulu-Natal* 1998 1 SA 765 (CC); Swanepoel (2011) Potchefstroom Electronic Law Journal 141.

⁴⁹³ *Ibid.*

⁴⁹⁴ *Ibid.*

right to life to mean that everyone requiring life-saving treatment, unable to pay for such treatment themselves was entitled to have the treatment provided at a state hospital without charge as it would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or physical infirmities that are emergent or not life-threatening.⁴⁹⁵ The court followed a holistic approach to the larger needs of society and did not focus on the specific needs of particular individuals within society.⁴⁹⁶

The *Soobramoney* decision “represents the low water-mark in relation to the application of socio-economic rights by the court.”⁴⁹⁷ This case highlights the availability of resources as the crucial consideration when determining the enforcement of a socio-economic right against the state.⁴⁹⁸ The Court failed to inquire whether priorities within the provincial and national governments’ health care budgets were in consonance with its constitutional obligation.⁴⁹⁹ The *Grootboom*⁵⁰⁰ case stressed that a balance must be struck between the objectives set out in the Constitution and the means available to achieve these goals.⁵⁰¹ These measures must seek to attain the aims expeditiously and effectively, but the availability of resources may play a significant role in determining what may be construed as reasonable and the yardstick of reasonableness is to be understood within the context of the Bill of Rights.⁵⁰²

The court in the *Treatment Action Campaign* case, the Constitutional Court found that government policy which restricted the availability of the drug Nevirapine in the public health sector (for prevention of mother-to-child transmission of HIV) was unreasonable and unconstitutional.⁵⁰³ The Court emphatically rejected arguments in favour of a minimum core interpretation of the right of access to health care services, and instead focused on the

⁴⁹⁵ Swanepoel (2011) Potchefstroom Electronic Law Journal 141.

⁴⁹⁶ Swanepoel (2011) Potchefstroom Electronic Law Journal 142.

⁴⁹⁷ Nevondwe and Odeku (2013) Mediterranean Journal of Social Sciences 840.

⁴⁹⁸ *Ibid*; Ngwena and Cook 134.

⁴⁹⁹ *Ibid*.

⁵⁰⁰ Government of the Republic of South Africa and Others v Grootboom and Others 2001 (1) SA 46 (CC).

⁵⁰¹ Swanepoel 292; Pieterse 27.

⁵⁰² *Ibid*.

⁵⁰³ Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC).

reasonableness of the policy.⁵⁰⁴ The court ordered government to remove restrictions that prevented the use of Nevirapine in the public sector, beyond research and training sites, where it was medically indicated and where the capacity to administer it existed, to permit and facilitate the use of the drug for this purpose and to progressively extend the capacity to administer it to other sites. The court concluded that Section 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in Section 27(2).⁵⁰⁵ Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights everyone possesses and the corresponding obligations on the state to “respect, protect, promote, and fulfil” such rights.⁵⁰⁶ The rights conferred by Sections 26(1) and 27(1) are to have “access” to the services that the state must provide in terms of Section 26(2) and 27(2).⁵⁰⁷ Swanepoel submits that this judgment clearly shows that the Constitutional Court will hold government to its constitutional duties, and that the government is also a servant of the Constitution.⁵⁰⁸

The translation of human rights into rights that transcend rhetoric is an ongoing challenge globally and mental health care is among the most neglected elements of the right to health care services to avoid unnecessary institutionalisation.⁵⁰⁹ Hunt submits that states should take steps to ensure a full package of community-based physical and mental healthcare and support services conducive to health, dignity and non-discrimination.⁵¹⁰ The ideal package should include medication, psychotherapy, ambulatory services, hospital care for acute admissions, residential facilities, rehabilitation for persons with psychiatric disabilities, programmes to maximise the independence and skills of persons with mental illness, supported housing and employment, income support, inclusive and appropriate education for children with mental illness, and respite care for families looking after a person with a mental disability twenty-four hours a day.⁵¹¹

⁵⁰⁴ Pieterse 28.

⁵⁰⁵ *Treatment Action Campaign v Minister of Health* 2002 (5) SA 721 (CC); Swanepoel 296; Ngwena and Cook 139.

⁵⁰⁶ Swanepoel 296; Ngwena and Cook 139.

⁵⁰⁷ *Ibid.*

⁵⁰⁸ *Ibid.*

⁵⁰⁹ Swanepoel (2011) Potchefstroom Electronic Law Journal 137.

⁵¹⁰ Hunt and Mesquita (2006) *Human Rights Quarterly* 345; Swanepoel (2011) *Potchefstroom Electronic Law Journal* 138.

⁵¹¹ *Ibid.*

Hunt further argues that augmenting interventions to ensure the equality of opportunity for the enjoyment of the right to health will require training adequate numbers of professionals, including psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, occupational therapists, speech therapists, behavioural therapists and caregivers in order to work toward the care and full integration of individuals with mental disabilities in the community.⁵¹² General practitioners and other primary care providers should be provided with essential mental healthcare and disability sensitisation training to enable them to provide front-line mental and physical healthcare to persons with mental disabilities.⁵¹³

Ngwena observed that “our courts are given jurisdiction to adjudicate over matters of policies, including budgetary appropriations”. A right of access to health care means being able to access health care that is affordable, available and effective.⁵¹⁴ As part of its social responsibility, government state must seek to deliver a package of essential health services according to universal standards within a scheduled period.⁵¹⁵ Pieterse also sees health care as a basic human right issue. He states that Section 27(1)(a) determines that “everyone” is entitled to access health care services may be understood to indicate that rationing decisions may not be discriminatory and should adhere to the dictates of the right to equality.⁵¹⁶ When read with the obligation of the state to “respect” the right in the Bill of Rights in Section 7(2) of the Constitution, Section 27(1)(a) may further be understood to require that rationing process and decisions respect existing access to health care services and may not have the effect of obstructing diminishing access (for instance, directing resources away from provision of services to which patients already have access to).⁵¹⁷ The doctrine of separation of powers and other concerns on whether courts are the correct forums to make decisions on the content of socio-economic rights in a democratic system such as that of South Africa where

⁵¹² *Ibid.*

⁵¹³ *Ibid.*

⁵¹⁴ Ngwena, C (2000) ‘The recognition of Access to Health Care as a Human Right in South Africa: Is it enough?’ 5 *Health and Human Rights* 1 26-44; Nevondwe and Odeku, (2013) *Mediterranean Journal of Social Sciences* 838.

⁵¹⁵ Nevondwe and Odeku (2013) *Mediterranean Journal of Social Sciences* 838.

⁵¹⁶ *Ibid.*

⁵¹⁷ Pieterse 10; Nevondwe and Odeku (2013) *Mediterranean Journal of Social Sciences* 838.

the judiciary is an unelected branch of government limits the jurisprudence available on the matter.⁵¹⁸ Chapter 6 further considers the issue in relation to budget and resource allocation.

2.4.10.1 International law considerations

Pieterse states that the classic formulation of the right to health in international law is found in the 1946 World Health Organisation (WHO) Constitution, the preamble proclaiming that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.⁵¹⁹ The preamble further defines “health” as “a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”. Rather than a right to be healthy, what is proclaimed appears to be an equal right to share in the spoils of a legal, political and social environment that allows for health maximisation.⁵²⁰ The right to health implicates the health promotion, health protection and health care provision arms of national health systems.⁵²¹ Despite recognition of the right to health across multiple sources, there is varying terminology and lack of specific elaboration, making the extent of the right unclear.⁵²² A right to mental health that is too broadly defined, lacks clear content and will have a less meaningful effect, therefore an unambiguous for the right to health is necessary.⁵²³

Article 25 of the UDHR recognises an interest in health as follows: “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”⁵²⁴ Though the UDHR does not place

⁵¹⁸ Hoexter, C. 'Administrative Law' Claremont: Juta 2012 139-142; Brand, D (2011) 'Judicial deference and democracy in socio-economic rights cases in South Africa' 22 Stellenbosch Law Review 614; Williams, L. (2010) "The Role of Courts in the Quantitative Implementation of Socio-Economic Rights: A Comparative Study" 3 CCR 141.

⁵¹⁹ Pieterse 10; Ngwena, C. and Cook, R. "Rights concerning health" in Brand, D. And Heyns, C. (eds.) "Socio-economic rights in South Africa" 2005 109.

⁵²⁰ Pieterse 11; Ngwena and Cook 109.

⁵²¹ *Ibid.*

⁵²² Gostin and Gable (2004) Maryland Law Review 101.

⁵²³ Gostin and Gable (2004) Maryland Law Review 103; Ngwena and Cook 109.

⁵²⁴ Ngwena and Cook 111.

an obligation on States to take positive measures to enable individuals to realise the rights proclaimed within it, this gap has been filled by the International Covenant on Economic, Social and Cultural Rights ('CESCR').⁵²⁵ The state, in the context of the CESCR, has “a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels” of these rights.⁵²⁶ The state only discharges a basic core obligation, provided that it is able to attribute its failure to meet the minimum level of delivery to a lack of available resources.⁵²⁷ The state has to demonstrate that every effort has been made to meet this minimum level.⁵²⁸

According to the Limburg principles on the implementation of the International Covenant of Economic, Social and Cultural Rights, progressive realisation does not imply that the state can defer indefinitely efforts for the full realisation of the right.⁵²⁹ On the contrary, State Parties are to “move expeditiously as possible towards the full realisation of the right and are required to make immediate steps to provide a minimum core entitlement”.⁵³⁰ The International Covenant on Economic, Social and Cultural Rights states in Article 12:

“1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

Article 12 has been interpreted as an obligation on governments to take specific steps to protect and promote health.⁵³¹ The right to health can be viewed both as a “positive” right to government action or services necessary to maximize health and as a “negative” right to

⁵²⁵ Ngwena and Cook 112.

⁵²⁶ Swanepoel 293; Ngwena and Cook 109.

⁵²⁷ Swanepoel 293; Pieterse 27.

⁵²⁸ Section 41(6)(d) of The International Covenant on Economic, Social and Cultural Rights; Swanepoel 293.

⁵²⁹ Limburg Principles on the Implementation of the International Covenant of Economic, Social and Cultural Rights in Economic, Social and Cultural Rights: A Compilation of Essential Documents International Commission of Jurists, 1977 Para 21 63-78; Nevondwe and Odeku (2013) Mediterranean Journal of Social Sciences 839; Ngwena and Cook 113.

⁵³⁰ Nevondwe and Odeku (2013) Mediterranean Journal of Social Sciences 839; Ngwena and Cook 113.

⁵³¹ Rosenthal and Sundram 27; Ngwena and Cook 113.

protection against unhealthy or dangerous conditions.⁵³² The Committee on Economic, Social and Cultural Rights' General Comment 14 provides the most authoritative interpretation of the right to health, and confirms that the right to health is not a right to be healthy.⁵³³ It is a right to facilities, goods, services, and conditions conducive to the realisation of the highest attainable standard of physical and mental health.⁵³⁴ The General Comment articulates a framework of norms and obligations that make up the right to health including, among other things, freedoms, entitlements, non-discrimination and equality, participation, international assistance and cooperation, and monitoring and accountability.⁵³⁵ The CESCR in General Comment 14 described the right to health in terms of both freedoms (right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference such as the right to be free from torture, non-consensual treatment and experimentation) and entitlements (the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable level of health).⁵³⁶

General Comment 14 also establishes that the right to health is “related to and dependent upon the realisation of other human rights as contained in the International Bill of Rights”, therefore it is important to recognise that implementation of the full range of human rights is essential in order to guarantee the right to health.⁵³⁷ The right to the “underlying determinants of health” also falls under the right to health.⁵³⁸ General Comment 5 makes clear that under Article 12 of the CESCR, governments are required to provide healthcare services “in such a way that the persons concerned are able to maintain full respect for their rights and dignity.”⁵³⁹ General Comment 14 refers to a range of health issues, including mental healthcare, it adopts a generic approach to the right to health.⁵⁴⁰ Hunt and Mesquita state that the generic analytical framework first identified in General Comment 14 and subsequently

⁵³² *Ibid*; Pieterse 11.

⁵³³ Hunt and Mesquita (2006) *Human Rights Quarterly* 341; Ngwena and Cook 115.

⁵³⁴ *Ibid*.

⁵³⁵ *Ibid*.

⁵³⁶ Rosenthal and Sundram 27; Pieterse 11; Ngwena and Cook 115.

⁵³⁷ Rosenthal and Sundram 27; Pieterse 12.

⁵³⁸ Rosenthal and Sundram 27; Pieterse 13.

⁵³⁹ Rosenthal and Sundram 27; Pieterse 12.

⁵⁴⁰ Hunt and Mesquita (2006) *Human Rights Quarterly* 341.

elaborated in the Special Rapporteur's reports needs to be applied to specific health specialisations, such as mental health, and to groups, such as persons with disabilities.⁵⁴¹

The right to the highest attainable standard of mental health under Article 12 entails a right on to services that are available, accessible (accessibility goes beyond physical access. it requires that services be affordable and available in a non-discriminatory manner), acceptable (culturally appropriate and respectful of medical ethics), and of appropriate and good quality (culturally acceptable, medically appropriate, and provided in a safe and clean environment).⁵⁴² To be appropriately available, services must be provided in "sufficient quantity" by "trained medical and professional personnel".⁵⁴³ The United Nations Committee on Economic, Social and Cultural Rights issued General Comment 14: The Right to the Highest Attainable Standard of Health that conceives the right to health as indispensable for the exercise of other human rights and that it encompasses public health and health care, as well as other conditions necessary for people to live healthy lives.⁵⁴⁴ General Comment 14 applies directly to states that have ratified the ICESCR, though broad acceptance over a period of time may lead to its recognition as customary international law.⁵⁴⁵

The CRPD guarantees the highest attainable standard of health for persons with disabilities and sets out the duty of the state to ensure access to health services, including early identification and intervention, and services to minimise and prevent further disabilities and rehabilitative services.⁵⁴⁶ The duties of State Parties under Article 25 include: providing persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including sexual and reproductive health and population-based public health programmes; providing those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons; providing these health services as

⁵⁴¹ *Ibid.*

⁵⁴² General Comment 14 at 12(a) - (d); Rosenthal and Sundram 27; Pieterse 13; Ngwena and Cook 116.

⁵⁴³ General Comment 14 at 12(a) - (d); Rosenthal and Sundram 27; Ngwena and Cook 116.

⁵⁴⁴ Gostin and Gable (2004) Maryland Law Review 103; Rosenthal and Sundram 14; Pieterse 11; Ngwena and Cook 117.

⁵⁴⁵ Gostin and Gable (2004) Maryland Law Review 109. Rosenthal and Sundram 14.

⁵⁴⁶ CRPD Article 25.

close as possible to people's own communities, including in rural areas; and to require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, *inter alia*, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care. Article 9 of the CRPD also provides that states have a duty to eliminate obstacles to accessibility as it applies to physical environment, transportation, information and services to the public in urban and rural areas, including medical facilities and emergency services.

The right to health in the CRPD contains both freedoms and entitlements, the freedoms include the right to control over one's health and body, the right to sexual and reproductive freedom, and the right to be free from cruel, degrading and inhuman treatment.⁵⁴⁷ The entitlements include a positive right to a system of health of health protection providing equality of opportunity for people to enjoy the highest attainable standard of health.⁵⁴⁸

The notion of “availability” requires the existence of functional health services, including trained health professionals and adequate treatment facilities and the term “accessibility” ensures that health facilities and services are available to all and prohibits discrimination and economic, geographic, physical and information barriers to access.⁵⁴⁹ Health services must be acceptable under medical ethics standards and from the perspective of cultural traditions.⁵⁵⁰ Violations to the right to health can occur through omission or action, where the state either takes no sufficient steps towards the progressive realisation of the right to health or where it makes policies that cause harm.⁵⁵¹ The UNCESCR has indicated that the standard of progressive realisation requires states to take “deliberate and concrete” steps in an effort to “move as expeditiously and effectively as possible” towards full realisation of the rights in the

⁵⁴⁷ Gostin and Gable (2004) Maryland Law Review 109; Hunt and Mesquita (2006) Human Rights Quarterly 343.

⁵⁴⁸ *Ibid*; Pieterse 11.

⁵⁴⁹ Gostin and Gable (2004) Maryland Law Review 109; Hunt and Mesquita (2006) Human Rights Quarterly 345.

⁵⁵⁰ Gostin and Gable (2004) Maryland Law Review 105; Hunt and Mesquita (2006) Human Rights Quarterly 347.

⁵⁵¹ *Ibid*; Pieterse 14.

ICESCR.⁵⁵² A violation by omission will not occur where there are lacking resources but the state is willing to comply.⁵⁵³ States must also “strive to ensure the widest possible enjoyment of the relevant rights” within prevailing resource constraints and prioritise expenditure aimed at satisfying the needs of the most vulnerable sectors of society.⁵⁵⁴ Although the concept of progressive realisation of rights give governments more time to comply with human rights laws, it does not provide an excuse for lack of progress due to the misdistribution of resources rather than the lack of resources.⁵⁵⁵

The international right to physical and mental health is subject to progressive realisation and resource constraints.⁵⁵⁶ This has several important implications, namely that all states are expected to be doing better in five years time than what they are doing today (i.e., progressive realisation); and what is legally required of a developed state is a higher standard than what is legally required of a developing country (i.e. resource constraints).⁵⁵⁷ Certain elements of socio-economic rights may be immediately enforceable.⁵⁵⁸ It has for instance been shown that the equality-guarantee underlying the protection of rights such as the right to health is immediately enforceable and operates unaffected by resource availability or progressive realisation.⁵⁵⁹ Due to their resonance with autonomy rights protected under the International Covenant on Civil and Political Rights the same may be said for health-related freedoms, such as the right to be free from non-consensual medical treatment.⁵⁶⁰

While many elements of the right to physical and mental health are subject to progressive realisation and resource availability, there is a great deal that countries can do, even with very

⁵⁵² Pieterse 14.

⁵⁵³ Gostin and Gable (2004) *Maryland Law Review* 105; Ngwena and Cook 117.

⁵⁵⁴ Pieterse 14.

⁵⁵⁵ Kanter 213.

⁵⁵⁶ Article 2(1) of the ICESCR; Hunt and Mesquita (2006) *Human Rights Quarterly* 342.

⁵⁵⁷ Hunt and Mesquita (2006) *Human Rights Quarterly* 342.

⁵⁵⁸ Hunt and Mesquita (2006) *Human Rights Quarterly* 342.

⁵⁵⁹ Limburg Principle 35; UNCESCR General Comment 14 par 30; Pieterse 14; Hunt and Mesquita (2006) *Human Rights Quarterly* 342.

⁵⁶⁰ Pieterse 14; Hunt and Mesquita (2006) *Human Rights Quarterly* 342.

limited resources, toward the realisation of the right.⁵⁶¹ For example, even a country with limited resources can:⁵⁶²

- include the recognition, care, and treatment (where appropriate) of mental disabilities in training curricula of all health personnel;
- promote public campaigns against stigma and discrimination of persons with mental disabilities;
- support the formation of civil society groups representative of mental healthcare users and their families;
- formulate modern policies and programs on mental disabilities;
- downsize psychiatric hospitals and, as far as possible, extend community care; and
- actively seek assistance and cooperation that benefits persons with mental disabilities from donors and international organisations.

Article 16 of the African Charter determines that every individual shall have the right to enjoy the best attainable state of physical and mental health, and that State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Principle 1 of the MI Principles underlines fundamental freedoms and rights to the “best available” mental health care; dignity; protection from exploitation, physical or other abuse, and degrading treatment; non-discrimination; natural justice prior to a finding of incapacity; and generally the right to exercise all rights found in the International Bill of Human Rights and other instruments.⁵⁶³ Principle 3 states that care should where possible rather be administered in the community, as it recognises the difficulties faced in protecting human rights in institutions.⁵⁶⁴ The duty to treat patients in the least restrictive environment and

⁵⁶¹ Hunt and Mesquita (2006) *Human Rights Quarterly* 342.

⁵⁶² Hunt and Mesquita (2006) *Human Rights Quarterly* 342; WHO, *World Health Report 2001*, World Health Organization (WHO), *The World Health Report 2001: Mental Health: New Understanding, New Hope 1* (2001), at 112–15.

⁵⁶³ Gostin and Gable (2004) *Maryland Law Review* 38.

⁵⁶⁴ *Ibid.*

improve their autonomy in Principle 9 reinforces the preference for community care.⁵⁶⁵ Principle 9(2) of the MI Principles states that “the treatment and care of every patient shall be based on an individually prescribed plan discussed with the patient, reviewed regularly, revised as necessary and provided by professional staff.”

MI Principle 8 recognises that, within health care systems, a person with mental disabilities “shall have the right to receive such health and social care as is appropriate to his or her health needs” and that “every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff, or others, or acts causing mental distress or physical discomfort.” Besides treatment that is individualized to meet a particular person’s health needs, the treatment of every person must also be “suited to his or her cultural background.”⁵⁶⁶ Principle 8 is very important because it makes clear that improper medical or psychiatric treatment constitutes a form of prohibited “harm” similar to abuse by other staff or patients. Safeguards against abuse are thus an essential part of enforcing the right to health.⁵⁶⁷

MI Principle 14 requires qualified staff in sufficient numbers. Principle 4 requires that “a determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.” Thus, domestic legislation will need to incorporate standard diagnostic processes and standards such as those in the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Diseases and address the qualifications of persons who make determination of mental illness.⁵⁶⁸ General Comment 5 adds specific content to the right to health, specifying that it includes a right of access to rehabilitation services.⁵⁶⁹

Principle 13 of the MI Principles provides for rights and conditions in mental health facilities to enable them to meet the needs of patients, while principle 14 provides specifically for resources including:⁵⁷⁰

⁵⁶⁵ *Ibid.*

⁵⁶⁶ Rosenthal and Sundram 30.

⁵⁶⁷ Rosenthal and Sundram 56.

⁵⁶⁸ Rosenthal and Sundram (2004) 27.

⁵⁶⁹ General Comment 5 at 34; Rosenthal and Sundram (2004) 27.

⁵⁷⁰ Rosenthal and Sundram 28.

- a) qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a program of appropriate and active therapy;
- b) diagnostic and therapeutic equipment for the patient;
- c) appropriate professional care; and
- d) adequate, regular and comprehensive treatment including supplies of medication.

The right to individualized treatment entails an obligation on governments to provide professional services tailored to individual needs (a) in the best judgment of professionals, but also (b) respecting the preferences of the individual receiving services.⁵⁷¹ The respect for individual choice in treatment is a key principle underlying the right to informed consent to treatment as established in Principle 11.⁵⁷² MI Principle 11 establishes that “no treatment shall be given to a patient without their informed consent”. MI Principle 11 recognises the core principle that “no treatment shall be given” without informed consent, but there are several major exceptions to this right.⁵⁷³ Under MI Principle 11(6), involuntary treatment may be ordered by an “independent authority” in the case of a person detained in an institution involuntarily. The independent authority must find that the “patient lacks the capacity to give or withhold informed consent” and that treatment is “in the best interest of the patient’s health needs.” Under MI Principle 11(8), a “qualified mental health practitioner” may order involuntary treatment if they determine that treatment is “urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons.”⁵⁷⁴ Hunt and Mesquita criticise MI Principle 11 and state that in practice the combined effect of the extensive exceptions and qualifications to informed consent tends to render the protection almost meaningless.⁵⁷⁵ They state that procedural safeguards to the involuntary admission of mentally ill persons is important as it amounts to an extremely serious interference with the

⁵⁷¹ Rosenthal and Sundram 30.

⁵⁷² Rosenthal and Sundram 34; Hunt and Mesquita (2006) *Human Rights Quarterly* 332-356 343.

⁵⁷³ Rosenthal and Sundram 36.

⁵⁷⁴ Rosenthal and Sundram 36.

⁵⁷⁵ Hunt and Mesquita (2006) *Human Rights Quarterly* 332-356 343.

right to liberty and security,⁵⁷⁶ and that it is crucial to note that the freedom element in the right to health is subject to neither progressive realisation nor resource availability.⁵⁷⁷

Finally, it is important to recognise that the lack of economic resources in any country is not a reason to limit any of the rights established by human rights conventions or standards, including the MI Principles or the Standard Rules.⁵⁷⁸ “While development facilitates the enjoyment of all rights,” the Vienna Declaration notes that “the lack of development may not be invoked to justify the abridgement of internationally recognised human rights.”⁵⁷⁹

Principle 2 of the WHO's Ten Basic Principles determines that adequate quality healthcare preserves the dignity of patients; provide accepted and relevant clinical and nonclinical care aimed at reducing the impact of the disorder and improving the quality of life of the patient; maintains a mental health care system of adequate quality (including primary health care, outpatient, inpatient and residential facilities). Also Principle 2 states that access to mental health care should be affordable and equitable, and mental health care should be geographically accessible. Principle 2 recognises that access to health care, including mental health care, is contingent upon the available human and logistical resources, and suggests actions to promote access to health care as follows:

- Having a specific provision in the law which guarantees quality health care, preferably a general provision on health care applying to mental health by extension;
- Having medical practices in keeping with quality assurance guidelines such as those developed by WHO;
- Having developed or adapted at national level quality assurance guidelines and instruments by and for all qualified professionals or governmental bodies;
- Offering mental health care which is culturally appropriate;

⁵⁷⁶ The importance of procedural safeguards was discussed in *Winterwerp v. The Netherlands*, App. No. 301/73, Eur. Ct. H.R. (1979) and *Purohit and Moore v. Gambia African Comm'n. on Hum. and Peoples' Rts.* Comm. No. 241/2001 (2003) par 30, 45, 85; *Rosario Congo v. Ecuador*, Case No. 11.427, Inter-Am. C.H.R., Report No. 63/99, OEA/ Ser.L/V/II.102, doc. 6 rev. (1998) par 55-59; *Hunt and Mesquita* (2006) *Human Rights Quarterly* 332-356 344.

⁵⁷⁷ *Hunt and Mesquita* (2006) *Human Rights Quarterly* 332-356 343-344.

⁵⁷⁸ Rosenthal and Sundram 19.

⁵⁷⁹ Vienna Declaration 10; Rosenthal and Sundram 19.

- Introducing a mental health component into Primary Health Care;
- Having mental health care geographically “accessible” according to WHO's indications by making basic mental health care available within one hour walking or travelling distance; and by making available the essential drugs identified by WHO (or drugs of the same family with similar properties: amitriptyline, biperiden, carbamazepine, chlorpromazine, clomipramine, diazepam, fenobarbitone, fluphenazine decanoate, haloperidol, imipramine, lithium carbonate and temazepam).

The European Court of Human Rights has issued several judgements relating to mental health and health care.⁵⁸⁰ Among its decisions, the Court has held that a psychiatric wing of a prison is not an appropriate place for “therapeutic” detention;⁵⁸¹ that particular treatment and inadequate medical care and monitoring of mentally ill persons in detention may amount to inhumane and degrading treatment;⁵⁸² and that detention for psychiatric reasons must involve a qualified psychiatric opinion.⁵⁸³ The African Commission on Human and Peoples’ Rights has only issued one decision focusing on mental disabilities, *Purohit and Moore v Gambia* (2002).⁵⁸⁴ The case is a landmark decision because it represents the first decision by an international mechanism finding a violation of the right to health on account of inadequate mental healthcare.⁵⁸⁵

In Chapter 6 the question of whether the State is failing to take sufficient steps towards the progressive realisation of the right to access to health is discussed in the light of statistics of regressing budgets, the fact that mental health budgets are not on par with general health

⁵⁸⁰ Hunt and Mesquita (2006) Human Rights Quarterly 332-356 339. For a fuller discussion of the European Court’s jurisprudence see, among others: Lewis ‘Protecting the Rights of People with Mental Disabilities: The European Court of Human Rights’ 9 Eur. J. Health L. 293 (2002).

⁵⁸¹ Aerts v Belgium, App. No. 25357/94, Eur. Ct. H.R. (1998) at 46. The Court held that there must be some relationship between the ground of permitted deprivation of liberty relied on and the place and conditions of detention. In principle, the “detention” of a person as a mental health patient will only be “lawful” for the purposes of subparagraph (e) of paragraph 1 if effected in a hospital, clinic or other appropriate institution (Hunt and Mesquita (2006) Human Rights Quarterly 332-356 339)

⁵⁸² Keenan v United Kingdom, App. No. 27229/95, Eur. Ct. H.R. (2001); Hunt and Mesquita (2006) Human Rights Quarterly 332-356 339.

⁵⁸³ Varbanov v Bulgaria, App. No. 31365/96, Eur. Ct. H.R. (2000); Hunt and Mesquita (2006) Human Rights Quarterly 332-356 339.

⁵⁸⁴ Purohit and Moore v. Gambia, African Comm’n. on Hum. and Peoples’ Rts. Comm. No. 241/2001 (2003)

⁵⁸⁵ Hunt and Mesquita (2006) Human Rights Quarterly 340.

budgets, and that there are not enough mental health professionals to service mental health care users to a reasonable standard.

2.4.11 The Rights of Children

Section 28(1) of the Constitution provides that every child has the right: to basic nutrition, shelter, basic health care services and social services;⁵⁸⁶ to be protected from maltreatment, neglect, abuse or degradation;⁵⁸⁷ not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under Sections 12 and 35.⁵⁸⁸ The child may be detained only for the shortest appropriate period of time, and has the right to be:⁵⁸⁹

- kept separately from detained persons over the age of 18 years; and
- treated in a manner, and kept in conditions, that take account of the child's age.

Every child also has the right to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and discuss constitutional rights relevant to mental health care and the child.⁵⁹⁰ A child's best interests are of paramount importance in every matter concerning the child, as stated in Section 28(2), and "child" means a person under the age of 18 years.⁵⁹¹ The Ethical Code for Psychologists also safeguards the rights of children and stipulates that: "A psychologist shall be cognisant that a child's best interests are of paramount importance in every professional matter concerning direct or indirect psychological services to children."⁵⁹²

Swanepoel⁵⁹³ opines that there are serious concerns about the placement, treatment and care of children in need of mental health care in South Africa and lists the problems inherent to the situation as follows:

⁵⁸⁶ Section 28(1)(c).

⁵⁸⁷ Section 28(1)(d).

⁵⁸⁸ Section 28(1)(g).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Section 28(1)(h).

⁵⁹¹ Section 28(3).

⁵⁹² Swanepoel 236.

⁵⁹³ Swanepoel 234.

- The criteria for admitting children in psychiatric institutions and the procedures followed for admission;
- whether children admitted to psychiatric institutions for observation are separated from institutionalised children receiving care on a continuing long-term basis;
- The staffing of the psychiatric wards, including: Whether staff members are specifically trained to care for children and young people or for children with special needs; and whether staff members receive continued training on how to care for such children.
- The procedures followed by staff when an incident occurs, including: Internal investigations to determine the cause of the incident and the course of action to remedy the situation; disciplinary measures taken by staff to discipline children when they break the rules in a ward or cause an incident; and notification of parents and family of children involved and/or injured in an incident.
- Safety measures to prevent children from absconding from the psychiatric institution and procedures followed by staff when children have absconded from the institution;
- The procedures followed to re-admit children who have absconded from a psychiatric institution, including: Treatment of children by staff members when they are returned to the psychiatric institution; appropriate measures to manage the behaviour of the children and the circumstances in which it would be necessary and appropriate to implement such measures; and disciplinary measures for absconding, taken by staff against the children, with specific reference to placing children in seclusion.
- The practice of placing children in seclusion with special reference to: guidelines for the staff and coherence to constitutional provisions on when and under which circumstances children may be placed in seclusion; whether there is a register recording when children are placed in seclusion and if so, what information is entered in the register and whether such information is sufficient.
- The authority of staff to discipline children and the extent of such authority, including measures allowed and under what circumstances.

Swanepoel further submits that child psychiatry represents a distinct field of practice, where training programs for children suffering from mental disorders should be integrated within departments of psychiatry through divisional administrative lines.⁵⁹⁴ The training of mental health practitioners and whether the regulations pertaining thereto complies with the rights of the child is discussed in Chapter 3.

According to the Children's Act⁵⁹⁵ in Sections 129(1) to (3), a child may consent to medical treatment or a surgical operation, provided the child is at least twelve years of age; and is of sufficient maturity and has the mental capacity to understand the benefits, risks and social implications of the treatment or operation.⁵⁹⁶ A child may not consent to a surgical operation without the assistance of the parent of the child; or the primary caregiver of the child.⁵⁹⁷ The parent or primary caregiver of a child may consent to the medical treatment of or a surgical operation on the child if the child is under the age of twelve years; or over that age but is of insufficient maturity or does not have the mental capacity to understand the benefits, risks and social implications of the treatment or operation.⁵⁹⁸

A key distinction between Section 28 of the Constitution governing the rights of children to, among other things, the provision of basic health care services, is that Section 28 is not qualified by a “progressive realisation” clause, implying that the rights of children regarding access to healthcare can be interpreted as intending that a minimum core provision of health services is ensured for children.⁵⁹⁹ This concept was rejected in the *Grootboom* and *TAC* cases, where the court held that the State must take reasonable legislative and other measures to ensure the realisation of children's rights in the light of available resources, and that children's rights to health care in terms of Section 28(1)(c) of the Constitution are not separate from the rights of their parents to access to health care, but rather a subset of the broader

⁵⁹⁴ Swanepoel 135.

⁵⁹⁵ 35 of 2008.

⁵⁹⁶ McQuoid-Mason, D, Dhali, A, and Gardner, J. ‘Consent’ in in Dhali, A. and McQuoid-Mason, D. ‘Bioethics, Human Rights and Health law: Principles and Practice’ (2011) 79.

⁵⁹⁷ *Ibid.*

⁵⁹⁸ *Ibid.*

⁵⁹⁹ Carstens and Pearmain 78; Buchner and Nienaber (2012) PER/PELJ 112.

right.⁶⁰⁰ The Court held also that the primary duty to provide for a child's basic needs rests with the parents,⁶⁰¹ where the parents then fail the State has to step in.⁶⁰² This has been criticised as it grants less rights to children as guaranteed in the CRC and Constitution, placing the rights of children above the rights of others.⁶⁰³

Buchner and Nienaber state that there is currently no comprehensive legislation in South Africa that regulates the health care rights of children, and that currently these rights are primarily dealt with by the National Health Act, the MHCA and the Children's Act.⁶⁰⁴ They criticise the National Health Act in that it does not describe and regulate basic health care and basic nutrition and therefore does not regulate the minimum services the State should provide to children under the Constitution.⁶⁰⁵ The MHCA, although containing an entire chapter dealing with the rights of mental health care users, does not specifically mention children.⁶⁰⁶ The National Health Act and the Children's Act⁶⁰⁷ include children in medical decision-making. It should be noted that to date no attempt has been made to determine the extent to which these legislative provisions are being implemented in practice.⁶⁰⁸

Article 4(3)(a) of the National Health Act provides free health care services at public health institutions to children under the age of six years, and Section 4(1) provides for provision of such services to children over the age of six years at the discretion of the Minister of Health.⁶⁰⁹ It is submitted that this provision can be criticised in light of the definition of a child as a person under the age of 18 years and that the State should progressively realise the right to free public health care services to all children of any age.

⁶⁰⁰ Government of the RSA v Grootboom 2001 (1) SA 46 (CC); Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC); Carstens and Pearmain 79-81; Buchner and Nienaber (2012) PER/PELJ 124.

⁶⁰¹ Bekink and Brand "Constitutional Protection of Children" in Davel (ed) "Introduction to Child Law in South Africa" 2000 188.

⁶⁰² Buchner and Nienaber (2012) PER/PELJ 125.

⁶⁰³ Buchner and Nienaber (2012) PER/PELJ 123.

⁶⁰⁴ Buchner and Nienaber (2012) PER/PELJ 113.

⁶⁰⁵ *Ibid.*

⁶⁰⁶ Buchner and Nienaber (2012) PER/PELJ 117.

⁶⁰⁷ In section 129 as mentioned in this chapter above.

⁶⁰⁸ Buchner and Nienaber (2012) PER/PELJ 136.

⁶⁰⁹ Buchner and Nienaber (2012) PER/PELJ 115.

2.4.11.1 International law considerations

The Convention on the Rights of the Child (CRC) provides the strongest convention based statement of the right to services that promote community integration.⁶¹⁰ Article 24 of the CRC guarantees the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, and that States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. Article 24(2) of the CRC further provides for measures that States Parties should take to ensure realisation of the right,⁶¹¹ and thus advocates for a holistic approach to health.⁶¹² Article 24 cannot be viewed in isolation from the other provisions in the CRC.⁶¹³

Article 23 on the rights of children with disabilities particularly emphasises these rights by recognising that a mentally or physically disabled child should enjoy a full and decent life, in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community. Article 23(3) requires that service systems be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's receiving the fullest possible social integration and individual development. Special protections are thus required in domestic legislation to ensure the community integration of children with disabilities.⁶¹⁴

⁶¹⁰ Rosenthal and Sundram 34; Buchner and Nienaber (2012) PER/PELJ 108.

⁶¹¹ Section 24(2) of the CRC determines:

- a) "States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality;
- b) (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- c) (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers;
- d) (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child."

⁶¹² Buchner and Nienaber (2012) PER/PELJ 108.

⁶¹³ Buchner and Nienaber (2012) PER/PELJ 108.

⁶¹⁴ Rosenthal and Sundram 34.

Article 9(1) of the CRC determines that State Parties shall ensure that a child shall not be separated from his or her parents against their will, unless competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Article 12(1) of the CRC provides that State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

According to Article 30, in those States in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language. Article 14 of the CRC further determines that State Parties shall respect the right of the child to freedom of thought, conscience and religion; respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child; and provide freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.

Article 16 of the CRC states that no child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honour and reputation. Article 24 provides that State Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health; and shall strive to ensure that no child is deprived of his or her right of access to such health care services. Article 37 of the CRC provides that no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment, and that no child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time. Until 2003 Section 24 of the CRC was not subject to availability of resources, but General Comment 5 of the UN Committee on the Rights of the Child was issued in 2003 to give guidance to States Parties and determines in Par 7: “The second sentence of Article 4 reflects a realistic acceptance that lack of resources – financial and other resources – can

hamper the full implementation of economic, social and cultural rights in some States; this introduces the concept of ‘progressive realisation’ of such rights: States need to be able to demonstrate that they have implemented ‘to the maximum extent of their available resources’ and, where necessary, have sought international cooperation...”⁶¹⁵

2.4.12 Right to Just Administrative Action

Section 33(1) of the Constitution states that everyone has the right to administrative action that is lawful, reasonable and procedurally fair, and everyone whose rights have been adversely affected by administrative action has the right to be given written reasons.⁶¹⁶ The principle of legality ensures that those who exercise public power over others may only act when empowered to do so and within the limits of the empowering provision.⁶¹⁷ In Chapter 3 and 4 the question of whether a decision by a Mental Health Review Board constitutes administrative action is discussed, especially pertaining to the remedies provided for in the MHCA if a mental health care user has been adversely affected by such a decision.

2.4.13 Right of Access to Information

Section 32(1)(b) of the Constitution determines that everyone has the right of access to any information held by another person and that is required for the exercise or protection of any rights. This right includes the right of a person to have access to their own medical records.⁶¹⁸

2.4.14 The rights of arrested, detained and accused persons

Section 35(1) of the Constitution determines that everyone arrested for allegedly committing an offence has the right to remain silent and to be informed promptly of this right and of the consequences of not remaining silent; that no person may be compelled to make any confession or admission that could be used in evidence against that person; and to be released

⁶¹⁵ Buchner and Nienaber (2012) PER/PELJ 110.

⁶¹⁶ Section 33(2).

⁶¹⁷ Landman and Landman 10.

⁶¹⁸ Potgieter v Lid van die Uitvoerende Raad: Gesondheid en Provinsiale Regering Gauteng en Andere (2001) 11 BCLR 1175 (CC).

from detention if the interests of justice permit, subject to reasonable conditions. According to Section 35(2), everyone who is detained, including every sentenced prisoner, has the right to be informed promptly of the reason for being detained, and to be detained in conditions consistent with human dignity and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment. The provisions of Section 35 apply to mentally disordered persons who are being detained as voluntary, involuntary, or assisted users in terms of the MHCA; as well as to mentally disordered persons who have been arrested but not charged with an offence, mentally disordered accused persons who are on trial, mentally ill persons under observation in terms of the Criminal Procedure Act, and mentally ill prisoners.

Detainees' health interests have been singled out for protection because of their inability to procure access to medical services for themselves, and because of the various potential health hazards posed by incarceration.⁶¹⁹ While limited to the provision of such health services as are "adequate" in light of the broader entitlement to dignified conditions of detention, it may be submitted that Section 35(2)(e) encompasses at least an entitlement to receive primary health care services, non-compliance with which is capable of justification only in terms of Section 36 of the Constitution, and that it entitles prisoners to have their individual health needs considered in all decisions impacting on the duration, locality and conditions of their detention.⁶²⁰ Therefore, as Section 35 of the Constitution is not expressly connected to the "progressive realisation" provision in Section 27(2) regarding the right to health, it can be argued that the rights of prisoners to adequate health care services, including mental health care services, are a priority area. Especially considering that a mentally ill prisoner is doubly vulnerable due to their illness as well as the position of power the state has over them during their detention. Indefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be cruel punishment.⁶²¹

⁶¹⁹ Pieterse 23.

⁶²⁰ Pieterse 24.

⁶²¹ Swanepoel (2011) Potchefstroom Electronic Law Journal 139.

In South Africa, prisoners enjoy a direct and immediate entitlement to the goods and services guaranteed by the constitution.⁶²² Section 237 in turn provides that all constitutional obligations must be performed diligently and without delay.⁶²³ Section 21(2)(b)(vi) enjoins the Director-General to “issue, and promote adherence to norms and standards on health matters, including health services for convicted persons and persons awaiting trial”.⁶²⁴ The Correctional Services Act places a duty on the Department of Correctional Services to provide all prisoners with adequate health care services.⁶²⁵ The Department must provide, within its available resources, adequate health care services, based on the principles of primary health care, to allow every prisoner live a healthy life in terms of Section 12(1).⁶²⁶

An individual sent for psychiatric observation should be informed properly of the reason for their referral or understand what the assessment encompasses.⁶²⁷ Either the accused’s own council or an officer of the court should explain the process before an accused is admitted to a facility and before conducting the inquiry, an attempt must be made to explain the forensic procedure, the possible outcomes and that the usual rules of confidentiality do not apply.⁶²⁸

There is a deceptive opinion that no treatment should be administered during the observation period of persons accused of crimes in terms of the Criminal Procedure Act as it may interfere with the assessment of the accused’s mental state.⁶²⁹ Kaliski is of the opinion that if there is a history of psychiatric illness and a record that shows the accused is on treatment, that it should be continued.⁶³⁰ There is less clarity when there is no history of treatment or when the only issue is competence to stand trial as opposed to criminal capacity at the time of the offence.⁶³¹ The state owes a duty to provide a person who is involuntarily detained due to a mental disorder with reasonable medical attention.⁶³² If medical attention reasonably well adapted to

⁶²² Nevondwe and Odeku (2013) *Mediterranean Journal of Social Sciences* 841.

⁶²³ *Ibid.*

⁶²⁴ *Ibid.*

⁶²⁵ Nevondwe and Odeku (2013) *Mediterranean Journal of Social Sciences* 843.

⁶²⁶ *Ibid.*

⁶²⁷ Kaliski, S. (ed.) “Psycholegal assessment in South Africa” 2006 94; Kaliski ‘Defendants are clueless – the 30 day psychiatric observation’ 1997 *South African Medical Journal* 1351-1355 1351.

⁶²⁸ Kaliski 95.

⁶²⁹ Kaliski 101.

⁶³⁰ *Ibid.*

⁶³¹ *Ibid.*

⁶³² Swanepoel (2011) *Potchefstroom Electronic Law Journal* 138.

his or her needs is not given, the person is not a patient but virtually a prisoner. The absence of treatment might draw the constitutionality of the mandatory access to health care services into question. It is also submitted by the author that failure to supply treatment may violate the right to access to healthcare, the rights of arrested, detained and accused persons to medical care, and the right to equality.

Section 15(1) of the MHCA determines that a mental health care user is entitled to a representative, including a legal representative, when:

- a) Submitting an application;
- b) Lodging an appeal; or
- c) Appearing before a magistrate, judge or a Review Board, subject to the laws governing rights of appearances at a court of law.

Section 15(2) states that an indigent mental health care user is entitled to legal aid provided by the State in respect of any proceeding instituted or conducted in terms of this Act subject to any condition fixed in terms of Section 3(d) of the Legal Aid Act 22 of 1969. Furthermore, section 17 of the MHCA states that every health care provider must, before administering any care, treatment and rehabilitation services, inform a mental health care user in an appropriate manner of their rights, unless the user has been admitted in emergent circumstances.

2.4.14.1 International law considerations

All of the International instruments mentioned contain some form of the rights of accused, detained and arrested persons and that such individuals must be treated fairly and with dignity. Article 1(e) of the ECHR permits detention of persons of “unsound mind” which has been interpreted as “true mental disorder” established by medical expertise and the disorder must be of a kind or degree warranting compulsory confinement, and continued confinement depends upon the persistence of such a disorder. Article 5 of the ECHR is a core provision governing arrest and detention, and protects the liberty and security of a person by to prevent

arbitrary deprivation of liberty.⁶³³ In *Ashingdon v United Kingdom*⁶³⁴ the ECtHR held that a person detained in a mental hospital under a compulsory detention order is also “detained” for the purposes of Article 5 and therefore entitled to its protection.

Principle 16 of the MI Principles sets out a set of legal standards and procedures for involuntary admission to hospital is adopted, stating that a mental health institution may only involuntarily admit a person if:

- 1) She has a mental illness diagnosed under internationally accepted medical standards; and
- 2) There is a serious possibility of immediate harm to the patient or others; or
- 3) If the patient is severely mentally ill, has impaired judgement, and there will be a drastic deterioration of the illness if the patient is not admitted.⁶³⁵

Principle 17 states that a patient will receive a fair hearing by a judicial or other independent and impartial review body to ensure involuntary admission meets the requirements.⁶³⁶ The patient may have representation in this hearing, may call independent experts, and can review all evidence and the reasons for the review body's decision.⁶³⁷ Principle 7 of the WHO's Ten Basic Principles states that there should be a review procedure available for any decision made by official or surrogate decision-makers and by health care providers, including judges and proxy decision-makers such as loved ones or the heads of health establishments. This principle includes the following components:

1. The procedure should be available at the request of interested parties, including the person involved;
2. The procedure should be available in a timely fashion (within three days of the decision);
3. The patient should not be prevented to access review on the basis of their health status;

⁶³³ Emmerson, Ashworth and Macdonald *et al.* 257.

⁶³⁴ (1985) 7 EHR 528 par 42.

⁶³⁵ Gostin and Gable (2004) Maryland Law Review 38.

⁶³⁶ *Ibid.*

⁶³⁷ *Ibid.*

4. The patient should be given an opportunity to be heard in person.

The importance of independent systems of review was a matter of human rights principle as affirmed in the case of *Winterwerp v The Netherlands*⁶³⁸ that requires that decisions about detention and treatment should be established by a competent national authority vested with the authority to approve ongoing treatment and confinement.⁶³⁹

2.5 Concluding remarks

This chapter sets out the framework of international human rights instruments, constitutionally guaranteed rights, and domestic legislation that pertains to the persons with mental disorders, including mental health care users (voluntary, involuntary or assisted), arrested and accused mentally disordered persons, and mentally ill prisoners. The purpose is to provide a standard against which to measure mental health laws that regulate matters regarding mentally disordered individuals in the chapters to come. The legislature and policy makers have great capacity to translate the mental health-related rights in the Constitution into lived reality through establishing a rights-based framework for access to health care services, but the limitations of legislation-driven health reform are highlighted in that legislative and executive tardiness, whether due to lack of capacity, lack of political will, competing priorities or other external pressures, has significantly hampered the effective translation of rights into practice.⁶⁴⁰ Legislation and policy can make abstract constitutional rights tangible by providing claimable entitlements to the beneficiaries of rights.⁶⁴¹

In Chapter 3 the regulation of the health profession is analysed to establish whether those provisions comply with the human rights principles and Constitutional mandate discussed in this chapter. Chapter 3 also discusses the psychology and psychiatric medicine underlying legal concepts and laws to ascertain whether the current legal framework is rooted in accepted science. In Chapter 4 the MHCA and its regulations are discussed against the backdrop of

⁶³⁸ (1979) 2 EHRR 387.

⁶³⁹ Weller 60.

⁶⁴⁰ Pieterse 49.

⁶⁴¹ Pieterse 57.

mental health care users' rights to establish whether the provisions and forms used in the execution of procedure promotes the protection of rights and the intention of the legislator. In Chapter 5 the criminal law and procedure that may affect mentally disordered persons are discussed, including a substantive discussion of the criminal law and analysis of the Criminal Procedure Act, and State Patients referred for observation are also discussed, as well as mentally ill prisoners. In Chapter 6, the practical implementation of mental health laws is discussed against the backdrop of human rights and the duties of the State.

CHAPTER 3: MENTAL HEALTH CARE PRACTICE: CONTEXT, CONCEPTS, CLASSIFICATION AND REGULATION IN SOUTH AFRICA

3.1 Introduction

This chapter lays a basic foundation of the clinical aspects of mental illness in psychiatry and psychology of importance in legal and forensic contexts to determine whether current mental health laws, criminal law and criminal procedure are legitimately based on accepted scientific, medical and psychological principles and whether psychiatric and psychological concepts are reconcilable with legal concepts in South Africa. This includes a discussion of the concepts of mental illness or disorder, the diagnosis and classification of diseases in a clinical and forensic context, and the role of the forensic mental health expert. The effect of culture in South Africa on the effective diagnosis and treatment in mental health care is also discussed in this chapter, especially concerning the recent adoption of the Traditional Health Practitioners Act¹ and its regulations. The mental health professions are discussed regarding the Health Professions Act² and the education and training requirements necessary to secure and maintain registration in terms of the Act. Lastly, this chapter contextualises mental health care in the national health system, particularly regarding mental health care institutions and their administration. Constitutionally guaranteed human rights, as discussed in Chapter 2, are referred to throughout this chapter to ascertain whether human rights abuses are being perpetrated, and to establish whether the State is fulfilling its constitutionally mandated duties relating to mentally disordered persons.

An in-depth analysis of clinical theory that covers all of psychiatry and psychology is unfeasible and outside the scope of the current study. A discussion of treatment and diagnostic methods in mental health care is outside the scope of this thesis, which concerns itself only with the conceptualisation of mental disorder and its classification for psycholegal purposes, and the regulation of the mental health professions. In this chapter it is assumed that diagnostic methods should be deferred to the expertise of the mental health care practitioner

¹ 22 of 2007.

² 56 of 1974.

and the question of whether these methods in themselves infringe upon the rights of mental health care users is a topic for another study.

Landman states that the MHCA brings the law into a close relationship with the mental health care profession and that law intrudes only in limited respects into the realm of medicine to protect human rights, or to convert good medical practises and some ethical considerations into legal obligations.³ It is submitted that Landman understates the interconnectedness between the law and mental health care, as the discussion of ethical decision-making in mental health practice in this chapter will illustrate by pointing out that ethical decision-making can only be achieved when a mental health professional has a proper knowledge of the legal and ethical system within which medicine is practiced. Law and ethics are intimately interrelated, as are ethics and medical decision-making.⁴ Due to the importance that accurate and standardised mental health assessments may have in private or public law, it is important that the legal and medical professions are in a position to interpret each other's language and terminology to effectively communicate, and act within acceptable and required parameters.

3.2 Conceptual differences between the legal and mental health care professions

3.2.1 Free will and determinism

Mental health care professionals follow a fairly deterministic school of thought, while the law presupposes freedom of will, which is the basis of criminal liability and more indeterministic⁵ Determinists are of the view that behaviour is influenced by circumstances (biological, psychological) and hence miscreants are not entirely to blame for their misdeeds.⁶ One crude

³ Landman, A.A. and Landman, W.J. 'A Practitioner's Guide to the Mental Health Care Act' (Cape Town; Juta& Co) 2014 14.

⁴See in general Dhali, A. and McQuoid-Mason, D. 'Bioethics, Human Rights and Health law: Principles and Practice' 2011; Moodley, K (ed.) 'Medical ethics, law and human rights: A South African Perspective' 2011.

⁵ Snyman, C.R. "Criminal law case book/Strafreg-vonnisbundel" 5th Edition 2013 148-149, The Rumpff Commission of Inquiry "Responsibility of Mentally Deranged Persons and Related Matters" RP 78/1967 (hereafter the 'Rumpff Report') 2 4; Burchell, J.M., Milton, J. "South African Criminal Law and Procedure Volume I: General Principles of Criminal Law" 4th Edition 2011 179.

⁶ Spammers, M. 'A critical analysis of the psycholegal assessment of suspected criminally incapacitated accused persons as regulated by the Criminal Procedure Act' (LLM dissertation, 2010, University of Pretoria, Pretoria) 19.

definition states that determinism is the hypothesis that everything that happens is caused by prior states in the world.⁷ The fundamental point is that everything that happens is taken to be sufficiently determined by prior states, therefore there could never have been any real alternatives to what actually happened.⁸ Whether determinism is true or not is still an open issue as there is not at the present stage of science a definitive answer.⁹ Determinism is a methodological supposition signifying the scientific area; that is if there is no known explanation as to why something happens, someone will search for one, and human behaviour is no exception.¹⁰ The indeterminists believe in free will, rational choice and if individuals choose to violate the law, they must be punished accordingly, working on the supposition that nothing that happens is predetermined.¹¹ According to Juth and Lorentzon, the indeterminist viewpoint regarding blameworthiness is moot, as it can be argued that if our actions are not determined by anything at all but randomness and arbitrariness, and if they truly happen out of the blue, we can also not be responsible for them.¹²

There are different approaches to interpreting what determinism means for moral blameworthiness, including libertarianism, compatibilism, and fatalism.¹³ Libertarianism is a position incompatible with determinism, claiming we could sometimes have acted differently than we did.¹⁴ Compatibilism is a popular position in the debate that attempts to reconcile free will with determinism which defines freedom as the power to act according to one's will, not being constrained by external or internal pressure to a degree that makes the action compelled.¹⁵ Compatibilism however does not actually state that our will is free: The will is caused by our character, our memories, our mood, and by our perception of the situation in

⁷ Juth and Lorentzon (2010) 'The concept of free will and forensic psychiatry' 33International Journal of Law and Psychiatry 1 1-6 2.

⁸ *Ibid.*

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ Chetty, V. (2008) "Incapacity to determine criminal capacity: mad or bad? A selected case study" *Acta Criminologica: CRIMSA Conference: Special Edition 2*: 129-138133; Kaliski, S. (2009) "My brain made me do it' - how neuroscience may change the insanity defence: editorial" 15 South African Journal of Psychiatry 1 4-6 4; Grant, J (2006) 'Determinism, neuroscience and responsibility' International Journal of Law in Context 2,3 221-231 224.

¹² Juth and Lorentzon (2010) International Journal of Law and Psychiatry 2. This view is supported by Grant, J (2006) 'Determinism, neuroscience and responsibility' International Journal of Law in Context 212-231 222.

¹³ Juth and Lorentzon (2010) International Journal of Law and Psychiatry 2; Grant (2006) International Journal of Law in Context 222.

¹⁴ *Ibid*; Grant (2006) International Journal of Law in Context 223.

¹⁵ Juth and Lorentzon (2010) International Journal of Law and Psychiatry 2.

which we act, leading to no true alternative choices as is advocated by libertarianism.¹⁶ Fatalism agrees with the libertarians that free will presupposes real alternatives, and with the compatibilist that there are no real alternatives on account of determinism being true.¹⁷ Libertarians believe we have this sort of freedom, fatalists do not.¹⁸ The conclusion to be drawn from the fatalist approach is not that we can never be blamed for anything we do, but rather that people are responsible for everything they do, based on the logic that since everything is strictly speaking predetermined, the fact that an action is predetermined is no excuse.¹⁹ Whether the determining factors are some psychiatric condition or something else is irrelevant.²⁰

Grant states that it is clear South African criminal law takes a libertarian view as it adopts the point of view of indeterminism, namely it accepts that man can direct his will regarding his actions.²¹ Criminal law does not allege that disposition, character, and environment exercise no influence in shaping the human will but holds all mentally sound persons accountable for punishable actions, irrespective of the influence of the factors mentioned in shaping the will.²² The importance of the question regarding free will and determinism plays no proper role in forensic practice or theory because the ability or not to act in accordance with one's own will is not a criterion of any civil or criminal law doctrine.²³ The criteria for criminal responsibility in the eyes of the law are not concerned with libertarian free will, but with mental states such as intention, capacity, and compulsion.²⁴ Whether a person can exercise free will, and in what circumstances they are accountable or should be held accountable for their actions is discussed further in Chapter 5 regarding the legitimacy of the criminal justice and corrective system and the current conceptualisation of criminal capacity in South Africa. In this chapter, it suffices to say that free will is a complex and controversial issue on which the legal profession and mental health care professions differ in viewpoint between and amongst

¹⁶ *Ibid.*

¹⁷ *Ibid.*; Grant (2006) *International Journal of Law in Context* 222-223.

¹⁸ *Ibid.*

¹⁹ Juth and Lorentzon (2010) *International Journal of Law and Psychiatry* 3.

²⁰ *Ibid.*

²¹ Grant (2006) *International Journal of Law in Context* 224.

²² *Ibid.*

²³ Juth and Lorentzon (2010) *International Journal of Law and Psychiatry* 4.

²⁴ *Ibid.*

themselves, leading to a complicated interface where the two spheres are called upon to collaborate.

3.2.2 Capacity and competence

While capacity in the legal sense refers to the ability to perform a specific juristic act, with criminal capacity encompassing the cognition to appreciate wrongfulness and the conation to act in accordance with this appreciation, capacity in the medical sense relates to the clinical evaluation of an individual's functional ability to make “autonomous, authentic decisions about his or her own life.”²⁵ Practically, capacity in the medical sense has been distilled into two components, namely; a person’s capacity to assimilate relevant facts and appreciation of their situation as it relates to the facts.²⁶ Thus a determination of mental capacity or a diagnosis of mental illness by a mental health professional does not necessarily simultaneously address the question if a person can be held to be legally capacitated.²⁷ Competency is discussed in Chapter 2 in relation to autonomy.

3.2.3 Legitimacy and purpose

Law, psychiatry and psychology, in spite of their differences, seek through conceptualisation procedures and techniques to codify, understand and correct human misbehaviour through punishment, rehabilitation and psychotherapy respectively.²⁸ Both law and psychology share a claimed interest in understanding and predicting human behaviour, but have different in terms of grounds of legitimate authority. Psychology is legitimated by means of scientific methodology in which objects appear in empirical reality and law by privileging logical argument and reason.²⁹ Legal practitioners want to protect their client’s fundamental rights,

²⁵ Zabow, T. “The Mental Health Care Act (17 of 2002)” in Kaliski, S. (ed.) .“Psycholegal assessment in South Africa” 2006 84; Spammers 2010 22.

²⁶ Zabow 85.

²⁷ Burchell and Milton 378; Zabow 85.

²⁸ Swanepoel, M “Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues” (Unpublished LLD thesis, 2009 Unisa) 2; Kruger, A. "Hiemstra's Criminal Procedure" 2008 13; Kotze, C., De Wet, PH. (2011) 'A 4-year review of psychiatrists' participation in prosecutorial workshops on criminal capacity' SAJP Vol 17 Nr 4 112-117 112.

²⁹ Tredoux, C.; Foster, D.; Allan, A.; Cohen, A.; Wassenaar, D. “Introduction” in Tredoux, C. *et al.* “Psychology and the law” 2008 25.

including a right to obtain treatment or refuse and rights within treatment.³⁰ Psychiatrists and psychologists advocate for the patient's interests as they understand them, not for their rights, and sometimes regard legal practitioners as practitioners preventing them from doing what is best for their patients.³¹ This tension between what is best for the patient from a paternalistic or medical perspective, and the rights of the patient which sometimes leads to them to making decisions contrary to their “best interests”, is a critical issue in the interface between the legal and mental health professions. What is in the best interest of the patient is a debatable topic, with the rights to autonomy and physical and mental integrity balanced between medical opinion and circumstances where that opinion overrides that of the patient. The law is obligated to ensure that patients’ rights are infringed as little as possible, while still recognising that in particular circumstances it needs to fulfil a paternalistic and protective role regarding vulnerable persons unable to make decisions for themselves.

The enactment of legislation is legitimised through the democratic parliamentary process in South Africa and the procedures mandated in the Constitution. The ways in which general medicine and mental health care practise are legitimised differ substantially. The key source of legitimising general medicine is the consent of the patient to be treated by the doctor, while mentally disordered patients may be incapable of giving a valid consent, or if they are capable of giving valid consent they may irrationally withhold consent to therapeutic interventions indicated as necessary in the interests of their wellbeing or for the protection of others.³² While general medicine is legitimised by consent and regulated almost wholly by medical, private and contract law, mental health care practice requires legitimisation through public law procedures sometimes as it may involve the intrusion of public authority into private life through the detention of a patient without their consent.³³

³⁰ Swanepoel 2.

³¹ *Ibid.*

³² *Ibid.*

³³ *Ibid.*

3.2.4 Conceptualising mental disorder in clinical and legal settings

Various concepts in law differ from those used in clinical language and it remains difficult for the psychiatrist to navigate the barriers of communication with the legal profession.³⁴ The clinical and legal definitions of “mental illness” differ significantly. The preciseness of scientific terminology is often achieved at the cost of clarity of meaning, and terms may have an entirely different connotation when used in lay language. It is therefore always important to explain terms to the court in lay terminology to prevent loss of the scientific meaning and to translate psychiatric knowledge into understandable opinions.³⁵ The essential, and obvious, starting point for a mental health professional during a psycholegal assessment is a thorough clinical assessment with accepted diagnoses, that should precede any consideration of the legal or juridical issues.³⁶ The mental health professional does therefore not start out an evaluation with legal principles and definitions in mind. The DSM-5 and ICD-10 are widely accepted standards of diagnosis used in the mental health profession and their use is discussed in-depth later in this chapter. DSM-5 refers to the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and ICD-10 to the International Classification of Diseases and Related Health Problems published by the World Health Organisation.³⁷ In clinical practice any diagnosis described and listed in the DSM-5 or ICD-10 manuals are regarded as disorders, including conditions that do not affect criminal responsibility or capacity.

Peay succinctly describes mental disorder as “a term of acute terminological inexactitude” and compares it to a concertina that expands and contracts depending on the scenario in which it is used to accommodate different client groups with little coherence.³⁸ The DSM-5

³⁴ Kotze and De Wet (2011) SAJP 112.

³⁵ Kotze and De Wet (2011) SAJP 112-113; Resnick, PJ. (1986) 'Perceptions of psychiatric testimony: A historical perspective on the hysterical incentive' Bull Am Acad Psychiatry Law 14 209-219.

³⁶ Kaliski 4.

³⁷ The ICD-11 is expected to be completed in 2017.

³⁸ Peay, J. (2002) 'Mental health professionals' attitudes towards legal compulsion: report of a national survey. International Journal of Forensic Mental Health 1 69-80 69.

acknowledges that the concept of mental disorder or mental illness lacks a definition that covers all situations.³⁹ “Mental disorder” is defined by the DSM-5 as follows:⁴⁰

“A mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one is not a mental disorder. Socially deviant behaviour (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual as described above.”

The DSM-5 definition was developed for clinical, public health, and research purposes and additional information is usually required to make legal judgements.⁴¹ The definition also seemingly rejects the philosophical criminological theory that all persons who commit crimes are in some way afflicted by mental disorder, compared to law abiding persons.

Mental illnesses present themselves through clusters of symptoms, or illness experiences.⁴² When these symptoms, or experiences, are associated with significant distress and impairment in one or more domains of human functioning (such as learning, working or family relationships), they are defined as clinically significant mental disorders, which include several distinct conditions that affect people across the life course, with diverse epidemiological characteristics, clinical features, prognoses and possible intervention strategies.⁴³ Mental health has multiple biological, psychological and social determinants that interact in a complex manner, to provide protection of mental health or increase the risk for the development of mental illness.⁴⁴ A person with mental illness may experience episodes of

³⁹ Kaliski 244; American Psychiatric Association “Diagnostic and statistical manual of mental disorders: DSM-5” 2013 xxx-xxxi (hereafter the ‘DSM-5’).

⁴⁰ DSM-5 20.

⁴¹ DSM-5 xxxi.

⁴² Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 11.

⁴³ *Ibid.* See also Vorster, M.(2005) "Psychiatry in the medico-legal setting" 11S Afr J of Psychiatry 2 42.

⁴⁴ Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 12. For example, a combination of genetic vulnerability, childhood trauma and adverse living circumstances brought about by poverty may predispose a particular woman to a major depressive episode.

mental ill-health, which interrupt that person's capacity to fulfil their work, family, social, academic and community roles.⁴⁵ The mental disorder might follow a chronic, episodic course, or may resolve after one or more episodes.⁴⁶ The relationship between poverty and mental ill-health has been described as a “vicious cycle”: people living in poverty are at increased risk of developing mental disorders through the stress of living in poverty, increased obstetric risks, lack of social support, increased exposure to violence and worse physical health, and persons with mental illness are at increased risk of sliding into or staying in poverty.⁴⁷

Mental illness is a disorder disease of the mind judged by experts to interfere substantially with a person's ability to cope with the demands of life daily and illness is manifested in behaviour that deviates notably from normal conduct.⁴⁸ According to the American Psychiatric Association the term “mental disorder” unfortunately implies a distinction between “mental disorders” and “physical disorders”, which is an oversimplification of the interconnectedness of the body and mind as mental illness may be as much a physical illness as purely a “disorder of the mind“ alone.⁴⁹ The issue of what mental illness is has practical as well as purely philosophical importance, as it touches on whether a physical or mental approach to treatment would be most effective.⁵⁰ Often a combination of treatment options including both physical interventions, such as drugs, and therapeutic interventions such as psychotherapy might be employed. This indicates that mental disorders are more complex than purely residing in the mind or in the body.

The term “disease of mind”, although it is almost never used in contemporary clinical mental health writings, has been the subject of considerable judicial analysis, which has been considered largely with determining what particular conditions of impaired consciousness come within the scope of the term as used in the M'Naghten Rules.⁵¹ This discrepancy between the terminology employed in legal discourse over the years and scientific and

⁴⁵ Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 12.

⁴⁶ *Ibid.*

⁴⁷ Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 13.

⁴⁸ Swanepoel 198. See the definition of terminology relating to mental illness as discussed in Chapter 1.

⁴⁹ Swanepoel 199.

⁵⁰ Swanepoel 100.

⁵¹ *Ibid.*

medical progress highlights the importance of a study of psychological and psychiatric nomenclature and theory to bring the legal profession up to date in their reasoning regarding the legal impact of mental disorder and the status of persons suffering from such disabilities. If legal rules and doctrines do not have their foundations on a contemporary, widely accepted, scientific conceptualisation of mental disorders and their impact, then those legal provisions are arbitrary and should be reviewed to make sure they do not lead to an undue deprivation of rights. If courts are to make decisions that are scientifically and medically justifiable, the legal construct of “mental disorder” needs to be in line with clinical theory.

In the *Clinical Handbook of Psychiatry and the Law* it is mentioned that when educating the lawyer, the psychiatrist should explain the process of mental illness, the signs and symptoms that constitute the syndrome and the typical course of the illness.⁵² The psychiatrist should clarify how features of the illness may create a specific need for care and treatment and how certain aspects may have particular effects on legal matters.⁵³

An issue that will be analysed in-depth in Chapter 5 pertains to criminal capacity and the understanding of “mental disorder” and “mental defect” for South African criminal law and procedure. The concepts of pathological criminal incapacity and non-pathological criminal incapacity rest on the foundation of an understanding of psychiatry and psychology that certain disorders are organic, inherent and pathological and that some disorders are external and non-pathological. In Chapter 5 this distinction is discussed to determine whether it is compatible with the fact that certain disorders can be both in the mind and body, and its implications for the outcome of a criminal case and a determination of lack of capacity.

3.3 Conceptual Differences Between The Mental Health Care Professions: Psychiatry and Psychology

In this section the differences and similarities between psychology and psychiatry as mental health professions are discussed. The regulation and training of mental health practitioners is

⁵² Kotze and De Wet (2011) SAJP 116; Applebaum, PS., Gutheil, TG. 'Clinical Handbook of Psychiatry and the Law' 4th Edition Lippincott Williams & Wilkins 2007218-222,262-269.

⁵³ Kotze and De Wet (2011) SAJP 116; Applebaum and Gutheil218-222,262-269.

discussed later in this chapter, therefore this section will focus on the content of the professions, and the potential impact their similarities and differences have when it comes to their interaction with the legal system in forensic settings.

Psychology and psychiatry are vastly different disciplines with varied schools of thought and methods of assessment. Psychiatry is a medical speciality and psychiatrists primarily assess and treat mental disorders as described in the DSM-5 or ICD-10 and generally use the same methods of examination as other medical specialists (e.g. brain scans, blood tests) and prefer to use biological elements along with psychotherapy.⁵⁴ Psychologists are more concerned with the emotional and psychological factors that contribute to mental states and Psychology is studied at undergraduate and post-graduate level, not medicine.⁵⁵ Psychologists' treatment methods usually follow a form of psychotherapy such as Intellectual assessment, Personality assessment or Neuropsychological tests.⁵⁶

It is common to refer to psychology as a single discipline or a set of closely related disciplines with a central, shared intellectual and scientific core, but this is not so, as the branches of psychology can be radically different and may have different foundations. This may lead to major disputes between schools of thought in psychology.⁵⁷ The background and theoretical base of each profession is thus vastly different, that is a cause for conflict and misunderstanding in the interface between mental health and law, as psychologists and psychiatrists both deliver opinions in legal matters and may not agree on a particular issue, further complicating matters for the cooperative relationship between professions.

Kaliski states that most clinicians base their diagnoses on the criteria listed in the psychiatric volumes, the DSM-5 or ICD-10, and that they should be challenged if they do not. He feels that there are many conditions, such as the “battered woman syndrome”⁵⁸ and “rape trauma

⁵⁴Swanepoel, M (2010) “Law, psychiatry and psychology: A selection of medico-legal and clinical issues” *THRHR* (73) 177-200181.

⁵⁵ Tredoux and Foster ‘What is Psychology?’ in Tredoux *et al.* ‘Psychology and the law’ 2008 8.

⁵⁶ Swanepoel (2010) *THRHR* 185.

⁵⁷ Tredoux and Foster 2.

⁵⁸ According to Reddi, M. (2005) “Battered woman syndrome : some reflections on the utility of this 'syndrome' to South African women who kill their abusers” *South African Journal of Criminal Justice*, Vol 18, Issue 3 259-278260, 264: ‘Battered woman syndrome’ is not and has never been a legal defence in its own right. The term

syndrome” that are in use that should be avoided as they are not recognised as clinical diagnoses. These labels should only be used if there is authoritative consensus that they are valid entries. He lists psychopathy as an example of a diagnosis not included in the DSM-5, but that has been extensively researched and described in the literature and is therefore an accepted valid disorder or personality style.⁵⁹ The problem with statements like that of Kaliski that a label such as "battered woman syndrome” (BWS) is invalid, as it is not recognised by psychiatry, is that many such labels are recognised in psychology. Where BWS is concerned, some traumatic effects of violence can be identified by using the DSM-5 criteria, such as for Post Traumatic Stress Syndrome (PTSD) and Carstens and Le Roux suggest that the effects of BWS can be accommodated in the diagnostic category of PTSD, thereby facilitating a psychiatric diagnosis which can support a defence of non-pathological criminal incapacity.⁶⁰ This difference in professional opinion is relevant, because a psychologist has to deliver an opinion alongside psychiatrists in terms of a report into the mental state for purposes of Section 79 of the Criminal Procedure Act, and it may cause confusion for the courts concerning what opinion carries more evidential weight if there are conflicting opinions.

3.4 The Psychology and Psychiatry underlying legal concepts

This section gives an overview of the medical science that describes and treats mental disorders to give a clear background to the discussion of whether South African mental health law is in line with accepted medical science regarding the capacity of mentally disordered persons and the way they should be treated by the law to ensure their rights are protected and that legal rules and legislation is based on a solid foundation of scientific principle, rather than outdated and harmful beliefs and stigmas pertaining to mental illness. If one has a better understanding of the impact that particular mental disorders have on a person, then better policy decisions will be made regarding their risk assessment, determination of criminal

‘battered woman syndrome’ is used to describe a pattern of psychological and behavioural symptoms found in women living in violent relationships and has been most often utilised and recorded in the United States of America and has been generally characterised in American courts as a category of post-traumatic stress disorder.

⁵⁹ Kaliski⁴

⁶⁰ Carstens, PA. and Le Roux, J.(2000)'The Defence of Non-Pathological Incapacity with Reference to the Battered Wife Who Kills Her Abusive Husband' 13SACJ 180 186.

liability, and regarding appropriate means to treat and rehabilitate without infringing on a person's autonomy or endangering the safety of the community.

The MHCA does not specifically dictate which principles must be used to assess the mental health of persons, though the Minister of Health may make regulations to this effect according to S66(1)(a) and (b) of the MHCA.⁶¹ The MHCA does ensure that qualified mental health care practitioners make assessments and diagnoses.⁶² The ICD 10 and DSM-5 is expected to be used to this effect, as they are internationally recognised standards.⁶³ Whether a person has a “mental illness” requires a positive diagnosis of a mental health-related disease in terms of accepted diagnostic criteria as mentioned, made by a mental health practitioner authorised to make such a diagnosis (Section 1 of the MHCA).⁶⁴ A mental health care practitioner includes a psychiatrist or registered medical practitioner (registered under the Health Professions Act 56 of 1974), or a nurse, occupational therapist, psychologist or social worker trained to provide prescribed mental health care services.⁶⁵

In most parts of the world the treatment of mental illness was alienated from the rest of medicine and health care at least until recently.⁶⁶ In the isolated setting of asylums, practitioners saw many seemingly incurable patients. The supposed incurability of insanity and melancholy made practitioners believe the causes were entirely biological.⁶⁷ The idea has since persisted that prevention of mental illness is “all or none”.⁶⁸ This concept of an irreversible process once a person becomes ill leads to a sense of therapeutic nihilism and a belief that prevention is either absolute and one-dimensional or unlikely to succeed at all.⁶⁹ This outdated traditional belief that mental illness is untreatable has undoubtedly been translated into criminal law and procedure, and mental health laws, designed to “protect” the community through unnecessary deprivations of liberty and lack of proper treatment. This

⁶¹ Landman and Landman 5.

⁶² *Ibid.*

⁶³ *Ibid.*

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ Herrman, H., Shekwar, S., Moody, R (eds.) 'Promoting Mental Health: Concepts, emerging evidence, practice' 2005 5.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

aspect is further discussed in Chapter 5, especially in relation to indefinite confinement and “dangerous” criminals, and in Chapter 4 regarding the involuntary admission of mental health care users.

3.4.1 Classification of mental disorders

An examination of a person with psychiatric or psychological problems commences with the attempt to recognise the individual pattern of symptoms and experiences that leads to the establishment of a specific psychiatric diagnosis.⁷⁰ This diagnosis should be expressed in a particular nomenclature according to a recognised classification system.⁷¹ The two main current systems of classification in South Africa are the ICD-10 and the DSM-5.⁷² DSM-5 refers to the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and ICD-10 to the International Classification of Diseases and Related Health Problems published by the World Health Organisation. Both contain standardised criteria for the diagnosis of psychiatric disorders and clinicians tend to use either one exclusively, as there are many differences between them.⁷³ Both classification systems, however, warn against their use if not supplemented by formal courses of instruction and training experience, as the classifications contained in them should only be interpreted by trained medical professionals able to make a value-judgement and diagnosis in each individual case.⁷⁴

There are textual differences between ICD-10 and DSM-5, but according to treaties between the United States and the World Health Organization, the diagnostic code numbers must be identical to ensure uniform reporting of national and international psychiatric statistics.⁷⁵ The ICD-10 is a uniaxial system that attempts to standardise, by using descriptive definitions of the syndromes and operational criteria, and producing directives on differential diagnosis. The DSM-5 has discontinued the multiaxial system used in its previous incarnations and revisions

⁷⁰Swanepoel 104.

⁷¹*Ibid.*

⁷²*Ibid.*

⁷³Kaliski 112.

⁷⁴DSM-5 xxxvii; World Health Organisation ‘ICD-10’ (2004) 1.

⁷⁵Swanepoel 104.

(The DSM-III to the DSM-VI-TR), that relied on operational criteria, rather than descriptive definitions.⁷⁶ The multi-axial system stated what symptoms need to be present (often quantifying their number and requiring a specific length of time for symptoms to be present) and exclusion criteria.⁷⁷ The multi-axial model allowed clinicians to capture a comprehensive range of information about the individual's medical history, psychological circumstances and current functioning.⁷⁸ A goal of developing a multi-axial system was to ensure that co-morbid medical disorders, or personality disorders and mental retardation (mental disability or development disorder) were appropriately recognised and not overlooked if the focus was on other presenting disorders.⁷⁹ Rather the DSM-5 has now adopted a non-axial system, as the multi-axial system is not strictly necessary to make a diagnosis.⁸⁰ The approach of separately noting diagnoses from psychosocial and contextual factors is consistent with established World Health Organisation and ICD guidance to consider and individual's functional status separately from their diagnosis or symptom status.⁸¹ It is submitted that this is more in line with the legal conception of mental illness, as in legal and forensic settings it must first be

⁷⁶ A multi-axial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. Using the multi-axial system facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psycho-social and environmental problems and the level of functioning that might be overlooked if the focus were on assessing a single presenting problem (See DSM-5) Swanepoel 104.

⁷⁷ Swanepoel 104.

⁷⁸ Axis I encompasses the mental disorders, substance abuse disorders and mental disorders related to medical conditions;

Axis II codes mental retardation and the personality disorders;

Axis III is used for coding the relevant co-morbid medical conditions;

Axis IV is used for recording the nature and severity of psychosocial stressors;

Axis V is for an estimation of the individual's current level of functioning and the highest level of functioning in the past year (This is measured on the Global Assessment of Relation Functioning scale (GAF). The GAF Scale considers psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. It does not include impairment in functioning due to physical or environmental limitations. The Global Assessment of Relational Functioning Scale (GARF), which can indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship. Other rating scales used in the DSM-IV include: the Social and Occupational Functioning Assessment Scale (SOFAS); Defensive Functioning Scale (DFS); Brief Psychiatric Rating Scale (BPRS); Hamilton Rating Scales for Depression and Anxiety (HAM-D and HAM-A); Positive and Negative Syndrome Scale (PANSS) and the Scales for the Assessment of Positive Symptoms (SAPS) and the Assessment of Negative Symptoms (SANS). It was recommended that the GAF scale be dropped from the DSM-5 for several reasons, including its conceptual lack of clarity and questionable psychometrics in routine practice. DSM-5 32.

⁷⁹ Black, D.W. and Grant, J.E. 'DSM-5 Guidebook: The Essential Companion to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition' (2014) American Psychiatric Publishing, Washington DC 17.

⁸⁰ DSM-5 Introduction; Black, D.W. and Grant, J.E. 'DSM-5 Guidebook: The Essential Companion to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition' 2014 17.

⁸¹ *Ibid.* Clinicians should however continue to list medical conditions important to the understanding or management of an individual's mental disorder.

established that a person suffers from a particular mental disorder, and secondly their functional status or the degree to which the disorder impacts their capacity or competence must be determined.

Criticisms levied against the former multi-axial system of the previous incarnations of the DSM manuals was that its inaccuracies led to the destabilisation of legal standards where courts relied on the distinction between Axis I disorders (mental illnesses) and Axis II disorders (personality disorders and mental retardation).⁸² Recent international jurisprudential literature has ventured to state that to exclude personality disorders categorically and generally from being categorized as mental illness is not justifiable as the reasons for doing so are arbitrary and not scientifically sound.⁸³

This change in the DSM-5 may have a great positive effect on the manner in which forensic reporting is done, and the manner in which the Mental Health Care Act forms are completed by practitioners, potentially leading to more value in the content of the forms for legal purposes, and for reference by other practitioners. This last aspect is discussed in Chapter 4, and the forensic report required in terms of criminal procedure is discussed in Chapter 5.

3.4.2 Using clinical assessment and diagnosis in forensic settings

The highest possible confidence level for diagnoses and other contributions in legal settings is necessary, as diagnosis often influences court findings, financial judgments, the liberty interests of defendants and even social policy.⁸⁴ The law does not prescribe the threshold for determining clinical illness, but it does determine "what particular forms and degree of psychopathology it will recognise as exculpatory" or otherwise relevant to the court's needs.⁸⁵ Individual behaviour and functioning are more important than diagnostic label.⁸⁶ The

⁸²Stork (2013) "A Competent Competency Standard: Should it Require a Mental Disease or Defect?" 44 Columbia Human Rights Review 927 939; Van der Bijl, C. and Pienaar, L. (2014) 'The DSM-5 and the role of personality disorders under the criminal law' *Obiter* 316-335 317.

⁸³ Van der Bijl and Pienaar (2014) *Obiter* 317.; Kinscherff (2010) "Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act" 38 *Journal of Law, Medicine & Ethics* 745 748.

⁸⁴Swanepoel 111.

⁸⁵Swanepoel 112.

⁸⁶*Ibid.*

DSM-5 is a classification of mental disorders that was developed primarily for clinical, educational and research settings.⁸⁷ There are significant risks that diagnostic information will be misused or misunderstood when the DSM-5 categories, criteria and textual descriptions are employed for forensic purposes, because of the imperfect fit between the questions of ultimate concern to the law and the information in a clinical diagnosis.⁸⁸ In most situations, the clinical diagnosis of a DSM-5 mental disorder is not sufficient to establish the existence for legal purposes of a mental disorder, mental disability, mental disease or mental defect.⁸⁹ In determining whether an individual meets a specified legal standard for competence, or capacity additional information is usually required beyond that contained in the DSM-5 diagnosis. Practitioners should be mindful of the tentative nature of psychiatric diagnoses and that courts require that such a diagnosis must have scientific credibility.⁹⁰ Using the DSM-5 may facilitate legal decision-makers' understanding of the relevant characteristics of mental disorders by providing a compendium based on a review of the pertinent clinical and research literature.⁹¹ The literature related to diagnoses serves as a check on ungrounded speculation about mental disorders and the functioning of a particular individual.⁹² Using the DSM-5 to assess the presence of a mental disorder or the degree of impact it has on an individual's competence, for example, by persons not sufficiently trained, is not advised and rather left to experts in the field.⁹³

The court also needs to determine whether the evidence given is scientifically trustworthy.⁹⁴ This is tested through enquiring whether the evidence has been empirically tested, subjected to peer review and publication, whether it has reliability and validity data and whether it has gained acceptance in the scientific community.⁹⁵ This indicates that a diagnosis not contained in either the DSM-5 or ICD-10 will probably not satisfy the criteria of being generally

⁸⁷ DSM-5 25.

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*

⁹⁰ Allan, A. (2005) "Psychiatric diagnosis in legal settings" 11 S Afr J of Psychiatry 2 52; Meintjes-Van der Walt, L. 'Expert evidence in the criminal justice process: A comparative perspective' 2001 1.

⁹¹ DSM-5 26.

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ Allan, A. and Meintjes-Van der Walt, L. "Expert evidence" in *Psycholegal assessment in South Africa* 2006 344.

⁹⁵ *Ibid.*

accepted within the scientific community, though it is debatable whether such evidence should be completely disregarded.

Allan⁹⁶ states that good descriptive validity of mental disorder or defect for the purposes of psycho-legal enquiry requires:

1. The features of the disorder must be well delineated, unambiguously and accurately described, and operationally defined.
2. There must be a clear indication regarding how the information on each of these features should be weighted and integrated.
3. Diagnostic criteria should provide explicit rules about what to do when information is insufficient or if other uncertainties exist.
4. The diagnosis should as far as possible rely on observable signs, or the results from reliable laboratory or psychological tests, rather than be inferred from symptoms and other subjective reports provided by the patient.
5. There should ideally be enough signs and symptoms unique to the specific disorder to make it distinct from other disorders or diseases.

Allan makes the point that the diagnosis must be generally accepted by other experts in the field, though in South African courts there are usually no experts available other than the one giving the evidence, therefore case law is vital and the system of precedence is always followed.⁹⁷ A phenomenon that must be noted is that researchers in psychology and psychiatry do not necessarily keep in mind that their research outputs may have any significant medico-legal consequence.⁹⁸ The importance of this can be demonstrated through the example of recent developments in neuroscientific research where it can be proven that humans subconsciously make decisions before becoming consciously aware of having made a decision (in effect acting in an automatic state for a few moments).⁹⁹

⁹⁶Allan (2005) *S Afr J of Psychiatry* 53

⁹⁷Swanepoel 113.

⁹⁸Kaliski (2009) *South African Journal of Psychiatry* 4.

⁹⁹*Ibid.*

3.4.3 Categories of mental disorders

Traditionally, mental disorder is differentiated into mental retardation (learning disability, in which features of the disorder have been present from birth or an early age), personality disorder (usually present from childhood or adolescence onwards), mental illness (where there is an identifiable onset of illness preceded by normal functioning), adjustment disorder (less severe than mental illness, occurring in relation to stressful events or changed circumstances), disorders of childhood and other disorders (those which do not fit into any other group, including behavioural disorders and substance misuse).¹⁰⁰ Mental illness has traditionally been differentiated into organic and functional (psychotic and neurotic) types.¹⁰¹

The ICD-10 assumes an explicitly descriptive approach and organises psychiatric disorders in ten categories on the basis of shared aetiologies:¹⁰²

1. Organic, including symptomatic, mental disorders. These are conditions in which brain functions are present and manifested by disturbances of cognition, mood, perception or behaviour (Including the subcategories of dementia,¹⁰³ delirium,¹⁰⁴ mental disorder due to physical disease, behavioural disorder due to brain disease or injury, and personality disorder due to brain disease or injury.)
2. Mental and behavioural disorders due to substance or drug abuse. These disorders include all mental disorders, which are considered to be a direct consequence of drug use, and that would not have occurred without using the drug or drugs. (Including subcategories: States of intoxication; harmful use; dependence and withdrawal states;

¹⁰⁰ Swanepoel 105.

¹⁰¹ *Ibid.*

¹⁰² Smith, P. "Diagnosis and classification" in Baumann, SE. (ed.) Primary healthcare psychiatry: A practical guide for Southern Africa 2007 90-101; Swanepoel 106.

¹⁰³ Dementia is an impairment or loss of memory, especially evident in the learning of new information and of thinking, language, judgment and other cognitive faculties without clouding of consciousness. The most important types are: Alzheimer's disease; Parkinson's disease; Huntington's disease; Creutzfeldt-Jakob disease and substance-induced persisting dementia resulting from alcohol, inhalants, sedatives, hypnotics or anxiolytics. See Swanepoel 103.

¹⁰⁴ Delirium is an acute mental disturbance marked by excitement, restlessness, confusion, disordered speech and frequently hallucinations. See Swanepoel 106.

psychosis resulting from the use of alcohol and Opioids; the use of cannabis and sedatives; the use of cocaine, tobacco, hallucinogens and other drugs.

3. Schizophrenia, schizotypal and delusional disorders. These disorders are Conditions in which there are distortions of thinking, perception and mood, not due to an organic condition, and which are most prominent in schizophrenia. (Including subcategories of Persistent delusional disorders; acute and transient psychotic disorders; and schizoaffective disorders.)
4. Mood (affective) disorders. These are a range of disorders in which disorders of mood (affect) is the main feature, together with other symptoms, that are easily understood in context of change of mood and activity. (Including subcategories of Manic episodes; depressive episodes; bipolar affective disorder; recurrent depressive disorder; and persistent affective disorders.)
5. Neurotic, stress-related and somatoform disorders. These are a group of disorders in which certain symptoms, (historically recognised as part of “neurosis”), are most marked, and which may have a psychological causation. (Including subcategories of Phobic disorder; other anxiety disorders; obsessive-compulsive disorder; stress and adjustment disorders; dissociative and conversion disorders; somatoform disorders.)
6. Mental disorders associated with physiological dysfunction and physical factors. These are disorders in which physiological and hormonal factors may be involved in causation or be prominent in association with the disorder. (Including subcategories of Eating disorders; psychogenic sleep disorders; sexual dysfunctions; and mental disorders associated with the puerperium.)
7. Abnormalities of adult personality and behaviour. These are Conditions of clinical significance in which behaviour patterns tend to be persistent and which are “the expression of the individual’s characteristic lifestyle and mode of relating to self and others”. (Subcategories include Personality disorder; enduring personality change; habit and impulse disorders; gender identity disorders; and sexual preference disorders.)

8. Mental retardation. this is a condition of “arrested or incomplete development of the mind” manifest by impairment of skills commonly associated with intelligence (subcategories include Mild mental retardation; moderate mental retardation; severe mental retardation; profound mental retardation; and other types of mental retardation.)
9. Developmental disorders. These are Conditions that begin in infancy or childhood; delay in the development of functions related to maturation of the nervous system, and which generally have a steady rather than remitting course. (Subcategories include Speech and language; specific developmental disorder of scholastic skills; specific developmental disorder of motor function; and pervasive developmental disorder, for example autism.
10. Behavioural and emotional disorders with onset usually occurring in childhood or adolescence. These are a mixture of disorders in which the only common features are an onset early in life and a fluctuating or unpredictable course. (Subcategories include Hyperkinetic disorder; conduct disorder; mixed disorder of conduct and emotions; emotional disorder of childhood; and disorders of social function.)

The overall structure and diagnostic groupings in the DSM-5 are:¹⁰⁵

- Neurodevelopmental disorders
- Schizophrenia Spectrum and Other Psychotic Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Anxiety Disorders
- Obsessive-Compulsive and Related Disorders
- Trauma- and Stressor Related Disorders
- Dissociative Disorders
- Somatic Symptom and Related Disorders

¹⁰⁵ DSM-5 13-24.

- Feeding and Eating Disorders
- Elimination Disorders
- Sleep-Wake Disorders
- Sexual Dysfunctions
- Gender Dysphoria
- Disruptive, Impulse-Control, and Conduct Disorders
- Substance Related and Addictive Disorders
- Neurocognitive Disorders
- Personality Disorders
- Paraphilic Disorders
- Other Mental Disorders
- Medication-Induced Movement Disorders and Other Adverse Effects of Medication
- Other Conditions that May Be a Focus of Clinical Attention

The DSM-5 states that intellectual disability involves impairments of general mental abilities, that impact adaptive functioning in three domains that determine how well an individual copes with everyday tasks, namely: The conceptual domain, the social domain and the practical domain.¹⁰⁶ The American Psychiatric Association stresses that when assessing intellectual ability, the DSM-5 must be used along with intelligence testing to ensure that IQ scores are not overemphasised as the defining factor of a person's ability.¹⁰⁷

The four categories of mental disorders likely to be associated with violent, serious criminal or antisocial behaviour and are often cited to support an insanity defence to criminal charges, and therefore most relevant to a discussion on law and mental disorder are:¹⁰⁸ schizophrenic disorders;¹⁰⁹ paranoid disorders;¹¹⁰ mood disorders;¹¹¹ and some personality disorders.¹¹²

¹⁰⁶ Landman and Landman 13.

¹⁰⁷ *Ibid.*

¹⁰⁸ Swanepoel 114.

¹⁰⁹ Schizophrenia is a syndrome composed of abnormal clinical signs and symptoms in the areas of behaviour, volition, attention, cognition and motor activities. While several of these features suggest the illness, none is pathognomonic of it. While many patients manifest some of these abnormalities, or a combination of it, few patients manifest all. The DSM-IV outlines five characteristic symptoms of schizophrenia, at least two of which must be manifested before diagnosis can be entertained: (1) delusions; (2) hallucinations; (3) disorganised speech; (4) grossly disorganised behaviour and; (5) inappropriate affect. According to ICD-10, nine groups of

3.4.4 Ethics in medical decision-making

The word ethics is derived from the Greek word ethos and can be loosely defined as a set of moral principles that determine good and bad and invokes a sense of morality and obligation.¹¹³ The legal and ethical regulation of the medical profession is interrelated, but not identical.¹¹⁴ Ethical regulation deals with right versus wrong, value systems and their relationships, and how they govern individual conduct.¹¹⁵ Ethics can be described as a set of

symptoms are important for diagnosing schizophrenia: (1) thought echo, insertion, withdrawal and broadcasting; (2) delusions of control, influence or passivity; (3) hallucinatory voices; (4) other persistent delusions that are culturally inappropriate and impossible; (5) persistent hallucinations; (6) breaks or interpolation in thinking; (7) catatonic behaviour; (8) negative symptoms resulting in social withdrawal and poor social performance but not caused by depression or medication and; (9) consistent, overall change in behaviour. See Swanepoel 115.

¹¹⁰ Paranoid disorders are characterised by the presence of one or more non-bizarre delusions that persist for at least one month. The judgment of whether the delusion's systems are bizarre or non-bizarre is especially important in deciding between a delusional disorder and schizophrenia. In paranoid personality disorder the delusions are reasonably believable and not completely far-fetched. Patients with paranoid personality disorder also have a long-standing suspiciousness of others and their motives, and a mistrust of people in general. Because of this they have an excessive need to be self-sufficient and a strong sense of autonomy. Brief psychotic episodes may occur during times of stress. Individuals suffering from this disorder rarely seek treatment but are usually brought in by family members or employers. Psychotherapy is the treatment of choice for paranoid personality disorder and pharmacotherapy is useful in dealing with agitation and anxiety. See Swanepoel 117.

¹¹¹ Mood disorders are a class of mental disorders with disturbance of mood as the predominant feature. Mood is defined as a temporary but relative sustained and pervasive affective state, often contrasted in psychology and psychiatry with a more specific and short-term emotion. These disorders are divided into depressive and bipolar disorders. The depressive disorders feature persistent feelings of sadness and despair and loss of interest in previous sources of pleasure. It further includes feelings of worthlessness or excessive inappropriate guilt, (which may be delusional), experienced nearly every day and is not merely self-reproach or guilt about being sick. In bipolar disorders, people experience both depressed and manic episodes. When an individual who suffers from bipolar disorder swings to the manic phase, the most prominent symptom of mania is a mood in which an individual feels highly energetic and extremely joyful. Manic persons may believe there is no limit to their possible accomplishments and may act accordingly. Occasionally, the manic person suffers from other delusions, for example, false beliefs that contradict known facts. They also have a greatly reduced need for sleep and tend to be immune from the fatigue that would hit most people after very strenuous periods of activity. See Swanepoel 118.

¹¹² Personality disorders represent persistent long-standing, maladaptive patterns of behaviour that cause significant distress and impairment of functioning. These disorders are more appropriately conceptualised in dimensional rather than categorical terms: The distress and impaired functioning are the defining criteria and separate this group of disorders from the wide range of emotional and behavioural problems encountered in the general population. Treatment is often complex, lengthy and difficult. See Swanepoel 119.

¹¹³ Dhai, A.; McQuoid-Mason, D.; and Knapp van Bogaert, D. 'Ethical concepts, theories and principles and their application in healthcare' in Dhai, A. and McQuoid-Mason, D. 'Bioethics, Human Rights and Health law: Principles and Practice' (2011) 3; Moodley, K. 'A place for ethics, law and human rights in healthcare' in Moodley, K (ed.) 'Medical ethics, law and human rights: A South African Perspective' (2011) 7; Burke, A.; Harper, M.; Rudnick, H.; Kruger, G. (2007) 'Moving beyond statutory ethical codes: Practitioner ethics as a contextual, character-based enterprise' South African Journal of Psychology, 37(1): 107-120 107.

¹¹⁴ Moodley, K. 'A place for ethics, law and human rights in healthcare' 11; Swanepoel 128.

¹¹⁵ Dhai; McQuoid-Mason and Knapp van Bogaert 3; Swanepoel 128.

formal and informal standards of conduct used to guide people's behaviour.¹¹⁶ Law rules on right or wrong when legal intervention is demanded.¹¹⁷

The Constitution, The National Health Act 61 of 2003, the Mental Health Care Act 17 of 2002, and the Promotion of Access to Information Act 2 of 2002 play a role in the provision of medical interventions and ethics.¹¹⁸ Oosthuizen and Verschoor state that the five most important issues in medicine that play a major role in ethical health care, especially in the doctor-patient relationship, are:¹¹⁹

- The way in which medical treatment and or services are rendered;
- The privacy of a patient;
- The confidentiality of patients' information;
- The patient's right to self-determination; and
- Informed consent by the patient.

In the mental health care profession and the training of practitioners, ethics is often equated with an ethical code, though in reality, the questions of moral obligation in general, and practitioner ethics in particular, are far more complex.¹²⁰ The HPCSA has, in terms of the Health Professions Act¹²¹ and in consultation with the professional boards, drawn up a code of conduct for medical practitioners to promote ethical conduct within the medical profession.¹²² Although courts of law are not bound by medico-legal codes of conduct, the Ethical Rules and prevailing practices of the medical and psychology professions are an important consideration in ascertaining what constitutes psychiatric and psychological malpractice.¹²³ The Ethical Code of Professional Conduct describes this as follows: "Psychologists shall develop,

¹¹⁶Burke, *et al.* (2007) South African Journal of Psychology 107.

¹¹⁷Swanepoel 128.

¹¹⁸Oosthuizen, H. And Verschoor, T (2008) 'Ethical Principles becoming statutory requirements' 50 SA Fam Practice 5 36-40 37.

¹¹⁹ Oosthuizen, H. And Verschoor, T (2008) SA Fam Practice 37.

¹²⁰Burke, *et al.* (2007) South African Journal of Psychology 107.

¹²¹56 of 1974.

¹²²Ethical Rules of Conduct for Practitioners Registered Under The Health Professions Act, 1974 Government Notice R717 in Government Gazette 29079 of 4 August 2006; Dhai, A. and Etheridge, H, 'Codes of Healthcare Ethics' in Dhai, A. and McQuoid-Mason, D. 'Bioethics, Human Rights and Health law: Principles and Practice' (2011) 30; Swanepoel 145.

¹²³Carstens and Pearmain 264.

maintain and encourage high standards of professional competence to ensure that the public is protected from professional practices that falls short of international and national best practice standards.”¹²⁴

Mental health care practitioners face complex ethical dilemmas; including the questions definition of what is “best for the patient”, and who gets to decide what is best.¹²⁵ The latter decision may lie with the patient (who might not be competent to decide what is best), the practitioner considered an “expert”, or the broader system within which the mental health care practice operates which does not always account for individual differences.¹²⁶ The fact the ethically correct decision does not always amount to the decision affecting a positive outcome illustrates the difficulty in boiling down ethically acceptable conduct to a set of standard universal rules.¹²⁷ An example of this tension is found in the question of whether to inform a patient that they are under no obligation to undergo therapeutic consultation prior to discharge even though it will be beneficial to them, which illustrates the possible discord between the practitioner’s ethical code of beneficence and the patient’s right to informed consent and autonomy.¹²⁸ Such a moral dilemma cannot simply be “solved” and illustrate that ethical principles cannot contain the full complexity of lived experience, and that personal desires or agendas often conflict with these principles, reveals the limitations of theory-based ethical systems.¹²⁹

Mental health care practitioners operate within complex contexts composed of organisational demands, the legal system, the therapeutic team, supervisors, and the patient.¹³⁰ In any given scenario, there will be tensions between these components that the practitioner should not only be aware of, but also successfully navigate.¹³¹ A hierarchy of ethical values such as the system utilised by the Canadian Psychological Association has been suggested by Burke, *et al.* as a way of assisting practitioners to deal with real-life ethical dilemmas by prioritising

¹²⁴ Swanepoel 147.

¹²⁵ Burke, *et al.* (2007) South African Journal of Psychology 108.

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

¹²⁸ Burke, *et al.* (2007) South African Journal of Psychology 109.

¹²⁹ *Ibid.*

¹³⁰ Burke, *et al.* (2007) South African Journal of Psychology 110.

¹³¹ *Ibid.*

certain considerations above others where a conflict exists.¹³² Burke *et al.* also submits that the current ethical code is in need of revision to reflect ethical norms as both prescriptive and educational, and never static; that the education of mental health practitioners should be reviewed to include a more comprehensive exposure to ethical theory than just working through the ethical code with students.¹³³

Three aspects important to consider in ethical decision-making by mental health care practitioners are:¹³⁴ Firstly, that psychiatrists and psychologists always have choices they can select from as they make decisions. Second, in making these decisions the consequences of these choices have to be taken into account. Lastly, the context or setting of the ethical dilemma will affect the decision to be made and this must be taken into account as well.¹³⁵

In Chapter 2 the doctor-patient relationship in forensic settings has been discussed regarding specifically the right to privacy and confidentiality. Further to that ethical questions come to light regarding the limits of the professional relationship. The boundaries of psycho-legal relationships should be regarded as more strict and formal than in most other clinical relationships¹³⁶ These boundaries are meant to maintain a professional distance and respect between the patient and the mental health assessor, otherwise it is possible that bias by the assessor may become an issue.¹³⁷ Bias may be evident, or suspected, if an expert has earned the label of “hired gun” and only presents the view requested by the hiring lawyer; or where the forensic expert receives financial incentives or only works for one particular firm.¹³⁸ It is of the utmost importance that experts must be impartial and honest and an awareness of these common ethical challenges in forensic psychology can help psychologists to examine their own practices and the practices of their colleagues.¹³⁹ If a mental health practitioner enters into a treatment and forensic role with a patient their objectivity might be in question. By mixing

¹³² Burke, *et al.* (2007) South African Journal of Psychology 110-111.

¹³³ Burke, *et al.* (2007) South African Journal of Psychology 119.

¹³⁴ Swanepoel 343; Singh, J.A. & Ngwena, C. "Bioethics" 33-52 in Dada, M.A. and McQuoid-Mason, D.J (eds.). Introduction to medico-legal practice (2001) 35.

¹³⁵ *Ibid.*

¹³⁶ Zabow, T.; Kaliski, S. "Ethical considerations" in Kaliski, S. (ed.) "Psycholegal assessment in South Africa" (2006) 359-360.

¹³⁷ Swanepoel 174.

¹³⁸ Swanepoel 175.

¹³⁹ Swanepoel 175; Allan and Meintjes-van der Walt 353.

valuation and treatment services the psychologist, if not careful to maintain boundaries, is at risk of violating ethical standards of practice by combining clinical and forensic roles.¹⁴⁰ There are also many reasons why a psychologist should not be retained or appointed as an expert to evaluate his or her own patient or client, such as:¹⁴¹ If the evaluation favours the patient the psychologist could be accused of favouritism; If it does not, the therapeutic relationship could be seriously harmed and the therapy accomplished up to that point may become relatively worthless. Additionally, in a therapeutic relationship, a person has a right to expect confidentiality, to expect the psychologist to do only what is in the person's best interest and to avoid doing anything harmful except in a "duty to warn or protect" situation.¹⁴² The only significant exception may be in rural areas where the psychologist is the only expert available to provide the necessary forensic services.¹⁴³

According to the Ethical Rules of Professional Conduct Section 68, a psychologist must ensure that psycho-legal assessments, recommendations and reports are based on information and techniques sufficient to provide appropriate substantiation for the finding, and Section 69 states that a psychologist must provide written or oral psycho-legal reports or testimony of the psychological characteristics of a client only after they have conducted an examination of the client which is adequate to support his or her findings, provided that despite reasonable efforts, such an examination is not feasible, the psychologist will clarify the impact of their limited information on the reliability and validity of his or her reports and testimony while appropriately limiting the nature and extent of his or her findings.¹⁴⁴ A psychologist must, according to Section 70(a) and (b) of the Ethical Rules, testify truthfully, honestly, candidly and consistently with applicable legal procedures; and describe fairly the basis for their testimony and conclusions. The Ethical Rules also provide that a psychologist should avoid performing multiple and potentially conflicting roles in psycho-legal matters, and if they are called upon to fulfil more than one role they must clarify their role expectations and the extent

¹⁴⁰Swanepoel 178.

¹⁴¹Swanepoel 184.

¹⁴²*Ibid.*

¹⁴³*Ibid.*

¹⁴⁴Swanepoel 175.

of confidentiality in advance to the extent feasible, to avoid compromising his or her professional judgement and objectivity.¹⁴⁵

Swanepoel proposes the following guidelines for the adherence to ethical decision-making in forensic psychology:¹⁴⁶

- Psychologists have to recognise that forensic practice constitutes a specialty area that demands specific clinical skills and knowledge of the ethical rules and the legal system. They should not venture into this arena without specialised training in the laws that regulate the profession; the interface of the forensic psychology practice with the legal system; and risk management. However, knowledge and experience is not enough - forensic psychologists must be committed to applying that knowledge in a manner consistent with ethical practice.
- When psychologists find themselves drawn into a legal case inadvertently they should seek consultation from a colleague with specialised forensic knowledge before responding to the legal proceeding.
- Child custody disputes constitute a frequent basis for ethical complaints, particularly when the psychologist makes a recommendation based on incomplete data or interviews with only one party. Psychologists should exercise great caution and follow professional guidelines when undertaking such assignments.
- Where professional competence has been established and is being maintained, the greatest risk to ethical misconduct in forensic psychology seems to be the potential influence of bias.
- Psychologists should carefully clarify their roles and stay within the agreed upon or court defined parameters in all forensic cases. To justify their positions and behaviours, clear and detailed documentation of the rationale should be maintained. Documentation that the psychologist understood the values at stake and followed a rational process of ethical decision-making will, if necessary inform any outside reviewer that the ethical challenge was addressed in thoughtful and systematic

¹⁴⁵ Rule 71(1) and (2); Swanepoel 178.

¹⁴⁶ Swanepoel 189.

manner. Such documentation of the decision-making process will be the forensic psychologist's best protection against liability

- Psychologists must distinguish carefully between legal issues and mental health issues and when acting as an expert witness they should remain focused on the legal issues

Sound ethical behaviour is ultimately based on a solid knowledge of ethical codes and regulations, sharpened by a clear understanding of the consequences of one's actions.¹⁴⁷ The starting point for examining the legal issues and implications surrounding psychiatry and psychology in South Africa is an investigation into the South African Constitution, common law and legislation in the field of mental health.¹⁴⁸

At the moment there is no uniform curriculum for the education and training of medical students in human rights, ethics and medical law at medical schools in South Africa and human rights and ethics have not been regarded as an integral part of the practice of medicine.¹⁴⁹ In certain instances trainers are not adequately qualified to teach on issues of moral philosophy, moral theology or even the law, and there is also no clear consensus concerning which ethics should be taught, how it should be taught and who should teach it.¹⁵⁰ The teaching of medical law is also integral to the education of mental health practitioners, as there is legislative and judicial control over the practice of medicine.¹⁵¹

It is submitted that that there should be a register of forensic psychiatrists and psychologists that are objective and involved on behalf of the court to find the truth, instead of opening up the possibility of bias and abuse. It is an untenable state of affairs that it is possible for a forensic expert charged with assessing the mental state of a person not to be called to testify where the testimony does not suit the case of the appointing party.

¹⁴⁷ Burke, *et al.* (2007) South African Journal of Psychology 115; Swanepoel 191.

¹⁴⁸ Oosthuizen, H. And Verschoor, T (2008) SA Fam Practice 40; Swanepoel 191.

¹⁴⁹ Oosthuizen, H. And Verschoor, T (2008) SA Fam Practice 36.

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

3.5 The role of the Psychologist and Psychiatrist in court

3.5.1 The forensic expert witness

The court requires expert evidence in matters that cannot be decided without expert guidance, namely matters that fall outside the ambit of the court's special knowledge and skill.¹⁵² The court will consider the expert evidence and all the facts of the case, including the nature of the accused's actions during the relevant period when making a decision.¹⁵³ Forensic expert witnesses are called to evaluate and report or testify on mental state in a variety of scenarios in the public and private law spheres. This includes assessment for purposes of determining criminal capacity and triability in the public law sphere, as well as determinations of capacity to act in the law of delict, law of contract, law of succession, and the capacity to consent to medical interventions in the private law sphere, among others. The question of legally valid decision-making and capacity is a core issue among persons with mental disorder and therefore it is necessary to explore the concept of capacity in clinical and legal contexts, as is done in this chapter.

Psycholegal assessment is the observation of a person by a mental health professional in order to deliver a diagnosis and form an expert opinion that will be of assistance to a legal process. In practice, it is largely here, at the level of assessment, that the mental health and legal professions have crossed paths for decades.¹⁵⁴ All psycholegal assessments have in common that a diagnosis must be reached; the functional demands in the legal brief - the reason for referral for assessment - must be appreciated and the strength of the causal link between the diagnosis and legal question posed must be determined.¹⁵⁵ In *Coopers (SA) (Pty) Ltd v Deutsche Gesellschaft Fur Schadlingsbekampfung MbH*¹⁵⁶ the court held that an expert's bald

¹⁵² Bellengere, A., *et al.* 'The law of Evidence in South Africa: Basic Principles' (2013) 397; Schwikkard, PJ. and Van der Merwe, SJ. 'Principles of Evidence' (2009) 3rd Edn 83.

¹⁵³ Bellengere, *et al.* 397; Schwikkard and Van der Merwe 83; Grant, J 'Criminal law' 2006 Annual Survey of South African Law 670; Eadie 2002 (1) SACR 633 (SCA)445H.

¹⁵⁴ Kaliski "Introduction" in Kaliski (ed.) Psycholegal Assessment (2006) 1, 93; Tredoux 'Psychology and the Law' (2008) iv.

¹⁵⁵ Kaliski 3; Burchell and Milton 373.

¹⁵⁶ 1976 (3) SA 352 (A) par 371.

statement of opinion is not of assistance to the court, and that the opinion must rather be based on a disclosure in court of the reasoning which resulted in the conclusions reached.¹⁵⁷

Kaliski explains that from the mental health practitioner's viewpoint, the first step in assessment of an accused would be to determine whether the accused suffers from a mental illness, defect or other important condition, then to decide whether the severity of the identified condition was enough to significantly impair the accused's cognitive or conative abilities and lastly whether these impairments influenced the accused's actions at the time of commission of the offence.¹⁵⁸ It is not the task of the mental health professional to establish whether the accused possessed capacity as that is an ultimate issue and solely the court's decision, but rather to determine if a disorder, condition or circumstance existed that negated it,¹⁵⁹ and only to pronounce an opinion on the degree of impact such a particular disorder may have had.¹⁶⁰ Individual behaviour and functioning are more important than diagnostic label.¹⁶¹

In *Schneider NO and Others v Aspeling and Another*¹⁶² the court held that the expert must give an unbiased opinion on matters within their expertise and not take over the role of advocate. The court still has the final decision after careful analysis of the opinion.¹⁶³ In the case of *S v Bull*,¹⁶⁴ the court held that the role of the expert psychiatric evidence was to provide the court with an expert opinion interpreting the accused's past conduct, personal characteristics and likely future conduct.¹⁶⁵ The psychiatrist and psychologist have four different roles to play in court proceedings, namely:¹⁶⁶ First, in context of criminal law, a finding that the accused lacked criminal capacity can only be made on the basis of expert psychiatric or psychological evidence. The court cannot arrive at a verdict on the basis of its own observations. Second, as a general rule of evidence, in the context of medical law, a plaintiff in a medical negligence action is required to present expert medical evidence to

¹⁵⁷ Bellengere, *et al.* 399.

¹⁵⁸ Kaliski 102.

¹⁵⁹ Kaliski 103.

¹⁶⁰ Kaliski 5.

¹⁶¹ Swanepoel(2010) THRHR 194.

¹⁶² 2010 (5) SA 203 (WCC) par 211.

¹⁶³ Bellengere, *et al.* 399.

¹⁶⁴ *S v Bull and Another* (2001) ZASCA 105.

¹⁶⁵ Landman and Landman 163.

¹⁶⁶ Swanepoel 170.

support allegations thereof. Expert psychiatric evidence, for example, will therefore be pivotal in support or defence of psychiatric negligence. Third, in context of professional conduct inquiries into the alleged unprofessional conduct of a psychiatrist or psychologist, falling within the jurisdiction of the HPCSA, expert psychiatric or psychological evidence must be led in support and defence of the allegations against the practitioner. Lastly, a psychologist may be summonsed to appear as a fact witness in court cases.

In view of the tentative nature of psychiatric and psychological disorders, it is imperative that practitioners remind themselves and legal practitioners that diagnostic constructs should be used with caution in legal settings, preferably only if the diagnosis satisfies the legal perception of scientific credibility.¹⁶⁷ This means that at the very least the witness must be able to demonstrate that the disorder is generally accepted as evidenced by its inclusion in a diagnostic manual and/or published peer reviews.¹⁶⁸ A competent witness should also have data on the other indicators of scientific credibility that may also be relevant depending on the specific issues contested in the case.¹⁶⁹ The legal system needs psychiatric and psychological knowledge about the interfaces of mental disorders, function and behaviour, though the legal issues must be left to the legal practitioners and the final determinations left to the judge.¹⁷⁰

The probative value of expert evidence is dependent upon the qualifications, skill and level of experience (competency rule) of the expert and the ability of the court to assess this testimony.¹⁷¹ Kaliski states that modern day psycholegal opinions not based on good evidence, but solely on the mental health professional's "experience" cannot be tolerated.¹⁷² Concerning what encompasses "good evidence", two questions should always be posed: Is the evidence-based on scientific enquiry? And does it enjoy widespread acceptance in the mental health community?¹⁷³ Some professionals in South Africa who conduct psycholegal assessment and testify in court do not have the requisite qualifications or expertise to do so, yet many claim they have a vast amount of experience to claim legitimacy, without conceding

¹⁶⁷ Allan (2005) S Afr J of Psychiatry 55;Swanepoel 126.

¹⁶⁸ Swanepoel 126.

¹⁶⁹ Allan (2005) S Afr J of Psychiatry 55; Swanepoel 126.

¹⁷⁰ Swanepoel 126.

¹⁷¹ Bellengere, *et al.* 398-399; Schwikkard and Van der Merwe 95-96; Swanepoel 343.

¹⁷² Kaliski4.

¹⁷³ *Ibid.*

they might be practising incorrectly and continue to do so.¹⁷⁴ There is no formal training programme or examinations for forensic mental health in South Africa.¹⁷⁵

Kaliski¹⁷⁶ submits that South African courts should adhere to the parameters of expert testimony, as set out in the USA case of *Daubert v Merrell Dow Pharmaceuticals Inc*,¹⁷⁷ in which psychiatric opinions offered during expert testimony essentially have to be held with “reasonable medical certainty”, as this will force experts to provide the courts with evidence that the opinions they offer are supported in the scientific literature, and have been obtained using acceptable methodology.¹⁷⁸ The United States Supreme Court stipulated that a court should also take three other factors into account:¹⁷⁹ First, whether the construct can be, and has been, tested; second, whether it has been subjected to peer review and publication; and finally, the known or potential rate of error.¹⁸⁰ If the *Daubert* criteria are to be met, psychologists and psychiatrists need to employ scientifically sound and valid methods and theories of high standards and be prepared to defend the credibility of methods used to form their opinion, as well as recognise that it may not be an exact science and strive for objectivity and acknowledge the limitations of their profession, though it is not value-free.¹⁸¹

The general applicable considerations in assessing expert medical evidence are set out in *Michael v Linksfield Park Clinic (Pty) Ltd*,¹⁸² in which the Supreme Court of Appeal authoritatively stated the general applicable considerations in assessing expert medical evidence. The approach to expert evidence followed by the Supreme Court of Appeal in this case can be summarised as follows:¹⁸³

¹⁷⁴ Swanepoel 171.

¹⁷⁵ Swanepoel 171.

¹⁷⁶ (2009) South African Journal of Psychiatry 4.

¹⁷⁷ *Daubert v Merrell Dow Pharmaceuticals Inc* 509 US 579, 113 S Ct 2786 (1993).

¹⁷⁸ Meintjes-Van der Walt, L. (2011) “Tracing trends: The impact of science and technology on the law of criminal evidence and procedure” 128 SALJ 1 147-171 150; Cohen, A; Malcolm, C “Psychological assessment for the courts” in Tredoux *et al.* “*Psychology and the law*” 200867.

¹⁷⁹ *Daubert v Merrell Dow Pharmaceuticals Inc* 509 US 579, 113 S Ct 2786 (1993) 2769; Meintjes-Van der Walt (2011) SALJ 150.

¹⁸⁰ Swanepoel 113.

¹⁸¹ Cohen and Malcolm 68.

¹⁸² 2001 (3) SA 1188 (SCA).

¹⁸³ *Michael and Another v Linksfield Park Clinic (Pty) Ltd and Another* 2001 (3) SA 1188 (SCA) par 34 – 40; Carstens, PA.(2002) "Setting the boundaries for expert evidence in support or defence of medical negligence: *Michael v Linksfield Park Clinic (Pty) Ltd* 2001 3 SA 1188 (SCA)"THRHR433. The approach to expert

- In delictual claims the issue of reasonableness or negligence of conduct is for the court to determine on the basis of the various expert opinions presented, and as a rule that determination will not involve considerations of credibility but rather the examination of the opinions their essential reasoning;
- In the case of professional negligence, the governing test is the standard of conduct of the reasonable practitioner in the particular professional field, but that criterion is not always itself a helpful guide to finding the answer, what is required is to determine whether and to what extent the expert opinions advanced are founded on logical reasoning;¹⁸⁴
- The court is not bound to absolve a defendant from liability for allegedly negligent professional conduct just because evidence of expert opinion is that the conduct in issue accorded with sound practice, the court must be satisfied that such opinion had a logical basis, in other words that the expert has considered comparative risks and benefits and has reached a defensible conclusion. If a body of professional opinion overlooks an obvious risk, which could have been guarded against, it will not be reasonable, even if almost universally held;
- A defendant can be held liable despite the support of a body of professional opinion if that body of opinion is not capable of withstanding logical analysis and is therefore not reasonable, though it will very seldom be concluded that views genuinely held by a competent expert are unreasonable;
- The assessment of medical risks and benefits is a matter of clinical judgment that the court would not normally be able to make without expert evidence, and it would be wrong to

evidence has been followed, to some extent or another, in several consequent cases: *Minister van Veiligheid en Sekuriteit v Geldenhuys* 2004 1 SA 515; *Van der Walt v De Beer* 2005 5 SA 151 (C); *Media 24 Ltd and Another v Grobler* 2005 6 SA 328 (SCA); *Louwrens v Oldwage* 2006 2 SA 161 (SCA); *Minister of Transport NO and Another v Du Toit and Another* 2007 1 SA 322 (SCA); *Springold Investments (Pty) Ltd v Guardian National Insurance Co Ltd* 2009 3 SA 235 (D); *Prinsloo v Road Accident Fund* 2009 5 SA 406 (SE); *Mutual and Federal Insurance Co Ltd v Ingram NO and Others* 2009 6 SA 53 (E) and *Mutual and Federal Insurance Co Ltd v SMD Telecommunications CC* 2011 1 SA 94 (SCA).

¹⁸⁴Meintjes-Van der Walt (2011) SALJ 154.

decide a case by simple preference where there are conflicting views on either side, both capable of logical support;

- Only where expert opinion cannot be logically supported at all will it fail to provide the benchmark by reference to which the defendant's conduct fails to be assessed;
- Finally, it must be borne in mind that expert scientific witnesses tend to assess likelihood in terms of scientific certainty and not in terms of where the balance of probabilities lies on a review of the whole of the evidence.

3.5.2 The liability of the expert witness

The role of the mental health professional in legal settings ranges from evaluating competence to stand trial, recommending child custody arrangements, and assessing emotional distress in civil actions.¹⁸⁵ Traditionally, expert witnesses have been granted legal immunity for their forensic work; for example, they could not be sued and have charges of negligence or defamation brought against them.¹⁸⁶ The argument has been that expert witnesses are an important part of the legal system and, in the interest of justice, they need to be protected from liability.¹⁸⁷ There is concern that the safeguards cited by courts to ensure honest expert witness testimony, for example potential prosecution for perjury and cross-examination, are not effective.¹⁸⁸ The field of expert witness ethics, unfortunately, is still undeveloped, and many professional societies do not have specific codes related to forensic work besides the general principles of honesty and avoidance of conflicts of interest.¹⁸⁹

In the American common law forensic experts are entitled to “quasi-judicial immunity” for actions taken concerning psychiatric evaluations.¹⁹⁰ Quasi-judicial immunity provides absolute immunity from subsequent damages liability for all persons—governmental or

¹⁸⁵ Appelbaum, P.S. (2001) 'Liability for forensic evaluations: A word of caution' 52 *Psychiatric Services* 7: 885-886 885.

¹⁸⁶ Swanepoel 331.

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid.*

¹⁸⁹ *Ibid.*

¹⁹⁰ Appelbaum (2001) *Psychiatric Services* 885.

otherwise— that were integral parts of the judicial process, including mental health professionals appointed by the court itself to assist the court.¹⁹¹In general, however, experts hired by one of the parties to litigation are not covered by quasi-judicial immunity.¹⁹² Though in *Briscoe v LaHue*,¹⁹³ the U.S. Supreme Court held that trial witnesses are entitled to absolute immunity from civil suits on the grounds that liability might induce two forms of self-censorship, namely that witnesses might be reluctant to come forward to testify, and testimony might be distorted by the fear of subsequent liability.¹⁹⁴ The court also noted that honest witnesses might erroneously be subjected to liability due to the difficulty of proving the truth of their statements, therefore to protect the truth-finding function of the court, absolute civil immunity for witnesses was essential.¹⁹⁵ The Supreme Court in *Martinez v Lewis*¹⁹⁶ stated that if the health care provider conducted an evaluation in a manner that worsened the examinee's mental health and the health care provider knew or should have known about information that would have cautioned against conducting the examination in that manner, a duty of care might arise.¹⁹⁷ Also a party that employs a forensic assessor might file a suit for professional malpractice if they have suffered ill consequences due to a negligently conducted evaluation.¹⁹⁸ Although the formulation and expression of an opinion are protected by witness immunity in the American legal system, the actual performance of the evaluation may not be covered if the subject suffers harm as a result.¹⁹⁹It is submitted that the American position is helpful in considering liability of forensic assessors in South Africa.

¹⁹¹ *Ibid*; Dalton v Miller 984 P 2d 666 (Colo App 1999).

¹⁹² Appelbaum (2001) Psychiatric Services 885. Exceptions may occur for example when a single mental health practitioner is agreed upon by both parties to act as a mediator.

¹⁹³ 460 US 325 (1983).

¹⁹⁴ Appelbaum (2001) Psychiatric Services 885.

¹⁹⁵ *Ibid*.

¹⁹⁶ 969 P 2d 213 (Colo 1998).

¹⁹⁷ Appelbaum (2001) Psychiatric Services 886.

¹⁹⁸ *Ibid*.

¹⁹⁹ *Ibid*.

3.6 The influence of culture on the diagnosis and treatment of mental disorder

3.6.1 South Africa

In this section the effect of culture in South Africa on the effective diagnosis and treatment in mental health care is discussed. Cross-cultural comparative studies have shown that the incidence of psychotic disorders among Africans is no different from rates of occurrence in other cultures.²⁰⁰ Several pervasive myths have influenced the practice of psychiatry in Africa, such as myths regarding lower rates of depression or that there is no stigma attached to mental disorder in African cultures (which it has been found is far from correct).²⁰¹ The realities of psychiatry in Africa may be that some important differences do in fact exist between Africans and other racial groups in the world and that such differences offer potential opportunities for a better understanding of mental disorders and how to treat them.²⁰²

South Africa has a pluralistic health care system, where a highly institutionalised First World medical system based on modern scientific medicine coexists with a variety of local indigenous systems founded on traditional beliefs and practices.²⁰³ African traditional healing is part of African culture and traditional healers in modern South Africa remain essential for the health and well-being of a great part of the black population.²⁰⁴ The introduction of biomedicine has never replaced the indigenous healing system and traditional healers continue to be consulted on a variety of health issues, with dual treatment regularly taking place.²⁰⁵ The modern health care system has several shortcomings, including a general shortage of personnel to deal with demand and patient numbers, geographical discrepancies in access to healthcare facilities, affordability of services, and the fact that modern services are often culturally irrelevant.²⁰⁶ Care of the mentally ill in Africa has for centuries been in the hands of

²⁰⁰Gureje, O (2007) "Psychiatry in Africa: The myths, the exotic, and the realities" 10 S Afr Psychiatry Rev 10 11-14 12.

²⁰¹*Ibid.*

²⁰²Gureje (2007) 10 S Afr Psychiatry Rev 10: 11-14 13.

²⁰³ Meissner, O 'Traditional medicine and its accommodation in the South African national health care system with special attention to possible statutory regulation' 2003 (unpublished LLD thesis, Unisa) 4.

²⁰⁴*Ibid.*

²⁰⁵*Ibid.*

²⁰⁶*Ibid.*

traditional and religious healers.²⁰⁷ The nature and practice of traditional healers have long been studied by anthropologists, but terms such as shaman, medicine man, diviner, witch doctor, medium, traditional healer, sangoma and others are often used interchangeably and without specification of the assumed common characteristics or consideration of the possible differences among such practitioners.²⁰⁸ Many religions advocate witchcraft and spirit possession, which are thought to influence the behaviour of a person to resemble that of a mentally ill individual.²⁰⁹ The important role that these religious beliefs of traditional healers may have on perceptions of mental illness cannot be ignored.²¹⁰

Historically African medicine differs widely from Western medicine. In African medicine the sick are treated or cared for in a particular way in terms of traditional African thinking, which is claimed to be different from Western thinking, as the African view of what a human being is differs from the so-called Western view.²¹¹ The African world view denotes a belief system encompassing the physical world and the sociological environment; it expresses continuity between the living and the dead; and lastly it comprises the metaphysical forces of the universe.²¹² The “wholeness” of the person is the interdependence of parts of a system including the individual’s family, the community in which he lives, and the influence of the ancestral spirits over him²¹³ Good health and ill health are regarded as the net result of a delicate and intricate balance between a person and his relationship with the ancestral spirits.²¹⁴ According to traditional beliefs, the well-being of the individual depends primarily not on the person himself but on his relationship with others, which is in keeping with the WHO’s definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.²¹⁵ A prominent issue raised in the past regarding African traditional health practice has been whether work by traditional healers

²⁰⁷Swanepoel 70.

²⁰⁸Swanepoel 69; Kale, R.(1995) "South Africa's health: Traditional healers in South Africa: A parallel healthcare system" 310 Br Medical J 6988 1182.

²⁰⁹ Swanepoel 70.

²¹⁰ *Ibid.*

²¹¹ *Ibid.*

²¹² Meissner 125-126.

²¹³ Meissner 126.

²¹⁴ *Ibid.*

²¹⁵ *Ibid.*

should be regarded as religion or psychotherapy, with some writers preferring the former view and some the latter.²¹⁶

The African view of mental illness encompasses a wide spectrum that ranges from ancestors, folk belief in witchcraft, to modern medical science.²¹⁷ All traditional types of psychotherapy reflect local beliefs regarding human nature, and in many cultures this means that the close links between individuals, their ancestors, and the spirit world play a prominent role in treatment.²¹⁸ Mkize explains that the patient does not consider the “illness” as something to be cured or controlled but as something to be understood and acknowledged.²¹⁹ Explanation plays a smaller role in traditional healing than it does in other forms of therapy.²²⁰ The lack of emphasis on diagnosis or patient history, the perfunctory and stereotyped nature of the spirit explanation and the complete lack of attention to the actions of the patient leading up to possession are all contrary to other psychotherapeutic methods.²²¹ Currently the practice of traditional healers are not fully understood or accepted by the medical profession.²²² Cases that involve spirit possession do not fit into the standard psychiatric classification of Western medicine.²²³ Meissner contends that Western psychology is unable address the mental health issues in African societies due to the cultural disconnect and lack of a shared world view that applies to the traditional healer and conveys the sense that someone “understands”.²²⁴ Without this understanding, the therapist is ineffective, and the treatment is irrelevant.²²⁵ The root cause of an unsuccessful handling of the cross-cultural encounter is that without knowledge

²¹⁶Janse van Rensburg, B. (ed.) (2012) ‘The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) Position Statements on Psychiatric Care in the Public Sector’ SAJP 18:3 133-147 139; Berg A. (2003)Ancestor reference and mental health in South Africa. *Transcult Psychiatry* 40(2):194-207.

²¹⁷Swanepoel 71.

²¹⁸Swanepoel 170.

²¹⁹Swanepoel 171; Mkize, DL. (2003) 'Towards an Afrocentric approach to psychiatry' SAJP 3-6 3.

²²⁰ Tantam, D. 'Psychotherapy and traditional healing' In Tantam, D., Duncan, A., *et al.* (eds) *Psychiatry for the Developing World*. London, Gaskell. Amer Psychiatric Pub 1996 61

²²¹Swanepoel 70-71.

²²²Swanepoel 170.

²²³Meissner 160.

²²⁴*Ibid.*

²²⁵*Ibid.*

and understanding of the client's belief system a medical practitioner can easily fall prey to errors of diagnosis, resulting in inappropriate management and poor patient compliance.²²⁶

Robertson proposes that there is a significant lack of information on the contribution of traditional healers in South Africa to mental health, and conducted three studies designed to fill some of the gaps.²²⁷ The studies suggest that, while traditional healers resemble faith based practitioners and counsellors more than medical practitioners, though they do provide a valued mental health service to certain clients.²²⁸ Robertson concludes that collaboration should be promoted, but further knowledge and debate is needed on the best way for mental health practitioners to collaborate with traditional healers, and on what basis it should be founded.²²⁹ Many mental health care practitioners in South Africa have little knowledge and understanding of the various local African cultures, although training programmes usually include seminars on transcultural psychiatry.²³⁰ Cultural competence requires the attainment of several qualities, namely:²³¹

- Cultural sensitivity that refers to recognition of the diversity of viewpoints, attitudes and lifestyles among human beings.
- Basic cultural knowledge about humankind as whole with which to put the particular client and family into perspective is desirable.

²²⁶ *Ibid.* See also Janse van Rensburg ABR. (2009) A changed climate for mental health care delivery in South Africa. *Afr J Psychiatry (Johannesburg)* 12 157-165; Jones LV. (2009) Black South African psychiatric recipients: have they been overlooked under the recent democratization? *Soc Work Public Health*24(1-2):76-88; Modiba P, Schneider H, Porteus K, Gunnarson V. (2001) Profile of community mental health service needs in the Moretele District (North-West Province) in South Africa'4 *J Ment Health Policy Econ*4189-196; Campbell-Hall V, Petersen I, Bhana A, Mjadu S, Hosegood V, Flisher AJ. (2010) 'Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services'47 *Transcult Psychiatry*4610-628; Sorsdahl KR, Flisher AJ, Wilson Z, Stein DJ. (2010) 'Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa' 13 *Afr J Psychiatry* 4284-290; Mkize LP, Uys LR. (2004)'Pathways to mental health care in KwaZulu-Natal'27 *Curatationis* 3 62-71; Sorsdahl K, Stein DJ, Flisher AJ. (2010) 'Traditional healer attitudes and beliefs regarding referral of the mentally ill to Western doctors in South Africa'47 *Transcult Psychiatry*4591-609.

²²⁷ Robertson, BA. (2006) "Does the evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies" 9 *S Afr Psychiatry Rev* 2: 87-90; Swanepoel 98.

²²⁸ *Ibid.*

²²⁹ Robertson (2006) *S Afr Psychiatry Rev* 90; Swanepoel 98.

²³⁰ Swanepoel 177.

²³¹ Tseng, WS. and Streltzer, J.'Cultural competence in Health Care' 2008 4; Swanepoel 177.

- Cultural empathy for the client that entails an intellectual understanding and the ability to feel and understand the client's own cultural perspectives on an emotional level.
- An understanding of the importance of culturally relevant interactions, such as an appreciation of gender interactions, what causes embarrassment and shame and ultimately how the psycho-legal assessment process itself may be biased according to the examinee's beliefs about authority figures.

In South Africa the impact of culture on the diagnosis and treatment of mental illness cannot be ignored.²³² The South African Medical Association has expressed the view that some degree of co-operation between African traditional healing and the Western biomedical system is desirable, based on the principle that the patient is pivotal in the healthcare equation and that traditional health practitioners play an important role in Africa.²³³ Though it should be noted that many patients with psychiatric conditions are still subject to various forms of abuse through the practices of some traditional healers, for example psychotic patients that are tied up and beaten, and where access to appropriate psychiatric intervention is delayed or restricted.²³⁴ Culture, religion and spirituality should be considered in the current approach to the practice and training of specialist psychiatrists within the professional and ethical scope of the discipline, and all faith traditions and belief systems in the heterogeneous SA society should be respected and regarded equally.²³⁵ Culture needs to be understood by mental health practitioners if they truly mean to assist in the proper care of mentally ill individuals from African cultures, as an individual cannot be viewed in isolation from their culture and beliefs. In addition the practice of traditional healers needs to be regulated effectively to ensure that patients are treated by sufficiently trained and registered persons. This is currently being undertaken by the enactment of the Traditional Health Practitioners Act.²³⁶ Its provisions and consequences are discussed hereafter.

²³² Swartz, L. 'Culture and language' in Baumann, SE. (ed.) 'Primary healthcare psychiatry: A Practical Guide for Southern Africa' 2007 47.

²³³ Janse van Rensburg (ed.) (2012) SAJP 139; South African Medical Association (SAMA). Bridging the Gap. Potential for a Health Care Partnership between African Traditional Healers and Biomedical Personnel in South Africa. Pretoria: SAMA, 2006

²³⁴ Janse van Rensburg (ed.) (2012) SAJP 139.

²³⁵ *Ibid*; Swartz 53.

²³⁶ 22 of 2007.

Burns *et al.* state that consultation with traditional healers may delay access to care for people with early mental illness and this may impact negatively on the course and outcome of the illness.²³⁷ Traditional healers are more geographically accessible and more culturally accessible to many citizens, particularly in the largely rural province of KwaZulu-Natal.²³⁸ A significant proportion of individuals experiencing mental health problems consult traditional healers as their first port of call despite the fact that the services of traditional healers are often more expensive than public health services.²³⁹ Societal stigma associated with the use of formal mental health services is another major factor leading individuals to traditional healers.²⁴⁰ No preference for one particular tradition should be given over another as a result of a practitioner or a dominant group being from the one tradition or the other.²⁴¹ Training and health education initiatives aimed at psychiatric practitioners, their patients, carers and students, and cultural and religious practitioners is required for relationships of mutual trust and understanding to be established.²⁴² The protection of individuals with psychiatric conditions within traditional and other religious/spiritual healing systems, however, needs to be ensured and all forms of abuse in this context, or neglect and delay regarding appropriate psychiatric care, should be identified and prevented

An important balance needs to be struck between respect for patient autonomy, respect for patients' right to cultural freedom, and freedom of belief (as discussed in Chapter 2), versus the protective role the law plays in ensuring vulnerable persons receive the medical assistance they need. The question regarding traditional healers in South Africa is when does legislation cross the line from ensuring due process and protections, to an overly prescriptive and western medicine approach that infringes on cultural beliefs to the degree that the situation becomes untenable and unconstitutional? The matter is anything but simple, as it is not the role of the State to prescribe to its citizens what to believe and how to practice it, though there is a duty on the State to protect vulnerable persons. The protection of persons with psychiatric

²³⁷ Burns, J.K. (2011) 'The mental health gap in South Africa – A human rights issue' *The Equal Rights Review*, Vol. 6 106.

²³⁸ Burns (2011) *The Equal Rights Review* 106; Mkize, L. P. and Uys, L. R., (1994) "Pathways to mental health care in KwaZulu-Natal", *Curationis*, Vol. 27(3) 62-71.

²³⁹ Burns (2011) *The Equal Rights Review* 106.

²⁴⁰ Burns (2011) *The Equal Rights Review* 106; See Thornicroft, G. (2008) "Stigma and discrimination limit access to mental health care" *17 Epidemiologia e Psichiatria Sociale* 14–19.

²⁴¹ Janse van Rensburg (ed.) (2012) *SAJP* 139.

²⁴² *Ibid.*

conditions within indigenous healing systems needs to be ensured and all forms of abuse, neglect and delay regarding appropriate psychiatric care should be identified and prevented.²⁴³

In the case of *S v Mahlalela*²⁴⁴ a traditional herbalist was convicted of culpable homicide after preparing a poisonous concoction of herbs mixed with traditional beer, and administering it to a child who consequently died.²⁴⁵ Where an accused is an expert, the standard of negligence required by the court is upgraded from the reasonable layperson to the reasonable expert.²⁴⁶ The court in *Mahlalela* stated that in this case the herbalist was, due to his profession and experience, more knowledgeable in the realm of plants and poisonous plant species than a lay person. Therefore the court concluded that the herbalist should have realised the dangerous nature of such an herb mixture and should have foreseen the consequence of possible death after ingestion thereof. Where the expert is a medical practitioner, the standard is that of the reasonable medical practitioner in the same circumstances.²⁴⁷ Carstens submits that the traditional herbalist cannot be compared to a qualified medical practitioner, but the general remarks of the court are applicable and confirms that physicians, like other professionals, are regarded as experts where an assessment has to be made of their alleged negligence.²⁴⁸

Although traditional healers cannot be compared to qualified medical practitioners, it would be imprudent not to hold them to higher standards of reasonableness than persons who do not purport to be experts in healing, as the practice of traditional healing can have a potentially negative impact on the health of persons who have a right to protection in law from misconduct. Traditional healers occupy a position in African cultures that sometimes borders on reverence within their cultural setting. This affords them influence over the manner in which illness and mental illness is perceived and treated, as well as the trust of many seeking medical attention. The Traditional Health Care Practitioners Act 22 of 2007 and its regulations that are due to become operational are interesting to note, as it will require strict

²⁴³ *Ibid.*

²⁴⁴ 1966 (1) SA 226 (A).

²⁴⁵ Swanepoel 334.

²⁴⁶ Carstens and Pearmain 621.

²⁴⁷ *Ibid*; Strauss 243.

²⁴⁸ Carstens & Pearmain 621; Swanepoel 334.

registration and training criteria. The Act and Regulations are discussed in the following section.

An example of change in the environment in which mental health care must be provided is the mainstreaming of traditional African health practice through the Traditional Health Care Act.²⁴⁹ The extent to which mental health care elements feature in the legal definition of traditional health practice, may even necessitate the consideration of whether the multidisciplinary mental health care team should actually be extended to include alternative or traditional practitioners as well, resulting in a still bigger demand on available mental health care resources.²⁵⁰ Several studies have emphasised that traditional healers may play an important role in addressing mental health care needs in South Africa by offering culturally appropriate treatment.²⁵¹ Equipping traditional healers to understand and effectively manage mental disorders in their communities may contribute towards scaling up services.²⁵²

3.6.2 The Traditional Health Practitioners Act 22 of 2007

The advent of the Constitution and the entrenchment of cultural, religious and anthropological values, and the right to equality and access to healthcare, meant that recognition had to be given to traditional medicine and traditional healers not trained in Western medicine.²⁵³ This recognition necessitated some form of statutory regulation; just as medical practitioners are regulated, giving rise to the Traditional Health Practitioners Act.²⁵⁴ The fact that only modern scientific medicine has been recognised as lawful until the introduction of this Act, pointed to a serious discrepancy between the law and reality, and between the monopolistic official health care system and the practices of traditional healers.²⁵⁵ By establishing a legal framework that facilitates cooperation between the two complementary health systems, a valuable cultural heritage could be preserved while at the same time guaranteeing quality care

²⁴⁹ Janse van Rensburg, ABR (2007) 'A framework for current public mental health care practice in South Africa' *Afr J Psychiatry* 10: 205-209 206.

²⁵⁰ *Ibid.*

²⁵¹ Sohrsdahl, K., Stein, DJ., and Lund, C. (2012) 'Mental Health Services in South Africa: Scaling up and future directions' *Afr J Psychiatry* 15:168-171 170.

²⁵² *Ibid.*

²⁵³ Carstens and Pearmain 280.

²⁵⁴ 22 of 2007; Carstens and Pearmain 280.

²⁵⁵ Meissner 4.

for all, with health care activities in whatever sector provided in a safe and competent manner.²⁵⁶

The purpose of Traditional Health Practitioners Act 22 of 2007 is to:²⁵⁷

- a) Establish the Interim Traditional Health Practitioners Council of South Africa;
- b) Provide for the registration, training and practices of traditional health; and to
- c) Serve and protect the interests of members of the public who use the services practitioners in the Republic; and of traditional health practitioners.

The Act applies to traditional health practice in the Republic; and traditional health practitioners and students engaged in or learning traditional health practice in the Republic.²⁵⁸

The Act in its entirety is not yet in operation and will only commence on a date to be published in the Government Gazette.²⁵⁹ The Traditional Health Practitioners Regulations No 1053 of 2015 were published in November 2014 and were open for comment from 3 November 2015 until 3 February 2016, three months after publication of the regulations. The regulations have provoked media interest on many fronts, with some commentators stating that the Act and Regulations are unrealistic and impracticable.²⁶⁰

3.6.2.1 Definitions

The following definitions are important in terms of the Traditional Health Practitioners Act:²⁶¹

²⁵⁶ Meissner 5.

²⁵⁷Section 2 of the Traditional Health Practitioners Act.

²⁵⁸Section 3(a) and (b) of the Traditional Health Practitioners Act.

²⁵⁹In terms of Section 52 of the Traditional Health Practitioners Act, 1 May 2014 was designated as the date upon which Sections 4, 5, 6, 8, 9, 16, 17, 18-28, 29-14, 42-46, 49, and 51 of the Act came into operation (Proclamation Nr 29 of 2014: Commencement of certain sections of the traditional health practitioners Act 22 of 2007). According to Proclamation Nr 17 of 2008: Commencement of Sections 7, 10, 11(3), 12 to 15, 47, 48 and 50 of the Traditional Health Practitioners Act 22 of 2007, the mentioned sections came into effect on 30 April 2008.

²⁶⁰ 'South Africa wants to regulate traditional healers – but it's not easy' 22 January 2016 The Conversation https://theconversation.com/south-africa-wants-to-regulate-traditional-healers-but-its-not-easy-53122#comment_875410 (accessed 14 March 2016).

²⁶¹Section 1 of Act 22 of 2007.

1. “Traditional health practice” is defined as the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object:
 - a) the maintenance or restoration of physical or mental health or function; or
 - b) the diagnosis, treatment or prevention of a physical or mental illness; or
 - c) the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or
 - d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death.²⁶²

2. “Traditional health practitioner” is defined in the Act as a person registered under the Act in one or more of the categories of traditional health practitioners.

3. “Traditional medicine” means an object or substance used in traditional health practice for:
 - a) the diagnosis, treatment or prevention of a physical or mental illness; or
 - b) any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug.

4. “Traditional philosophy” means indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice.

²⁶² But this excludes the professional activities of an individual practising any of the professions contemplated in the Pharmacy Act, 1974 (Act No. 53 of 1974), the Health Professions Act, 1974 (Act No. 56 of 1974), the Nursing Act, 1974 (Act No. 50 of 1974), the Allied Health Professions Act, 1982 (Act No. 63 of 1982), or the Dental Technicians Act, 1979 (Act No. 19 of 1979), and any other activity not based untraditional philosophy.

5. “Unprofessional conduct” means any act or omission which is improper or disgraceful or dishonourable or unworthy of the traditional health profession.

3.6.2.2 Traditional Health Practitioners Council

Before the Act, no single regulatory body existed for traditional healers and traditional activities were regulated primarily by various cultural norms and values.²⁶³ Traditional healers were organised and licensed by approximately 100 organisations which are officially registered under the Companies Act 71 of 2008 and not as health care providers, and although their members subscribe to a code of ethics, these associations had no mechanisms of enforcement.²⁶⁴

Section 4 of the Act establishes the Interim Traditional Health Practitioners Council. The objects of the Council are to²⁶⁵ promote public health awareness; ensure the quality of health services within the traditional health practice; protect and serve the interests of members of the public who use or are affected by the services of traditional health practitioners; promote and maintain appropriate ethical and professional standards required from traditional health practitioners; promote and develop interest in traditional health practice by encouraging research, education and training; promote contact between the various fields of training within traditional health practice in the Republic and to set standards for such training; compile and maintain a professional code of conduct for traditional health practice; and ensure that traditional health practice complies with universally accepted health care norms and values.

The Council may:²⁶⁶

- a) make enquiries and conduct investigations into complaints and allegations concerning the conduct of registered traditional health practitioners;
- b) issue guidelines concerning traditional health practice;

²⁶³Meissner 113.

²⁶⁴*Ibid.*

²⁶⁵Section 5 of the Traditional Health Practitioners Act.

²⁶⁶Section 6(1) of the Traditional Health Practitioners Act.

- c) consider any matter affecting the registration of traditional health practitioner sand make representations or take other action in connection therewith;
- d) approve minimum requirements pertaining to the education and training of traditional health practitioners in consultation with relevant departments, quality assessment bodies or a body of traditional health practitioners accredited by the Council for this specific purpose.

The Council must:²⁶⁷

- a) in the interests of the public, promote and regulate, liaison between traditional health practitioners and other health professionals registered under any law;
- b) implement health policies determined by the Minister concerning traditional health practice;
- c) advise the Minister on any matter falling within the scope of this Act, including the health needs of the people of South Africa, and the traditional health practice, and on matters of democracy, transparency, equity, accessibility and community involvement affecting the occupation of traditional health practice.

3.6.2.3 Registration of Traditional Health Care Practitioners

No person may practise as a traditional health practitioner within the Republic unless they are registered in terms of the Traditional Health Care Practitioners Act.²⁶⁸ Section 22(1) of the Act determines that the Minister may, on the recommendation of the Council, prescribe the minimum qualifications to be obtained by virtue of examinations conducted by an accredited institution, educational authority or other examining authority in the Republic. Regulation 2(1) of the Traditional Health Practitioners Regulations No 1053 of 2015 determines that any person wishing to be registered as a traditional health practitioner must apply on FORM THPA1 to the Registrar to be registered and practice as Practitioner as contemplated in Section 21 of the Act. The following categories of traditional health practice must undergo

²⁶⁷ Section 6(2) of the Traditional Health Practitioners Act.

²⁶⁸ Section 21(1) of the Traditional Health Care Practitioners Act.

education or training at any accredited training institution or educational authority or with any traditional tutor.²⁶⁹

- a) Divination;
- b) Herbalism;
- c) Traditional birth attendant's practice; and
- d) Traditional surgeon (circumcision) practice.

A diviner is an expert at carrying out a diagnosis, and defines the illness and its ultimate cause in the African belief system.²⁷⁰ The diviner is a person able to communicate with the spirits when in a state of possession and may have knowledge of medicinal herbs.²⁷¹ Diviners differ from one another and some may carry out a diagnosis while in a state of possession, while others use possession and the casting of bones to read, or the use of other objects.²⁷² Once a certain spirit has been identified as the cause of an illness or misfortune, the practitioner advises the patient on the procedure necessary to propitiate the spirit, and may also prescribe a herbal remedy.²⁷³ According to traditional beliefs, a person does not choose to become a diviner; only a person "called" or "chosen" by the ancestors can become one.²⁷⁴ After a person has been identified as being "called", they leave their home to live with and be tutored by a reputable master sangoma, where they undergo a variety of exercises and training and must pass multiple tests.²⁷⁵

An herbalist practises the art of healing and is not "called", but chooses the profession as it is freely accessible.²⁷⁶ A novice completes an apprenticeship under a practising reputable herbalist for several years and learns by observation and instruction to identify and name relevant herbs, plants and animals; to mix ingredients; and to administer medicines.²⁷⁷ The training of herbalists differs from region to region, is not standardised and is principally based

²⁶⁹ Regulation 3 of the Traditional Health Practitioners Regulations No 1053 of 2015.

²⁷⁰ Meissner 132.

²⁷¹ *Ibid.*

²⁷² *Ibid.*

²⁷³ Meissner 133.

²⁷⁴ *Ibid.*

²⁷⁵ Meissner 133-134.

²⁷⁶ Meissner 134.

²⁷⁷ *Ibid.*

on hands-on experience, but it is also possible for individuals to acquire the necessary knowledge through formal training at a school of traditional medicine, although the number of such schools is still small.²⁷⁸

Regulation 5 of the Traditional Health Practitioners Regulations No 1053 of 2015 determines that no one may be registered as a student practitioner unless they have attained an ABET Level 1 educational level or equivalent and have in their possession a letter of admission indicating the training or course to be done from the tutor or institution registered and accredited by the Council to provide or offer the training or course. Regulation 6(1) provides that the Divination student must attend or undergo training for minimum period of twelvemonths in which period the student practitioner must learn at least diagnosis, preparation of herbs, and traditional consultation, while Regulation 6(2) states that the student herbalist must undergo training for a minimum period of twelve month in which period the student must learn to identify and prepare herbs, sustainable collection of herbs and dispense herbs and consultation.

Regulation 10 provides that the applicant who, on promulgation of the Regulations, is a Diviner, Herbalist, Traditional Birth Attendant or Traditional Surgeon may be registered as such by the Registrar on the basis of the documentary proof they may produce to the Registrar, or on basis that the community regarded him or her to a Diviner, Herbalist, Traditional Birth Attendant or Traditional Surgeon.²⁷⁹ The Council must register the persons undergoing training on a FORM THPA3 on payment of fee as determined or reflected in the Table of Fees attached to these Regulations.²⁸⁰

The Minister may, after consultation with the Council, make regulations relating to:²⁸¹

- the registration by the Council of students in any prescribed category of traditional health practice undergoing education or training at any accredited training institution or

²⁷⁸ *Ibid.*

²⁷⁹ Traditional Health Practitioners Regulations No 1053 of 2015.

²⁸⁰ Regulation 8 of the Traditional Health Practitioners Regulations No 1053 of 2015.

²⁸¹ Regulations 47(1) of the Traditional Health Practitioners Regulations No 1053 of 2015.

educational authority or with any traditional tutor, the fees payable in respect of such registration and the removal by the Council from the register in question of the names of such students;

- the minimum standards of education and training required of students as a condition precedent to registration;
- the duration of the educational programme to be followed by students at an educational or training institution or with a traditional tutor;
- the minimum requirements of the curricula and the minimum standards of education or examinations which must be maintained at every educational or training institution or by every traditional tutor offering training in traditional health practice, in order to secure registration and recognition of the qualifications obtained under this Act; (viii)
- the nature and duration of the practical training to be completed by persons before they may be registered;
- the nature and duration of the training to be completed by a person who has obtained a qualification as a traditional health practitioner, but who is not yet registered as such, before they may be registered as such;
- the conditions under which a registered person may practise as a traditional health practitioner or practise in any category of traditional health practice;
- the registration of the categories of registered persons, which includes diviners, herbalists, traditional birth attendants and traditional surgeons;
- the registration of specialities;
- the requirements to be satisfied, including the experience to be obtained, the nature and duration of the training to be undergone and the qualifications or additional qualifications required from a person before any category or speciality may be registered;
- standards of traditional health practice in order to ensure that practices are not detrimental to the health of patients or the general public;
- scopes of practice of the various categories of traditional health practitioners.

3.6.2.4 *The DSM and its uses in culturally diverse environments*

The DSM-5 states that mental disorders are defined in relation to cultural, social and familial norms and values that provide interpretive frameworks that shape the experience and expressions of symptoms, signs and behaviours that are diagnostic criteria.²⁸² Some key aspects of culture relevant to diagnostic classification and assessment have been considered in the development of the DSM-5 as an individual's experiences and symptoms may differ from sociocultural norms and this needs to be considered in diagnostic assessment.²⁸³ In Section III "Cultural formulation" the DSM-5 contains a detailed discussion of culture and diagnosis, including tools for in-depth cultural assessment. The boundaries of normality vary across cultures for specific types of behaviour, therefore the level at which an experience becomes problematic or pathological differs.²⁸⁴ Culture also has various impacts on stigma surrounding illness, support and coping strategies, adherence to treatments, as well as the conduct of the clinical encounter.²⁸⁵ Cultural differences between the clinician and patient have implications for the accuracy and acceptance of the diagnosis, treatment decisions prognostic considerations and clinical outcomes.²⁸⁶ It is therefore important that mental health care practitioners are aware of and knowledgeable in cultural differences and peculiarities when conducting assessments, as well as being well versed in the tools available to facilitate in-depth cultural assessment. In a country like South Africa with its rich cultural heritage, it is not acceptable that cultural aspects in mental health care training and practice are lacking, as it leads to an untenable situation where there is a disconnect between a mental health care practitioner, the patient and an accurate diagnosis that will lead to effective treatment and the protection of fundamental rights to access to healthcare and dignity, among others.

In the DSM-5 the concept of culture-bound syndrome has been replaced by three concepts that offer greater clinical utility, that can be used to understand and describe illness experiences and can be elicited in the clinical encounter, namely:²⁸⁷

²⁸² DSM- 5 Introduction.

²⁸³ *Ibid.*

²⁸⁴ *Ibid.*

²⁸⁵ *Ibid.*

²⁸⁶ *Ibid.*

²⁸⁷ *Ibid.*

- Cultural syndrome is a cluster or group of co-occurring, relatively invariant symptoms found in a specified cultural group, community or context. The syndrome may or may not be recognised as an illness within the culture, but the cultural patterns of distress and features of illness may nevertheless be recognisable by an outside observer.
- Cultural idiom of distress is linguistic term or way of talking about suffering amongst individuals of a cultural group referring to shared concepts of pathology or disorder.
- Cultural explanation or perceived cause is a label, attribution or feature of an explanatory model that provides a culturally conceived etiology or cause of symptoms, illness or distress. Causal explanations may be salient features of folk classifications of disease used by laypersons or healers.

The above assumes an in-depth knowledge of a person's particular cultural context relating to experiences of pathology and terminology to effectively identify and treat mental illness in culturally diverse contexts, and requires great sensitivity by the mental health care practitioner in the exercise of their expertise. In South Africa the required level of knowledge and training opportunities in this regard is lacking and needs to be addressed to ensure accuracy in diagnoses and treatment, and to ensure the State is fulfilling its duty to provide access to healthcare by competent and effective medical professionals, while respecting the constitutionally entrenched cultural rights of persons.

3.6.2.5 Concluding remarks

It is submitted that the Traditional Health Practitioners Act²⁸⁸ is doing much to elevate traditional healing practice from “informal” health care and to legitimise acts of traditional healing. The signing of the Act means that traditional healers are permitted to issue medical certificates for purposes of sick leave.²⁸⁹ The Act and its regulations necessitate that serious questions are asked regarding the status of traditional healing in relation to the formal health care system, particularly regarding mental health practice. As the traditional healer is regulated the next steps in the process of fully realising an integrated health system is to

²⁸⁸ 22 of 2007.

²⁸⁹ Mawere, M. And Awuah-Nyamekye, S. (eds.) ‘Between Rhetoric and Reality: The State and Use of Indigenous Knowledge in Post-Colonial Africa’ 2015120.

determine the role a traditional healer might play in forensic investigations and the treatment of mentally disordered prisoners and State Patients.

An issue of contention in the lay media has been responses from traditional healers concerning the unfeasibility of the Act and Regulations, fearing that it will change the essence of their profession and transform it into something they do not recognise or support.²⁹⁰ The yardstick by which the new Act measures the efficacy, safety and quality of services in traditional health care seems to be modern medicine, indicating that the scientific recognition of traditional medicine remains unresolved.²⁹¹ It is imperative that the Act and Regulations strike a balance between the protection of vulnerable persons from harm, and the preservation of constitutionally enshrined cultural rights.

3.7 The regulation of mental health care practitioners

The mental health care profession is primarily regulated by statute, the most important pieces of legislation being the Health Professions Act 56 of 1974, and the Mental Health Care Act 17 of 2002.²⁹² These statutes are discussed in this section as far as they are applicable to mental health care practitioners. The section includes a discussion of the registration and training of mental health practitioners, specifically psychiatrists, psychologists, and forensic mental health experts. Mental health practitioners play a fundamental role in the medical treatment, quality of life, and protection of persons with mental disorders. A mental health practitioner can impact on the legal status, freedom, and ultimately the course of a patient's life, therefore it is imperative that a high standard of knowledge, training, and experience is maintained to ensure that the rights of persons with mental disorder are adequately protected. The Health Professions Council of South Africa (the HPCSA) and its strategic role is also discussed.

²⁹⁰ 'Regulation is against our calling and nature: traditional healers' 7 December 2015 eNCA <https://www.enca.com/south-africa/regulation-against-our-calling-and-nature-traditional-healers> (accessed 14 March 2016).

²⁹¹ Mawere and Awuah-Nyamekye (eds.) 119.

²⁹² Carstens and Pearmain 249-250.

The following legislation impacts on the medical profession in general:²⁹³ The South African Medical Research Council Act 58 of 1991; Pharmacy Act 53 of 1974 as amended by Act 88 of 1997 and Act 1 of 2000; Medical, Dental and Supplementary Health Service Professions Act 56 of 1974 as amended by Act 89 of 1997 (now known as the Health Professions Act), Nursing Act 50 of 1978; Chiropractors, Homeopaths and Allied Health Service Professions Act 63 of 1982 as amended; Dental Technicians Act 19 of 1979 as amended; Academic Health Centres Act 86 of 1993 as amended; Choice of Termination of Pregnancy Act 92 of 1996 as amended; Medical Schemes Act 131 of 1998; Inquests Act 58 of 1959 as amended; South African Institute of Drug-Free Sport Act 14 of 1997; Prevention and Treatment of Drug Dependency Act 20 of 1992 as amended by Act 14 of 1999; National Road Traffic Act 93 of 1996; Medicines and Related Substances Control Amendment Act 90 of 1997; Health Act 63 of 1977; Births and Deaths Registration Act 51 of 1992; Child Care Act 74 of 1983 as amended; Boxing and Wrestling Control Act 39 of 1954 as amended; Compensation for Occupational Injuries and Diseases Act 130 of 1993; Sterilisation Act 44 of 1998; Aged Persons Amendment Act 100 of 1998; Domestic Violence Act 116 of 1998; Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000; Promotion of Administrative Justice Act 3 of 2000; National Health Laboratory Act 37 of 2000; Council for Medical Schemes Levies Act 58 of 2000.

A discussion of the bases of liability of mental health practitioners for professional malpractice, including criminal and civil sanctions, is outside the scope of this thesis. In this section the discussion is limited to the disciplinary inquiries in terms of the Health Professions Act²⁹⁴ and the liability and accountability measures regarding traditional healers. Therefore the focus is not on the bases for legal liability, but on the measures in place to ensure that the treatment of mentally disabled persons are within the rights afforded to them, and that individuals purporting to be qualified mental health practitioners are in fact adequately qualified and registered. It follows that where measures to ensure compliance and accountability are lacking that the abuse of human rights is a distinct possibility, especially concerning vulnerable persons such as mentally disabled persons.

²⁹³ McQuoid-Mason, D. 'Health law – the basics' in Dhali, A. and McQuoid-Mason, D. 'Bioethics, Human Rights and Health law: Principles and Practice' 201148-49.

²⁹⁴ 56 of 1974.

McQuoid-Mason and Dhai state the three main purposes of regulating health practitioners as:²⁹⁵

1. To protect the public from unsafe practices;
2. To set professional, ethical standards to ensure quality service; and
3. To confer accountability, identity and professional status upon practitioners.

3.7.1 The definition of “mental health care practitioner”

The Mental Health Care Act offers the following definitions:²⁹⁶

- A “mental health care practitioner” means a psychiatrist, registered medical practitioner, nurse, clinical psychologist, occupational therapist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services.”
- A “medical practitioner” means a person registered as such in terms of the Health Professions Act 56 of 1974;
- A “mental health care provider” means a person providing mental health care services to mental health care users and includes mental health care practitioners.

The Health Professions Act offers the following definitions:²⁹⁷

- “health practitioner” means any person, including a student, registered with the council in a profession registrable in terms of this Act;
- “health profession” means any profession for which a professional board has been established in terms of Section 15 and includes any category or group of persons provided for by such a board (professional boards established in terms of Section 15 are discussed in this chapter below);

²⁹⁵McQuoid-Mason, D. and Dhai, A. ‘Professionalism and the healthcare practitioner-patient relationship’ in Dhai, A. and McQuoid-Mason, D. ‘Bioethics, Human Rights and Health law: Principles and Practice’ 2011 61.

²⁹⁶Section 1 of the MHCA.

²⁹⁷Section 1 of the Health Professions Act 56 of 1974.

- “medical practitioner” means a person registered as such under this Act;
- “psychologist” means a person registered as such under this Act;
- “register”, when used as a noun, means a register kept in accordance with the provisions of this Act, and when used in relation to any registration category or a member of any class of persons in respect of which a register is kept, means the register kept for that class;
- “registrar” means the registrar appointed under section 12 or a person lawfully acting in that capacity;
- “speciality”, in relation to a person registered in respect of any profession under this Act, means any particular discipline, division or subdivision of a profession which is recognised under this Act as a speciality in which such person specialises or intends to specialise.

The definitions highlight the importance of registration of mental health practitioners in terms of the Health Professions Act²⁹⁸ in order for practitioners to be recognised as having the required expertise in their field. An important part of the definition of “mental health practitioner” in the MHCA is the word “trained”, so ensuring that mental health services are carried out by those who are competent and qualified to do so.²⁹⁹

3.7.2 The Health Professions Act 56 of 1974.

The purpose of the Act as stated in its long title is to establish the Health Professions Council of South Africa and professional boards; to provide for control over the education, training and registration for and practising of health professions registered under this Act; and to provide for matters incidental thereto.

²⁹⁸56 of 1974.

²⁹⁹ Simpson, B.; Chipps, J. (2012) ‘Mental Health Legislation: Does it protect the rights of people with mental health problems?’ 1 Social Work 48: 47-57 50.

3.7.3 The Health Professions Council of South Africa (The HPCSA)

This section considers the role of the HPCSA in regulating mental health care practitioners, also investigating whether the authorising legislation is drafted in such a way that the HPCSA is properly empowered to reach the aims of the legislature. The resources available to the HPCSA in the execution of its duties, pending policy matters, and current legislation are considered. The appointment of members and general procedure of the HPCSA is outside of the scope of this thesis, which only focuses on its functions and duties.

The HPCSA is established by the Health Professions Act³⁰⁰ as the supreme statutory body regulating the medical profession and is as such the guardian of the prestige, status and dignity of the profession and public interests.³⁰¹ The HPCSA must ultimately protect the public and guide the medical profession by ensuring professional competence and fostering compliance with standards.

Together with twelve Professional Boards that operate under its jurisdiction, the HPCSA endeavours to promote the health of the South African population, determine standards of professional education and training and set and maintain fair standards for professional practice.³⁰² The Medical and Dental Professions Board, which includes psychiatry, and the Professional Board for Psychology both operate under the jurisdiction of the HPCSA.³⁰³ Additionally the Traditional Health Practitioners Act³⁰⁴ was introduced to establish the Interim Traditional Practitioners Council of South Africa and the Traditional Practitioners Council of South Africa to give recognition to the role of traditional healers practising in conjunction with medical practitioners trained in western medicine in South Africa.³⁰⁵ The Traditional Practitioners Councils of South Africa are discussed in this Chapter above.

³⁰⁰ Section 2 of Act 56 of 1997.

³⁰¹ Carstens Foundational Principles of South African Medical Law (2007) 251.

³⁰² Swanepoel 127.

³⁰³ Swanepoel 127.

³⁰⁴ 22 of 2007.

³⁰⁵ Carstens and Pearmain 250.

The objects and functions of the HPCSA are:³⁰⁶

- a) The co-ordination of professional boards established in terms of the Act (such as the Professional Board for Psychology).
- b) To promote and regulate inter-professional relations between health professions in the interest of the public;
- c) to determine strategic policy in accordance with national health policy as determined by the Minister, and to make decisions in terms thereof, regarding the professional boards and the health professions, for matters such as finance, education, training, registration, ethics and professional conduct, disciplinary procedure, scope of the professions, inter-professional matters and maintenance of professional competence;
- d) to consult and liaise with relevant authorities on matters affecting the professional boards in general;
- e) to assist in the promotion of the health of the population of the Republic;
- f) subject to legislation regulating health care providers and consistency with national policy determined by the Minister, to control and to exercise authority in respect of all matters affecting the education and training of persons in, and the manner of the exercise of the practices pursued in connection with, the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in human kind;
- g) to promote liaison in the field of education and training referred to in paragraph (f), both in the Republic and elsewhere, and to promote the standards of such education and training in the Republic;
- h) to advise the Minister on any matter falling within the scope of this Act in order to support the universal norms and values of health professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement;
- i) to communicate to the Minister information of public importance acquired by the council in the course of the performance of its functions under the Health Professions Act³⁰⁷;

³⁰⁶ Section 3 of the Health Professions Act 56 of 1974.

³⁰⁷ 56 of 1974.

- j) to serve and protect the public in matters involving the rendering of health services by persons practising a health profession;
- k) to exercise its powers and discharge its responsibilities in the best interest of the public and in accordance with national health policy determined by the Minister;
- l) to be transparent and accountable to the public in achieving its objectives and when performing its functions and exercising its powers;
- m) to uphold and maintain professional and ethical standards within the health professions;
- n) to ensure the investigation of complaints concerning persons registered in terms of this Act and to ensure that appropriate disciplinary action is taken against such persons in accordance with this Act in order to protect the interest of the public;
- o) to ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly;
- p) to submit to the Minister –
 - i. a five-year strategic plan within six months of the council coming into office which includes details concerning how the council plans to fulfil its objectives under this Act;
 - ii. every six months a report on the status of health professions and on matters of public importance that have come to the attention of the council in the course of the performance of its functions under this Act; and
 - iii. an annual report within six months of the end of the financial year; and
- q) To ensure that an annual budget for the council and the professional boards is drawn up and that the council and the professional boards operate within the parameters of such budget.

The council may after consultation with the relevant professional board, consider any matter affecting the health professions registrable under this Act and, consistent with national health

policy determined by the Minister, make representations or take such action in connection therewith as the council deems necessary.³⁰⁸ The council may also consistent with national health policy determined by the Minister, make rules on all matters the council considers necessary or expedient that the objects of this Act may be achieved;³⁰⁹ delegate to any professional board or committee or any person such of its powers as it may determine, but shall not be divested of any power so delegated;³¹⁰ and perform such other functions as may be prescribed, and do all such things as the council deems necessary or expedient to achieve the objects of this Act within the framework of national health policy determined by the Minister.³¹¹

3.7.3.1 The establishment, objectives and powers of professional boards

Section 15 of the Health Professions Act³¹² provides that the Minister of Health shall establish a professional board regarding any health profession in respect of which a register is kept in terms of the Act and make regulations relating to the constitution, functions and functioning of a professional board on recommendation of the HPCSA. The objects of a professional board are:³¹³

- a) to consult and liaise with other professional boards and relevant authorities on matters affecting the professional board;
- b) to assist in the promotion of the health of the population of the Republic on a national basis;
- c) subject to legislation regulating health care providers and consistency with national policy determined by the Minister, to control and to exercise authority in respect of all matters affecting the education and training of persons in, and the manner of the exercise of the practices pursued concerning, any health profession falling within the ambit of the professional board;

³⁰⁸ Section 4(c) of the Health Professions Act 56 of 1974.

³⁰⁹ Section 4(d) of the Health Professions Act 56 of 1974.

³¹⁰ Section 4(e) of the Health Professions Act 56 of 1974.

³¹¹ Section 4(f) of the Health Professions Act 56 of 1974.

³¹² 56 of 1974.

³¹³ Section 15A of the Health Professions Act 56 of 1974.

- d) to promote liaison in the field of the education and training contemplated in paragraph (c), both in the Republic and elsewhere, and to promote the standards of such education and training in the Republic;
- e) to make recommendations to the council to advise the Minister on any matter falling within the scope of this Act as it relates to any health profession falling within the ambit of the professional board in order to support the universal norms and values of such profession or professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement;
- f) to make recommendations to the council and the Minister on matters of public importance acquired by the professional board in the course of the performance of its functions under this Act;
- g) to maintain and enhance the dignity of the relevant health profession and the integrity of the persons practising such profession; and
- h) to guide the relevant health profession or professions and to protect the public.

Section 15B(1) grants general powers to professional boards to appoint examiners and moderators, conduct examinations and grant certificates, and charge such fees in respect of such examinations or certificates as may be prescribed;³¹⁴ and subject to prescribed conditions, approve training schools.³¹⁵ According to Section 15B(1)(d) a professional Board (such as the Professional Board for Psychology) may consider any matter affecting any profession falling within the ambit of the professional board and make representations or take such action in connection therewith as the professional board deems advisable. A professional board may also perform such other functions as may be prescribed, and generally, do all such things as the professional board deems necessary or expedient to achieve the objects of this Act in relation to a profession falling within the ambit of the professional board.³¹⁶ Any decision of a professional board relating to a matter falling entirely within its ambit shall not be subject to ratification by the council, and the council shall, for this purpose, determine whether a matter falls entirely within the ambit of a professional board.³¹⁷ A significant

³¹⁴Section 15B(1)(b) of the Health Professions Act 56 of 1974.

³¹⁵Section 15B(1)(c) of the Health Professions Act 56 of 1974.

³¹⁶Section 15B(1)(g) of the Health Professions Act 56 of 1974.

³¹⁷Section 15B(2) of the Health Professions Act 56 of 1974.

overlap can be noted between the objects of the HPCSA and those of the professional Boards, indicating that the professional boards are an extension of the HPCSA operating as the bureaucratic arm that regulates the medical professions on a daily basis, while the HPCSA is the executive body.³¹⁸

3.7.4 Education, training and registration of mental health care practitioners

No person or educational institution, excluding a university or a Technicon, may offer or provide any training having as its object to qualify any person for the practising of any profession to which the provisions of this Act apply or for the carrying on of any other activity directed to the mental or physical examining of any person or to the diagnosis, treatment or prevention of any mental or physical defect, illness or deficiency in man, unless such training has been approved by the professional board concerned.³¹⁹ A professional board must first grant an application for persons wishing to offer such training and may prescribe conditions and requirements attached to the training as it sees fit.³²⁰ Failing to comply with this mandated application process before offering training is an offence punishable by a fine or imprisonment not exceeding six months.³²¹

Section 17(1) of the Health Professions Act determines that no person shall be entitled to practise within the Republic any health profession registrable in terms of this Act,³²² or any health profession the practice of which mainly consists of the physical or mental examination of persons; the diagnosis, treatment or prevention of physical or mental defects, illnesses or deficiencies in man humankind; the giving of advice regarding such defects, illnesses or deficiencies; or the prescribing or providing of medicine concerning such defects, illnesses or deficiencies (except in so far as it is authorised by legislation regulating health care providers and Sections 33, 34 and 39 of this Act) unless they are registered in terms of this Act.³²³ A relevant professional board or a committee of a professional board to whom the function has

³¹⁸ Carstens and Pearmain 253-254.

³¹⁹ Section 16(1) of the Health Professions Act 56 of 1974.

³²⁰ Sections 16(2) and 16(3) of the Health Professions Act 56 of 1974.

³²¹ Section 16(5) of the Health Professions Act 56 of 1974.

³²² Section 17(1)(a) of the Health Professions Act 56 of 1974.

³²³ Section 17(1)(b) of the Health Professions Act 56 of 1974.

been delegated may authorise the registrar to suspend the registration of any person who has failed to comply with the requirements regarding continuing professional development as prescribed under Section 26.³²⁴

The Minister may, on the recommendation of the council, prescribe the qualifications obtained by examinations conducted by an accredited university, or other educational institution or examining authority in the Republic, which, when held singly or conjointly with any other qualification, shall entitle any holder thereof to registration in a registration category in terms of this Act if they have, before or concerning or after the acquisition of the qualification in question, complied with such conditions or requirements as may be prescribed.³²⁵ The Minister may also after consultation with the HPCSA designate that certain qualifications not prescribed for registration indicate a satisfactory standard of professional education and training for registration, and set appropriate examinations that must be passed to enable registration by individuals holding those qualifications.³²⁶

3.7.5 Continuing Professional Development

The council may, after consultation with a professional board, make rules which:³²⁷

- a) Determine conditions relating to continuing professional development to be undertaken by persons registered in terms of this Act in order to retain such registration;
- b) Determine the nature and extent of continuing professional development to be undertaken by persons registered in terms of this Act;
- c) Relate to the criteria for recognition by the professional board of continuing professional development activities and of providers offering such activities; and
- d) Relate to offences regarding, and penalties for, non-compliance with this section.

³²⁴ Section 19A(1)(d) of the Health Professions Act 56 of 1974.

³²⁵ Section 24 of the Health Professions Act 56 of 1974.

³²⁶ Sections 25(1), 25(2) and 25(3) of the Health Professions Act 56 of 1974.

³²⁷ Section 26 of the Health Professions Act 56 of 1974.

It has become compulsory for all medical practitioners registered in South Africa to undergo continuing education and training for which the HPCSA prescribes rules dictating conditions regarding this continued education for professionals to retain registration, the nature of the education and training and the criteria for recognition by the council of continuing education courses and institutions offering them.³²⁸ The HPCSA introduced a system of compulsory Continuing Professional Development (CPD) in terms of Section 26 of the Health Professions Act³²⁹ designed to improve overall patient care, the CPD system requires all professionals registered with HPCSA to earn a prescribed number of Continuing Education Units (CEUs) annually by attending HPCSA-approved education initiatives. Every practitioner is required to accumulate 30 Continuing Education Units (CEUs) per twelve-month period and five of the units must be on ethics, human rights and medical law. Mandatory random audits are conducted to ensure compliancy.³³⁰ The Health Professions Act³³¹ accordingly authorises the HPCSA and its boards to mandate compulsory training of forensic mental health practitioners that would bridge the gap in understanding and knowledge between the mental health care profession and the law and result in a more effective system to serve the needs of justice and the community.³³²

3.7.6 Regulations to the Health Professions Act 56 of 1974

Section 61(1)(a) provides that the Minister may, after consultation with the council, make regulations relating to the minimum requirements of the curricula and the standards of education, training and examinations to qualify for registration in terms of this Act, which must be maintained at every educational institution or training facility offering education and training in any such profession, to secure recognition under this Act of the qualifications in question at such educational institution or training facility; the standards of general education

³²⁸Carstens 256; Section 16 of Act 56 of 1974; Tredoux, Foster, Allan, Cohen, Wassenaar 11.

³²⁹ Health Professions Act 56 of 1974, in terms of which the HPCSA may from time to time prescribe rules relating to continuing education and the nature and extent thereof.

³³⁰ HPCSA Council Overview <http://www.hpcsa.co.za/about-council-overview.php>. (Accessed 16 April 2016). Several steps may be taken against the medical practitioner by the HPCSA in case of non-compliance with CPD guidelines, as set out in the HPCSA CPD Guidelines: http://www.hpcsa.co.za/downloads/rules_reg_constitution/cpd_guidelines_april_2009.pdf. (Accessed 16 April 2016).

³³¹56 of 1974.

³³² Spamers 2010 64.

required of such students as a condition precedent to such registration; and the duration of the curricula to be followed by such students at such educational institution or training facility. Section 61(1)(b) provides that the Minister may make regulations relating to the minimum age and the standard of general education required of a candidate for examination for a certificate entitling the holder thereof to registration in terms of this Act; the persons who may be admitted to such examinations; the courses of study and the training required for such examinations; the institutions and facilities at which such education or training may be taken or undergone and any other requirements concerning such education or training.

In addition the Minister may also regulate the registration in terms of Section 35 of the specialities or subspecialties or professional categories or additional professional categories of the health professions; the requirements to be satisfied, including the education and training to be obtained, the nature and duration of the education and training to be undergone and the qualifications to be held by persons before any person may be registered as a specialist or in any subspecialty, professional category or additional professional category; the circumstances under which any applicant for registration as a specialist shall be exempted from any of such requirements; and conditions regarding the practising of a specialist or a person whose subspecialty, professional category or additional professional category has been registered, including conditions restricting the practice of such a specialist or any such person to the speciality, subspecialty or professional category or additional professional category in which they hold registration.³³³ Generally, the Minister may also regulate all matters which the Minister considers necessary or expedient to prescribe so that the purposes of this Act may be achieved, and the generality of this provision shall not be limited by the preceding paragraphs of this subsection,³³⁴ as well as amend or repeal any regulation or rule in consultation with the HPCSA.³³⁵

³³³ Section 61(1)(e) of the Health Professions Act 56 of 1974.

³³⁴ Section 61(1)(k) of the Health Professions Act 56 of 1974.

³³⁵ Section 61(2) of the Health Professions Act 56 of 1974.

3.7.7 Offences by unregistered persons under the Health Professions Act

The Health Professions Act creates certain offences that can be perpetrated by unregistered persons punishable by a fine or imprisonment not exceeding twelve months, or both a fine and such imprisonment.³³⁶ The criminalisation of certain acts by unregistered persons highlights the high importance placed on registration by the legislator to regulate the provision of health care services. No person shall perform any act deemed to be an act pertaining to any health profession as may be prescribed under this Act unless they are:³³⁷ registered in terms of this Act in respect of such profession; registered in terms of this Act in respect of any other profession referred to in Section 33 to which such act is also deemed to pertain; or practise a health profession in respect of which the registrar in terms of this Act keeps a register and such act is deemed to be an act which also pertains to such profession.

Furthermore, according to Section 40 of the Act, any person not registered in respect of any health profession, but pretends to be so registered in respect of such profession; or uses any name, title, description or symbol indicating, or calculated to lead persons to infer that they are the holder of any qualification which by rule under this Act is recognised by the relevant professional board as acceptable for registration in respect of such profession, but of which qualification they are not the holder; or uses any name declared by regulation to be a name that may not be used, shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding five years, or to both a fine and such imprisonment. In addition Section 59(1) determines that an unregistered person shall not be able to recover remuneration in respect of any act performed pertaining to the profession of a registered person.

3.7.8 Unprofessional conduct

Section 41(1) provides that a professional board shall have power to institute an inquiry into any complaint, charge or allegation of unprofessional conduct against any person registered

³³⁶ Section 39(2) of the Health Professions Act 56 of 1974.

³³⁷ Section 39(1) of the Health Profession Act 56 of 1974.

under this Act, and, on finding such person guilty of such conduct, to impose any of the penalties prescribed in Section 42(1), namely: A caution or a reprimand or a reprimand and a caution; suspension for a specified period from practising or performing acts specially pertaining to his or her profession; removal of his or her name from the register; a prescribed fine; a compulsory period of professional service as may be determined by the professional board; or the payment of the costs of the proceedings or a restitution or both. Every person whose conduct is the subject of an inquiry under Section 41, shall be afforded an opportunity, by himself or herself or through his or her legal representative, of answering the charge and of being heard in his or her defence.³³⁸ The effect of a suspension or removal from the register is that such a person may not lawfully practice their profession.³³⁹

The Health Professions Amendment Act 29 of 2007 amended Section 41 to refer to unprofessional conduct, instead of “misconduct”. The Amendment Act also substituted the references to “improper or disgraceful conduct” for “unprofessional conduct”. Unprofessional conduct is defined as “improper or disgraceful or dishonourable or unworthy conduct” regarding the profession of a person registered under the Act.³⁴⁰ Improper or disgraceful conduct can be viewed under four separate headings, namely medical malpractice,³⁴¹ improper or disgraceful behaviour concerning patients,³⁴² improper or disgraceful conduct concerning fellow practitioners,³⁴³ or other improper conduct unbecoming a medical practitioner.³⁴⁴ The Code of Ethical Rules of the HPCSA was drawn up for medical practitioners and psychologists and is an important consideration in determining what constitutes unprofessional conduct, even though they are not binding on a court of law.³⁴⁵

³³⁸ Section 42(2) of the Health Professions Act 56 of 1974.

³³⁹ Section 44 of the Health Professions Act 56 of 1974.

³⁴⁰ Carstens and Pearmain 262.

³⁴¹ This is medical treatment that may be regarded as negligent or improper or not in accordance with good medical practice.

³⁴² Acts that are contrary to accepted ethical behaviour and standards by members of the medical profession fall under this category, for example breaches of confidentiality, or illicit sexual relationships with patients.

³⁴³ These concern acts where a medical practitioner knowingly takes over patients treated by another medical professional, touting, or discussing colleagues and their abilities with laymen in a scandalous manner.

³⁴⁴ Carstens and Pearmain 263.

³⁴⁵ Carstens and Pearmain 264.

3.7.9 The disciplinary powers of professional boards

A professional board may institute an enquiry in terms of the Health Professions Act into any complaint, charge or allegation of unprofessional conduct against registered practitioners (as discussed above), and on a guilty finding, may impose one or more of the following penalties:³⁴⁶

- A caution or a reprimand and a caution; or
- A suspension for a specified period from practicing or performing acts specially pertaining to his profession; or
- Removal of the name from the registrar; or
- A fine not exceeding R10 000; or
- A compulsory period of professional service as may be determined by the professional board; or
- Payment of the costs of the proceedings or a restitution.

3.7.10 Psychiatry

Psychiatry is a medical speciality and is defined as: “The branch of medicine devoted to the diagnosis, classification, treatment, and prevention of mental disorders.”³⁴⁷ After completing the medical undergraduate degree (usually an MB Ch.B or MB B.Ch) an aspiring psychiatrist has to complete a one-year internship in a general hospital.³⁴⁸ After at least two years of further general practice the doctor enters into a four-year registrar training programme under the auspices of an academic department of psychiatry, while working full time in a state psychiatric hospital.³⁴⁹ The registrar works during the course of the four years in six-month rotations in various specialised areas of psychiatry, such as acute and emerge psychiatry, child and adolescent psychiatry, old age psychiatry, neuropsychiatry, psychotherapy units as well as

³⁴⁶ Section 42(a)-(f) of the Health Professions Act 56 of 1974.

³⁴⁷ Kaliski 377; Swanepoel 85; Stevens, GP ‘The role of expert evidence in support of the defence of criminal incapacity’ (LLD thesis, 2011 University of Pretoria) 57.

³⁴⁸ *Ibid.*

³⁴⁹ *Ibid.*

liaison and consultation for the medically ill.³⁵⁰ The training psychiatrist further has to write examinations administered in two parts: One for basis neurosciences and psychology and two for neurology and clinical psychiatry.³⁵¹ Universities offer a degree (M.Med.), and the College of Psychiatry a fellowship (FCPsych(SA)) to successful candidates.³⁵² Psychiatrists are further required to register with the Health Professions Council of South Africa.³⁵³ Psychiatrists use the same methods of examination as other medical specialists (including blood tests and brain scans), and prefer to use biological treatment methods, along with psychotherapy.³⁵⁴

Parker *et al.* are of the opinion that the training of psychiatrists in South Africa, although making progress as an academic discipline, is lacking in terms of ensuring improved mental health care for the wider population.³⁵⁵ This is attributed to knowledge by strong public mental health academics not put into practice, as they do not become practicing psychiatrists.³⁵⁶ If psychiatrists in South Africa are to play an important role in developing our mental health services, public mental health as a core discipline must be nurtured and developed as a central feature of each academic psychiatry department and the broader field of psychiatry.³⁵⁷ The issue regarding lack of human resources in the public mental health care sector is discussed in Chapter 6.

3.7.11 Psychology

Psychology is defined as: “The scientific study of the nature, functions, and phenomena of behaviour”.³⁵⁸ A person is required to complete a university undergraduate degree in social sciences with a three-year major in Psychology to qualify as a psychologist, where after they

³⁵⁰ *Ibid.*

³⁵¹ *Ibid.*

³⁵² *Ibid.*

³⁵³ Section 17 of the Health Professions Act 56 of 1974.

³⁵⁴ Kaliski 377; Stevens 59.

³⁵⁵ Parker, J.S., Allen, R.R. and Lund, C. (2013) ‘Are we training our psychiatrists adequately as public mental health practitioners?’ 19 SAJP 1:2-3 3.

³⁵⁶ Parker, Allen, and Lund (2013) SAJP 2.

³⁵⁷ Parker, Allen, and Lund (2013) SAJP 2.

³⁵⁸ Swanepoel 89.

have to do a one-year Honours degree, followed by a Masters' Degree in Psychology.³⁵⁹ At the Honours level, students begin to specialise in particular areas, for example, counselling, clinical and educational and industrial psychology. A recent requirement is a one-year community placement before the person can practise as a fully qualified psychologist.³⁶⁰ A psychologist also has to register in terms of the Health Professions Act³⁶¹ in order to practice. The minimum degree requirement for registration as a professional psychologist is currently a Masters level degree, but the Professional Board of Psychology has tabled a proposal that will make a professional doctorate a requirement in the near future.³⁶² The Professional Board does not recognise specialist categories in the sense that the Medical and Dental Professional Board recognises specifically trained medical doctors as paediatricians, for example. Expertise is recognised implicitly in the field, though a psychologist who refers to himself as a child psychologist, does not do so by dint of specialist registration.³⁶³

The Practice framework for Psychology was formulated by the Professional Board for Psychology as the Standards Generating Body and revised after consultation with all relevant stakeholders such as the Psychological Society of South Africa, Society for Industrial and Organisational Psychology of South Africa and Heads of Department of Psychology and all registered psychology professionals on various occasions in meetings and other forms of communication, and was adopted in September 2007.³⁶⁴ The purpose of the document is to define and delineate the various registration categories within the profession of psychology. In the document each category is described in terms of scope of practice, psychological assessment, psychological intervention, and so forth.³⁶⁵ New categories were introduced such as Neuropsychology and Mental Health Assistant.³⁶⁶ The Board took a resolution that the final status of Forensic Psychology be determined at a later stage after further consultation.³⁶⁷

³⁵⁹ Swanepoel 89; Stevens 68.

³⁶⁰ Swanepoel 89; Stevens 68.

³⁶¹ 56 of 1974.

³⁶² Tredoux and Foster 12.

³⁶³ *Ibid.*

³⁶⁴ Swanepoel 169.

³⁶⁵ *Ibid.*

³⁶⁶ *Ibid.*

³⁶⁷ *Ibid.*

Clinical psychology is the branch of psychology, which is the closest to psychiatry.³⁶⁸ The clinical psychologist evaluates a person's mental and emotional problems through methods such as intelligence and personality tests, and then helps him or her through counselling.³⁶⁹ Clinical psychologists further assess, diagnose and intervene to alleviate or contain relatively serious forms of psychological distress and dysfunction, particularly psychopathology or “abnormal” behaviour.³⁷⁰

3.7.12 Forensic mental health experts

Forensic psychiatry operates at the interface of law and psychiatry, and is a subspecialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters; forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry.³⁷¹ There is no formal training programme or examinations for forensic mental health in South Africa, and a formal postgraduate course is envisaged in future.³⁷² It is submitted that this would be preferable to a system with no medium to ensure forensic experts adhere to a certain standard and reliable level of expertise. The principle difference between a psychiatrist and forensic psychiatrist lies therein that a forensic psychiatrist is a psychiatrist who has additional training or experience related to the various interfaces of mental health and law.³⁷³

Forensic psychology can also be defined as the interface between psychology and the legal system and is a subspecialty of applied psychology concerned with the collection, examination and presentation of psychological evidence for judicial purposes.³⁷⁴ A forensic psychologist is therefore any psychologist who by virtue of training or experience may assist a court in arriving at a decision.³⁷⁵ An important aspect of forensic psychology (and in fact all

³⁶⁸ Swanepoel 89; Stevens 62.

³⁶⁹ *Ibid.*

³⁷⁰ *Ibid.*

³⁷¹ Swanepoel 88; Stevens 60.

³⁷² Kaliski 3.

³⁷³ Stevens 61.

³⁷⁴ Stevens 71.

³⁷⁵ Stevens 72.

forensic mental health practice) is the ability to testify and reformulate findings into legal language.³⁷⁶

The practitioner should have worked in an academic forensic facility for an appreciable period and be convincingly experienced in order to be considered a recognised forensic expert.³⁷⁷ The fact that a person is a mental health practitioner does not mean that they are experts in every area of mental health and thus need to demonstrate to the court that they are in fact specialists in the relevant field of expertise, demonstrating both theoretical and practical knowledge.³⁷⁸ In *Mohammed v Shaik*³⁷⁹ it was held that it is the task of the court to determine whether an expert possesses the necessary qualifications and experience that would enable him to deliver reliable opinions.

Until very recently there has not been any formal training programme or examinations for forensic psychiatry in South Africa.³⁸⁰ A formal course for psychiatrists to specialise in forensic psychiatry was introduced when a certificate in forensic psychiatry as a sub-specialty was approved by the College of Medicine of South Africa in May 2010.³⁸¹ In South Africa court professionals appear to receive limited formal training in mental disorders and how they affect criminal capacity.³⁸² From the literature no formal guidelines or specific training methods or requirements that involved psychiatrists training prosecutors could be sourced.³⁸³

3.8 Mental health care institutions and their administration

3.8.1 Introduction

In this section the decentralised national health system is discussed regarding the duties imposed by the National Health act on national, provincial and district health services, and the

³⁷⁶Stevens 71.

³⁷⁷Kaliski 3.

³⁷⁸ Allan and Meintjes-van der Walt 343-344.

³⁷⁹ 1978 4 SA 523 N.

³⁸⁰ Kotze and De Wet (2011) SAJP 112.

³⁸¹*Ibid.*

³⁸²*Ibid.*

³⁸³*Ibid*; Gutheil, TG. (2006) 'Psychiatric expert witnesses in the new millennium' *Psychiatr Clin North Am* 29:823-832.

minister of health. In South Africa the health system consists of the public and private health sectors, with the majority of the population receive health care services from the public health system funded largely by government.³⁸⁴ Services in the private health sector are rendered to members of medical aid schemes or those who can afford private health care.³⁸⁵ There is currently no system of national health insurance.³⁸⁶ A means test is applied to patients presenting at public hospitals for health care services and if they are employed and earning above a certain income they are required to pay a fee based on their level of income.³⁸⁷ The National Health Act stipulates that state funded health establishments must provide free care to children below the age of six years and pregnant and lactating women who are not members of medical schemes.³⁸⁸ Everyone except members of medical schemes and their dependents, and persons receiving compensation for occupational diseases must be provided with free primary health care.³⁸⁹ This thesis focuses on the public health system. The National Health Act is central to the regulation of the health system and is discussed in this chapter below.

State hospital and medical services are generally owned and controlled by the provincial government in each province.³⁹⁰ Health Services is a functional area that falls under Schedule 4 of the Constitution which means that the national and provincial governments have concurrent legislative authority in this area.³⁹¹ The provinces are legally obliged to implement the provisions of the National Health Act, but they have the power to determine provincial health policy and legislate on provincial health issues.³⁹² The development and implementation of national health policy is the prerogative of national government, and national health policy determines at macro level how public health resources should be allocated and what areas of public health should be given priority at particular times.³⁹³

³⁸⁴ Carstens and Pearmain 229.

³⁸⁵ *Ibid*; Meissner 87.

³⁸⁶ Carstens and Pearmain 229. The proposed new system of National Health Insurance falls outside the scope of this thesis. See in this regard Wayburn, PA. “Developing a constitutional law paradigm for a national health insurance scheme in South Africa” (PhD thesis, University of the Witwatersrand, 2014).

³⁸⁷ Carstens and Pearmain 230.

³⁸⁸ *Ibid*.

³⁸⁹ Carstens and Pearmain 230.

³⁹⁰ Carstens and Pearmain 231.

³⁹¹ *Ibid*.

³⁹² *Ibid*.

³⁹³ Carstens and Pearmain 239.

If the allocation of national resources and the determination of national or provincial health policy amounts to administrative action, then judicial review and other administrative law remedies might be available if a party has been disadvantaged. Another question is whether a public hospital can be a victim of unjust administrative action if resource allocation was done unfairly. In the case of *President of the Republic of South Africa v South African Rugby Football Union*³⁹⁴ the court held that some acts of a legislature may constitute administrative action. It matters less the functionary as the function performed in order to deem it administrative action. The focus of the enquiry is on the conduct and the nature of the power being exercised, not the arm of government performing the function. General rules derived from the dicta are:³⁹⁵

- The nature of the power or function exercised is more important than the nature of the functionary;
- Other considerations apart from the nature of the power exercised are the source of the power, the subject matter, whether the exercise of a public duty is involved, and how closely it is related to the implementation of legislation;
- The list of considerations is not exhaustive;
- The source of the power must be balanced in relation to other factors;
- The nature of the task is an important factor;
- The assessment must be made in light of the Constitution and the constitutional purpose of an efficient, equitable and ethical public administration; and
- The assessment must be done on a case by case basis and each particular set of circumstances.

The administration of the MHCA and other legislation affecting mental health care users lies with the national and provincial Departments of Health. The Minister of Health and MEC plays an important role in the administration of the mental health care system, especially since resources and facilities are controlled by provincial health departments.³⁹⁶

³⁹⁴ 2000 (1) SA 1 (CC) par 141.

³⁹⁵ Carstens and Pearmain 241.

³⁹⁶ Landman and Landman 47.

3.8.2 Levels of health establishments

Health establishments operate principally on three levels, namely the primary level which refers to health establishments such as a clinic which provides primary health care, the secondary level which refers to general hospitals, and the tertiary level which refers to specialist hospitals such as psychiatric hospitals (Section 1 of the MHCA).³⁹⁷ A health establishment may have maximum security facilities (Regulation 1 of the General Regulations to the MHCA). The level of health care services available at a health establishment depends on the level of the establishment in the health system.³⁹⁸ The concept of a health care establishment includes community health and rehabilitation centres, clinics, hospitals (district, regional, tertiary, central), and psychiatric hospitals (Section 1 of the MHCA).³⁹⁹ The public health system, including the mental health care system, operates on a referral system by which a patient must present themselves to a primary mental health facility where the user is assessed and then referred to secondary and tertiary facilities if required.⁴⁰⁰

“Primary care” refers to services provided by general practitioners, nurses or other allied health professionals and is the first point of entry to the health system.⁴⁰¹ This level of care allows for early diagnosis and treatment management, and referral to secondary and tertiary care, thereby providing the potential for continuity of care.⁴⁰² “Primary health care” is a strategy of public health based on the social model and the philosophy that health goals are better met when the basic needs of people are met first.⁴⁰³ Basic needs of people and their health are influenced by many factors, including unemployment and basic living conditions, therefore the strength of primary health care is to respond to basic needs through a comprehensive, holistic approach with communities as the main unit of intervention.⁴⁰⁴ The principles of primary health care such as efficiency and effectiveness in health service

³⁹⁷Landman and Landman 67; Thom, R. ‘Psychiatry at the primary healthcare level’ in Baumann, SE. (ed.) ‘Primary healthcare psychiatry: A Practical Guide for Southern Africa’ 2007 5.

³⁹⁸*Ibid.*

³⁹⁹Landman and Landman 68.

⁴⁰⁰Landman and Landman 70.

⁴⁰¹Dookie, S. and Singh, S. (2012) ‘Primary health services at district level in South Africa: a critique of the primary health care approach’ BMC Family Practice 1367-70 68; Thom 9.

⁴⁰²*Ibid.*

⁴⁰³Landman and Landman 72.

⁴⁰⁴*Ibid.*; Dookie and Singh (2012) BMC Family Practice 67.

delivery; and equitable distribution of health services are identified as core elements with the potential to contribute to improved community health through properly coordinated district health systems.⁴⁰⁵ The major challenges facing primary health care include adequate political, financial, human and material commitments; optimal use of available resources; changing management techniques including decentralization; and ensuring effective community participation and intersectoral collaboration.⁴⁰⁶

3.8.3 The National Health Act 61 of 2003

The purpose of the Act as stated in its Long Title is to provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments regarding health services; and to provide for matters connected therewith. The Act establishes a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation; and promotes a spirit of co-operation and shared responsibility among public and private health professionals and providers.⁴⁰⁷ The rights and duties of users and healthcare personnel in Chapter 2 of the National Health Act, is discussed in Chapter 2 of this thesis regarding the human rights of mental health care users.

The National Health Act defines “health establishment” as the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative, or other health services.⁴⁰⁸ A “private health establishment” means a health establishment not owned or controlled by an organ of state.⁴⁰⁹ “User” in terms of the National Health Act means the person receiving

⁴⁰⁵Dookie and Singh (2012) 'Primary BMC Family Practice 67.

⁴⁰⁶Dookie and Singh (2012) BMC Family Practice 68.

⁴⁰⁷Preamble to the National Health Act 61 of 2003, Thom 9.

⁴⁰⁸Section 1 of the National Health Act 61 of 2003.

⁴⁰⁹*Ibid.*

treatment in a health establishment, including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is:⁴¹⁰

- a) Below the age contemplated in Section 39(4) of the Child Care Act, 1983 (Act No. 74 of 1983) (“User” includes the person’s parent or guardian or another person authorised by law to act on the first mentioned person’s behalf); or
- b) Incapable of taking decisions (“User” includes the person’s spouse or partner or, in the absence of such spouse or partner, the person’s parent, grandparent, adult child or brother or sister, or another person authorised by law to act on the first mentioned person’s behalf.)

3.8.3.1 Eligibility for free health services

Section 4 of the National Health Act determines that the Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed and must have regard to-

- a) The range of free health services currently available;
- b) The categories of persons already receiving free health services;
- c) The impact of any such condition on access to health services; and
- d) The needs of vulnerable groups such as women, children, older persons and persons with disabilities.

3.8.3.2 National health

The Director-General must ensure the implementation of national health policy and issue guidelines for its implementation, as well as issue and promote adherence to norms and health standards on environmental conditions that constitute a health hazard; the provision of health services (including mental health care); and health services for convicted persons and persons

⁴¹⁰ *Ibid.*

awaiting trial; participate in intersectoral and interdepartmental collaboration; and identify national health goals and priorities and monitor the progress of their implementation.⁴¹¹

A National Health Council is established in terms of Section 22 of the Act, which must advise the Minister on policy concerning any matter that will protect, promote, improve and maintain the health of the population, including:⁴¹²

- Targets, priorities, norms and standards relating to the equitable provision and financing of health services;
- The design and implementation of programmes to provide for effective referral of users between health establishments or health care providers, or to enable integration of public and private health establishments;
- Proposed legislation pertaining to health matters prior to such legislation being introduced into Parliament or a provincial legislature;
- Norms and standards for the establishment of health establishments;
- Guidelines for the management of health districts; and
- The implementation of national health policy.

3.8.3.3 Provincial health

The relevant member of the Executive Council must ensure the implementation of national health policy, norms and standards in his or her province, as determined in Section 25 of the National Health Act. The head of the provincial department must, *inter alia*, provide the following that have bearing on the mental health establishment and mental health care user: specialised hospital services; plan and manage the provincial health system; participate in interprovincial and intersectoral collaboration; plan, coordinate and monitor health services and evaluate the rendering of health services; plan the development of public and private hospitals, other health establishments and health agencies; control and manage the cost and financing of public health establishments and public health agencies; control the quality of all

⁴¹¹Section 21 of the National Health Act 61 of 2003.

⁴¹²Section 23 of the National Health Act 61 of 2003.

health services and facilities; and consult with communities regarding health matters. A Provincial Health Council is also established in terms of Section 26 of the Act that must advise the National Health Council on matters within its province analogous to the functions of the National Council as mentioned above.⁴¹³

3.8.3.4 District health system

Section 29 of the National Health Act establishes a district health system, divided into several districts within provinces and sometimes falling in more than one province, the boundaries of which coincide with district and metropolitan municipal boundaries. Section 31 of the Act provides for the establishment of district health councils, provincial legislation providing do their regulation and functioning. A major responsibility of district hospitals, in terms of the MHCA, is to provide 72-hour admission and observation for MHCUs. This requirement has given rise to many problems, shared by most district hospitals throughout the country, which are very practical in nature and relate to operational aspects of implementing this legal requirement.⁴¹⁴ The problems do not relate to the *idea* or *concept* of an observation period, but to their translation into practice.⁴¹⁵ The problems experienced in practice are discussed further in Chapter 6.

3.8.3.5 Health establishments

Section 35 determines that the Minister may classify all health establishments into appropriate categories, based on their role and function within the national health system, among other considerations such as size and location and level of health services they are able to provide. According to Section 36 of the Act, the Director-General must issue a certificate of need before anyone is allowed to establish or modify a health establishment, increase the number of beds, or provide prescribed health services. The Director-General will take into account various factors before issuing or renewing a certificate of need, including the need to ensure

⁴¹³ Section 27 of the National Health Act 61 of 2003.

⁴¹⁴ Burns, J. K., (2008) "Implementation of the Mental Health Care Act (2002) at District Hospitals in South Africa: Translating Principles into Practice" 98 South African Medical Journal 1 46-51 47.

⁴¹⁵ *Ibid.*

consistency of health services development in terms of national, provincial and municipal planning; the need to promote an equitable distribution and rationalisation of health services and health care resources, and the need to correct inequities based on racial, gender, economic and geographical factors; and the need to ensure the availability and appropriate utilisation of human resources and health technology, among other factors. The Minister may, after consultation with the National Health Council, make regulations relating to the requirements for the issuing or renewal of a certificate of need.⁴¹⁶ Regulations made must ensure the equitable distribution and rationalisation of health, with special regard to vulnerable groups such as woman, older persons, children and people with disabilities; must ensure and promote access to health services and the optimal utilisation of health care resources, with special regard to vulnerable groups such as woman, older persons, children and people with disabilities.⁴¹⁷

3.8.3.6 Evaluating services of health establishments

Section 47(1) determines that all health establishments must comply with quality requirements and standards prescribed by the Minister after consultation with the National Health Council. The quality requirements and standards may relate to human resources, health technology, equipment, hygiene, premises, and the delivery of health services, business practices, safety and the manner in which users are accommodated and treated. Section 48 of the Act determines that the National Health Council must develop policy and guidelines for, and monitor the provision, distribution, development, management and utilisation of, human resources within the national health system, including the adequate distribution of human resources, the adequate distribution of human resources, the provision of appropriately trained staff at all levels of the national health system to meet the population's health care needs, and the effective and efficient utilisation, functioning, management and support of system human resources within the national health system.

⁴¹⁶ Section 39(1) of the National Health Act 61 of 2003.

⁴¹⁷ Section 39(2) of the National Health Act 61 of 2003.

The relevant member of the Executive Council must establish an inspectorate in their province to be known as the Inspectorate for Health Establishments, which must monitor and evaluate compliance with this Act by health establishments and submit a quarterly report on its activities and findings to the relevant member of the Executive Council.⁴¹⁸ The Director-General must establish an Office of Standards Compliance within the national department which must include a person who acts as ombudsperson in respect of complaints in terms of the National Health Act.⁴¹⁹ The Office of Standards Compliance must keep the Minister informed of the quality of the health services provided throughout the Republic as measured against prescribed health standards; advise the Minister on norms and standards for quality in health services; recommend to the Minister any changes which should be made to the prescribed health standards; recommend to the Minister new systems and mechanisms to promote quality of health services.⁴²⁰

3.8.3.7 Forum of Statutory Health Professional Councils

Section 50(1) of the National Health Act establishes a forum to be known as the Forum of Statutory Health Professional Councils on which all the statutory health professional councils must be represented. According to Section 50(4), the Forum of Statutory Health Professional Councils must protect the interests of the public and users; ensure communication and liaison between the statutory health professional councils upon matters affecting more than one of the registered professions; monitor and advise the Minister on the implementation of health policy insofar as it impacts on health care providers and the registered professions; and advise the Minister on the development of coherent policies relating to the education and training and optimal utilisation and distribution of healthcare providers. Section 50(4)(n) also prescribes that the forum must advise the Minister and the individual statutory health professional councils on the scope of practice of the registered professions, common educational and training requirements of health care providers, and targets priorities, norms and standards relating to the equitable distribution of health care providers. In performing its duties the Forum of Statutory Health Professional Councils may consult or hear

⁴¹⁸ Section 77(1) and (2) of the National Health Act 61 of 2003.

⁴¹⁹ Section 78(1) of the National Health Act 61 of 2003.

⁴²⁰ Section 78(2) of the National Health Act 61 of 2003.

representations by any person, body or authority; and establish a committee to advise it on any matter. The Office of Standards Compliance or its agents must inspect every health establishment and health agency at least once every three years, according to Section 79(1) of the Act. The Office of Standards Compliance must issue a written notice of noncompliance to the head of a health establishment if the Office of Standards compliance determines that the health establishment does not comply with:⁴²¹

- Any provision of this Act;
- Any condition imposed in a certificate of need;
- Building regulations; or
- The provisions of any other law.

The Office of Standards Compliance, in the event of failure to comply with the requirements of a notice of non-compliance, may:⁴²²

- Temporarily suspend the operation of, or shut down, the whole operation of the health establishment or health agency, pending compliance with the notice of non-compliance;
- Recommend to the Director-General that the certificate of need of the health establishment or health agency be withdrawn; or
- Recommend to the Director-General that an application for the renewal of a Certificate of Need in respect of the health establishment or health agency be refused.

If a health officer has reasonable grounds to believe that any condition exists which: constitutes a violation of the right contained in Section 24(a) of the Constitution; constitutes pollution detrimental to health; is likely to cause a health nuisance; or constitutes a health nuisance, the health officer must investigate such condition.⁴²³ The health officer will then determine the person responsible for the condition and issue a compliance notice.⁴²⁴ A person

⁴²¹ Section 79(4) of the National Health Act 61 of 2003.

⁴²² Section 79(7) of the National Health Act 61 of 2003.

⁴²³ Section 83(1) of the National Health Act 61 of 2003.

⁴²⁴ Section 83(2) and (3) of the National Health Act 61 of 2003.

is guilty of an offence if they fail to comply with a compliance notice issued by a health officer in terms of the Act, and liable to a fine or imprisonment for a period not exceeding five years or both a fine and imprisonment.⁴²⁵ The Minister, after consultation with the National Health Council, may make regulations regarding- anything which may or must be prescribed in terms of the National Health Act, including the rendering of forensic pathology, forensic medicine and related laboratory services, including the provision of medico-legal mortuaries and medico-legal services.⁴²⁶

3.8.4 The Mental Health Care Act 17 of 2002

The Mental Health Care Act (MHCA) was promulgated in 2002 and implemented in December 2004.⁴²⁷ The main aims of the act are to promote the human rights of people with mental disabilities, to improve mental health services through a primary health care approach, to emphasise community care and to protect the safety of the public.⁴²⁸ Public mental health practitioners had high expectations for resources to follow the passing of the new MHCA, but no national or provincial capital interventions materialized subsequent to the Act's promulgation in most of the country's nine provinces.⁴²⁹ It became clear that the act was passed without due consideration of the financial implications of implementation, resulting in previous patterns of clinical practice and factors determining management decisions in the public sector services simply continuing as before.⁴³⁰ Public mental health care practice continued to be dictated by inadequate nursing staff ratios and suboptimal or structurally inappropriate facilities.⁴³¹

A trend that established itself since the passing of the MHCA, mainly due to the extensive and costly physical and staffing requirements that private facilities must fulfil to be licensed for assisted or involuntary care, is that private practitioners and service providers have generally

⁴²⁵ Section 89 of the National Health Act 61 of 2003.

⁴²⁶Section 90(1)of the National Health Act 61 of 2003.

⁴²⁷Janse van Rensburg, ABR (2007) 'A framework for current public mental health care practice in South Africa' African Journal of Psychiatry 10: 205-209 205.

⁴²⁸Janse van Rensburg (2007) African Journal of Psychiatry 205.

⁴²⁹*Ibid.*

⁴³⁰*Ibid.*

⁴³¹*Ibid.*

distanced themselves from categories of service provision other than “voluntary” users, therefore the bulk of assisted and involuntary users are now routinely routed through the already compromised acute units of general state hospitals as the first point of entry to the mental health care system.⁴³² While strict requirements were laid down for the private sector, no norms and standards for public facilities aligning the State’s own services with the new legislation were adopted.⁴³³

This section discusses provisions in the MHCA that relate specifically to the provision of mental health care services at health establishments, within the community and at home. The MHCA and its provisions are discussed at length in the following chapters of this thesis as well. Chapter 2 of the MHCA clarifies the responsibility of the State with regards to the establishment and maintenance of mental health infrastructure.⁴³⁴

Mental health services are delivered broadly at primary, secondary and tertiary levels in South Africa.⁴³⁵ Primary mental health care should be provided at community, primary health care, community health care and district hospital levels.⁴³⁶ This includes outreach to community health care and primary health care, outpatient care, screening and follow-up, appropriate referral and provision of short-term inpatient care for a period of 72 hours.⁴³⁷ The secondary level of mental health care should be located at regional hospitals, where a psychiatric unit with dedicated beds should be available. The regional team (including a psychiatrist) is responsible for inpatient and outpatient care and provision of support and outreach to all clinics and district hospitals in that region.⁴³⁸ Tertiary care should be located at designated psychiatric hospitals providing specialised services such as forensic psychiatry, child and adolescent psychiatry, addiction treatment and psychogeriatrics.⁴³⁹

⁴³²Janse van Rensburg (2007) *African Journal of Psychiatry* 206.

⁴³³*Ibid.*

⁴³⁴Janse van Rensburg (2007) *African Journal of Psychiatry* 207.

⁴³⁵ Lund, C., Petersen, I., Kleintjies, S. Bhana, A. (2012) 'Mental Health Services in South Africa: Taking stock' *African Journal of Psychiatry* 15 402-405 403.

⁴³⁶Burns (2008) *South African Medical Journal* 47.

⁴³⁷*Ibid.*

⁴³⁸*Ibid.*

⁴³⁹*Ibid.*

Section 4 of the MHCA states that every organ of the State responsible for health services must determine and coordinate the implementation of its policies and measures in a manner that ensures the provision of mental health care, treatment and rehabilitation services at primary, secondary and tertiary levels and health establishments; promotes the provision of community-based care, treatment and rehabilitation services; promotes the rights and interests of mental health care users; and promotes and improves the mental health status of the population. Section 3 of the MHCA incorporates the concept of available resources in the equation by providing:⁴⁴⁰

“To regulate mental health care in a manner that:

- a) Makes the best possible mental health care, treatment and rehabilitation available equitably, efficiently and in the best interest of users within limits of available resources;
- b) Provides access to care treatment and rehabilitation to voluntary, assisted, involuntary users, State Patients and mentally ill prisoners; and
- c) Clarifies rights and obligations”.

According to the MHCA, the State is responsible for the promotion and provision of community-based mental health care, treatment and rehabilitation while also responsible for the designation and operation of health establishments such as psychiatric hospitals, care and rehabilitation centres and 72-hour assessment units.⁴⁴¹ Functions of psychiatric hospitals and assessment units include multi-tiered parallel programs such as voluntary, assisted and involuntary mental health care, care of State Patients, care of mentally ill prisoners, assessment of persons referred by court for psychiatric observation in terms of the Criminal Procedure Act, No. 51 of 1977 and care of persons admitted for long-term care, treatment and rehabilitation.⁴⁴²

⁴⁴⁰Janse van Rensburg (2007) African Journal of Psychiatry 207.

⁴⁴¹*Ibid.*

⁴⁴²*Ibid.*

3.8.4.1 Provision of mental health care, treatment and rehabilitation services at health establishments

Sections 6(1)(a) and (b) of the MHCA determines that health establishments must provide any person requiring mental health care, treatment and rehabilitation services with the appropriate level of mental health care, treatment and rehabilitation services within its professional scope of practice; or refer such person, according to established referral and admission routes, to a health establishment that provides the appropriate level of mental care, treatment and rehabilitation services. Section 6(3) provides that the head of the national department must, with the concurrence of the heads of the relevant provincial departments regarding health establishments designated in terms of Section 5(1), determine the nature of the care, treatment and rehabilitation services to be provided at every establishment so designated. Section 5(1)(a) and (b) provide that the head of the national department must, with the concurrence of the head of the relevant provincial department within 120 days of the commencement of this Act, designate health establishments or part of a health establishment which must serve as psychiatric hospitals or care and rehabilitation centres. A designation referred to in Section 5(1) may be revoked any time or varied by the head of the national department with the concurrence of the head of the relevant provincial department.⁴⁴³

Section 6(5) of the MHCA determines that tertiary level mental health care, treatment and rehabilitation services may be provided at a tertiary health establishment or a psychiatric hospital designated in terms of Section 5(1), while Section 6(6) states that psychiatric hospitals may admit, care for, treat and rehabilitate:

- a) Voluntary mental health care users in special programmes;
- b) Assisted mental health care users;
- c) Involuntary mental health care users;
- d) State Patients;
- e) mentally ill prisoners;

⁴⁴³ Section 5(2) of the MHCA.

- f) persons referred by court for psychiatric observation in terms of the Criminal Procedure Act; and
- g) Persons admitted for a long period as part of their care, treatment and rehabilitation.

Sections 6(7)(a) and (b) state that care and rehabilitation centres may conduct assessments of intellectual abilities; and provide care, treatment and rehabilitation services to persons with severe or profound intellectual disabilities, including assisted and involuntary mental health care users. Section 6(8) states that persons providing care, treatment and rehabilitation services must provide such services in a manner that facilitates community care of mental health care users.

3.8.4.2 Community care

Section 6(8) of the MHCA states that persons providing care, treatment and rehabilitation services must provide such services in a manner that facilitates community care of mental health care users. Regulation 5(1) of the General Regulations to the MHCA determines that programmes and facilities for the community care, treatment and rehabilitation of people with mental health problems must be provided where possible.

Regulation 5(2) provides that community programmes or health establishments may be run by:

- a) Organs of the State;
- b) Health establishments under the auspices of the State;
- c) Non-profit organisations;
- d) Volunteer or consumer groups;
- e) Profit-making organisations;
- f) Persons registered with a relevant health or social service statutory council; or
- g) Registered training institutions.

Services by a grouping referred to in Regulation 5(2) may, within their professional scope of practice, include medical care, residential community accommodation, day-care centres, counselling, support or therapeutic groups, psychotherapy, vocational rehabilitation

programmes, psychosocial rehabilitation programmes or other services, which would assist the recovery of the person to optimal functioning.⁴⁴⁴

3.8.4.3 Authorization and licensing of private hospital providing mental health services

Regulation 42(1) of the General Regulations to the MHCA determines that an application for a licence to operate a hospital must be made in accordance with the applicable general health legislation. A hospital, which wishes to admit assisted or involuntary mental health care users, such hospital must in addition to a licence contemplated in Regulation 42(1), apply in writing to the national department for a licence to admit such users.⁴⁴⁵ A written application for a licence contemplated in Regulation 42(2) must indicate that:⁴⁴⁶

- a) The mental health care practitioners involved in the procedures relating to Sections 27 and 33 of the Act will have no material or financial interest in that hospital;
- b) The hospital has been inspected and audited by designated officials of the provincial department concerned and found to be suitable to accommodate assisted and/or involuntary mental health care users or assisted and voluntary mental health care users, as the case may be; and

“Suitable to accommodate” in Regulation 42(3)(b) includes:⁴⁴⁷

- a) a lockable ward in addition to an open ward;
- b) suitable mental health care practitioners, including at least one psychiatrist, as well as other trained staff deemed necessary to carry out all necessary duties in accordance with the minimum norms and standards of the Department of Health;
- c) procedures for ensuring the safety of assisted and involuntary mental health care users and other health users in that hospital; and
- d) an approved activity or psychosocial rehabilitation ward programme.

⁴⁴⁴ Regulation 5(3) of the General Regulations to the MHCA.

⁴⁴⁵ Regulation 42(2) of the General Regulations to the MHCA.

⁴⁴⁶ Regulation 42(3) of the General Regulations to the MHCA.

⁴⁴⁷ Regulation 42(4) of the General Regulations to the MHCA.

The conditions of a licence contemplated in Regulation 42(2) must be clearly stipulated by the national department concerned, and must include:⁴⁴⁸

- a) The number of people to be accommodated;
- b) Whether such service is to be used for children, adults or geriatrics;
- c) Service requirements;
- d) Duration of the licence;
- e) That the licence is not transferable; and
- f) That the renewal of a licence must be done by the province, based on an inspection.

If a condition of a licence contemplated in Regulation 42(5) is not complied with, the provincial department concerned may withdraw that a licence.⁴⁴⁹

3.8.4.4 Licensing of community facilities

Regulation 43(1) of the General Regulations to the MHCA determines that any service which is not a designated psychiatric hospital or care and rehabilitation centre, but which provides residential or day-care facilities for five people or more with mental disorders must in terms of the Act:

- a) Obtain a licence from the provincial department concerned to operate; and
- b) Be subjected to at least an annual audit by designated officials of the provincial department concerned.

The conditions of a licence contemplated in Regulation 43(1) must be clearly stipulated by the provincial department concerned and must include:⁴⁵⁰

- a) The physical address of the relevant service;
- b) The number of people to be accommodated;

⁴⁴⁸ Regulation 42(5) of the General Regulations to the MHCA.

⁴⁴⁹ Regulation 42(6) of the General Regulations to the MHCA.

⁴⁵⁰ Regulation 43(2) of the General Regulations to the MHCA.

- c) Whether such service is to be used for children, adults or geriatrics;
- d) Service requirements;
- e) The duration of the licence; and
- f) That the licence is not transferable.

If a condition of a licence as contemplated in Regulation 43(1) or 43(2) is not complied with, the provincial department concerned may withdraw that licence.⁴⁵¹

3.8.4.5 Co-ordination and implementation of mental health services

Regulation 2(1) of the General Regulations to the MHCA provides that a person requiring, or deemed to require, mental health services must ordinarily present himself or herself at a health establishment that provides primary health care. A mental health care user must be assessed and, if such user requires care, treatment and rehabilitation services they must be:⁴⁵²

- a) Treated and cared for at such primary health care level health establishment;
- b) Referred to a community-based mental health care practitioner to be assessed and if treatment is required, be treated in the community; or
- c) Referred to a hospital for assessment and/or admission.

A mental health care user who requires tertiary or specialised mental health care must be referred to a health establishment that provides tertiary or specialised services.⁴⁵³

A mental health care user referred to a secondary or tertiary level who, following his or her discharge requires follow-up services at primary health or community levels must be referred back to the latter level and shall be provided with the relevant care, treatment and rehabilitation programme within the available resources.⁴⁵⁴

⁴⁵¹ Regulation 43(3) of the General Regulations to the MHCA.

⁴⁵² Regulation 2(2) of the General Regulations to the MHCA.

⁴⁵³ Regulation 2(3) of the General Regulations to the MHCA.

⁴⁵⁴ Regulation 2(4) of the General Regulations to the MHCA.

3.8.4.6 Decision by Head of health establishment

Regulation 3(1) of the General Regulations to the MHCA determines that when a head of a health establishment makes a decision in terms of these regulations that falls outside his or her scope of professional practice, they must act after consultation with the mental health care practitioners that conducted the assessment and or any other mental health practitioner(s). The duties and functions to be performed by the head of a health establishment in terms of the Act or these Regulations may in the absence of such head, be performed by the person acting as head of such a health establishment.⁴⁵⁵

3.8.4.7 Home visits

Regulation 4 of the General Regulations to the MHCA determines that providers of mental health care may visit homes and places of employment of persons deemed to be mentally ill or intellectually disabled, within the catchment areas where they operate, if such home visit is required for the care, treatment or rehabilitation of a mental health care user.

3.8.4.8 Subsidies or transfers to non-government organisations or volunteer organisations

The State must provide subsidies to appropriate non-profit organisations or volunteer organisations for the provision of community care, treatment and rehabilitation to meet the objectives of the Act.⁴⁵⁶

3.9 Concluding remarks

In this chapter emphasis is placed on the importance of understanding the role of mental health practice relative to the legal profession, the classification of mental disorders and the role of the forensic expert witness. The regulation of mental health care practitioners,

⁴⁵⁵ Regulation 3(2) of the General Regulations to the MHCA.

⁴⁵⁶ Regulation 6 of the General Regulations to the MHCA.

traditional health practitioners, and the mental health care system is also discussed in order to contextualise the discussion of legislation, law and policy in the coming chapters.

The definition of mental illness is a concept that has been the focus of much discussion and debate in research relating to the interface of law, psychiatry and psychology. It is submitted that there can be no definition of mental illness that will account for all situations and contexts, and that in situations where mental illness becomes a pertinent topic where a legal outcome or decision is required, the only necessary definition of mental illness is to be found in the ever changing sciences of psychology and psychiatry. As was discussed in the introduction to this thesis, in order for the legal system to keep abreast of the constantly evolving nature of medical and scientific advancement, it needs to be flexible in accommodating changes and the accepted standards of the day. In order to keep this fluidity, mental illness or disorder for legal purposes remains an issue to be testified to by mental health experts making use of accepted diagnostic criteria, with sufficient knowledge and experience. It is submitted that for legal purposes it is only necessary to acknowledge that a mental disorder is a recognised affliction that may influence an individual's ability to actively participate in society in a productive manner, that it may influence a person's capacity to make decisions regarding their own lives, and that in certain cases it may lead to circumstances where an individual becomes a danger to themselves or others. The first step in forensic assessments by mental health care experts is to establish whether such an affliction exists, and the second step is to determine the extent to which it affects decisional capacity, dangerousness, or the ability to function within accepted parameters in society.

Given the fluid and ever changing nature of science and the medical profession that can be seen in the history and evolution of psychiatry and psychology, it makes more sense to allow for an expert witness through the ages to assist the court to come to a decision by testifying as to the most up to date medical knowledge of the day than, year by year, to change legal definitions in an attempt to keep up with medicine. A few *caveats* accompany this statement, namely that for this system to work, there must be proper training and registration systems in place to make sure that forensic mental health experts utilise standardised and accepted reliable methods of assessment. To ensure that the report generated is of the highest value to the fact finder in court, experts must be trained in legal terminology, the legal process and legal language to facilitate the transfer of information accurately and smoothly. The second *caveat* if this system is to work is that legal professionals, especially fact finders in court,

must be trained in the art of reading and interpreting forensic reports so that the valuable information contained therein is not wasted and for the interests of justice, the community and the patient to be respected.

CHAPTER 4: A CRITICAL DISCUSSION OF THE MENTAL HEALTH CARE ACT: PROVISIONS, REGULATIONS, AND FORMS

4.1 Introduction

This chapter discusses the Mental Health Care Act 17 of 2002 (hereafter referred to as the MHCA), focussing on the purpose and objects of the Act, the Mental Health Review Boards and other measures to ensure accountability. In South African mental health law there are many different ways in which a person can be admitted as a mental health care user, namely as a voluntary user, an assisted user, and an involuntary user.¹ These categories of admission are discussed in this chapter, as well as the role of the South African Police Service (SAPS) regarding mental health care users, the MHCA forms prescribed for use in the Act, and other provisions regarding the regulations to the Act and offences committed under the Act. Important aspects also considered are the right to appeal and periodic review, consent, and children as mental health care users. An important goal of this thesis is to establish the procedures stipulated in the MHCA are satisfactory, or in need of reform, therefore this chapter approaches the provisions critically with reference to the framework of human rights principles and evidence-based medicine discussed in Chapters 2 and 3 as standards against which the Act must be measured. Issues of particular interest include the fact that MHCA forms may be deficient in the information required for informed decision-making by Review Boards and courts, that mental health practitioners and the SAPS are insufficiently trained to complete the forms satisfactorily, and that information used to complete the forms is often vague and unscientific as it is not clearly prescribed in the legislation what standards are acceptable. The time periods in assessment and detention of mental health care users is also scrutinised to ensure their justification.

Suggestions for amendment or solutions discussed throughout this chapter and are reiterated in Chapter 7. The MHCA as it applies to State Patients and mentally disordered prisoners is discussed in context of criminal law and procedure in Chapter 5, and the practical

¹ Another way of becoming a mental health care user is via the criminal justice process, which is discussed in Chapter 5.

implementation of the MHCA is discussed in Chapter 6 to determine whether the State is reaching its objectives in line with its Constitutional mandate as described in the MHCA. The care and administration of property of mentally ill person or person with severe or profound intellectual disability is outside the scope of this thesis, as are determinations of mental state in civil matters such as family law and the law of succession.

The MHCA defines “mental health care user” as meaning a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State Patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include:

- i. The prospective user;
- ii. The person's next of kin;
- iii. A person authorised by any other law or court order to act on behalf of someone;
- iv. An administrator appointed in terms of this Act; and
- v. An executor of that deceased person's estate and “user” has a corresponding meaning;

4.2 The Mental Health Care Act 17 of 2002

4.2.1 Introduction and fundamental provisions

The MHCA was assented to on 28 October 2002 and commenced on 15 December 2004. The Act has been amended by the Judicial Matters Amendment Act 55 of 2002 and the Legal Aid South Africa Act 39 of 2014 with effect from 1 March 2015. Further amendments were introduced by the Mental Health Care Amendment Act 12 of 2014, which commenced on 1 July 2016.² The MHCA in its preamble discusses the aims of the legislation as follows:

² Proclamation 37 of 2016 GG 40107, 30 Jun 2016, Notice 37, page 4.

- The Act aims to protect people with mental or other disabilities from unfair discrimination as it is prohibited in the Constitution;
- Considering that mental health is a part of general health, the Act recognises that mental health services should be provided as part of primary, secondary and tertiary health services;
- It recognises that the person and property of a person with mental disorders or mental disabilities, at times require protection and that members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities;
- Further that there is a need to promote the provision of mental health care services in a manner which promotes the maximum mental well-being of users of mental health care services and communities where they reside.

The Minister of Health has under Sections 9(2)(a), 12(2), 16, 27(2), 29(2)(a), 33(2), 34(1)(b), (3)(b)(i), (5)(a) and (7)(a), 35(2)(c), 44(4), 47(2), 48(6), 57(4), 66 and 67 of the Mental Health Care Act, in accordance with Section 68 of the said Act, made the regulations in the Schedule. The General Regulations to the Mental Health Act (as amended) are for purposes of readability and brevity discussed under the section in the MHCA to which it applies. In doing this, it is hoped that a clear picture of the regulation of the different aspects dealt with under the MHCA is created. Highly technical regulations and sections in the legislation are outside the scope of the discussion where they do not directly influence the daily reality of the mental health care user.³ The structure of the analysis follows the structure of the MHCA for purposes of uniformity. Where regulations are important to the analysis but not directly applicable to a specific section of the MHCA, they are discussed separately. The MHCA forms contained in the General Regulations to the MHCA are discussed in relation to particular sections they relate to, namely the Review Boards, categories of mental health care user, the SAPS, appeals, periodic reviews, and the transfer of users.

³ This included the particulars of vacancies and remuneration of the Review Board.

4.2.1.1 Interpretation of the Act

In terms of Section 2(1) of the MHCA provides that the Act must be interpreted in a manner consistent with the objectives of the Act as set out below in Section 3. Where there is conflict between the MHCA and another Act, apart from the Constitution, the MHCA must prevail.⁴

4.2.1.2 Objects of the Act

Section 3(a) determines that the objects of the MHCA are to regulate mental health care in a manner that 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; coordinates access to mental health care, treatment and rehabilitation services to various categories of mental health care users; and integrates the provision of mental health care services into the general health services environment. Section 3(b) provides that the MHCA seeks to regulate access to and provide mental health care, treatment and rehabilitation services to voluntary, assisted and involuntary mental health care users; State Patients; and mentally ill prisoners. The MHCA does not define “equitably, efficiently and in the best interest of mental health care users”, and it is submitted that it should be taken to mean “in line with the rights set out in the Bill of Rights in the Constitution and the principles of science based medicine”.⁵ This will often entail a balancing exercise, with the best interest of the user to be determined in each individual case.

4.2.1.3 Implementation of policies and measures by the State

Section 4 determines that every organ of State responsible for health services must determine and co-ordinate the implementation of its policies and measures in a manner that ensures the provision of mental health care, treatment and rehabilitation services at primary, secondary and tertiary levels and health establishments (psychiatric hospitals or care and rehabilitation centres);⁶ promotes the provision of community-based care, treatment and rehabilitation

⁴ Section 2(2) of the MHCA.

⁵As discussed at length in Chapter 2 and Chapter 3.

⁶ Sections 4(a) and 5(1) of the MHCA.

services;⁷ promotes the rights and interests of mental health care users;⁸ and promotes and improves the mental health status of the population.⁹ “Mental health status” means the level of mental wellbeing of a person as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis, and is discussed in this chapter in relation to the requirements for voluntary, assisted and involuntary admission as mental health care user and the relevant MHCA forms.¹⁰ The implementation of policies and measures by the State is discussed in Chapter 6 regarding available resources, statistics of prevalence of mental disorder, stigma, discrimination, infrastructure, and human resources such as the availability and expertise of mental health care practitioners.

4.3 General comments on the MHCA forms and their completion

In a study by Madlala and Sodikela,¹¹ the authors measured the effect of the MHCA by selecting a sample at Weskoppies Hospital in Gauteng from June to December 2009 focusing on the following aspects of care: the way diagnoses were formulated; the appropriateness of the treatment provided; the correction of abnormal results of investigations; the quality of record-keeping; and compliance with the procedural matters of the MHCA.¹² Although care should be taken to extrapolate the findings of the study to other hospitals and other provinces, it is helpful to consider the mistakes made when implementing the MHCA in this study to prevent the same from occurring in other settings and to guide legislative reform and training where required to remedy the situation.

A retrospective descriptive study was carried out and the clinical files of the first 200 mental healthcare users over the age of 18 years admitted with an involuntary or assisted status were retrospectively reviewed.¹³ For the purposes of the study, the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR) diagnostic criteria were used to assess

⁷ Section 4(b) of the MHCA.

⁸ Section 4(c) of the MHCA.

⁹ Section 4(d) of the MHCA.

¹⁰ Section 1 of the MHCA.

¹¹ Madlala, DP., Sodikela, FB. (2014) 'The care, treatment, rehabilitation and legal outcomes of referrals to a tertiary psychiatric hospital according to the Mental Health Care Act No. 17 of 2002' SAJP 20(4): 172-176.

¹² Madlala and Sodikela (2014) SAJP 173.

¹³ *Ibid.*

the appropriateness of signs and symptoms.¹⁴ According to the DSM-IV-TR, symptoms are grouped together to make up a criterion for a particular disorder.¹⁵ Symptoms used to formulate a diagnosis for a particular disorder were assessed for uniformity with the symptoms described in the DSM-IV-TR criteria for that particular disorder and symptoms reported in the MHCA documentation were considered appropriate if they met the criteria described by DSM-IV-TR for a particular diagnosis; inappropriate symptoms were those that did not meet the criteria.¹⁶ The treatment was appropriate if it was in keeping with treatment outlined by treatment guidelines generally accepted in clinical practice locally.¹⁷ Documentation procedure in line with the MHCA was defined as fulfilling all the requirements regulated by the MHCA.¹⁸ From the MHCA 04 form, demographic data of the mentally ill person must be documented, including details of the person applying and the reasons for the application.

The study found the following at 72-hour facilities:¹⁹

- Appropriate symptoms and signs were documented in 174/200 patients (87%).
- The following symptoms, signs and their respective diagnoses were considered inappropriate as they were not in line with descriptive symptoms outlined by DSM-IV-TR for a particular diagnosis:²⁰ confusion and disorientation prompting a diagnosis of psychosis; crying as the only symptom prompting a diagnosis of depression; hyperactivity prompting a diagnosis of substance-induced psychotic disorder; and pressured speech and mutism prompting a diagnosis of schizophrenia.
- In three files, no symptoms were outlined, a statement “known psych patient” was given and the diagnosis was given as acute mental illness.²¹

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid.*

¹⁸ *Ibid.*

¹⁹ Madlala and Sodikela (2014) SAJP 173-174.

²⁰ Madlala and Sodikela (2014) SAJP 174.

²¹ *Ibid.*

- Treatment was considered appropriate in 139 patients (63%), as assumed of local practice. In one-third of patients, treatment given was not documented, and neither were abnormalities corrected that were detected from investigations.
- In approximately 50% of files, the documentation procedure did not adhere to the requirements of the MHCA.
- In 34 files, the information regarding the past and present mental status of the patient as reported by the family was not written on the MHCA form 05. This information is pivotal and is needed for holistic understanding of the patient; it points out the previous treatment response of the patient and aids in the future management of the patient.
- Twenty-seven files had both spaces for assisted and involuntary application filled, making the application invalid and admission of the patient against their volition unlawful.
- In eight files, the same mental health care practitioner filled in both forms 05 and 06. It is clearly stated in the MHCA that the patient should be examined by two practitioners (Section 27(4)(a) and Section 33(4)(a)). If one person completed both forms, this may indicate that only one person saw the patient and admission was on the basis of only one practitioner's findings.
- From one file, the physical status of the patient was described as average, which is vague.
- In 12 files, the forms were not filled in completely.

The study also found the following at Weskoppies hospital:²²

- The majority of individuals (92%) received a correct diagnosis (according to DSM-IV-TR criteria) and treatment.
- Six patients presented with abnormal results that were detected at Weskoppies Hospital and corrected. However, in four patients, abnormal urea and creatinine results found were not corrected at Weskoppies Hospital. Although adequate information was

²² Madlala and Sodukela (2014) SAJP 174-175.

captured, it was not filed in a consistent manner in 60% of the files. This made it difficult to find some vital information at times.

- In one file, notes were not written in English, the official language of Weskoppies Hospital. This was assessed as inappropriate because information about the patient must be accessed by all clinicians, including those who do not understand South African languages other than English.
- Regarding discharge status, more than two-thirds were discharged as involuntary outpatients and only one tenth were discharged as voluntary mental healthcare users.
- Regarding length of hospital stay, the majority of patients stayed between 43 days and 90 days; only one-fifth stayed for less than 21 days. A significant association between the legal status at discharge and length of stay was found, with involuntary status associated with a longer duration of stay.

Inappropriate symptoms that contributed to inappropriate diagnoses in the study included the use of confusion and disorientation as terminology to define psychosis, and the use of hyperactivity and mutism as criteria for the diagnosis of schizophrenia.²³ The use of the term “known psych patient” instead of exploring current presenting symptoms was also prevalent.²⁴ The authors state that a need for continuous training of non-psychiatric health practitioners in identifying symptoms is signified by their findings.²⁵ Good clinical practice and good standards of care as promoted by the MHCA imply that all mental health care users, and not just the majority, must receive appropriate diagnoses.²⁶ The authors also argue that record-keeping is central to patient management and communication in a multidisciplinary system, helping to prevent negative healthcare outcomes by reducing miscommunication errors, therefore documentation procedures outlined in the MHCA need to be followed when patients are admitted, whether as involuntary or assisted mental healthcare users.²⁷ The findings related to poor adherence to legal requirements and the documentation thereof in this study signify a breach of the MHCA and if MHCA forms are not properly completed, then

²³ Madlala and Sodikela (2014) SAJP 175.

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ *Ibid.*

²⁷ *Ibid.*

admission is illegal and technically treatment ought not to be granted without the patient's consent.²⁸

It is common for mental health care patients to be described by clinicians as “lacking insight” or “with only partial insight”.²⁹ The concept of insight is clinically orthodox, but the concept is difficult as on the one hand it is said to be highly characteristic of schizophrenia, but on the other hand has been identified as unclear in its features and boundaries.³⁰ David has argued that “insight” has three elements, namely recognition that they have a mental illness; acknowledgement that certain mental events are pathological; and complying with treatment.³¹ It is submitted that “insight” is not a diagnosis and is therefore not an acceptable terminology to use by practitioners when completing MHCA forms on its own, without first identifying a diagnosis of a mental disorder and then describing the effect the mental disorder has on the mental health care user's competence. The same is applicable to terminology such as “non-compliant”, “unstable”, and “violent”.

As discussed in Chapter 3 on the DSM-5 and its classification of mental disorders, it is imperative that MHCA forms are completed appropriately by referring to the clinically accepted diagnosis and symptoms in a clear and consistent manner. Vague descriptions of disorders or symptoms that do not match accepted diagnoses are unacceptable and will render a completed form invalid and the resulting detention of an assisted or involuntary mental health care user unlawful, or make record keeping and treatment by other practitioners difficult or impossible. It is also contended that MHCA forms must be completed in line with current DSM-5 guidelines, that is disregarding the previous multiaxial system and presenting diagnoses on the forms in a manner that defines the disorder and makes a judgment concerning the effect the disorder has on the mental health care user's competence and dangerousness (if applicable).

²⁸ *Ibid.*

²⁹ Freckelton, I 'Extra-legislative factors in Involuntary Status decision-making' in McSherry, B. and Weller, P. Rethinking rights-based mental health laws Hart Publishing, Oxford and Portland Oregon 2010 206.

³⁰ Freckelton 206-207.

³¹ Freckelton 208; David, A. (1990) 'Insight and psychosis' British Journal of Psychiatry 156 798.

4.4 Mechanisms of accountability and transparency

In this section mechanisms that exist to ensure accountability and transparency in the implementation of the MHCA are discussed, including the Mental Health Review Board, the judiciary, administrative law measures, and the head of the health department. The only way of reaching the objectives of the MHCA is to ensure that all role players are performing their tasks in accordance with the legislation and Constitution. The purpose of this section is to determine whether adequate mechanisms are in place to oversee the MHCA and protect mental health care users' rights. "Adequate" in this instance is submitted to mean that the relevant authority is sufficiently empowered to exercise its functions, and that the mechanism is the most efficient and competent way of ensuring oversight. Accountability measures are necessary to ensure that requirements for admission as an assisted or involuntary user are met, that periodic reviews are conducted, that appeals are heard, and that timeframes mentioned in the MHCA are adhered to, among other things are discussed in this chapter. The possibility of human rights abuses exist where legislation is lacking or not complied with, or where the overseeing authority is not sufficiently empowered to enforce its recommendations or sufficiently resourced to meet the demand for its services. In this chapter legislation, regulations and MHCA forms are discussed, whilst in Chapter 6 the implementation and effectiveness of Review Boards in practice is analysed.

4.4.1 The Judiciary

The high courts, as well as magistrates courts in some instances, play a role in the enforcement of the MHCA, which distinguishes between open court where a judge or judges discharge judicial functions in court before the public or *in camera* (excluding the public in certain cases); and a "judge in chambers" where a judge is not formally sitting in court normally where no oral representations are made.³² A magistrates court sitting as a criminal court will normally try contraventions of Section 70 of the MHCA.³³ Both a high court and a magistrates court may order an accused be sent for observation or examination in terms of the

³² Landman, A.A. and Landman, W.J. 'A Practitioner's Guide to the Mental Health Care Act' 2014237.

³³*Ibid.*

MHCA regulations, and both a magistrates court and high court may declare an accused to be a State Patient or order an accused be treated as an assisted or involuntary user.³⁴

A detained person has the right not to be detained unlawfully and may apply to the courts for an order of *habeus corpus* (the *interdictum de homine lebero exhibendo*) to be released where there is no justification for their detention.³⁵ The burden of proving justification for detention rests on the detaining authority.³⁶ The high court retains its powers to appoint a curator for a person (*curator personae*) or for a particular function (*curator ad litem*) or for the preservation and management of the property of a person of unsound mind (*curator bonis*).³⁷ Sections 59, 60 and 61 of the MHCA also provide for the preservation and management of the property of a person of unsound mind, although its discussion is outside the scope of this thesis. The high court has an inherent jurisdiction for judicial review that is entrenched in Section 13 of the Constitution, which gives it the power to review administrative actions in terms of PAJA, and actions by administrative organs that do not fall under the definition of administrative action for purposes of PAJA (both of which may include decisions regarding mental health care users by a Review Board, mental health care practitioner, the SAPS, or the head of the health establishment) are reviewable for compliance with the founding values of the rule of law, including the principle of legality.³⁸ A high court also has powers to hear urgent matters and will be cognisant of the rights of persons in terms of the constitution and applicable legislation.³⁹ Several mechanisms exist to enforce court orders, including the interdict or *mandamus*, the award for damages and contempt of court orders.⁴⁰ Appeal against the decision of the high court lies to a full bench of the high court or to the Supreme Court of Appeal or Constitutional Court in circumstances that warrant it.⁴¹ The high court has an important role to play in terms of the MHCA which falls within its traditional role as guardian of the vulnerable members of society, though comments by mental health practitioners

³⁴ *Ibid.*

³⁵ Landman and Landman 238.

³⁶ *Ibid.*

³⁷ Landman and Landman 239.

³⁸ Landman and Landman 240.

³⁹ Landman and Landman 241.

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

suggest that there is room for improvement.⁴² The court's functions in terms of the MHCA is discussed in this chapter and the next in the relevant sections to avoid unnecessary repetition and if there are suggestions to be made for reform they are summarised in the final chapter of this thesis.

4.4.2 Administrative law

Section 33(1) of the Constitution provides that everyone has the right to administrative action that is lawful, reasonable and procedurally fair. Everyone whose rights have been adversely affected by administrative action has the right to be given written reasons.⁴³ National legislation must be enacted to give effect to these rights,⁴⁴ and must provide for the review of administrative action by a court or, where appropriate, an independent and impartial tribunal; impose a duty on the state to give effect to these rights; and promote an efficient administration. In order for administrative law remedies to apply to decisions relating to mental health care users, it must be determined whether such decisions amount to administrative action. Administrative action is defined in Section 1 of the Promotion of Administrative Justice Act 3 of 2000 (hereafter referred to as PAJA) as:

“Any decision taken, or any failure to take a decision, by an organ of state, when exercising a public power or performing a public function in terms of any legislation; or by a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision, which adversely affects the rights of any person and which has a direct, external legal effect.”

The MHCA is the empowering provision in terms of decisions taken regarding mental health care users. “Decision” means “any decision of an administrative nature made, proposed to be made, or required to be made, as the case may be, under an empowering provision”, including a decision relating to the making of an order or determination; giving a direction; approval or

⁴² Landman and Landman 250.

⁴³ Section 33(2) of the Constitution.

⁴⁴ Section 33(3) of the Constitution. The legislation that has been enacted to give effect to Section 33 of the Constitution is the Promotion of Administrative Justice Act 3 of 2000 (PAJA).

consent; imposing a condition or restriction; and failure to take any such action.⁴⁵ An “Organ of state” includes “any department of state or administration in the national, provincial or local sphere of government; or any other functionary or institution exercising a power or performing a function in terms of the Constitution or a provincial constitution; or exercising a public power or performing a public function in terms of any legislation.” The definition of an organ of state includes State hospitals and public mental health facilities, which are owned or controlled by the State.⁴⁶ A private institution can also be an administrator, since the decision to grant or not grant an application for involuntary treatment or admission most certainly has a “direct, external legal effect” on an affected party.⁴⁷ This direct, external legal effect could include the infringement of the mental health care user’s right to freedom of movement or it could lie in the fact that his status has been affected by being declared mentally incapacitated.⁴⁸ Not granting the application could lead to society’s right to safety and security being infringed if the application was brought under s 9(1)(c) of the MHCA.⁴⁹

The decision to grant an application for involuntary treatment or admission, or the refusal to grant such an application, does amount to administrative action.⁵⁰ The head of the health establishment to which an application is submitted will thus qualify as an administrator, as will the Review Board making the final decision.⁵¹ Therefore any decision taken regarding mental health care users by administrators must be lawful,⁵² reasonable,⁵³ and procedurally

⁴⁵ Section 1 of PAJA.

⁴⁶ Kersop, M., Van den Berg, F. (2015) 'Obtaining involuntary mental health care in the South African constitutional dispensation' *Obiter* 679-701 694.

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² Lawful administrative action under the Constitution basically means that administrators must “obey the law and must have authority in law for their decisions”. See Currie, I. and De Waal, J. “The Bill of Rights Handbook” 6th Edition (Cape Town: Juta & Co) 2013666.

⁵³ A decision will be reasonable if it is capable of objective substantiation, tested against the suitability, necessity and proportionality of the decision (as was held in *Roman v Williams NO 1998 (1) SA 270 (C)*). In *Bato Star Fishing (Pty) Ltd v Minister of Environmental Affairs and Tourism and Others 2004 (4) SA 490 (CC)*, the court held that what will constitute reasonable administrative action will depend on the circumstances of each case, factors to consider include: the nature of the decision; the identity and expertise of the decision-maker; the range of factors relevant to the decision; the reasons given for the decision; the nature of competing interests; and the impact of the decision. Currie and De Waal 669.

fair.⁵⁴ If a decision taken by an administrator regarding mental health care users does not amount to just administrative action, then the remedies in PAJA will be applicable, namely the right to be given written reasons,⁵⁵ and the judicial review of administrative action,⁵⁶

⁵⁴In order for a decision affecting an individual person to be procedurally fair, Section 3(2) of PAJA determines that an administrator must give the affected person i) adequate notice of the nature and purpose of the proposed administrative action; ii) a reasonable opportunity to make representations; iii) a clear statement of the administrative action; iv) adequate notice of any right of review or internal appeal, where applicable; and v) adequate notice of the right to request reasons in terms of section 5. Currie and De Waal 672-673.

⁵⁵Section 5 of PAJA.

⁵⁶Section 6 of PAJA. Section 6 of PAJA states:

- 1) Any person may institute proceedings in a court or a tribunal for the judicial review of an administrative action.
- 2) A court or tribunal has the power to judicially review an administrative action if-
 - a) the administrator who took it-
 - (i) was not authorised to do so by the empowering provision;
 - (ii) acted under a delegation of power which was not authorised by the empowering provision; or
 - (iii) was biased or reasonably suspected of bias;
 - b) mandatory and material procedure or condition prescribed by an empowering provision was not complied with;
 - c) the action was procedurally unfair;
 - d) the action was materially influenced by an error of law;
 - e) the action was taken-
 - (i) for a reason not authorised by the empowering provision;
 - (ii) for an ulterior purpose or motive;
 - (iii) because irrelevant considerations were taken into account or relevant considerations were not considered;
 - (iv) because of the unauthorised or unwarranted dictates of another person or body;
 - (v) in bad faith; or
 - (vi) arbitrarily or capriciously;
 - f) the action itself-
 - (i) contravenes a law or is not authorised by the empowering provision; or
 - (ii) is not rationally connected to-
 - (aa) the purpose for which it was taken;
 - (bb) the purpose of the empowering provision;
 - (cc) the information before the administrator; or
 - (dd) the reasons given for it by the administrator;
 - g) the action concerned consists of a failure to take a decision;
 - h) the exercise of the power or the performance of the function authorised by the empowering provision, in pursuance of which the administrative action was purportedly taken, is so unreasonable that no reasonable person could have so exercised the power or performed the function; or
 - (i) the action is otherwise unconstitutional or unlawful.
- 3) If any person relies on the ground of review referred to in subsection (2)(g), he or she may in respect of a failure to take a decision, where-
 - a)
 - (i) an administrator has a duty to take a decision;
 - (ii) there is no law that prescribes a period within which the administrator is required to take that decision; and
 - (iii) the administrator has failed to take that decision,
 institute proceedings in a court or tribunal for judicial review of the failure to take the decision on the ground that there has been unreasonable delay in taking the decision; or
 - b)

above and beyond the provisions in the MHCA that make provision for the review of decisions by the head of the health establishment and mental health review board. It is therefore important that mental health care users are aware of their rights under the Constitution and PAJA, as well as under the MHCA.

4.4.3 Mental Health Review Boards

The role of the Mental Health Review Board (hereafter referred to as “the Review Board”) in regulating mental health care and mental health practitioners is discussed in this section. South Africa has a system of multiple mental health review boards, one or more for each province intended to ensure the rights of mental health care users are protected and that their care is appropriate.⁵⁷ Initial monitoring is triggered by a report to a board and thereafter chronologically based on the required fixed time frames that health establishments are required to provide information to a board.⁵⁸ The board is created by statute and has only the powers assigned to it by law.⁵⁹ Boards play no role with voluntary users.⁶⁰ The Review Board is structured so that it may act independently of the provincial government.⁶¹ It is not a court of law and is dependent on the provincial department for logistical services.⁶² Board members do not enjoy security off tenure like the judiciary.⁶³ The Review Board represents the interests of a democratic society in ensuring mental health care users are treated expeditiously with dignity and the available expertise.⁶⁴ The Board monitors compliance with the rights of the user and the duties of mental health care practitioners.⁶⁵

-
- (i) an administrator has a duty to take a decision;
 - (ii) a law prescribes a period within which the administrator is required to take that decision; and
 - (iii) the administrator has failed to take that decision before the expiration of that period,

institute proceedings in a court or tribunal for judicial review of the failure to take the decision within that period on the ground that the administrator has a duty to take the decision notwithstanding the expiration of that period.

⁵⁷ Landman and Landman 205.

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

⁶¹ Landman and Landman 9.

⁶² *Ibid.*

⁶³ *Ibid.*

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

While Review Boards have been set up in most regions, their efficiency and effectiveness varies considerably.⁶⁶ A recent review conducted in KwaZulu-Natal Province, for example, reported that the Review Board had visited only seven of the 36 hospitals in the region in the preceding six months, while 10 hospitals had never been visited or had not been visited for more than two years.⁶⁷ Ramlall, Chipps, and Mars observe that operational inefficiencies limit substantially the capacity of the Review Board or judiciary to intervene timeously in the event of a violation of the Act.⁶⁸

4.4.3.1 Establishment

The Review Board is established in terms of Section 18(1) and (2) of the Act, which determines that a member of the Executive Council responsible for health services in a province must, after consultation with the head of the provincial department concerned, establish a Review Board regarding every health establishment providing mental health care, treatment and rehabilitation services in that province. The Review Board may be established for a single, a cluster or all health establishments providing mental health care services in that province. Section 18(3) provides that the relevant provincial department must, subject to the laws governing public service appoint, second or designate persons in its employ; and make available other resources, to the Review Board to enable it to perform its administrative functions.

4.4.3.2 Powers and functions of the Review Board

The Powers and functions of the Review Board are determined by Section 19(1) stating the Review Board must:

- a) Consider appeals against decisions of the head of a health establishment;

⁶⁶ Burns (2011) *The Equal Rights Review* 105.

⁶⁷ Ramlall, S., Chipps, J. and Mars, M. (2010) "Impact of the South African Mental Health Care Act No. 17 of 2002 on regional and district hospitals designated for mental health care in KwaZulu-Natal" 100 *SAMJ* 10 667-670; Burns (2011) *The Equal Rights Review* 105.

⁶⁸ Ramlall, Chipps, and Mars. (2010) 667-670. This is further discussed in Chapter 6.

- b) Make decisions regarding assisted or involuntary mental healthcare, treatment and rehabilitation services;
- c) Consider reviews and make decisions on assisted or involuntary mental health care users;
- d) Consider 72-hour 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.

Landman divides the functions of a review board into the broad categories of receipt of information; reviews and appeals (appeals mean reviews initiated by application of the user); requests and applications, and monitoring.⁶⁹ The purpose of an appeal or review is to ensure that a decision is valid in law and supported by a correct diagnosis following an appropriate medical examination.⁷⁰ Monitoring by a review board includes checking that the health establishment and other institutions are notifying and reporting to the board as required in terms of the MHCA and regulations.⁷¹

Several shortcomings regarding the exercise of the functions of review boards have been pointed out by experts, particularly regarding the system of record keeping and quality of the referral system that need to be dramatically improved.⁷² Data regarding mental health care users is frequently unavailable in a format that makes it possible to track the transfer and changing legal status of users; several entries in the Mental Health Review Board Database refer to the same user where no records exist for other users; no overview of the number of patients in a facility at a specific time is routinely obtained by the boards, making it impossible to draw conclusions about the completeness of records; there is under reporting of admissions in hospitals, forms might become lost and the review boards do not sufficiently

⁶⁹ Landman and Landman 213.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

⁷² Janse van Rensburg, ABR. (2011) 'Applications to Mental Health Review Boards by institutions in Gauteng' 17 SAJP 64 64.

follow up on the matter.⁷³ An effective and relevant tracking system, without which human rights of mental health care users will continue to be compromised, must be ensured.⁷⁴ Section 19(2) provides that the Review Board may, when performing its functions, consult or obtain representations from any person, including a person or body with expertise.

It is submitted that the MHCA does not expressly provide for the establishment of a national data tracking system of mental health care users and that legislation should be enacted on consultation with data capture experts in the healthcare environment that calls for an effective national system to be established. Failing this, the Review Boards are not sufficiently empowered to exercise their duties as they do not have access to the necessary information. It is necessary that each mental health care establishment and its health care practitioners, as well as the Review Boards, are able to access patient records (including dates of admission, patient history and forthcoming dates for periodic review) to prevent human rights abuses of mental health care users to ensure that no individual patient falls through the cracks of the system.

The functions that a mental health review board fulfils are broadly discussed in section 19(1) of the MHCA, but in various sections of the MHCA specific roles and duties are referred to. The particular functions are mentioned and discussed throughout this chapter and the rest of the thesis in the sections where they are relevant and are therefore not repeated here. If reform concerning a particular function or provision is suggested, it is summarised here and in the final chapter of the thesis as well.

4.4.3.3 Composition of Review Board

According to Section 20 of the MHCA the Review Board consists of no fewer than three persons and no more than five persons who are South African citizens appointed by the relevant member of the Executive Council in each province, and must at least consist of a mental health care practitioner; magistrate, an attorney or an advocate admitted in terms of the

⁷³ *Ibid.*

⁷⁴ *Ibid.*

law of the Republic; and member of the community concerned. Before appointing any person the relevant member of the Executive Council must by notice in the Provincial Gazette, and any other widely circulated means of communication in that Province call for nominees and state the criteria for such nominations; specify a period within which nominations must be submitted; and consider all nominations and make an appointment, and Executive Council must determine the term of office of members appointed. Such term of office may be staggered.

4.4.3.4 Removal

Section 21 of the MHCA determines that a member of the Review Board may be removed from office after an enquiry on account of:

- a) Ceasing to practise the profession in terms of which they were appointed;
- b) Inability to perform his or her duties effectively;
- c) Absence from two consecutive meetings of the Review Board without prior permission, except on good cause shown;
- d) Ceasing to be a South African citizen; or
- e) The public interest.

4.4.3.5 Procedures of Review Board⁷⁵

Section 24(1) provides that a Review Board may determine its own procedures for conducting business. Section 26(3) states that whenever a Review Board is considering a matter that involves health establishment at which one of the members of the Review Boards is a mental health care practitioner, that practitioner may not be involved in the consideration of the matter. A board is free to develop its own procedures, but is subject to the Constitution and rules of administrative law, including the rules of natural justice, namely the rule of *audi alteram partem* (to hear the other side) and the *nemo iudex in sua propria causa* rule (the rule

⁷⁵A discussion of the provisions in Section 22 and 23 of the Act regarding vacancies on the Review Board and the remuneration of its members are outside the scope of this discussion, as they do not directly relate effect the mental health care user.

against bias).⁷⁶ Apart from the provision in section 22(3) of the MHCA, the common law rule applies that where functions are entrusted to a statutory body it may only act if all its members are present and the decision is unanimous, which is a problem for a board since its members may be absent for six months before removal from office.⁷⁷ It is suggested that the MHCA be amended to make provision for the valid exercise of the Review Board's functions if not all members are present to prevent a backlog of issues to be decided upon and delay in resolving them, such as the introduction of a quorum, by allowing the Review Board to expand its membership to more than five members, or by creating more Review Boards per area to deal with the case load should one Board be unavailable.⁷⁸

The court in *Ex parte: G and Sixty six others, In re: Special Hearing in regard to The Mental Health Care Act, No 17 of 2002*⁷⁹ held that the procedure followed by a board is satisfactory if there is evidence that the board in question is actively trying to comply with procedural elements, such as ensuring that users are represented if needed, despite practical difficulties such as the board as a collective interviewing all individuals.⁸⁰ In this case interviews were delegated to individual board members who then informed the rest of the board.⁸¹ The functioning of the review boards and judiciary has generally not been perceived as effective by the medical community.⁸² In the case of *Ex parte: G and Sixty six others* the court recommended that a permanent ad hoc curator *ad litem* should be appointed to the Legal Aid Board to serve on each board who would represent the interests of users and would have *locus standi* to make representations in court on behalf of users and be entitled to launch application procedures in appropriate circumstances.⁸³ Landman endorses this suggestion but states that the *curator ad litem* should not be a member of a board.⁸⁴

⁷⁶ Landman and Landman 211.

⁷⁷ Landman and Landman 208.

⁷⁸ Resource allocation to support the implementation of the MHCA and Review Boards is discussed in Chapter 6.

⁷⁹ (2008) ZAKZHC 37.

⁸⁰ (2008) ZAKZHC 37 par 35-39; Landman and Landman 216-217.

⁸¹ Landman and Landman 216-217; *Ex parte: G and Sixty six others* par 35.

⁸² Landman and Landman 236; Ramlall, Chipps, and Mars. (2010) 667

⁸³ Landman and Landman 236; *Ex parte: G and Sixty six others* par 41.

⁸⁴ Landman and Landman 236.

4.4.3.6 *Legal nature of Review Board*

Section 34 of the Constitution provides that “Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum.” The reference to an “independent and impartial tribunal or forum” begs the question whether review boards fall under this description, as their functions include dispute resolution between users and the head of a health establishment.⁸⁵ Landman states that a board does not satisfy the test for independence and members do not enjoy security of tenure or immunity for the consequences of their actions.⁸⁶ Even a member that is a magistrate is appointed in their personal capacity, and all decisions relating to legal or medical aspects are taken by all its members and legal questions are not reserved for the legal practitioner member.⁸⁷ A board does not represent the user and in this manner does not fulfil the position of *curator ad litem* that existed in the repealed Act, but must take into account the best interests of the user.⁸⁸ Though as discussed above, a board is an organ of state and performs a public function in terms of the Act which may adversely affect the rights of a person and which has a direct external legal effect and is therefore an administrative organ and subject to administrative law, for example the duty to give written reasons and to act in a manner that is lawful, reasonable and procedurally fair in terms of Section 33 of the Constitution.⁸⁹

A board may only act within the limits of the authorising legislation (*intra vires*), in terms of area of jurisdiction, person, and situation or event.⁹⁰ Time limits must be honoured in line with the principle of legality and because they are set for a reason.⁹¹ Individual board members are not authorised to assign certain tasks to certain members and the decision must be that of the collective board, in line with the principle of legality and procedural fairness.⁹² In Chapter 6 the triumphs and failures of the Review Boards in practice is discussed, and

⁸⁵ Landman and Landman 208.

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ Landman and Landman 209.

⁸⁹ *Ibid.*

⁹⁰ Landman and Landman 210.

⁹¹ *Ibid.*

⁹² *Ibid.*

while many of the problems leading to inefficient Boards are related to a lack of resources, the Review Boards also lack the authority to enforce its own recommendations without it being ratified and reviewed by the already overburdened judiciary.

A restructuring of the system might be a solution and it is recommended that a specialised high court that deals with mental health care matters be created to ensure speedy and expert review of decisions by the Review Boards and the settling of matters pertaining to the MHCA.⁹³ This specialised court would lighten the case load on the court system and prevent infringements of mental health care users' rights by delivering judgement in a more efficient and expedient manner by members of the judiciary specialising in mental health care law. Alternatively, the creation of a special independent mental health care tribunal that deals exclusively with issues pertaining to the MHCA and Review Boards would serve the same purpose.

4.5 Voluntary users

The Act defines “voluntary care, treatment and rehabilitation” as the provision of health interventions to a person who gives consent to such interventions. Section 25 provides that a mental health care user, who submits voluntarily to a health establishment for care, treatment and rehabilitation services, is entitled to appropriate care, treatment and rehabilitation services or to be referred to an appropriate health establishment. In cases of voluntary admission, informed consent must be present, as is discussed in Chapter 2 on the right to bodily and psychological integrity, which includes the right to security in and control over their body as guaranteed in Section 12 of the Constitution.⁹⁴

⁹³See:Kinscherff (2010) “Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act” 38 *Journal of Law, Medicine & Ethics* 745;Frailing (2010) “How Mental Health Courts Function: Outcomes and Observations” 33 *International Journal of Law and Psychiatry* 207; Fisher (2005) “Building Trust and Managing Risk: A Look at a Felony Mental Health Court” 11 *Psychology, Public Policy and Law* 587 589; Watson, Lanraham, Luchins and Lurigio (2001) “Mental Health Courts and the Complex Issue of Mentally Ill Offenders” 52 *Psychiatric Services* 477.

⁹⁴ Section 7(3) of the National Health Act 61 of 2003 determines that ‘informed consent’ means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in Section 6. Section 6 requires that a health care user is to have full knowledge of their health status, the treatment and diagnostic options available to them, the benefits, risks, costs and consequences associated with each option, and their right to refuse health services and the implications of such a refusal.

The MHCA provides for voluntary mental health care users, but does not regulate their situation in detail.⁹⁵ The voluntary user is usually legally able to submit or consent to treatment and generally has the legal capacity to make decisions about their admission, care, rehabilitation and discharge.⁹⁶ The MHCA does not regulate the criteria or prescribe steps to be followed for admission as voluntary user, every establishment may decide on its own admission process.⁹⁷ A user normally has to sign a consent form similar to forms used for surgical procedures.⁹⁸ The MHCA does not stipulate the content to be included in the consent form. The MHCA also does not specifically regulate discharge of voluntary users and the particular health establishment is free to follow its own procedure.⁹⁹ Sections 10(1) and (2) of the National Health Act¹⁰⁰ state that a health care provider must provide a user with a discharge report at the time of discharge from a health establishment containing such information as may be prescribed by the Minister regarding the nature of the health service rendered, the prognosis of the user and the need for follow-up treatment. Section 10(3) states that a discharge report may be verbal in the case of an outpatient, but must be in writing in the case of an inpatient. Landman states that it would be helpful if a user was given a discharge report or certificate to present to a treating medical practitioner or community clinic.¹⁰¹ It is submitted that this should be compulsory, especially in the light of poor record keeping and the difficulty in gathering data on mental health care users from which statistics may be compiled to guide policy and resource allocation in the mental health care sector.¹⁰²

It is submitted that the MHCA and its regulations should be amended to prescribe a minimum of information that should be included in the consent form to be used by voluntary mental health care users to ensure proper informed consent is obtained prior to admission. It is submitted that standard consent forms used for medical and surgical procedures might not contain sufficient information to indicate that the user did possess the necessary competence

⁹⁵ Landman and Landman 82.

⁹⁶ *Ibid.*

⁹⁷ Landman and Landman 89.

⁹⁸ *Ibid.*

⁹⁹ *Ibid.* Althou MHCA 03 is suggested for use in discharge of voluntary users as well.

¹⁰⁰ Act 61 of 2003.

¹⁰¹ *Ibid.*

¹⁰² Chapter 6 discusses the difficulties inherent in the South African mental health care sector pertaining to acquiring accurate data on mental health care users (including regarding their numbers, diagnoses, and treatment).

or capacity to make an informed decision in the light of their mental disorder, and that they were properly informed and understood the consequences of consent. The training of mental health care professionals in the specifics of informed consent is an important aspect of ensuring that valid consent is obtained and the HPCSA should mandate CPD training on the topic.

It is submitted that the following applies in situations where consent is withdrawn or where a voluntary user no longer possesses the capacity to give informed consent:

- In a situation where a voluntary mental health care user with the necessary capacity withdraws consent, the user is to be discharged.
- In a scenario where a voluntary mental health care user becomes incapable of giving valid consent, but does not protest to continued detainment, an application for admission as an assisted user must be made for continued detention to be lawful.¹⁰³
- In a situation where a user becomes incapable of consenting after their admission as a voluntary user and wishes to be discharged or refuses treatment, an application must be made for further involuntary detention to avoid their unlawful detention against their will.¹⁰⁴

4.6 Assisted mental health care users

4.6.1 Care, treatment and rehabilitation services for mental health care users incapable of making informed decisions

The Act defines “assisted care, treatment and rehabilitation” as the provision of health interventions to people incapable of making informed decisions due to their mental health status and who do not refuse the health interventions. Section 26, subject to Section 9(1)(c), determines that a mental health care user may not be provided with assisted care, treatment and rehabilitation services at a health establishment as an outpatient or inpatient without his or her consent, unless:

¹⁰³ The procedure regarding an application for admission as an assisted user is discussed in this chapter below.

¹⁰⁴ The procedure regarding an application for involuntary admission is discussed in this chapter below.

- (a) A written application for care, treatment and rehabilitation services is made to the head of the health establishment concerned and they approve it; and
- (b) At the time of making the application there is a reasonable belief that the mental health care user is suffering from a mental illness or severe or profound mental disability, and requires care, treatment and rehabilitation services for his or her health or safety, or for the health and safety of other people;¹⁰⁵ and the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services.¹⁰⁶

An assisted user is reluctant or unresponsive and could be subject to some form of duress from family or friends.¹⁰⁷ Once such a person expresses a refusal to consent to care, they cannot be treated as assisted users.¹⁰⁸ If a child is over the age of 12 years and of a level of maturity to have legal capacity, they may validly refuse treatment and should rather be treated as an involuntary user.¹⁰⁹ A health establishment may not offer services of its own accord; it must be approached by application (MHCA 04).¹¹⁰ When a user has been admitted as an assisted user, but later becomes resistant to treatment, it is submitted that they should be transferred from assisted to involuntary status. In this scenario there is no specified form in the MHCA to be used specifically, which allows for an indication of the reasons for the transfer (MHCA 06 which is used for application for involuntary admission does not fulfil this need). It is submitted that the MHCA and its regulations should be amended to make provision for such a scenario and provide an appropriate form.

4.6.2 Application for assisted care, treatment and rehabilitation services

In terms of Section 27(1)(a) of the Act an application referred to in Section 26 may only be made by the spouse, next of kin, partner, associate, parent or guardian of a mental health care user, but where the user is below the age of 18 years on the date of the application, the

¹⁰⁵ Section 26(a)(i) of the MHCA.

¹⁰⁶ Section 26(a)(ii) of the MHCA.

¹⁰⁷ Landman and Landman 91.

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

¹¹⁰ Landman and Landman 92. Form MHCA 04 and other forms regarding assisted users are discussed in this chapter below under 'MHCA forms pertaining to involuntary users', so as to prevent duplicate discussion.

application must be made by the parent or guardian of the user; or spouse, next of kin, partner, associate, parent or guardian of the user is unwilling, incapable or not available to make such an application, the application may be made by a health care provider. The applicants must also have seen the mental health care user within seven days before making the application.

An application for assisted mental health care under Section 26 must be made in the prescribed manner and according to Section 27(2) the application must:

- (a) Set out the relationship of the applicant to the mental health care user;
- (b) If the applicant is a health care provider, state:
 - (i) the reasons why they are making the application; and
 - (ii) what steps were taken to locate the relatives of the user in order to determine their capability or availability to make the application;
- (c) Set out grounds on which the applicant believes that care, treatment and rehabilitation services are required; and
- (d) State the date, time and place where the user was last seen by the applicant within seven days before the application is made.

The application may be withdrawn at any time.¹¹¹ Withdrawal of the application must be done by the applicant, who does not need to give reasons for the withdrawal.¹¹² The withdrawal is valid from the moment it is communicated to the head of the health establishment.¹¹³ No formalities for withdrawal are prescribed by the MHCA, though it is recommended that the establishment insist that it be done in writing or confirm in writing that it has been received.¹¹⁴ The application is an administrative action as the head of the health establishment is an organ of state that makes a decision that has legal consequences for the user and imposes rights and duties.¹¹⁵ It is a provisional decision if the application is accepted, as the user must then be

¹¹¹ Section 27(3) of the MHCA.

¹¹² Landman and Landman 92.

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ Landman and Landman 93.

examined in accordance with the MHCA.¹¹⁶ After the examination, the application can be finally approved or rejected.¹¹⁷

Regulation 9(1) of the General Regulations to the MHCA determines that an application for assisted mental health care by a person contemplated in Section 27(1) of the Act must be made in the form of form MHCA 04. MHCA 04 is also used for applications for involuntary care, treatment and rehabilitation and is discussed below in relation to Section 33(1) of the MHCA. Where an applicant is unable, for whatever reason, to complete a written application, that applicant must be assisted by a staff member at the health establishment concerned.¹¹⁸ An application form referred to in Regulation 9(1) must be available at all health establishments where there are at least two mental health care practitioners able to examine such person in terms of Section 27(4) of the Act.¹¹⁹ On completion of the examination referred to in Regulation 9(3), the mental health care practitioners must submit their finding in the form of form MHCA 05 to the head of the health establishment concerned.¹²⁰ MHCA 05 is also used regarding involuntary users and is discussed below in this chapter relating to Section 33(5) of the MHCA. A health establishment that is unable to provide the examination contemplated in Section 27(4) of the Act, must refer an applicant to a health establishment within the closest proximity that provides that examination.¹²¹

According to Section 27(4)(a), the head of a health establishment concerned must, on receipt of the application, cause the mental health care user to be examined by two mental health care practitioners. Such mental health care practitioners must not be the persons making the application and at least one of them must be qualified to conduct physical examinations (Section 27(4)(b)). Section 27(5) requires that on completion of the examination, the mental health care practitioners must submit their written findings to the head of the health establishment concerned on whether the circumstances referred to in Section 26(b) are applicable; and whether the mental health care user should receive assisted care, treatment

¹¹⁶ *Ibid.*

¹¹⁷ *Ibid.*

¹¹⁸ Regulation 9(2) of the General Regulations to the MHCA.

¹¹⁹ Regulation 9(3) of the General Regulations to the MHCA.

¹²⁰ Regulation 9(5) of the General Regulations to the MHCA.

¹²¹ Regulation 9(6) of the General Regulations to the MHCA.

and rehabilitation services as an outpatient or inpatient. If satisfied, the head of the health establishment must give written notice to the applicant of his or her decision concerning assisted care, treatment and rehabilitation in question and reasons thereof.¹²² Section 27(6)(a) determines that if the findings of the two mental health care practitioners differ, the head of the health establishment concerned must cause the mental health care user to be examined by another mental healthcare practitioner, and Section 27(6)(b) requires that the mental health care practitioner must, on completion of such examination, in writing, submit a report on the aspects referred to in Section 27(5).

The head of the health establishment may only approve the application if the findings of two of the mental health care practitioners referred to in Sections 27(4) or 27(6) concur that conditions for assisted care, treatment and rehabilitation exist.¹²³ The head of the health establishment may only approve assisted care, treatment and rehabilitation of a prospective user as an inpatient if the findings of two mental health care practitioners concur that conditions for inpatient care, treatment and rehabilitation exist;¹²⁴ and satisfied that the restrictions and intrusions on the rights of the mental health care user to movement, privacy and dignity are proportionate to the care, treatment and rehabilitation services required.¹²⁵ The definition of mental health care practitioner as defined in the MHCA,¹²⁶ and mentioned above, is broader than just referring to a psychologist or psychiatrist, which means that in primary health care establishments it is likely that the two mental health practitioners called upon to deliver the report on whether a person will be admitted as assisted user might not be specialised in, or sufficiently trained to recognise, mental disorder. It is imperative that the training of mental health practitioners therefore be of a high quality and that ongoing CPD training is mandated to keep practitioners abreast of the latest developments in mental health care. It is submitted that the practice of one practitioner completing two forms, or where one practitioner completes an assessment that is merely signed off by another without completing

¹²² Section 27(9) of the MHCA.

¹²³ Section 27(7) of the MHCA.

¹²⁴ Section 27(8)(a) of the MHCA.

¹²⁵ Section 27(8)(b) of the MHCA.

¹²⁶ Section 1 of the MHCA defines mental health care practitioner as a psychiatrist, or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker trained to provide prescribed mental health care treatment and rehabilitation services.

an independent assessment and delivering an individual opinion is not procedurally fair and would lead to an unlawful detention if detainment is effected on the grounds of the reports.

When the form is submitted, the head of the health establishment must consider the application to make sure it has been fully completed and whether all of the provisions in the MHCA have been complied with.¹²⁷ If the head of the health establishment approves the application for inpatient assisted care, treatment and rehabilitation services, they must, within five days, cause the mental health care user to be admitted to that health establishment or to be referred to another health establishment with appropriate facilities.¹²⁸ The head of the health establishment concerned must give notice in terms of Section 27(9) of the Act to the applicant in the form of form MHCA 07 of their decision concerning the application for assisted care, treatment and rehabilitation in question and reasons thereof.¹²⁹ MHCA 07 is also used with regard to involuntary users and is discussed in this chapter below relating to Section 33(8) of the MHCA. After the decision to approve the application, it may no longer be withdrawn and must be implemented within five days in the case of an inpatient.¹³⁰

It is submitted that the MHCA does not specifically determine the time from which the five days should be counted, e.g. whether the five days is from the date of admission, the date the application has been made or from the date the head of the health establishment has made their decision. The MHCA also does not stipulate the timeframe within which the head of the head establishment must come to a decision or when they are considered to have received the application (when it has been delivered to their office, once it has been logged on a system of information capture, or when they actually become aware of it). In addition the MHCA does not specify a mechanism by which a follow up procedure to enforce the timeframe is created. The MHCA should be amended to provide for clarity and the prevention of unduly long periods of detention and decision-making that could infringe on users' rights.

¹²⁷ Landman and Landman 94.

¹²⁸ Section 27(10) of the MHCA.

¹²⁹ Regulation 9(7) of the General Regulations to the MHCA.

¹³⁰ Landman and Land man 94.

If it is permissible to withdraw the application after the decision to approve the application is taken, a further administrative action is necessary to withdraw the approval.¹³¹ If the police have been requested to apprehend the user and the decision is withdrawn before the apprehension and the police are not notified of the withdrawal, the user might have a claim for unlawful apprehension and detention as the basis for the request would fall away.¹³² This indicates that once the application is approved, it can no longer be withdrawn.¹³³ The decision also imposes a legal duty on the mental health establishment to care for the user which may lead to a right to sue for damages if care is withdrawn for harm suffered when it was not in the best interest of the user.¹³⁴ It is submitted that the MHCA and its regulations are lacking because it does not prescribe a specific procedure for withdrawal of the application. At the very least confusion and arbitrary treatment could be avoided if the MHCA were amended to prescribe a specific form and procedure for withdrawal of the application.

The MHCA does not require the head of the establishment to inform the applicant if the application has been unsuccessful and this should be done as it is a serious omission from the act as the right to appeal the decision is provided for in Section 29.¹³⁵ It is suggested that although the MHCA does not expressly provide for it, the user must be properly informed of the decision to provide assisted care and that this is in line with Section 35(2)(a) of the Constitution that provides that everyone who is detained has the right to be informed properly of the reason for being detained and that this right is limited only to the extent of the person not being able to understand.¹³⁶

4.6.3 Recovery of capacity of assisted mental health care users to make informed decisions

Section 31(1) determines that if the head of a health establishment, at any stage after approving an application for assisted care, treatment and rehabilitation services, has reason to

¹³¹ *Ibid.*

¹³² *Ibid.*

¹³³ *Ibid.*

¹³⁴ *Ibid.*

¹³⁵ Landman and Landman 97.

¹³⁶ *Ibid.*

believe from personal observation, from information obtained or on receipt of representations by the user that an assisted mental health care user has recovered the capacity to make informed decisions, they must enquire from the user whether the user is willing to voluntarily continue with care, treatment and rehabilitation services. If the assisted mental health care user consents to further care, treatment and rehabilitation services, Section 25 applies.¹³⁷

If the assisted mental health care user is unwilling to continue with care, treatment and rehabilitation services, and the head of the health establishment is satisfied that the user is no longer suffering from the mental illness or mental disability referred to in Section 26(b), the head of the health establishment concerned must immediately cause the user to be discharged according to accepted clinical practices.¹³⁸ If the user is still suffering from the mental illness or mental disability referred to in Section 26(b),¹³⁹ the head of the health establishment concerned must, in writing, inform the person who made the application in terms of Section 27;¹⁴⁰ and mental health care practitioner, registered social worker or nurse administering care, treatment and rehabilitation services to that mental health care user.¹⁴¹ Section 31(4) provides that the head of the health establishment must advise the persons referred to in Section 31(3)(b) that they may make an application within 30 days of receipt of such report to the head of the relevant health establishment to provide involuntary care, treatment and rehabilitation services to the user and that Sections 32 and 33 apply. If the application is not made within 30 days, the assisted mental health care user must be discharged.¹⁴² Implied in this provision is that the head of the establishment may detain the user for 30 days and the MHCA does not oblige the head of the establishment to inform the user of this decision, which is a serious omission.¹⁴³ The intention of Section 31(3)(b), (4) and (5) is to give the head the power to detain the person for another 30 days and the head only has to consider whether the user suffers from “mental illness or severe or profound disability” and not whether the user requires more care or if they pose a danger.¹⁴⁴ The restriction on liberty is

¹³⁷ Section 31(2) of the MHCA.

¹³⁸ Section 31(3)(a) of the MHCA.

¹³⁹ Section 31(3)(b) of the MHCA.

¹⁴⁰ Section 31(3)(b)(i) of the MHCA.

¹⁴¹ Section 31(3)(b)(ii) of the MHCA.

¹⁴² Section 31(5) of the MHCA.

¹⁴³ Landman and Landman 107.

¹⁴⁴ *Ibid.*

questionable.¹⁴⁵ Regulation 17 of the General Regulations to the MHCA determines that the discharge report must be issued by way of form MHCA 03.

It is submitted that if a person has regained the ability to make informed decisions, it is against their rights to be detained for a period of 30 days, in addition to not be informed of this decision if they are deemed to not pose a risk to themselves or others. The MHCA must be amended accordingly. It is submitted that if a user does not require further care to protect the safety of the user or others, then the 30 day period is untenable and that the user must be discharged and interested persons may bring an application for involuntary care if they so wish to do after the discharge and if the requirements are satisfied.

The issue of ‘revolving door syndrome’ where a mentally ill person refuses treatment after their symptoms improve and capacity is regained, only to later relapse and restart the cycle,¹⁴⁶ deserves mention here. Zwart contends that although the autonomy of the user and right to freedom and security of the person should not be undermined by providing treatment against their wishes, the consequences of this dilemma may be mitigated by achieving a more integrated mental health care system as intended in the MHCA and providing community care and services instead of inpatient care where possible.¹⁴⁷

4.6.4 MHCA forms pertaining to assisted users

The MHCA forms relevant to the admission as an assisted MHCA user are MHCA 04, MHCA 05, and MHCA 07. These forms are also applicable to the admission of involuntary mental health care users and are for purposes of non-repetition discussed below in this chapter under MHCA forms pertaining to involuntary mental health care users. The MHCA forms pertaining to periodic reviews, appeals, discharge and the SAPS that may be relevant to assisted users are discussed below their discrete headings in this chapter.

¹⁴⁵ *Ibid.*

¹⁴⁶ Zwart, L. “An analysis of informed consent and clinical aspects regarding mental capacity in context of the Mental Health Care Act 17 of 2002” (Unpublished LLM dissertation, University of Pretoria, 2015) 85.

¹⁴⁷ Zwart 86.

4.7 Involuntary mental health care users

The Mental Health Care Act defines “involuntary care, treatment and rehabilitation” as meaning the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others. An “involuntary mental health care user” in terms of the Act means a person receiving involuntary care, treatment and rehabilitation. The MHCA recognises autonomy of persons, but also the fact that in certain circumstances it may be necessary to infringe upon the rights of dignity and liberty to provide treatment without consent of the user.¹⁴⁸ The MHCA carefully regulates the manner in which involuntary users may be admitted for treatment and the circumstances that justifies the deprivation of liberty.¹⁴⁹ The MHCA envisages two routes for involuntary treatment, firstly through the criminal justice system and secondly, the civil route where certain persons may apply for the involuntary treatment of persons who require mental health care services for their own protection or the protection of others.¹⁵⁰ A person accused of a crime may be detained as if they were an involuntary user; this is discussed in more detail in Chapter 5 under State Patients.

4.7.1 Care, treatment and rehabilitation of mental health care users without consent

Section 32 determines that a mental health care user must be provided with care, treatment and rehabilitation services without his or her consent at a health establishment on an outpatient or inpatient basis if an application in writing is made to the head of the health establishment concerned to obtain the necessary care, treatment and rehabilitation services and the application is granted;¹⁵¹ if at the time of making the application, there is reasonable belief that the mental health care user has a mental illness of such a nature that the user is likely to inflict serious harm to themselves or others;¹⁵² or if care, treatment and rehabilitation

¹⁴⁸ Landman and Landman 109.

¹⁴⁹ *Ibid.*

¹⁵⁰ *Ibid.*

¹⁵¹ Section 32(a) of the MHCA.

¹⁵² Section 32(b)(i) of the MHCA.

of the user is necessary for the protection of the financial interests or reputation of the user.¹⁵³ 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.¹⁵⁴

4.7.2 Application to obtain involuntary care, treatment and rehabilitation

An application for involuntary care, treatment and rehabilitation services may only be made by the spouse, next of kin, partner, associate, parent or guardian of a mental health care user,¹⁵⁵ but where the user is below the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user;¹⁵⁶ or spouse, next of kin, partner, associate, parent or guardian of the user is unwilling, incapable or is not available to make such application, the application may be made by a health care provider.¹⁵⁷ The applicants referred to must have seen the mental health care user within seven days before making the application.¹⁵⁸ An application for involuntary mental health care by a person contemplated in Section 33(1) of the Act must be made in the form of form MHCA 04.¹⁵⁹ Where an applicant is unable, for whatever reason, to complete in the written application, that applicant must be assisted by a staff member at the health establishment concerned.¹⁶⁰

An application to obtain involuntary care must set out the relationship of the applicant to the mental health care user.¹⁶¹ If the applicant is a health care provider,¹⁶² the application must state the reasons why the application is made by him or her;¹⁶³ and what steps were taken to locate the relatives of the user to determine their capability or availability to make the application.¹⁶⁴ The application must also set out the grounds on which the applicant believes

¹⁵³ Section 32(b)(ii) of the MHCA.

¹⁵⁴ Section 32(c) of the MHCA.

¹⁵⁵ Section 33(1)(a) of the MHCA.

¹⁵⁶ Section 33(1)(a)(i) of the MHCA.

¹⁵⁷ Section 33(1)(a)(ii) of the MHCA.

¹⁵⁸ Section 33(1)(b) of the MHCA..

¹⁵⁹ Regulation 10(1) of the General Regulations to the MHCA.

¹⁶⁰ Regulation 10(2) of the General Regulations to the MHCA.

¹⁶¹ Section 33(2)(a) of the MHCA.

¹⁶² Section 33(2)(b) of the MHCA.

¹⁶³ Section 33(2)(b)(i) of the MHCA.

¹⁶⁴ Section 33(2)(b)(ii) of the MHCA.

that care, treatment and rehabilitation are required;¹⁶⁵ and state the date, time and place where the user was last seen by the applicant within seven days before making the application.¹⁶⁶

Section 33(3) determines that an application for involuntary care, treatment and rehabilitation services may be withdrawn at any time. It can be argued that the application for involuntary care can only be withdrawn before the head of the health establishment makes a decision in terms of Section 33(7), as after that it no longer is an application.¹⁶⁷ The procedure for withdrawal of the application is not specified in the MHCA, and as was discussed regarding assisted users it is submitted that the Act should be amended to make the procedure for withdrawal of an application clear and standardised. A concerned mental health care worker may still lodge the application as the applicant is therefore considered “unwilling”.¹⁶⁸ An applicant who withdraws an application for involuntary admittance may be held liable for damages if they have a legal duty to care for the user.¹⁶⁹

On receipt of the application in the form of MHCA 04, the head of the health establishment concerned must cause the mental health care user to be examined by two mental health care practitioners.¹⁷⁰ It is submitted that the practice of one practitioner completing two forms, or where one practitioner completes an assessment that is merely signed off by another without completing an independent assessment and delivering an individual opinion is not procedurally fair and would lead to an unlawful detention if detainment is effected on the grounds of the reports. It is submitted that the accountability mechanisms to ensure compliance with the MHCA provisions are insufficiently utilised to ensure that this practice does not happen. It is submitted that the MHCA does not determine what is meant with “on receipt of the application” or the timeframe within which the head of the health establishment must be made or should have been made aware of such an application. It is submitted that a system of record keeping and effective communication is imperative in ensuring that users’ needs are attended to as quick as possible and that users do not become “lost” in the system

¹⁶⁵Section 33(2)(c) of the MHCA.

¹⁶⁶ Section 33(2)(d) of the MHCA.

¹⁶⁷Landman and Landman 112.

¹⁶⁸*Ibid.*

¹⁶⁹Landman and Landman 113.

¹⁷⁰ Section 33(4)(a) of the MHCA; Regulation 10(4) of the General Regulations to the MHCA.

awaiting the necessary assessments and treatments. Such mental health care practitioners must not be the person making the application and at least one of them must be qualified to conduct physical examinations.¹⁷¹

The application form MHCA 04 must be available at all health establishments where there are at least two mental health care practitioners able to examine a person in accordance with Section 33(4) of the Act.¹⁷² Section 33(5) determines that on completion of the examination the mental health care practitioners must submit to the head of the health establishment their written findings in the form of form MHCA 05 on whether the circumstances referred to in Section 32(b) and (c) are applicable;¹⁷³ and mental health care user must receive involuntary care, treatment and rehabilitation services.¹⁷⁴ If the findings of the two mental health care practitioners differ, the head of the health establishment concerned must cause the mental health care user to be examined by another mental health care practitioner,¹⁷⁵ and that mental health care practitioner must, on completion of such examination submit a written report on the aspects referred to in Section 33(5).¹⁷⁶ The head of the health establishment may only approve the application if the findings of two of the mental health care practitioners referred to in Sections 33(4) or 33(6) concur that conditions for involuntary care, treatment and rehabilitation exist.¹⁷⁷ A health establishment that is unable to provide an examination contemplated in Section 33(4) of the Act, must refer an applicant to a health establishment within the closest proximity which provides that examination.¹⁷⁸ A person must be mentally ill in order to be admitted as involuntary user, therefore other possible medical causes of the symptoms must be excluded.¹⁷⁹

Involuntary mental health care is reliant on effective clinical assessment to justify forcible or coerced treatment, though in practice this is sometimes sorely lacking.¹⁸⁰ The vast majority of

¹⁷¹ Section 33(4)(b) of the MHCA.

¹⁷² Regulation 10(3) of the General Regulations to the MHCA.

¹⁷³ Section 33(5)(a) of the MHCA; Regulation 10(5) of the General Regulations to the MHCA.

¹⁷⁴ Section 33(5)(b) of the MHCA.

¹⁷⁵ Section 33(6)(a) of the MHCA.

¹⁷⁶ Section 33(6)(b) of the MHCA.

¹⁷⁷ Section 33(7) of the MHCA.

¹⁷⁸ Regulation 10(6) of the General Regulations to the MHCA

¹⁷⁹ Landman and Landman 114.

¹⁸⁰ Kersop and Van den Berg (2015) 698.

involuntary mental health care admissions are channelled through hospital-casualty centres where an initial assessment is performed by medical clinicians, not psychologists or psychiatrists.¹⁸¹ This evaluation is conducted to determine whether the patient satisfies the criteria for involuntary treatment, but as emergency rooms are aimed at lifesaving treatment, stabilisation and referral, these *quasi*-psychological evaluations are conducted by means of an unstructured, non-clinical interview mainly based on information obtained from friends, family or alternative sources, such as the South African Police Service or ambulance personnel.¹⁸² The accuracy of such informal psychological assessments is questionable, and although this admission process is merely a start of an extensive process, an insufficient assessment could very well limit the rights of a person by means of an involuntary admission.¹⁸³ It could be argued that clinical psychological evaluations, carried out during the observation period, should rectify the result of an incorrect admission assessment, but an unneeded involuntary admission would already constitute a traumatic and gross infringement on the rights of the person involuntarily detained.¹⁸⁴ It can also be argued that the state has a duty not to infringe upon the rights of its citizens and that by not providing the necessary expertise in personnel and resources that it would be shirking that duty. In addition if a person is detained unlawfully, in this case an involuntary detention where no mental disorder is present, the person so detained may have a civil claim for damages if it can be proven the decision to detain them was taken by a person with insufficient expertise to make a decision in the matter.

The head of the health establishment must, in writing, inform the applicant and give reasons on whether to provide involuntary care, treatment and rehabilitation services.¹⁸⁵ If the head of the health establishment approves involuntary care, treatment and rehabilitation services, they must within 48 hours cause the mental health care user to be admitted to that health establishment.¹⁸⁶ It is submitted that the MHCA does not specify whether the 48 hours must be counted from the date the application is made or from the date the decision has been made

¹⁸¹*Ibid.*

¹⁸²Kersop and Van den Berg (2015) 699.

¹⁸³*Ibid.*

¹⁸⁴*Ibid.*

¹⁸⁵Section 33(8) of the MHCA.

¹⁸⁶Section 33(9)(a) of the MHCA.

by the head of the health establishment, nor does the MHCA specify a timeframe within which the decision must be made and that the MHCA should be amended to clarify the situation and prevent unduly long periods of detention without lawful admission.

The head of the health establishment concerned must give notice in terms of Section 33(8) of the Act to the applicant in the form of form MHCA 07 of his or her decision concerning the application for involuntary care, treatment and rehabilitation in question and reasons thereof.¹⁸⁷ Alternatively with the concurrence of the head of any other health establishment with the appropriate facilities, refer the user to that health establishment.¹⁸⁸ It is not a requirement of the MHCA that the mental health care user be informed of the outcome of the decision to provide involuntary care or not, which is problematic as an appeal is not possible without receiving reasons for a decision and the right to appeal to a Review Board has been discussed above.¹⁸⁹ It is submitted that the MHCA must be amended in order to insure notice of the outcome of an application for involuntary care and the reasons for the decision be given to the mental health care user in addition to the applicant, to enable the user to use their right to appeal. The right to request written reasons where a person has been adversely affected by administrative action is also a requirement for just administrative action as set out in Section 5 of PAJA, so at the very least a mental health care user should be made aware that they are entitled to request reasons if none were given. From a paternalistic point of view, it serves no purpose to apply the *audi alteram partem* rule to involuntary users, since the user does not have the capability to decide what is truly in their best interest.¹⁹⁰ When compared to the paternalistic view, this right to appeal is what is referred to as a non-instrumental rationale for procedural fairness, where the purpose of fairness is simply to uphold an individual's right to dignity by giving them an opportunity to partake in decisions affecting themselves.¹⁹¹

It appears that the MHCA is trying to maintain a balance between the protection of mental health care users' right to dignity and the upholding of mental health care users' best interests

¹⁸⁷ Regulation 10(7) of the General Regulations to the MHCA.

¹⁸⁸ Section 33(9)(b) of the MHCA.

¹⁸⁹ Kersop and Van den Berg (2015) 688.

¹⁹⁰ Kersop and Van den Berg (2015) 697.

¹⁹¹ *Ibid.*

in instances where these two objectives are irreconcilable.¹⁹² It can thus be defended that the MHCA provides for reasons to be given to the applicant in cases of involuntary mental health care users, as they are the party acting in a paternalistic and protective role. The role of the Review Boards in these instances cannot be overstated, as they fulfil the role of guardian of the interests of the user and need to ensure that the rights of the user are protected where capacity to make their own decisions is lacking.

4.7.3 72-Hour assessment and subsequent provision of further involuntary care, treatment and rehabilitation

If the head of the health establishment grants the application for involuntary care, treatment and rehabilitation services, they must ensure that the user is given appropriate care, treatment and rehabilitation services;¹⁹³ admit the user and request a medical practitioner and another mental health care practitioner to assess the physical and mental health status of the user for a period of 72 hours in the manner prescribed.¹⁹⁴ The head of the health establishment must also ensure that the practitioners also consider whether the involuntary care, treatment and rehabilitation services must be continued;¹⁹⁵ and such care, treatment and rehabilitation services must be provided on an outpatient or inpatient basis.¹⁹⁶ The head of the health establishment must, within 24 hours after the expiry of the 72-hour assessment period make available the findings of the assessment to the applicant.¹⁹⁷

Section 34(3) provides that if the head of the health establishment following the assessment is of the opinion that the mental health status of the mental health care user does not warrant involuntary care, treatment and rehabilitation services, the user must be discharged immediately, unless the user consents to the care, treatment and rehabilitation services.¹⁹⁸ If the head of the health establishment following the assessment, is of the opinion that the mental health status of the mental health care user warrants further involuntary care, treatment

¹⁹² *Ibid.*

¹⁹³ Section 34(1)(a) of the MHCA.

¹⁹⁴ Section 34(1)(b) of the MHCA.

¹⁹⁵ Section 34(1)(c)(i) of the MHCA.

¹⁹⁶ Section 34(1)(c)(ii) of the MHCA.

¹⁹⁷ Section 34(2) of the MHCA.

¹⁹⁸ Section 34(3)(a) of the MHCA.

and rehabilitation services on an outpatient basis, they must discharge the user subject to the prescribed conditions or procedures relating to his or her outpatient care, treatment and rehabilitation services;¹⁹⁹ and in writing, inform the Review Board.²⁰⁰

If the mental health status of the mental health care user warrants further involuntary care, treatment and rehabilitation services on an inpatient basis, the head of the health establishment must within seven days after the expiry of the 72-hour assessment period submit a written request to the Review Board to approve further involuntary care, treatment and rehabilitation services on an inpatient basis.²⁰¹ This request must contain the following;²⁰² a copy of the application referred to in Section 33, a copy of the notice given in terms of Section 33(8), a copy of the assessment findings, and the basis for the request. The head of the establishment must also give notice to the applicant of the date on which the relevant documents were submitted to the Review Board.²⁰³

Section 34(4) determines that if the mental health care user is to be cared for, treated and rehabilitated on an inpatient basis and the user has been admitted to a health establishment which is a psychiatric hospital, that hospital must keep, care for, treat and rehabilitate the user;²⁰⁴ or not a psychiatric hospital, that user must be transferred to a psychiatric hospital for care, treatment and rehabilitation services, until the Review Board makes its decision.²⁰⁵ Regulation 19 of the General Regulations to the MHCA determines that arrangement for a transfer contemplated Section 34(4)(b) of the Act must be made in accordance with form MHCA 11 between the head of the psychiatric hospital, care and rehabilitation centre concerned and the head of a health establishment where the involuntary mental health care user is currently admitted.

If at any time after the expiry of the 72-hour assessment period, the head of the health establishment is of the opinion that the user who was admitted on an involuntary inpatient

¹⁹⁹ Section 34(3)(b)(i) of the MHCA.

²⁰⁰ Section 34(3)(b)(ii) of the MHCA.

²⁰¹ Section 34(3)(c)(i) of the MHCA.

²⁰² Section 34(3)(c)(i)(aa) to (dd) of the MHCA.

²⁰³ Section 34(3)(c)(ii) of the MHCA.

²⁰⁴ Section 34(4)(a) of the MHCA.

²⁰⁵ Section 34(4)(b) of the MHCA.

basis is fit to be an outpatient, they must discharge the user according to the prescribed conditions or procedures;²⁰⁶ and inform the Review Board in writing.²⁰⁷ Regulation 17 of the General Regulations to the MHCA determines that the discharge report must be issued by way of form MHCA 03. The head of the health establishment may cancel the discharge and request the user to return to the health establishment on an involuntary inpatient basis, if they have reason to believe to believe that the user fails to comply with the terms and conditions of such discharge.²⁰⁸ Where required in terms of 34(4), 34(5) or 34(6) of the Act, a mental health care user may be transferred from inpatient to outpatient care and vice versa, using form MHCA 12.²⁰⁹ Arrangements for a transfer must be made between the head of the psychiatric hospital concerned and the head of a health establishment where the involuntary outpatient mental health care user is being reviewed.²¹⁰ Where such a transfer has taken place, notice of such transfer must be given within two weeks thereafter by the head of the health establishment concerned to the Review Board concerned for their consideration in terms of Section 34(7) of the Act.²¹¹

Regulation 20(3) of the MHCA is problematic as it purports by delegated legislation to make the full provisions of section 34(7) applicable to the discharge of an involuntary user as outpatient.²¹² Section 66(1) of the MHCA does not authorise the Minister to make such a regulation.²¹³ A delegated legislature cannot impose functions or confer powers on a high court, as Section 20(3) purports to do.²¹⁴ Landman further states that Section 34(6) of the MHCA does not provide for the rights of a detainee as provided for in the Constitution Section 35(2)(d) that the detainee has the right to challenge the lawfulness of the detention before a court and to be released if the detention is unlawful and submits that the user must be given a similar opportunity as envisaged in Section 34(3)(c)(i) in the case of an initial decision to detain a user.²¹⁵ It is submitted that this assertion is flawed and that the same

²⁰⁶ Section 34(5)(a) of the MHCA.

²⁰⁷ Section 34(5)(b) of the MHCA.

²⁰⁸ Section 34(6) of the MHCA.

²⁰⁹ Regulation 20(1) of the General Regulations to the MHCA.

²¹⁰ Regulation 20(2) of the General Regulations to the MHCA.

²¹¹ Regulation 20(3) of the General Regulations to the MHCA.

²¹² Landman and Landman 215.

²¹³ *Ibid.*

²¹⁴ *Ibid.*

²¹⁵ Landman and Landman 216.

argument advanced by Kersop and Van den Berg²¹⁶ applies, because the MHCA is attempting to establish a balance between the user's right to dignity and rights under Section 35 of the Constitution, and what is in the best interest of the user by lawful detention in narrowly defined circumstances to effect care, treatment and rehabilitation. Users who lack capacity are by definition unable to act in their own best interests and are therefore in need of the protection of the MHCA.

The Review Board must, within 30 days of receipt of documents referred to in Section 34(3)(c)(i) consider the request in the prescribed manner, and give the applicant, mental health care practitioners referred to in Section 33 or an independent mental health care practitioner, if any, and the head of the health establishment an opportunity to make oral or written representations on the merits of the request;²¹⁷ send a decision in writing with reasons to the applicant and the head of the health establishment;²¹⁸ and if the Review Board decides to grant the request, submit to the Registrar of a High Court the documents referred to in subsection(3)(c)(i) and the written notice for consideration by a High Court.²¹⁹ Although the MHCA is silent on this, the court in *Ex parte: G v Sixty six others* held that the Section 34(7) proceedings must of necessity require the Review Board to furnish the High Court with its reasons for not upholding the appeal.²²⁰ If at any stage before making a decision on further involuntary care, treatment and rehabilitation services on an inpatient basis, an appeal is lodged against the decision of the head of the health establishment in terms of Section 35, the Review Board must stop the review proceedings and consider the appeal.²²¹

It is submitted that the MHCA is unsatisfactory regarding the timeframes imposed with regard to involuntary users. The fact that the head of the health establishment must inform the user of the outcome within 24 hours of the assessment after expiry of the 72 hour period, but has seven days to send MHCA 08 to the board to approve further involuntary services, and the board then has 30 days in which to approve it, is unacceptable. It is submitted that the

²¹⁶ See fn 189 above.

²¹⁷ Section 34(7)(a) of the MHCA.

²¹⁸ Section 34(7)(b) of the MHCA.

²¹⁹ Section 34(7)(c) of the MHCA.

²²⁰ (19/2007) (2008) ZAKZHC 37 par 29.

²²¹ Section 34(8) of the MHCA.

submission of form MHCA 08 to the Review Board must also be done within 24 hours, as by that time the head of the health establishment already has the necessary information. This would expedite the process of review and ensure that a mental health care user is not unlawfully deprived of their liberty for longer than is absolutely necessary to finalise the matter. This would also enable the user or applicant to submit an appeal against the decision of the head of the health establishment to the Review Board speedily and enable the Board to reach a decision more quickly. The 30 day window within which the Review Board must reach its decision is a long time to be unlawfully deprived of liberty and it would be more respectful of users' rights to shorten the timeframe, though the nature of the Review Board and the available resources in light of the workload imposed upon it indicate the 30 day period to be reasonable. It is submitted that the system record keeping and administration in mental health care establishments is imperative to ensure that the timeframes in the MHCA are adhered to. If the system is deficient, it leads to a lack of compliance and difficulty implementing legislative provisions. The system of record keeping and administration in terms of the MHCA and available resources is discussed in chapter 6. It is submitted that without a proper system in place to ensure accountability and transparency, the possibility of serious rights abuses and users being "lost" in the system with no one advocating for their best interests exists.

Regulation 11(1) of the General Regulations to the MHCA determines that the assessment contemplated in Section 34 of the Act must be done in accordance with form MHCA 06. A registered medical practitioner conducting an assessment contemplated in Section 34 of the Act may determine the treatment programme and the place within the hospital where the mental health care user must be kept during the 72-hour assessment period to ensure the safety of such user and others.²²² The registered medical practitioner must make a provisional diagnosis of any mental illness and initiate treatment according to standard treatment guidelines or protocols as soon as possible.²²³ A registered medical practitioner must monitor the condition of the mental health care user closely and give a written report to the head of the health establishment concerned on such user's mental status at least every 24 hours during the

²²² Regulation 11(2) of the General Regulations to the MHCA.

²²³ Regulation 11(4) of the General Regulations to the MHCA.

72-hour assessment period.²²⁴ The registered medical practitioner and another mental health care practitioner who conducted 72-hour assessment must within 12 hours after the expiry of the 72-hour assessment period each submit a joint written report in the form of form MHCA 06 to the head of the health establishment concerned, indicating their assessment on the physical and mental health status of the mental health care user and their recommendations concerning further treatment.²²⁵

If the facilities at the health establishment concerned are unsuitable for the 72-hour assessment or personnel within that health establishment are unable to cope with a mental health care user due to the potential harm which that user may inflict on himself, herself, others or property if they remain in that health establishment, that health establishment must transfer that user to another health establishment with suitable personnel or facilities to conduct the assessment. The time period for the 72-hour assessment shall not be more than 72-hour irrespective of transfers or interruptions.²²⁶ The head of a health establishment concerned may discharge or transfer a mental health care user to voluntary status during the 72-hour assessment if that user's mental condition warrants it.²²⁷

Regulation 12 of the General Regulations to the MHCA determines that the head of a provincial department must submit to all health establishments under the auspices of the State, private health establishments within the province concerned, the South African Police Service and the national department a list of the health establishments in each district in that province that provide the 72-hour assessments contemplated in Section 34 of the Act.²²⁸ The head of such provincial department must update and publish in the Government Gazette the list contemplated in sub-regulation (1) on an annual basis indicating which health establishment falls in which district and submit that updated list to the bodies referred to in regulation 12(1).²²⁹

²²⁴ Regulation 11(5) of the General Regulations to the MHCA.

²²⁵ Regulation 11(6) of the General Regulations to the MHCA.

²²⁶ Regulation 11(3) of the General Regulations to the MHCA.

²²⁷ Regulation 11(7) of the General Regulations to the MHCA.

²²⁸ Regulation 12(1) of the General Regulations to the MHCA.

²²⁹ Regulation 12(2) of the General Regulations to the MHCA.

4.7.4 Involuntary outpatient mental health care user

If the head of the health establishment concerned, following the 72-hour assessment, is of the opinion that the mental health status of the mental health care user warrants further involuntary care, treatment and rehabilitation services on an inpatient basis, they must request the Review Board in the form of form MHCA 08 to approve such further care, treatment and rehabilitation.²³⁰ The Review Board must within 30 days of receipt of documents referred to in Section 34(3)(c)(i) of the Act send a decision on further involuntary care, treatment and rehabilitation on an inpatient basis in the form of form MHCA 14 with reasons to the applicant and the head of the health establishment.²³¹ If the head of the health establishment concerned, following the 72-hour assessment, is of the opinion that the mental health status of the mental health care user warrants further involuntary care, treatment and rehabilitation services on an outpatient basis, they must inform the Review Board in the form of form MHCA 09 thereof.²³² Neither the MHCA nor the National Health Act 61 of 2003 provides a definition for the term “outpatient”.²³³ It is defined by the Oxford Dictionary as “a patient who attends a hospital for treatment without staying there overnight.”²³⁴ Similarly, neither the MHCA nor the National Health Act 61 of 2003 provides a definition for the term “inpatient”.²³⁵ It is defined by the Oxford Dictionary as “a patient who lives in hospital while under treatment.”²³⁶ It is submitted that the MHCA should be amended to include definitions for the terms “inpatient” and “outpatient” in order to ensure no misunderstandings concerning the status and treatment of a mental health care user arises.

Regulation 18(1) of the General Regulations to the MHCA determines that if a mental health care user’s mental health care status warrants further involuntary care, treatment and rehabilitation services on an outpatient basis in terms of Section 34(3) or Section 34(5) of the Act, the head of the health establishment concerned must provide that user and his or her custodian with a schedule of conditions relating to his or her outpatient care, treatment and

²³⁰ Regulation 11(9) of the General Regulations to the MHCA.

²³¹ Regulation 11(10) of the General Regulations to the MHCA.

²³² Regulation 11(8) of the General Regulations to the MHCA.

²³³ Kersop and Van den Berg (2015) 691.

²³⁴ *Ibid*; See Hornby "Oxford Advanced Learner's Dictionary of Current English" 2005 1017.

²³⁵ Kersop and Van den Berg (2015) 691.

²³⁶ *Ibid*; See Hornby "Oxford Advanced Learner's Dictionary of Current English" 2005 733.

rehabilitation in the form of form MHCA 10. The schedule of conditions contemplated in sub-regulation (1) must be read and explained to the mental health care user and to his or her custodian or read and translated into one of the official languages that such user can understand.²³⁷ The conditions contemplated must include:²³⁸

- a) The name of a custodian into whose care the mental health care user must be given;
- b) The name of the health establishment where the mental health care user's mental health status must be monitored or reviewed and the timeframe of each review; and
- c) The name of the health establishment where treatment will be provided if such treatment is not provided in the health establishment referred to in paragraph (b);
- d) Behaviour which must be adhered to by the mental health care user; and
- e) The name of the psychiatric hospital or care and rehabilitation centre concerned where the mental health care user is to be admitted if -
 - (i) they relapse to the extent of being a danger to himself, herself or others if they remain an involuntary outpatient; or
 - (ii) the conditions of outpatient care are violated.

The health establishment concerned must forward the schedule of conditions to the mental health care user;²³⁹ the custodian contemplated in sub-regulation 3(a);²⁴⁰ every health establishment contemplated in Regulation 18(3)(b) and (c);²⁴¹ and the Review Board concerned.²⁴² A mental health care user who does not accept the conditions regarding his or her involuntary outpatient care, treatment and rehabilitation must remain an involuntary inpatient mental health care user.²⁴³ A custodian into whose control a mental health care user has been entrusted must take over the responsibility for that user when the user is discharged from the health establishment concerned where they received inpatient care.²⁴⁴ If a custodian into whose control a mental health care user has been entrusted when that user was

²³⁷ Regulation 18(2) of the General Regulations to the MHCA.

²³⁸ Regulation 18(3) of the General Regulations to the MHCA.

²³⁹ Regulation 18(4)(a) of the General Regulations to the MHCA.

²⁴⁰ Regulation 18(4)(b) of the General Regulations to the MHCA.

²⁴¹ Regulation 18(4)(c) of the General Regulations to the MHCA.

²⁴² Regulation 18(4)(d) of the General Regulations to the MHCA.

²⁴³ Regulation 18(5) of the General Regulations to the MHCA.

²⁴⁴ Regulation 18(6) of the General Regulations to the MHCA.

discharged, intends to change the place where that user resides and that change requires using another health establishment where that user's mental health status will be monitored or reviewed;²⁴⁵ and where treatment will be provided, that custodian must apply in writing to the head of the current health establishment for transfer of that user to the other health establishment.²⁴⁶

If the head of the current health establishment and the head of the health establishment to where the mental health care user is to be transferred approve the application contemplated in sub-regulation (7), that mental health care user can be transferred to the other health establishment.²⁴⁷ Where a mental health care user does not present themselves for monitoring and review according to the conditions referred to in Regulation 18(1), and after the necessary measures have been taken by the health establishment concerned to locate such user, such user must be deemed to have absconded in terms of Section 40(4) of the Act and in such a case the health establishment concerned must inform the South African Police Service in the form of form MHCA 25.²⁴⁸

4.7.5 Recovery of capacity of involuntary mental health care users to make informed decisions

If the head of a health establishment is of the opinion from personal observation, information obtained or on receipt of representations by the user, that an involuntary mental health care user is capable of making informed decisions, they must enquire from the user whether the user is willing to voluntarily continue with the care, treatment and rehabilitation services.²⁴⁹ If the involuntary mental health care user consents to further care, treatment and rehabilitation services, Section 25 applies.²⁵⁰ If the involuntary mental health care user is unwilling to continue with care, treatment and rehabilitation services and the head of the health establishment is satisfied that the user no longer has a mental illness as referred to in Section

²⁴⁵ Regulation 18(7)(a) of the General Regulations to the MHCA.

²⁴⁶ Regulation 18(7)(b) of the General Regulations to the MHCA.

²⁴⁷ Regulation 18(8) of the General Regulations to the MHCA.

²⁴⁸ Regulation 18(9) of the General Regulations to the MHCA.

²⁴⁹ Section 38(1) of the MHCA.

²⁵⁰ Section 38(2) of the MHCA.

32(b), the head of the health establishment concerned must immediately cause the user to be discharged according to accepted clinical practices.²⁵¹

4.7.6 MHCA Forms pertaining to involuntary users

The forms relevant to the admission of involuntary mental health care users discussed in this section are: MHCA 04, MHCA 05, MHCA 06, MHCA 07, MHCA 08, MHCA 09, MHCA 10, MHCA 11, MHCA 12, and MHCA 16.

4.7.6.1 Application for assisted or involuntary care treatment and rehabilitation in terms of Section 27(1) or 33(1) of the Act – MHCA 04

MHCA 04 is used for assisted and involuntary users, therefore the requirements for each separate category of user must be identifiable in the form and easily distinguishable, and mental health care practitioners must be adequately trained in the requirements of the MHCA to ensure proper completion of the form. It is submitted that the following checklist should serve as a guide to completion of the form:

- The applicant in both assisted and involuntary admissions must have seen the user within seven days prior to the application, failing that the application will be invalid.
- It must be clearly noted which person made the application and that they have signed the form and, if possible, that they have given as much information on the history of the user as possible.
- If the user is under the age of 18 years, a parent or legal guardian must be the applicant. If the child is resistant to treatment, they must be admitted as an involuntary rather than assisted user.
- In the event that the applicant is the health care provider, it must be clearly noted which attempts to contact the user's next of kin have been made.
- It is insufficient to complete the form in vague language and to leave sections unanswered.

²⁵¹ Section 38(3) of the MHCA.

Landman states that the form MHCA 04 must be signed and endorsed by Commissioner of Oaths that the applicant confirms the truth and correctness of the factual allegations in form MHCA 04.²⁵² A Commissioner of Oaths signing the form is not explicitly mentioned in the MHCA or Regulations, nor does the form indicate it. It is submitted that should the legislature have intended a Commissioner of Oaths to sign off on the MHCA 04 form, the Regulations must be amended to reflect this. It is further submitted that the only real function a Commissioner of Oaths can fulfil in this context is to verify the identity of the persons mentioned in the form, as the truth and factual correctness of the information regarding the user's mental condition or history is unverifiable. Furthermore a Commissioner of Oaths is not specifically trained in the intricacies of the MHCA and its Regulations and as such is the incorrect person needed to evaluate the application, which duty lies with the head of the health establishment.

With regards to the formulation of the form, it is submitted that in general it is satisfactory in the information that is required and in clarity for purposes of its completion. It is submitted that the form should be amended to clearly indicate whether assisted or involuntary care is applied for on the first page (*figure 1*), as the requirements are different. The form must also be amended to indicate clearly whether the user is refusing treatment or not. For purposes of application for involuntary detention, it is submitted that the form is lacking because it does not make provision for the applicant to indicate that the user is a danger to themselves or others and should be amended to include such a question in order to comply fully with the requirements of involuntary detention. It is submitted that MHCA 04 does not make provision for a practitioner to indicate the exact time of admission, which is needed to help calculate whether applicable time frames are complied with.

²⁵² Landman and Landman 112.



DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 04

DEPARTMENT OF HEALTH

APPLICATION FOR ASSISTED OR INVOLUNTARY CARE, TREATMENT AND
REHABILITATION

[Section 27(1) or 33(1) of the Act]

I hereby apply for assisted care or involuntary care for:

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation Marital status: S M D W

Residential address:

.....

.....

.....

Surname of applicant

First name(s) of applicant

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

Residential address:

.....

.....

.....

.....

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

Spouse Next of kin Partner Associate

Guardian Health care provider Parent

(If user is under 18 this application must be made by the parent or guardian)

Figure 1 - MHCA 04



I last saw the user on at
(date) (time) (place)

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

Where the applicant is the health care provider:

If the spouse, next of kin, partner, associate, parent or guardian is unwilling to make the application, state the reasons why:

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

If the spouse, next of kin, partner, associate, parent or guardian is incapable or not available to make the application, state the steps that have been taken to locate them:

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

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

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

and believe that assisted- or involuntary care, treatment and rehabilitation is needed because

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

Figure 2 - MHCA 04

In the case of an application for involuntary care:

I further give reasons which show that the person is so ill that he / she will not accept treatment as a voluntary mental health care user or cannot be admitted as an assisted mental health care user

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

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

- Medical certificates
 - History of past mental illness / intellectual disability
 - Other:
-

Print initials and surname.....

Signature:

(Applicant)

Date:

Place:

Figure 3 - MHCA 04

4.7.6.2 MHCA 05 - Examination and finding of mental health care practitioner following an application for assisted or involuntary care, treatment and rehabilitation in terms of Section 27(5) and 33(5) of the Act

MHCA 05 makes provision to indicate which category of mental health care user the individual belongs to, which leads to clarity in terms of the requirements for admission. It is imperative that the two mental health care practitioners required to complete the form conduct their own individual assessments, instead of merely signing off on one practitioner's assessment. It is submitted that the form be amended to include a checkbox requiring the practitioner to indicate their designated category (e.g. registered medical practitioner,

occupational therapist, nurse, and the like as indicated in the definition of mental health care practitioner), as well as indicating whether they are qualified to conduct a physical examination. This provides important information regarding data of practitioners dealing with mental health care users in establishments for purposes of guiding policy, as well as providing information that could be useful in a review of the decision of the head of the health establishment or review board if it was based on the opinions of practitioners not specialised in diagnosing mental disorder. It should also be noted that if a practitioner is the applicant for assisted or involuntary care on MHCA 04, they are not permitted to complete MHCA 05.



MHCA 05

DEPARTMENT OF HEALTH

**EXAMINATION AND FINDING OF MENTAL HEALTH CARE PRACTITIONER
 FOLLOWING AN APPLICATION FOR ASSISTED- OR INVOLUNTARY CARE,
 TREATMENT AND REHABILITATION
 [Sections 27(5) and 33(5) of the Act]**

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation Marital status: S M D W

Residential address:

.....

.....

.....

Date of examination: Place of examination:

Category of designated mental health care practitioner:

Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health

.....

.....

.....

.....

(a) Are there signs of injuries? Yes No

(b) Are there signs of communicable diseases? Yes No

If the answer to (b) or (c) is Yes, give further particulars:

.....

.....

Figure 4 - MHCA 05

It is submitted that the completion of the category “(a) General physical health” (*figure 4*) is not acceptable if it merely states that the health of the user is “good”, as more information is

required. Alternatively the practitioner might refer in that section to attached medical records of the patient where assessments are indicated in more detail to avoid unnecessary duplication of writing. It is further submitted that in the category “Information on user received from other person(s)/family” (*figure 5*) it should be indicated whether such information was unavailable due to absence of such persons to question or where such persons were unhelpful or uninformed, instead of leaving the question blank. It is submitted that MHCA 05 does not make provision for a practitioner to indicate the exact time of completion, which is needed to help calculate whether applicable time frames are complied with.

Information on user received from other person(s) or family (state names and contact details)

.....

Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places):

.....

Mental health status of the user at the time of the present examination:

.....

Type of illness (provisional diagnosis):

.....

In my opinion the above-mentioned user

Has homicidal tendencies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has suicidal tendencies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is dangerous	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Recommendation to head of health establishment – application for assisted care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes No

The user is suffering from a mental illness / severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for their own health and safety or the health and safety of others Yes No

If Yes, this should be on an inpatient or outpatient basis: Inpatient Outpatient

Figure 5 - MHCA 05

Give reasons:

.....
.....

Recommendation to head of health establishment – application for involuntary care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes No

The user is willing to receive care, treatment and rehabilitation services Yes No

In my view, the user is likely to inflict serious harm on him / herself or others Yes No

In my view, care, treatment and rehabilitation is necessary for the user's financial interests and reputation Yes No

The user should receive involuntary care, treatment and rehabilitation Yes No

If No, would you recommend that the user receive assisted care? Yes No

Print initials and surname.....

Signature:

(mental health care practitioner)

Date:

Place:

Figure 6 - MHCA 05

4.7.6.3 MHCA 06 - 72-hour assessment and finding of a medical practitioner or mental health care practitioner after head of health establishment granted application for involuntary care, treatment and rehabilitation in terms of Section 34(1) of the MHCA

Form MHCA 06 can be completed by the same mental health care practitioners that completed MHCA 05, but if the applicant for assisted or involuntary care in terms of MHCA 04 was a practitioner, that practitioner is not permitted to complete MHCA 06. It is again imperative that the two practitioners to complete the form base their findings on their own individual assessments and do not copy the findings of another practitioner, as this would be procedurally unfair and lead to unlawful detention or a negligent discharge if there is a duty of care on the practitioner.



MHCA 06

DEPARTMENT OF HEALTH

72-HOUR ASSESSMENT AND FINDING OF MEDICAL PRACTITIONER OR MENTAL
HEALTH CARE PRACTITIONER AFTER HEAD OF HEALTH ESTABLISHMENT
GRANTED APPLICATION FOR INVOLUNTARY CARE, TREATMENT AND REHABILITATION
[Section 34(1) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation Marital status: S M D W

Residential address:

.....

.....

.....

.....

Date of 72-hour assessment: Place of assessment:

Category of designated mental health care practitioner or medical practitioner:

.....

Physical health status (filled in only by mental health care practitioner qualified to conduct physical examination):

(a) General physical health

.....

.....

.....

(a) Are there signs of injuries? Yes No

(b) Are there signs of communicable diseases? Yes No

If the answer to (b) or (c) is Yes, give further particulars:

.....

Figure 7 - MHCA 06

It is submitted that the form be amended to include a checkbox requiring the practitioner to indicate their designated category (e.g. registered medical practitioner, occupational therapist, nurse, and the like as indicated in the definition of mental health care practitioner), as well as indicating whether they are qualified to conduct a physical examination.

.....

Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places):

.....

Mental health status of the user at the time of the present assessment:

.....

Type of illness (provisional diagnosis):

.....

In my opinion the above-mentioned user

Has homicidal tendencies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has suicidal tendencies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is dangerous	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Recommendation to head of health establishment – application for assisted care

The user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services: Yes No

The user is suffering from a mental illness / severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for their own health and

Figure 8 - MHCA 06

It is submitted that the completion of the category “(a) General physical health” (*figure 7*) is not acceptable if it merely states that the health of the user is “good”, as more information is required. Alternatively the practitioner might refer in that section to attached medical records of the patient where assessments are indicated in more detail to avoid unnecessary duplication of writing. It is submitted that MHCA 06 does not make provision for a practitioner to indicate the exact time of completion, which is needed to help calculate whether applicable time frames are complied with.



MHCA 07

DEPARTMENT OF HEALTH

NOTICE BY HEAD OF HEALTH ESTABLISHMENT ON WHETHER TO PROVIDE ASSISTED OR INVOLUNTARY CARE, TREATMENT AND REHABILITATION [Sections 27(9), 28(1) and 33(8) of the Act]

I hereby consent / do not consent
(name of head of health establishment)
to the inpatient assisted care, treatment and rehabilitation or involuntary care, treatment and rehabilitation of
(name of user)

The findings of two mental health care practitioners concur that the user –
(a) should / should not receive assisted care, treatment and rehabilitation services as an outpatient / inpatient; or
(b) must / must not receive involuntary care, treatment and rehabilitation services

I am satisfied / not satisfied, that the restrictions and instructions on the mental health care user's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

The reasons for consenting / not consenting are as follows:
.....
.....
.....
.....

Print initials and surname.....

Signature:
(head of health establishment)

Date:

Place:
(Copy to applicant)

Figure 10 - MHCA 07

It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment. It is further submitted that the form be amended so that the word "...contemplated" be replaced with the words "...warranted in the circumstances". It is submitted that MHCA 07 does not make provision for a practitioner to indicate the exact time of completion, which is needed to help calculate whether applicable time frames are complied with.

4.7.6.5 MHCA 08 - Notice by head of health establishment to Review Board requesting approval for further involuntary care, treatment and rehabilitation on an inpatient basis in terms of Section 34(3)(c) of the MHCA



MHCA 08

DEPARTMENT OF HEALTH

**NOTICE BY HEAD OF HEALTH ESTABLISHMENT TO REVIEW BOARD
REQUESTING APPROVAL FOR FURTHER INVOLUNTARY CARE,
TREATMENT AND REHABILITATION ON AN INPATIENT BASIS
[Section 34(3)(c) of the Act]**

I hereby request
 (name of head of health establishment)
 approval from the Review Board for further involuntary care, treatment and rehabilitation on
 an inpatient basis of
 (name of user)

The findings of the mental health care practitioner and medical practitioner are that the user
 requires further involuntary care, treatment and rehabilitation.

I am satisfied / not satisfied that the restrictions and intrusions on the mental health care
 user's right to movement, privacy and dignity are proportionate to the care, treatment and
 rehabilitative services contemplated.

Attached hereto please find –

- (a) a copy of the application to obtain involuntary care, treatment and rehabilitation [MHCA 04];
- (b) a copy of the notice given in terms of section 33(8) [MHCA 07]; and
- (c) a copy of the assessment findings [MHCA 06].

The basis of this request for further involuntary care, treatment and rehabilitation on an
 inpatient basis is

Signature:
 (head of health establishment)

Date:

Place:

Figure 11 - MHCA 08

It is submitted that form MHCA 08 (*figure 11*) would only be completed if the head of the health establishment felt that further involuntary care was warranted and if they were satisfied that the infringement of the user's rights were necessary, therefore the form should be amended to remove the words "not satisfied". The form should also be amended to include check boxes by which to indicate which attachments have been included. If a person other than the head of the health establishment completes and signs the form they must be properly

authorised to do so by written delegation, which must also be submitted to the Review Board. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment. It is further submitted that the form be amended so that the word “...contemplated” be replaced with the words “...warranted in the circumstances”.

4.7.6.6 MHCA 09 - Notice by head of health establishment after 72-hour assessment period informing Review Board that mental health care user warrants further involuntary care, treatment and rehabilitation on an outpatient basis in terms of Section 34(3)(c) of the MHCA

It is submitted that form MHCA 09 (*figure 12*) would only be completed if the head of the health establishment felt that further involuntary care was warranted and if they were satisfied that the infringement of the user’s rights were necessary, therefore the form should be amended to remove the words “not satisfied”. The form should also be amended to include check boxes by which to indicate which attachments have been included. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment. It is further submitted that the form be amended so that the word “...contemplated” be replaced with the words “...warranted in the circumstances”.



DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 09

DEPARTMENT OF HEALTH

**NOTICE BY HEAD OF HEALTH ESTABLISHMENT AFTER 72-HOUR
ASSESSMENT PERIOD INFORMING REVIEW BOARD THAT MENTAL HEALTH CARE
USER WARRANTS FURTHER INVOLUNTARY CARE, TREATMENT AND
REHABILITATION ON AN OUTPATIENT BASIS
[Section 34(3)(c) of the Act]**

I hereby inform
(name of head of health establishment)
the Review Board that
(name of user)
requires further involuntary care, treatment and rehabilitation on an inpatient basis.

I am satisfied / not satisfied that the restrictions and intrusions on the mental health care user's right to movement, privacy and dignity are proportionate to the care, treatment and rehabilitative services contemplated.

Signature:
(head of health establishment)

Date:

Place:

(Copy to mental health care user) -

Figure 12 - MHCA 09

It is further submitted that MHCA 09 should be amended to add a question where the head of the health establishment must provide reasons that outpatient services is recommended instead of inpatient services.

4.7.6.7 MHCA 10 - Transfer of involuntary mental health care user – Schedule of conditions relating to his or her outpatient care, treatment and rehabilitation in terms of Section 34(3)(b) or (5) of the MHCA

It is submitted that MHCA 10 (figure 13 and figure 14) is sufficient in the information required and clarity in presentation. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.



DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 10

DEPARTMENT OF HEALTH

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

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation Marital status: S M D W

Residential address:

.....

.....

.....

.....

Name of custodian into whose charge the user is discharged:

.....

Address of custodian:

.....

.....

.....

The user's mental health status will be monitored and reviewed at

..... (name of health establishment)

The user is to present him / herself to this health establishment every weeks / months to be monitored and his or her mental health status reviewed.

Figure 13 - MHCA 10

Name of health establishment(s) where involuntary mental health care, treatment and rehabilitation will be provided on an outpatient basis:

Conditions of behaviour which must be adhered to by the user:

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

Name of psychiatric hospital / care and rehabilitation centre where the user is to be admitted if he / she relapses to the extent of being a danger 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:

(accepting the stipulated conditions)

Figure 14 - MHCA 10

4.7.6.8 MHCA 11 - Transfer of involuntary mental health care user on inpatient basis to psychiatric hospital in terms of Section 34(4), (5) and (6) of the MHCA

It is submitted that MHCA 11 (*Figure 15*) is sufficient in the information required and clarity in presentation. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.



MHCA 11

DEPARTMENT OF HEALTH

**TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER ON
INPATIENT BASIS TO PSYCHIATRIC HOSPITAL
[Section 34(4), (5) or (6) of the Act]**

..... an involuntary
(name and surname of user)
mental health care user on an inpatient basis who was admitted to
..... (name of health establishment)
which is not a psychiatric hospital on (date) must be
transferred to (name of psychiatric hospital).

Print initials and surname
(head of health establishment)

Signature:
(head of health establishment)

Date:

Place:

Figure 15 – MHCA 11

**4.7.6.9 MHCA 12 - Transfer of involuntary mental health care user from inpatient to
outpatient care and vice versa**

It is submitted that MHCA 12 (Figure 16) is sufficient in the information required and clarity in presentation, though the addition of check boxes through which the head of the health establishment may indicate which transfer is being effected, as well as to indicate the reason for transfer from outpatient to inpatient care is necessary. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.



DEPARTMENT OF HEALTH

TRANSFER OF INVOLUNTARY MENTAL HEALTH CARE USER FROM
INPATIENT TO OUTPATIENT CARE AND VICE VERSA
[Section 34(4) or (5) of the Act]

Transfer from inpatient to outpatient care

The mental health status of
(name and surname of user)
an involuntary inpatient at
(name of health establishment)
has improved / altered to such an extent that he / she should be provided with care, treatment and
rehabilitation services as an outpatient. The schedule of conditions attached to this transfer are
outlined in the attached MHCA 10.

Transfer from outpatient to inpatient care

..... an involuntary outpatient being
(name and surname of user)
monitored and reviewed at
(name of health establishment)
has not complied with the terms and conditions applicable to his / her discharge / relapsed to the
extent of being a danger to him / herself or others if he / she remains an involuntary outpatient, and
must be admitted as an involuntary inpatient to
..... (name of health establishment).

Specific reasons for transfer to inpatient care are:
.....
.....
.....

Print initials and surname

Signature:
(head of health establishment)

Date:

Place:

Figure 16 - MHCA 12

**4.7.6.10 MHCA 16 - Order by High Court for further treatment and
rehabilitation/discharge of an involuntary user on an inpatient basis in terms of
Section 36(c) of the MHCA**

It is submitted that MHCA 16 (Figure 17) should be amended for comprehension and readability purposes by adding check boxes by which the court can clearly indicate what order it has made.



DEPARTMENT OF HEALTH
Republic of South Africa

DEPARTMENT OF HEALTH

**ORDER BY HIGH COURT FOR FURTHER TREATMENT AND
REHABILITATION / DISCHARGE OF AN INVOLUNTARY USER ON AN
INPATIENT BASIS
[Section 36(c) of the Act]**

In the High Court of South Africa Division

In the matter of

(involuntary user's name)

at present being confined at

(name of health establishment)

as an involuntary user following the decision of the Review Board under sections 34(7) or
35(4) of the Act dated the

IT IS HEREBY ORDERED

That the said

(name of user)

- (a) (i) be further kept / provided with care, treatment and rehabilitation services until the
said user has recovered or is otherwise legally discharged;
- (ii) the financial affairs of the said user be managed and administered according to
the provisions of Chapter VIII of the Act; or
- (b) the said user be discharged immediately.

By order of the Honourable Justice

Date:

Place:

Registrar:

Figure 17 - MHCA 16

4.8 Consent to treatment for mental disorder and other medical interventions

4.8.1 Consent to treatment for mental illness

4.8.1.1 *Electroconvulsive treatment*

The spectrum of clinical opinion regarding the use of Electroconvulsive therapy (ECT) to treat mental disorder ranges from outright rejection of the method as a treatment to support.²⁵³ The major problem in its acceptance more widely may be due to the fact that it is potentially harmful if used incorrectly and that goes against the bioethical principle of nonmaleficence.²⁵⁴ In South Africa the MHCA recognises the uniqueness of ECT and determines specific requirements regarding usage, though South Africa and many other countries are not sufficiently protecting the mentally disordered patient's constitutional right to refuse such an invasive and controversial treatment.²⁵⁵ This situation is plainly evident if one compares South Africa and international circumstances. In many countries, psychiatrists have to undergo specific training in the use of ECT.²⁵⁶ These psychiatrists are then registered as ECT practitioners and are consequently afforded the "privileging" rights to utilise the procedure in the treatment of their patients, but in South Africa this situation does not exist and the MHCA simply states that a person administering ECT must be "trained".²⁵⁷ Segal and Thom state that the single biggest shortcoming in local ECT practice is likely to be in the area of disclosure, including disclosure of practitioners' training inadequacies in competence to prescribe and perform the procedure, through to inadequacies of disclosure of procedural risk.²⁵⁸

Among mental health care users treated with ECT, the group most non-controversial are those who have mental capacity and may either refuse or request electroconvulsive therapy.²⁵⁹ Such individuals have statutory, common-law and constitutional protections of autonomy and self-

²⁵³ Segal and Thom (2006) 'Consent procedures and electroconvulsive therapy in South Africa: Impact of the Mental Health Care Act' 9 South African Psychiatry Review 206-215 207.

²⁵⁴ *Ibid.*

²⁵⁵ Swanepoel, M. (2011) 'A selection of constitutional aspects that impact on the mentally disordered patient in South Africa' 32 *Obiter* 2 282-303 291; Segal and Thom (2006) South African Psychiatry Review 207.

²⁵⁶ Segal and Thom (2006) South African Psychiatry Review 207.

²⁵⁷ *Ibid.*

²⁵⁸ Segal and Thom (2006) South African Psychiatry Review 207-208.

²⁵⁹ Swanepoel (2011) *Obiter* 291.

determination.²⁶⁰ The more controversial group are those patients who are mentally incapacitated and either refused electroconvulsive therapy, requested electroconvulsive therapy or who have not expressed a decision either way.²⁶¹ A group of concern are those patients who were competent, but are now incapacitated.²⁶² When these individuals enjoyed capacity, they may have either created medical advance directives that did not provide for mental health-care decisions or they failed to provide directives at all.²⁶³

The MHCA General Regulations of 2004 stipulate in Regulation 35, that regardless of the patient's status (voluntary, assisted or involuntary) those who are capable of informed consent must decide about their treatment.²⁶⁴ Segal and Thom suggest a procedure to obtain valid informed consent to ECT in terms of the MHCA as follows:²⁶⁵

1. Determine competence
2. Provide full relevant information (and enable user to question)
3. Determine voluntariness and willingness
4. Provide opportunity to withdraw consent

Other guidelines suggested refer to the status of a mental health care user as voluntary, assisted or involuntary and the degree of mental illness affecting a user's decision-making capacity.²⁶⁶ A voluntary mental health care user should be able to consent to ECT and other procedures, but it should not be assumed that an assisted or involuntary mental health care user is incapable of consenting due to their status as assisted or involuntary user alone, as competence to make informed decisions must be determined on each individual case.²⁶⁷ If a mental health care user is unable to consent to ECT, the MHCA makes provision for the use of a proxy. If a user who is incapable of consent actively refuses ECT, but a proxy is willing, the treatment should not be done without the knowledge of a mental health review board and

²⁶⁰ *Ibid.*

²⁶¹ *Ibid.*

²⁶² *Ibid.*

²⁶³ Swanepoel (2011) *Obiter* 291.

²⁶⁴ Segal and Thom (2006) *South African Psychiatry Review* 208.

²⁶⁵ *Ibid.*

²⁶⁶ Segal and Thom (2006) *South African Psychiatry Review* 208-209.

²⁶⁷ *Ibid.*



**CONSENT FOR ELECTROCONVULSIVE THERAPY (ECT) FOR ALL MENTAL
HEALTH CARE USERS WITH CAPACITY TO CONSENT IN TERMS OF
THE MHCA 17 OF 2002**

CONSENT FORM ONE	
1. ECT must only be conducted within the terms of the MHCA with particular reference to Chapters III (8,9,17) and V (25,26,32) of the Act and to General Regulations, Chapter 5, section 33 & 35. 2. ECT may only be carried out in health care facilities authorised and licensed to do so by the Provincial Government. 3. This consent form must be used in conjunction with the Patient ECT Information Sheet. 4. Consent must be obtained with the help of an interpreter if the patient is not proficient in English. 5. This form is only for the use of mental health care users who have the capacity to consent regardless of their status outlined in 1.	Hospital Number: Patient Name: Date of Birth/Age: Ward: Sex: Race: Hospital Sticker Hospital: City: Province: Dr in Charge:

I, _____, presently a _____ mental health
First Name Surname Insert one: voluntary, assisted, involuntary
 care user at _____ have discussed the use of ECT for the
Hospital
 treatment of my condition with my mental health care practitioner _____
Name/s of Mental Health Care Practitioner/s

- I have been informed of and understood and discussed the following:
1. The procedure of ECT and what it involves.
 2. The potential benefits of ECT.
 3. The potential risks and discomforts of ECT to me and my health.
 4. I have had all my questions relating to ECT answered to my satisfaction.
 5. I have been given a copy of the Patient ECT Information Sheet and Consent Form.
 6. I reserve the right to withdraw my consent for ECT at any time without fear.
 7. The person obtaining my consent may not be the person performing the procedure.
 8. In order to have ECT I agree to the administration of a general anaesthetic.
 9. If I receive the ECT as an outpatient I will not drive a car on the day concerned.
 10. In signing this consent I agree to have ECT only on the stipulated date below.

This consent was obtained by _____ on the _____
MHCP: Print name and qualifications Date

For Unilateral / Bilateral ECT to be performed on the _____
Delete as appropriate Date

Signed: _____ Date: _____
MHCP

I swear that I am the mental health care user named above and that I <u>voluntarily consent</u> to treatment with ECT on the date indicated above.	
Signed: _____	Date: _____
Witness: _____	Date: _____
NOTE: the witness must not be the person obtaining the consent.	

Figure 19



**INFORMED CONSENT FOR ELECTROCONVULSIVE THERAPY (ECT)
FOR MENTAL HEALTH CARE USERS INCAPABLE OF INFORMED CONSENT
IN TERMS OF THE MHCA 17 OF 2002**

CONSENT FORM TWO

<p>1. ECT must only be conducted within the terms of the MHCA with particular reference to Chapters III (8,9,17) and V (25,26,32) of the Act and to General Regulations, Chapter 5, section 33 & 35.</p> <p>2. ECT may only be carried out in health care facilities authorised and licensed to do so by the Provincial Government.</p> <p>3. This consent form must be used in conjunction with the Patient ECT Information Sheet.</p> <p>4. Consent must be obtained with the help of an interpreter if the patient is not proficient in English.</p> <p>5. This form is only for the use of mental health care users who DO NOT have the capacity to consent as outlined in 1.</p>	<p>Hospital Number:</p> <p>Patient Name:</p> <p>Date of Birth/Age:</p> <p>Ward:</p> <p>Sex:</p> <p>Race: Hospital Sticker</p> <p>Hospital:</p> <p>City:</p> <p>Province:</p> <p>Dr in Charge:</p>
---	---

I, _____, the _____ of the
First Name Surname Insert: spouse, partner, guardian, parent, next of kin, curator

ASSISTED/INVOLUNTARY mental health care user named _____
Delete as appropriate First Name Surname
 at _____ have discussed the use of ECT for the treatment of her/his condition
Hospital
 with the mental health care practitioner _____
Name/s of Mental Health Care Practitioner/s

I have been informed of and understood and discussed the following:

1. The procedure of ECT and what it involves.
2. The potential benefits of ECT.
3. The potential risks and discomforts of ECT to the patient and their health.
4. I have had all my questions relating to ECT answered to my satisfaction.
5. I have been given a copy of the Patient ECT Information Sheet and Consent Form.
6. I reserve the right to withdraw my consent for ECT at any time without prejudice.
7. The person obtaining my consent may not be the person performing the procedure.
8. In order to have ECT I agree to the administration of a general anaesthetic.
9. If the patient receives ECT as an outpatient she/he will not drive a car on the day concerned.
10. In signing this consent it is agreed that ECT will only be given on the stipulated date below.

This consent was obtained by _____ on the _____
MHCP: Print name and qualifications Date

For **Unilateral / Bilateral** ECT to be performed on the following date _____
Delete as appropriate

Signed: _____ Date: _____
MHCP

I swear that I am the _____ to the mental health care user named above and that I <small>Insert: spouse, partner, guardian, parent, next of kin, curator</small> consent to ECT being performed on the patient named above on the date indicated above.	
Signed: _____	Date: _____
Witness: _____	Date: _____
NOTE: the witness must not be the person obtaining the consent.	

Figure 20

4.8.1.2 Seclusion

Seclusion can be defined as the involuntary confinement of an agitated, unstable person alone in a contained, controlled environment.²⁷¹ The General Regulations to the MHCA define seclusion in Regulation 1 as “the isolation of a user in a space, where his or her freedom of movement is restricted.” The use of seclusion for patients who are at a risk of harm to themselves or others has been a generally accepted medical practice for many years, although seclusion and restraint they are not benign interventions and significant rates of morbidity and mortality have been associated with them, including attempted suicide or self-harm while in seclusion.²⁷² There are many views on seclusion and despite the ethical debate, the MHCA makes provision for seclusion in certain circumstances, namely that seclusion may only be used in patients with “severely disturbed behaviour” for containment and not as punishment.²⁷³ Observation must be done every 30 minutes and documented in clinical notes.²⁷⁴ A register must be signed by a doctor, the time period and reason for seclusion must be documented and the head of the health establishment must be notified daily of all seclusion incidents.²⁷⁵ A transcript of the register must be submitted by the health establishment to the Review Board on a quarterly basis using form MHCA 48.²⁷⁶ The MHCA states that seclusion may only be used to contain severely disturbed behaviour, which is likely to cause harm to others.²⁷⁷ The Regulations of the MHCA only provide for seclusion if the safety of others is involved and not when “own safety” is involved.

In a study by Chiba and Subramoney, they found that just fewer than half the seclusions occurred “for user’s own safety”.²⁷⁸ The authors suggest that perhaps these users should be termed as being “bedded alone” instead of recorded as being secluded.²⁷⁹ These users had to be recorded on the seclusion register (MHCA 48 – *Figure 21*) as they had been placed in a

²⁷¹ Chiba, G., Subramaney, U. (2015) 'Is the seclusion policy of mental healthcare users a necessary evil?' SAJBL 8:1 30-34 30.

²⁷² *Ibid.*

²⁷³ Regulation 39(1) of the General Regulations to the MHCA.

²⁷⁴ Regulation 39(2) of the General Regulations to the MHCA.

²⁷⁵ Regulation 39(3) of the General Regulations to the MHCA.

²⁷⁶ Regulation 39(4) of the General Regulations to the MHCA.

²⁷⁷ Regulation 39(1) of the General Regulations to the MHCA.

²⁷⁸ Chiba and Subramaney (2015) 34.

²⁷⁹ *Ibid.*

vulnerable state, it is the dangerous user that should be secluded instead.²⁸² It is submitted that the MHCA should be amended to state that seclusion for the safety of a user, and not for the safety of others, is not allowable if the seclusion is likely to have a negative effect on the mental state of the person. The mental health review board must make sure that this is complied with to guard against human rights infringements.

4.8.1.3 *Psycho-surgery and sleep therapy*

Regulation 34(1) of the General Regulations to the MHCA determines that no psycho-surgery shall be performed on a mental health care user who is not capable of giving informed consent for such surgery and such consent shall be given in writing by such mental health care user. A person at a health establishment who intends to perform any form of psychosurgery as therapeutic intervention for mental illness shall, within a period not less than 30 days before the intended date of such surgery request written approval from the head of the provincial department concerned.²⁸³ A medical report constructed and signed by at least two independent psychiatrists shall state whether in their opinion, all mental health treatment previously applied has failed and psycho-surgery is necessary.²⁸⁴ The psycho-surgery shall be performed only by a registered neurosurgeon who has agreed to perform the operation.²⁸⁵ Regulation 36 determines that the prescription of neuroleptics, benzodiazopines or intravenous anti-depressants at doses and durations sufficient to cause significant sedation for several days is not permitted.²⁸⁶

4.8.2 Consent to treatment or operations other than mental illness

Where treatment is necessary for medical conditions or operations unrelated to mental illness, it is submitted that the capacity of the user to give informed consent is the most important question. Capacity must be determined irrespective of the user's mental health care status and

²⁸² Chiba and Subramaney (2015) 33.

²⁸³ Regulation 34(2) of the General Regulations to the MHCA.

²⁸⁴ Regulation 34(3) of the General Regulations to the MHCA.

²⁸⁵ Regulation 34(4) of the General Regulations to the MHCA.

²⁸⁶ General Regulations to the MHCA.

it cannot be assumed that an assisted or involuntary user lacks capacity without an assessment in the specific scenario to which must be consented.²⁸⁷

4.9 Children as mental health care users

There are currently serious concerns about the placement, treatment and care of children in need of mental health care in South Africa.²⁸⁸ The concern that arises regarding mentally disordered children in South Africa is that there are no clear, written policies in place which are adequate and appropriate; where policies are in place, they are not adhered to consistently in practice; and that no measures or insufficient measures are taken when such policies are breached.²⁸⁹

The question to be posed is whether a child can consent for purposes of mental health care services and medical care. “Submits voluntarily” in the MHCA means informed consent.²⁹⁰ A child (under the age of 18) may consent as long as they are able to make an informed decision, but Buchner and Nienaber argue that this approach does not take sufficient account of the law that limits the ability of a child to consent before a certain age is reached.²⁹¹ Because the MHCA does not fully provide for consent of children, the Children's Act applies.²⁹² The best interest of the child must be taken into account when deciding on their treatment, and Landman submits that where children are involved, the Children's Act lists several considerations that have to be taken into account when determining the best interest of the child (Section 7(1)(c), (g), (h), (i) and (j) of the Children's Act).²⁹³

The Children's Act permits a child to consent to their own medical treatment or to the medical treatment of their child, if they are above the age of 12 and of sufficient maturity and mental

²⁸⁷ The issues pertaining to capacity and informed consent have been extensively discussed in Chapters 2 and 3 and are applicable in this section as well.

²⁸⁸ Swanepoel 346.

²⁸⁹ *Ibid.*

²⁹⁰ Landman and Landman 82.

²⁹¹ Buchner-Eveleigh and Nienaber 'Gesondheidsorg vir kinders: Voldoen Suid-Afrika se wetgewing aan die land se vpligtinge ingevolge die Konvensie oor die regte van the Kind en die Grondwet?' (2012) 15 PER/PELJ 1 104-146 117; Landman and Landman 82.

²⁹² *Ibid.*

²⁹³ Landman and Landman 85.

capacity to understand the benefits and risks, social and other implications of the treatment.²⁹⁴ A child under the age of 12, or over the age of 12 but of insufficient maturity or mental capabilities, may not consent to medical treatment, but a parent, guardian or care-giver may consent to the medical treatment of the child.²⁹⁵ The Children's Act takes cognisance of the UN Convention on the Rights of the Child (as discussed in Chapter 2) and its principle that children should have a say in their medical treatment.²⁹⁶ Buchner and Nienaber submit that there are weaknesses in existing legislation regarding the rights of children when compared to the UN Convention on the Rights of the Child and the Constitution.²⁹⁷ There is currently no all-encompassing legislation that deals with children's healthcare rights, and primarily it is currently dealt with by three independently promulgated pieces of legislation (The Children's Act, The National Health Act and the MHCA) from different sectors protecting different aspects of children's healthcare rights and failing to comprehensively do so in a coherent manner.²⁹⁸ Buchner and Nienaber advocate for subject-specific legislation to be drafted to deal with children's healthcare rights and clarification in the National Health Act and MHCA on the minimum duties of the State regarding children and healthcare.²⁹⁹

It is submitted, that although the MHCA does not make a distinction between persons younger than 18 years and persons younger than 18, but older or younger than 12 years for purposes of consent to medical treatment, the Children's Act does make this distinction. As such it is strictly unnecessary to amend the MHCA to reflect this difference, due to the fact that the Children's Act takes precedence in its interpretation. It is further submitted that mental health care practitioners and other stakeholders that deal with the MHCA and with children as mental health care users may be familiar with the provisions of the MHCA as part of their work, but not with the Children's Act and the relatively complex workings of statutory interpretation. It would be prudent to amend the MHCA to make plain the difference in the inability of children under the age of 12 to consent to medical treatment, and the ability of children over the age of 12 but under the age of 18 to consent if they have the competence to

²⁹⁴ Section 129(2) of the Children's Act 38 of 2005.

²⁹⁵ Section 129(4)(a) subject to Section 31 of the Children's Act and Section 129(4)(b)

²⁹⁶ Buchner-Eveleigh and Nienaber (2012) 128.

²⁹⁷ Buchner-Eveleigh and Nienaber (2012) 136.

²⁹⁸ *Ibid.*

²⁹⁹ Buchner-Eveleigh and Nienaber (2012) 136.

make informed decisions. It is further submitted that the MHCA should specify categories of mental health care user in accordance with their age and consequently the manner in which they should be accommodated in treatment facilities, integrated with or separate from the general population in the facility in children's wards, especially pertaining to children who due to their young age are considered more vulnerable.

4.10 Leave of absence

The head of the health establishment concerned may grant leave of absence in the form of form MHCA 27 to an assisted- or involuntary mental health care user for a period not exceeding two months at a time: Provided that the terms and conditions to be complied with during such period of leave are stipulated on such form.³⁰⁰ The head of a health establishment concerned may, during a period of leave contemplated in terms of Section 45 of the Act, cancel the leave when they are authorised to it in the form of form MHCA 28 and direct on that form that the assisted- or involuntary mental health care user concerned be returned to the health establishment by the custodian or in terms of Regulations 28 or 29.³⁰¹ Landman suggests that the one-step approach envisioned in Regulation 26(3) requires a two-step approach - first cancellation of leave brought to the attention of the user and then action regarding absence without leave (unless the other circumstances in Section 40(1) exists).³⁰² There is no provision regarding leave of absence in the MHCA specifically pertaining to assisted or involuntary users and the Regulations are the only place it is mentioned, Section 45 of the MHCA only pertains to leave of absence for State Patients. It is submitted that the MHCA should be amended to correctly reflect the aims of the legislator and include a provision on the leave of absence for assisted and involuntary users. Regulations 28 and 29 of the General Regulations to the MHCA are discussed in this chapter under heading 4.15 “*The South African Police Service and mental health care*”.

³⁰⁰ Regulation 26(1) of the General Regulations to the MHCA.


³⁰¹ Regulation 26(3) of the General Regulations to the MHCA.

³⁰² Landman and Landman 129.

4.10.1 MHCA Forms pertaining to leave of absence

4.10.1.1 *MHCA 27 - Leave of absence to State Patients in terms of Section 45 of the MHCA; or assisted or involuntary mental health care users in terms of Section 66(1)(j) of the MHCA*

It is submitted that if a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, therefore it is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment (*Figure 23*).



MHCA 27

DEPARTMENT OF HEALTH

LEAVE OF ABSENCE TO –

STATE PATIENTS IN TERMS OF SECTION 45 OF THE ACT; OR

ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USERS IN TERMS OF

SECTION 66(1)(j) OF THE ACT

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Residential address or custodian's name and address whilst on leave of absence:

.....

.....

.....

.....

The user is: (mark with a cross)

State patient Assisted user Involuntary user

Date of commencement of leave:

Due date of return from leave:

Name of health establishment where the user's mental health status will be monitored and reviewed:

The user is to present him- / herself to this health establishment every weeks / months to be monitored and his / her health status reviewed.

Figure 22 - MHCA 27

4.10.1.2 MHCA 28 - Cancellation of leave of absence - a State Patient in terms of Section 45 of the MHCA; or an assisted or involuntary mental health care user in terms of Section 66(1)(j) of the MHCA

MHCA 28 as it pertains to State Patients is discussed in Chapter 5. It is submitted that if a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, therefore it is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment (*Figure 24*).

Name of health establishment(s) where care, treatment and rehabilitation will be provided and the nature of this:

Conditions of behaviour which must be adhered to by the user:

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

Name of psychiatric hospital where the user is to be admitted if he / she relapses and / or is not complying with the terms and conditions applicable to the leave:

.....

Print initials and surname:

Signature:

(head of health establishment)

Date:

Place:

Print initials and surname:

Signature:

(custodian)

Date:

Place:

Figure 23 - MHCA 27



DEPARTMENT OF HEALTH
Republic of South Africa

DEPARTMENT OF HEALTH

**CANCELLATION OF LEAVE OF ABSENCE –
A STATE PATIENT IN TERMS OF SECTION 45 OF THE ACT; OR
AN ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USER IN TERMS
OF SECTION 66(1)(j) OF THE ACT**

I hereby cancel the leave of absence of
(name of State patient, assistant- or involuntary mental health care user)

File No.

You are not complying with the terms and conditions applicable to the leave of absence
and/or have/has relapsed to the extent of requiring hospitalization.

Reasons for cancellation of leave of absence:

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

You must return to
(name of health establishment)

by (date) or you will be reported to the
South African Police Services as absconded.

Print initials and surname:

Signature:
(head of health establishment)

Date:

Place:
(Copy to custodian)

Figure 24 - MHCA 28

4.11 Appeals against the decision of the head of a health establishment regarding assisted or involuntary mental health care users

Section 29(1)(a), in the case of assisted mental health care users, and Section 35(1), in the case of involuntary mental health care users, determine that a mental health care user, spouse, next of kin, partner, associate, parent or guardian may, within 30 days of the date of the written notice issued in terms of Section 27(9) (assisted users) or Section 33(8) (involuntary users), appeal against the decision of the head of the health establishment to the Review Board. Such an appeal must contain the facts and the grounds upon which the appeal is based.³⁰³ The procedure for appealing against a decision of the Review Board is discussed in relation to MHCA 14 in this chapter concerning the MHCA forms to be used by Review Boards. In the case of assisted users, within 30 days after receipt of the appeal, the Review Board must consider the appeal in the prescribed manner;³⁰⁴ provide the appellant, applicant, the relevant mental health care practitioners and the head of the health establishment concerned an opportunity to make oral or written representations on the merits of the appeal;³⁰⁵ and send a written notice of its decision together with reasons for such decision to the appellant, applicant, head of the health establishment in question and the relevant mental health care practitioner.³⁰⁶

In the case of involuntary users, within 30 days after receipt of the notice of appeal, the Review Board must obtain from the head of the health establishment concerned, a copy of the application made in terms of Section 33, notice given in terms of Section 33(8) and a copy of the findings of the assessment conducted in terms of Section 34 (1), if applicable.³⁰⁷ The Review Board must give the appellant, applicant, mental health practitioners referred to in Section 33, an independent mental health care practitioner, if any, and the head of the health establishment concerned an opportunity to make written or oral representations on the merits of the appeal;³⁰⁸ consider the appeal in the prescribed manner;³⁰⁹ and send a written notice of

³⁰³ Section 29(1)(b) and Section 35(1)(b) of the MHCA.

³⁰⁴ Section 29(2)(a) of the MHCA.

³⁰⁵ Section 29(2)(b) of the MHCA.

³⁰⁶ Section 29(2)(c) of the MHCA.

³⁰⁷ Section 35(2)(a) of the MHCA.

³⁰⁸ Section 35(2)(b) of the MHCA.

its decision and the reasons for such decision to the appellant, applicant, the head of the health establishment concerned and head of the relevant provincial department.³¹⁰

If the Review Board upholds an appeal regarding an assisted user all care, treatment, and rehabilitation services administered to a mental health care user must be stopped according to accepted clinical practices and the user, if admitted, must be discharged by the health establishment, unless the user consents to the care, treatment and rehabilitation services.³¹¹ If the review board dismisses the appeal it can confirm that the user must be treated as either an inpatient or an outpatient.³¹² If the Review Board upholds the appeal regarding an involuntary user all care, treatment, and rehabilitation services administered to the mental health care user must be stopped according to accepted clinical practices; and the user, if admitted, must be discharged by the head of the health establishment, unless the user consents to the care, treatment and rehabilitation services. If the Review Board does not uphold the appeal, it must submit the documents referred to in subsection (2)(a) and (d) to the Registrar of a High Court for the review by the High Court. Section 35 of the MHCA does not specify whether the documentation submitted to the high court will be enrolled or reviewed by a judge in chambers.³¹³ The court is also empowered to obtain additional information and may require attendance of the user in court or visit them where they are being detained even if it is not regulated by the MHCA.³¹⁴

The user enjoys a right to appeal, which is predicated on a right to know about adverse action taken against them and the reasons for it.³¹⁵ The MHCA does not specifically provide that the head of the health establishment must provide the user with reasons, but should inform them in terms of Section 35(2)(a) of the Constitution that guarantees the rights of detained persons, and includes the right to be informed properly of the reasons for being detained and can only be limited to the extent that the person is unable to understand the information.³¹⁶ It is

³⁰⁹ Section 35(2)(c) of the MHCA.

³¹⁰ Section 35(2)(d) of the MHCA.

³¹¹ Section 29(3) of the MHCA.

³¹² Landman and Landman 102.

³¹³ Landman and Landman 242.

³¹⁴ *Ibid.*

³¹⁵ Landman and Landman 120.

³¹⁶ *Ibid.*

submitted that a provision to this effect must be explicitly added to the MHCA to prevent infringement of rights in line with the Constitution. Section 33 of the constitution that guarantees just administrative action also includes the right to be given written reasons.

Regulation 13(1) of the General Regulations to the MHCA determines that a person referred to in Section 29(1) of the Act (an assisted mental health care user) may within 30 days of the date of the written notice issued in terms of Section 27(9), appeal in the form of form MHCA 15 against the decision of the head of the health establishment to the Review Board. Regulation 14(1) determines that a person referred to in Section 35(1) of the Act (an involuntary mental health care user) may within 30 days of the date of the written notice issued in terms of Section 33(8), appeal in the form of form MHCA 15 of Annexure against the decision of the head of the health establishment. Landman submits that the date from which the 30 days starts to run is from the day the appellant receives the form, not from the day on which it is signed.³¹⁷ An appeal contemplated regarding assisted and involuntary mental health care users may be made directly to the Review Board concerned or submitted to the head of the health establishment where the application in terms of Section 27 of the Act was made, who must immediately submit that appeal to the Review Board concerned.³¹⁸

The Board must interview the involuntary user to determine whether the user is able to receive notice of the proceedings and participate in the process, instead of operating under the assumption that the user lacks competence as that is the very question that the Board must decide.³¹⁹ The Review Board would enquire whether there was a reasonable belief that user suffers from a mental illness/profound mental disability.³²⁰

4.11.1 Judicial review on need for further involuntary care, treatment and rehabilitation services

Section 36 determines that within 30 days after receipt of the documents submitted by the Review Board in terms of Section 34(7) or 35(4), the High Court must consider information

³¹⁷ Landman and Landman 99.

³¹⁸ Regulation 13(2)(a) and (b), Regulation 14(2)(a) and (b) of the General Regulations to the MHCA.

³¹⁹ Landman and Landman 123.

³²⁰ Landman and Landman 124.

submitted and any other representations made by any person referred to in Section 35(1). The High Court may also obtain information from any relevant person; and must thereafter order further hospitalisation of the mental health care user and, if necessary, the financial affairs of the mental health care user be managed and administered according to the provisions of Chapter VIII; or immediate discharge of the mental health care user. Regulation 16 of the General Regulations to the MHCA determines that within 30 days after receipt of the documents submitted by the Review Board in terms of Sections 34(7) or 35(4), the High Court must in terms of Section 36 of the Act in the form of form MHCA 16 order further hospitalization of the mental health care user and, if necessary, that the financial affairs of such user be managed and administered according to provisions of Chapter VIII of the Act;³²¹ or immediate discharge of such user.³²²

4.11.2 MHCA Forms pertaining to appeals

4.11.2.1 *MHCA 15 - Appeal to Review Board against decision of head of health establishment on assisted- or involuntary mental health care, treatment and rehabilitation in terms of Section 29(1) and 35(1) of the MHCA*

It is submitted that MHCA 15 (*Figure 25* and *Figure 26*) is satisfactory in the information required and clarity of presentation. If more space is required for the writing of reasons or facts (*Figure 26*) provision should be made for the attachment of additional pages.

³²¹ Regulation 16(a) of the General Regulations to the MHCA.

³²² Regulation 16(b) of the General Regulations to the MHCA.



DEPARTMENT OF HEALTH
Republic of South Africa

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 35(1) of the Act]

Details of user

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Residential address:

.....

.....

.....

Is the user the applicant? Yes No

If No to the above:

Surname of appellant:

First name(s) of appellant:

Residential address:

.....

.....

.....

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

Spouse
Next of kin

Partner
Parent

Associate
Guardian

Figure 25 - MHCA 15

Grounds for the appeal:

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

Facts on which the appeal is based:

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

Signature:

(appellant)

Date:

Place:

Figure 26 - MHCA 15

4.12 Periodical reports

The MHCA does not provide for the period a person may be admitted as involuntary user and a user will remain either an inpatient or outpatient until found fit for discharge conditionally or unconditionally. The MHCA does provide for periodic review.³²³ Six months after the commencement of care, treatment and rehabilitation services, and every 12 months thereafter, the head of the health establishment concerned must cause the mental health status of an

³²³Landman and Landman 126.

assisted and involuntary mental health care user to be reviewed.³²⁴ Such review must state the capacity of the mental health care user to express themselves on the need for care, treatment and rehabilitation services;³²⁵ state whether there are other care, treatment and rehabilitation services that are less restrictive or intrusive on the right to movement, privacy and dignity of the user;³²⁶ and make recommendations regarding a plan for further care, treatment and rehabilitation services.³²⁷ Additionally for involuntary mental health care users, the review must also state whether the mental health care user is likely to inflict serious harm on themselves or other people;³²⁸

A summary report of the review must be submitted to the Review Board for both assisted and involuntary mental health care users,³²⁹ and within 30 days after receipt of the report, the Review Board:

- May consult with any person who may have information concerning the mental health status of the user;³³⁰
- Must decide on the review;³³¹ and
- Must send a written notice of its decision and the reasons thereof to the mental health care user in question, applicant concerned, head of the health establishment where the user is admitted and the head of the relevant provincial department.³³²

In terms of Section 30(5)(a) and 37(5)(a), if the Review Board decides that the assisted or involuntary mental health care user be discharged: all care, treatment and rehabilitation services administered to the user must be stopped according to accepted clinical practices;³³³ and the user, if admitted, must be discharged by the health establishment

³²⁴ Section 30(1) and 37(1) of the MHCA.

³²⁵ Section 30(2)(a) and 37(2)(a) of the MHCA.

³²⁶ Section 30(2)(b) and 37(2)(c) of the MHCA.

³²⁷ Section 30(2)(c) and 37(2)(d) of the MHCA.

³²⁸ Section 37(2)(b) of the MHCA.

³²⁹ Section 30(3) and 37(3) of the MHCA.

³³⁰ Section 30(4)(a) and 37(4)(a) of the MHCA.

³³¹ Section 30(4)(b) of the MHCA.

³³² Section 30(4)(c) and 37(4)(b) of the MHCA.

³³³ Section 37(5)(a)(i) and 30(5)(a)(i) of the MHCA.

concerned, unless the user consents to the care, treatment and rehabilitation services.³³⁴ The head of the health establishment must comply with the decision of the Review Board.³³⁵ In addition, regarding involuntary mental health care users, the Registrar of the High Court must be notified in writing of a discharge made in terms of this section.³³⁶

Regulation 21(1) of the General Regulations to the MHCA determines that a periodic review must be done by:

- a) An assisted mental health care user in terms of Section 30 of the Act using form MHCA 13A;
- b) An involuntary mental health care user in terms of Section 37 of the Act using form MHCA 13A;

Regarding a person referred to in Regulation 21(1)(a) and (b) :³³⁷

- a) The first review must be done by a psychiatrist or registered medical practitioner six months after the commencement of care, treatment and rehabilitation services;
- b) The second review must be done by any mental health care practitioner 12 months after the first review referred to in paragraph (a); and
- c) The reviews thereafter must be done every 12 months, provided that every alternate review shall be done by a psychiatrist or registered medical practitioner.

Within 30 days after the Review Board concerned has received a summary report of a periodic review referred to in Regulation 21(1)(a) and (b), such Review Board must decide on the review in the form of form MHCA 17.³³⁸ It is submitted that the timelines attached to periodic reviews (6 months and 12 months) are too long, considering that the mental health status of a user may change on short notice. To prevent unlawful detainment once a user has recovered their mental health, it is necessary to impress upon mental health care practitioners

³³⁴ Section 37(5)(a)(ii) and 30(5)(a)(ii) of the MHCA.

³³⁵ Section 37(5)(b) and 30(5)(b) of the MHCA.

³³⁶ Section 37(6) of the MHCA.

³³⁷ Regulation 21(2) of the General Regulations to the MHCA.

³³⁸ Regulation 21(4) of the General Regulations to the MHCA.

that it is their duty to take positive steps for the review of a user's case once it becomes apparent that a user has recovered their mental health. It is furthermore submitted that periodic reviews are an integral mechanism by which the lawfulness of continued detainment is assessed and it is imperative that the system of record keeping is effective in ensuring periodic reviews happen within the required timeframes to prevent an infringement of rights and the possibility of liability for unlawful detention.

4.12.1 MHCA Forms pertaining to periodical reports

4.12.1.1 MHCA 13 - Periodical report on mental health care user in term of Section 30(2), 37(2), 46(2) or 55(1) of the MHCA



MHCA 13

DEPARTMENT OF HEALTH

PERIODICAL REPORT NO. ON MENTAL HEALTH CARE USER
 [Sections 30(2), 37(2), 46(2) or 55(1) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

The user is an: (mark with a cross)

Assisted user Involuntary inpatient Involuntary outpatient
 State patient Mentally ill prisoner

Name of health establishment concerned:

Registration number (if any):

Date of first admission of mental health care user under this section:

Mental health status: (Short statement of the mental health status before and since admission, since the last report, and the present condition, with special reference to any symptom indicating homicidal, suicidal or dangerous tendencies)

Before admission:

.....

Figure 27 - MHCA 13

MHCA 13 as it pertains to State Patients and mentally ill prisoners and the many issues regarding terminology and information required is discussed in Chapter 5. It is submitted that MHCA 13 (*Figure 27-32*) should be revised and amended in terms of general grammar and readability as there are numerous spelling and grammar mistakes. It is submitted that if a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, therefore it is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

Since admission / previous report:

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

Present mental status:

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

Present psycho-pharmaceutical treatment:

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

Present physical condition:

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

Diagnosis at present date:

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

Figure 28 - MHCA 13



Family contacts:

Personal Correspondence Regular Seldom Never

In the case of never, what has been done to trace the family?

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

Assisted mental health care user (section 30 of the Act)

Does the user have the capacity to express him / herself on the need for care, treatment and rehabilitation? Yes No

Comment:
.....

Is there other care, treatment or rehabilitation which is less restrictive or intrusive on the user's rights to movement, privacy and dignity? Yes No

Comment:
.....

Should the user be discharged? Yes No

Comment:
.....

Involuntary mental health care user (section 37 of the Act)

Does the user have the capacity to express him / herself on the need for care, treatment and rehabilitation? Yes No

Comment:
.....

Figure 29 - MHCA 13

Pertaining to less restrictive means of care, treatment and rehabilitation (*Figure 29* and *Figure 30*), the question should rather be amended to read “Are there any other less restrictive or intrusive measures of care, treatment and rehabilitation available that would serve the same purpose as the current treatment plan?”



Is the user likely to inflict serious harm on him / herself or others? Yes No

Comment:
.....

Is the other care, treatment or rehabilitation which is less restrictive or intrusive on the user's rights to movement, privacy and dignity? Yes No

Comment:
.....

Should the user be discharge? Yes No

Comment:
.....

If the user is an inpatient, should he / she be transferred to outpatient involuntary care?
Yes No

Comment:
.....

State patients (section 46 of the Act)

Charge faced:
.....
.....

Should the user be discharged conditionally? Yes No

Comment:
.....

Figure 30 - MHCA 13



Should the user be discharged unconditionally? Yes No

Comment:

Give reasons if the "present mental status" reflects a normal picture and further confinement is recommended:

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

Comment on the merit of granting the user leave of absence:

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

Mentally ill prisoner

Comment on the merits of returning the user to the prison from which he / she was transferred:

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

Recommendation on a plan for further care, treatment and rehabilitation

(Specify treatment programme followed, give details of psychiatric interviews, counselling, group therapy sessions etc., stating clearly the aims of treatment, progress made, assessments done, changes made an patient's reactions to changes):

Figure 31 - MHCA 13



Please add additional paper as this is extremely important!!

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

Print initials and surname of assessing practitioner:

Signature:
(assessing practitioner)

Date:

Place:

Instructions and remarks:

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

Signature:
(head of health establishment)

Date:

Place:

Figure 32 - MHCA 13

4.13 Discharge

Section 16 of the MHCA determines that the head of a health establishment must issue a discharge report to the user who was admitted for purposes of receiving care, treatment and rehabilitation services. Section 56 of the Act regarding the recovery of the mental health status of mentally ill prisoners is discussed in Chapter 5. Regulation 17 of the General Regulations to the MHCA determines that the discharge report must be issued by way of form MHCA 03.

4.14 MHCA forms used by the Review Board

This section examines the forms prescribed by the MHCA for use by the Review Board in the exercise of its duties.

4.14.1 MHCA 01 - Review of emergency admission or admission without consent (Section 9(2) of the MHCA)

Apart from the different categories of mental health care user discussed in this chapter (voluntary, involuntary or assisted users), there is another route by which a mentally ill person may become a mental health care user, namely via emergency admission in terms of Section 9(1)(c) of the MHCA. As discussed in Chapter 2 regarding patient autonomy and consent, a health care provider or health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if:³³⁹

- a) The user has consented;
- b) Authorised by a court order or a Review Board;
- c) Due to mental illness, any delay in providing such services may result in the death or irreversible harm to the user; the user inflicting serious harm to himself or others; or the user causing serious damage to or loss to property belonging to themselves or others.

Where a person or health establishment provides services to or admits a mental health care user in circumstances such as those mentioned in Section 9(1)(c), they must report it in writing and in the prescribed manner to the relevant Review Board, and may not continue to provide services to the user concerned for longer than 24 hours unless an application in terms of Chapter V for admission as a voluntary, assisted and involuntary mental health care users is made within the 24 hour period.³⁴⁰ Admission as a voluntary user would require consent from the patient, whereas admission as an assisted user requires that the patient does not refuse

³³⁹ Section 9(1) of the MHCA.

³⁴⁰ Section 9(2) of the MHCA.

treatment.³⁴¹ Admission as an involuntary user has its own specific requirements, including that the user refuses treatment and establishing the presence of a mental disorder during an initial assessment and a 72-hour assessment following an application.³⁴² These different categories of user are discussed below. The MHCA does not clarify whether, when a person is admitted in emergent circumstances and an application for involuntary admission is brought within the 24 hour period, if the 72-hour assessment period starts anew from the time the application is brought or from the time of original admission. It is submitted that the MHCA should be amended to include a provision stipulating that the 72-hour assessment period required for an application of involuntary admission should start from the time the application is brought, not from the time the patient was admitted as emergency mental health care user, as the requirements under assessment are different.

³⁴¹ Sections 25 and 27 of the MHCA.

³⁴² Sections 33 and 34 of the MHCA.



MHCA 01

DEPARTMENT OF HEALTH

EMERGENCY ADMISSION OR TREATMENT WITHOUT CONSENT
REPORT TO MENTAL HEALTH REVIEW BOARD
[Section 9(2) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation Marital status: S M D W

Residential address:

.....

.....

.....

.....

Date of admission of person for emergency care without their consent

Time of admission of person for emergency care without their consent

Name of health establishment

Reason for admission without consent:

In my/practitioners at this health establishment's assessment, due to mental illness, any delay in providing care, treatment and rehabilitation services / admitting may have resulted in:

(a) the death or irreversible harm to the user
Reasons for this assessment (including mental health status and behavioural reasons)

.....

.....

(b) the user inflicting serious harm to him/herself or others

Figure 34- MHCA 01

Regulation 8 of the General Regulations to the MHCA determines that the report in terms of Section 9(2) must be completed in writing in the form of MHCA 01 (Figure 34 and Figure 35). It is submitted that MHCA 01 would be clearer and easier to complete if check boxes were inserted to enable a mental health care practitioner to check the reason for admission in terms of Section 9(1)(c) (Figure 34 and Figure 35). It is further submitted that the form MHCA 01 should be amended as it does not make provision for noting if and when an application for assisted mental health care was made as is provided for in Section 9(2) of the

MHCA (*Figure 35*). It is submitted that MHCA 01 should be amended to include an option (d) stating that within 24 hours the user was referred for medical follow up and was not in need of further psychiatric care.³⁴³

Reasons for this assessment (including mental health status and behavioural reasons)

.....

.....

(c) the user causing serious damage to or loss of property belonging to him/herself or to others

Reasons for this assessment (including mental health status and behavioural reasons)

.....

.....

Within 24 hours -

- (a) An application for involuntary care, treatment and rehabilitation was made
Date of application Time of application.....
- (b) The user agreed to voluntary care, treatment and rehabilitation.
- (c) The user was discharged.

Print initials and surname.....

Signature:
(health care provider or head of health establishment)

Date:

Figure 35 – MHCA 01

It is submitted that if a person other than the head of the health establishment completes and signs the form, they must be properly authorised to do so by written delegation and the form should be amended to provide for the name of the head of the health establishment and for the

³⁴³As per the Gauteng Provincial Government Department of Health ‘Guidelines for the implementation of emergency, assisted, and involuntary care in accordance with the Mental Health Care Act No 17 of 2002’ 1-11 2.

details of a person signing the form on the delegated authority of the head of the health establishment.

4.14.2 MCHA 02 - Report on exploitation, physical or other abuse, neglect or degrading treatment of a mental health care user as prohibited by Section 11(2) of the MHCA)



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]

I
 (name)

..... (address)

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

(where known)

Surname of user

Date of birth or estimated age

Gender: Male Female

Occupation Marital status: S M D W

Residential address:

Name of health establishment or other place where exploitation, physical or other abuse, neglect or degrading treatment occurred

Address:

Figure 36 - MHCA 02

Board with the South African Police Service.³⁴⁵ It is submitted that the form is satisfactory in terms of the information required and clarity of the presentation.

4.14.3 MHCA 14 - Recording a decision by the Review Board

MHCA 14 is used in cases where a decision is made by Review Board concerning:

- a) Assisted mental care, treatment and rehabilitation in terms of Section 28(3) of the MHCA.
- b) Appeal against decision of head of health establishment concerning assisted care, treatment and rehabilitation in terms of Section 29(2) of the MHCA;
- c) Further involuntary care, treatment and rehabilitation on an inpatient basis in terms of Section 34(7) of the MHCA; or
- d) Appeal against decision of head of health establishment on involuntary care, treatment and rehabilitation in terms of Section 35(2) of the MHCA.

With regard to a decision made by the Review Board concerning (a) assisted mental care, treatment and rehabilitation in terms of Section 28(3) of the MHCA, the following provisions and regulations apply:

Section 28(1) determines that the head of the health establishment concerned must, within seven days of their decision made under Section 27(9), send a copy of the application to the relevant Review Board together with a confirmation of their decision. Within 30 days of receipt of the documents, the Review Board must conduct an investigation into the following aspects:³⁴⁶

- a) Incapacity of the mental health care user to make an informed decision on the need for the assisted care, treatment and rehabilitation services; and

³⁴⁵ Regulation 7(2) of the General Regulations to the MHCA.

³⁴⁶ Section 28(2) of the MHCA.

- b) Circumstances under which the mental health care user is receiving care, treatment and rehabilitation services.

The head of the health establishment concerned must in terms of Section 28(1) of the Act, within seven days of his or her decision regarding providing assisted care, treatment and rehabilitation on receipt of assessment reports by two mental health care practitioners,³⁴⁷ send a copy of the application for assisted care, treatment and rehabilitation to the relevant Review Board together with a copy of the findings of the two mental health care practitioners.³⁴⁸ Section 28(3) requires that on completion of the investigation, the Review Board must request the head of the health establishment to continue providing the mental health care user with the appropriate care, treatment and rehabilitation services;³⁴⁹ or discharge the mental health care user according to accepted clinical practice;³⁵⁰ and report on its findings and the steps taken to the head of the relevant provincial department.³⁵¹ If at any stage before the completion of the investigation, an appeal is lodged in terms of Section 29, the Review Board must stop the investigation and consider the appeal in question.³⁵² The Review Board concerned must, after receiving the documentation referred to in Regulation 9(8) and after completing an investigation in terms of Section 28(3) of the Act within 30 days, report on its findings and decision to the head of the health establishment concerned, the applicant and the head of the relevant provincial department in the form of form MHCA 14.³⁵³

Regarding a decision made by the Review Board concerning (c) further involuntary care, treatment and rehabilitation on an inpatient basis in terms of Section 34(7) of the MHCA, the following provisions and regulations apply:

If the mental health status of the mental health care user warrants further involuntary care, treatment and rehabilitation services on an inpatient basis, the head of the health establishment must within seven days after the expiry of the 72-hour assessment period

³⁴⁷ Assisted care is discussed in this chapter below.

³⁴⁸ Regulation 9(8) of the General Regulations to the MHCA.

³⁴⁹ Section 28(3)(a)(i) of the MHCA.

³⁵⁰ Section 28(3)(a)(ii) of the MHCA.

³⁵¹ Section 28(3)(b) of the MHCA.

³⁵² Section 28(4) of the MHCA.

³⁵³ Regulation 9(9) of the General Regulations to the MHCA.

submit a written request to the Review Board to approve further involuntary care, treatment and rehabilitation services on an inpatient basis.³⁵⁴ This request must contain:³⁵⁵ a copy of the application referred to in Section 33, a copy of the notice given in terms of Section 33(8), a copy of the assessment findings, and the basis for the request. The head of the establishment must also give notice to the applicant of the date on which the relevant documents were submitted to the Review Board.³⁵⁶ The Review Board must, within 30 days of receipt of documents referred to in Section 34(3)(c)(i) consider the request in the prescribed manner, and give the applicant, mental health care practitioners referred to in Section 33 or an independent mental health care practitioner, if any, and the head of the health establishment an opportunity to make oral or written representations on the merits of the request;³⁵⁷ send a decision in writing with reasons to the applicant and the head of the health establishment;³⁵⁸ and if the Review Board decides to grant the request, submit to the Registrar of a High Court the documents referred to in subsection(3)(c)(i) and the written notice for consideration by a High Court.³⁵⁹

If the head of the health establishment concerned, following the 72-hour assessment, is of the opinion that the mental health status of the mental health care user warrants further involuntary care, treatment and rehabilitation services on an inpatient basis, they must request the Review Board in the form of form MHCA 08 to approve such further care, treatment and rehabilitation.³⁶⁰ The Review Board must within 30 days of receipt of documents referred to in Section 34(3)(c)(i) of the Act send a decision on further involuntary care, treatment and rehabilitation on an inpatient basis in the form of form MHCA 14 with reasons to the applicant and the head of the health establishment.³⁶¹

³⁵⁴ Section 34(3)(c)(i) of the MHCA.

³⁵⁵ Section 34(3)(c)(i)(aa) to (dd) of the MHCA.

³⁵⁶ Section 34(3)(c)(ii) of the MHCA.

³⁵⁷ Section 34(7)(a) of the MHCA.

³⁵⁸ Section 34(7)(b) of the MHCA.

³⁵⁹ Section 34(7)(c) of the MHCA.

³⁶⁰ Regulation 11(9) of the General Regulations to the MHCA.

³⁶¹ Regulation 11(10) of the General Regulations to the MHCA.

Regarding a decision made by the Review Board concerning (b) an appeal against decision of head of health establishment concerning assisted care, treatment and rehabilitation in terms of Section 29(2) of the MHCA; and (d) an appeal against decision of head of health establishment on involuntary care, treatment and rehabilitation in terms of Section 35(2) of the MHCA, the following provisions and regulations apply:

In the case of assisted users, within 30 days after receipt of the appeal, the Review Board must consider the appeal in the prescribed manner;³⁶² provide the appellant, applicant, the relevant mental health care practitioners and the head of the health establishment concerned an opportunity to make oral or written representations on the merits of the appeal;³⁶³ and send a written notice of its decision together with reasons for such decision to the appellant, applicant, head of the health establishment in question and the relevant mental health care practitioner.³⁶⁴

In the case of involuntary users, within 30 days after receipt of the notice of appeal, the Review Board must obtain from the head of the health establishment concerned, a copy of the application made in terms of Section 33, notice given in terms of Section 33(8) and a copy of the findings of the assessment conducted in terms of Section 34(1), if applicable.³⁶⁵ The Review Board must give the appellant, applicant, mental health practitioners referred to in Section 33, an independent mental health care practitioner, if any, and the head of the health establishment concerned an opportunity to make written or oral representations on the merits of the appeal;³⁶⁶ consider the appeal in the prescribed manner;³⁶⁷ and send a written notice of its decision and the reasons for such decision to the appellant, applicant, the head of the health establishment concerned and head of the relevant provincial department.³⁶⁸ The MHCA does not require the Board to inform the user of the outcome of the appeal unless the user is the appellant, but it is suggested that the user should also be informed.³⁶⁹

³⁶² Section 29(2)(a) of the MHCA.

³⁶³ Section 29(2)(b) of the MHCA.

³⁶⁴ Section 29(2)(c) of the MHCA.

³⁶⁵ Section 35(2)(a) of the MHCA.

³⁶⁶ Section 35(2)(b) of the MHCA.

³⁶⁷ Section 35(2)(c) of the MHCA.

³⁶⁸ Section 35(2)(d) of the MHCA.

³⁶⁹ Landman and Landman 102.

Regulation 15(1) of the General Regulations to the MHCA provides that if an appeal against a decision contemplated in Section 27(9) and 33(8) to provide assisted or involuntary care, treatment and rehabilitation is made to a Review Board, the secretariat of that Review Board must ensure that all documentation in terms of Section 29 and 35 of the Act is obtained and delivered to the members of that Review Board at least one week prior to the appeal being considered by that Review Board. The secretariat of a Review Board must in writing and by registered post inform the appellant, the person referred to in Section 27(1) or 33(1) of the Act, the relevant mental health care practitioners, the head of the health establishment concerned and any other person whom the Review Board considers to be important to the appeal hearing, of the date of the appeal and whether written or oral representation, as appropriate, must be made to the Review Board.³⁷⁰ The Review Board may specifically invite such persons to the appeal hearing.³⁷¹ The Review Board must give notice of the appeal hearing at least two weeks before the date of such hearing.³⁷²

Regarding Regulation 15(2), Landman opines that the regulation removes the choice from the appellant whether written or oral representations are to be made and gives the choice to the secretariat acting under direction of the board.³⁷³ The Regulations are delegated legislation and have no power to restrict the wording of the empowering legislation.³⁷⁴ Written representations may be appropriate where the board only requires evidence on a technical or medical aspect.³⁷⁵ Insistence on written representations may disadvantage a large proportion of the population if they are not literate by precluding them from making submissions.³⁷⁶ The opportunity to make oral submissions holds a therapeutic element for the user.³⁷⁷ If only written representations are allowed, it may lead to a court finding that the user was not afforded a fair hearing.³⁷⁸ Landman contends that Regulation 15(2) is in conflict with the Constitution, as it provides for legal aid only if the person involved is an indigent user and

³⁷⁰ Regulation 15(2) of the General Regulations to the MHCA.

³⁷¹ Regulation 15(3) of the General Regulations to the MHCA.

³⁷² Regulation 15(4) of the General Regulations to the MHCA.

³⁷³ Landman and Landman 101.

³⁷⁴ *Ibid.*

³⁷⁵ *Ibid.*

³⁷⁶ *Ibid.*

³⁷⁷ *Ibid.*

³⁷⁸ *Ibid.*

that substantial injustice would otherwise result of the assisted user were not represented before a body that may confirm his continued detention.³⁷⁹

Consideration of Form MHCA 14

It is submitted that the MHCA 14 (*Figure 38* and *Figure 39*) form is unclear and can be improved upon by adding check boxes for the Review Board to check the issues that were in fact considered. A lack of check boxes makes it difficult to establish which of the four types of matter had been before the Board to decide upon. It appears from the current form that all aspects in the four different types of decision the form is used for has been considered simultaneously. The form therefore does not offer enough of an explanation of the information it considered to reach its decision, making it difficult to establish a causal nexus between the information considered, the decision reached, and the reasons for the decision.³⁸⁰ This leads to insufficient information before an applicant on which to base an appeal and may lead to a court ruling on review that the decision of the Review Board was unreasonable and therefore not administratively just. It could also lead to a determination of unlawful detention if it cannot be ascertained whether the reasons for detention were authorised and justified in terms of the MHCA.

³⁷⁹ *Ibid.*

³⁸⁰ If a decision cannot be objectively justified it is not reasonable. Reasonableness is a ground for judicial review in terms of Section 6 of PAJA, as discussed above. The decision must be shown to be rationally connected to the reasons for the decision.



DEPARTMENT OF HEALTH
Republic of South Africa

DEPARTMENT OF HEALTH

- DECISION BY REVIEW BOARD CONCERNING –**
- (a) assisted mental care, treatment and rehabilitation [section 28(3) of the Act];
 - (b) appeal against decision of head of health establishment concerning assisted care, treatment and rehabilitation [section 29(2) of the Act];
 - (c) further involuntary care, treatment and rehabilitation on an inpatient basis [section 34(7) of the Act]; or
 - (d) appeal against decision of head of health establishment on involuntary care, treatment and rehabilitation [section 35(2) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Residential address:

The Review Board of

(name of review Board)

have considered documentation and issues relevant to:

Application for assisted- or involuntary care, treatment and rehabilitation of the above user.

The Review Board have considered (inter alia) whether:

- (a) the user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services.
- (b) the user is suffering from a mental illness or severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for his / her health and safety or the health and safety of others.
- (c) the user is willing to receive care, treatment and rehabilitation services.
- (d) the user is likely to inflict serious harm on him / herself or others.

Figure 38 - MHCA 14

The form does not make provision for dates to be filled in to indicate when a decision by the head of the health establishment was taken (to ensure that the decision was referred to the Review Board within seven days as is determined in Section 28(2) of the MHCA), or to determine the dates on which the matter was considered by the Review Board and reported back to the head of the health establishment (to ensure that the 30 day period has been complied with as determined in Sections 28(3) and 29(2) of the MHCA).



- (e) care, treatment and rehabilitation is necessary for the user's financial interest and reputation.
- (f) the user's right to movement, privacy and dignity will be unnecessarily restricted.

Application to appeal against decision of head of health establishment on assisted- or involuntary care, treatment and rehabilitation

The Review Board have requested / provided the opportunity for the following to make oral or written representations on the merits of the request:

- (a) applicant
- (b) appellant
- (c) independent mental health care practitioner(s)
- (d) head of health establishment
- (e) others

The Review Board concludes that:

- (a) the user should not receive care, treatment and rehabilitation services without his / her consent either as an assisted- or involuntary user.
- (b) the user should receive care, treatment and rehabilitation services as an assisted user.
- (c) the user should receive involuntary care, treatment and rehabilitation services as an inpatient.
- (d) the user should receive involuntary care, treatment and rehabilitation services as an outpatient.

Reasons for this decision:

.....

.....

.....

.....

Print initials and surname

Signature:

(chair of Review Board)

Date:

Place:

[Copy to be sent (as applicable) to: applicant, appellant, head of health establishment concerned, head of provincial department and High Court Judge]

Figure 39 - MHCA 14

A lack of simple accountability measures, such as the recording of relevant dates, lead to insufficient data capturing, and a skewed picture of the efficiency of the Review Board and the implementation of the MHCA. If a mental health care user were denied their rights under the MHCA to have a decision reached speedily and an appeal considered within the required timeframes, it is an abuse of their human rights. Without expedient decision-making and communication, a mental health care user might be detained for longer time periods than required even when detention is no longer necessary, which would be an unlawful deprivation of their liberty. It is further submitted that the forms pertaining to initial review of a decision by a head of the health establishment, should physically differ from the forms used for an

appeal to avoid seeming biased in contravention of the *nemo iudex*-rule and perhaps exposing the decision to judicial review in terms of Section 6 of PAJA.³⁸¹

4.14.4 MHCA 17 - Decision of Review Board following summary report of review on assisted or involuntary mental health care users and mentally ill prisoners in terms of Sections 30(4), 37(4) or 55(2)(a) of the MHCA

Six months after the commencement of care, treatment and rehabilitation services, and every 12 months thereafter, the head of the health establishment concerned must cause the mental health status of an assisted and involuntary mental health care user to be reviewed.³⁸² Such review must state the capacity of the mental health care user to express themselves on the need for care, treatment and rehabilitation services;³⁸³ state whether there are other care, treatment and rehabilitation services that are less restrictive or intrusive on the right to movement, privacy and dignity of the user;³⁸⁴ and make recommendations regarding a plan for further care, treatment and rehabilitation services.³⁸⁵ Additionally for involuntary mental health care users, the review must also state whether the mental health care user is likely to inflict serious harm on themselves or other people.³⁸⁶

A summary report of the review must be submitted to the Review Board for both assisted and involuntary mental health care users,³⁸⁷ and within 30 days after receipt of the report, the Review Board:

- May consult with any person who may have information concerning the mental health status of the user;³⁸⁸
- Must decide on the review;³⁸⁹ and

³⁸¹ A mere suspicion of bias is sufficient grounds for judicial review.

³⁸² Section 30(1) and 37(1) of the MHCA.

³⁸³ Section 30(2)(a) and 37(2)(a) of the MHCA.

³⁸⁴ Section 30(2)(b) and 37(2)(c) of the MHCA.

³⁸⁵ Section 30(2)(c) and 37(2)(d) of the MHCA.

³⁸⁶ Section 37(2)(b) of the MHCA.

³⁸⁷ Section 30(3) and 37(3) of the MHCA.

³⁸⁸ Section 30(4)(a) and 37(4)(a) of the MHCA.

³⁸⁹ Section 30(4)(b) of the MHCA.



- Must send a written notice of its decision and the reasons thereof to the mental health care user in question, applicant concerned, head of the health establishment where the user is admitted and the head of the relevant provincial department.³⁹⁰



MHCA 17

DEPARTMENT OF HEALTH

DECISION BY REVIEW BOARD FOLLOWING SUMMARY REPORT OF REVIEW
ON ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USERS AND
MENTALLY ILL PRISONERS
[Sections 30(4), 37(4) or 55(2)(a) of the Act]

Surname of user
 First name(s) of user
 Date of birth or estimated age
 Gender: Male Female

Occupation: Marital status: S M D W
 Health establishment concerned
 (name of health establishment)

The Review Board of have considered
 (name of Review Board)
 documentation and issues relevant to the periodic review of the above user.

The Review Board have considered (inter alia) whether:

- the user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services.
- the user is suffering from a mental illness or severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for his / her health and safety or the health and safety of others.
- the user is willing to receive care, treatment and rehabilitation services.
- the user is likely to inflict serious harm on him / herself or others.
- care, treatment and rehabilitation is necessary for the user's financial interest and reputation.
- the user's right to movement, privacy and dignity will be unnecessarily restricted.

The Review Board have requested the following people to make oral or written representations:

- applicant
- independent mental health care practitioner(s)
- head of health establishment

Figure 40 - MHCA 17

³⁹⁰ Section 30(4)(c) and 37(4)(b) of the MHCA.

(d) others

The Review Board concludes that:

- (a) the user should cease to receive care, treatment and rehabilitation services without his / her consent.
- (b) the user should continue to receive care, treatment and rehabilitation services as an assisted user.
- (c) the user should continue to receive involuntary care, treatment and rehabilitation services as an inpatient.
- (d) the user should continue his / her confinement within a psychiatric hospital / care and rehabilitation center, but should not be subjected to treatment against his / her wishes.
- (e) the user should continue to receive involuntary care, treatment and rehabilitation services as an outpatient.
- (f) the user should be transferred from being an involuntary inpatient to being an involuntary outpatient.

Reasons for this decision:

.....

Print initials and surname

Signature:

(chair of Review Board)

Date:

Place:

[Copy to be sent to mental health care user, applicant, head of health establishment and to the head of the national department in respect of mentally ill prisoners and to the High Court Judge in respect of an involuntary mental health care user]

Figure 41 - MHCA 17

It is submitted that MHCA 17 (Figure 40 and 41) is unclear and should be amended to improve comprehension and readability. The title of the form (Figure 40) should be amended to clearly refer to periodic review as follows: “*Decision of Review Board following summary report of **periodic or annual** review on assisted or involuntary mental health care users and mentally ill prisoners...*”

It is submitted further that the form can be improved for ease of completion and readability by adding check boxes to indicate clearly:

- a) Whether the form pertains to an annual report or periodic review (Figure 40);

- b) Which of the criteria have been considered (*Figure 40*), as well as adding additional writing space in which other criteria not mentioned that were considered can be added;
- c) Which person or persons have been requested to make oral or written submissions (*Figure 40*); and
- d) Which conclusion or decision has been reached (*Figure 41*)

4.14.5 MHCA 18 - Summons to appear before a Review Board in terms of Section 29(2)(a) and 35(2)(c) of the MHCA



MHCA 18

DEPARTMENT OF HEALTH

**SUMMONS TO APPEAR BEFORE A REVIEW BOARD
[Sections 29(2)(a) and 35(2)(c) of the Act]**

.....
(name of person summoned and his or her address)
is hereby summoned to appear at (place)
on (date and time) before the Review Board of
..... (name of health establishment)
to give evidence in respect of
.....
.....
(if the person summoned is to produce any book, record, document or thing, add)
and you are hereby directed to produce:
.....
.....
.....
(specify the book, record, document or thing concerned)
Given under the hand of the chairperson of the Review Board, this day
of
Signature:
(chairperson of Review Board)

Figure 42 - MHCA 18

The Review Board may summon any person in the form of form MHCA 18 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 appeal.³⁹¹ Such a person must be compensated by funds appropriated by the provincial department concerned for any reasonable expenses which such person may have incurred in order to attend the appeal hearing.³⁹² The MHCA does clarify the procedure by which the person summoned is to be reimbursed, and it is submitted that this falls under the discretion of the Review Board to regulate their own procedures. It is submitted that MHCA 18 (*Figure 42*) is presented clearly pertaining to appropriate and sufficient information to enable a person summoned to appear before the Review Board to be aware of the matter at hand and what is required of them. However it would be prudent to insert text into the form informing the person summoned that they may be compensated for reasonable costs associated with attending the hearing. This will ensure that the relevant person is fully aware of their rights as stated in the Regulations, which may not be common knowledge.

4.15 The South African Police Service and mental health care

In this section the functions of the police pertaining to the MHCA is discussed, along with a focus more broadly on the training of police officers in mental health matters. The police service is required under the MHCA to assist with the following 3 tasks relating to mental health care users:³⁹³

1. Apprehension of a person likely to inflict serious harm to himself or others due to his mental illness or severe or profound intellectual disability (Section 40(1) of the MHCA);
2. Transfer an assisted or involuntary user under Sections 27(10), 33(9), 34(4)(b), 34(6) and 39 of the MHCA.

³⁹¹ Regulation 15(6) of the General Regulations to the MHCA.

³⁹² Regulation 15(7) of the General Regulations to the MHCA.

³⁹³ Landman and Landman 263.

3. Locate and apprehend and return an assisted or involuntary user who has absconded or is deemed to have absconded on request of the head of a health establishment (Section 40(4) of the MHCA).

4.15.1 Intervention by members of South African Police Service

Section 40(1) of the Act determines that if a member of the South African Police Service has reason to believe, from personal observation or from information obtained from a mental health care practitioner, that a person due to his or her mental illness or severe or profound intellectual disability is likely to inflict serious harm to themselves or others, the member must apprehend the person and cause that person to be:

- a) Taken to an appropriate health establishment administered under the auspices of the State for assessment of the mental health status of that person; and
- b) Handed over into custody of the head of the health establishment or any other person designated by the head of the health establishment to receive such persons.

Regulation 28 of the General Regulations to the MHCA determine that if a member of the South African Police Services apprehends a person in terms of Section 40(1) of the Act, that member must cause that person to be:

- a) Taken to a health establishment administered under the auspices of the State, listed in terms of Regulation 12 by the provincial department concerned, for assessment of the mental health status of that person; and
- b) Handed over using form MHCA 22 into the custody of the head of the health establishment, or any other person designated by the head of the health establishment to receive such persons.

If a mental health care practitioner, after the assessment referred to in Section 40(1), is of the view that the person apprehended is due to mental illness or severe or profound intellectual disability, likely to inflict serious harm to themselves or others, must admit the person to the

health establishment for a period not exceeding 24 hours for an application to be made in terms of Section 33;³⁹⁴ or if the person is deemed unlikely to cause harm, the practitioner must release the person immediately.³⁹⁵ If an application is not made within the 24 hour period, the person apprehended must be discharged immediately.³⁹⁶ Accountability for enforcement is not specifically mentioned in the MHCA and it is submitted that the burden of ensuring the MHCA is complied with rests on the head of the health establishment and that the MHCA should be amended to reflect this. It is also submitted that a person not released within this period will have cause to claim civil damages for unlawful apprehension by the police, as well as for the unlawful detention by the head of the health establishment or the police.³⁹⁷

The right to security and freedom of the person as guaranteed in Section 12(1)(a) the Constitution, including the right to not be deprived of freedom arbitrarily or without just cause, was discussed in Chapter 2 is applicable in this scenario. When it is proven that an arrest has taken place, the onus rests on the defendant to justify an arrest.³⁹⁸ The two provisions dealing with arrest by members of the police are Section 40(1) of the Criminal Procedure Act³⁹⁹ (hereafter referred to as the CPA), which authorises an arrest without a warrant; and Section 43 of the CPA, which provides that a magistrate may issue a warrant for the arrest of any person on the written application of the Director of Public Prosecutions, a public prosecutor or commissioned members of the SAPS.⁴⁰⁰ Any arrest by a member of the SAPS and the consequent detention in conflict with the provisions of the CPA is unlawful, unless it is specifically authorised in terms of any other laws.⁴⁰¹ Section 40 provides authority to apprehend and detain mental health care users.⁴⁰²

³⁹⁴ Section 40(2)(a) of the MHCA.

³⁹⁵ Section 40(2)(a) of the MHCA.

³⁹⁶ Section 40(3) of the MHCA.

³⁹⁷ Moffat, N (2015) 'Examining s 40 of the Mental Health Care Act: Unlawful arrest and detention' *De Rebus* September 34-35 34.

³⁹⁸ *Ibid*; This was stated in *Rudolph and Others v Minister of Safety and Security and Another* 2009 (5) SA 94 (SCA) at par 14.

³⁹⁹ Act 51 of 1977.

⁴⁰⁰ Moffat (2015) 34-35.

⁴⁰¹ Moffat (2015) 35.

⁴⁰² *Ibid*.

The decision whether to apprehend is a discretionary power of police officers who have to decide whether to act, the manner in which to act, and considering the safety of the community, the mentally ill person and themselves.⁴⁰³ The apprehending officer must reasonably believe that the person is dangerous to himself or others due to his mental state for the apprehension to be lawful.⁴⁰⁴ To be reasonable the belief must have a factual foundation stemming from personal observation or from the information obtained from a medical professional trained to provide mental health care, treatment and rehabilitation services.⁴⁰⁵ Information obtained from other sources is unacceptable, though the officer may rely on such information in order to personally observe the person concerned.⁴⁰⁶ Police will be aware that unlawful apprehension will constitute a delict entitling the apprehended person to claim damages from the Minister of Police.⁴⁰⁷

The infringement of Section 40 may occur in two ways:⁴⁰⁸

- The member of the SAPS may intentionally decide to apprehend a person with no reason to believe that the person is likely to inflict serious harm to themselves or others. Section 40 of the Act should be viewed in light of the authority of members of the SAPS to arrest persons in terms of the CPA. Members of the SAPS do not have the authority to apprehend any person without limitation.
- Even if a member of the SAPS believes that the person is dangerous due to their mental state, it might be an unlawful apprehension if such reason cannot be objectively justified.⁴⁰⁹

It should also be noted that Section 40 of the MHCA only authorises the SAPS to apprehend and handover the mental health care user to the head of the health establishment, therefore

⁴⁰³ Landman and Landman 264; Moffat (2015) 35.

⁴⁰⁴ *Ibid.*

⁴⁰⁵ *Ibid.*

⁴⁰⁶ *Ibid.*

⁴⁰⁷ Landman and Landman 265.

⁴⁰⁸ Moffat (2015) 35.

⁴⁰⁹ 'Reasonable belief' must be constituted by facts giving rise to such a belief, and a blind belief or belief on hearsay evidence is not permissible. *Vumba Intertrade CC v Geometric Intertrade CC* 2001 (2) SA 1068 (W) at 1071 F-H; Moffat (2015) 35.

detention of mental health care users by the SAPS would be in breach of Section 40 of the Act and such detention would be unlawful.⁴¹⁰

Jonsson, Moosa and Jeenah present the following diagram of the process regarding Section 40 and MHCA 22:⁴¹¹

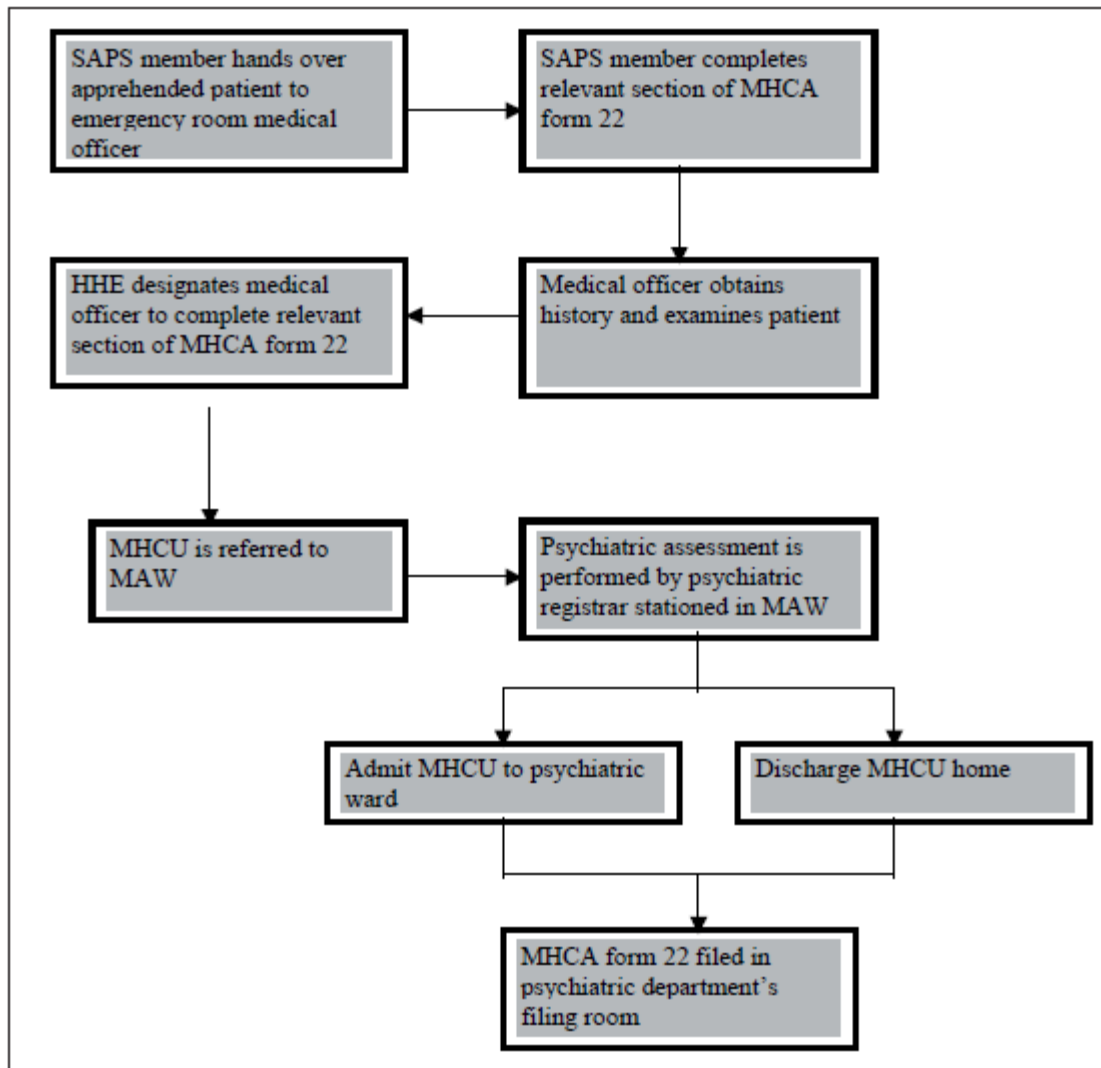


Figure 43 - Process in terms of Section 40 of the MHCA

While the legislation is clear in its requirements, the compliance of various stakeholders in its implementation is in question.⁴¹² In a study of outcomes of police responses to mental health

⁴¹⁰Moffat (2015) 35.

⁴¹¹Jonsson, G., Moosa, MYH, Jeenah, FY. (2009) 'The Mental Health Care Act: Stakeholder compliance with Section 40 of the Act' SAJP 15:2 37-42 38.

emergencies, it was concluded that current police training is inadequate to prepare police officers to identify and deal with the mentally ill, and that police officers did not know how to recognise mental illness, how to deal with psychotic and violent behaviour, or what to do with someone trying to commit suicide.⁴¹³ This lack of knowledge affects proper compliance with legislation.⁴¹⁴

Jonsson, Moosa and Jeenah conducted a study on stakeholder compliance with Section 40 of the MHCA, in which they assessed the completion of all MHCA 22 forms during the time period of July 2007 to December 2007 of suspected mentally ill patients over the age of 18 years handed over from custody by the South African Police Service to medical services at Chris Hani Baragwanath Hospital.⁴¹⁵ During the study period, 708 of the 718 patients handed over by SAPS to the Emergency Department of CHBH were entered on MHCA forms 22. SAPS officials had correctly completed 86% of the forms, whereas the medical practitioners had only correctly completed 9.9% of the forms.⁴¹⁶ It is evident from this study that the SAPS are more compliant about completing form MHCA 22 and the MHCA Regulations compared with mental health care practitioners in the hospital.⁴¹⁷ Although training in the specifics of the MHCA is not formally carried out for SAPS, they may be more compliant in completing MHCA 22 because it forms part of their standard operating procedures, regardless of their understanding of the MHCA.⁴¹⁸ A similar standard operating procedure does not exist for medical practitioners at that hospital.⁴¹⁹

The study also found that the physical condition of mental health care users at the time of hand-over by SAPS was recorded in only 10% of all referrals.⁴²⁰ It is possible that the mental health care practitioners were either not examining patients properly or were not entering their findings on form MHCA 22, which may be due to high patient loads at the emergency

⁴¹² Jonsson, Moosa, Jeenah (2009) SAJP 37.

⁴¹³ *Ibid*; Steadman HJ, Deane MW, Borum R, Morrissey J. (2000) 'Comparing outcomes of major models of police responses to mental health emergencies' *Psychiatry Services* 51 645-649.

⁴¹⁴ *Ibid*.

⁴¹⁵ Jonsson, Moosa, Jeenah (2009) SAJP 37.

⁴¹⁶ *Ibid*.

⁴¹⁷ Jonsson, Moosa, Jeenah (2009) SAJP 40.

⁴¹⁸ *Ibid*.

⁴¹⁹ *Ibid*.

⁴²⁰ *Ibid*.

department.⁴²¹ As a result of failure by admitting practitioners to perform a proper physical examination, the burden of excluding medical illness is transferred to the psychiatric registrar.⁴²² Additionally, documented evidence of the physical state of the user on hand-over before admission is crucial when claims of physical abuse while in the care of SAPS or the hospital are raised.⁴²³ The study further noted that family members usually did not accompany mental health care users to the hospital, therefore, no collateral information is available to the emergency doctor.⁴²⁴ Jonsson, Moosa and Jeenah recommend that the accompaniment of family members should be insisted upon by the SAPS and should be written into SAPS standard operating procedures.⁴²⁵

The inclusion of mental illness does not form part of SAPS training,⁴²⁶ and training in psychiatry and the MHCA has been included in undergraduate medical training over the past few years, however it has only recently been incorporated into the newly established postgraduate degree in emergency medicine.⁴²⁷ Due to a lack of emergency medicine specialists, general practitioners often form the bulk of emergency room staff, consequently most current emergency doctors lack the knowledge, understanding, skills and competence to implement the MHCA and to examine and assess acutely psychotic patients.⁴²⁸ Special emphasis is needed on training in carrying out the procedures of the MHCA for undergraduate and postgraduate medical students.⁴²⁹ Additionally, regular audits of the processes and procedures need to be carried out in all hospital EDs to assist in establishing protocols specific to the hospital situation.⁴³⁰

⁴²¹ *Ibid.*

⁴²² *Ibid.*

⁴²³ *Ibid.*

⁴²⁴ *Ibid.*

⁴²⁵ *Ibid.*

⁴²⁶ Jonsson, Moosa, Jeenah (2009) SAJP 41.

⁴²⁷ *Ibid.*

⁴²⁸ Jonsson, Moosa, Jeenah (2009) SAJP 40-41.

⁴²⁹ Jonsson, Moosa, Jeenah (2009) SAJP 41.

⁴³⁰ *Ibid.*

The findings of Jonsson, Moosa and Jeenah suggest that not all stakeholders are fully compliant with the procedure as set out in Section 40 of the MHCA, and they recommend that implementation may be improved by:⁴³¹

- Providing training to all stakeholders;
- Making amendments to the MHCA form 22 (use of check boxes may increase the likelihood of all components being completed appropriately without delaying the police officers);
- Increasing the quality of the partnerships of all stakeholders concerned.

In another article on the same data regarding Section 40 of the MHCA, Jonsson, *et al.* determined that many referrals by police may not be necessary as most mental health care users end up not being admitted.⁴³² The characteristics of police referrals suggest that the receiving facility should have the capacity to identify factors that favour outpatient care (especially substance abuse problems) and divert users presenting with such factors to appropriate treatment facilities without admitting them to the hospital.⁴³³ Police officers are faced with a complex decision, namely whether to take a suspected mentally ill person to the police cells or to the hospital for psychiatric evaluation.⁴³⁴ The decision should rest on whether the individual meets the criteria for involuntary admission or is deemed a danger to self or others (the criteria for involuntary admission specifically requires the presence of a mental illness), which is often unclear to the police officer. In a South African setting where training of police officers in the identification of mental disorders is limited, it might be more appropriate to take all suspected mentally ill patients to hospital for assessment.⁴³⁵ The only way of rectifying the situation is to ensure training of police officers in these aspects. Areas of training and development should include training of SAPS members in identification of common psychiatric conditions and MHCP's in the correct implementation of the MHCA.⁴³⁶

⁴³¹ *Ibid.*

⁴³² Jonsson, G., Moosa, MYH., Jeenah, FY., Musenge, E (2013) 'The outcome of Mental Health Care Users admitted under Section 40 of the South African Mental Health Care Act (No 17 of 2002)' *African Journal of Psychiatry* 16 94-103 94.

⁴³³ *Ibid.*

⁴³⁴ Jonsson *et al.* (2013) 95.

⁴³⁵ *Ibid.*

⁴³⁶ Jonsson *et al.* (2013) 101.

The fact that almost half of persons handed over by police in terms of Section 40 of the MHCA were discharged could possibly be due to the fact that person, once removed from the volatile situation pre-admission, settles and voluntarily accepts treatment, thus reducing the need for admission to hospital in favour of outpatient care.⁴³⁷ The MHCA states that mental health care users must be treated in the least restrictive environment and that those who do not meet criteria for admission are required to be discharged for care to an under-resourced and overloaded outpatient community service where they are often not adequately treated or referred for substance rehabilitation.⁴³⁸ Substance abuse played a large role in those presented for admission, the effects of which may also have subsided by the time of assessment so as to not necessitate admission.⁴³⁹ Resource constraints and bed shortages may also play a crucial role in encouraging outpatient care.⁴⁴⁰ It can be argued that police will act to prevent someone from harming themselves or others, no matter what the underlying cause may be and that this will lead to lawful apprehension, even if the officer at the time does not believe that the person suffers from a mental illness or was informed as such by a medical professional.

Section 40 applies to children and there is no provision requiring police to inform the child's parents of the apprehension, the omission of which is probably unconstitutional.⁴⁴¹ Standing Order(G) 361 regarding the Treatment of Persons in the Custody of the Police Service discourages the detention of children and determines that the Community Service Centre Commander must ensure the member who made the arrest or another member must ascertain the identity of an appropriate adult so that they may be informed of the child's whereabouts and detention.⁴⁴²

If an assisted or involuntary mental health care user has absconded or is deemed to have absconded or if the user has to be transferred under Sections 27(10), 33(9), 34(4)(b), 34(6) and 39, the head of the health establishment may request assistance from the South African Police Service to locate, apprehend and return the user to the health establishment

⁴³⁷ Jonsson *et al.* (2013) 99.

⁴³⁸ Jonsson *et al.* (2013) 99, 101.

⁴³⁹ Jonsson *et al.* (2013) 100.

⁴⁴⁰ *Ibid.*

⁴⁴¹ Landman and Landman 265.

⁴⁴² Landman and Landman 266.

concerned;⁴⁴³ or transfer the user in the prescribed manner.⁴⁴⁴ Section 40(5) determines that the South African Police Service must comply with the request. When requesting the assistance, the South African Police Service must be informed of the estimated level of dangerousness of the assisted or involuntary mental health care user.⁴⁴⁵ A person apprehended in terms of subsection (4) may be held in custody at a police station for such period as prescribed to effect the return or the transfer in the prescribed manner.⁴⁴⁶ A member of the South African Police Service, may use such constraining measures as may be necessary and proportionate in the circumstances when apprehending a person or performing any function in terms of this section.⁴⁴⁷

4.15.2 Transfer of assisted or involuntary mental health care user, State Patient or mentally ill prisoner with the assistance of the South African Police Service

The head of the health establishment concerned may only in exceptional circumstances and upon the recommendation of a mental health care practitioner, request assistance of the South African Police Service with the transfer of an assisted or an involuntary mental health care user, State Patient or mentally ill prisoner.⁴⁴⁸ A request contemplated in Regulation 27(1) must only be made if the head of the health establishment is satisfied that medical care has been provided to such user or that an attempt was made to provide such care and such head is of the opinion that such mental health care user, State Patient or mentally ill prisoner is too dangerous to be transferred in a vehicle staffed only by health personnel or is likely to abscond during such transfer unless guarded.⁴⁴⁹ A mental health care user contemplated in Regulation 27(1) who has to be transferred, may be held in custody at a police station for a period of not more than 24 hours to effect the transfer.⁴⁵⁰ A health care practitioner must accompany the mental health care user contemplated in Regulation 27(1) during transfer.⁴⁵¹

⁴⁴³ Section 40(4)(a) of the MHCA.

⁴⁴⁴ Section 40(4)(b) of the MHCA.

⁴⁴⁵ Section 40(6) of the MHCA.

⁴⁴⁶ Section 40(7) of the MHCA.

⁴⁴⁷ Section 40(8) of the MHCA.

⁴⁴⁸ Regulation 27(1) of the General Regulations to the MHCA.

⁴⁴⁹ Regulation 27(2) of the General Regulations to the MHCA.

⁴⁵⁰ Regulation 27(3) of the General Regulations to the MHCA.

⁴⁵¹ Regulation 27(4) of the General Regulations to the MHCA.

The assistance of the police may be requested in terms of Section 40(4) of the MHCA if an assisted user needs to be transferred in terms of Section 27(10) of the MHCA and the police are obliged to transfer the user in the prescribed manner.⁴⁵² It is problematic that Section 27(10) does not refer to a “transfer”, but rather that the head of a health establishment must cause an assisted user to be admitted the establishment or referred to another establishment.⁴⁵³ This may be interpreted as meaning that a referral from one establishment to another implies that a transfer is needed and that the help of the police may be required in terms of Section 40(4).⁴⁵⁴ If the user has not yet been admitted, transfer in terms of Section 40(1) is more appropriate to apprehend the user and bring them to the establishment.⁴⁵⁵ The police should be used sparingly and only in the circumstances mentioned in the MHCA, but the MHCA does not list exceptional circumstances as a requirement and the regulations may not limit the provision in an Act of Parliament, possibly creating scenarios where the police are unnecessarily involved.⁴⁵⁶ It is submitted that in instances where a mentally disordered person or mental health care user is not considered to be dangerous to themselves or others, it might be more prudent to investigate whether speciality ambulance units are a better option to use for the transfer of users who are not prisoners.

4.15.3 Return of an absconded person who has been apprehended and is being held in custody by South African Police Service

Regulation 29(1) of the General Regulations to the MHCA determines that if a mental health care user has absconded or is deemed to have absconded, the head of the health establishment concerned may in terms of Section 40(4), of the Act and in the form of form MHCA 25 notify and request assistance from the South African Police Service to locate, apprehend and return the user to the health establishment concerned. If a mental health care user referred to in Regulation 29(1) is apprehended by the South African Police Service in terms of Section 40(4), of the Act in the vicinity of such health establishment, the South African Police Service must return such user immediately to such establishment and hand over to the head of such

⁴⁵² Landman and Landman 98.

⁴⁵³ *Ibid.*

⁴⁵⁴ *Ibid.*

⁴⁵⁵ *Ibid.*

⁴⁵⁶ Landman and Landman 298.

health establishment or any other person so designated by that head to receive such user, provided that form MHCA 26 must be completed at the time the user is handed over.⁴⁵⁷

There are two problems regarding utilising the police to return the user in terms of Regulations 28 and 29, namely:⁴⁵⁸

1. Regulation 28 deals with the powers of the police in terms of Section 40(1) of the MHCA and cancellation of leave on its own is not a sufficient ground to invoke Section 40(1);
2. Regulation 29 deals with a user who absconds and the cancellation of leave on its own does not warrant it to be said that the user has absconded until the user receives notice of cancellation of leave in terms of Section 26(3).

If a mental health care user who has absconded from a health establishment is apprehended by the South African Police Service in terms of Sections 40(4), 44(1) or 57(1) of the Act and that apprehension does not take place in the vicinity of that health establishment, the South African Police Service must:⁴⁵⁹

- a) Notify the head of the health establishment that such user has been apprehended and is in the custody of the South African Police Service; and
- b) Provide the information regarding the physical and mental condition of that user that the notifying member is able to provide.

The head of the health establishment contemplated in Regulation 29(1) must, if circumstances so require, take steps to ensure that a mental health care practitioner from a health establishment nearest to the police station where the mental health care user is held in custody or another suitable mental health care practitioner, examines that mental health care user and provides the treatment that may be required at the police station or the nearest local health

⁴⁵⁷ Regulation 29(2) of the General Regulations to the MHCA.

⁴⁵⁸ Landman and Landman 129.

⁴⁵⁹ Regulation 29(3) of the General Regulations to the MHCA.

establishment.⁴⁶⁰ After an examination contemplated in Regulation 29(4), it is the responsibility of the member in command of the South African Police Service station where the mental health care user is being detained, to consult with the head of the health establishment concerned and to make arrangements for the return of such mental health care user, taking into account the physical and mental condition of such user.⁴⁶¹ Provided that if that user is too dangerous to be transferred in a vehicle staffed only by health personnel;⁴⁶² or likely to abscond during the transfer, unless guarded, that user must be conveyed by the South African Police Service or a member of the South African Police Service must accompany that user while being conveyed.⁴⁶³ A mental health care user may be held in custody at a police station for a period of not more than 24 hours to effect the return of that user.⁴⁶⁴

The police may take the word of head of the health establishment that the person has absconded at face value and should be informed if they are not deemed to have absconded as Section 40 of the MHCA does not apply if an apprehension is then made.⁴⁶⁵

4.15.4 Mentally ill detainees in police cells and lockups

Standing Order (G) 349 Medical Treatment and Hospitalisation of a Person in Custody stipulates that police are responsible for detainees in their care , which includes attending to their basic human rights as detainees and their general and mental health needs although police custodial facilities are considered a temporary measure intended mainly to ensure their appearance in court.⁴⁶⁶ Custody is also used in practice as a preventative measure for people who have threatened harm to themselves or others or pending investigation.⁴⁶⁷ The Standing Order requires the exercise of discretion to determine whether a detainee is seriously ill and in need of urgent medical attention even before being taken to the police station and whether that

⁴⁶⁰ Regulation 29(4) of the General Regulations to the MHCA.

⁴⁶¹ Regulation 29(5) of the General Regulations to the MHCA.

⁴⁶² Regulation 29(5)(a) of the General Regulations to the MHCA.

⁴⁶³ Regulation 29(5)(b) of the General Regulations to the MHCA.

⁴⁶⁴ Regulation 29(6) of the General Regulations to the MHCA.

⁴⁶⁵ Landman and Landman 267.

⁴⁶⁶ Landman and Landman 269.

⁴⁶⁷ *Ibid.*

should happen in a police vehicle or by ambulance.⁴⁶⁸ When in doubt it is better that the officer arranges steps to enable treatment.⁴⁶⁹ The updating of an Occurrence Book and the Custody register is also required in terms of Standing order (G) 362 Custody Register (SAPS 14).⁴⁷⁰

4.15.5 MHCA Forms used by the SAPS

4.15.5.1 MHCA 22 - Handing over custody by the South African Police Services (SAPS) of a person suspected of being mentally ill or severely or profoundly intellectually disabled and likely to inflict serious harm in terms of Section 40(1) of the MHCA

It is submitted that MHCA 22 (*Figure 44*) should be amended to enable the police officer to indicate whether the reasonable belief stems either from personal observation, or from information obtained from a mental health care professional. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment (*Figure 45*).

⁴⁶⁸ Landman and Landman 270.

⁴⁶⁹ *Ibid.*

⁴⁷⁰ *Ibid.*



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**HANDING OVER CUSTODY BY THE SOUTH AFRICAN POLICE SERVICES
(SAPS) OF A PERSON SUSPECTED OF BEING MENTALLY ILL OR
SEVERELY OR PROFOUNDLY INTELLECTUALLY DISABLED AND LIKELY TO
INFLECT SERIOUS HARM
[section 40(1) of the Act]**

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 professional that

.....
.....

(user's name or description if no name is available)
is suffering from a mental disability and is likely to inflict serious harm.

I have apprehended the person and have brought him / her to

(name of health establishment)
for 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:
(member of SAPS)

Date:

Time:

Place:

Figure 44 - MHCA 22

I
(name of head of health establishment or designated person)
accept 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 user will be assessed by two mental health care practitioners in terms of section 33 of the Act.

Signature:
(head of health establishment or designated person)
Date:
Time:
Place:
[Copy to be sent to SAPS to confirm in writing the physical condition as stated above during handing over of custody]

The SAPS hereby confirms that the physical condition as stated above was present during the handing over of 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:

Figure 45 - MHCA 22

4.15.5.2 MHCA 25 - Notice of abscondment to South African Police Service (SAPS) and request for assistance to locate, apprehend and return user in terms of Section 40(4), 44(1) and 57(1) of the MHCA

It is submitted that MHCA 25 is satisfactory regarding the information required to enable the SAPS to lawfully apprehend an absconded mental health care user (*Figure 46* and *Figure 47*). It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment (*Figure 47*).



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Republic of South Africa

MHCA 25

DEPARTMENT OF HEALTH

NOTICE OF ABSCONDMENT TO SOUTH AFRICAN POLICE SERVICE (SAPS)
AND REQUEST FOR ASSISTANCE TO LOCATE, APPREHEND

AND RETURN USER

[Sections 40(4), 44(1) or 57(1) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Date of admission to health establishment:

The above user absconded from:

(name of health establishment)

Address:
.....
.....
.....
.....

Date of abscondment:

User is: (mark with a cross)

Assisted user Involuntary user State patient Mentally ill prisoner

Figure 46 - MHCA 25



Diagnosis on medical condition:

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

Estimation of likelihood of doing harm to self or others: (mark with a cross)

Little chance	<input type="checkbox"/>	Reasonable chance	<input type="checkbox"/>	Highly likely	<input type="checkbox"/>	Extremely likely	<input type="checkbox"/>
Self/others		Self/others		Self/others		Self/others	

Circumstances of abscondment:

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

Attach full report (if available)

Your assistance in locating and apprehending the above user is appreciated

Print initials and surname:

Signature:
(head of health establishment)

Date:

Place:

[In case of an assisted- or involuntary user: copy of this notice to be submitted to head of provincial department]

[In case of a State patient: copy of this notice to be submitted to Registrar or Clerk of the relevant Court official *curator ad litem* and head of national department]

[In case of a mentally ill prisoner: copy of this notice to be submitted to head of the prison from where the user was initially transferred and to head of national department]

Figure 47 - MHCA 25

4.15.5.3MHCA 26 - Notice of return of absconded user to the health establishment in terms of Section 40(4), 44(1) and 57(1) of the Act

It is submitted that MHCA 26 is satisfactory regarding the information required to enable the SAPS to lawfully apprehend an absconded mental health care user (Figure 48 and Figure 49). It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment (Figure 49).



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DEPARTMENT OF HEALTH

NOTICE OF RETURN OF ABSCONDED USER TO THE HEALTH
ESTABLISHMENT

[Sections 40(4), 44(1) or 57(1) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Date of admission to health establishment:

The above user absconded from:
(name of health establishment)

Address:
.....
.....
.....
.....

Date of abscondment:

Date of return:

Returned by (e.g. SAPS, self, relative):

Figure 48 - MHCA 26

State physical / mental condition:

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

Print initials and surname:
(head of health establishment)

Signature:

Date:

Place:

[In case of an assisted- or involuntary mental health care user: copy of this notice to be submitted to head of provincial department]

[In case of State patient: copy of this notice to be submitted to Registrar or Clerk of the relevant Court, official *curator ad litem* and head of national department]

[In case of a mentally ill prisoner: copy of this notice to be submitted to the head of the prison from where the user was initially transferred and to head of national department]

Figure 49 - MHCA 26

4.16 Transfer of mental health care users between health establishments or to a maximum security facility

The transfer of involuntary mental health care users between health establishments and to maximum security facilities is discussed in this chapter. The transfer of State Patients and mentally ill prisoners between health establishments and to maximum security facilities is discussed in Chapter 5.

Section 39(1) provides that the head of a health establishment may submit a request in writing to the relevant Review Board for an order for transfer of an assisted or involuntary mental

health care user to a health establishment with maximum security facilities if the user has previously absconded or attempted to abscond;⁴⁷¹ or inflicted or is likely to inflict harm on others in the health establishment.⁴⁷² The head of the health establishment must submit a copy of the report to the applicant to enable the applicant to submit representations to the Review Board on the merits of the transfer.⁴⁷³ The Review Board must not approve the request to punish the mental health care user concerned;⁴⁷⁴ or if not satisfied that the mental health status of the user warrants a transfer to maximum security facilities.⁴⁷⁵

If the Review Board approves the request it must forward a copy of the order concerned to the head of the health establishment and the head of the relevant provincial department.⁴⁷⁶ Within 14 days of receipt of the order, the head of the provincial department concerned must make the necessary arrangements with the appropriate health establishment and effect the transfer as ordered.⁴⁷⁷ The head of a health establishment may, with the concurrence of the head of the health establishment with maximum security facilities, effect transfer pending the decision of the Review Board if the conduct of the mental health care user has or is likely to give rise to an emergency.⁴⁷⁸

Regulation 22 of the General Regulations to the MHCA determines that the head of a health establishment may in terms of Section 39(1) of the Act in the form of form MHCA 19 request the Review Board concerned to order the transfer of an assisted-or involuntary mental health care user and a State Patient or mentally ill prisoner to another health establishment or a designated health establishment with a maximum security facility.

⁴⁷¹ Section 39(1)(a) of the MHCA.

⁴⁷² Section 39(1)(b) of the MHCA.

⁴⁷³ Section 39(2) of the MHCA.

⁴⁷⁴ Section 39(3)(a) of the MHCA.

⁴⁷⁵ Section 39(3)(b) of the MHCA.

⁴⁷⁶ Section 39(4) of the MHCA.

⁴⁷⁷ Section 39(5) of the MHCA.

⁴⁷⁸ Section 39(6) of the MHCA.

4.16.1 MHCA forms used in the transfer of mental health care users

4.16.1.1 MHCA 19 - Request by head of health establishment to Review Board to transfer-

- a) An assisted or involuntary mental health care user in terms of Section 39(1) of the MHCA to maximum security facilities;
- b) A State Patient between designated health establishments in terms of Section 43 of the MHCA; or
- c) A mentally ill prisoner between designated health establishments in terms of Section 54(2) of the MHCA



MHCA 19

DEPARTMENT OF HEALTH

REQUEST BY HEAD OF HEALTH ESTABLISHMENT TO REVIEW BOARD TO TRANSFER -

- (a) an assisted or involuntary mental health care user in terms of section 39(1) of the Act to maximum security facilities;**
- (b) a State patient between designated health establishments in terms of section 43 of this Act; or**
- (c) a mentally ill prisoner between designated health establishments in terms of section 54(2) of the Act.**

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Health establishment from where the request is made:

State clearly the reason(s) for the request:

.....

.....

.....

.....

Has the user previously absconded or attempted to abscond? Yes No

Explain circumstances:

.....

.....

.....

.....

Figure 50 - MHCA 19

It is submitted that MHCA 19 (*Figure 50*) must be amended to clearly indicate to which of the scenarios of transfer the request pertains to. It is further submitted that MHCA 19 is satisfactory regarding the information required (*Figure 50* and *Figure 51*). It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment (*Figure 51*).

Has the user inflicted harm on others at the health establishment? Yes No

Explain circumstances:

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

In your opinion is the user likely to inflict harm on others in the health establishment

Yes No

Explain:

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

Other reason(s) for making the request:

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

Print initials and surname

Signature:

(head of health establishment)

Date:

Place:

Figure 51 - MHCA 19

4.16.1.2 MHCA 20 - Order by Review Board to Transfer

- a) *An assisted or involuntary mental health care user in terms of Section 39(1) of the MHCA to maximum security facilities;*
- b) *A State Patient between designated health establishments in terms of Section 43 of the MHCA; or*
- c) *A mentally ill prisoner between designated health establishments in terms of Section 54(2) of the MHCA.*

It is submitted that MHCA 20 (*Figure 52*) must be amended to clearly indicate to which of the scenarios of transfer the request pertains to. It is further submitted that MHCA 20 is satisfactory regarding the information required (*Figure 52* and *Figure 53*). It is submitted that the form should be amended to add check boxes to enable the Review Board to indicate clearly which points the Board have considered, and to add additional spaces to mention other information also considered (*Figure 52*).



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Republic of South Africa

DEPARTMENT OF HEALTH

ORDER BY REVIEW BOARD TO TRANSFER -

- (a) an assisted or involuntary mental health care user in terms of section 39(4) of the Act to maximum security facilities;
- (b) a State patient between designated health establishments in terms of section 43(3) of this Act; or
- (c) a mentally ill prisoner between designated health establishments in terms of section 54(2) of the Act.

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Health establishment making the request:

The Review Board of

(name of Review Board)

have considered documentation and representation relevant to the transfer of the above user to a maximum security facility.

The Review Board have considered *inter alia* that:

- (a) the transfer is not being done in order to punish the user.
- (b) The transfer is warranted taking cognizance of the mental health status of the user.

Reason(s) for transfer:

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

Figure 52 - MHCA 20

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

The above user must be transferred to a health establishment with maximum security facilities.

Print initials and surname

Signature:

(chairperson of Review Board)

Date:

Place:

[Copy to:

- with respect to assisted- and involuntary mental health care users, this order must be sent to the head of the provincial department.
- With respect to State patients and mentally ill prisoners the order must be sent to the head of the national department]

Figure 53 - MHCA 20

4.17 Offences and penalties under the MHCA

Section 70(1) determines that it is an offence for any person to:

- a) Misrepresent a fact in any application, report, record, certificate;
- b) Obstruct or hinders any person in the performance of his or her functions;
- c) Neglects, abuses or treats a mental health care user in any degrading manner or allows the user to be treated in that manner;
- d) Assist or incite a mental health care user -
 - (i) To abscond from a health establishment at which they are admitted; or
 - (ii) Not to comply with any care, treatment and rehabilitation plan or terms of a leave of absence or conditional discharge; or
- e) Refuse to furnish information or provides false information to a member of the South African Police Service about the whereabouts of a mental health care user who has absconded or is deemed to have absconded.

Any person found guilty of an offence under this Act is liable on conviction to a fine or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment.⁴⁷⁹

4.18 Miscellaneous general regulations to the MHCA

4.18.1 Compulsory records

Regulation 44 determines that the following records must be kept in a health establishment designated to serve as a psychiatric hospital or care and rehabilitation centre in terms of Section 5 of the Act:

- a) A register recording the admission, discharge, death, transfer and change in legal status of every mental health care user in that facility and leaves of absence or abscondment;
- b) A medical record of all information concerning the physical and mental health of a mental health care user and records of treatments which have been prescribed and administered including the date on which an entry into such records has been made, the full signature, name in print and all the qualification(s) of the mental health care practitioner who made that entry;
- c) Administrative records of legal documents and copies of correspondence concerning the mental health care user; and
- d) A record of any minor or major injury sustained by a mental health care user in that psychiatric hospital or care and rehabilitation centre.

4.18.2 Monthly reports

The head of a health establishment must on a monthly basis submit to the head of the provincial department a return of the number of patients, their legal status and the information contemplated in Regulation 44.⁴⁸⁰

⁴⁷⁹ Section 70(2) of the MHCA.

4.18.3 Payment of maintenance costs and expenses in health establishments

Regulation 46(1) determines that voluntary or assisted mental health care users must be assessed and charged according to a patient fee structure. Appeals against a fee contemplated in Regulation 46(1) must be directed for consideration to the head of the health establishment concerned.⁴⁸¹ An involuntary mental health care user is exempted from payment of a fee contemplated in Regulation 46(1).⁴⁸² An awaiting trial prisoner admitted for observation in terms of the Criminal Procedure Act, must be charged in accordance with the tariff agreed to between the Department of Health and the Department of Justice and Constitutional Development and must be paid by the latter Department.⁴⁸³ A mentally ill prisoner admitted for treatment must be charged in accordance with the tariff agreed to between the Department of Health and the Department of Correctional Services and must be paid by the latter Department.⁴⁸⁴

4.19 Concluding remarks

This chapter comprehensively describes the procedures and forms prescribed by the MHCA and its regulations regarding voluntary, assisted and involuntary mental health care users, while suggesting the ways in which provisions should be interpreted or, where applicable, amended to be in line with the constitutional values and principles of science based medicine discussed in Chapters 2 and 3. A main feature of the chapter is the reflection on the MHCA forms and the manner in which they should be completed, whether they are satisfactory and in line with the objects of the legislator, and suggestions for their amendment. Furthermore the mechanisms to ensure accountability and transparency were discussed, as well as the role of the SAPS in terms of the MHCA.

The main objections to provisions in the MHCA are concerned with issues of clarity to ensure a minimum possibility of misunderstanding and miscommunication among the different role

⁴⁸⁰ Regulation 40 of the General Regulations to the MHCA.

⁴⁸¹ Regulation 46(2) of the General Regulations to the MHCA.

⁴⁸² Regulation 46(3) of the General Regulations to the MHCA.

⁴⁸³ Regulation 46(4) of the General Regulations to the MHCA.

⁴⁸⁴ Regulation 46(5) of the General Regulations to the MHCA.

players charged with the care of mental health care users; as well as issues of lack of training of mental health care practitioners and the SAPS; and lack of guidelines to ensure that MHCA forms are completed correctly.

The MHCA complies with many MI Principles discussed in Chapter 2. Apart from Chapter III of the MHCA that protects the rights of mentally ill persons in line with MI Principle 1, MI Principle 4 is reflected in Section 12 of the MHCA that provides that a determination of mental health status should not be based on cultural, socio-political or economic background.⁴⁸⁵ MI Principle 12 on the notice of rights is reflected in Section 17 of the MHCA.⁴⁸⁶ The MHCA further recognises that the concurrence of two medical practitioners and the requirement of dangerousness is essential for involuntary detainment, and that the involuntary detainment should be brief pending a review to ensure that the rights of an individual are not unnecessarily infringed upon.⁴⁸⁷ Both the MI Principles and the MHCA contain provisions relating to the creation of mental health review boards, periodical reviews and the right to appeal.⁴⁸⁸ According to the WHO, the MHCA is consistent with international human rights standards and appears to be a highly appropriate and important milestone in the development of the mental health system in South Africa.⁴⁸⁹ Despite this, the WHO has noted that it does not appear to be enough to bring forward major reforms greatly needed in South Africa's mental health system.⁴⁹⁰

The MHCA is, in general, a piece of legislation lauded for its paving the way to better respecting the rights of mentally ill persons and providing adequate care. Apart from the necessary amendments pointed out in this chapter to ensure the infringement of users' rights is limited and justified, the next question to be answered after the legislative framework has been established is that of implementation and its influence on the protection of rights. The general standard of implementation of the MHCA has been described as "pretty horrific" by

⁴⁸⁵ McCrea, N.L. (2010) 'An Analysis of South Africa's Mental Health Legislation' Digital Commons @ American University Washington College of Law 1-8 5.

⁴⁸⁶ *Ibid.*

⁴⁸⁷ *Ibid.*

⁴⁸⁸ *Ibid.*

⁴⁸⁹ *Ibid.*; WHO (2008) *Mental Health Policy Development and Implementation in South Africa: A Situation Analysis* 10.

⁴⁹⁰ *Ibid.*

Dr Zabow (Emeritus Professor of Psychiatry at the University of Cape Town) in 2010.⁴⁹¹ The provincial government has been urged to invest more funds to improve mental health human resources and infrastructure at all health establishments and to recommend education of mental healthcare professionals and the public on a “massive scale”.⁴⁹² The barriers to successful implementation of the MHCA, particularly concerning resource constraints such as human resources and infrastructure, are discussed in Chapter 6 to determine whether the State is properly facilitating the implementation of the MHCA to prevent human rights abuses in accordance with its Constitutional duties.

⁴⁹¹ Bateman, C. (2012) 'Dismal use of legal safety net for mental health patients' 102 *SAMJ* 2 68-69 68.

⁴⁹² *Ibid*; Moosa MYH, Jeenah FY (2010) 'A review of the applications for involuntary admissions made to the Mental Health Review Boards by institutions in Gauteng in 2008' *South African Journal of Psychiatry* 16(4) 125-130.

CHAPTER 5: MENTALLY DISORDERED PERSONS IN CRIMINAL LAW, CRIMINAL PROCEDURE AND CORRECTIVE SERVICES

5.1 Introduction

In this chapter the discussion turns to mental health in the criminal justice system, as the Criminal Procedure Act 51 of 1977 (hereafter referred to as the CPA) and the Mental Health Care Act 17 of 2002 (hereafter referred to as the MHCA) create another avenue through which mentally ill accused persons or prisoners may become mental health care users. The different categories of mental health care user, namely voluntary, assisted and involuntary users, were discussed in Chapter 4. In Chapter 3, the medical science of psychiatry and psychology that underlie legal concepts was discussed to create a framework against which the terminology employed in criminal law and in the CPA can be evaluated to establish whether current legal principle is based on a solid scientific foundation. This is necessary to determine whether current law can be reconciled with the medical and scientific community, or whether it must be amended. It is submitted that legal principles that are not founded on an evidence-based framework are inherently arbitrary and should be amended to prevent the infringement of rights.

South African criminal law is discussed in this chapter, with a focus on the multiple ways in which a mental disorder may impact the elements of a crime to absolve an accused of guilt or lead to mitigation of sentence. Criminal Procedure, specifically the workings of Chapter 13 of the CPA, is critically discussed to illustrate the process where an accused lacks capacity to stand trial due to a mental disorder, or contends that a mental disorder has negated their criminal capacity and is therefore exculpatory. In addition, the MHCA and its Regulations regarding State Patients and mentally ill prisoners is discussed, as well as the MHCA forms that pertain to these categories of mental health care user. It is outside the scope of this thesis to present a detailed account of all criticisms and nuances on the ways in which criminal law and procedure operates regarding mental health, as the main purpose of the discussion is to provide a backdrop for the analysis of whether the provisions of the Criminal Procedure Act and MHCA are meeting the aims of the legislator while respecting the rights of mentally ill

offenders, mental health care users and mentally ill prisoners.¹ Particular focus is given to the internal logical consistency of provisions in the CPA and MHCA, as well as the composition of the MHCA forms as their wording and interpretation have a great impact on the manner in which mentally ill accused persons, State Patients and prisoners are dealt with.

5.2 Criminal justice principles

To provide a backdrop for the discussion on mental health in criminal law and criminal procedure it is necessary to consider the principles on which the criminal justice system is modelled, as well as the ultimate aims of punishment, without which it is difficult to evaluate the legitimacy of the goals of legal rules and provisions. The process of law enforcement and criminal justice is subject to the influence of a wide range of cultural and political forces that value goals according to different priorities, and is not only shaped by the law in books.² McConville opines that the criminal procedure of any country is the present day incarnation of a process in constant evolution and should be analysed and understood by looking at the underlying principles of criminal justice.³ He also rightly cautions that when investigating a criminal justice system, it is easy to fall into the trap of thinking they are inevitable and have a clear rationale, though it may be difficult to ascertain.⁴ Ashworth and Redmayne support the view that procedure in a system of criminal justice should serve the rule of law by making decisions consistent, predictable and non-arbitrary.⁵

There are many theoretical frameworks within which criminal justice can be evaluated, all of which have their own merits and shortcomings. These approaches include Herbert Packer's

¹ Excellent sources for further reading on criminal law with regard to mental health include: Burchell, J.M., Milton, J. 'South African Criminal Law and Procedure Volume I: General Principles of Criminal Law' 4th Edition 2011; Kruger, A. 'Hiemstra's Criminal Procedure' 2008; Snyman, CT 'Strafreg' 5th Edition 2006; Van Oosten (1993) 'Non-pathological criminal incapacity versus criminal incapacity' SACJ 127.

² Bottomley, A.K. 'Monitoring and Understanding Criminal Justice: Statistics, Research and Evaluation' in McConville, M and Wilson, G (eds.) 'The Handbook of the Criminal Justice Process' 2002; Spamers, M. 'Mental incapacity in the criminal justice system: A comparative study across jurisdictions' (MPhil dissertation, 2012, University of Cambridge) 19

³ McConville, M. 'Introduction' in McConville, M and Wilson, G (eds.) 'The Handbook of the Criminal Justice Process' Oxford: OUP 2002; Spamers 2012 19

⁴ *Ibid.*

⁵ Ashworth, A. and Redmayne, M. *The Criminal Process* (3rd edn) Oxford: OUP 2005; Spamers 2012 20

models of Crime Control and Due Process,⁶ Roach's punitive and non-punitive model of victim's rights, the metaphor of balancing, Jeremy Bentham and John Stuart Mill's utilitarian perspective, and consequentialism, of which an in-depth discussion does not fall within the scope of this dissertation.⁷ All these approaches have in common that they are in some way contrary to, or neglectful of, a human rights perspective. Consequentialism and utilitarianism basically advocate the approach that would cause least pain, or put differently, the most benefit for the majority of people. The risk here is that the individual rights of minority groups might be sacrificed for the good of the majority, which is inconsistent with human rights requirements.

Packer's models of Crime Control and Due Process,⁸ are two distinct and opposing ideologies that explain the opposing values that underlie the South African criminal justice system.⁹ Joubert opines that the two models are not necessarily mutually exclusive and that no system of criminal justice is based solely on the tenets of a single value system, but rather that it is an issue of balance and emphasis.¹⁰ The central value of the crime control model is the effective, efficient prevention of crime based on the proposition that the repression of criminal conduct is by far the most important function to be performed by the criminal process.¹¹ The Crime Control model values efficiency above formality, speed above deliberation, and results above means.¹² Although the Due Process model accepts that it is necessary to suppress crime, its central value is the protection of the constitutionally recognised rights of citizens and it is structured as a system of checks designed to ensure that the citizen taken up in the process is not denied any constitutional right to which he is entitled.¹³

⁶ Packer, H.L. 'The limits of the Criminal Sanction' 1969 158; Joubert JJ (ed.) 'Criminal Procedure Handbook' 9th edition 2009 8.

⁷ For further discussion of these approaches refer to: Packer, H.L. *The limits of the criminal sanction* Stanford: Stanford University Press 1968; Roach (1999) 'Four Models of the Criminal Process' 89(2) *Journal of Criminal law and Criminology* 671; Quinton, A. (1989) *Utilitarian ethics*, London : Duckworth; Darwall, S. (2003) *Consequentialism* Oxford: Blackwell; Hopkins-Burke, R. (2011) *Criminal justice theory* Abingdon, Oxon: N.Y. : Routledge; Joubert JJ (ed.) *Criminal Procedure Handbook* 9th edition (2009) 10-12; Burchell and Milton 8.

⁸ Packer 158. Joubert 8; Burchell and Milton 106-111.

⁹ Milton, JRL. (1987) 'Criminal Law in South Africa 1976-1986' *Acta Juridica* 34-54 35.

¹⁰ Joubert 8.

¹¹ Packer 158; Milton (1987) *Acta Juridica* 35.

¹² Packer 158-159; Milton (1987) *Acta Juridica* 35.

¹³ Packer 163-165; Milton (1987) *Acta Juridica* 35.

In South Africa the enactment of the Constitution and its Bill of Rights makes it clear that the Due Process model is to be favoured, although the inclusion of the limitation clause (Section 36 of the Constitution),¹⁴ means that rights are not absolute and may be limited in the correct circumstances.¹⁵ This is further underlined by the role of legality and the rule of law as values that underlie the supreme Constitution. The rule of law stands even in matters of criminal law where the interests of victims and the community are considered, but the rights of accused persons must remain intact throughout the criminal process.¹⁶

The concept of “balance” has been given a central role in the dialogue of criminal justice by governments, policy-makers, courts and other relevant bodies.¹⁷ There are many conflicting goals and interests in criminal justice and those employing “balancing” terminology must not fail to stipulate exactly what is being balanced and what weight is attached to each factor.¹⁸ “Balance” and “proportionality” are seemingly understood in terms of a trade-off between a conception of public interest where human rights issues are largely ignored, and the rights of the individual. Ashworth and Redmayne do not argue that “balancing” has no place in reasoning about criminal process, it should be employed with caution and reiterate that some rights are too fundamental to be “balanced”.¹⁹

James and Raine portray criminal justice policy as being shaped by four key factors, namely politicisation, managerialism, administrative processing and public voice. Each factor contributes its own logic and rationale based on a set of values, has made its own mark on

¹⁴ Section 36 of the Constitution provides as follows:

"36(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including—

- (a) the nature of the right;
- (b) the importance of the purpose of the limitation;
- (c) the nature and extent of the limitation;
- (d) the relation between the limitation and its purpose; and
- (e) less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights."

¹⁵ The Bill of Rights and limitation clause has been extensively discussed in Chapter 2 of this thesis and its values and principles remain relevant in this Chapter.

¹⁶ Joubert 10, Snyman 41; Section 7 of the Constitution. The rights of accused and detained persons as guaranteed in Section 35 of the Constitution is discussed in Chapter 2.

¹⁷ Ashworth and Redmayne (2005); Spamers 2012 21

¹⁸ *Ibid.*

¹⁹ *Ibid.*

policy and practice and each has its own legitimacy, though they are often at odds with one another.²⁰ Increasing managerialism of criminal justice require all agencies to be more efficient and cost effective at a time of more politicization of law and order.²¹ James and Raine emphasise a need for increased public voice and participation as a counter measure. The argument is that certain problems in criminal justice may reflect the fact that public opinion was not always understood or taken into account by policy makers and legislators, and that the public are not well informed about the circumstances surrounding the problem of crime or the criminal justice agencies and their processes.²² In terms of managerialism in South African criminal law and procedure, and mental health establishments, resource management and assignment plays a large role in whether the goals of the criminal justice system can be attained and whether the rights of mentally ill offenders are respected. This aspect is discussed in Chapter 6.

5.3 The theories of punishment

In the discussion on mentally ill persons in the criminal process it is useful to consider the aims of punishment in order to determine whether provisions regarding such offenders are legitimate in their goals. The purpose of the theories of punishment is not only the justification of the criminal process, but also in answering whether the scope of sentencing and other consequences in the criminal law are just in specific cases.²³ The different theories can be grouped into absolute, utilitarian and combined categories.²⁴ The absolute theory is that retribution is the only purpose of the criminal process.²⁵ The utilitarian theories view punishment the means through which other goals can be achieved, namely rehabilitation, deterrence (individual or general), and prevention.²⁶ South African courts accept that no single theory is entirely comprehensive of the aims of punishment and therefore a combination of all of the theories operates in the criminal law.²⁷ Each of these theories must

²⁰ James, A. And Raine, J. 'The new politics of criminal justice' 1998 20; Spamers 2012 20.

²¹ Bottomley 34; Spamers 2012 21.

²² James and Raine 24; Spamers 2012 21.

²³ Snyman 13.

²⁴ Snyman 13; Burchell and Milton 71-80.

²⁵ Burchell and Milton 69; Terblanche 'A guide to sentencing in South Africa' 2nd ed. 2007 165-169.

²⁶ Snyman 13; Burchell and Milton 71-80; Terblanche 156-164.

²⁷ Snyman 22-23; Terblanche 174.

be considered regarding the crime, the criminal, and the interests of the community, as was determined in the *Zinn* case.²⁸

A balance must be achieved between each of these interests and theories, and the alternative punishments or options available.²⁹ In cases concerning mentally ill offenders who lack criminal capacity, it must be considered which of these must carry more weight, and even whether certain theories apply. In considering the offender who lacks capacity, it immediately becomes clear that the retribution theory cannot apply, as one cannot be punished if they cannot be held accountable.³⁰ The interests of the offender further discount individual deterrence as a reason to punish, as the offending conduct is motivated by reasons other than criminal desire. General deterrence of the community is also discounted for the same reasons, otherwise punishment sends the message that therapeutic and preventative measures are cast aside in favour of harsh and undeserved measures not addressing the cause of the offending conduct. The need for rehabilitation is highlighted, which would also lead to prevention of further crime by the same individual in future if successful. The interests of the community include protection from dangerous individuals, which justifies detention of such individuals until the risk of harm to the community has passed. Though it is also in the interest of the community that mental health care measures are in place to ensure prevention of crime in future. Against this backdrop the legal position in the criminal law, and criminal procedure is considered below.

5.4 Mental health in criminal law

South Africa has a common law and largely uncodified criminal law that relies on five principles of criminal liability to be present before an offender may be guilty of a crime.³¹ The five requirements for criminal liability are legality, an act or omission, unlawfulness, criminal capacity and fault; whilst the three elements of a crime are an act or omission, unlawfulness

²⁸ 1969 (2) SA 537 (A); Snyman 23; Terblanche 147-155.

²⁹ *S v Makwanyane* 1995 (3) SA 391 (CC) par 448 B-C; Burchell and Milton 85; Terblanche 146.

³⁰ Snyman 157.

³¹ Burchell and Milton 138.

and fault, of which each are enquired into in sequence.³² This means that one cannot have unlawful conduct without voluntary conduct, nor can an accused be at fault without having the requisite criminal capacity (after it has been determined that an unlawful act had been committed by the accused). Conduct that constitute and offence is either prohibited by statutory or common law.³³

Mental illness may affect different requirements of criminal liability in that it may negate the voluntary conduct requirement, it may affect the criminal capacity of the offender, the unlawfulness of the conduct, or it may affect the offender's *mens rea* or fault.³⁴ Direct evidence of a person's mental condition at the time when they were involved in the commission of a crime is seldom available and whether a person lacked capacity at a specific point in time needs to be proven by expert evidence.³⁵ However, the fact that mental state may affect criminal liability in a variety of ways, functioning as a multiple defence, creates a conflict with the mental health profession, as the legal constructs contained in criminal law do not necessarily reflect the mental health profession's schools of learning on corresponding mental disorders and their effects. This section will discuss how mental disorder affects an offender's possible defences to liability in a criminal trial and examines the related terminology.

In South African criminal law *mens rea* (fault, either in the form of intent or negligence) is required for accountability for a crime that has been committed.³⁶ *Mens rea* presupposes the presence of mental faculties that enable the person to act with the necessary fault, namely criminal capacity.³⁷ Criminal capacity is therefore a prerequisite for fault and criminal liability and a separate element of a crime in South African law.³⁸ Criminal capacity can be either pathological or non-pathological, the difference is discussed below, although this thesis will

³² Snyman 34-39; Burchell and Milton 138.

³³ *Ibid.*

³⁴ Van Oosten, FFW. (1990) 'The insanity defence: its place and role in the criminal law' 3 SACJ 1 1-9 1.

³⁵ Snyman 169, 170.

³⁶ Rumpff Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters RP 69 of 1697 (the Rumpff Report) par 9.1.

³⁷ *Ibid.*; Stevens, GP 'The role of expert evidence in support of the defence of criminal capacity' (LLD Thesis, UP, 2011) 17.

³⁸ Burchell and Milton 359; Snyman 157; S v Adams 1986 4 SA (A) 901; Van Oosten (1993) SACJ 129; Stevens 17; Kruger, A. 'Hiemstra: Suid-Afrikaanse Strafproses' 7th Ed (2010) Butterworths, Durban 202.

focus on pathological criminal incapacity, as non-pathological criminal incapacity does not lead to a person being admitted as mental health care user (State Patient) in terms of the MHCA.

5.4.1 Voluntary conduct

A voluntary human act or omission is required for criminal liability.³⁹ Voluntariness implies that the person's conduct is subject to their conscious will.⁴⁰ Absolute force or automatism can be raised as defences that excludes voluntary conduct.⁴¹ Conduct is generally deemed to be involuntary if it occurs during a state of automatism.⁴² Automatism occurs where a person acts in a mechanical fashion and can occur in a variety of ways, either due to pathological (internal) or non-pathological (external) causes.⁴³ Mental disorder can potentially cause a person to act in an automatic state, whereby they do not possess control over their bodily movements.⁴⁴ In such a case the accused will be dealt with in terms of Section 78(6) of the CPA which gives the court discretion to order that the accused must be admitted to a mental health care establishment.

It is not an easy task for the court to determine whether a person acted voluntarily, and it is submitted that expert evidence is necessary to lay a factual basis for a defence of automatism. The courts have used the presence of true amnesia as a factor indicating that the accused had

³⁹ Snyman 53-58; Burchell and Milton 179; S v Henry 1999 (1) SACR 13 (SCA) at 19; Stevens 43.

⁴⁰ Snyman 53-58; Burchell and Milton 179.

⁴¹ Snyman 57-58, 172; Burchell and Milton 180. Absolute force implies the voluntary muscle movements of the accused are controlled physically by another person or outside factor, for example where another person places their hand over the hand of the accused when holding a gun or knife, and physically overpowers them into pulling the trigger or stabbing a victim. Relative force refers to a situation where the accused is not physically overpowered, but rather forced to act via threats or coercion, which would not exclude the voluntariness of their act, but rather unlawfulness or intention.

⁴² Stevens 44; Burchell and Milton and Milton; Snyman 58.

⁴³ Including sneezing fits, epileptic episodes, and sleepwalking. Snyman 60; Stevens 44; Burchell and Milton 180-182. Automatism due to external factors is also referred to as 'sane automatism' as it arises from causes other than mental illness, whereas automatism due to pathological factors is referred to as 'insane automatism'. A full discussion and critique of this terminology lies outside the scope of this thesis.

It is submitted that terminology referring to 'sane' and 'insane' automatism is inaccurate and confusing (Louw 38), as well as being politically incorrect and unacceptable. It is recommended that this terminology be avoided and that insane automatism rather be referred to as automatism due to mental pathology and sane automatism as automatism not due to mental pathology (Louw 38; Spammers, M. 'A critical analysis of the psycholegal assessment of suspected criminally incapacitated accused persons as regulated by the Criminal Procedure Act' (LLM dissertation, 2010, University of Pretoria, Pretoria) 18-19.

⁴⁴ Snyman 172.

been acting in an automatic state at the time of the commission of the act. Often persons acting in an automatic state have clear and vivid memories of events leading up to the incident as well as afterwards, but cannot recall the offensive act, which is consistent with true amnesia.⁴⁵ In the case of *Henry* the court held that there is a difference between true or dissociative amnesia and psychogenic amnesia. The difference being that true amnesia implies true involuntariness and is consistent with a state of sane automatism, where psychogenic amnesia is the brain's way of suppressing unpleasant memories and does not indicate involuntariness.⁴⁶

5.4.2 Unlawfulness

Conduct is unlawful where it satisfies the descriptive elements of a crime, and the offender cannot rely on a ground of justification that would render the conduct lawful.⁴⁷ In this case “unlawfulness” means that the conduct was “unjustifiable”.⁴⁸ The grounds of justification include:⁴⁹ private defence, necessity, impossibility, superior orders, disciplinary chastisement, public authority, and consent.

Van Oosten⁵⁰ states that there is scant authority for the view that if a defence of mental disorder took the form of irresistible impulse it could negate the unlawfulness of the accused's act, either because it acts as a ground of justification, or because criminal prohibitions would

⁴⁵ Henry 1999 1 SACR 13 SCA. See also Hooctor, S. (2000) "Amnesia and criminal responsibility" 13 S Afr J Criminal Justice 3: 273-287.

⁴⁶ Henry 1999 1 SACR 13 SCA; Spammers 2010 16. Where malingering (the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs (DSM-5)) is suspected, there are mechanisms in place to ensure that an accurate diagnosis is made by the forensic assessor. Malingering in patients remains a factor that influences many opinions in the legal profession on whether mental disorder should be considered exculpatory in criminal matters. The discussion of malingering falls outside the scope of this thesis. See also: Resnick (1999) 'The detection of malingered psychosis' *The psychiatric clinics of North America* 172; Pensa (1996) 'Detection of Malingered Psychosis with the MMPI-2' *Psychotherapy in Private Practice* 47-63; Jelicic (2006) 'Detection of Feigned Psychosis with the Structured Inventory of Malingered Symptomatology (SIMS): A Study of Coached and Uncoached Simulators' *Journal of Psychopathology and Behavioral Assessment* 19-22; Erlacher, H.; Reid, I. "Detection of malingering" in Kaliski, S. (ed.) "Psycholegal assessment in South Africa" 2006 312- 316.

⁴⁷ Burchell and Milton 226; Snyman 93-95.

⁴⁸ Snyman 95.

⁴⁹ Snyman 101-146; Burchell and Milton 230-357. A full discussion of the grounds of justification are outside the scope of this thesis.

⁵⁰ Van Oosten (1990) SACJ 4.

not apply. He further states that this is an unconvincing argument and that where a person that alleges their innocence due to the presence of a mental disorder manifesting as an irresistible impulse, it could more readily be imagined to exclude the voluntariness of the act as it can be argued that the accused had no control over their own body.⁵¹ It is submitted that where a mental disorder caused a person to believe that they were acting under one of the grounds of justification, even though objectively that was not the case, that the defence would be a putative ground of justification that could possibly negate their intention (fault).

5.4.3 Criminal capacity

A person's criminal capacity may also be negated by mental disorder. Capacity is, in legal terms, a person's ability to perform a specific juristic act, and it is a threshold requirement and is needed if a person is to be held accountable for performing certain acts.⁵² The prosecution in a criminal case must prove, beyond reasonable doubt, that the accused possessed criminal capacity at the time of commission of a crime in order for that person to be held accountable.⁵³ The Rumpff Report describes three categories of mental function that form an integrated unit in persons to bestow on them criminal capacity, namely:⁵⁴

1. Cognitive functions, including the ability to perceive, think, reason, remember and to have insight;
2. Conative (volitional) functions, including ability to control behaviour by the voluntary exercise of free will (can also be described as "self-control");
3. Affective functions, including the capacity to experience emotions such as anger and jealousy.

With this in mind, criminal capacity is defined in terms of two legs, which are set out in Section 78(1)(a) and (b) of the Criminal Procedure Act, of which both requirements must be

⁵¹Van Oosten (1990) SAJC 5.

⁵² Burchell and Milton 359; Snyman 157; S v Adams 1986 4 SA 882 A at 901; Van Oosten 1993 SACJ 129.

⁵³ Burchell and Milton 358.

⁵⁴Rumpff Report par 9.10

present and proven for a person to be held criminally capacitated:⁵⁵

- The cognitive ability or the ability to understand and appreciate the wrongfulness of the act, as well as
- The conative ability or the ability to act in accordance with this understanding.

If either the cognitive or conative leg of the test for capacity is impaired in a significant way or absent in a person, due to either a pathological or non-pathological reason,⁵⁶ that person will be considered criminally incapacitated.⁵⁷ In addition to the two legs of the test for criminal capacity (the psychological test), a “biological” test also has to be satisfied, namely that the accused must, at the time of the commission of the alleged offence, have been subject to, certain specified physical (age limits) or mental (mental illness or mental defect) conditions.⁵⁸ Thus the test for criminal incapacity is a mixed one, combining biological and psychological elements, rather than a purely psychological one.⁵⁹ Although the affective functions are not part of the test for criminal capacity, it is possible that in certain circumstances the emotional state of the accused may negate either the cognitive or conative functions, leading to incapacity.⁶⁰ The test for criminal capacity is subjective concerning the mental state of the particular person involved.⁶¹

The “appreciation” referred to in the CPA is more than “knowledge” possessed by the accused, but also a capacity to evaluate the act and its effects on the accused himself and others possibly involved. A “deliberate judgement” or “perception” is implied.⁶² It is unclear

⁵⁵Act 51 of 1977; Rumpff Commission Report 94; Burchell and Milton 358; Snyman 159, 168; Van Oosten (1990) SACJ 5. It is clear from the content of Section 78(1) that the words “an act which constitutes an offence” do not refer to an offence for which the accused is liable, but only to an act which corresponds to the definitional elements of the relevant crime (Swanepoel, M ‘Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues’ (LLD thesis, 2009 Unisa) 216).

⁵⁶ Van Oosten 1993 SACJ 129; Burchell (1995) J “Non-pathological incapacity: Evaluation of psychiatric testimony” 8 S Afr J Criminal Justice 1: 37-42; Strauss SA (1995) “Nie-patologiese ontoerekenbaarheid as verweer in die strafreg” 16 S Afr Practice Management 4: 14-34.

⁵⁷ Rumpff Report 95; Burchell and Milton 358; Snyman 160; Van Oosten (1993) SACJ 129; Le Roux, Mureriwa ‘Paedophilia and the South African criminal justice system: a psychological perspective’ 2004 SACJ 41-5648.

⁵⁸Van Oosten (1993) SACJ 129.

⁵⁹*Ibid.*

⁶⁰ S v Arnold 1985 (3) SA 256 (CPD) at 263 C-D; Stevens 30.

⁶¹ Burchell, JM. (2003) ‘A provocative response to subjectivity in the criminal law’ Acta Juridica 23-47 23.

⁶² Burchell and Milton 381.

whether this “wrongfulness” that needs to be appreciated refers to legal wrongfulness, as opposed to moral wrongfulness.⁶³ It has been argued that this wrongfulness refers to moral wrongfulness and not knowledge of illegality alone.⁶⁴ A person who knows his conduct is illegal, but is under the impression that he is under a divine or moral obligation to commit the offence,⁶⁵ or has the mistaken belief that he was acting in self-defence due to hallucinations,⁶⁶ illustrates that a strict understanding of legal wrongfulness is insufficient. It has also been argued, however, that an evaluation of moral wrongfulness alone is vague and not always effective, with the example given of a mentally ill person who knowingly commits a crime whilst under the impression that its commission would be for the good of humanity.⁶⁷ It has been submitted that this “wrongfulness” should rather be formulated as whether a person knew the act was wrong according to the ordinary standard adopted by reasonable men.⁶⁸ Van Oosten opines that “wrongfulness” includes both the legal and moral wrongfulness of the act, which means that where the accused is capable of appreciating the former but not the latter, the reliance on mental illness as defence will not be available.⁶⁹

Section 78(1)(b) does not require that the urge be physically irresistible or based on a sudden, unplanned action as opposed to a reflection over a period of time. The formulation of the test as being an “irresistible impulse” as was the formulation of the M’Naghten Rules, is thus inaccurate, as not all mental illnesses manifest in impulsive actions.⁷⁰ The normal capacity for self-control needs to be significantly impaired, the accused need not have been subjected to an overpowering force (as the term “irresistible” implies).⁷¹ The court in *Kavin* held that a gradual disintegration of the mind resulting from a recognised illness or disorder is sufficient to significantly impair the conation leg of capacity and that a person should thus be held incapacitated.⁷²

⁶³ Burchell and Milton 367; Snyman 171; Louw, R. “Principles of Criminal Law: Pathological and non-pathological criminal incapacity” in Kaliski, S. (ed.) *Psycholegal assessment in South Africa* 200648.

⁶⁴ Snyman 171.

⁶⁵ Snyman 171.

⁶⁶ Kaliski 103.

⁶⁷ Burchell and Milton 378-379.

⁶⁸ Burchell and Milton 379.

⁶⁹ Van Oosten 1993 SACJ 131; Van Oosten (1990) SACJ 6.

⁷⁰ *S v Campher* 1987 1 SA 940 A.

⁷¹ Burchell and Milton 382; Kaliski 104.

⁷² 1978 2 SA 731 W. In this case the accused one evening shot his wife and two children. It was found on an enquiry into his mental state that the accused suffered from severe reactive depression that led to a state of

5.4.3.1 Pathological and non-pathological criminal incapacity

Pathological criminal incapacity is due to an organic brain disease, either a mental illness or mental defect.⁷³ It refers to conditions inherent to the individual, including such brain diseases as dementia and psychosis.⁷⁴ A pathological mental illness refers to a disease of the mind and it does not matter whether the illness is temporary or permanent, curable or incurable, or likely to recur or not.⁷⁵ The cause is also irrelevant, provided it is an internal cause. Physical illness elsewhere in the body than the brain may interfere with the mind as well. Mental malfunctions that occur after a blow to the head or consumption of drugs, for example, are external causes and do not result in mental illness,⁷⁶ except in the case of the *delirium tremens*.⁷⁷

A mental illness or defect is a threshold requirement for the defence of pathological criminal incapacity,⁷⁸ but the fact that a person suffers from a mental illness also does not automatically establish criminal incapacity.⁷⁹ Non-pathological criminal incapacity is of a temporary nature and is caused by the effects of external factors, such as youthfulness, intoxication, emotional stress or provocation.⁸⁰ In the case of *S v Stellmacher*,⁸¹ the court held that mental disorder means a “pathological disturbance of the accused's mental capacity and not a mere temporary mental confusion which is not attributable to a mental abnormality but rather to external stimuli such as alcohol, drugs or provocation.”⁸²

The distinction between pathological and non-pathological criminal incapacity is critical in

dissociation during which both assessors agreed that Kavin could not act in accordance with an appreciation of the unlawfulness of the act. Kavin was held to be not guilty due to criminal incapacity based on the second leg (conative function) of the test for criminal capacity.

⁷³ Snyman 169; Louw 38.

⁷⁴ Kaliski 97.

⁷⁵ Burchell and Milton 376; Louw 47; Snyman 169.

⁷⁶ Louw 47.

⁷⁷ See Substance-related disorders below.

⁷⁸ Burchell and Milton 359; Sec 78(1) of Act 51 of 1977.

⁷⁹ Burchell and Milton 177.

⁸⁰ Burchell and Milton 362, Louw 39; Kaliski 97; Snyman 161; Carstens and Le Roux “The defence of non-pathological incapacity with reference to the battered wife who kills her abusive husband” 2000 *SACJ* 13 181; Van der Merwe, RP. (1997) “Sielkundige perspektiewe op tydelike nie-patologiese ontoerekeningsvatbaarheid” 18 *Obiter* 1: 138-144.

⁸¹ 1983 (2) SA 181 (SWA) at 187.

⁸² Stevens 37; Swanepoel 217.

the legal system, firstly as expert evidence is required when pathological criminal incapacity is alleged,⁸³ whereas it is not a strict requirement when non-pathological incapacity is alleged.⁸⁴ Secondly, Burchell submits that the burden of proof is affected, as the onus is on the person who raises pathological criminal incapacity to prove on balance of probabilities that the accused was incapacitated and with non-pathological incapacity the onus is still on the State, with the accused having to raise reasonable doubt concerning his capacity.⁸⁵ Pathological criminal incapacity is basically a statutory defence that requires a pathological condition and must be proven by the accused, while non-pathological criminal incapacity is a common law defence that does not require a pathological condition and must be disproved by the prosecution.⁸⁶

The procedural difference between pathological and non-pathological criminal incapacity lies therein that a person acquitted because of non-pathological reasons, may go free, whereas a person acquitted because of pathological reasons needs mental health care and the court may order for them to be detained as a mental health care user.⁸⁷ In the case of *Nursingh*,⁸⁸ the accused was acquitted of the murder of family members following an “emotional storm” due to non-pathological criminal incapacity due to provocation, after the expert evidence led indicated that he was predisposed to violent reactions due to his family circumstances and sexual abuse. It was also held that the reason for his non-pathological state of mind was now no longer present and that he would not constitute a danger to the community if acquitted.

⁸³ Van Oosten describes expert evidence in this case as pivotal and that it is borne out by the fact that the legislation requires an enquiry by a panel of experts. Van Oosten 1993 SACJ 131.

⁸⁴ Van Oosten (1993) SACJ 141; Deane, T. (2006) ‘Criminal procedure: from the law reports’ 47 *Codicillus* 1 91-9392; Louw 39. In the case of *Calitz* 1990 1 SACR 119 A, the court held that the expert evidence was not indispensable, as the court could determine for itself whether the accused was in fact non-pathologically incapacitated on the facts. Van Oosten opines that the matter is not quite settled, as there are cases where it was held expert evidence is a prerequisite, while in other cases the court holds that it is unnecessary, as the court is in a position to rule on the facts alone. Carstens and Le Roux (2000) SACJ submit that expert evidence is essential for this defence to succeed, even though the position is unclear and though certain judgements suggest the courts do not deem it indispensable.

⁸⁵ Burchell and Milton 390. For a discussion of the possible problems that can result from this reverse onus, see Burchell and Milton 392-395 as it falls outside the ambit of this dissertation.

⁸⁶ Van Oosten (1993) SACJ 145; *S v Laubscher* 1988 (1) SA 163 (A) at 167 E-I.

⁸⁷ Section 78(6) of the CPA. The orders a court is authorised to make in terms of this section is discussed in this chapter below.

⁸⁸ 1995 2 SACR 331 D.

5.4.3.2 *Criminal incapacity versus automatism*

It is important to note the difference between criminal capacity and a voluntary human act, which are separate elements of criminal liability and have different requirements and defences,⁸⁹ though the conation leg of the criminal capacity test in cases where non-pathological criminal incapacity due to provocation is raised as a defence, has been confused with acting in an automatic state in recent years.⁹⁰ This lack of clarity is partly a result of the development of the defence of incapacity, particularly cases involving provocation and mental stress and partly as a result of its application in practice.⁹¹ The inability to act in accordance with an appreciation of wrongfulness must not be confused with the inability to wilfully control the movements of one's body.⁹² While criminal capacity is the ability to appreciate the wrongfulness of an act and act in accordance with this appreciation and is thus a psychological element, a voluntary human act is a physical element.⁹³ Criminal capacity refers to an ability or potential circumstance which the perpetrator possesses that justifies condemnation by the legal system.⁹⁴

The question with voluntariness is whether the conduct was willed and consciously controlled by the individual and thus whether they had physical control of their actions (as opposed to in an automatic state, like an epileptic attack, where the conscious will is "overridden").⁹⁵ During an automatism, Kaliski⁹⁶ states that a person has no control over his behaviour (thus a physical loss of control over his actions), which is usually inappropriate to the circumstances and "out of character" for the person. If a person lacks the conative ability to act in accordance with an appreciation of wrongfulness, it means that he does have voluntary

⁸⁹ Snyman 160; Ngobese 2002 (1) SACR 562 (W) 565; Pietersen 1983 (4) SA 904 (OK) 910; Spammers 2010 13.

⁹⁰ As in the case of Eadie 2002 (1) SACR 633 (SCA); Louw SACJ 2001 207.

⁹¹ Louw, R. (2001) "S v Eadie: Road Rage, Incapacity and Legal Confusion" South African Journal of Criminal Justice, Vol 14 206-216206.

⁹² Snyman 160.

⁹³ Snyman 160.

⁹⁴ Badenhorst 'Vrywilligedronkenskap as verweer teen aanspreeklikheid in die Strafreë – 'n Suiwerregsteoretiese benadering' 1981SALJ 151.

⁹⁵ Kaliski 107; Snyman 160; Lambrechts (2006) 'Die nie-patologiese ontorekeningsvatbaarheids-verweer van automatisme in die Suid-Afrikaanse strafreg' Interim: Interdisciplinary Journal 45. This was also reiterated in the case of Chretien 1981 1 SA 1097 A where the Appeal Court held that an act for the purpose of the criminal law can only be considered an act if it was controlled by the conscious will and is more than an involuntary muscle movement; Spammers 2010 14.

⁹⁶ Kaliski 106.

control over his muscle movements, but that he is unable to resist acting in a way contrary to his insight.⁹⁷ Criminal capacity is assessed subjectively, while the voluntariness of conduct is assessed objectively.⁹⁸ Where automatism due to non-pathological reasons is raised, the onus is on the state to prove beyond reasonable doubt that the conduct was voluntary,⁹⁹ and where criminal incapacity is raised, the onus differs as discussed above.

This separateness of criminal capacity and automatism has been reiterated by the courts many times, for example in the cases of *Ngobese*¹⁰⁰ and *Pietersen*.¹⁰¹ The court in the *Stellmacher* case held that the accused was not guilty, either on account of not acting voluntarily or, if he did act, that he was non-pathologically criminally incapacitated.¹⁰² Implicit in this conclusion is that the two represent separate elements and defences. A state of automatism excludes voluntariness by resulting in circumstances where a person loses intelligent control over their muscle movements. Thus the action is not under the conscious control of the person due to external, non-pathological factors not attributable to mental illness or mental defect.¹⁰³ Criminal liability would then be excluded, as a voluntary act is required. Such a loss of voluntariness differs from a simple loss of temper, as illustrated in the cases of *Henry*¹⁰⁴ and *Macdonald*.¹⁰⁵ In *Henry* the court required an identifiable trigger of an extreme nature and in *Macdonald* the court an identifiable trigger of an extraordinary nature.

It is accepted that for a person to have acted in an automatic state due to non-pathological factors, the person needed to have been subjected to a great deal of stress that resulted in internal tension, building to a climax after the person has endured ongoing humiliation and stress. The automatic state is then triggered by an event unusual in intensity or unpredictable in its occurrence.¹⁰⁶ The cognitive functions are absent and the actions of the person are thus unplanned and the accused is unable to appreciate surrounding events. Acts by the accused

⁹⁷ Snyman 164.

⁹⁸ Louw 2001 SACJ 207.

⁹⁹ Snyman 172.

¹⁰⁰ 2002 1 SACR 562 W 565.

¹⁰¹ 1983 4 SA 904 OK 910.

¹⁰² 1983 2 SA 181 SWA.

¹⁰³ Kaliski 107.

¹⁰⁴ 1999 1 SACR 13 SCA.

¹⁰⁵ 2000 2 SACR 493 N.

¹⁰⁶ Kaliski 105.

may appear purposeful but are typically out of character and after the event the accused would make no attempt to escape and would usually have amnesia regarding the event, but be able to remember preceding and subsequent events. Conduct is thus automatic, involuntary, reflexive, uncontrolled, unconscious, not goal directed and not motor controlled, where the person is in a dissociative state.¹⁰⁷

5.4.3.3 Criminal capacity: A legal or medical term?¹⁰⁸

There is no definition of mental illness or mental defect in the Criminal Procedure Act and even though mental illness is defined in the Mental Health Act as meaning “a positive diagnosis of a mental health-related illness in terms of accepted diagnostic criteria made by a mental health practitioner authorised to make such a diagnosis,”¹⁰⁹ the definition is not binding in a criminal trial.¹¹⁰ Van Oosten states that “mental illness” and “mental defect” is not clearly defined by the legislator, as it remains an issue of expert evidence to be adjudicated upon by the courts.¹¹¹ Burchell and Milton submit that the essential distinction between mental illness and mental defect is that mental defect constitutes a mental state identifiable by an intellect so exceptionally low as to deprive the accused of the normal cognitive or conative capacities.¹¹² There is no closed list of mental illnesses or defects in criminal law, and each presentation of mental illness in each individual will also be different from the next person, even those with similar afflictions may differ in significant ways.¹¹³ An accused’s criminal capacity needs to be determined in each case individually and as the test is wholly subjective to the particular individual, the particular degree in which mental illness affects capacity in each case will be different.¹¹⁴

¹⁰⁷ Kaliski 105

¹⁰⁸ Chapter 3 includes a discussion of mental disorders, their systems of classification, and the use of these classifications in forensic settings.

¹⁰⁹ Act 19 of 1973.

¹¹⁰ Louw 46; Le Roux, J. and Stevens, GP (2012) 'Pathological criminal incapacity and the conceptual interface between law and medicine' SACJ 1 44-66 50.

¹¹¹ Van Oosten 1993 SACJ 132. This is also the view of Kaliski in (2009) South African Journal of Psychiatry 4.

¹¹² Burchell and Milton 358; Le Roux, J. and Stevens, GP (2012) 'Pathological criminal incapacity and the conceptual interface between law and medicine' SACJ 1 44-66 47.

¹¹³ DSM-5 xxxii.

¹¹⁴ Louw 47; Snyman 169.

In the case of *S v Mahlinza*¹¹⁵, the court held that due to a lack of definition of the concept of mental illness, medical psychiatric evidence becomes indispensable.¹¹⁶ The court also held that in the light of the fact that a court has to assess each case according to the facts and the medical psychiatric evidence before it, it would be impossible and also dangerous to attempt to identify a general symptom whereby it may be diagnosed as a pathological mental disorder as this could amount to speculation by the courts in a field which they do not have expertise in.¹¹⁷ Such an approach could be medically and scientifically unjust.¹¹⁸ For purposes of the defence of pathological criminal incapacity in South Africa there is therefore no formal definition of mental illness.¹¹⁹

While capacity in the legal sense refers to the ability to perform a specific juristic act, with criminal capacity encompassing the cognition to appreciate wrongfulness and the conation to act in accordance with this appreciation, capacity in the medical sense relates to the clinical evaluation of an individual's functional ability to make “autonomous, authentic decisions about his or her own life.”¹²⁰ A diagnosis of mental illness by a mental health professional does not necessarily simultaneously address the question if a person can be held to be legally responsible or competent.¹²¹ Additionally, legal systems generally fail to recognise that there are different levels of consciousness, whilst the medical profession allows for at least five different levels of consciousness, namely:¹²²

1. Full consciousness (normal),
2. Clouded consciousness,
3. Delirium causing disorientation and hallucination, normally the result of a toxic process,
4. Stupor causing decreased mobility, normally of organic origin,
5. Coma (no consciousness or mobility of any kind).

¹¹⁵ 1967 (1) SA 408 (A) at 417E-F

¹¹⁶ *Le Roux and Stevens*(2012) SACJ 52.

¹¹⁷ *Ibid*; Swanepoel (2015) 'Legal aspects with regard to mentally ill offenders in South Africa' PER Vol 18 Nr 1 3238-3258 3248.

¹¹⁸ 1967 (1) SA 408 (A) at 417F-H; *Le Roux and Stevens*(2012) SACJ 53.

¹¹⁹ Swanepoel (2015) PER 3248.

¹²⁰ Zabow 84.

¹²¹ *Burchell and Milton* 358.

¹²² *Bottomley* 74.

Automatism may occur in 2, 3 or 4. When the law requires unconsciousness, it cannot require coma and must recognise that different levels of consciousness exist.¹²³

The concept of mental illness is an ever changing and evolving concept.¹²⁴ Le Roux and Stevens opine that it is often difficult to assess where the borderline between medical and legal prerogatives lie when the assessment of pathological criminal incapacity is evaluated, and the question remains whether the definition of mental illness should be a legal or medical prerogative, or both, with the acceptance of a diagnosis as sufficient to negate capacity still being a legal question.¹²⁵ They further state that the law needs medicine to provide meaning to mental illness or defect and accordingly medical expert evidence is pivotal to legal decision-making.¹²⁶ Kaliski states that both definitions of mental disorder in law and medicine cannot provide objective criteria for a certain diagnosis and the legal definition defers to the judgement of the mental health expert who is authorised to make such a judgement.¹²⁷ Diamond states that it is not up to the law to establish the threshold for the existence of mental illness in an accused, but rather to determine the particular forms and degree of psychopathology it will recognise as exculpatory.¹²⁸ Smith and Hogan¹²⁹ define mental illness in broad terms by stating that any disease which produces a malfunctioning of the mind is a disease of the mind.¹³⁰

Le Roux and Stevens further state that the law should not lay down general criteria for the existence of mental illness or mental defect as this is an area where the law lacks adequate

¹²³ *Ibid.*

¹²⁴ Slovenko. R *Psychiatry and Criminal Culpability* 1995 1-66; Le Roux and Stevens(2012) SACJ 47; Emmerson, Q.C, Ashworth, A. and Macdonald, A. *et al.* 'Human rights and criminal justice' 2012 737; Winterwerp v The Netherlands (1979) 2 EHRR 387par 37.

¹²⁵ Le Roux and Stevens(2012) SACJ 49.

¹²⁶ *Ibid*; Winterwerp v The Netherlands(1979) 2 EHRR 387; Emmerson, Ashworth and Macdonald *et al.* 738.

¹²⁷ Kaliski 245.

¹²⁸ Diamond, B (1985) 'Reasonable medical certainty, diagnostic thresholds, and definitions of mental illness in the legal context' *Bulletin American of the Academy of Psychiatry and the Law* 121; Swanepoel (2015) PER 3245.

¹²⁹ As quoted by Le Roux and Stevens(2012) SACJ 53-54.

¹³⁰ Smith and Hogan 'Criminal Law' 2008 12th Edition 258-259. This implies that it need not be a disease of the brain, and that certain physical illnesses of the brain, such as arteriosclerosis, a tumour on the brain, epilepsy, diabetes, sleepwalking, pre-menstrual syndrome and all physical diseases, may amount in law to a disease of the mind if they produce the relevant malfunction. Le Roux and Stevens(2012) SACJ 53-54. See also Blackbeard, M. (1969) "Epilepsy and criminal liability" *S Afr J Criminal Justice* 2: 191-210.

expertise,¹³¹ but that there exist certain guidelines according to which mental disorders should be measured to determine whether the defence of pathological criminal incapacity will stand:¹³²

- Only mental disorders that are the product of a disease will be sufficient for purposes of Section 78(1) and the condition must be the consequence of a pathological disturbance or disease of the mind.¹³³
- The fact that the accused's mental state deviated from what is accepted as normal behaviour, is not indicative of mental illness.¹³⁴
- There exists a similarity between physical disease and mental disease in that both are inherent to the individual and are produced involuntarily.¹³⁵
- The origin of mental illness can be psychological or organic and either permanent or temporary in nature.¹³⁶
- Once it is established that the accused indeed suffered from a disease of the mind, it has to be ascertained whether the specific disease originated spontaneously within the mind of the accused (therefore that it was "internal"), or whether it is the consequence of external stimuli (such as substance abuse, or physical injury) in which case it will not constitute a mental illness for purposes of the defence of pathological criminal incapacity.¹³⁷
- The particular mental illness the accused suffered from must have existed at the time of the commission of the offence.¹³⁸

5.4.3.4 Mental disorders and crime

Chapter 3 detailed the differences between the legal profession and the mental health care profession, as well as discussing mental disorders that underlie legal concepts, the manner in

¹³¹ Emmerson, Ashworth and Macdonald *et al.* 737; Winterwerp v The Netherlands (1979) 2 EHRR par 37-39.

¹³² Le Roux and Stevens (2012) SACJ 55.

¹³³ *Ibid.*

¹³⁴ *Ibid.*

¹³⁵ *Ibid.*

¹³⁶ Le Roux and Stevens (2012) SACJ 56.

¹³⁷ Le Roux and Stevens (2012) SACJ 58.

¹³⁸ *Ibid.*

which they are classified, and the use of clinical assessment and diagnosis in legal settings. The purpose of the discussion in Chapter 2 was to lay a framework of science based medical principle against which legal concepts such as criminal capacity could be measured to determine whether they are reconcilable with science. The foundation of this approach being that where legal principles are too far removed from a scientifically justifiable foundation, they are inherently arbitrary and unjustifiable.

As there is no closed list of mental illnesses or defects in criminal law, each presentation of mental illness in each individual will also be different from the next person, even those with similar afflictions may differ in significant ways.¹³⁹ An accused's criminal capacity needs to be determined in each case individually and as the test is wholly subjective to the particular individual, the particular degree in which mental illness affects capacity in each case will be different.¹⁴⁰ This is especially true as the defence of pathological criminal is described in terms of the effects that a mental illness or defect has on the cognition or conation of a person, not in terms of a specific affliction or condition.¹⁴¹ "Mental defect" refers to a condition that has resulted in cognitive deficits and an abnormally low intellectual ability, such as mental handicap and dementia.¹⁴² It is possible that individuals suffering from a mental defect have such low levels of intellectual ability, that they lack normal cognitive or conative functions and thus criminal capacity. The most important difference between mental illness and mental defect in legal terms is that it is a gradual difference.¹⁴³

In clinical practice any of the diagnoses described and listed in the DSM-5 or ICD-10 manuals are regarded as mental disorders.¹⁴⁴ This includes conditions that do not normally affect criminal capacity, like nicotine addiction, therefore it has become convention for "mental illness or disorder" in a forensic and judicial context to mean a major psychiatric disorder that is known to be associated with significant cognitive and conative impairments.¹⁴⁵ In *S v*

¹³⁹ DSM-IV-TR xxxii.

¹⁴⁰ Louw 47; Snyman 169.

¹⁴¹ Chetty (2008) CRIMSA Conference: Special Edition 132.

¹⁴² Louw 41, 48; Kaliski 98; Snyman 169.

¹⁴³ Louw 48.

¹⁴⁴ Kaliski 95.

¹⁴⁵ Burchell and Milton 374; Kaliski 98.

*Stellmacher*¹⁴⁶ it was held that a mental illness should at least meet the criteria that it should be a pathological disturbance of the accused's mental capacity and not a mere temporary mental confusion which is not attributable to a mental abnormality but rather to external stimuli such as alcohol, drugs or provocation.¹⁴⁷ This criterion identifies only those disorders that are the result of a disease and of internal origin as "mental illnesses".¹⁴⁸ In considering which mental illnesses satisfy the legal definition of mental disorder that may result in criminal incapacity, disorders can be classified as follows according to the DSM-5:¹⁴⁹

- Organic disorders: These disorders are due to a general medical condition and may be temporary or chronic. Symptoms of such disorders include impairment of orientation, memory, comprehension and self-control. Depending on the severity of the disorder, it may well satisfy the legal definition of insanity and result in criminal incapacity.¹⁵⁰
- Substance-related disorders: Disorders are divided into substance use disorders and substance induced disorders. Substance use disorders such as alcoholism and addictions to mind-altering drugs is not necessarily pathological, endogenous or permanent and persons suffering from these disorders are not necessarily legally insane.¹⁵¹ Substance induced disorders may be pathological and include the delirium tremens, a mental disorder representing serious alcohol withdrawal and is brought about by excessive and continuous abuse of alcohol. Persons suffering from a delirium tremens act in a confused state and their behaviour would not be purposeful or goal-oriented and may be aggressive and violent due to a misperception of the environment.¹⁵²
- Psychotic disorders: This category is marked by psychotic or related symptoms. A psychotic illness is a type of organic disorder characterised by gross distortions of

¹⁴⁶1983 (2) SA 181 (SWA).

¹⁴⁷ Burchell and Milton 375; Snyman 170.

¹⁴⁸ Burchell and Milton 375.

¹⁴⁹ Spammers 2010 24-25.

¹⁵⁰ Burchell and Milton 384.

¹⁵¹ Burchell and Milton 384.

¹⁵² Peter, L.P. "The effects of alcohol and substances" in Kaliski, S. (ed.) "Psycholegal assessment in South Africa" 2006 135.

reality and perception. These disorders are pathological, endogenous and capable of depriving the sufferer of insight or self-control and may satisfy the legal test for criminal incapacity.¹⁵³

- Mood and anxiety disorders: These disorders are divided into disorders where the predominant feature is disturbance in mood and where the predominant feature is anxiety attacks and phobias. Depressions are capable of depriving the sufferer of criminal capacity.¹⁵⁴ Anxiety disorders may manifest as “anxiety” disorders such as phobias, or “dissociative” disorders such as amnesia or dual personalities. Anxiety disorders do not affect the perception of reality, but dissociative disorders may deprive the sufferer of insight or self-control and thus criminal capacity.¹⁵⁵
- Personality disorders: This is a group of disorders characterised by immature or distorted development of the personality, resulting in maladapted ways of perceiving, thinking or relating to others.¹⁵⁶ Personality disorders are defined and included in all classification schemes of psychiatric disorders, such as the DSM-5 and the ICD-10, but Kaliski opines that few psychiatrists regard them as “mental disorders or illnesses” and no psychiatric institution would admit under certification anyone whose only diagnosis was a personality disorder, nor would a court find a person to be incapacitated on that basis alone.¹⁵⁷ According to Kaliski, the assessment of personality disorders should only be used to enhance the understanding of the accused and not to influence a judicial outcome.¹⁵⁸ Psychopathy can be included under this classification of disorder.

According to Dietz,¹⁵⁹ certain patterns occur in the relationship between mental disorder and

¹⁵³ Burchell and Milton 385.

¹⁵⁴ *S v Kavin* 1978 (2) SA 731 (W).

¹⁵⁵ Burchell and Milton 386.

¹⁵⁶ Burchell and Milton 386.

¹⁵⁷ Kaliski 244. Kendell (2002) in ‘The distinction between personality disorder and mental illness’ *British Journal of Psychiatry* 110-115 states that many, and perhaps most, contemporary British psychiatrists seem not to regard personality disorders as illnesses.

¹⁵⁸ Kaliski 248.

¹⁵⁹ Dietz, PE.(1992) "Mentally disordered offenders: Patterns in the relationship between mental disorder and crime" 15 *Psychiatric Clinics of North Am* 3: 539 at 540, 544, 546, 547, 549; Swanepoel 124.

crime with sufficient frequency that should be considered in every case. Dietz explains that Pattern 1 offenders do meet legal criteria for insanity, depending on the facts of each case and the applicable legal standards.¹⁶⁰ It is arguable whether Pattern 2 offenders ever meet legal criteria of insanity and offenders evidencing only Patterns 3, 4, or 5 are not candidates for an insanity defence.¹⁶¹ Dietz describes the five patterns frequently observed among mentally disordered offenders as:¹⁶²

- Pattern 1: Crime in response to psychotic symptoms: Crimes committed in obedience to command hallucinations or in accordance with other psychotic perceptions sometimes meet cognitive tests of insanity, but it is less clear whether they ever meet volitional tests of insanity, which prove for exculpation of offenders who acted under an irresistible impulse or whose capacity to conform their conduct to the requirements of law was impaired substantially by mental disease at the time of the offence.
- Pattern 2: Crime to gratify compulsive desire: In these cases mental disorder provides the motive for the crime, but does not impair the offender's knowledge of what they are doing or that it is wrong. Examples are crimes motivated by sexual sadism; crimes committed by kleptomaniacs and; illegal gambling by compulsive gamblers.
- Pattern 3: Crime reflecting personality disorder: Many mentally disordered offenders are pattern three offenders, most often antisocial adults or conduct-disordered youngsters. Some of these defendants have other conditions as well that provide an arguable, though sometimes unsuccessful basis for presenting an insanity defence or for mitigation at sentencing, for example, post-traumatic stress disorder.
- Pattern 4: Coincidental crime and mental disorder: In this pattern there occurs to be a crime committed, which is unrelated to and not a result of the person's mental disorder. It illustrates the coincidental occurrence of mental disorder and criminality in a single individual.

¹⁶⁰ *Ibid.*

¹⁶¹ *Ibid.*

¹⁶² *Ibid.*

- Pattern 5: True or feigned mental disorder in response to crime: This pattern refers to the offender developing symptoms of mental disorder that were not present before or during committing the crime. Such cases often pose a difficult diagnostic challenge, particularly because there are usually no pre-offence psychiatric records. Perhaps the most diagnostically challenging of all cases are talented and well-trained malingerers, such as those who have succeeded in malingering mental illness for so long that they have learned all the symptomatic nuances from fellow patients or those who have been trained to enact the role of multiple personality disorder by therapists and examiners who specialise in the condition.

5.4.3.5 Personality disorders and criminal incapacity

The use of the DSM-5 in clinical and forensic environments and the manner in which mental disorders are classified according to the DSM-5¹⁶³ and ICD-10¹⁶⁴ systems were discussed in Chapter 3. It was noted that the most important difference between the new DSM-5 and the previous DSM-IV-TR is the abolishment of the multi-axial system of classification of disorders in favour of a uniaxial system. The multi-axial system differentiated between personality disorders and clinical conditions, whereas the new DSM-5 and its uniaxial system does not.¹⁶⁵

The DSM-5 defines a personality disorder as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment”.¹⁶⁶ The DSM-5 makes provision for 10 specific types of personality disorders as mental disorders,¹⁶⁷ and groups them into three subtypes,¹⁶⁸ namely

¹⁶³American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders *DSM-5* (2013) (Hereafter referred to as the DSM-5).

¹⁶⁴International Classification of Diseases and Related Health Problems published by the World Health Organisation.

¹⁶⁵Van der Bijl, C. and Pienaar, L. (2014) 'The DSM-5 and the role of personality disorders under the criminal law' *Obiter* 316-335 317.

¹⁶⁶DSM-5 645

¹⁶⁷DSM-5 645. Namely: narcissistic, avoidant, paranoid, schizoid, antisocial, schizotypal, borderline, histrionic, dependent, obsessive-compulsive, and personality changes due to medical conditions or unspecified personality disorders.

Cluster A,¹⁶⁹ Cluster B,¹⁷⁰ and Cluster C.¹⁷¹ Van Der Bijl and Pienaar mention that as far as personality disorders are concerned, there is very little jurisprudential literature, with only psychopathy (which is grouped under antisocial personality disorders in Cluster B) is discussed in any depth.¹⁷² Psychopathy has not been accepted as a ground for exemption of criminal liability, nor as a ground for a mitigation of sentence based on diminished accountability, and has also neither been accepted as a mental disease in law since 1996, after the DSM-III recast psychopathy as a personality disorder instead of a mental disorder.¹⁷³ Section 268A of CPA was created which provides for the declaration of certain individuals, such as psychopaths, as “dangerous offenders” and prescribes indeterminate sentences of detention.¹⁷⁴

Certain challenges have been identified in the distinction between personality disorders and mental illness by Kaliski, namely:¹⁷⁵ the diagnostic criteria for a particular personality disorder, as set out in the DSM, can overlap with the diagnostic criteria of another disorder, making exact diagnosis difficult; and diagnoses is problematic where the examinee is suffering from a psychiatric disorder as the examinee might incorrectly appear to have a personality disorder instead. Kendell has advanced the opinion that the issue to be considered is whether the personality disorder responds to treatment, which accords with a mental disorder.¹⁷⁶ It is submitted that a reconsideration of the legal position regarding personality disorders and criminal capacity is necessary. In determining whether a personality disorder would meet the legal criteria for negating criminal capacity and therefore liability, it is

¹⁶⁸ DSM-5 646

¹⁶⁹ Cluster A is characterized by peculiar or eccentric behaviour and includes the paranoid, schizoid and schizotypal personality disorders. DSM-5 649-659. Van der Bijl and Pienaar (2014) Obiter 320.

¹⁷⁰ Cluster B is characterised by dramatic and emotional personality disorders, and includes the histrionic, borderline, narcissistic and antisocial personality disorders.. DSM-5 659-672. Van der Bijl and Pienaar (2014) Obiter 320.

¹⁷¹ Cluster C consists of the anxious-fearful personality types, including obsessive-compulsive, passive-aggressive, avoidant and dependent personality disorders. DSM-5 672-682. Van der Bijl and Pienaar (2014) Obiter 321.

¹⁷² Van der Bijl and Pienaar (2014) Obiter 321; Slovenko *Psychiatry and Criminal Culpability* (1995) 104–105.

¹⁷³ DSM-5 659; Kaliski 247; Burchell and Milton 288; Snyman 177; Slovenko 'Psychiatry and Criminal Culpability' 1995 104–105; S v Mnyanda 1976 (2) SA 751 (A) 763E–G; Van der Bijl and Pienaar (2014) Obiter 322.

¹⁷⁴ Kaliski 247; Van der Bijl and Pienaar (2014) Obiter 322. The declaration as a dangerous offender in terms of Section 268A of the CPA is discussed below, particularly with reference to the constitutionality of indefinite detention.

¹⁷⁵ Kaliski 243-244. Also discussed by Van der Bijl and Pienaar (2014) Obiter 330.

¹⁷⁶ Kendell (2002) *British Journal of Psychiatry* 114.

necessary to consider the test for criminal capacity in Section 78 of the CPA, which requires a mental illness or mental defect that affects the cognitive and conative abilities of the accused. The fact that personality disorders under the new DSM-5 are no longer separated from mental illness,¹⁷⁷ as well as the inherent difficulties in conceptual boundaries, it might be prudent for the courts to consider rather the effect of a condition such as a personality disorder on the two legs of the test for incapacity, rather than focusing overly on the particular diagnostic label.¹⁷⁸

5.4.4 Fault

Fault (or *mens rea*) takes the form of either intent or negligence.¹⁷⁹ It is a general rule of criminal law that there can be no criminal liability without fault.¹⁸⁰ Intention is subjectively assessed consists in a person directing their will at achieving a certain result, while they possess a particular knowledge.¹⁸¹ The person must know that what they are doing is a crime and that they are not covered by a ground of justification.¹⁸²

Mental disorder can conceivably cause a person (who can appreciate the wrongfulness of their conduct and act in accordance with such an appreciation) to make a material mistake concerning the circumstances or facts surrounding a situation, or a mistake of law, which could negate their intention by excluding the knowledge requirement.¹⁸³ A mistake that excludes intention need not be reasonable.¹⁸⁴ Putative defence is another possibility where a mentally ill accused genuinely believes that they are acting in accordance with a ground of

¹⁷⁷ Stork (2013) *Columbia Human Rights Review* 929–938; Van der Bijl and Pienaar (2014) *Obiter* 334.

¹⁷⁸ Le Roux and Stevens (2012) SACJ46-47; Van der Bijl and Pienaar (2014) *Obiter* 334; Stork (2013) *Columbia Human Rights Review* 929–938; Kinscherff (2010) 38 *Journal of Law, Medicine & Ethics* 752.

¹⁷⁹ Burchell and Milton 455.

¹⁸⁰ *Ibid*; S v Coetzee 1997 (3) SA 527 (CC). Some statutory crimes however are based on strict liability, or liability without fault. The full discussion of which is outside the scope of this thesis. See also Currie, I. and De Waal, J. ‘The Bill of Rights Handbook’ 6th Edition (Cape Town: Juta&Co) 2013 274-276 regarding the violation of bodily integrity in light of strict liability crimes where blameworthiness is not considered by the court.

¹⁸¹ Burchell and Milton 459, Snyman 184-186, 188. Intention can take various forms, either direct intent, indirect intent, or *dolus eventualis*. The discussion of which is outside the scope of the thesis, as the focus lies on whether mental illness could have negated the ability direct their will at a certain result while having a particular knowledge.

¹⁸² Burchell and Milton 460 Snyman 181. Snyman refers to the cognitive element of intent meaning that the accused must have knowledge of unlawfulness and the nature of the act, and the conative element as meaning that the accused directed their will towards a result (made a decision).

¹⁸³ S v De Blom 1977(3) SA 513 (A); Burchell and Milton 502-504, Snyman 191, 203.

¹⁸⁴ Burchell and Milton 502; Snyman 191.

justification as a legitimate defence.¹⁸⁵ An example of this would be where a mental disorder causes a person to believe that they are in fact attacking another in private defence, where their attack was objectively unjustified and unlawful.

Van Oosten argues that because the “wrongfulness” that must be appreciated is widely accepted to mean moral and legal wrongfulness, and that it is possible that a person due to their mental disorder did foresee and reconcile themselves with the unlawfulness of their conduct, but that they considered it to be morally justified.¹⁸⁶ In such circumstances it is submitted that the mentally disordered accused person would not escape liability either by the exclusion of their criminal capacity or by the exclusion of intention, at most it could be argued as mitigating factor when sentencing is considered.

Negligence as a form of fault entails that the offender has not conformed to the standard of conduct expected from the reasonable person, and has therefore acted unreasonably.¹⁸⁷ Negligence is objectively assessed without considering the mental state of the accused.¹⁸⁸ In the case of *Ngema* the court however held that the test for negligence (that of the reasonable man) must refer to a reasonable person of the same background, educational level, and other personal attributes as the accused.¹⁸⁹ It is submitted that a mental illness should be taken into account by the courts in determining whether an accused (suffering from such a disorder) had acted in a negligent manner.

5.4.5 Diminished criminal capacity

The Rumpff Commission in 1967 acknowledged that there are varying degrees of mental abnormality and not all presentations of mental disorder satisfy the legal requirements for incapacity.¹⁹⁰ Section 78(7) of the CPA makes provision for a plea of diminished capacity so that a mentally disordered person deemed to be criminally liable, but if their capacity to

¹⁸⁵ Burchell and Milton 514.

¹⁸⁶ Van Oosten (1990) SACJ 7.

¹⁸⁷ Burchell and Milton 522, Snyman 209.

¹⁸⁸ Burchell and Milton 525-527.

¹⁸⁹ 1992 (2) SACR 651 (D); Burchell and Milton 527.

¹⁹⁰ Rumpff Commission Report par 8.3; Joubert, WA. and Faris, JA. *The Law of South Africa* 2nd edition vol 6 (2004) LAWSA 63.

appreciate the wrongfulness of the act, or act in accordance with such an appreciation, was diminished by reason of mental illness or mental defect would have a lesser punishment imposed. Lack of criminal capacity is exculpatory, diminished criminal capacity is mitigating and only taken into account when considering sentence.¹⁹¹ In *S v Mnisi*¹⁹² the court held that, in contrast to temporary non-pathological criminal incapacity, diminished responsibility does not exclude culpability, but only reduces such culpability that should be reflected in a reduced sentence.¹⁹³ Diminished responsibility can reduced punishment on the basis of it can be justified as the need for deterrence is generally reduced in applicable cases.¹⁹⁴ Section 78(7) only provides for cases where a mental disorder or defect lead to the diminished capacity, although Stevens submits that it should also apply to cases of non-pathological causes of diminished capacity.¹⁹⁵

It is submitted that in cases where a mental disorder or mental defect did not lead to a finding of incapacity, though the mental disorder is of a serious nature, the court must consider in making its order whether detention in a mental health care establishment would be advisable as opposed to a prison term.

5.5 The Criminal Procedure Act 51 of 1977

In this Section Chapter 13 of the CPA (Sections 77, 78 and 79), that codifies the procedure to be followed in a criminal trial if it is alleged that a person suffers from a mental disorder that negates their capacity at the time of the trial, or at the time of the commission of the offence, is critically discussed and recommendations made for amendment where necessary. Section 77 of the CPA deals with the issue of capacity to understand proceedings at the time of the trial, and Section 78 regulates the procedure regarding criminal capacity (or responsibility). Section 79 provides for the panel for purposes of enquiry and report under Sections 77 and 78. This report forms the basis of the forensic mental health expert witness's testimony in court

¹⁹¹ *Ibid*; Terblanche 198.

¹⁹² 2009 (2) SACR 227 (SCA). In this case the accused shot the deceased while under emotional stress. The court at par 5 held that a mere loss of temper is not mitigating as society is expected to keep their emotions in check to avoid harming others.

¹⁹³ *Ibid* at par 4; Terblanche, S. (2010) 'Sentencing' SACJ 1 159-176 159.

¹⁹⁴ Terblanche (2010) SACJ 159; Terblanche 198.

¹⁹⁵ Stevens 41.

and it is imperative that it be as accurate as possible.

5.5.1 Capacity of accused to understand proceedings (triability)

The trial must take place in the presence of the accused for a person's right to a fair trial to be respected.¹⁹⁶ The presence at the trial includes both physical presence, as well as a psychological element which requires that the accused must have the required mental capacity to understand and follow the trial, in other words the person must be triable.¹⁹⁷ An accused is unfit to stand trial if they are incapable of understanding court proceedings, and conducting a proper defence and this could be due to physical causes, or mental illness or defect.¹⁹⁸ Not all mental disorders lead to incapacity to stand trial, but examples of disorders that could lead to such a finding include organic mental illness, psychotic disorders, and delusional disorders, among others.¹⁹⁹

Section 77 of the CPA determines that only persons who are capable of understanding the nature of trial proceedings or conducting a proper defence can be tried and states the procedure for inquiry. Section 77(1) of the CPA determines that if it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of Section 79.²⁰⁰ At proceedings in terms of Section 77(1)²⁰¹ the court may, if it is of the opinion that substantial injustice would otherwise result, order that the accused be provided with the services of a legal practitioner in terms of Section 22 of the Legal Aid South Africa Act, 2014.²⁰² The question of fitness to stand trial may be raised by either the

¹⁹⁶ Section 158 of the Criminal Procedure Act; Stevens 442. Section 35 of the Constitution and the rights of detained and accused persons was discussed in Chapter 2.

¹⁹⁷ Cassim, F.(2004) "The accused person's competency to stand trial: a comparative perspective" 45 *Codicillus* 17-27 17; Stevens 442.

¹⁹⁸ Stevens 443.

¹⁹⁹ Oosthuizen, H. and Verschoor, T (1991) 'Faktore wat 'n invloed op die verhoorbaarheid van 'n beskuldigde kan he' TRW 143; Stevens 444.

²⁰⁰ Burchell and Milton 372; Section 79 is discussed below and provides for the appointment of a panel of forensic mental health assessors and the compilation of a report on the mental state of the accused, as well procedural matters related thereto.

²⁰¹ Also in the case of proceedings in terms of Section 78(2) regarding the criminal capacity of the accused at the time of commission of the Act, which is discussed in this chapter below.

²⁰² Section 77(1A) of the CPA.

prosecution or defence, and is then determined by a psychiatric examination and report in terms of Section 79.

Section 77(2) of the CPA provides that if the finding contained in the relevant report is the unanimous finding of the persons who under Section 79 enquired into the mental condition of the accused and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence. If the finding in the report is not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under Section 79 enquired into the mental condition of the accused.²⁰³ In such a case the party disputing the finding may subpoena and cross-examine any person who under Section 79 has enquired into the mental condition of the accused.²⁰⁴

If the court finds that the accused is capable of understanding the proceedings so as to make a proper defence, the proceedings shall be continued in the ordinary way.²⁰⁵ Section 77(8)(a) provides that an accused who is convicted after a finding that they are capable of understanding proceedings so as to make a proper defence, may appeal against such finding and that such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence.²⁰⁶ Section 77(9) of the CPA provides that where such an appeal is allowed, the court of appeal shall set aside the conviction and sentence and direct that the person concerned be detained in accordance with the provisions of Section 77(6).

Section 77(6)(a) of the CPA determines that if the court finds that the accused is not triable, the court may order that evidence be placed before the court as it deems fit to determinewhether the accused has committed the act in question on a balance of

²⁰³ Section 77(3) of the CPA.

²⁰⁴ Section 77(4) of the CPA.

²⁰⁵ Section 77(5) of the CPA.

²⁰⁶ Section 77(8)(b) of the CPA.

probabilities.²⁰⁷ Kaliski opines that the use of a balance of probabilities using limited evidence does not on the face of it seem like fair carriage of justice.²⁰⁸ In taking such a decision the court must be of the opinion that it is in the interests of the accused, taking into account the nature of the accused's incapacity.²⁰⁹ Section 77(6)(a) authorises the court to direct that the accused be dealt with in one of two ways (discussed in this chapter hereafter). It is submitted that the CPA does not specify what is meant by the court being of the opinion that it is in the “interests of the accused” to order that evidence be placed before it to determine whether the act in question had been committed. In *S v Sithole* the court held that “the interests of the accused” seemed to exclude prejudicial information and evidence even though it might be highly relevant.²¹⁰ The phrasing creates uncertainty concerning whether it is in the discretion of the court to decline to have information put in front of it in order to make a directive in terms of Section 77(6)(a), though the wording “the court shall direct” implies that there is no discretion and that a directive must be issued no matter whether the *actus reus* had been committed or not. The section does not make provision for cases where the onus of proof of balance of probabilities regarding whether the act had been committed had not been discharged, nor does it make provision for circumstances where the court does not order information to be put in front of it to determine whether the act had been committed or not. It is suggested that the section be amended to ensure clarity.

Section 77(6)(a) further determines that the court shall direct that:

- i. The accused be detained in a psychiatric hospital or a prison pending the decision of a judge in chambers in terms of Section 47 of the MHCA in the following cases: a charge of murder, culpable homicide, rape, or compelled rape²¹¹; a charge involving serious violence; if the court considers it to be necessary in the public interest; or where the court finds that the accused has committed the act in question. It is

²⁰⁷ Section 77(6)(a) of the CPA. The court in *S v Sithole* 2005 (1) SACR 311 (W) held that the phrase ‘has committed the act in question’ carries no connotation of *mens rea* or criminal responsibility and is intended to refer purely to the physical commission of the *actus reus*.

²⁰⁸ Kaliski, S (2012) ‘Does the insanity defence lead to an abuse of human rights?’ 15 *Afri J Psychiatry* 83-87 83.

²⁰⁹ *Ibid*.

²¹⁰ 2005 (1) SACR 311 (W).

²¹¹ As contemplated in sections 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007

submitted that Section 77(6)(a)(i) refers to a charge involving serious violence twice and that it should be amended to remove the repetition.

- ii. Where the court finds that the accused has committed an offence other than one contemplated in paragraph 77(6)(a)(i) or that they have committed no offence, the court shall direct that the accused be admitted to and detained in an institution stated in the order as if they were an involuntary mental health care user contemplated in Section 37 of the MHCA.²¹²

If the court so directs in terms of Section 77(6)(a)(i) or (ii) after the accused has pleaded to the charge, the accused shall not be entitled under Section 106(4) to be acquitted or to be convicted regarding the charge in question. If the court makes a finding in terms of 77(6)(a) after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside, and if the accused has pleaded guilty it shall be deemed that he has pleaded not guilty.²¹³ This provision seems to take cognisance of the fact that a person deemed not capable of understanding proceedings and laying a proper defence should not be prejudiced by allowing a guilty plea and a conviction to stand in the absence of their full participation in the adversarial criminal process. Section 77(6) does not make provision explicitly for the acquittal of the accused if it has been found on balance of probabilities that they did not commit the act in question, and it is submitted that this is due to the lower burden of proof “on balance of probabilities” normally used in civil cases, and the fact that the merits of the case had not been subjected to the more stringent criminal law burden of proof “beyond reasonable doubt”. Therefore an acquittal might lead to an untenable state of affairs where the accused may not be tried again on the same facts if new evidence comes to light.

If the accused is not the party alleging lack of capacity to stand trial and a finding is made in terms of Section 77(6), the accused may appeal against such finding, and the appeal must be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence.²¹⁴ Where an appeal against a finding under Section 77(6) is

²¹² Section 77(6)(a)(ii)(aa). Section 77(6)(a)(ii)(bb) was removed by amendment in terms of Section 12 of Act 55 of 2002 and gave the option that the accused be treated as an outpatient.

²¹³ Section 77(6)(b) of the CPA.

²¹⁴ Sections 77(8)(a) and (b) of the CPA.

allowed, the court of appeal shall set aside the direction issued under that subsection and remit the case to the court which made the finding, whereupon the relevant proceedings shall be continued in the ordinary way.²¹⁵

If a direction is issued in terms of Section 77(6) or 77(9), the accused may at any time thereafter, when they are capable of understanding the proceedings so as to make a proper defence, be prosecuted and tried for the offence in question.²¹⁶ In *S v Leeuw*²¹⁷ it was held that a person detained as a State Patient under Section 77(6) of the CPA was not absolved from prosecution and can be tried when fitness to stand trial had been regained.²¹⁸ Kaliski submits that where an accused is found to be unfit to stand trial the court should set a date when the accused must be returned to court, unless the treating physicians provide a report that the accused remains unfit to stand trial.²¹⁹ It is submitted that the sentiment of attempting legal certainty and set time periods is desirable, but that the National Prosecuting Authority should rather be obliged to indicate, shortly after it has been found that the accused did not commit the act in question on a balance of probabilities, whether it intends to prosecute the matter in future or not.

5.5.1.1 Constitutional validity of Section 77(6)(a)(i) and (ii)

Orders made in terms of Section 77(6) of the CPA are not subject to automatic review in terms of Section 302(1)(a) of the CPA,²²⁰ but as the court has powers at common law to exercise powers of review it was held in *S v Ramokoka*²²¹ that it is a matter of good practice to refer such orders for review to a high court. The court in *Ramokoka* also held at par 12 that Section 47 of the MHCA does not have an automatic review mechanism, so that a person

²¹⁵ Section 77(10) of the CPA.

²¹⁶ Section 77(7) of the CPA.

²¹⁷ 1987 (3) SA 97 (A).

²¹⁸ The debate surrounding the re-establishing of triability through the use of medication and treatment is outside the scope of this thesis. See Stevens 465-469; Oosthuizen and Verschoor (1990) *TRW*. Treatment during observation and detention discussed below in this chapter. Kaliski notes that the best approach would be to commence treatment as soon as a definitive assessment has been concluded, and if the accused becomes fit to stand trial the report should mention this (Kaliski 98).

²¹⁹ Kaliski (2012) *Afri J Psychiatry* 86.

²²⁰ Stevens 464.

²²¹ 2006 (2) SACR 57 (WLD) par 14-16.

detained in terms of Section 77(6) of the CPA remains detained until an application is made to a Judge in Chambers and the Judge orders the release. The system of automatic review does not include Section 77(6) orders, but the High Court has an inherent right to review decisions of lower courts as these orders have the potential to seriously prejudice a vulnerable accused.²²²

The case of *S v Mapey*²²³ illustrates several issues that deserve attention and remedy, namely the construction of Section 77(6) of the CPA, as well as the application of the act in practice by the judiciary, and the mechanisms in place to detect incorrect application and prevent the unjustified detention and infringement upon the rights of accused persons and mental health care users. In this case the accused was charged with malicious damage to property in November 2002 after smashing a window at Wynberg Magistrates Court.²²⁴ At the trial an order was made for an enquiry into the accused's mental health in terms of Sections 77(1) and 78(2) of the CPA and in February 2003 a psychiatrist at the forensic psychiatry unit at Valkenburg Hospital and a clinical psychologist had examined the accused and found that he suffered from a psychotic disorder, that he was not fit to stand trial and that he was not able to appreciate the wrongfulness of the alleged offence and act accordingly.²²⁵ The report recommended that the accused be admitted to the hospital for treatment in terms of Section 9 of the Mental Health Act 18 of 1973.²²⁶ When the matter came before the magistrate again in March 2003 the magistrate ordered that it was in the public interest that the accused be admitted to a prison hospital in terms of Section 77(6)(a)(i) of the CPA pending the decision of a judge in chambers.²²⁷ The matter was never brought before a judge in chambers and the accused spent three years and seven months in prison.²²⁸

The court in *Mapey* held that Section 77(6)(a)(i) regarding serious offences presents difficulty as “pending a decision of judge in chambers” is a misnomer as there is no application pending in this matter, the State Patient is simply indefinitely detained until they make a successful

²²² *S v Mapey* (2007) JOL 19909 (C) par 12-16; *S v Ramokoka* 2006 (2) SACR 57 (W) par 12-17.

²²³ (2007) JOL 19909 (C).

²²⁴ (2007) JOL 19909 (C) par 2.

²²⁵ (2007) JOL 19909 (C) par 3-4.

²²⁶ (2007) JOL 19909 (C) par 4.

²²⁷ (2007) JOL 19909 (C) par 5.

²²⁸ (2007) JOL 19909 (C) par 6.

application for discharge in terms of Section 47 of the MHCA.²²⁹ The court held that the fact that the accused was not examined in terms of Section 79 of the CPA before the order was made is a serious defect in the order and that a court cannot simply order detention without such an enquiry merely because they are of the opinion that it is in the public interest to do so, and that the magistrate in the case also erred in making an order under Section 77(6)(a)(i) where no violent crime had been committed.²³⁰ The court determined that the appropriate order to make is that the accused be detained at Valkenberg Hospital in terms of Section 77(6)(a)(ii)(aa) of the CPA and Section 37 of the MHCA as an involuntary user.²³¹ Section 37 makes provision for periodic review and annual reports.²³²

In the case of *De Vos N.O and Another v Minister of Justice and Constitutional Development and Others; In Re Snyders and Another v Minister of Justice and Constitutional Development and Others*²³³ (hereafter referred to as “the *De Vos*-case”) the constitutionality of Section 77(6)(a) of the CPA was questioned in that an order as contemplated amounts to a deprivation of freedom as guaranteed in Section 12(1)(a) of the Constitution. The Court held that Section 77(6)(a), in limiting or threatening the rights to freedom of the person and the rights of children, was unconstitutional and could not be saved by the limitations clause.²³⁴ The fundamental enquiry before the court was whether detention in terms of Sections 77(6)(a)(i) and (ii) was arbitrary or without just cause, and whether the sections apply to less serious offences or even where no offence was committed.²³⁵

The court referred to the safeguards contained in Section 32(b) of the MHCA, namely that there must be a reasonable belief that the mental health care user suffers from a mental illness of such a nature that the user is likely to inflict serious harm upon themselves or others, or that

²²⁹ (2007) JOL 19909 (C) par 17; Landman, A.A. and Landman, W.J. ‘A Practitioner’s Guide to the Mental Health Care Act’ (Cape Town; Juta & Co) 2014 155. This sentiment was echoed by the court in *S v Pedro* (2014) 4 All SA 114 (WCC) at par 114 when it finds it concerning that there is no legislative mechanism for periodic reports in terms Section 77(6)(a)(ii).

²³⁰ (2007) JOL 19909 (C) par 20-23.

²³¹ (2007) JOL 19909 (C) par 28.

²³² Section 37 was discussed in Chapter 4. As mentioned in Chapter 4 regarding Section 37, the accused can only be detained as an involuntary mental health care user as long as they are in fact suffering from a mental disorder, therefore the user must be discharged if and when their mental state improves.

²³³ (2014) 4 All SA 374 (WCC).

²³⁴ (2014) 4 All SA 374 (WCC) par 72.

²³⁵ Landman and Landman 156.

the care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user.²³⁶ No similar enquiry or safeguards exist in Section 77(6)(a)(i) and (ii).²³⁷ The court concluded that it was possible to detain a person in terms of these sections even where they do not suffer from a mental illness, or where they are not a danger to society or themselves, or where it was apparent that their mental condition could not be treated and could not improve.²³⁸

The court held at par 48 that although it is universally recognised that persons of unsound mind may, in suitable circumstances, be detained involuntarily, and that this can be justified either on the grounds of the protection of society or for the treatment of the individual patient, or both. It may be accepted, therefore, that *in principle* detention of persons with mental defects serves a legitimate purpose.²³⁹ The court further held that Sections 77(6)(a)(i) and (ii) are lacking as it does not recognise that there are degrees of dangerousness and does not require that this be inquired into for purposes of detention, or that an assessor express a view concerning the appropriateness of involuntary detention.²⁴⁰ The court states that a mandatory and pre-determined process such as the one contained in Section 77(6) is not fair as it excludes material information and is against notions of individual justice.²⁴¹ Due to the absence of judicial discretion in the section, its unconstitutionality was sealed, especially compared to the parallel provision of Section 78(6) and the lack of inevitability of detention applied there.²⁴²

Sections 77(6)(a)(i) and (ii) are also unconstitutional as it infringes on the provisions of the Child Justice Act as every child has the right to not be detained except as a measure of last

²³⁶ (2014) 4 All SA 374 (WCC) par 40. This is also in line with Article 5 of the ECHR which prohibits arbitrary detention, and *Winterwerp v The Netherlands* par 39 where it was held that deprivation of liberty is only justified if the mental disorder is of a kind or degree warranting compulsory detention, and that no one may be confined as a person of unsound mind in the absence of medical evidence establishing that the present mental state justifies compulsory hospitalisation. *Emmerson, Ashworth, and Macdonald et al.* 739.

²³⁷ (2014) 4 All SA 374 (WCC) par 41.

²³⁸ (2014) 4 All SA 374 (WCC) par 42.

²³⁹ (2014) 4 All SA 374 (WCC) par 48.

²⁴⁰ (2014) 4 All SA 374 (WCC) par 49.

²⁴¹ (2014) 4 All SA 374 (WCC) par 50-52.

²⁴² Section 78(6) is discussed in this chapter below, where amendment to the Section is also suggested to ensure the court exercises its discretion while taking into account the relevant information.

resort.²⁴³ Section 48(5)(b) of the Child Justice Act 75 of 2008 (the “CJA”) provides that the preliminary inquiry that takes place prior to the hearing into the charges against a child accused may be postponed where “the child has been referred for a decision relating to mental illness or defect in terms of Sections 77 or 78 of the CPA.”²⁴⁴ The CJA is, however, silent concerning what happens in the event that the child in question is found to be unable to follow the proceedings or who is found not to be criminally responsible, with the result being that the diversion options provided for in Section 53 of the CJA for child offenders cannot be invoked by the court and the provisions of Sections 77 or 78 of the CPA must be applied in all their rigour to such a child.²⁴⁵ This is the preordained result, irrespective of the child’s individual circumstances, even where there is evidence available to the court that suggests that detention would be detrimental to his or her interests.²⁴⁶ Section 77(6)(a)(i) and (ii) discriminates unfairly against children with a mental illness or an intellectual disability in terms of Section 9(3) and (4) of the Constitution.

The court rejects the application of the limitations clause as it was not shown that the law serves a constitutionally acceptable purpose and that there was sufficient proportionality between the provision and the harm.²⁴⁷ The order by the court was that Section 77(6)(a)(i) and

²⁴³ (2014) 4 All SA 374 (WCC) par 53-57: Section 28(1)(g), read with Section 28(2) of the Constitution.. The constitutional provisions in Section 28 have been given further statutory content in the form of the Child Justice Act 75 of 2008, which contains elaborate provisions, *inter alia*, regarding preliminary inquiries to be held prior to any trial (Chapter 7) and for diversion of the matter (Chapter 8). The diversion options set out in Section 53 of the CJA are available even in the case of children found to have committed crimes that fall within Schedule 2 to the CJA, which includes murder, culpable homicide, rape and compelled rape. Through Section 53 of the CJA, the Legislature has afforded courts a wide discretion to deal with child offenders in many different ways that give effect to the right in Section 28(1)(g) of the Constitution to resort to incarceration only as a means of last resort, and in so doing enable courts to give effect to the injunction in Section 28(2) to act at all times in the best interests of the child. The diversion options include, by way of example:

- a) compulsory attendance at a specified centre or place for a specified vocational, educational or
- b) therapeutic purpose, which may include a period or periods of temporary residence;³⁸
- c) referral to intensive therapy to treat or manage problems that have been identified as a cause of the
- d) child coming into conflict with the law, which may include a period or periods of temporary residence;³⁹
- e) and
- f) placement under the supervision of a probation officer on conditions which may include restriction of the
- g) child’s movement outside the magisterial district in which the child usually resides without the prior written approval of the probation officer.

²⁴⁴ (2014) 4 All SA 374 (WCC) par 59.

²⁴⁵ *Ibid.*

²⁴⁶ *Ibid.*

²⁴⁷ (2014) 4 All SA 374 (WCC) par 63-67; Landman and Landman 159.

(ii) is unconstitutional must be confirmed by Constitutional Court and was suspended for 24 months to give parliament time to correct the defect, and temporary relief in the form of reading-in to afford judicial discretion similar to that granted in terms of Section 78(6)(i) of the CPA for the duration of the suspension.²⁴⁸ During the period of suspension, Section 77(6)(a)(i) is deemed to read as follows (words inserted by this order are underlined and words omitted are deleted):²⁴⁹

- "(i) in the case of a charge of murder or culpable homicide or rape or compelled rape as contemplated in sections 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, respectively, or a charge involving serious violence or if the court considers it to be necessary in the public interest, where the court finds that the accused has committed the act in question, or any other offence involving serious violence, ~~be detained in a psychiatric hospital or a prison pending the decision of a judge in chambers in terms of section 47 of the Mental Health Care Act, 2002~~
- (aa) detained in a psychiatric hospital or prison pending the decision of a judge in chambers in terms of section 47 of the Mental Health Care Act, 2002;
- (bb) be admitted to and detained in an institution stated in the order and treated as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act, 2002;
- (cc) released subject to such conditions as the court considers appropriate; or
- (dd) released unconditionally."

Figure 54 - Section 77(6)(a)(i) interim relief

During the period of suspension, subparagraph 77(6)(a)(ii) is deemed to read (words inserted by this order are underlined):

- "(ii) where the court finds that the accused has committed an offence other than one contemplated in subparagraph (i) or that he or she has not committed any offence –
- (aa) be admitted to and detained in an institution stated in the order as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act, 2002;
- (bb) released subject to such conditions as the court considers appropriate; or
- (cc) released unconditionally."

Figure 55 - Section 77(6)(a)(ii) interim relief

The case was referred to the Constitutional Court for a confirmation ruling on the matter and the judgement was delivered on 26 June 2015.²⁵⁰ The Constitutional Court declined to confirm the High Court's interim order that Section 77(6)(i) be adopted verbatim as the court

²⁴⁸(2014) 4 All SA 374 (WCC) par 72.

²⁴⁹*Ibid.*

²⁵⁰ De Vos NO and others v Minister of Justice and Constitutional Development and others 2015 (9) BCLR 1026 (CC); De Vos NO and others v Minister of Justice and Constitutional Development and others (Cape Mental Health, amicus curiae) (2016) JOL 33412 (CC).

suggests in *Figure 54*, though it found Section 77(6)(a)(i) to be inconsistent with the Constitution and invalid to the extent that it provided for compulsory imprisonment of accused persons and compulsory hospitalisation of children.²⁵¹ The court held that imprisonment should only be available to accused persons who pose a serious danger to society or themselves, and in the absence of such a threat resource constraints alone cannot dictate that an accused person be placed in prison.²⁵² Further, if resources are significantly constrained such that a bed in a psychiatric hospital is unavailable, then a presiding officer should be able to craft an appropriate order that encompasses treating the accused as an outpatient, for example, by extending the bail conditions, or any other appropriate order pending the availability of a bed in a psychiatric hospital.²⁵³ The court states that the difference in the discretion of the court between Sections 77(6) and 78(6) is due to the different purposes served by the sections, in that a person is found not guilty by reason of criminal incapacity in terms of Section 78(6) and may not suffer from mental illness at the time of the trial, making mandated hospitalisation irrational, in which case the different options become available.²⁵⁴ In terms of Section 77(6) the person has been determined to lack the fitness to stand trial due to their mental status and have not been acquitted. The order of invalidity is suspended for 24 months in order to allow the legislature to remedy the defect.²⁵⁵

The court also held that detainment as an involuntary mental health care user in terms of Section 77(6)(a)(ii) could not be justified on the basis that the accused person "nevertheless needed treatment".²⁵⁶ Section 77(6)(a)(ii) has the effect that accused persons could be more readily institutionalised under the Criminal Procedure Act without the ordinary safeguards prescribed by the MHCA, which is untenable.²⁵⁷ The court found that from article 14 of the United Nations Convention on the Rights of Persons with Disabilities (the CRPD) it is clear

²⁵¹ 2015 (9) BCLR 1026 (CC) par 61-63. Children in the criminal justice system and the Child Justice Act 75 of 2008 falls outside the scope of this thesis as youth as a factor rendering the child unfit to stand trial or criminally incapacitated falls under non-pathological criminal incapacity. See also: Karels, M and Pienaar, L (2015) 'Determination of criminal capacity for child offenders – interfacing the procedural requirements of the Child Justice and Criminal Procedure Act' *Obiter* 57-78; Skelton A, and Badenhorst C 'The Criminal Capacity of Children in South Africa - International Developments and Considerations for a Review' 2011.

²⁵² 2015 (9) BCLR 1026 (CC) par 63.

²⁵³ *Ibid.*

²⁵⁴ 2015 (9) BCLR 1026 (CC) par 39.

²⁵⁵ 2015 (9) BCLR 1026 (CC) par 65.

²⁵⁶ 2015 (9) BCLR 1026 (CC) par 66.

²⁵⁷ *Ibid.*

that one cannot remove persons with mental illnesses or intellectual disabilities from society for the mere fact that they have mental illnesses or intellectual disabilities.²⁵⁸ The provision therefore breached the substantive component of the right to freedom and security of the person as guaranteed in Section 12 of the Constitution as its effect was an arbitrary deprivation of freedom, leading to constitutional invalidity, as there is no rational connection between the purpose of the limitation and the deprivation of liberty.²⁵⁹ In the case of Section 77(6)(a)(ii), the court held that reading-in was an appropriate interim measure and Section 77(6)(a)(ii) is to read:

“(ii) where the court finds that the accused has committed an offence other than one contemplated in subparagraph (i) or that he or she has not committed any offence –

(aa) be admitted to and detained in an institution stated in the order as if he or she were an involuntary mental health care user contemplated in Section 37 of the Mental Health Care Act 17 of 2002;
(bb) be released subject to such conditions as the court considers appropriate; or
(cc) be released unconditionally.”

In the case of *Young*,²⁶⁰ judgement was delivered on 3 March 2015, 3 months before the Constitutional Court ruling in *De Vos* as discussed above. In this case Young was initially charged with sexual assault in contravention in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 for flashing his genitals in public.²⁶¹ An order in terms of Section 77(6)(a)(ii) for involuntary detention was made and the Chairperson of the Unthungulu Mental Health Review Board raised concerns about the procedure followed by the court in which the user was referred and sought direction from the court regarding:²⁶²

- i. The correct interpretation of the phrase “admitted to and detained in an institution stated in the order as if they were an involuntary mental health user” in Section

²⁵⁸ 2015 (9) BCLR 1026 (CC) par 29. Article 14 of the CRPD determines that State Parties shall ensure that persons with disabilities, on an equal basis with others, enjoy the right to liberty and security of the person and are not deprived of their liberty unlawfully or arbitrarily. Any deprivation of liberty must be in conformity with the law and the existence of a disability shall in no case justify a deprivation of liberty. The right to equality is discussed in Chapter 2.

²⁵⁹ 2015 (9) BCLR 1026 (CC) par 31.

²⁶⁰ In re: *Young* (2015) JOL 32909 (KZP).

²⁶¹ (2015) JOL 32909 (KZP) par 5.

²⁶² (2015) JOL 32909 (KZP) par 12-13.

77(6)(a)(ii) of the Criminal Procedure Act.²⁶³

- ii. There being no certainty if the mental health care user could be discharged from the hospital, if fit for discharge, without reverting to the court.
- iii. The order in terms of Section 77(6)(a)(ii) of the Criminal Procedure Act was made without the mental health care user, having being referred in terms of Section 77(1) of the Criminal Procedure Act for an enquiry and reports in accordance with the provisions of Section 79(1) of the Criminal Procedure Act.

The court found that Section 77(6)(a)(ii) required an enquiry in terms of Section 79 of the CPA where it is established that the accused is unfit to stand trial due to a mental disorder or mental defect, and provided the Section 79 procedure had been followed correctly, an initial assessment as safeguard to establish mental disorder is present had already been completed for purposes of Section 33(1)(a) of the MHCA.²⁶⁴ The court held further that in the absence of a proper enquiry by the court *a quo*, the referral by the Magistrate in terms of Section 77(6)(a)(ii) of the Criminal Procedure Act, should be declared a nullity and set aside.²⁶⁵ The court also held that the Mental Health Review Board may decide that the involuntary mental health care user should be discharged or may approve further involuntary care.²⁶⁶

5.5.2 Mental illness or mental defect and criminal responsibility

Section 78(1) of the CPA determines that a person who commits an act or makes an omission which constitutes an offence, and who at the time of such commission or omission suffers from a mental illness or mental defect which makes him or her incapable of:

²⁶³ The question to be answered was whether an order issued in terms of Section 77(6)(a)(ii) of the CPA dispensed with the statutory requirements of Section 33(1)(a) of the Mental Health Care Act 17 of 2002 read with regulation 10(1) of the General Regulations made in terms of Section 66(1) of the said Act which makes provision for an application for involuntary care, treatment and rehabilitation to be made on form MHCA 04 by a spouse, next of kin, partner, associate, parent, guardian, by a health care provider. Section 33(4)(a) requires the head of the establishment, upon receipt of the application to cause the mental health care user to be examined by two mental health care practitioners. The mental health care practitioners submit their reports in writing to the head of the establishment. It is on the basis of these reports that the head of the establishment approves the application for involuntary care, treatment and rehabilitation. Where the treatment is approved the mental health care user will be admitted and subjected to a 72 hour assessment as prescribed in Section 34(1) of the said Act. In re: Young (2015) JOL 32909 (KZP) par 14.

²⁶⁴ (2015) JOL 32909 (KZP) par 15-19.

²⁶⁵ (2015) JOL 32909 (KZP) par 24.

²⁶⁶ (2015) JOL 32909 (KZP) par 22.

- a) Appreciating the wrongfulness of his or her act or omission; or
- b) Acting in accordance with an appreciation of the wrongfulness of his or her act or omission, shall not be criminally responsible for such act or omission.

If it is alleged at criminal proceedings that the accused is by reason of mental illness or mental defect not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of Section 79.²⁶⁷ This refers to instances where pathological criminal incapacity is alleged or suspected by the court. However, Section 78(2) also provides that the court may direct that the matter be enquired into and be reported on in accordance with the provisions of Section 79 where it is suspected or alleged that the accused is lacking criminal capacity due to in any other reason, which refers to cases where the criminal incapacity is due to non-pathological reasons.²⁶⁸ Where pathological reasons for incapacity are suspected, the provision is obligatory, though in cases of non-pathological incapacity the provision is discretionary.²⁶⁹ The difference between pathological and non-pathological criminal incapacity is discussed in this chapter below.

Section 78(3) of the CPA states that if the finding contained in the relevant report is the unanimous finding of the persons who under Section 79 enquired into the relevant mental condition of the accused, and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence. If the said finding is not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under

²⁶⁷ Section 78(2) of the CPA. The report required in terms of Section 79 is discussed below in this chapter.

²⁶⁸ Deane (2006) *Codicillus* 92

²⁶⁹ This is indicative of the controversial nature of the defence of non-pathological criminal incapacity in South African criminal law, the discussion of which is outside the scope of this thesis. The fact that Section 78(1) makes no mention of reasons other than mental illness or mental defect as the possible cause of criminal incapacity (though the court may direct an enquiry based on such reason be performed) illustrates the uncertain and controversial nature of the defence and some authors have called for the amendment of the CPA to include non-pathological reasons for criminal incapacity in Section 78(1).

Section 79 enquired into the mental condition of the accused.²⁷⁰ Section 78(5) of the CPA determines that the party disputing the finding may subpoena and cross-examine any person who enquired into the mental state of the accused under Section 79.

If the court finds that the accused committed the act in question and that they at the time of such commission were by reason of mental illness or intellectual disability not criminally responsible for such act.²⁷¹

- a) The court shall find the accused not guilty; or
- b) If the court so finds after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside and find the accused not guilty, by reason of mental illness or intellectual disability, as the case may be, and direct:
 - (i) in a case where the accused is charged with murder, culpable homicide, rape or compelled rape,²⁷² or another charge involving serious violence, or if the court considers it to be necessary in the public interest that the accused be:
 - (aa) detained in a psychiatric hospital or a prison pending the decision of a judge in chambers in terms of Section 47 of the Mental Health Care Act, 2002;
 - (bb) admitted to and detained in an institution stated in the order and treated as if they were an involuntary mental health care user contemplated in Section 37 of the Mental Health Care Act, 2002;²⁷³
 - (dd) released subject to such conditions as the court considers appropriate; or
 - (ee) released unconditionally;
 - (ii) in any other case that the accused:
 - (aa) be admitted to and detained in an institution stated in the order and treated

²⁷⁰ Section 78(4) of the CPA.

²⁷¹ Section 78(6) of the CPA.

²⁷² As contemplated in sections 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.

²⁷³ Section 78(6)(i)(cc) made provision for treatment as an outpatient, but has since been removed by Section 13 of Act 55 of 2002.

as if they were an involuntary mental health care user contemplated in Section 37 of the Mental Health Care Act, 2002;²⁷⁴

(cc) be released subject to such conditions as the court considers appropriate;
or

(dd) be released unconditionally.

The most conspicuous difference between Sections 77(6) and 78(6), as discussed above, is that the court in terms of the latter provision has a fairly wide discretion concerning a range of orders that can be made, whereas the court under the former provision has no discretion.²⁷⁵ It is submitted that section 78(6)(a) is not sufficiently clear due to the use of the word “or”. In reading the provision it states that if an accused was found to have committed the act in question while lacking criminal capacity that they should be found not guilty, and then continues to paragraph 78(6)(b) after an “or”, which indicates that that is the end of the matter and the only finding a court is authorised to make. Section 78(6)(a) has however been interpreted to mean that the court will find the accused not guilty and in addition make one of the directives listed in Section 78(6)(b). It is submitted that the legislator would not have meant for a mentally ill accused person lacking criminal capacity to be declared not guilty, without making provision for discretionary special directives such as those listed in Section 78(6)(b), therefore it is recommended that Section 78(6) be amended to ensure clarity and legal certainty on the matter. The amendment should take the form of combining the wording of Section 78(6)(a) and (b) and only listing the discretionary objectives in Section 78(6)(b), as follows:

- a) “the court shall find the accused not guilty, *or if the court so finds after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside and find the accused not guilty, by reason of mental illness or intellectual disability, as the case may be; and*”
- b) “*the court shall direct: ...*”

²⁷⁴ Section 78(6)(ii)(bb) made provision for treatment as an outpatient, but has since been removed by Section 13 of Act 55 of 2002

²⁷⁵ De Vos N.O and Another v Minister of Justice and Constitutional Development and Others; In Re Snyders and Another v Minister of Justice and Constitutional Development and Others (2014) 4 All SA 374 (WCC) par 11.

An accused against whom a finding is made under Section 78(6) may appeal against such finding if the finding is not made in consequence of an allegation by the accused.²⁷⁶ Such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence.²⁷⁷ Where an appeal against such a finding is allowed, the court of appeal shall set aside the finding and the direction and remit the case to the court which made the finding, whereupon the relevant proceedings shall be continued in the ordinary course.²⁷⁸ Milton regards the “special verdict” in Section 78(6) as problematic from a human rights perspective, as a verdict of “not guilty” in terms of Section 78(6)(a) cannot rely upon the finding of not guilty to avoid detention, and equates such a verdict to a conviction due to the fact that Section 78(8) makes it possible to appeal against the acquittal.²⁷⁹ To compound the issue such a person is also denied the right to judicial review.²⁸⁰ The provisions of Section 78(6) also make it possible for the curious contradiction to arise where a sane person is detained in a mental institution (or a prison) because he committed a crime for which, in law, he is not responsible and has accordingly been found “not guilty”.²⁸¹

It is submitted that Section 78(6) should be amended to include safeguards or standards against which the court must exercise their discretion to make an order for detention, namely that present mental disorder must be a requirement for detention otherwise release is the prudent directive to make. It must also be considered that Section 37 of the MHCA regarding involuntary detention requires that the mental health care user must be suffering from a mental disorder otherwise detention would be imprudent and unlawful.²⁸² This implies that if an accused lacks criminal capacity due to mental defect and it does not fit into the medical conception of “mental disorder”, detention under Section 37 of such a person would be unwarranted and unlawful.

²⁷⁶ Section 78(8)(a) of the CPA.

²⁷⁷ Section 78(8)(b) of the CPA.

²⁷⁸ Section 78(9) of the CPA.

²⁷⁹ Milton, JRL (1998) ' Law Commission Project 89: Declaration and detention of State Patients' South African Journal of Criminal Justice 11 228-233 230.

²⁸⁰ *Ibid.*

²⁸¹ *Ibid.*

²⁸² Section 37 of the MHCA was discussed in Chapter 4.

Kaliski suggests the following amendments to Section 78 of the CPA.²⁸³

- 1) The finding under Section 78 of the Criminal Procedure Act should be changed to a “guilty but insane” verdict, which will enable the court to issue an order that could initially limit the period that a State Patient would remain certified. The court could either impose mandatory periods, which could compare to those that may have been imposed for a comparable conviction, or every State Patient could be certified for an initial period, for example, two years.

It is submitted that this suggestion is untenable, as a South African court cannot find a person guilty when they have been found to lack criminal capacity. The period which a person can be involuntarily detained under Section 78 is already limited in terms of the provisions of Section 37 and 47 of the MHCA which provides for periodic reviews and annual reports.²⁸⁴ It is submitted that where review mechanisms for State Patients and Involuntary mental health care users is found to be lacking, they should rather be amended accordingly.

- 2) At the end of the court ordered period of certification the State Patient would automatically be discharged (as a prisoner would be released at the end of a sentence), unless the treating clinicians motivate for a further designated period of certification.

It is submitted that this is also an untenable suggestion, as the order in terms of Section 78(6) is not tantamount to a prison sentence and the purpose of the detention is to ensure care, treatment and rehabilitation of the user, whilst ensuring their safety and the safety of others. Due to the duration of treatment or affliction with mental disorders being difficult to predict, mandatory periods of certification are imprudent and the provisions of the MHCA regarding periodic and annual review already provide for this function.

²⁸³ Kaliski (2012) *Afri J Psychiatry* 86.

²⁸⁴ Section 37 was discussed in Chapter . Section 47 regarding State Patients is discussed below in this chapter.

5.5.2.1 *Onus on proving lack of criminal capacity*

Every person is presumed not to suffer from a mental illness or mental until the contrary is proved on a balance of probabilities, and whenever the criminal responsibility of an accused is in issue, the burden of proof regarding the criminal responsibility of the accused shall be on the party who raises the issue.²⁸⁵ The criminal capacity of children is considered differently from adults, as children under seven years of age are presumed to irrebuttably lack criminal capacity, and children between seven and fourteen years of age are rebuttably presumed to lack criminal capacity.²⁸⁶ Sections 78(1A) and (1B) do not take cognisance of the rights and special considerations regarding children, nor does the Criminal Justice Act 75 of 2008 provide explicitly for such cases, leading to a situation where the rights of children, and particularly mentally disordered children, are infringed upon. This is discussed above in this chapter regarding the case of *De Vos*.²⁸⁷

A judicial declaration that a person is mentally ill or the person's subjection to the provisions of mental health legislation is not decisive in the determination of whether a person acted voluntarily, possessed criminal capacity or acted with intention; it must be proven before the court in each trial.²⁸⁸ Judicial declaration or subjection to mental health legislation is however relevant as far as the onus of proof is concerned as it creates a rebuttable presumption of incapacity, shifting the onus of proof to the party who seeks to hold the accused person criminally liable.²⁸⁹

Milton states that from a human rights perspective one of the most egregious issues relating to mentally ill persons charged with committing a crime is the matter of the reversal of the onus

²⁸⁵ Sections 78(1A) and 78(1B) of the CPA.

²⁸⁶ Louw 39; Snyman 157, 178; Burchell and Milton 366; Van Oosten (1993) SACJ 132, 133; Community Law Centre (2003) "Rebutting the presumption of criminal capacity. *S v Ngobesi and others* 2001 (1) SACR 562" 5 Article 40 36; Skelton(2006) 'Examining the age of criminal capacity' Article 40: The Dynamics of Youth Justice and the Convention on the Rights of the Child in South Africa 3.

²⁸⁷ *De Vos N.O and Another v Minister of Justice and Constitutional Development and Others; In Re Snyders and Another v Minister of Justice and Constitutional Development and Others* (2014) 4 All SA 374 (WCC); *De Vos NO and others v Minister of Justice and Constitutional Development and others* 2015 (9) BCLR 1026 (CC); *De Vos NO and others v Minister of Justice and Constitutional Development and others* (Cape Mental Health, amicus curiae) [2016] JOL 33412 (CC).

²⁸⁸ Chetty (2008) *Acta Criminologica: CRIMSA Conference: Special Edition* 131.

²⁸⁹ Snyman 170.

of proof, requiring persons who plead incapacity to prove that they are insane.²⁹⁰ Milton states that it is remarkable that the Rumpff Commission declined to recommend any change to the onus of proof, as it is anomalous in reversing the onus only in cases of pathological incapacity but not in cases of non-pathological incapacity.²⁹¹ The South African Law Commission in 1995 and 2001 already proposed that the reverse onus is untenable and possibly unconstitutional as it is neither reasonable nor justified.²⁹² The Law Commission in 2001 rejected the contention that shifting the onus of proving insanity back to the prosecutor would lead to a situation that is “impossible” to disprove if insanity was alleged, due to the panel of enquiry into mental state that the accused is referred to in terms of Section 79 of the CPA.²⁹³ It is submitted that the report generated by this panel of expert forensic assessors would constitute an objective statement of fact upon which both the defence and prosecution could argue in favour of or opposing an acquittal.

In the case of *H v United Kingdom*,²⁹⁴ it was determined that the reverse onus does not infringe upon article 6(2) of the ECHR and that it is not unreasonable or arbitrary.²⁹⁵ Emmerson *et al.* state that the reverse onus may be unjustified in terms of article 6, and that the arguments advanced in *H v United Kingdom* neglected the difference between merely requiring the defence to “present evidence” and shifting the ultimate burden of proving insanity to the defence; and the questionable argument that the shift should rather be viewed as regarding the presumption of sanity as opposed to the presumption of innocence.²⁹⁶

It is submitted that the reverse onus is not justified and should not be applicable to persons

²⁹⁰ Milton, JRL (1998) 'Law Commission Project 89: Declaration and detention of State Patients' South African Journal of Criminal Justice 11 228-233 228.

²⁹¹ Milton (1998) 230.

²⁹² Law Commission 'The Declaration and Detention of Persons as State Patients under the Criminal Procedure Act 1977 and the Discharge of Such Persons under the Mental Health Act 1973, including the Burden of Proof with Regard to the Mental State of an Accused or Convicted Person' Project 89 (1995) par 8.38; Milton (1998) South African Journal of Criminal Justice 231-232. South African Law Commission Report 'The Application of the Bill of Rights to criminal procedure, criminal law, the law of evidence and sentencing' Project 101 (2001) par 2.57-2.59.

²⁹³ Emmerson, Q.C, Ashworth, A. and Macdonald, A. *et al.* 'Human rights and criminal justice' 2012 Sweet and Maxwell, London 742.

²⁹⁴ App No. 15023/89 (1990) Unreported; Emmerson, Ashworth Macdonald *et al.* 673.

²⁹⁵ Section 6(2) of the ECHR determines that “everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.” Emmerson, Ashworth and Macdonald 673.

²⁹⁶ Emmerson, Ashworth Macdonald *et al.* 740.

who allege criminal incapacity due to mental disorder or defect (while not applying to other defences in criminal law),²⁹⁷ as it is an arbitrary and unjustified infringement of their right to a fair trial under Section 35 of the Constitution, as well as the right to equality enshrined in Section 9 of the Constitution.²⁹⁸

5.5.3 Panel for purposes of enquiry and report under Sections 77 and 78

Section 79(1)(a) determines that where a court issues a direction under Sections 77(1) or 78(2) above, the relevant enquiry shall be conducted and be reported on by the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by the medical superintendent at the request of the court where the accused is charged with an offence other than one referred to in Section 79(1)(b).²⁹⁹ According to Section 79(1)(b) of Act 51 of 1977, where an accused has committed murder, culpable homicide, rape or compelled rape as contemplated in Sections 3 and 4 of Act 32 of 2007, or an offence involving serious violence or if the court considers it necessary in the public interest, or where the court in a particular case so directs, a panel of two or three psychiatrists will be appointed to report on the accused:

²⁹⁷ Milton (1998) South African Journal of Criminal Justice 232.

²⁹⁸ Section 78(1B) infringes upon Section 9(1) of the Constitution as it differentiates between mentally ill accused persons by only reversing the onus only in defences of non-pathological criminal incapacity, and the differentiation is not justified, legitimate or rational. Section 78(1B) also amounts to unfair discrimination in terms of Section 9(3) of the Constitution. See Mare, R 'The Constitutional Validity of Section 78(1b) of the Criminal Procedure Act 51 Of 1977 with regard to Section 9 of the Constitution of the Republic of South Africa, 1996' (LLM dissertation, UP, 2011) for a detailed exposition on the issue.

²⁹⁹ Section 79(12) states that for the purposes of this section a psychiatrist or a clinical psychologist means a person registered as a psychiatrist or a clinical psychologist under the Health Professions Act 56 of 1974.

Section 79(9) provides that the Director-General: Health shall compile and keep a list of-

- a) psychiatrists and clinical psychologists who are prepared to conduct any enquiry under this section; and
- b) psychiatrists who are prepared to conduct any enquiry under Section 286A (3), and shall provide the registrars of the High Courts and all clerks of magistrate's courts with a copy thereof.

Section 79(8) determines that a psychiatrist and a clinical psychologist, other than a psychiatrist and a clinical psychologist appointed for the accused, shall, be appointed from the list of psychiatrists and clinical psychologists. Where the list does not include a sufficient number of psychiatrists and clinical psychologists who may conveniently be appointed for any enquiry, a psychiatrist and clinical psychologist may be appointed for the purposes of such enquiry notwithstanding that their name does not appear on such list (Section 79(10)).

79(11)(a) and (b) determine that a psychiatrist or clinical psychologist designated or appointed under Section 79(1) by or at the request of the court to enquire into the mental condition of an accused, or a psychiatrist appointed under Section 79(1)(b)(iii) for the accused to enquire into the mental condition of the accused, and who is not in the full-time service of the State, shall be compensated for his or her services in connection with the enquiry from public funds in accordance with a tariff determined by the Minister in consultation with the Minister of Finance.

- i. By the medical superintendent of a psychiatric hospital designated by the court, or by a psychiatrist appointed by the medical superintendent at the request of the court;
- ii. By a psychiatrist appointed by the court and who is not in the fulltime service of the State unless the court directs otherwise, upon application of the prosecutor, in accordance with directives issued under Section 79(13) by the National Director of Public Prosecutions;³⁰⁰
- iii. By a psychiatrist appointed for the accused by the court; and
- iv. By a clinical psychologist where the court so directs.³⁰¹

In *S v Pedro*,³⁰² the court held that where the relevant legislative procedures have not been complied with in terms of Section 79(1)(b) the proceedings will be set aside and remitted to the court *a quo*.³⁰³ In this case it was held that the appointment of a private psychiatrist is mandatory unless the court, upon application from the prosecutor, directs that the appointment of a private psychiatrist may be dispensed with.³⁰⁴ The court further held that the “medical superintendent” refer to in Section 79(1) should be amended to refer to current nomenclature that would indicate the most senior forensic psychiatric position at the hospital.³⁰⁵

The court may for the purposes of the relevant enquiry commit the accused to a psychiatric hospital or to any other place designated by the court for periods not exceeding thirty days at a time, as the court may from time to time determine.³⁰⁶ When the period of committal is extended for the first time, Section 79(2)(b) determines it may be granted in the absence of the accused, unless the accused requests otherwise. The assessment consists of:³⁰⁷

³⁰⁰ Section 79(13)(a) determines that the National Director of Public Prosecutions must, in consultation with the Minister, issue directives regarding the cases and circumstances in which a prosecutor must apply to the court to appoint a psychiatrist as provided for in Section 79(1)(b)(ii). Section 79(13)(b) states that the directives must ensure that adequate disciplinary steps will be taken against a prosecutor who fails to comply with any directive.

³⁰¹ Louw 50; Kaliski 95.

³⁰² (2014) 4 All SA 114 (WCC).

³⁰³ (2014) 4 All SA 114 (WCC) par 117.

³⁰⁴ (2014) 4 All SA 114 (WCC) par 116.

³⁰⁵ *Ibid.*

³⁰⁶ Section 79(2)(a) of Act 51 of 1977.

³⁰⁷ Erlacher and Reid 315; Barrett (2007) ‘Profile of mentally ill offenders referred to the Free State Psychiatric Complex: article’ South African Journal of Psychiatry 56. Calitz, F.J.W. *et al.* (2006) “Psychiatric evaluation of offenders referred to the Free State Psychiatric Complex according to Sections 77 and / or 78 of the Criminal Procedures Act” 12 South African Journal of Psychiatry 3 47-5048.

- A full physical and neurological examination, including blood tests and tests for substance abuse;
- Interviews by a mental health professional;
- Social work involvement;
- Psychological assessment and tests;
- Other investigations deemed necessary;
- 24-hour observation by nursing staff.

In the recent case against famous former Olympian, Oscar Pistorius,³⁰⁸ the court ordered the observation of the accused of 30 days in terms of Section 79 of the CPA after it was alleged at proceedings that he suffered from a personality disorder. The order provided that the accused need only be observed as an outpatient during the day and could spend nights away from the facility, even though it had been alleged that part of the anxiety disorder included vivid nightmares and trouble sleeping. It is submitted that these concessions rendered the findings in the report inaccurate and incomplete, and that a custodial inpatient observation should be mandatory in each case.

The report must include:³⁰⁹

- a) A description of the nature of the enquiry; and
- b) A diagnosis of the mental condition of the accused; and
- c) If the enquiry is under Section 77 (1), include a finding as to whether the accused is capable of understanding the proceedings in question to make a proper defence; or
- d) If the enquiry is in terms of Section 78(2), include a finding as to the extent to which the capacity of the accused at the time of the commission of the act in question affected by mental illness or mental defect to appreciate its wrongfulness, or to act in accordance with an appreciation.

Swanepoel advances that where it is certain that the opinions of forensic experts will not be

³⁰⁸ S v Pistorius (CC113/2013); Director of Public Prosecutions, Gauteng v Pistorius (96/2015) (2015) ZASCA 204.

³⁰⁹ Section 79(4) of the CPA.

seriously challenged it may be sufficient if they simply generally describe the nature of their investigations and conclusions, though in most cases forensic experts must testify and give an accurate account of the investigations that they carried out and substantiate their conclusions.³¹⁰ Reports should be clear and accurate to ensure that decision makers make appropriate decisions.³¹¹ It is submitted that it is not up to the expert witness to decide in which cases more careful scrutiny and elucidation is required, as it is for the court to decide on the ultimate issue based on all the evidence. It is the role of the expert witness as forensic assessor to commit the same attention to detail to each case. Though there is no strict format prescribed (other than that the report must be in writing),³¹² a report should always address the required legal issues with clarity, relevance and ethical content, keeping in mind that ultimate issues are not to be addressed, thus an opinion on the guilt of the accused must be avoided and only the matter of criminal capacity discussed.³¹³ A good report would be comprehensive, objective, instructional, unbiased and expressive of the level of confidence the expert has in the findings.³¹⁴

Kaliski explains that from the mental health practitioner's viewpoint, the first step in assessment of an accused would be to determine whether the accused suffers from a mental illness, defect or other important condition, then to decide whether the severity of the identified condition was enough to significantly impair the accused's cognitive or conative abilities and lastly whether these impairments influenced the accused's actions at the time of commission of the offence.³¹⁵ This is also formulated by Burchell as the test for insanity.³¹⁶ It is not the task of the mental health professional to establish whether the accused possessed criminal capacity as that is an ultimate issue and solely the court's decision, but rather to determine if a disorder, condition or circumstance existed that negated it,³¹⁷ and only to pronounce an opinion on the degree of impact such a particular disorder may have had.³¹⁸ It is

³¹⁰ Swanepoel 180.

³¹¹ Swanepoel 180.

³¹² Section 79(3) of the CPA.

³¹³ Kaliski, S.; Allan, A.; Meintjes-van der Walt, L. "Writing a psycholegal report" in Kaliski, S. (ed.) "Psycholegal assessment in South Africa" 2006 329-335.

³¹⁴ Erlacher and Reid 332.

³¹⁵ Kaliski 102.

³¹⁶ Burchell and Milton 373.

³¹⁷ Kaliski 103.

³¹⁸ Kaliski5; *Michael and Another v Linksfeld Park Clinic (Pty) Ltd and Another* 2001 3 SA 1188 (SCA) par 34.

for the Court to decide the question of the accused's criminal capacity, having regard to the expert evidence and all the facts of the case, including the nature of the accused's actions during the relevant period.³¹⁹ This was also the position of the court in *S v Van As*.³²⁰ Individual behaviour and functioning are more important than diagnostic label.³²¹

The District Surgeon, in the case of *Young* submitted a report which states "He is not 100% insane, however not 100% in full '*compos mentos*' with his environment. He is a loner and makes an income by begging at robots".³²² On the strength of this report detention in terms of Section 77(6)(a)(ii) of the CPA was ordered by the court as if the accused was an involuntary mental health care user. It is submitted that a report that is this vague and uses such inexact terminology should be declared invalid.

Swanepoel states that while there is nothing to prevent a lawyer from settling or finalising the report of an expert, it should always reflect the unbiased, independent opinion of the expert that is uninfluenced by the requirements of litigation.³²³ It is submitted that it should be an express rule that an expert witness is acting as an aid to the court in the quest to find the truth and that it must be forbidden for the report of an expert witness to be "settled" by a legal practitioner, as the impartiality of the report is then called into question. In cases where a forensic mental health assessor is discovered to be acting as a "hired gun" by allowing their testimony to be tailored to the benefit of a particular party, it should be tantamount to perjury and the evidence should be disallowed as the credibility of the expert is called into question.

According to Section 79(5) of the CPA, if the persons conducting the relevant enquiry are not unanimous in their finding, such fact shall be mentioned in the report and each of such persons shall give his or her finding on the matter in question. It is unclear whether the members of the panel are required or allowed to confer with each other in order to reach

³¹⁹ Grant, J (2006) 'Determinism, neuroscience and responsibility' 2 International Journal of Law in Context 3 221–231 670; Eadie 2002 (1) SACR 633 (SCA)445H.

³²⁰ 1991 2 SACR 74 (W).

³²¹ Swanepoel 'Law, psychiatry and psychology: A selection of medico-legal and clinical issues' 2010 THRHR 194.

³²² (2015) JOL 32909 (KZP) par 7.

³²³ Swanepoel 180. Swanepoel refers to the English case of *Whitehouse v Jordan and Another* [1981] 1 All ER 267 (HL) where the court highlighted the dangers of allowing a report by experts to be settled by council, as the report will suffer and more closely resemble a special pleading than an impartial report.

consensus.³²⁴ Each member of the multi-disciplinary team conducts an enquiry and at some stage ought to present their findings in a case conference, when hypotheses are discussed and any further assessments planned. Ultimately the resulting report represents the consensus of the team.³²⁵ This can be criticised in that the court requires an objective finding from each expert and the consensual report may negate this objectivity when there are dissenting opinions and different views and issues of seniority in the profession or work environment. The report of each individual expert mandated to report on the accused should ideally be untainted by the opinion of another, to enable the court to make its own decision on the evidence presented.

The prosecutor must provide the panel with the following information in order for them to conduct a thorough investigation:³²⁶

- a) Whether the accused is being assessed for criminal capacity or fitness to stand trial;
- b) Who requested the referral;
- c) The nature of the charge against the accused;
- d) The stage in the proceedings when the referral was made;
- e) Statements made in court by the accused prior to referral that are relevant to the enquiry;
- f) The relevance of the evidence to the enquiry;
- g) Any information concerning the accused's social background and family composition and the names and addresses of his or her near relatives; and
- h) Any other relevant information.

During the process of compiling a report in terms of a Section 77, 78 or 79 of the CPA enquiry, the *audi alteram partem* rule does not apply as the forensic mental health assessor is not acting in a judicial, quasi-judicial or administrative role, but rather as an independent

³²⁴ Spammers 2010 36

³²⁵ Kaliski 97.

³²⁶ Section 79(1A) of the CPA; Kaliski 95.

observer.³²⁷ Therefore information acquired by such an assessor in order to facilitate a meaningful assessment of the accused is not required to be given to the accused at the stage of observation as the accused will have a chance to cross-examine and challenge the forensic assessor in court and in that manner the *audi alteram partem* rule is then realised.³²⁸

A statement made by an accused at the relevant enquiry shall not be admissible in evidence against the accused at criminal proceedings, except to the extent to which it may be relevant to the determination of the mental condition of the accused, in which event such statement shall be admissible.³²⁹ Regulation 41(1) of the General Regulations to the MHCA determines that a person referred by a court of law to a health establishment in terms of Section 79 of the Criminal Procedure Act, 1977 for observation, must be informed that a report will be submitted by a mental health care practitioner to the court of law and that they are under no obligation to divulge information. Regulation 41(1) of the MHCA does not stipulate who must inform the accused of this right, though it will likely fall on the panelists.³³⁰ It is submitted that the MHCA should be amended to provide explicitly that the forensic assessor conducting the observation should inform the accused of this right. The accused should be advised that they do not have to divulge information, but also that information may not be used against them as evidence of their guilt, but only of their mental state.³³¹ There are at present no forms prescribed in the MHCA or other accountability measures in place to make sure the accused is informed of this right. It is suggested that Section 79(4) of the CPA should be amended to state that the report should also include a statement that the accused has been informed of this right, which must be signed by the accused, or their proxy or lawyer if the accused lacks the necessary capacity to understand. Such an amendment would ensure that there is less risk of infringing the right to privacy, as is guaranteed in Section 14 of the Constitution, the discussion of which can be found in Chapter 2 of this thesis.

If a person contemplated in Regulation 41(1) is found to be mentally ill to the degree that they

³²⁷ *S v Dobson* 1993 (4) SA 55 (E); Stevens 459-461. See also Labuschagne, JMT. (1994) "Die audi alteram partem-reël by 'n psigiatriese ondersoek deur 'n hof bevel" 9 SAPL 1: 204-206.

³²⁸ *Ibid.*

³²⁹ Section 79(7) of the CPA.

³³⁰ Landman and Landman 150.

³³¹ Landman and Landman 151.

are a danger to himself or herself or others and psychiatric treatment has become a matter of urgency, such treatment must be commenced immediately even before the report contemplated in Regulation 41(1) has been submitted to a court of law.³³² Where a person has been referred by a court of law to a health establishment for observation, such person may, with the assistance of the South African Police Services, be taken to a health establishment for any neuro-psychiatric or physical health investigation that cannot be done at the place where that person is being detained provided that, while the person is undergoing investigation at the health establishment, the South African Police Services shall remain responsible for the safe custody of that person.³³³ When the person contemplated in Regulation 41(2) has undergone that investigation contemplated in Regulation 41(3), that person must be transferred with the assistance of the South African Police Services to the place where that person is being detained, or that alternative place, including a psychiatric hospital, that may have been arranged arising from the investigation, provided that the documentation relating to that investigation must be sent together with the person to the place where they are being transferred.³³⁴

There is a deceptive opinion that no treatment should be administered during the observation period as it may interfere with the assessment of the accused's mental state.³³⁵ Kaliski is of the opinion that if there is a history of psychiatric illness and a record that shows the accused is on treatment, that it should be continued.³³⁶ There is less clarity when there is no history of treatment or when the only issue is competence to stand trial as opposed to criminal capacity at the time of the offence.³³⁷ In the USA, treatment during the observation period is only administered if it is deemed to be medically necessary and not for the sole purpose of returning an accused to competency to stand trial or if the accused refuses treatment.³³⁸ Treatment should not be imposed on an unwilling accused undergoing assessment, unless ethical reasons are compelling.³³⁹ Kaliski also feels that the approach that would serve justice

³³² Regulation 41(2) of the General Regulations to the MHCA.

³³³ Regulation 41(3) of the General Regulations to the MHCA.

³³⁴ Regulation 41(4) of the General Regulations to the MHCA.

³³⁵ Kaliski 101; Spammers 2010 44.

³³⁶ *Ibid.*

³³⁷ *Ibid.*

³³⁸ Kaliski 102; Spammers 2010 44.

³³⁹ *Ibid.*

best would be to commence treatment as soon as a definitive diagnosis has been reached.³⁴⁰ If accused is mentally ill to the degree that they pose a danger to themselves or others, treatment must commence immediately, even before the report is sent to the court. This must be voluntary, otherwise the user must be admitted as assisted or involuntary user.³⁴¹

The court may make the following orders after the enquiry has been conducted:³⁴²

- i. Postpone the case periods not exceeding 30 days at a time, as the court may from time to time determine;
- ii. Refer the accused at the request of the prosecutor to the court referred to in Section 77(6) which has jurisdiction to try the case;
- iii. Make any other order it deems fit regarding the custody of the accused; or
- iv. Any other order.

5.6 The Mental Health Care Act 17 of 2002

5.6.1 State Patients

The MHCA defines “State Patient as a person so classified by a court directive in terms of Section 77(6)(a) or 78(6) of the CPA. Where a court issues an order in terms of the CPA for a State Patient to be admitted for mental health care, treatment and rehabilitation services, the Registrar or the Clerk of the court must send a copy of that order to the relevant official curator ad litem,³⁴³ and officer in charge of the detention centre where the State Patient is or will be detained.³⁴⁴ The officer in charge of the detention centre must forward a copy of the order in question to the head of the national department within 14 days, requesting that the State Patient be transferred to a health establishment designated in terms of Section 41.³⁴⁵ The

³⁴⁰ Kaliski 102; Spammers 2010 44.

³⁴¹ Landman and Landman 151.

³⁴² Section 79(2)(c) of the CPA.

³⁴³ Section 42(1)(a) of the MHCA.

³⁴⁴ Section 42(1)(b) of the MHCA.

³⁴⁵ Section 42(2) of the MHCA. Section 41 of the MHCA determines that the head of the national department must, with the concurrence of the relevant heads of the provincial departments, designate health establishments, which may admit, care for, treat and provide rehabilitation services to State Patients.

head of the national department must immediately after receipt of the order determine the health establishment to which the State Patient must be transferred;³⁴⁶ ensure that arrangements are made to effect the transfer of the State Patient to the health establishment designated in terms of Section 41;³⁴⁷ and in writing notify the relevant official curator ad litem;³⁴⁸ and the official in charge of the detention centre at which the State Patient is detained, of the details of the transfer.³⁴⁹ Within 14 days of being notified of the details of the transfer, the officer in charge of the detention centre must cause the State Patient to be transferred to the health establishment specified in the notice.³⁵⁰

Section 42 of the MHCA provides for the admission of State Patients, and for the provision of care, treatment and rehabilitation services, although neither the CPA nor MHCA determines that these services must be provided on an involuntary basis. Landman argues that due to this gap in the CPA and MHCA there is no authority on which to force involuntary mental health care on State Patients, although once the State Patient is admitted on receipt of the order, even if it does not mandate treatment, the patient is provided with involuntary services on compulsory basis.³⁵¹ As there is no provision in the CPA that authorises that a State Patient may be medicated and treated without consent, the common law and the provisions of the MHCA must provide guidance and may entitle a psychiatric hospital to treat a patient depending on the facts of each case, but this decision may be challenged after the fact.³⁵² Landman states that the common law is not sufficient in this regard and that Section 32 of the MHCA must be referred to instead to ensure the treatment of the State Patient is sanctioned by law and does not amount to an assault.³⁵³ The admission of State Patients under Section 32 of the MHCA has the advantage of being subject to periodic review, as this does not happen at present due to Review Boards not having jurisdiction regarding State Patients.³⁵⁴ Landman opines that it would be simplest if the MHCA were amended to deem a State Patients also to

³⁴⁶ Section 42(3)(a) of the MHCA.

³⁴⁷ Section 42(3)(b) of the MHCA.

³⁴⁸ Section 42(3)(c)(i) of the MHCA.

³⁴⁹ Section 42(3)(c)(ii) of the MHCA.

³⁵⁰ Section 42(4) of the MHCA.

³⁵¹ Landman and Landman 172.

³⁵² Landman and Landman 173.

³⁵³ *Ibid.*

³⁵⁴ *Ibid.*

be an involuntary user.³⁵⁵

It is submitted that to simply admit State Patients as involuntary users and not as State Patients would not be in line with the intention of the legislator, as Sections 77(6) and 78(6) of the CPA already contain provisions that allow an accused under particular circumstances to be admitted as an involuntary user, as discussed above.³⁵⁶ These circumstances generally refer to situations where a less serious crime has been committed,³⁵⁷ or where on balance of probabilities the offending conduct was not committed.³⁵⁸ In other circumstances the legislator explicitly makes provision for detention as a State Patient, which has its or particular provisions that differ from those regulating involuntary users.³⁵⁹ It is submitted that the MHCA should be amended in that Section 42 should explicitly clarify that State Patients are to be admitted on an involuntary basis, thus as a special type of involuntary mental health care user with the necessary special provisions that differ from provisions regarding involuntary users.

5.6.2 Leave of absence of State Patients

The head of a health establishment may, in writing, grant leave of absence to a State Patient from a designated health establishment.³⁶⁰ Written notice of leave of absence must state the commencement and the return date of the State Patient to the health establishment and must be submitted to the head of the national department;³⁶¹ and terms and conditions to be complied with during the period of leave.³⁶² The head of the health establishment may, during the period of leave, if they have reason to believe that the State Patient does not comply with the terms and conditions applicable to such leave, cancel the leave and direct as to when the

³⁵⁵ *Ibid.*

³⁵⁶ Suggestions for amendment to the particular sections have already been discussed above in this chapter as well, particularly regarding the absence of safeguard mechanisms that ensure involuntary treatment is only mandated when the presence of a mental illness has been established and that risk and dangerousness should be taken into account.

³⁵⁷ Section 77(6) and 78(6) of the CPA.

³⁵⁸ Section 77(6) of the CPA.

³⁵⁹ The provisions regarding transfer, discharge and leave of absence of State Patients are discussed in this chapter below.

³⁶⁰ Section 45(1) of the MHCA.

³⁶¹ Section 45(2)(a) of the MHCA.

³⁶² Section 45(2)(b) of the MHCA.

State Patient must return to the health establishment.³⁶³ If the State Patient fails to return to the health establishment on the return date, they will be deemed to have absconded.³⁶⁴

The head of the health establishment concerned may grant leave of absence in the form of form MHCA 27 to an assisted- or involuntary mental health care user for a period not exceeding two months at a time.³⁶⁵ Whereas the head of a health establishment concerned may grant leave of absence in the form of form MHCA 27 to a State Patient for a period not exceeding six months at a time, provided that the terms and conditions to be complied with during such period of leave is stipulated on such form.³⁶⁶ The head of a health establishment concerned may, during a period of leave, contemplated in terms of Section 45 of the Act, cancel the leave when they are authorised to it in the form of form MHCA 28 and direct on that form that the State Patient concerned be returned to the health establishment by the custodian or in terms of Regulations 28 or 29.³⁶⁷

It is submitted that State Patients differ from involuntary users in the purpose of their detention and the fact that they might pose a risk to society, as has already been stated. Therefore it seems illogical that an involuntary or assisted user may be granted a leave of absence of up to two months at a time, but a State Patient is allowed a leave of absence of up to six months at a time. Should leave of absence be deemed logical and in line with the purpose of the legislator in light of the purpose of detention of State Patients, it is submitted that leave of absence of State Patients should only be granted where it has explicitly been determined that they do not pose a risk to society, or a risk of reoffending. In light of the *Carmichele* case,³⁶⁸ it can be argued that the State has a duty to protect its citizens from harm, and therefore to consider the risk a State Patient may pose in deciding whether it is prudent to release them on a leave of absence. It must be considered that if a person is sufficiently recovered in their mental state to warrant a leave of absence, it might be a better course of action in cases involving State Patients to establish whether discharge is the appropriate

³⁶³ Section 45(3) of the MHCA.

³⁶⁴ Section 45(4) of the MHCA.

³⁶⁵ Regulation 26(1) of the General Regulations to the MHCA.

³⁶⁶ Regulation 26(2) of the General Regulations to the MHCA.

³⁶⁷ Regulation 26(3) of the General Regulations to the MHCA.

³⁶⁸ *Carmichele v Minister of Safety and Security* (CCT 48/00) [2001] ZACC 22; 2001 (4) SA 938 (CC); 2001 (10) BCLR 995 (CC).

decision instead.

A Review Board does not have jurisdiction to order the discharge of a State Patient,³⁶⁹ therefore it seems illogical that a health establishment would have jurisdiction to grant a leave of absence and the MHCA should be amended either to determine that a leave of absence is not applicable to State Patients, or that a leave of absence must be confirmed by a judge in chambers.

5.6.2.1 MHCA forms pertaining to the leave of absence of State Patients

5.6.2.1.1 MHCA 27 - Leave of absence to State Patients in terms of Section 45 of the MHCA; or assisted or involuntary mental health care users in terms of Section 66(1)(j) of the MHCA

It is submitted that MHCA 27 (*Figure 56* and *Figure 57*) contains the necessary information for purposes of the MHCA as it currently stands. It should however be amended to include a reference to the judge in chambers who must sign off on the decision to grant a leave of absence (*Figure 57*). In addition, if the MHCA should be amended as is proposed above, it is submitted that form MHCA 27 should include a section where it can be indicated that the State Patient has been assessed and is deemed to not pose a risk to society or a risk of reoffending. If the MHCA is amended as suggested to determine that a leave of absence is not an appropriate mechanism for use in cases involving State Patients, MHCA 27 would no longer be applicable to them.

³⁶⁹ Section 47 of the MHCA regarding discharge of State Patients is discussed below in this chapter.



DEPARTMENT OF HEALTH

LEAVE OF ABSENCE TO –
STATE PATIENTS IN TERMS OF SECTION 45 OF THE ACT; OR
ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USERS IN TERMS OF
SECTION 66(1)(j) OF THE ACT

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Residential address or custodian's name and address whilst on leave of absence:

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

The user is: (mark with a cross)

State patient Assisted user Involuntary user

Date of commencement of leave:

Due date of return from leave:

Name of health establishment where the user's mental health status will be monitored and reviewed:

The user is to present him- / herself to this health establishment every weeks / months to be monitored and his / her health status reviewed.

Figure56 – MHCA 27

Name of health establishment(s) where care, treatment and rehabilitation will be provided and the nature of this:

Conditions of behaviour which must be adhered to by the user:

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

Name of psychiatric hospital where the user is to be admitted if he / she relapses and / or is not complying with the terms and conditions applicable to the leave:

.....

Print initials and surname:

Signature:
(head of health establishment)

Date:

Place:

Print initials and surname:

Signature:
(custodian)

Date:

Place:

Figure 57 – MHCA 27

5.6.2.1.2 MHCA 28 - Cancellation of leave of absence - a State Patient in terms of Section 45 of the MHCA; or an assisted or involuntary mental health care user in terms of Section 66(1)(j) of the MHCA

It is submitted that MHCA 28 (*Figure 58*) should be amended to include reference to a judge in chambers, in whose authority it should be to cancel leave of absence of a State Patient or to whom it should be applied for confirmation of cancellation. If the MHCA is amended as suggested to determine that a leave of absence is not an appropriate mechanism for use in cases involving State Patients, MHCA 28 would no longer apply to them.



DEPARTMENT OF HEALTH

CANCELLATION OF LEAVE OF ABSENCE –
A STATE PATIENT IN TERMS OF SECTION 45 OF THE ACT; OR
AN ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USER IN TERMS
OF SECTION 66(1)(j) OF THE ACT

I hereby cancel the leave of absence of
(name of State patient, assistant- or involuntary mental health care user)

File No.

You are not complying with the terms and conditions applicable to the leave of absence
and/or have/has relapsed to the extent of requiring hospitalization.

Reasons for cancellation of leave of absence:
.....
.....
.....
.....

You must return to
(name of health establishment)
by (date) or you will be reported to the
South African Police Services as absconded.

Print initials and surname:

Signature:
(head of health establishment)

Date:
Place:
(Copy to custodian)

Figure 58 – MHCA 28

5.6.3 State Patients who abscond

Section 44(1) determines that if a State Patient has absconded or is deemed by the head of the relevant designated health establishment to have absconded, the head of that health establishment must, in writing immediately notify and request the South African Police Service to locate, apprehend and return the patient to the relevant health establishment;³⁷⁰ and notify the Registrar or Clerk of the court concerned and the official *curator ad litem*, within

³⁷⁰ Section 44(1)(a) of the MHCA.

14 days of having notified the South African Police Service.³⁷¹ The South African Police Service must comply with the request.³⁷² If a State Patient is considered dangerous, the head of the health establishment must notify the South African Police Service.³⁷³ A State Patient who is apprehended must be held in custody for such period as prescribed to affect their return.³⁷⁴ A member of the South African Police Service may use such constraining measures as may be necessary and proportionate in the circumstances when apprehending any person or performing any function in terms of this Section.³⁷⁵ If the State Patient returns to the hospital of their own accord, the hospital must notify the police, although it is not stated in the regulations explicitly.³⁷⁶

5.6.4 Discharge of State Patients

5.6.4.1 Application for discharge of State Patients

The court in *S v Ramokoka*³⁷⁷ held that Section 47 of the MHCA does not have an automatic review mechanism, so that a person detained in terms of Section 77(6) of the CPA remains detained until an application is made to a Judge in Chambers and the Judge orders the release. It is submitted that the MHCA should be amended to include an automatic review mechanism, in order to prevent a situation where a State Patient is detained whilst not suffering from a mental disorder as that would amount to arbitrary and unlawful detention in terms of Section 35 of the Constitution. Reference can be made to the case of *Young* as discussed above, where the court held that if the procedure in terms of Section 77 or 78 had been meticulously followed in that an assessment and report in terms of Section 79 was carried out and compiled, a safeguard was already in place to establish whether a mental disorder was present or not.³⁷⁸ As was discussed above, the CPA should be amended to include a provision that mandatory detention of State Patients may only be ordered in the presence of a mental

³⁷¹ Section 44(1)(b) of the MHCA.

³⁷² Section 44(2) of the MHCA.

³⁷³ Section 44(3) of the MHCA.

³⁷⁴ Section 44(4) of the MHCA.

³⁷⁵ Section 44(5) of the MHCA.

³⁷⁶ Landman and Landman 178.

³⁷⁷ 2006 (2) SACR 57 (WLD) par 12.

³⁷⁸ (2015) JOL 32909 (KZP) par 15-19.

disorder warranting compulsory treatment and detention.

According to Section 47(1), any of the following persons may apply to a judge in chambers for the discharge of a State Patient:

- a) The State Patient;
- b) An official *curator ad litem*;
- c) An administrator, if appointed;
- d) The head of the health establishment at which a State Patient is admitted;
- e) The medical practitioner responsible for administering care, treatment and rehabilitation services to a State Patient;
- f) A spouse, an associate or a next of kin of a State Patient; or
- g) Any other person authorised to act on behalf of a State Patient.

Such an application must be in a prescribed form and contain reasons for the application;³⁷⁹ and a report by a psychologist, if the State Patient has been assessed by such a person.³⁸⁰ Where the applicant is an official *curator ad litem* or an administrator, a report containing a history and a prognosis of a mental health status of the State Patient from the head of the health establishment where the State Patient is admitted;³⁸¹ and two mental health practitioners and one of whom must be a psychiatrist must be provided.³⁸² A person contemplated in Section 47(1) of the MHCA who is not the official *curator ad litem* or administrator of a State Patient may apply in the form of form MHCA 29 to a judge in chambers for the discharge of that State Patient.³⁸³ The official *curator ad litem* or administrator of a State Patient may apply in the form of form MHCA 30 to a judge in chambers for the discharge of a State Patient.³⁸⁴

Details of any application made for the discharge of the State Patient within 12 months before

³⁷⁹ Section 47(2)(a) of the MHCA.

³⁸⁰ Section 47(2)(b) of the MHCA.

³⁸¹ Section 47(2)(c)(i) of the MHCA.

³⁸² Section 47(2)(c)(ii) of the MHCA.

³⁸³ Regulation 30(1) of the General Regulations to the MHCA.

³⁸⁴ Regulation 30(2) of the General Regulations to the MHCA.

the application in question should be included,³⁸⁵ and in the case where the applicant is not an official curator ad litem or administrator, an indication of whether the current curators may have a conflict of interest with the State Patient must be indicated and proof supplied that a copy of the application has been given to the curators concerned.³⁸⁶ Where the applicant is an associate or the person referred to in paragraph (e), the nature of the substantial or material interest or the nature of the conflict, if any must be declared;³⁸⁷ and any information relevant to the application held by the applicant must be provided.³⁸⁸

Section 47(3) determines that the Registrar of the High Court must submit a copy of the application to an official *curator ad litem*, where the applicant is not an official *curator ad litem*. The official *curator ad litem* must within 30 days of receipt of the application, submit a written report to the judge in chambers and such report must set out and contain a history and a prognosis of the mental health status of the State Patient from the head of the designated health establishment at which the State Patient has been admitted;³⁸⁹ and two mental health practitioners and one of whom must be a psychiatrist.³⁹⁰ The report must also contain a report from a psychologist if the State Patient has been assessed by such a person;³⁹¹ indicate whether another application was made for the discharge of the State Patient concerned within a period of 12 months and the status of such application;³⁹² and make recommendations on whether the application should be granted and the basis for the recommendation.³⁹³

It is submitted that the timeframe of 30 days granted to the *curator ad litem* in which to compile and submit a report to a judge in chambers amounts to an undue deprivation of freedom of the State Patient who remains in detention despite the possible existence of reasons that would render their continued detention unlawful. Additionally there is no mechanism to ensure that the 30 day period is adhered to, nor is it clear from when the 30 days should be counted (from the date of the application or the date of receipt of the report or

³⁸⁵ Section 47(2)(d) of the MHCA.

³⁸⁶ Section 47(2)(e) of the MHCA.

³⁸⁷ Section 47(2)(f) of the MHCA.

³⁸⁸ Section 47(2)(g) of the MHCA.

³⁸⁹ Section 47(3)(a)(i) of the MHCA.

³⁹⁰ Section 47(3)(a)(ii) of the MHCA.

³⁹¹ Section 47(3)(b) of the MHCA.

³⁹² Section 47(3)(c) of the MHCA.

³⁹³ Section 47(3)(d) of the MHCA.

the date the curator becomes aware of the report).

5.6.4.2 Judicial consideration of the report

Section 47(4) provides that on considering the application, the judge in chambers must establish whether another application for the discharge of the State Patient concerned is pending or had been considered within a period of 12 months, in which case, the application referred to in Section 47(3) must be dismissed.³⁹⁴ The Judge must also establish whether the official *curator ad litem* has a conflict of interest with the State Patient, in which case a legal practitioner must be appointed to assist in the processing of the present application;³⁹⁵ and may call for further information and assistance from the applicant, mental health practitioner or a relevant curator, as may be necessary to process the application.³⁹⁶ On considering an application, the judge in chambers may make an order in the form of form MHCA 31 that the State Patient:

- a) Remain a State Patient; or
- b) Be reclassified; or
- c) Be discharged conditionally; or
- d) Be discharged unconditionally.³⁹⁷

In terms of Section 47(5), the legal practitioner appointed in terms of subsection 4(b) must adduce any available evidence relevant to the application;³⁹⁸ perform the functions and duties as required by the judge in chambers concerned to process the application;³⁹⁹ and be remunerated by the national department responsible for justice and constitutional development according to the tariffs and scale of benefits and allowances determined for this purpose by the member of Cabinet responsible for justice and constitutional development.⁴⁰⁰ For the purposes of this section "legal practitioner" means an attorney or an advocate who has

³⁹⁴ Section 47(4)(a) of the MHCA.

³⁹⁵ Section 47(4)(b) of the MHCA.

³⁹⁶ Section 47(4)(c) of the MHCA.

³⁹⁷ Regulation 30(3) of the General Regulations to the MHCA.

³⁹⁸ Section 47(5)(a) of the MHCA.

³⁹⁹ Section 47(5)(b) of the MHCA.

⁴⁰⁰ Section 47(5)(c) of the MHCA.

a right of appearance in a High Court.⁴⁰¹

It is submitted that Section 47(4)(a) of the MHCA is fundamentally unfair in that it requires the outright rejection of an application for discharge if another application had been brought in the previous 12 months. It is submitted that this is an inordinate amount of time to be deprived of liberty when a State Patient may no longer be suffering from a mental disorder warranting their continued confinement. The section is possibly in breach of Section 35(2)(d) of the Constitution that provides that every detained person has the right to challenge the lawfulness of their detention; as well as Section 10 pertaining to human dignity; Section 9 protecting equality (especially since State Patients are treated differently from other mental health care users in this instance in a manner that does not seem justified in its reasoning); and Section 12 regarding arbitrary deprivation of liberty. The purpose of Section 47(4)(a) seems to be to prevent spurious applications for discharge that are continuously made without justification. If a State Patient is deemed to no longer have a mental illness, the application could contain a justification for submitting another application within a year or the MHCA should be amended to determine that if a mental health professional supports the application that it is permissible to apply again.

The MHCA gives little guidance for a judge considering a discharge report and Landman compiles a list of possible grounds to be considered in the application, including:⁴⁰² the purpose of detention as State Patient (namely to protect society); the facts of the particular case; the type of act committed; the likelihood of threat to society; and the State Patient's present mental status and prognosis; and the State Patient's constitutional rights, among other factors. It is submitted that the MHCA should be amended to include guidance to the judge that considers such an application.

5.6.4.3 Orders to be made on application for discharge

On considering the application, the judge in chambers in terms of Section 47(6) may make the

⁴⁰¹ Section 47(7) of the MHCA.

⁴⁰² Landman and Landman 182-183.

following orders regarding the State Patient:

- a) Remain a State Patient;
- b) Be reclassified and dealt with as a voluntary, assisted or involuntary mental health care user;
- c) Be discharged unconditionally; or
- d) Be discharged conditionally.

5.6.4.4 Conditional discharge of State Patients, amendments to conditions or revocation of conditional discharge

Section 48(1) determines that where a State Patient is discharged conditionally in terms of Section 47(6)(d), such an order must specify the terms and conditions of the discharge and the period of the conditional discharge. The head of the health establishment from which the State Patient was conditionally discharged must cause the mental health status of the State Patient to be monitored at that health establishment;⁴⁰³ or arrange for another health establishment to monitor the State Patient, if the conditional discharge requires the State Patient to present him or herself at that health establishment for care, treatment and rehabilitation services.⁴⁰⁴ The person monitoring the State Patient must submit a written report to the head of the health establishment at which the State Patient was discharged relating to any terms and conditions applicable to the discharge;⁴⁰⁵ at the end of every six months from the date on which the conditional discharge order was made;⁴⁰⁶ and at the end of the conditional discharge period.⁴⁰⁷

If at the end of the conditional discharge, the head of the health establishment is satisfied that the State Patient has fully complied with the terms and conditions applicable to the discharge, and that the mental health status of the State Patient has not deteriorated, the head of that health establishment must immediately discharge the State Patient unconditionally,⁴⁰⁸ and in

⁴⁰³ Section 48(2)(a) of the MHCA.

⁴⁰⁴ Section 48(2)(b) of the MHCA.

⁴⁰⁵ Section 48(3)(a) of the MHCA.

⁴⁰⁶ Section 48(3)(b) of the MHCA.

⁴⁰⁷ Section 48(3)(c) of the MHCA.

⁴⁰⁸ Section 48(4)(a) of the MHCA.

writing, inform the State Patient, the Registrar concerned and the official *curator ad litem*.⁴⁰⁹ Regulation 17 of the General Regulations to the MHCA determines that the discharge report must be issued by way of form MHCA 03.

If after considering any report submitted in terms of Section 48(3), the head of the health establishment has reason to believe that the State Patient has not fully complied with the terms and conditions applicable to the discharge;⁴¹⁰ or mental health status of the State Patient has deteriorated, the head of the health establishment may apply to the Registrar of the High Court concerned for an order amending the conditions or revoking the conditional discharge, and forward a copy of the application to the official *curator ad litem*.⁴¹¹ If the head of a health establishment, after receiving a report contemplated in Section 41(3) of the Act, has reason to believe that the State Patient has not fully complied with the terms and conditions applicable to the discharge or that the mental health status of the State Patient has deteriorated, that head must use form MHCA 34 for the purpose of Section 48(5) of the Act.⁴¹²

A State Patient who has been discharged conditionally may at any time after six months from the date on which the order was made, and thereafter, at no less than six months intervals, apply in the prescribed manner to the judge in chambers concerned for an amendment of any condition applicable to the discharge;⁴¹³ or unconditional discharge.⁴¹⁴ A State Patient who has been discharged conditionally, must for the purpose of Section 48(6) of the MHCA, make an application in the form of form MHCA 35.⁴¹⁵ Section 48(7) determines that the application referred to in Section 48(6), must set out the following:

- a) condition to be amended;
- b) duration of such amendment; and
- c) reasons for the amendment or revocation of the conditional discharge.

⁴⁰⁹ Section 48(4)(b) of the MHCA.

⁴¹⁰ Section 48(5)(a) of the MHCA.

⁴¹¹ Section 48(5)(b) of the MHCA.

⁴¹² Regulation 30(4) of the General Regulations to the MHCA.

⁴¹³ Section 48(6)(a) of the MHCA.

⁴¹⁴ Section 48(6)(b) of the MHCA.

⁴¹⁵ Regulation 30(5) of the General Regulations to the MHCA.

A state official has a legal duty to act reasonably regarding the discharge of a State Patient and if in breach of this duty risks a claim for wrongful detention.⁴¹⁶

5.6.5 MHCA forms pertaining to discharge of State Patients

5.6.5.1 MHCA 29 - Application for discharge of State Patient to judge in chambers (where applicant is not an official curator ad litem or administrator) in terms of Section 47(2)(e) of the MHCA

It is submitted that MHCA 29 should be amended so that after the indication of whether an application had been made in the previous 12 months (*Figure 59*), the form makes provision to indicate whether the mental state of the State Patient has improved to such an extent that continued detention is unwarranted (*Figure 60*), and also to indicate whether the application is supported by a mental health care practitioner if it was not brought by such a practitioner. In such a case the rest of the form can be completed, even though another application had been brought in the previous 12 months (as is in line with the suggested amendments to the MHCA above).

⁴¹⁶ Landman and Landman179.



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Republic of South Africa

DEPARTMENT OF HEALTH

APPLICATION FOR DISCHARGE OF STATE PATIENT TO JUDGE IN CHAMBERS
(WHERE APPLICANT IS NOT AN OFFICIAL *CURATOR AD LITEM* OR
ADMINISTRATOR)

[Section 47(2)(e) of the Act]

Surname of user

First name(s) of user

File No. (if known)

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

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

Charge against user:

Person making application (mark with a cross)

State patient him/herself Administrator Head of health establishment
(state what)

Responsible medical practitioner Spouse Associate Next of kin Other

Reason for application:
.....
.....
.....
.....

Has an application been made for discharge of the user within the preceding 12 months by
any application other than an official *curator ad litem*? Yes No

Figure 59 – MHCA 29



If Yes provide details of the status of that application (and no need to proceed further with this form)

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

Report from psychologist (if available)

Yes

No

In your opinion does the official *curator ad litem* have a conflict of interest with the user?

Yes

No

Give reasons:

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

Supply proof that a copy of the application has been given to the official *curator ad litem* concerned.

Where the applicant is an "associate" state the nature of the substantial or material interest in the user

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

Attach all reports you have available relevant to this application.

Provide details of any prior application for discharge that you are aware of:

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

Print initials and surname:

Signature:

(Applicant)

Date:

Place:


Figure 60 – MHCA 29

**5.6.5.2 MHCA 30 - Application for discharge of State Patient to judge in chambers
(where applicant is an official curator ad litem or administrator) in terms of
Section 47(2)(c) of the MHCA**

It is submitted that MHCA 30 (*Figure 61*) should be amended so that after the indication of whether an application had been made in the previous 12 months (*Figure 61*), the form makes provision to indicate whether the mental state of the State Patient has improved to such an extent that continued detention is unwarranted (*Figure 61*), and also to indicate whether the application is supported by a mental health care practitioner if it was not brought by such a practitioner. In such a case the rest of the form can be completed, even though another

application had been brought in the previous 12 months (as is in line with the suggested amendments to the MHCA above).

It is further submitted that MHCA 30 be amended to make provision for the mental health practitioners indicated in Section 47(2) and (3) to indicate their exact profession, to ensure that one of the practitioners is in fact a psychiatrist as is required in the MHCA (*Figure 63* and *Figure 64*). MHCA 30 should also provide for situations where a person other than the head of the health establishment signs off on the form on permission of the head of the establishment and provide a space to indicate as such.



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Republic of South Africa

MHCA 30

DEPARTMENT OF HEALTH

APPLICATION FOR DISCHARGE OF STATE PATIENT TO JUDGE IN CHAMBERS
(WHERE APPLICANT IS AN OFFICIAL CURATOR AD LITEM OR ADMINISTRATOR)
[Section 47(2)(c) of the Act]

Surname of user

First name(s) of user

File No. (if known)

Date of birth or estimated age

Gender: Male Female

Address:

Date of admission:

Charge against user:

Date declared a State patient:

Health establishment where user is being treated:

Application for discharge made by official *curator ad litem* / other
 If other, state whom:

Has an application been made for discharge of the user within the preceding 12 months by any applicant other than an official *curator ad litem*? Yes No

If yes, provide details of the status of that application (and no need to proceed further with this form)

Report from psychologist (attach if available) Yes No

Attach reports containing the history of the user's mental health status and a prognosis concerning their mental health status from:

Figure 61 – MHCA 30



- Head of the relevant health establishment
 - Two mental health care practitioners at least one of whom should be a psychiatrist
- Recommendations and comments on whether the application should be granted:

.....

Print initials and surname:

Signature:
(official *curator ad litem*)

Date:

Place:

Psychiatric report in terms of section 47(2) and 47(3)(a) of the Act

General information regarding:

- (a) escapes / attempted escapes
- (b) violent behaviour
- (c) seclusions and reasons for this
- (d) attempts at obtaining alcohol and dagga
- (e) any other unacceptable behaviour

Summarized history of user's mental health status:

.....

Description of present mental condition:

.....

Figure 62 – MHCA 30

It is submitted that MHCA 30 does not make clear the date which the curator submitted the report to the judge in chambers, nor does it provide for a space to indicate that the submission happened within the 30 day timeframe and the form should be amended as such.



Prognosis:

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

Recommendation(s):

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

Print initials and surname:
(head of health establishment)

Signature:

Date:

Place:

Psychiatric report in terms of section 47(2) and 47(3)(a) of the Act by a psychiatrist / medical practitioner

Educational qualifications

Occupation before admission

Nature of charge

Review of medical and psychiatric history before admission:

.....
.....

Present mental state and duration

.....
.....

Diagnosis

.....

Figure 63 – MHCA 30



.....

Treatment received in hospital

.....

.....

Prognosis

.....

.....

Recommendations

.....

.....

Print initials and surname:

Signature:
(psychiatrist / medical practitioner)

Date:

Place:

Psychiatric report in terms of section 47(2) and 47(3)(a) of the Act by a psychiatrist / medical practitioner

Educational qualifications

Occupation before admission

Nature of charge

Review of medical and psychiatric history before admission:

.....

.....

Present mental state and duration

.....

.....

Figure 64 – MHCA 30

.....
Diagnosis
.....
.....
.....
Treatment received in hospital
.....
.....
.....
Prognosis
.....
.....
.....
Recommendations
.....
.....
.....
Print initials and surname:

Signature:
(psychiatrist / medical practitioner)

Date:

Place:

Figure 65 – MHCA 30

5.6.5.3 MHCA 31 - Order by judge in chambers for conditional discharge of State Patient in terms of Section 47(6) of the MHCA

It is submitted that MHCA 31 (*Figure 66* and *Figure 67*) is satisfactory for in terms of the information required and clarity of the presentation.



DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 31

DEPARTMENT OF HEALTH

ORDER BY JUDGE IN CHAMBERS FOR CONDITIONAL DISCHARGE OF STATE
PATIENT
[Section 47(6) of the Act]

Surname of user

First name(s) of user

File No. (if known)

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Residential address

Nature of charge:

The above-mentioned State patient is hereby ordered to be conditionally discharged under the following terms and conditions:

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

Period of conditional discharge (years)

Name and address of custodian into whose charge the user is transferred:
.....
.....
.....

Figure 66 – MHCA 31

Where the user's mental health status will be monitored and reviewed:

.....
(name of health establishment)

The user is to present him / herself to this health establishment every weeks / months to be monitored and his / her mental health status reviewed.

Name of the health establishment(s) where care, treatment and rehabilitation will be provided and the nature of this:

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

Name of psychiatric hospital / care and rehabilitation center where the user is to be admitted if he / she relapses or if the conditions of the conditional discharge are violated.
.....

Print initials and surname:

Signature:
(Judge in chambers)

Date:

Place:

Figure 67 – MHCA 31

5.6.5.4 MHCA 32 - Six monthly report on conditionally discharged State Patient in terms of Section 48(3) of the MHCA

It is submitted that MHCA 32 (*Figure 68*) should be amended to provide that the person monitoring the State Patient must state their name and occupation and also the date that the next six-monthly report should be submitted, if applicable.



DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 32

DEPARTMENT OF HEALTH

SIX MONTHLY REPORT ON CONDITIONALLY DISCHARGED STATE PATIENT
[Section 48(3) of the Act]

Surname of user

First name(s) of user

File No. (if known)

Date of birth or estimated age

Gender: Male Female

Address:

Nature of charge:

Date of conditional discharge:

Date of last report:

Comment on the extent to which the user is adhering to the terms and conditions of the discharge:
.....
.....

Current mental health status of user:
.....
.....

Recommendation to head of health establishment from where the user was conditionally discharged
.....
.....

Print initials and surname:

Signature:
(person monitoring the State patient)

Date:

Place:

(Copies to be forwarded to the State patient, head of relevant health establishment, clerk of the court and head of national department)

Figure 68 – MHCA 32

5.6.5.5 MHCA 33 - Unconditional discharge by head of health establishment of State Patient previously discharged conditionally in terms of Section 48(4)(a) of the MHCA

It is submitted that MHCA 33 (Figure 69) is satisfactory in the information required and in the clarity of the presentation. It should however be amended in order that the details of a person other than the head of the health establishment must be provided where such a person was authorised to sign the form on behalf of the head.



MHCA 33

DEPARTMENT OF HEALTH

**UNCONDITIONAL DISCHARGE BY HEAD OF HEALTH ESTABLISHMENT OF STATE
PATIENT PREVIOUSLY DISCHARGED CONDITIONALLY
[Section 48(4)(a) of the Act]**

Surname of user

First name(s) of user

File No. (if known)

Date of birth or estimated age

Gender: Male Female

Address:

Date of conditional discharge:

Date of expiry of conditional discharge:

I hereby state that the period of the above user's conditional discharge has expired, that he / she has complied with the terms and conditions applicable to his / her mental health status and that his / her mental health status has not deteriorated.

The above user is hereby unconditionally discharged.

Print initials and surname:

Signature:
(head of health establishment)

Date:

Place:

(Copies to be forwarded to the State patient, Registrar of the Court concerned, the official *curator ad litem* and national department)

Figure 69 – MHCA 33

5.6.5.6 MHCA 34 - Application to registrar of the high court for an order amending the conditions/revoking the conditional discharge of a State Patient in terms of Section 48(5) of the MHCA

It is submitted that MHCA 34 (Figure 70 and Figure 71) is satisfactory in the information required and in the clarity of the presentation. It should however be amended in order that the details of a person other than the head of the health establishment must be provided where such a person was authorised to sign the form on behalf of the head.



MHCA 34

DEPARTMENT OF HEALTH

APPLICATION TO REGISTRAR OF THE HIGH COURT FOR AN ORDER
AMENDING THE CONDITIONS / REVOKING THE CONDITIONAL DISCHARGE
OF A STATE PATIENT
[Section 48(5) of the Act]

Surname of user

First name(s) of user

File No. (if known)

Date of birth or estimated age

Gender: Male Female

Address:

Nature of charge:

Residential address:

.....

.....

.....

I hereby request that the conditional discharge of the above State patient be amended or revoked

The above State patient has not complied with the following terms and conditions of his/her conditional discharge (explain)

.....

.....

.....

and his/her mental health status has deteriorate (explain)

.....

.....

.....

Figure 70 – MHCA 34

(if applicable) I recommend that the terms and conditions of the discharge be amended along the following lines:

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

Print initials and surname:

Signature:
(head of health establishment)

Date:

Place:

(Copies to be forwarded to the official *curator ad litem* and national department)

Figure 71 – MHCA 34

5.6.5.7 MHCA 35 - Application by State Patient to judge in chambers for amendment of any condition applicable to discharge or requesting unconditional discharge in terms of Section 48(6) and (7) of the MHCA

It is submitted that MHCA 35 (*Figure 72* and *Figure 73*) is satisfactory in the information required and in the clarity of the presentation. It should however be amended in order that the details of a person other than the head of the health establishment must be provided where such a person was authorised to sign the form on behalf of the head.



DEPARTMENT OF HEALTH

APPLICATION BY STATE PATIENT TO JUDGE IN CHAMBERS FOR
AMENDMENT TO ANY CONDITION APPLICABLE TO DISCHARGE OR
REQUESTING UNCONDITIONAL DISCHARGE
[Section 48(6) and (7) of the Act]

Surname of user
First name(s) of user
File No. (if known)
Date of birth or estimated age
Gender: Male Female

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

Date of conditional discharge:

Date of last request for amendment / revocation of conditional discharge:
(may not be within six months of current application)

I hereby request that the following terms(s), condition(s) of my discharge be amended:
.....
.....
.....

Reasons for amending condition / requesting unconditional discharge:
.....
.....

Figure 72 – MHCA 35

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

Print initials and surname:

Signature:

(State patient)

Date:

Place:

Decision by Judge in Chamber:

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

Print initials and surname:

Signature:

(Judge in Chambers)

Date:

Place:

(Copy to State patient, head of health establishment, head of the national department,
Registrar of the High Court and *curator ad litem*)

Figure 73 – MHCA 35

5.6.6 Mentally ill prisoners

This section discusses the provisions in the MHCA regarding mentally ill prisoners. In situations where mental disorder is identified in prison, prisoners may be referred for further psychiatric observation. If mentally disordered prisoners are detained and kept in prison without being removed to mental institutions, this constitutes a violation of rights.⁴¹⁷

⁴¹⁷ Morodi, L.R. (2001) “The Constitutional Rights of Prisoners within the South African Criminal Justice System” *Crime Research in South Africa* 4 4.

The Mental Health Care Act defines “mentally ill prisoner” as a prisoner as defined in Section 1 of the Correctional Services Act⁴¹⁸ in respect of whom an order has been issued in terms of Section 52(3)(a) to enable the provision of care, treatment and rehabilitation services at a health establishment designated in terms of Section 49.⁴¹⁹ Section 53(2)(a) is discussed below. The new Correctional Services Act of 1998 (hereafter the CSA) was enacted after the MHCA came into effect and the definitions and terminology have changed in the interim.⁴²⁰ The previous definition of mentally ill prisoner was “any person, whether convicted or not, who is detained in custody in any prison or who is being transferred in custody or is en route in custody from one prison to another prison, to be read with the definition of prison in section 1 of the CSA.”⁴²¹

A prisoner is now termed in the CSA as an “inmate”, the definition of which was inserted into the CSA 111 of 1998 by Section 1(j) of Act 25 of 2008 and amended by Section 1(a) of Act 5 of 2011.⁴²² An inmate is defined as “any person, whether convicted or not, who is detained in custody in any correctional centre or remand detention facility or who is being transferred in custody or is *en route* from one correctional centre or remand detention centre to another correctional centre or remand detention facility”.⁴²³ A prison is now termed a “correctional centre” as defined in Section 1 of the CSA and includes police cells or lockups. This means that detained persons in police cells also fall under the definition of “inmate” and may become “mentally ill prisoners” for purposes of the MHCA.⁴²⁴ The CSA also classifies persons into “unsentenced offenders”, sentenced offenders”, “remand detainees”, and mentally ill remand detainees”.⁴²⁵ Sections 51, 52 and 53 of the MHCA narrow the definition of mentally ill prisoner to convicted prisoners.⁴²⁶ The notion of an unsentenced offender is important for the MHCA's definition of “mentally ill prisoner”, as inmates who do not comply with the term

⁴¹⁸Act 111 of 1998.

⁴¹⁹ Section 49 of the MHCA determines that the head of the national department must, with the concurrence of the heads of the provincial departments, designate health establishments, which may admit, care for, treat and provide rehabilitation services to mentally ill prisoners.

⁴²⁰ Landman and Landman 191.

⁴²¹ *Ibid.*

⁴²² Landman and Landman 192.

⁴²³ Section 1 of the CSA.

⁴²⁴ Landman and Landman 192.

⁴²⁵ *Ibid.*

⁴²⁶ Landman and Landman 191.

“mentally ill prisoner” (meaning a convicted prisoner) that suffer from mental illness also fall under the ambit of the MHCA and are entitled to care, treatment and rehabilitation.

It is submitted that the MHCA must be amended to reflect the same terminology as the CSA in order to clear up any confusion that might lead to unfair treatment of persons suffering from mental illness that are entitled to treatment but are refused or fall through the cracks due to a terminology discrepancy. The new CSA terminology that refers to inmates and to correction facilities are preferable and have fewer stigmas attached to them than “prisoner” and “prison”. It is further submitted that the MHCA must be amended to not only include convicted prisoners in its ambit. It is unacceptable that persons who are mentally ill would be denied or delayed treatment only because they are awaiting conviction or sentencing, as this would infringe upon their rights under Section 35 of the Constitution as detained persons, as well as the right to access to healthcare. Refusing mental health care based solely on the fact that the prisoner has not been convicted may infringe upon the right to not be treated in a cruel and inhumane manner. It is submitted that the a mechanism is necessary to ensure that persons with mental disorders do not need to wait their turn in court before possibly being diverted as a State Patient, or sent for observation under Section 77 or 78 of the CPA. It would be preferable if such an assessment could be initiated after recommendation by the correctional facility as well.

5.6.6.1 Awaiting trial prisoners (mentally ill remand detainees)

The MHCA caters for prisoners who do not fall within the definition of “mentally ill prisoner” as voluntary, involuntary or assisted users.⁴²⁷ The CSA refers to “remand detainees ”that are defined as “(a) a person detained in a remand detention facility awaiting the finalisation of his or her trial, whether by acquittal or sentence, if such a person has not commenced serving a sentence or is not already serving a prior sentence; or (b) a person contemplated in Section 9 of the Extradition Act 67 of 1962 detained for the purposes of extradition” detained in “remand detention facilities” as defined in the CSA. A remand detainee may also be treated by their own medical practitioner in terms of Section 35 of the Constitution.

⁴²⁷ Landman and Landman 201.

5.6.6.2 Enquiry into mental health status of prisoner

Section 50(1) determines that if it appears to the head of a prison through personal observation or from information provided that a prisoner may be mentally ill, the head of the prison must cause the mental health status of the prisoner to be enquired into by a psychiatrist;⁴²⁸ or where a psychiatrist is not readily available, by a medical practitioner;⁴²⁹ and a mental health care practitioner.⁴³⁰ The person conducting the enquiry must submit a written report to the head of the prison, and must specify in the report the mental health status of the prisoner;⁴³¹ and a plan for the care, treatment and rehabilitation of that prisoner.⁴³² The head of a prison has the duty of causing an inquiry to be made into the mental health status of a prisoner and this includes the head of a police station detained in a police cell.⁴³³

5.6.6.3 Care, treatment and rehabilitation of prisoners with mental illnesses in prison

If the person conducting the enquiry referred to in Section 50, finds that the mental illness of the convicted prisoner is of such a nature that the prisoner concerned could appropriately be cared for, treated and rehabilitated in the prison, the head of the prison must take the necessary steps to ensure that the required levels of care, treatment and rehabilitation services are provided to that prisoner.⁴³⁴ The care, treatment and rehabilitation of prisoners with mental illness in prisons is obscured by the wording of Sections 51 and 52 of the MHCA, both of which refer to “convicted” prisoners who are referred to as “unsentenced prisoners” in the CSA. The effect of this wording is that it does not refer to awaiting trial prisoners.⁴³⁵ It is submitted that the MHCA and CPA should be amended as suggested above to accommodate awaiting trial prisoners and unconvicted prisoners. It is further submitted that an appeal process should be enacted to enable a mentally ill prisoner treated in prison under Section 51 to appeal the decision to not transfer them to a health establishment. It is submitted that

⁴²⁸ Section 50(1)(a) of the Act

⁴²⁹ Section 50(1)(b)(i) of the MHCA.

⁴³⁰ Section 50(1)(b)(ii) of the MHCA.

⁴³¹ Section 50(2)(a) of the MHCA.

⁴³² Section 50(2)(b) of the MHCA.

⁴³³ Landman and Landman 192.

⁴³⁴ Section 51 of the MHCA.

⁴³⁵ Landman and Landman 193.

Section 51 does not explicitly determine whether care, treatment and rehabilitation of mentally ill prisoners is to be provided on an involuntary basis and the MHCA should be amended to reflect this.

5.6.6.4 Magisterial enquiry concerning transfer to designated health establishments

If the person conducting the enquiry referred to in Section 50, finds that the mental illness of the convicted prisoner is of such a nature that the prisoner concerned ought to be cared for and treated in a health establishment designated in terms of Section 49, the head of the prison must request a magistrate to cause a subsequent enquiry to be conducted into the mental health status of the prisoner as to whether a transfer to a health establishment designated in terms of Section 49 would be appropriate.⁴³⁶ The magistrate must commission two mental health care practitioners of whom at least one must be a psychiatrist, psychologist or medical practitioner with special training in mental health to enquire into the mental health status of the prisoner concerned and to make recommendations on whether the prisoner concerned should be transferred to a health establishment designated in terms of Section 49.⁴³⁷

If the mental health care practitioners recommend that the prisoner should be cared for, treated and rehabilitated at a health establishment designated in terms of Section 49, the magistrate must issue a written order to the head of the prison to transfer the prisoner concerned to that health establishment according to the procedure set out in Section 54.⁴³⁸ Alternatively if the prisoner need not be cared for and treated in a health establishment designated in terms of Section 49, but instead be cared for and treated in the prison in which the convicted prisoner is in custody, the magistrate must issue a written order to the head of the prison to take the necessary steps to ensure that the required levels of care and treatment are provided to the prisoner concerned.⁴³⁹ Regulation 22 of the General Regulations to the MHCA determines that the head of a health establishment may in terms of Section 54(2) of the Act in the form of form MHCA 19 request the Review Board concerned to order the

⁴³⁶ Section 52(1) of the MHCA.

⁴³⁷ Section 52(2) of the MHCA.

⁴³⁸ Section 52(3)(a) of the MHCA.

⁴³⁹ Section 52(3)(b) of the MHCA.

transfer of an assisted-or involuntary mental health care user and a State Patient or mentally ill prisoner to another health establishment or a designated health establishment with a maximum security facility.

The MHCA does not define the degree of severity or type of mental illness that can be treated in prison in terms of Section 51, and those who need to be transferred to designated health establishments after requesting a magistrate to cause an inquiry to be made (Sections 49 and 52). It is submitted that there should be guidelines as to which prisoners can be treated in prisons and which must be transferred to a health establishment. The MHCA and regulations must be amended to give clearer guidelines as to which prisoners warrant transfer for treatment and which do not, also considering the type of prison facilities and medical care on hand. It is also submitted that the longer process in terms of Section 52 of requesting a magistrate to decide whether it is appropriate to ask medical experts to assess the mental health status of a prisoner is not time or resource efficient. Additionally a magistrate does not have the required medical knowledge to make a decision on the mental state of the prisoner; rather the head of prison should be able to commission the required mental health assessors personally. It is submitted that Section 52 does not explicitly determine whether care, treatment and rehabilitation of mentally ill prisoners is to be provided on an involuntary basis and the MHCA should be amended to reflect this.

5.6.6.5 Procedure to transfer mentally ill prisoners to designated health establishments

On receipt of a written order referred to in Section 52(3)(a), the head of the prison concerned must forward a copy of the order to the administrator, if appointed;⁴⁴⁰ and the head of the national department, together with a request that the mentally ill prisoner be transferred to a health establishment designated in terms of Section 49.⁴⁴¹ The head of the national department must immediately determine the health establishment to which the mentally ill prisoner must be transferred;⁴⁴² ensure that arrangements are made to effect the transfer of the mentally ill

⁴⁴⁰ Section 53(1)(a) of the MHCA.

⁴⁴¹ Section 53(1)(b) of the MHCA.

⁴⁴² Section 53(2)(a) of the MHCA.

prisoner to the appropriate health establishment designated in terms of Section 49;⁴⁴³ and in writing, notify the head of the prison and the administrator, if appointed, of the details of such transfer.⁴⁴⁴ The head of the prison must, within 14 days of receipt of the notice of the details of the transfer, cause the mentally ill prisoner to be transferred to the specified health establishment.⁴⁴⁵ Whenever a transfer is effected in terms of this section, the head of the health establishment receiving a mentally ill prisoner is deemed to have lawful custody of the prisoner only on admission;⁴⁴⁶ and responsible for the safe custody of the prisoner.⁴⁴⁷

5.6.6.6 Transfer of mentally ill prisoners between designated health establishments

Transfer of mentally ill prisoners between designated health establishments is discussed below in this chapter along with the transfer of State Patients between health establishments, and transfer of involuntary mental health care users and State Patients to maximum security facilities.

5.6.6.7 Mentally ill prisoners who abscond from health establishments

If a mentally ill prisoner has absconded or is deemed to have absconded, the head of the relevant health establishment must, in writing immediately notify and request members of the South African Police Service to locate, apprehend and return the mentally ill prisoner to the health establishment in question;⁴⁴⁸ and notify the relevant magistrate and the head of the prison within 14 days of having notified the South African Police Service.⁴⁴⁹ The South African Police Service must comply with the request.⁴⁵⁰ If the mentally ill prisoner is considered dangerous, the head of the health establishment must notify the South African Police Service.⁴⁵¹ A mentally ill prisoner apprehended must be held in custody for such period

⁴⁴³ Section 53(2)(b) of the MHCA.

⁴⁴⁴ Section 53(2)(c) of the MHCA.

⁴⁴⁵ Section 53(3) of the MHCA.

⁴⁴⁶ Section 53(4)(a) of the MHCA.

⁴⁴⁷ Section 53(4)(b) of the MHCA.

⁴⁴⁸ Section 57(1)(a) of the MHCA.

⁴⁴⁹ Section 57(1)(b) of the MHCA.

⁴⁵⁰ Section 57(2) of the MHCA.

⁴⁵¹ Section 57(3) of the MHCA.

as prescribed to effect a return.⁴⁵² A member of the South African Police Service may use such constraining measures as may be necessary and proportionate in the circumstances when apprehending a person or performing any function in terms of this section.⁴⁵³

5.6.6.8 Procedure on expiry of term of imprisonment of mentally ill prisoner

Section 58(1) determines that a mentally ill prisoner must, subject to Sections 58(2) and 58(3), be released from prison or a health establishment designated in terms of Section 49 at which the prisoner is detained on expiry of the term of imprisonment to which that prisoner was sentenced. At least 90 days before expiry of the term of imprisonment, an application may be made according to the relevant provisions in Chapter V to the head of the health establishment in which the mentally ill prisoner is detained for the provision of assisted or involuntary care, treatment and rehabilitation.⁴⁵⁴ At least 30 days before the expiry of the term of imprisonment, an application may be made to a magistrate for the continued detention of a mentally ill prisoner in the designated health establishment where such prisoner was cared for, treated and rehabilitated pending the finalisation of the application referred to in Section 58(2).⁴⁵⁵ An application in terms of Section 58(3) of the Act must be made in the form of form MHCA 38.⁴⁵⁶ It is submitted that where the term of imprisonment expires before the application for assisted or involuntary care is approved, the prisoner should be released as their continued detention is no longer lawful, unless compelling reasons exist to continue detention such as the risk of harm to the prisoner or others; or where the mentally ill prisoner submits to treatment as a voluntary user.

⁴⁵² Section 57(4) of the MHCA.

⁴⁵³ Section 57(5) of the MHCA.

⁴⁵⁴ Section 58(2) of the MHCA.


⁴⁵⁵ Section 58(3) of the MHCA.

⁴⁵⁶ Regulation 31 of the General Regulations to the MHCA.

5.6.7 MHCA forms pertaining to mentally ill prisoners

5.6.7.1 MHCA 36 - Assessment of mental status of prisoner following request from head of prison and/or magistrate in terms of Section 50(2) or 52 of the MHCA

It is submitted that MHCA 36 (Figure 74, Figure 75 and Figure 76) is sufficient in terms of the information required and presentation.



DEPARTMENT OF HEALTH
Republic of South Africa

MHCA 36

DEPARTMENT OF HEALTH

ASSESSMENT OF MENTAL HEALTH STATUS OF PRISONER FOLLOWING REQUEST FROM HEAD OF A PRISON AND/OR MAGISTRATE

[Sections 50(2) or 52 of the Act]

Surname of user

First name(s) of user

File No. (if known)

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Residential address:

.....

.....

Nature of charge:

Prison number:

Date of examination: Place of examination:

Category of designated mental health care practitioner:

Physical health status (filled in only by practitioner qualified to conduct physical examination)

(a) General physical health

.....

.....

(b) Are there signs of injuries? Yes No

(c) Are there signs of communicable disease? Yes No

If the answer to (b) or (c) if Yes, give further particulars:

.....

.....

.....

Figure 74 – MHCA 36



Report facts on previous observations of mental illness (state who provided this information)

.....

Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places)

.....

Mental health status of the user at the time of the present examination:

.....

Type of illness (provisional):

.....

In my opinion the above-mentioned user:

Has homicidal tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has suicidal tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is dangerous	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Recommendation to head of prison

The prisoner is mentally ill and requires care, treatment and rehabilitation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
--	------------------------------	-----------------------------

In my opinion the prisoner can be given care, treatment and rehabilitation within the prison and/or in a prison hospital	Yes <input type="checkbox"/>	No <input type="checkbox"/>
--	------------------------------	-----------------------------

In my opinion the mental illness is of such a nature that the prisoner should be sent to a psychiatric hospital for care, treatment and rehabilitation:

.....

Figure 75 – MHCA 36



DEPARTMENT OF HEALTH
Republic of South Africa

DEPARTMENT OF HEALTH

**MAGISTERIAL ORDER TO HEAD OF PRISON TO TRANSFER PRISONER TO HEALTH
ESTABLISHMENT FOR PURPOSES OF PROVIDING CARE, TREATMENT AND
REHABILITATION
[Sections 52(3) of the Act]**

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Residential address:

.....

.....

Prison number:

Charge against prisoner:

Where a prisoner must be transferred to

I hereby order that due to mental illness / intellectual disability the above user be transferred to a designated health establishment for care, treatment and rehabilitation in accordance with the procedure in section 45 of the Act.

Where the prisoner must be provided with care, treatment and rehabilitation within the prison environment.

I hereby order that the above user be provided with the required levels of care within the prison / prison hospital.

Print initials and surname:

Signature:

(magistrate)

Date:

Place:

[Copy to be forwarded to the Administrator (if appointed) and the head of the national department]

Figure 77 – MHCA 37



Facts concerning the mental condition of the user which were observed on previous occasions (State dates and places):

.....

Mental health status of the user at the time of the present examination:

.....

Type of illness (provisional):

.....

In my opinion the above-mentioned user:

Has homicidal tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has suicidal tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is dangerous	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Recommendation to head of prison

The prisoner is mentally ill and requires care, treatment and rehabilitation Yes No

In my opinion the prisoner can be given care, treatment and rehabilitation within the prison and/or in a prison hospital Yes No

In my opinion the mental illness is of such a nature that the prisoner should be sent to a psychiatric hospital for care, treatment and rehabilitation:

.....

Figure 78 – MHCA 37



DEPARTMENT OF HEALTH
Republic of South Africa

DEPARTMENT OF HEALTH

APPLICATION TO MAGISTRATE FOR CONTINUED DETENTION OF A MENTALLY ILL
PRISONER
[Sections 58(3) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Health establishment concerned:

File No:

Prison number:

Charge against person:

The above user has been admitted at:
(name of health establishment)

as a mentally ill prisoner since: (date of admission)

The date of expiry of his / her prison sentence is:
(date of expiry of sentence)

Application for further confinement of the user in terms of Chapter V of this Act was made on
..... by

In terms of section 58(3) of the Act, I hereby request permission to keep this user at this health establishment and provide care, treatment and rehabilitation pending the outcome of the application.

Print initials and surname:

Signature:
(head of health establishment)

Date:

Place:

Figure 80 – MHCA 38

5.6.8 Periodic Review

5.6.8.1 Periodic review of mental health status of State Patients

Section 46(1) of the MHCA determines that the head of a health establishment where a State Patient is admitted or if on leave of absence or conditional discharge must cause the mental health status of the State Patient to be reviewed after six months from the date on which care, treatment and rehabilitation services were commenced, and every 12 months thereafter. The review must make recommendations on:

- a) A plan for further care, treatment and rehabilitation service;
- b) The merits of granting leave of absence; or
- c) The discharge of the State Patient.⁴⁵⁷

The head of the health establishment must submit a summary report of the review to the head of the national department; official curator ad litem; and the administrator, if appointed.⁴⁵⁸

Within 30 days after receipt of the report, the head of the national department:

- a) May consult with any person who has information concerning the mental status of the State Patient concerned;
- b) Must make written recommendations regarding the issues referred to in subsection (2); and
- c) Must send the written recommendation and reasons to the head of the health establishment concerned.⁴⁵⁹

5.6.8.2 Periodic reviews of mental health status of mentally ill prisoners

The head of a health establishment in which a mentally ill prisoner is detained must cause the mental health status of that mentally ill prisoner to be reviewed every six months from the date on which the prisoner was received in that health establishment.⁴⁶⁰ The review must specify the mental health status of the mentally ill prisoner;⁴⁶¹ and set out recommendations regarding a plan for further care, treatment and rehabilitation services for the mentally ill prisoner;⁴⁶² and the merits of returning the mentally ill prisoner to the prison from which the prisoner was initially transferred.⁴⁶³

The head of the health establishment must submit a summary report of the review to the following in terms of Section 55(3):

⁴⁵⁷ Section 46(2) of the MHCA.

⁴⁵⁸ Section 46(3)(a)-(c) of the MHCA.

⁴⁵⁹ Section 46(4) of the MHCA.

⁴⁶⁰ Section 55(1) of the MHCA.

⁴⁶¹ Section 55(2)(a) of the MHCA.

⁴⁶² Section 55(2)(b)(i) of the MHCA.

⁴⁶³ Section 55(2)(b)(ii) of the MHCA.

- a) Review Board;
- b) Relevant magistrate;
- c) Administrator, if appointed; and
- d) Head of the relevant prison.

Within 30 days after receipt of the report, the Review Board may consult with any person who may have information concerning the mental status of the prisoner concerned,⁴⁶⁴ must make recommendations regarding a plan for further care, treatment and rehabilitation of the mentally ill prisoner concerned;⁴⁶⁵ and the return of that prisoner to the prison from which the prisoner was initially transferred;⁴⁶⁶ and must send a written notice of its recommendation and the reasons for such recommendation to the mentally ill prisoner, the administrator if appointed, the head of the relevant health establishment, the head of the national department and the magistrate concerned.⁴⁶⁷ It is submitted that there are no clear guidelines in the MHCA or regulations regarding the circumstances in which a mentally ill prisoner must be transferred back prison (such as recovery of mental status or manageability of the disorder in the prison setting) and the MHCA should be amended to that effect.

5.6.8.3 The General Regulations regarding Periodic Review

Regulation 21(1) of the General Regulations to the MHCA determines that a periodic review must be done for:

- a) A State Patient in terms of Section 46 of the Act using form MHCA 13B;
- d) A mentally ill prisoner in terms of Section 55 of the Act, using form MHCA 13A.

Regarding a person referred to in Regulation 21(1)(c):⁴⁶⁸

- d) The first review must be done by a psychiatrist or registered medical practitioner six

⁴⁶⁴ Section 55(4)(a) of the MHCA.

⁴⁶⁵ Section 55(4)(b)(i) of the MHCA.

⁴⁶⁶ Section 55(4)(b)(ii) of the MHCA.

⁴⁶⁷ Section 55(4)(c) of the MHCA.

⁴⁶⁸ Regulation 21(2) of the General Regulations to the MHCA.

- months after the commencement of care, treatment and rehabilitation services;
- e) The second review must be done by any mental health care practitioner 12 months after the first review referred to in paragraph (a); and
 - f) The reviews thereafter must be done every 12 months, provided that every alternate review shall be done by a psychiatrist or registered medical practitioner.

Regarding a person referred to in Regulation 21(1)(d), periodic reviews must be done every six months by a psychiatrist or registered medical practitioner.⁴⁶⁹

Within 30 days after the Review Board concerned has received a summary report of a periodic review referred to in Regulation 21(1)(a), (b) and (d), such Review Board must decide on the review in the form of form MHCA 17.⁴⁷⁰ It is submitted that 12 months is too long a time between periodic reviews and that an order must be made on a case by case basis, especially if the State Patient suffers from a highly treatable form of mental illness. It amounts to arbitrary conduct if periodic reviews of State Patients happen in longer timeframes than that of other mental health care users, particularly as the rationale behind the delay is unjustified.

5.6.8.4 Recovery of mental health status of mentally ill prisoners

Section 56 determines that if the head of a health establishment has reason to believe from personal observation or from information obtained, that a mentally ill prisoner has recovered from the mental illness to such an extent that the prisoner no longer requires care, treatment and rehabilitation or that the required care, treatment and rehabilitation can be appropriately given at a prison, the head of the establishment must:

- a) Compile an appropriate discharge report;
- b) Inform the head of the prison that the prisoner is ready for discharge and collection by the prison officials; and

⁴⁶⁹Regulation 21(3) of the General Regulations to the MHCA.

⁴⁷⁰Regulation 21(4) of the General Regulations to the MHCA.

MHCA 13 has already been discussed in Chapter 4, apart from the last page regarding State Patients and mentally ill prisoners, which is discussed in this section and is presented as *Figure 81*. It is submitted that MHCA 13 should be amended to provide for the date of the next periodic review for record purposes and to ensure compliance with the MHCA. Further should the recommendations above regarding leave of absence be accepted and the leave of absence of State Patients deemed inappropriate, or should it be determined that the appropriate authority to grant leave of absence should vest in a judge in chambers, MHCA 13 should be amended to reflect as such.

5.6.9.2 MHCA 17 – Decision by Review Board following summary report of review on assisted or involuntary mental health care users and mentally ill prisoners

It is submitted that MHCA 17 (*Figure 82*) should be amended to provide for check boxes to enable the Review Board to indicate clearly which factors were considered, and to indicate which persons are requested to make representations. *Figure 82* should also be amended to provide for a space where the Board can indicate which additional factors not mentioned were considered in arriving at the decision. Furthermore, check boxes should be added to *Figure 83* to enable the Review Board to clearly indicate the decision concluded.



DEPARTMENT OF HEALTH

DECISION BY REVIEW BOARD FOLLOWING SUMMARY REPORT OF REVIEW
ON ASSISTED OR INVOLUNTARY MENTAL HEALTH CARE USERS AND
MENTALLY ILL PRISONERS
[Sections 30(4), 37(4) or 55(2)(a) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

Health establishment concerned

(name of health establishment)

The Review Board of have considered

(name of Review Board)

documentation and issues relevant to the periodic review of the above user.

The Review Board have considered (inter alia) whether:

- (a) the user is capable of making an informed decision on the need to receive care, treatment and rehabilitation services.
- (b) the user is suffering from a mental illness or severe or profound intellectual disability, and as a consequence of this requires care, treatment and rehabilitation for his / her health and safety or the health and safety of others.
- (c) the user is willing to receive care, treatment and rehabilitation services.
- (d) the user is likely to inflict serious harm on him / herself or others.
- (e) care, treatment and rehabilitation is necessary for the user's financial interest and reputation.
- (f) the user's right to movement, privacy and dignity will be unnecessarily restricted.

The Review Board have requested the following people to make oral or written representations:

- (a) applicant
- (b) independent mental health care practitioner(s)
- (c) head of health establishment

Figure 82 – MHCA 17

(d) others

The Review Board concludes that:

- (a) the user should cease to receive care, treatment and rehabilitation services without his / her consent.
- (b) the user should continue to receive care, treatment and rehabilitation services as an assisted user.
- (c) the user should continue to receive involuntary care, treatment and rehabilitation services as an inpatient.
- (d) the user should continue his / her confinement within a psychiatric hospital / care and rehabilitation center, but should not be subjected to treatment against his / her wishes.
- (e) the user should continue to receive involuntary care, treatment and rehabilitation services as an outpatient.
- (f) the user should be transferred from being an involuntary inpatient to being an involuntary outpatient.

Reasons for this decision:

.....

Print initials and surname

Signature:

(chair of Review Board)

Date:

Place:

[Copy to be sent to mental health care user, applicant, head of health establishment and to the head of the national department in respect of mentally ill prisoners and to the High Court Judge in respect of an involuntary mental health care user]

Figure 83 – MHCA 17

5.6.10 Transfer between health establishments or to maximum security facilities

5.6.10.1 *Transfer of State Patients between designated health establishments*

Section 43(1) provides that despite the determination by the head of the national department in terms of Section 42(3)(a), a head of the relevant provincial department may thereafter transfer a State Patient to another health establishment designated in terms of Section 41 in

the province which the head of the provincial department has jurisdiction,⁴⁷¹ or another province with the concurrence of the head of that other provincial department.⁴⁷² Transfer may only be done if it is necessary for the care, treatment and rehabilitation of the State Patient concerned.⁴⁷³ Despite the determination of the national department, a relevant Review Board may order the State Patient to be transferred to another designated health establishment with maximum security facilities in terms of Section 41.⁴⁷⁴

In terms of Section 43(4) an order referred to in subsection (3) may only be given if the State Patient has or is likely to inflict harm on others,⁴⁷⁵ and on receipt of a written application from the head of the health establishment at which the State Patient is detained setting out the facts on which the request is based.⁴⁷⁶ On issuing the order, the Review Board concerned must forward a copy of the order concerned to the head of the national department.⁴⁷⁷ The head of the national department must within 14 days of receipt of the order determine the health establishment at which the State Patient must be transferred to;⁴⁷⁸ and ensure that the necessary arrangements are made with the appropriate health establishment to effect the transfer as ordered.⁴⁷⁹ The head of the health establishment may, with the consent of the head of the health establishment with maximum security facilities, effect the transfer pending the decision of the Review Board if the conduct of the State Patient has or is likely to give rise to an emergency.⁴⁸⁰ The person responsible for effecting a transfer in terms of this section must, in writing, notify the official curator ad litem.⁴⁸¹

Regulation 22 of the General Regulations to the MHCA determines that the head of a health establishment may in terms of Section 43 of the Act in the form of form MHCA 19 request the Review Board concerned to order the transfer of an assisted-or involuntary mental health

⁴⁷¹ Section 43(1)(a) of the MHCA.

⁴⁷² Section 43(1)(b) of the MHCA.

⁴⁷³ Section 43(2) of the MHCA.

⁴⁷⁴ Section 43(3) of the MHCA.

⁴⁷⁵ Section 43(4)(a) of the MHCA.

⁴⁷⁶ Section 43(4)(b) of the MHCA.

⁴⁷⁷ Section 43(5) of the MHCA.

⁴⁷⁸ Section 43(6)(a) of the MHCA.

⁴⁷⁹ Section 43(6)(b) of the MHCA.

⁴⁸⁰ Section 43(7) of the MHCA.

⁴⁸¹ Section 43(8) of the MHCA.

care user and a State Patient or mentally ill prisoner to another health establishment or a designated health establishment with a maximum security facility.

5.6.10.2 *Transfer of mentally ill prisoners between designated health establishments*

Section 54(1) determines that the head of the national department may from time to time order the transfer of a mentally ill prisoner from one health establishment designated in terms of Section 49 to another if it is necessary for the care, treatment and rehabilitation of the mentally ill prisoner. Despite the determination of the national department in terms of Section 53(2), the relevant Review Board may only order the transfer of a mentally ill prisoner to another health establishment designated in terms of Section 49 with maximum security facilities if the mentally ill prisoner previously absconded or attempted to abscond,⁴⁸² or has inflicted or is likely to inflict harm to others;⁴⁸³ and on receipt of a written application setting out the facts on which the request is based made by the head of the health establishment at which the mentally ill prisoner is detained.⁴⁸⁴ The Review Board must forward a copy of the order in question to the head of the national department.⁴⁸⁵

The head of the national department must, within 14 days of receipt of the order determine the health establishment to which the mentally ill prisoner must be transferred;⁴⁸⁶ and ensure that the necessary arrangements are made with the appropriate health establishment to effect the transfer.⁴⁸⁷ The head of a health establishment in which a mentally ill prisoner is detained may, with the concurrence of the head of a health establishment with maximum security facilities, effect a transfer to such health establishment pending an order by the relevant Review Board if the conduct of the mental health care user has or is likely to give rise to an emergency.⁴⁸⁸

Whenever a transfer is effected in terms of this section the person or body ordering the

⁴⁸² Section 54(2)(a)(i) of the MHCA.

⁴⁸³ Section 54(2)(a)(ii) of the MHCA.

⁴⁸⁴ Section 54(2)(a)(iii) of the MHCA.

⁴⁸⁵ Section 54(3) of the MHCA.

⁴⁸⁶ Section 54(4)(a) of the MHCA.

⁴⁸⁷ Section 54(4)(b) of the MHCA.

⁴⁸⁸ Section 54(5) of the MHCA.

transfer must, in writing within 14 days of the transfer, notify the head of the prison where the prisoner is detained of the details of the transfer;⁴⁸⁹ and the head of the health establishment receiving the mentally ill prisoner is regarded as having lawful custody of the prisoner concerned only upon receiving the prisoner;⁴⁹⁰ and is thereafter responsible for the safe custody of the prisoner.⁴⁹¹

5.6.10.3 *Notice of transfer of State Patient or mentally ill prisoner between health establishments*

If the Review Board concerned approves in terms of Section 43(3) or 54(1) of the Act the request of a head of a health establishment referred to in Regulation 20(2) or (3), such Review Board may in the form of form MHCA 20 order the transfer of a State Patient or mentally ill prisoner to another designated health establishment with a maximum security facility.⁴⁹² Regulation 24(1) provides that the person responsible for affecting a transfer of a State Patient in terms of Section 43 of the MHCA, must in the form of form MHCA 21, notify the official curator ad litem. The person or body ordering the transfer in terms of Section 54 of the Act, must, within 14 days of such transfer, in the form of form MHCA 21 notify the head of the prison where the prisoner is detained of the details of the transfer.⁴⁹³

5.6.10.4 *Transfer of State Patient from detention centre to designated health establishment and between designated health establishments*

Regulation 25(1) determines that the head of the national Department of Health must immediately after receipt of an order referred to in Section 42(1) of the Act make arrangements in terms of Section 42(3) of the Act in the form of form MHCA 23 for the transfer of the State Patient concerned from the detention centre to the health establishment designated in terms of Section 41 of the Act. Despite the determination by the head of the national department in terms of Section 42(3) concerning which health establishment the State

⁴⁸⁹ Section 54(6)(a) of the MHCA.

⁴⁹⁰ Section 54(6)(b)(i) of the MHCA.

⁴⁹¹ Section 54(6)(b)(ii) of the MHCA.

⁴⁹² Regulation 23(2) of the General Regulations to the MHCA.

⁴⁹³ Regulation 24(2) of the General Regulations to the MHCA.

Patient concerned must be transferred to from the detention centre, the head of the relevant provincial department may thereafter in terms of Section 43(1) of the Act make arrangements in the form of form MHCA 24 for the transfer of such State Patient to another health establishment designated in terms of Section 41.⁴⁹⁴

5.6.11 MHCA forms pertaining to the transfer of State Patients and Mentally ill prisoners

5.6.11.1 MHCA 19 - Request by head of health establishment to Review Board to transfer a State Patient between designated health establishments in terms of Section 43 of the MHCA

MHCA 19 has been discussed in Chapter 4.

5.6.11.2 MHCA 20 - Order by Review Board to transfer a State Patient between designated health establishments in terms of Section 43(3) of the MHCA

MHCA 20 has been discussed in Chapter 4.

5.6.11.3 MHCA 21 - Notice of transfer of State Patient or Mentally ill prisoner in terms of Section 43(8) or 54(6) of the MHCA

It is submitted that MHCA 21 (*figure 84*) should be amended to provide for the details and designation of the person or body ordering the transfer in terms of Section 43(8) or 54(6) of the MHCA.

⁴⁹⁴ Regulation 25(2) of the General Regulations to the MHCA.



MHCA 21

DEPARTMENT OF HEALTH

NOTICE OF TRANSFER OF STATE PATIENT OR MENTALLY ILL PRISONER
[sections 43(8) or 54(6) of the Act]

Surname of user
First name(s) of user
Date of birth or estimated age
Gender: Male Female

Occupation: Marital status: S M D W

The above State patient or mentally ill prisoner has been transferred:
From:
(name of health establishment)
To:
(name of health establishment)

Reasons for transfer:
.....
.....

Date of transfer:

Print initials and surname

Signature:
(person affecting the transfer)

Date:

Place:

[Copy:

- In respect of State patient to be sent to official *curator ad litem* and national department.
- In respect of mentally ill prisoner to be sent to the head of the relevant prison and national department as well as to the administrator where appointed]

Figure 84 – MHCA 21

5.6.11.4 MHCA 23 - Transfer of State Patients from detention centre to a designated health establishment in terms of Section 42(3) of the MHCA

It is submitted that MHCA 23 (Figure 85) is sufficient in the information required and presentation.



DEPARTMENT OF HEALTH

TRANSFER OF STATE PATIENTS FROM DETENTION CENTRE TO A DESIGNATED
HEALTH ESTABLISHMENT
[Section 42(3) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

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

The above State patient, currently held in detention at
(name of detention centre)

must be transferred to
(name of health establishment)

for care, treatment and rehabilitation services.

Signature:
(head of national department)

Date:

Place:
[Copy to be forwarded to head of detention centre and the official *curator ad litem*]

[On receipt of a court order in terms of section 42(1) of the Act, Form J105, the national department must complete MHCA 23 and forward a copy to the detention centre and head of health establishment concerned]

Figure 85 – MHCA 23

5.6.11.5 MHCA 24 - Transfer of State Patients between designated health establishments in terms of Section 43(1) of the MHCA

It is submitted that MHCA 24 (Figure 86 and Figure 87) is sufficient in the information required and presentation.



DEPARTMENT OF HEALTH
Republic of South Africa

DEPARTMENT OF HEALTH

TRANSFER OF STATE PATIENTS BETWEEN DESIGNATED HEALTH
ESTABLISHMENTS
[Section 43(1) of the Act]

Surname of user

First name(s) of user

Date of birth or estimated age

Gender: Male Female

Occupation: Marital status: S M D W

The above State patient shall be transferred:

From: (name of health establishment)

To: (name of health establishment)

Reasons for transfer:

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

Print initials and surname:

Signature:
(head of provincial department)

Date:

Place:

Figure 86 – MHCA 24

Concurrence of head of province to where the State patient is to be transferred must be obtained where inter-provincial transfers are contemplated.

Signature:
(head of provincial department)

Date:

Place:

(Copy to be forwarded to official *curator ad litem*, head of national department and head of health establishment to where State patient is transferred)

Figure 87 – MHCA 24

5.6.12 The constitutionality of the regime relating to State Patients

As discussed above regarding Section 77(6) and 78(6) of the CPA, it is submitted that when ordering that an accused be detained as a State Patient, it is unacceptable that the risk or dangerousness that leads to detention is inferred merely from the fact that an accused performed an act that is an element of a dangerous crime. In order for detention as a State Patient to be valid and constitutional, risk of dangerousness needs to be determined independently and not based solely on the presence of mental disorder and the commission of a dangerous act. If this is not done, it amounts to discrimination between persons with mental disorders and those without mental disorders who commit the same acts. Landman states that it is discriminatory towards persons with mental disorders when risk of future offending is not taken into account when detention is ordered.⁴⁹⁵ Declaration as a dangerous criminal in terms of Section 286A of the CPA results in indefinite incarceration, as does a declaration as habitual criminal in terms of Section 286, though for these forms of detention safeguards are in place where risk of dangerousness and risk of reoffending is determined before the detention order is made.

In *S v Bull*⁴⁹⁶ the SCA considered the Constitutionality of Sections 286A and 286B of the CPA concerning the indefinite confinement of dangerous offenders in light of Section 12(1)(e) of the Constitution.⁴⁹⁷ Section 12(1)(e) determines that everyone has the right to freedom and security of the person which includes the right not to be treated in a cruel, inhuman or degrading way. The Constitution does not define “cruel, inhuman or degrading”, though guidance can be found in society's conception of decency and human dignity,⁴⁹⁸ and the concept of proportionality.⁴⁹⁹ The SCA states that indefinite detention is not inherently unconstitutional as the protection of society is a legitimate purpose of sentencing, especially considering South Africa's high statistics regarding violent crime.⁵⁰⁰ The SCA held that the judicial discretion involved in declaration of a dangerous criminal saves it from

⁴⁹⁵ Landman and Landman 168.

⁴⁹⁶ *S v Bull and Another* (2001) ZASCA 105.

⁴⁹⁷ Landman and Landman 186.

⁴⁹⁸ *Ibid*; *S v Williams and Others* 1995 (7) BCLR 961 (CC) para 35; *S v Bull and Another* (2001) ZASCA 105 par 11.

⁴⁹⁹ *Ibid*; *S v Dodo* 2001 (3) SA 382 (CC) para 37; *S v Bull and Another* (2001) ZASCA 105 par 12.

⁵⁰⁰ *S v Bull and Another* (2001) ZASCA 105 par 15.

unconstitutionality and protects against gross disproportionality, rejecting the notion that because the provisions do not mention specific crimes that it is too general, but rather saved by discretionary judicial control because of its flexibility.⁵⁰¹ In order to make a judgement of risk of future dangerousness the court must examine the personal characteristics of the accused revealed by psychiatric assessment, the facts and circumstances of the case and the history of violent behaviour of the accused.⁵⁰²

5.7 Concluding remarks

This chapter dealt with common law and legislation affecting a mentally disordered person in the criminal justice system. The different ways in which a mental disorder can function as a multiple defence in the criminal law was discussed, as well as Chapter 13 of the CPA that creates the procedural framework for dealing with mentally disordered accused persons, regarding the aims of punishment and the rights guaranteed in the Bill of Rights. The MHCA and its regulations pertaining to State Patients and mentally ill prisoners were also critically discussed, along with the MHCA forms. Main points of criticism levelled against the MHCA and CPA, and the MHCA forms, include anomalies in internal logical consistency and possible violations of human rights.

⁵⁰¹ S v Bull and Another (2001) ZASCA 105 par 16.

⁵⁰² S v Bull and Another (2001) ZASCA 105 par 19.

CHAPTER 6: THE APPLICATION OF MENTAL HEALTH LAW IN PRACTICE

6.1 Introduction

The MHCA provides an excellent framework for mental health services and actively seeks to protect the rights of people with mental health problems, though it is clear that there remain enormous challenges in its implementation, which results in a situation in which the rights of people with mental health problems are not respected and upheld.¹ Empirical evidence is mounting that serious challenges remain and that the lack of resources has dire consequences in terms of the human rights of people with mental health problems.² In particular, the rights of mental health care users to be provided with mental health care services that improve their mental capacity to develop to their full potential and facilitate their integration into community life that are of the same standard as other health care services are being violated.³ Social, economic and political barriers interact to create conditions of underdevelopment, marginalisation and unequal access to resources.⁴ One of the central factors that contributed to these conditions is the failure of our society to recognise the rights of mentally disordered individuals as equal to those of able-bodied persons.⁵

Although the MHCA has good intentions, it is questionable whether its objectives can be fully applied in clinical settings.⁶ The task of implementing the requirements of the MHCA at community and district hospital levels is fraught with problems, including lack of infrastructure, inadequate skills, poor support and training, enormous workloads on health workers and inadequate resources.⁷ In many facilities, inpatient care has been subjected to

¹ Simpson, B.; Chipps, J. (2012) 'Mental Health Legislation: Does it protect the rights of people with mental health problems?' 1 *Social Work* 48: 47-57 54.

² Simpson and Chipps (2012) *Social work* 55.

³ *Ibid.*

⁴ Swanepoel, M 'Law, Psychiatry and Psychology: A Selection of Constitutional, Medico-Legal and Liability Issues' (LLD thesis, 2009 Unisa) 3.

⁵ *Ibid.*

⁶ Madlala, DP., Sodukela, FB. (2014) 'The care, treatment, rehabilitation and legal outcomes of referrals to a tertiary psychiatric hospital according to the Mental Health Care Act No. 17 of 2002' *SAJP* 20(4): 172-176 172.

⁷ Burns, J. K. (2008) "Implementation of the Mental Health Care Act (2002) at District Hospitals in South Africa: Translating Principles into Practice" *South African Medical Journal* Vol. 98, No. 1 46-51 46.

criticism.⁸ South Africa, like most other Low and Middle Income Countries (LAMICs), is characterised not just by inadequacies in the availability of resources for mental health care but also by numerous barriers to access to mental health services.⁹ The National Mental Health Policy Framework and Strategic Plan 2013-2020 was developed by the Department of Health which identifies several ongoing challenges that face mental health in South Africa, namely:¹⁰

- Until the development of the policy, there has been no officially endorsed national Mental Health Policy for South Africa;
- Mental health care continues to be under-funded and under-resourced compared to other health priorities in the country, despite the fact that neuropsychiatric disorders are ranked third in their contribution to the burden of disease in South Africa, after HIV/AIDS and other infectious diseases;
- There is enormous inequity between provinces in the distribution of mental health services and resources;
- There is a lack of public awareness of mental health and widespread stigma against those who suffer from mental illness;
- There is a lack of accurate routinely collected data regarding mental health service provision;
- Mental health services continue to labour under the legacy of colonial mental health systems, with heavy reliance on psychiatric hospitals; and
- While the integration of mental health into primary health care is enshrined in the White Paper and the MHCA, in practice mental health care is usually confined to management of medication for those with severe mental disorders, and does not include detection and treatment of other mental disorders, such as depression and anxiety disorders.

⁸ Madlala and Sodikela (2014) SAJP 172; Gillis L, Robertson BA, Zabow T, Stein DJ (2012) 'No health without mental health: Establishing psychiatry as a major discipline in an African faculty of health sciences' 102 S Afr Med J 6449-451 449; Suliman S, Stein DJ, Myer L, Williams DR, Seedat S. (2010) 'Disability and treatment of psychiatric and physical disorders in South Africa' 198 J Nerv Ment Dis 1 8-15 8.

⁹ Burns, J.K. (2011) 'The mental health gap in South Africa – A human rights issue' The Equal Rights Review, Vol. 6 106.

¹⁰ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 9.

This chapter the prevalence of mental disorders in South Africa is discussed, as well as its impact, in relation to resource, infrastructure and human resource issues that hamper the effective implementation of the MHCA. Issues regarding Mental Health Review Boards, mental health in criminal justice, and the administrative burden of the MHCA is also discussed. Recommendations and solutions for positive change are suggested, as well as impressing upon the importance of effective mental health care in light of the devastating effect it has on the economy and society. The purpose of the Chapter is to illustrate that mental health care and the protection of human rights is a multidisciplinary exercise and that the goals of the legislator in protecting persons with mental disorders cannot be achieved through legislation alone, but through collaboration of all arms of government, review boards, professional boards, training institutions and universities.

6.2 The prevalence and effect of mental disorder in South Africa

Mental illnesses are common and universal.¹¹ Around the world, mental and neurological disorders are responsible for approximately 14% of the global burden of disease,¹² with this prevalence expected to increase to 15% by 2020.¹³ Depression was the fourth largest contributor to the disease burden in 1990 and is expected to be the second largest after ischemic heart disease by 2020.¹⁴ Neuropsychiatric disorders are ranked third in their contribution to the overall burden of disease in South Africa, after HIV and AIDS and other infectious diseases.¹⁵ At present, neuropsychiatric disease surpasses both cardiovascular disease and cancer as the leading cause of disability due to non-communicable diseases.¹⁶ One in every four persons is likely to be affected by mental disorder at some stage during their

¹¹ Herrman, H., Shekwar, S., Moody, R (eds.) 'Promoting Mental Health: Concepts, emerging evidence, practice' World Health Organisation, Geneva 2005 5.

¹² Burns (2011) *The Equal Rights Review* 100; Madlala and Sodikela (2014) *SAJP* 172; Saxena S, Skeen S. (2012) 'No health without mental health: Challenges and opportunities in global mental health' *15 Afr J Psychiatry* 6 397-400 397.

¹³ Herman, Shekwar and Moody (eds.) 5; Burns JK. (2010) 'Mental health services funding and development in KwaZulu-Natal: a tale of inequity and neglect' *100 South African Medical Journal* 10662-666 662.

¹⁴ Herman, Shekwar and Moody (eds.) 5.

¹⁵ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 11; Lund, C., Petersen, I., Kleintjies, S. Bhana, A. (2012) 'Mental Health Services in South Africa: Taking stock' *African Journal of Psychiatry* 15 402-405 402; Kakuma, R., Kleintjes, S., Lund, C., Drew, N., Green, A., Flisher, AJ., MHaPP Research Programme Consortium (2010) 'Mental Health Stigma: What is being done to raise awareness and reduce stigma in South Africa?' *Afr J Psychiatry* 13 116-124 116.

¹⁶ Burns (2011) *The Equal Rights Review* 100.

lifetime.¹⁷ Approximately 1 in 6 South Africans are likely to experience a common mental disorder (depression, anxiety or substance use disorder) during the current year.¹⁸ Mental disorders are responsible for:¹⁹

- Increased mortality due to suicide and reduced life expectancy;
- Considerable individual and collective suffering;
- Significant loss of social and occupational functioning and productivity;
- Extensive disability; and
- A major burden on caregivers and families.

Worryingly, Williams *et al.* found that 75% of people living with mental disorders in South Africa do not receive the care they need.²⁰ Despite these alarming facts, services for mental illness and disability are almost universally inadequate.²¹ Recent data collected by WHO demonstrates the large gap that exists between the burden caused by mental health problems and the resources available in countries to prevent and treat them.²² Mental health is among the most grossly neglected elements of the right to health, as is evident in the fact that in most countries less than 1% of the total health expenditure is available to the mental health budget.²³

The first nationally representative psychiatric epidemiological study, the South African Stress and Health Study (SASH),²⁴ which was part of the WHO World Mental Health (WMH)

¹⁷ Hunt and Mesquita (2006) “Mental Disabilities and the Human Right to the Highest Attainable Standard of Health” *Human Rights Quarterly* 332-356 333; World Health Organization (WHO), *The World Health Report 2001: Mental Health: New Understanding, New Hope* 1 (2001) x.

¹⁸ Lund, Petersen, Kleintjies, Bhana (2012) *Afr J Psychiatry* 402.

¹⁹ Burns (2011) *The Equal Rights Review* 100.

²⁰ Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H. and Kessler, R. C., (2008) “Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study” *38 Psychological Medicine* 2 211-220; Madlala and Sodukela (2014) *SAJP* 172; Lund, Petersen, Kleintjies, Bhana (2012) *Afr J Psychiatry* 402; Sohrsdahl, K., Stein, DJ., and Lund, C. (2012) 'Mental Health Services in South Africa: Scaling up and future directions' *Afr J Psychiatry* 15 168-171 168.

²¹ Burns (2011) *The Equal Rights Review* 100; Herman, Shekwar and Moody (eds.) 5.

²² WHO *World Health Report, Mental Health: new understanding, new hope* 2001 Geneva;.Herman, Shekwar and Moody (eds.) 5.

²³ Hunt and Mesquita (2006) *Human Rights Quarterly* 333.

²⁴ Williams, Herman, Stein, *et al.* (2008) *Psychological Medicine*; Sohrsdahl, Stein and Lund (2012) *Afr J Psychiatry* 168.

Survey Initiative conducted between 2002 and 2004, reported results of a population based survey of 4351 adults.²⁵ The 12 month prevalence of any DSM-IV or CIDI disorder²⁶ was 16,5%,²⁷ with the most common disorders being agoraphobia (4.8 %), major depressive disorder (4.9%) and alcohol abuse or dependence (4.5 %).²⁸ Herman *et al.*, the authors of the SASH study, note that prevalence rates of common mental disorders are significantly higher in South Africa than in another WMH African country.²⁹ South Africa is ranked 22nd in the world regarding the national suicide rate of 15.4 per 100,000 population.³⁰ The lifetime prevalence for any mental health problems in South Africa is 30.3% and neuropsychiatric disorders rank third in their contribution to the burden of disease in South Africa.³¹

There is no evidence that there are any differences between socially defined racial groups or cultural groups in the prevalence of mental disorders,³² though there are important gender differences as women are at increased risk of developing depression and anxiety disorders, whereas men are at increased risk of developing substance use disorders.³³ The burden of mental illness is felt not only through the primary presentations of mental disorders, but through its high co-morbidity with other illnesses.³⁴ South Africa is considered a country with a “quadruple disease burden,” and mental ill-health features prominently in its high level of co-morbidity with infectious diseases, such as HIV/AIDS and tuberculosis; its association with non-communicable diseases, such as cardiovascular disease and diabetes mellitus; high

²⁵ Burns (2011) The Equal Rights Review 103.

²⁶The CIDI (Composite International Diagnostic Interview) is a comprehensive, fully-structured interview designed to be used by trained lay interviewers for the assessment of mental disorders according to the definitions and criteria of ICD-10 and DSM-IV. It is intended for use in epidemiological and cross-cultural studies as well as for clinical and research purposes. Burns (2011) The Equal Rights Review 103.

²⁷Landman, A.A. and Landman, W.J. ‘A Practitioner’s Guide to the Mental Health Care Act’ (Cape Town; Juta & Co) 2014 4; Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 11; Lund, C., Kleintjes, S., Kakuma, R., Flisher A. J. and MHaPP Research Programme Consortium (2010) “Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications” 45 *Social Psychiatry and Psychiatric Epidemiology* 3393-404 394; Sohrsdahl, Stein and Lund (2012) *Afr J Psychiatry* 168.

²⁸ Burns (2011) The Equal Rights Review 103.

²⁹ Williams, Herman, Stein, *et al.* (2008) *Psychological Medicine*; Burns (2011) The Equal Rights Review 103.

³⁰ Herman Williams, Herman, Stein, *et al.* (2008) *Psychological Medicine*; Burns (2011) The Equal Rights Review 103.

³¹ Williams, Herman, Stein, *et al.* (2008) *Psychological Medicine*; Simpson and Chipps (2012) *Social work* 47.

³² Lund, Kleintjes, Kakuma, Flisher, MHaPP Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 394.

³³ Williams, Herman, Stein, *et al.* (2008) *Psychological Medicine*; Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 11.

³⁴ Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 12.

levels of violence and injury; and maternal and child illness.³⁵ In the South African context, the relationship between HIV/AIDS and mental illness is particularly pertinent as mental health impacts on and is exacerbated by the HIV/AIDS epidemic, and both are mutually reinforcing risk factors.³⁶ Mental health problems are common in HIV disease, cause considerable morbidity, and are often not detected by physicians.³⁷

6.3 Barriers to the effective implementation of mental health legislation in practice

6.3.1 Mental health care resources

Despite progressive mental health legislation such as the MCHA, multiple barriers to the financing and development of mental health services exist in South Africa, resulting in:³⁸

- Psychiatric hospitals remaining outdated, falling into disrepair, and often unfit for human use;³⁹
- Serious shortages of mental health professionals;
- An inability to develop vitally important tertiary level psychiatric services (such as child and adolescent services, psychogeriatric services, neuropsychiatric services, etc.); and
- Community mental health and psychosocial rehabilitation services remaining undeveloped, so that patients end up institutionalised, without hope of rehabilitation back into their communities.

The resources required to deliver mental health services (including human resources, service facilities and budgets) have been consistently shown being inadequate.⁴⁰ There is no specific budget for mental health at national or provincial level and mental health services are funded

³⁵ *Ibid*; Sohrsdahl, Stein and Lund (2012) *Afr J Psychiatry* 168.

³⁶ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 12.

³⁷ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 12; Burns (2010) *SAMJ* 662.

³⁸ Burns (2011) *The Equal Rights Review* 104.

³⁹ Simpson and Chipps (2012) *Social work* 52.

⁴⁰ Lund, Petersen, Kleintjies, Bhana (2012) *Afr J Psychiatry* 404; Lund C, Flisher AJ. (2006) 'Norms for mental health services in South Africa' *Social Psychiatry and Psychiatric Epidemiology* 41 587-594 587.

out of general health budgets where they end up at the bottom of a list of pressing needs.⁴¹ Lund *et al.* found that only 3 in 9 provinces in South Africa could report data on mental health expenditure, and the allocation of the health budget reported amounted to 1%, 5% and 8% respectively.⁴² While this range is about average for most middle-income countries, it reflects the disproportionately low allocation made to mental health (given the high prevalence of mental disorders and the fact that over 30% of disability-adjusted life-years (DALYs) are attributable to these disorders). The median percentage of health expenditures dedicated to mental health is 0.5% in low income countries and 5.1% in high income countries,⁴³ while a study by Ramlall *et al.* found that in Kwazulu-Natal the figure is 0.03% and that the figure that had not increased over a 10 year period spanning the implementation of the MHCA.⁴⁴ In that province, a mean increase of 10.2% per annum in budget allocations was made to general hospitals as opposed to 3.8% to public psychiatric hospitals over the same period; and additionally, four out of six psychiatric hospitals saw a reduction in their allocations, while no such reductions occurred in general hospitals.⁴⁵ Ramlall opines that such practices amount to discrimination and signifies a poor prognosis for mental health care in South Africa.⁴⁶

In Chapter 3 the integration of mental health care services into the general health care system was discussed, and although this has been done for several good reasons (such as availability and accessibility of services, and decreased stigma, as discussed in Chapter 3), the integration process has been fraught with its own difficulties. There are a number of obstacles to managing mental health users in the general health system in the Western Cape, finding that it is extremely difficult to manage acutely suicidal and disruptive psychotic patients in medical wards together with frail medically ill people.⁴⁷ The absence of safe observation facilities and limited availability of psychotropic medicines in general health establishments hampered the effective care of mental health care users, as well as limited staff numbers, lack of

⁴¹ Burns (2011) *The Equal Rights Review* 104; Burns (2010) *SAMJ* 663.

⁴² Lund, Kleintjes, Kakuma, Flisher and MHaPP Research Programme Consortium, (2010) *Social Psychiatry and Psychiatric Epidemiology* 393; Burns (2011) *The Equal Rights Review* 104.

⁴³ World Health Organization 'Mental Health Atlas' 201111; Ramlall, S (2012) 'The Mental Health Care Act No 17 – South Africa. Trials and triumphs:2002-2012' *African Journal of Psychiatry* 15 407-410 409.

⁴⁴ Ramlall, Chipps and Mars (2010) *South African Medical Journal* 667; Ramlall (2012) *Afr J Psychiatry* 409.

⁴⁵ Ramlall (2012) *Afr J Psychiatry* 409; Burns (2010) *SAMJ* 663.

⁴⁶ Ramlall (2012) *Afr J Psychiatry* 409.

⁴⁷ Simpson and Chipps (2012) *Social work* 52.

competencies in existing staff and staff prejudices towards the treatment of mental health users.⁴⁸

Ramlall states that the integration of mental health into general health has precipitated an infrastructure crisis regarding a shortage of both acute and chronic beds throughout the country, undermining the successful implementation of the MHCA.⁴⁹ Lund *et al.* conducted a study of public sector mental health service resources and utilisation using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2. in the 2005 calendar year, and reported the following: There are 3460 outpatient facilities that offer mental health services in South Africa, although these are general health facilities in which the provision of specific mental health services is not monitored.⁵⁰ Only 1.4% of these facilities provide services exclusively for children and adolescents.⁵¹ Data on service utilisation were only available from 4 provinces, where these facilities treat 1,660 users per 100,000 general population annually.⁵² In terms of community-based services, there are only 80 day treatment facilities available in the entire country, treating 3.4 users per 100,000 general population, of which half of the facilities are provided and run by the South African Federation of Mental Health (the SAFMH - a non-governmental organisation).⁵³ None of the facilities offer services exclusively for children and adolescents.⁵⁴

There are 41 psychiatric inpatient units in general hospitals in the country with a total of 2.8 beds per 100,000 population.⁵⁵ Only 3.8% of these beds are reserved for children and adolescents.⁵⁶ In comparison the European median is 8 beds per 10,000 population.⁵⁷ The figure represents just over 60% of the beds required to comply with norms established by the

⁴⁸ *Ibid.*

⁴⁹ Ramlall (2012) *Afr J Psychiatry* 409.

⁵⁰ Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 396.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ Burns (2011) *The Equal Rights Review* 105; Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 395.

⁵⁴ Burns (2011) *The Equal Rights Review* 105; Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 396.

⁵⁵ Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 397.

⁵⁶ *Ibid.*

⁵⁷ Burns (2011) *The Equal Rights Review* 105.

South African National Department of Health,⁵⁸ though availability of beds for psychiatric care varies substantially from province to province.⁵⁹ KwaZulu-Natal has only 25% of the number of acute beds required to comply with norms.⁶⁰ There are 63 community residential facilities available in the country, of which 47% are provided by the SAFMH.⁶¹ These facilities provide a total of 3.6 beds per 100,000 population.⁶² There are 23 mental hospitals in South Africa, providing a total of 18 beds per 100,000 population (provincial range 8–39).⁶³ 79% of these facilities are organisationally integrated with mental health outpatient facilities.⁶⁴ Only 1% of the beds in mental hospitals are reserved specifically for children and adolescents.⁶⁵ The number of mental hospital beds decreased by 7.7% between 2000 and 2005.⁶⁶ In addition to beds in mental health facilities, there are 3.5 beds per 100,000 population for people with mental disorders in forensic inpatient units.⁶⁷

National Department of Health officials report that 53% of all health establishments (hospitals) have been designated to provide 72 hour assessments of psychiatric emergencies, in keeping with the provisions of the MHCA.⁶⁸ This includes 131 of 251 district hospitals, 28 of 59 secondary hospitals, and 14 of 33 tertiary hospitals.⁶⁹ Service users are frequently admitted to general wards in these listed facilities as there are as yet no separate psychiatric

⁵⁸ National Department of Health: Pretoria, Norms Manual for Severe Psychiatric Conditions, 2003; Burns (2011) *The Equal Rights Review* 105.

⁵⁹ Burns (2011) *The Equal Rights Review* 105; Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 393.

⁶⁰ Burns (2011) *The Equal Rights Review* 105; Burns, J. K. (2010) “Mental health services funding and development in KwaZulu-Natal Province: A tale of inequity and neglect” *South African Medical Journal*, Vol. 100(10) 662-666 663.

⁶¹ Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 397; Kleintjies, S., Lund, C., Flisher A. J. and MHaPP Research Programme Consortium, (2010) “A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia” *African Journal of Psychiatry* 13 132-139; Burns (2011) *The Equal Rights Review* 105.

⁶² Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 397; Kleintjies, Lund, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* ; Burns (2011) *The Equal Rights Review* 105.

⁶³ Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 397.

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

inpatient units in most of these facilities.⁷⁰ Most institutions are experiencing problems in providing 72-hour observations and that this is leading to sub-optimal care.⁷¹

The implementation of the MHCA without due consideration being given to the infrastructure requirements has resulted in hospitals being left to manage potentially dangerous patients in sub-optimum clinical environments.⁷² At the time of implementation of the MHCA, more than 60% of hospitals did not have adequate facilities to fulfil the legislative requirements,⁷³ 41.7% admitted mental health care users to general medical or surgical wards, and only 27.8% had a dedicated psychiatric unit.⁷⁴ Common complaints related to the lack of sufficient beds, seclusion rooms and staff to accommodate the clinical demand and the challenges of managing disruptive patients in a general hospital setting.⁷⁵ The lack of seclusion facilities posed another major challenge with more than half (55.6%) of designated hospitals having no seclusion facility, while those with seclusion facilities were dissatisfied with the infrastructure or the number of facilities, with five hospitals using inadequately refurbished wards or medical isolation units as “seclusion” facilities.⁷⁶ 72-hour assessments are currently predominantly performed in unsafe, inappropriate structures with inadequate trained staff, or a lack thereof, regarding numbers and expertise.⁷⁷ 72-hour assessments require a separate area in district hospitals, with dedicated psychiatric beds, no such facilities exist in most hospitals.⁷⁸ Only 10 district hospitals nationally have an admission unit. Currently, the regular 72-hour assessments are often conducted in an inadequate locked room adjacent to casualty sections, or in open-area non-secure medical beds.⁷⁹

Simpson and Chipps cite one of the primary reasons for the challenges in implementing the MHCA as the fact that the promulgation of the Act was not accompanied by required

⁷⁰ *Ibid.*

⁷¹ Simpson and Chipps (2012) Social work 52; Janse van Rensburg (ed.) (2012) 'The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) Position Statements on Psychiatric Care in the Public Sector' 18 SAJP 3 133-147 135

⁷² Ramlall (2012) Afr J Psychiatry 409; Janse van Rensburg (ed.) (2012) SAJP 135.

⁷³ Simpson and Chipps (2012) Social work 52.

⁷⁴ Ramlall (2012) Afr J Psychiatry 409.

⁷⁵ Ramlall (2012) Afr J Psychiatry 409; Simpson and Chipps (2012) Social work 52.

⁷⁶ Ramlall (2012) Afr J Psychiatry 409; Ramlall, Chipps and Mars (2010) SAMJ 668.

⁷⁷ Janse van Rensburg (ed.) (2012) SAJP 136.

⁷⁸ *Ibid.*

⁷⁹ Janse van Rensburg (ed.) (2012) SAJP 136.

provision of resources by national or provincial government.⁸⁰ Janse van Rensburg commented that it is clear that the financial considerations of the MHCA were not considered and that in many instances services simply continued as before.⁸¹ After implementation of the MHCA, public mental health care practice continued to be dictated by inadequate nursing staff ratios and suboptimal or structurally inappropriate facilities.⁸² A major problem is the low priority given to mental health and the inability of planners to translate the principles enshrined in the MHCA into implementable policies.⁸³

In the SASH study, only 28% of adults with a severe or moderately severe disorder and only 24.4% of those with mild cases received treatment.⁸⁴ In KwaZulu-Natal a large proportion of the population relies on informal services in the community for mental health treatment.⁸⁵ In a sample of patients with first-episode psychosis (FEP), Burns and colleagues reported that 38.5% had consulted a traditional healer for the incipient psychotic illness prior to making contact with formal psychiatric services.⁸⁶

In an examination of barriers to the improvement of mental health services in low- and middle-income countries (LAMICs) for the Lancet's 2007 Series on Global Mental Health, A variety of reasons for the inadequacy of funding for mental health in such countries have been identified, including:⁸⁷

- A lack of consensus among mental health advocates generally and psychiatrists in particular, regarding priorities for spending in mental health;
- Difficulties in communicating the sometimes complex concepts in mental health to those outside of the field;

⁸⁰ Simpson and Chipps (2012) Social work 54.

⁸¹ Janse van Rensburg, ABR (2007) 'A framework for current public mental health care practice in South Africa' Afr J Psychiatry 10 205-209 205; Simpson and Chipps (2012) Social work 54; Janse van Rensburg (ed.) (2012) SAJP 135.

⁸² Janse van Rensburg (2007) Afr J Psychiatry 205.

⁸³ Simpson and Chipps (2012) Social work 54.

⁸⁴ Williams, Herman, Stein, *et al.* (2008) Psychological Medicine; Burns (2011) The Equal Rights Review 106

⁸⁵ Burns (2011) The Equal Rights Review 106.

⁸⁶ *Ibid.*

⁸⁷ Saraceno, B; Levav, I; Kohn, R. (2005) 'The public mental health significance of research on socio-economic factors in schizophrenia and major depression' World Psychiatry 4 181-185; Parker, J.S., Allen, R.R. and Lund, C. (2013) 'Are we training our psychiatrists adequately as public mental health practitioners?' 19 SAJP 12-3 3.

- Perceptions among decision-makers that mental health indicators are not sufficiently strong and that mental healthcare is not cost-effective;
- A lack of public interest in the subject; and
- Weak advocacy due to the lack of visibility of people living with mental illness and their families.

6.3.1.1 Human resources

Burns states that human resources for mental health care in South Africa are desperately inadequate.⁸⁸ According to the South African Society of Psychiatrists (SASOP) database of 2009 there are 693 practicing psychiatrists in the country, of whom 343 work full-time in public service.⁸⁹ Lund *et al.* found in 2010 that per 100,000 population, the country has only 0.28 psychiatrists, 0.32 psychologists, 0.45 other medical doctors (not specialised in psychiatry), 0.4 social workers, 0.13 occupational therapists and 10 nurses.⁹⁰ South Africa therefore has less than 30% of the number of psychiatrists required to comply with national norms of 1 per 100,000 population.⁹¹ The figure of 0.28 psychiatrists per 100,000 population falls far below the average for other middle-income countries (which is approximately 5 per 100,000 population) and even further below the average for high-income countries (which is approximately 15 per 100,000 population).⁹² In addition, most mental health professionals tend to be located within urban centres, leaving large rural regions of the country without such services.⁹³ There are 2692 clinical psychologists registered with the HPCSA, but only around

⁸⁸ Burns (2011) The Equal Rights Review 105.

⁸⁹ Ogunlesi, AO., Ogunwale, A., De Wet, P., Roos, L., Kaliski, S. (2012) 'Forensic psychiatry in Africa: prospects and challenges' *Afr J Psychiatry* 5 3-7 5.

⁹⁰ Lund, C., Kleintjes, S., Kakuma, R., Flisher A. J. and MHaPP Research Programme Consortium (2010) "Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications", 45 *Social Psychiatry and Psychiatric Epidemiology* 3 393-404; Burns (2011) The Equal Rights Review 105; Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

⁹¹ Burns (2011) The Equal Rights Review 105.

⁹² *Ibid.*

⁹³ *Ibid.*

14% of registered clinical psychologists are in the public sector.⁹⁴ In 2007 there were about 350 practicing psychiatrists in South Africa, of which only 40% work in the public sector.⁹⁵

Benjamin *et al.* conducted a study on the level and determinants of awareness of the MHCA and the integration of mental health care in primary care systems at King Sabata Dalindyebo Municipality, a tertiary referral psychiatric service in Mthatha, Eastern Cape Province.⁹⁶ They found that only 57.7% of health professionals interviewed were aware of the MHCA.⁹⁷ Professionals working in advantaged clinics were significantly more aware about the MHCA than their counterparts working in disadvantaged clinics (90% awareness vs. 38% awareness), and awareness about the MHCA was significantly lower among workers with lower education qualifications, such as high school or undergraduate diploma and degree, than in their counterparts with the highest educational qualification with postgraduate diploma in psychiatry (47% awareness vs. 86 % awareness).⁹⁸ Awareness about the MHCA was significantly higher at 71.9% among workers who reported the presence of workshop on the MHCA than in those who did not, at 35%.⁹⁹ Although this study is limited in that it may not be extrapolated to the wider population, it nonetheless points at worrying levels of implementation and training among mental health care professionals on the MHCA in rural settings, indicating a lack of accountability and likelihood of human rights abuses.

Freeman states that there too few trained professionals to meet need for mental health care in South Africa.¹⁰⁰ In order to solve the problem, more professionals must be trained but better use of health staff at all levels through integrated mental health care and greater use of community health workers needs to be achieved, as well as more equitable care between the

⁹⁴ Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

⁹⁵ Thom, R. 'Psychiatry at the primary healthcare level' in Baumann, SE. (ed.) 'Primary healthcare psychiatry: A Practical Guide for Southern Africa' 2007 5.

⁹⁶ Benjamin, L. *et al.* (2014) 'Determinants of Awareness about of Mental Health Care Act 17 to be Integrated into Primary Health Care System at King Sabata Dalindyebo Municipality' 16 *Journal of Psychiatry* 6 14-20 14.

⁹⁷ Benjamin *et al.* (2014) *Journal of Psychiatry* 14.

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*

¹⁰⁰ Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

private and public sectors.¹⁰¹ Freeman states that it is not acceptable that only 14% of psychologists are available to treat nearly 85% of the population.¹⁰²

6.3.1.2 Children

Amongst children and adolescents the prevalence of mental illness is estimated to be about the same as that in adults, namely one in five during their lifetime will suffer from a diagnosable mental disorder.¹⁰³ Approximately 75% of mental disorders in adulthood have their onset in youth, and persistent disorders in adulthood tend to be those with onset during the 12-24 year age group.¹⁰⁴ Kleintjies *et al.* state that the promotion of mental wellbeing, strengthening of protective factors, reduction of preventable risk factors, early detection of disorders and provision of effective services for the treatment of mental disorders during childhood and adolescence should be a central concern on the public health agenda.¹⁰⁵

Despite this evidence of the burden of mental disorder on child health, there is a substantial shortfall particularly in resources for child and adolescent mental health services.¹⁰⁶ Only 1.4% of outpatient facilities, 3.8% of acute beds in general hospitals and 1% of beds in psychiatric hospitals are for children and adolescents.¹⁰⁷ Information is not available for the total number of child and adolescent psychiatrists in South Africa, but in general there are very few.¹⁰⁸ In KwaZulu-Natal, which has a population of 10 million, there are only two such specialists within the public health system.¹⁰⁹

¹⁰¹ *Ibid.*; Thom 5.

¹⁰² *Ibid.*

¹⁰³ Kleintjies, S., Lund, C., Flisher A. J. and MHaPP Research Programme Consortium (2010) "A situational analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia" *African Journal of Psychiatry* 13 132-139 132.

¹⁰⁴ Kleintjies, Lund, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 133; Patel, V, Flisher, AJ, McGorry, P. (2007) 'The mental health of young people: A global public health challenge' *Lancet* 369.

¹⁰⁵ Kleintjies, Lund, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 133.

¹⁰⁶ Lund, Petersen, Kleintjies, Bhana (2012) *Afr J Psychiatry* 404; Burns (2011) *The Equal Rights Review* 105.

¹⁰⁷ Burns (2011) *The Equal Rights Review* 105.

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

The WHO Mental Health Legislation Checklist, 2007 recommends inclusion of six provisions for protection of minors receiving mental health care which Kleintjies *et al.* considered in their survey of South African mental health services regarding children and adolescents, namely:¹¹⁰

- Limitation of involuntary placement of minors in mental health facilities,
- Provision of separate living area from adults in mental health facilities,
- Age appropriate environment and developmentally appropriate services,
- Adult representation in all matters affecting the minor,
- Consideration of opinions of minors in all issues affecting them, depending on their age and maturity, and
- Banning of all irreversible treatments on children.

The authors found that stigma regarding mental health is a pervasive problem that contributes toward active discrimination and the violation of human rights, and leads to reduced willingness to disclose mental disorder and seek treatment.¹¹¹ The low priority of mental health care and the link between mental ill health and poverty was also identified as contributing factors to unmet mental health care needs in children and contribution to development of mental health problems such as stress, depression and anxiety.¹¹² The authors suggest a multi-disciplinary approach to scaling up child and adolescent mental health care through anti-stigma campaigns, lobbying for greater priority of and investment in mental health, and clear policy directives.¹¹³

6.3.1.3 Mental health resources and socio-economic rights jurisprudence

In Chapter 2 the right to access to health care in terms of Section 27 of the Constitution was discussed, especially on Constitutional Court jurisprudence in socio-economic matters, likethe

¹¹⁰ Kleintjies, Lund, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 133; World Health Organisation. *Mental Health Legislation Checklist*. Geneva: World Health Organisation, 2007.

¹¹¹ Kleintjies, Lund, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 134.

¹¹² Kleintjies, Lund, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 136-137.

¹¹³ Kleintjies, Lund, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 137-138.

cases of *Soobramoney*, *Grootboom* and *TAC*.¹¹⁴ In these cases factors in judicial decision-making like the doctrine of separation of powers, and the threat to institutional integrity where decisions are made impossible to implement were a prominent consideration.¹¹⁵ The Constitutional Court has been cautious in awarding substantive content to health-related constitutional rights which minimises the guidance that its jurisprudence provides to policy makers, as discussed in Chapter 2, but the Court is becoming bolder in insisting that the state provides adequate justification where health-related rights go unrealised due to a lack of resources.¹¹⁶ Pieterse states that the Constitutional Court's jurisprudence, particularly its reasonableness approach, is increasingly providing yardsticks by which the human-rights sector is measuring state compliance with the financial dimensions of socio-economic rights.¹¹⁷ In *Grootboom* the Court indicated that the purpose of its reasonableness test is to determine whether a measure under evaluation falls within the bounds of reasonableness, and not to determine what would be the best or most appropriate measure to address the social problem at issue, as an issue being decided by another arm of government.¹¹⁸

The Court's strategy of judicial deference in socio-economic rights cases, where courts defer to other branches of government when faced with technical or contested social issues, was investigated and critiqued by Brand.¹¹⁹ Brand criticises judicial deference as amounting to a failure in the democracy-related aspect of the transformative duty on courts by reflecting a conception of democracy at odds with the Constitutional vision, and it is both a limited and an inappropriate response to the problem of democratic illegitimacy of review in socio-economic rights matters.¹²⁰ The court should consider the interests of the “people” as well in reaching its

¹¹⁴*Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC); *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC); *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC).

¹¹⁵*Soobramoney v Minister of Health, KwaZulu-Natal* 1998 1 SA 765 (CC) par 58; *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) par 128; M Pieterse “Coming to Terms with Judicial Enforcement of Socio-Economic Rights” (2004) 20 *SAJHR* 383-417; Pieterse, M. (2008) ‘Health, social movements and rights based litigation in South Africa’ 35 *Journal of Law and Society* 364-381 379-380.

¹¹⁶Pieterse, M ‘Can rights cure?:The Impact of human rights litigation on South Africa's health system’ 2014 *PULP* 124.

¹¹⁷*Ibid.*

¹¹⁸*Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) par 41; Brand, D (2011) ‘Judicial deference and democracy in socio-economic rights cases in South Africa’ 22 *Stellenbosch Law Review* 614 619; Hoexter *Administrative Law* 302.

¹¹⁹Brand (2011) *Stellenbosch Law Review* 614.

¹²⁰Brand (2011) *Stellenbosch Law Review* 624.

decision to find creative solutions to socio-economic issues, instead of only considering the institutional limitations it faces.¹²¹ Brand suggests that instead of leaving decision of certain matters to other branches of government, courts should engage those branches in a process aimed at resolving the issues in question by creating such a process in institutional terms and setting the parameters within which such a resolution should occur.¹²² Brand suggests that courts should employ different techniques of involving persons or institutions in litigation that are not directly party to that litigation but who possess the expertise or political representivity required to assist the court to resolve those issues, when confronted with technically complex or socially contested questions that they feel incapable of deciding on their own can instead of falling back on deference.¹²³ In this regard Brand refers to *Blue Moonlight Properties 39 (Pty) Ltd v Occupiers of Saratoga Avenue*¹²⁴ where the courts joined local authorities to eviction proceedings on the argument that such local authorities, although they have no direct interest in the litigation, have a constitutional duty to provide adequate housing to squatters.¹²⁵ It is submitted that in cases involving the right to access to health care and mentally disordered persons, it would be prudent of the court to make use of such a technique in its decision-making.

Pieterse advocates a rights based approach to resource allocation in the health sector,¹²⁶ and makes the point that the substantive values reflected in the Constitution should guide and constrain resource allocation and rationing decisions at various levels.¹²⁷ Pieterse further states that the limitations clause (Section 36, as discussed in Chapter 2), which determines that rights may be limited only by way of a law of general application “reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom”,

¹²¹ Brand (2011) Stellenbosch Law Review 637; Cooper, C. ‘South Africa: Health rights litigation: Cautious constitutionalism’ in Yamin, E and Gloppen, S (eds.) *Litigating health rights: Can courts bring more justice to health?* 2011 190, 210

¹²² Brand (2011) Stellenbosch Law Review 630-632.

¹²³ Brand (2011) Stellenbosch Law Review 634.

¹²⁴ 2009 1 SA 470 (W).

¹²⁵ Brand (2011) Stellenbosch Law Review 634. Brand mentions other cases in which this technique has been deployed as well, namely: *ABSA Bank Ltd v Murray* 2004 2 SA 15 (C); *Cashbuild (South Africa) (Pty) Ltd v Scott* 2007 1 SA 332 (T); *Lingwood v The Unlawful Occupiers of R/E of Erf 9 Highlands* 2008 3 BCLR 325 (W); *Sailing Queen Investments v The Occupants La Colleen Court* 2008 6 BCLR 666 (W); *Chieftain Real Estate Incorporated in Ireland v Tshwane Metropolitan Municipality* 2008 5 SA 387 (T).

¹²⁶ Pieterse 123.

¹²⁷ Pieterse 100.

fosters a culture of justification meaning that all resource allocation decisions and processes need to be justifiable regarding these substantive values.¹²⁸ Constitutional health rights may therefore be interpreted to require that resource-allocation decisions prioritise the satisfaction of certain vital and urgent needs, or the needs of particularly vulnerable sectors of society, over others.¹²⁹ Accountability in resource allocation is fostered by two provisions in the Constitution, namely:¹³⁰

- Section 214 which determines that budget allocations must take into account, among other factors, the need to ensure effective basic service provision, developmental needs and the legal obligations of provincial and local government; and
- Section 184(3) which grants the South African Human Rights Commission powers to require financial arms of government to report on their endeavours in pursuit of the progressive realisation of socio-economic rights.

A rights-based approach to resource allocation enhances public accountability for, public participation in and transparency of health-related resource distribution decisions and processes, demands that government takes its socio-economic responsibilities seriously, and requires that it justifies decisions and policies that have the effect of hindering individual access to care.¹³¹ Mere assertions of resource scarcity are not sufficient to absolve the state of responsibility for the realisation of health-related rights.¹³² The constitutional inclusion of health-related rights has elevated the level of public deliberation over resource distribution in the health sector.¹³³

6.3.2 The cost of mental illness

Mental health problems have serious economic and social costs, including direct costs related to the provision of health care, and indirect costs, such as reduced productivity at home and

¹²⁸ *Ibid.*

¹²⁹ Pieterse 101.

¹³⁰ *Ibid.*

¹³¹ Pieterse 123.

¹³² Pieterse 124.

¹³³ *Ibid.*

work, loss of income and loss of employment.¹³⁴ These costs have a direct effect on the mental health care user and their families' financial situation. The indirect cost of mental disorders outweighs direct treatment cost by two to six times in developed countries and may be even higher in developing countries.¹³⁵ In the first nationally representative survey of mental disorders in South Africa, lost earnings among adults with severe mental illness during the previous 12 months amounted to R28.8 billion.¹³⁶ This represented 2.2% of GDP in 2002, and far outweighs the direct spending on mental health care for adults (of approximately R472 million), therefore it costs South Africa more to not treat mental illness than to treat it.¹³⁷

The social costs of mental illness include disrupted families and social networks, stigma, discrimination, loss of future opportunities, marginalization and decreased quality of life.¹³⁸ Stigmatizing beliefs reported in South Africa include beliefs that a people with mental illness are bewitched, weak, lazy, mad, insane, not capable of doing anything or unable to think.¹³⁹ The consequences of such inaccurate beliefs are that individuals who have been labelled as having mental illnesses are feared, ridiculed or exploited, and many individuals have also been neglected, isolated, rejected by family and peers, abused or excluded from social engagement and basic rights.¹⁴⁰ Stigma can act as a barrier to accessing education, employment, adequate housing and other basic needs.¹⁴¹

Regarding the funding of health care, including mental health care, it is important to take note of the proposed new national health insurance system.¹⁴² Private healthcare, funded through private health insurance and out-of-pocket payments, serves approximately 16% of the population, compared with about 84% served by public health care, though Yet gross

¹³⁴ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 14.

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*; Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

¹³⁷ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 14; Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

¹³⁸ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 14.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*

¹⁴¹ *Ibid.*

¹⁴² See Department of Health, Republic of South Africa 'National health insurance in South Africa: Policy paper (2011).

domestic product spend on each is similar (4.1% and 4.2% respectively).¹⁴³ To redress these inequities, South Africa is phasing in (over 14 years) a national health insurance system, to ensure universal access to appropriate, efficient and high-quality health services.¹⁴⁴ The introduction of national health insurance involves an overhaul of services as well as systems to support service delivery, including a re-engineering of primary health care at district level.¹⁴⁵ This includes the establishment of district specialist clinical teams to provide support to ward-based primary healthcare teams comprising primary healthcare staff at fixed primary healthcare facilities as well as community outreach teams comprising a professional nurse and community health workers, which is a noteworthy development that will enable better implementation of the MHCA.¹⁴⁶ A full discussion of the new national health insurance plan is outside the scope of this thesis. It is however noteworthy that national health insurance might be a mechanism of ensuring better access to mental health care services in future by lessening the impact of poverty as a barrier to access for a significant portion of the population. Petersen *et al.* recommend that the introduction of national health insurance in South Africa should be used to leverage additional resources for mental healthcare.¹⁴⁷ To strengthen this possibility, cost–benefit studies demonstrating the health benefits and cost savings of integrated mental health are needed.¹⁴⁸

6.3.3 Service provision

Current mental health service provision in South Africa, is marked by several features, as outlined in a recent situation analysis of the mental health system in South Africa:¹⁴⁹

¹⁴³ Department of Health, Republic of South Africa 'National health insurance in South Africa: Policy paper' (2011); Petersen, I., Fairall, L., Bhana, A., Kathree, T. *et al.* (2015) 'Integrating mental health into chronic care in South Africa: the development of a district mental healthcare plan' *British Journal of Psychiatry* s1-s11 s1.

¹⁴⁴ Department of Health, Republic of South Africa 'National health insurance in South Africa: Policy paper (2011); Petersen, Fairall, Bhana, Kathree *et al.* (2015) *British Journal of Psychiatry* s1.

¹⁴⁵ Petersen, Fairall, Bhana, Kathree *et al.* (2015) *British Journal of Psychiatry* s1.

¹⁴⁶ Petersen, Fairall, Bhana, Kathree *et al.* (2015) *British Journal of Psychiatry* s1-s2.

¹⁴⁷ Petersen, Fairall, Bhana, Kathree *et al.* (2015) *British Journal of Psychiatry* s10.

¹⁴⁸ *Ibid.*

¹⁴⁹ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 15; Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A *et al.* (2008) *Mental health policy development and implementation in South Africa. Phase 1 Country Report* Cape Town, Mental Health and Poverty Project, University of Cape Town.

1. There is wide variation between provinces in the availability of service resources for mental health;
2. Mental health services continue to labour under the legacy of colonial and apartheid era mental health systems, with heavy reliance on psychiatric hospitals;
3. Some progress has been made with the integration of mental health into general health care;
4. Most provincial services endorse the importance of integrating mental health into PHC, and some training initiatives have been undertaken for PHC nurses. At the District level, the integration of mental health care into primary health care is focused on the emergency management and ongoing psychopharmacological care of patients with chronic stabilised mental disorders, with little coverage of children and adolescents, or adults with depression and anxiety disorders;
5. The total number of human resources working in mental health in the Department of Health and NGOs is 9.3 per 100,000 populations;
6. There is an urgent need for mental health training of general health staff;
7. There is currently only one indicator for mental health on the District Health Information System, namely the number of mental health visits;
8. There is a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders in South Africa, namely the National Directorate: Mental Health and Substance Abuse, Department of Health;
9. A few consumer and family associations have been established in some provinces, often with the support of NGOs, such as the SA Federation for Mental Health. There are a few locally based, user run self-help associations;
10. Some important steps have been taken towards intersectoral collaboration, particularly at the national level. However, at the district level, and in many provinces, such intersectoral collaborations are the exception

rather than the rule. This situation is improving with the legal requirement that districts should produce Integrated Development Plans (IDPs);

10. The emphasis on current spending for mental health falls on treatment and rehabilitation. There are few scaled up, evidence-based mental health promotion and prevention programmes; and

11. Deinstitutionalisation has progressed at a rapid rate in South Africa, without the necessary development of community-based services. This has led to a high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns of care.

6.3.4 National Mental Health Policy

The objectives of the National Mental Health Policy Framework and Strategic plan 2013-2020 include:¹⁵⁰

- To scale up decentralized integrated primary mental health services, which include community-based care, PHC clinic care, and district hospital level care.
- To increase public awareness regarding mental health and reduce stigma and discrimination associated with mental illness.
- To promote the mental health of the South African population, through collaboration between the Department of Health and other sectors.
- To empower local communities, especially mental health service users and carers, to participate in promoting mental wellbeing and recovery within their community.
- To promote and protect the human rights of people living with mental illness.
- To adopt a multi-sectoral approach to tackling the vicious cycle of poverty and mental ill-health.
- To establish a monitoring and evaluation system for mental health care.
- To ensure that the planning and provision of mental health services is evidence-based.

¹⁵⁰ Department of Health ‘National Mental Health Policy Framework and Strategic Plan 2013-2020’ 19.

The National Mental Health Policy Framework and Strategic Plan 2013-2020 further sets out goals pertaining to these objectives regarding:¹⁵¹

- Community mental health services, the district mental health system, psychiatric services in general hospitals, and specialised psychiatric hospitals by 2020;
- Financing according to the principles of health financing in South Africa by 2014;¹⁵²
- The integration of mental health into all aspects of general health care by 2015;
- Intersectoral collaboration by 2013;
- Advocacy for political support by 2015;
- The human rights protection of mentally ill persons through active implementation of the MHCA by 2014;
- Quality improvement initiatives and development of guidelines by 2014;
- Monitoring and evaluation from 2013 to include National mental health indicators that will be integrated with the district health information system (DHIS), based on a set of nationally agreed indicators and a minimum data set, and the promotion of a culture of information use for mental health service development;
- By 2015 regarding human resources and training the mental health workforce expansion will be actively pursued by all provincial Departments of Health, all health staff working in general health settings will receive basic mental health training, and ongoing routine supervision and mentoring, and a task-shifting approach will be used in the development of the mental health workforce, whereby trained non-specialist workers deliver evidence-based psychosocial interventions, with supervision and support from specialists; and
- By 2015 all psychotropic medicines, as provided on the standard treatment guidelines and essential drugs list will be available at all levels of care, including primary health care clinics.

¹⁵¹ Department of Health 'National Mental Health Policy Framework and Strategic Plan 2013-2020' 23-29.

¹⁵² A key feature of the financing goals include parity of mental health financing with other health conditions, and parity required from private medical aids.

It is submitted that the acknowledgement by the Department of Health of the issues inherent in the successful implementation of the MHCA and access to mental health care is a positive step towards the achievement of its goals. The objectives and goals detailed in the policy document are laudable, but it is submitted that the achievement of these goals within the timeframes set (some of which have already passed) remains to be monitored by ongoing research. It is unfortunate that there exists no comprehensive database of statistics regarding mental health care users, the mental health care system, infrastructure and financing, and until such data is available it will be impossible to truly assess the scope of successful implementation or the effects of failure on the human rights of mentally ill persons and the community as a whole.

6.3.5 Mental health and stigma

Stigma regarding mental illness was discussed regarding the right to equality in chapter 2. The few studies that have investigated levels of stigma in the community towards people with mental illnesses in South Africa,¹⁵³ have found consistently found high levels of stigmatizing attitudes towards individuals with mental health conditions in the communities.¹⁵⁴ One study by Kakuma *et al.*¹⁵⁵ explored the scope and impact of structural stigma and discrimination and found that structural stigma is highly prevalent and stigma-reduction strategies are urgently needed to address these issues to provide high quality mental health care and protect the rights of individuals with mental health conditions.¹⁵⁶ Structural discrimination refers to policies of the dominant group institutions, and the behaviour of individuals controlling these institutions

¹⁵³ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 117. These studies include Hugo, CJ., Boshoff, DE., Traut, A., Zungu-Dirwayi, N., Stein, DJ. (2003) "Community attitudes toward and knowledge of mental illness in South Africa" *Soc Psychiatry Psychiatr Epidemiol* Dec 12 715-719; Botha, UA., Koen, L., Niehaus, DJ. (2006) "Perceptions of a South African schizophrenia population with regards to community attitudes towards their illness" *Soc Psychiatry Psychiatr Epidemiol* 8619-23; and Lupuwana, BW., Simbayi, LC., Elkonin, D. (1999) "Psychological services in the Black community of Port Elizabeth in South Africa: Assessment of awareness, attitudes, practices and needs" *Journal of Psychology in Africa* 25-57.

¹⁵⁴ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 117.

¹⁵⁵ Kakuma, R., Kleintjies, S., Lund, C., Flisher, AJ., Goering, P., the MHaPP Research Programme Consortium. (2008) "Development and implementation of mental health policy and law in South Africa: What is the impact of stigma?" Presented at 15th Biennial National Congress of the South African Society of Psychiatrists 10-14.

¹⁵⁶ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 117.

and implementing policies, unintentionally having a differential or harmful impact on minority groups, while structural stigma refers to the violation of human rights through loss of access to employment, housing, and in some instances, voting, holding public office, marriage and parenting.¹⁵⁷

A survey of the public education and awareness activities across South Africa in 2010 has revealed that there are numerous anti-stigma activities already in place and that several key organisations in both government and non-government sectors, are pushing this agenda forward.¹⁵⁸ The Department of Health coordinates and oversees the public awareness and education campaigns, and is assisted by various NGO's including the SAFMH,¹⁵⁹ the South African Depression and Anxiety Group (SADAG),¹⁶⁰ Mental Health Information Centre (MHIC),¹⁶¹ and other professional, consumer and advocacy bodies.¹⁶² All nine provinces have had government agencies and NGOs promote public awareness and education campaigns in the last five years.¹⁶³ Only the Western Cape, Free State and Gauteng provinces reported

¹⁵⁷ *Ibid.*

¹⁵⁸ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 118.

¹⁵⁹ A national, not-for-profit, NGO affiliated with the African Regional Council for Mental Health and the World Federation for Mental Health. The SAFMH coordinates, monitors, and promotes services for persons with psychiatric and/or intellectual disabilities and promotes mental health and wellbeing. They are comprised of 17 mental health societies and numerous member organisations across the country. Creating public awareness of mental health issues is one of their main missions and they do so through various activities. Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 118.

¹⁶⁰ A user-led organisation based in Johannesburg is another highly active organisation in raising awareness and working towards reducing stigma. In operation since 1995, SADAG is one of the largest mental health support and advocacy groups in Africa and provides counselling services, mental health awareness programmes, media campaigns, school talks and rural outreach activities across the country. SADAG boasts about 180 support groups across the country and has an extensive referral guide that extends into the most remote regions of South Africa. Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 118.

¹⁶¹ Based at the University of Stellenbosch in the Western Cape, MHIC serves numerous functions. They provide telephone information to the public, provide the media with accurate information about mental disorders, support health professionals and develop and distribute a mental health resource guide annually. The Mental Health Resource Guide is a comprehensive list of mental health professionals, consumer organisations delivering a mental health service, and institutions that offer mental health treatment across the country. The guide is updated annually. The MHIC also produces other publications and participates in consumer-related mental health research. The MHIC promotes public awareness of mental health issues and research into mental illness, addresses the stigma associated with mental illness, and promotes good mental health of all South Africans. The MHIC serves the entire country and hence receives calls from all over South Africa. Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 118.

¹⁶² Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 118.

¹⁶³ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 119.

involvement of professional associations in these activities; and only the Western Cape reported involvement of private trusts, foundations and international agencies.¹⁶⁴ In various parts of the country, mental health care users are becoming involved in NGO's and community activities to provide education about mental illnesses, and obtaining training in skills for supported employment and increasing visibility.¹⁶⁵ The Free State, Gauteng and North-West provinces indicated that less than 20% of primary and secondary schools have school-based activities to promote mental health and prevent mental disorders.¹⁶⁶ In the Western Cape 51-80% of schools have such activities, and no other provinces indicated any school-based promotion or prevention activities.¹⁶⁷ In prisons, less than 20% of police officers have participated in educational activities on mental health in the last five years in Gauteng and Free State, while 21-50% have participated in such activities in Mpumalanga.¹⁶⁸ No other provinces reported training activities for police officers.¹⁶⁹ Newspapers, television shows, performing arts, radio shows, brochures and pamphlets are used for international events such as World Mental Health Day, and Mental Health Awareness month by organisations such as the SAFMH, SADAG and MHIC, who have worked closely with the media in providing accurate information about mental illnesses and promoting mental health.¹⁷⁰

Kakuma *et al.* conclude that though there are significant and seemingly effective mental health education activities occurring across South Africa, lack of reporting in scientific journals and in annual reports of the various organisations about evaluation of these activities indicate that they are not being systematically assessed for their effect on increasing awareness and reducing stigma, therefore their impact on reducing stigma is unknown.¹⁷¹ The authors assert that the success of any anti-stigma intervention relies heavily on the content and mode of the intervention as well as the selection of an appropriate measure and method to evaluate its impact, and that one cannot assume that increasing awareness about mental

¹⁶⁴ *Ibid.*

¹⁶⁵ *Ibid.*

¹⁶⁶ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 120.

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

¹⁶⁹ *Ibid.*

¹⁷⁰ *Ibid.*

¹⁷¹ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 121.

illnesses will lead to change in attitudes and behaviour.¹⁷² In order to properly assess stigma-reduction interventions, a better understanding of the complex manifestation of stigma in the South African context must first be gained in order to develop intervention strategies, therefore promotion of such research that would allow for stronger evidence-based policy, and inform future planning of ant stigma campaigns in South Africa and elsewhere is suggested.¹⁷³

Sohrsdahl *et al.* assert that one of the most significant barriers to accessing care for people with a mental disorder in South Africa is low mental health literacy, defined as “knowledge and beliefs about mental illness that aid their recognition, management or prevention”.¹⁷⁴ In a study investigating barriers to treatment in a nationally representative study in South Africa, the most common reason for not accessing mental health services was a low perceived need for treatment (93%).¹⁷⁵ Common mental disorders are viewed as the result of everyday life challenges, rather than as treatable conditions.¹⁷⁶ There is some evidence from abroad to suggest that population-wide and individual level interventions designed to improve mental health literacy are effective and a mental health literacy component may be integral to developing mental health care.¹⁷⁷

6.4 Involuntary mental health care users

Involuntary mental health care in South Africa is therefore undermined by unstructured and non-evidence-based initial assessments and treatment, which might require *ex post facto* correction by psychiatric institutions and ineffective Mental Health Review Boards.¹⁷⁸

¹⁷² Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 122.

¹⁷³ Kakuma, Kleintjies, Lund, Drew, Green, Flisher, MHaPP Research Programme Consortium (2010) *Afr J Psychiatry* 122-123.

¹⁷⁴ Sohrsdaahl, Stein and Lund (2012) *Afr J Psychiatry* 169.

¹⁷⁵ Bruwer, B., Sorsdahl, K., Harrison, J., Stein, DJ., Williams, D., Seedat, S. (2011) "Barriers to mental health care and predictors of treatment dropout in the South African Stress and Health Study" *62 Psychiatr Serv* 7 774-781; Hugo, Boshoff, Traut, Zungu-Dirwayi, Stein (2003) *Soc Psychiatry Psychiatr Epidemiol* 715; Sohrsdaahl, Stein and Lund (2012) *Afr J Psychiatry* 169.

¹⁷⁶ Sohrsdaahl, Stein and Lund (2012) *Afr J Psychiatry* 169.

¹⁷⁷ *Ibid.*

¹⁷⁸ Kersop, M., Van den Berg, F. (2015) 'Obtaining involuntary mental health care in the South African constitutional dispensation' *Obiter* 679-701 700.

Without properly structured and standardised practices, the effective implementation of a constitutionally sound legislative framework for involuntary mental health care becomes increasingly difficult – if not impossible.¹⁷⁹ With due regard to the principles of separation of powers, these concerns should be dealt with by the relevant executive authority, at both national and provincial level, and should not frustrate the courts with applications for administrative review.¹⁸⁰

Burns states that the reality of providing 72-hour observations at district hospitals throughout the country is that most institutions encounter serious problems leading to suboptimal levels of care and occasional disasters relating to the practical implementation rather than the validity of the MHCA, such as:¹⁸¹

1. Mental health care users heavily sedated throughout the observation period, preventing adequate review.¹⁸²
2. Highly agitated or psychotic MHCUs inadequately sedated and difficult to contain within general ward settings, leading to unsafe conditions.¹⁸³
3. Inappropriate medications or doses of medications used for behavioural control of mental health care users, sometimes leading to iatrogenic problems.
4. Inadequate screening of medical conditions; having been labelled “a psych patient”, the mental health care user is thereafter neglected in terms of routine examination and investigation.
5. Failure, at district hospital level, to comply with the requirements of the MHCA regarding completion of MHCA forms.

Burns is of the opinion that the principles of the MHCA are sound, and that it is their day-to-day realisation that is problematic.¹⁸⁴ Infrastructural and functional shortcomings leading to the mentioned practical problems include:¹⁸⁵

¹⁷⁹ *Ibid.*

¹⁸⁰ *Ibid.*

¹⁸¹ Burns, J. K. (2008) “Implementation of the Mental Health Care Act (2002) at District Hospitals in South Africa: Translating Principles into Practice” 98 South African Medical Journal 1 46-5147-48.

¹⁸² Simpson and Chipps (2012) Social work 52.

¹⁸³ *Ibid.*

- Inadequate facilities for containing disturbed, aggressive mental health care users.
- Inadequate skills of health workers in managing psychiatric patients.
- Poor understanding and knowledge of the MHCA and its forms.
- Inadequate medications, treatment protocols and guidelines as well as awareness of referral options.
- The roles of the South African Police Services (SAPS) and Emergency Medical Rescue Services (EMRS) regarding the management of mental health care users are not clear, and their involvement is often unhelpful.

Challenges exist in terms of the clinical assessment of the different categories of mental health care users.¹⁸⁶ For example, appropriate criteria for judging a user's capacity to make an informed decision about his/her health care may include the ability: to understand information relevant to decisions; to appreciate its significance; to reason using relevant information; and to choose and express one's choice.¹⁸⁷ Capacity in this sense may therefore also be compromised due to limitations such as language, culture and literacy, consultation time available, responsibility allocated to give and explain information and age.¹⁸⁸

6.5 Human rights abuses perpetrated in the provision of mental health care

There have been instances where the system has completely failed to provide mental health care for people with severe mental health problems who require hospitalisation.¹⁸⁹ In a study by Lucas and Stevenson, more than 50% of patients who participated reported experiences of abuse from staff and patients, and almost 44% of patients were frightened to stay in the hospital for treatment.¹⁹⁰ Abuses that occurred at a specialist psychiatric hospital in KwaZulu-

¹⁸⁴ Burns (2008) SAMJ 48.

¹⁸⁵ *Ibid.*

¹⁸⁶ Janse van Rensburg (2007) Afr J Psychiatry 207.

¹⁸⁷ *Ibid.*

¹⁸⁸ *Ibid.*

¹⁸⁹ Simpson and Chipps (2012) Social work 52.

¹⁹⁰ Lucas, M. and Stevenson, D. (2006) 'Violence and abuse in psychiatric in-patient institutions: A South African perspective' 29 International Journal of Law and Psychiatry 3 195-203; Simpson and Chipps (2012) Social work 52.

Natal in 2005 necessitated an investigation by a Commission of Enquiry.¹⁹¹ The findings of the commission confirmed media allegations of human rights abuses at the hospital and identified a range of systemic defects, including:¹⁹² weak management over a long period of time, the absence of a hospital board, inadequacies in the physical layout and quality of facilities, patients abusing staff, staff reporting on duty under the influence of alcohol, a high rate of absenteeism, a shortage of staff, lack of discipline, evidence of racism, nepotism and favouritism as well as strained relations between the management and labour unions.

Far from providing a supportive environment, institutional care settings for the mentally disordered are often where human rights abuses occur.¹⁹³ This is particularly true in segregated services including residential psychiatric institutions and psychiatric wings of prisons.¹⁹⁴ Persons with mental disorders are often inappropriately institutionalized on a long-term basis in psychiatric hospitals and other institutions.¹⁹⁵ While institutionalized, they may be vulnerable to being chained to soiled beds for long periods of time, violence and torture, the administration of treatment without informed consent, unmodified use of electroconvulsive therapy, grossly inadequate sanitation, and inadequate nutrition.¹⁹⁶ Women are particularly vulnerable to sexual abuse and forced sterilizations.¹⁹⁷ Persons from ethnic and racial minorities are often victims of discrimination in institutions and care systems.¹⁹⁸ A lack of monitoring of psychiatric institutions and weak or nonexistent accountability structures allow these human rights abuses to flourish away from the public eye.¹⁹⁹

Janse van Rensburg argues that there are currently no measures to incentivise the national and state departments to actively establish infrastructure for mental health care services, and to make resources available in a transparent and accountable way to enforce the agreed upon human rights standards in the MHCA, unless successful litigation to do so is pursued.²⁰⁰ Very

¹⁹¹ Simpson and Chipps (2012) Social work 52.

¹⁹² *Ibid.*

¹⁹³ Hunt and Mesquita (2006) Human Rights Quarterly 333; Simpson and Chipps (2012) Social work 293.

¹⁹⁴ *Ibid.*

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

¹⁹⁷ Hunt and Mesquita (2006) Human Rights Quarterly 334; Simpson and Chipps (2012) Social work 293.

¹⁹⁸ *Ibid.*

¹⁹⁹ *Ibid.*

²⁰⁰ Janse van Rensburg (2007) Afr J Psychiatry 208.

few users of state facilities or their families have the financial means to pursue litigation in the event of human rights and other abuses.²⁰¹ The notion that the current mental health legislation only allows for a negative incentive such as eventual litigation to take up responsibility for providing infrastructure and staffing is an unfortunate state of affairs.²⁰² It is not clear to what extent the State or individuals working within inadequate, insecure public mental health environments are responsible for abuses or incidents of human rights violations that may occur.²⁰³ These incidents are often largely due to inadequate staffing and structure of hospitals.²⁰⁴

6.6 Mental health review boards

Review Boards have been designated to provide a “critical and legally-specified role” to guide and support the hospitals and protect the rights of mental health care users by investigating abuse, neglect and exploitation.²⁰⁵ They are ideally and strategically placed between consumers and clinicians as well as the Health Ministry and Judiciary to advocate for mental health.²⁰⁶ Review Boards generally labour under the challenges of budgetary constraints, poor administrative and political support, a lack of basic resources to conduct business as well as the challenges and limitations of the services that they are tasked to oversee.²⁰⁷ Procedurally they are expected to report directly to their provincial health ministers who refuse to meet with them.²⁰⁸ Activity levels vary with 80% of KZN hospitals not having had a single visit in a 6 month period.²⁰⁹ Ramlall states that Review Boards are generally perceived as being unhelpful in addressing practical issues, difficult to communicate with and lacking power to meaningfully contribute to transformation of neglected services, and the limited powers accorded to the Board rendered them ineffective in summoning investigations in cases of abuse and exploitation²¹⁰ Despite these challenges, reports of well-functioning boards,

²⁰¹ *Ibid.*

²⁰² *Ibid.*

²⁰³ Janse van Rensburg (2007) *Afr J Psychiatry* 209.

²⁰⁴ *Ibid.*

²⁰⁵ Ramlall (2012) *Afr J Psychiatry* 409.

²⁰⁶ *Ibid.*

²⁰⁷ *Ibid.*

²⁰⁸ *Ibid.*

²⁰⁹ *Ibid.*

²¹⁰ *Ibid.*

committed to championing mental health and taking initiatives to promote and advocate for mental health bear testimony to their potential to fulfil their legislated responsibility if they were appropriately supported and resourced.²¹¹

Ramlall *et al.* found that visits by Review Boards to psychiatric facilities were infrequent and generally not found to be useful.²¹² Even when visits were found to be useful, this usefulness was hampered by the limited powers of the Boards to improve funding and infrastructure development.²¹³

Review Boards review procedural matters, and have no jurisdiction to rule on conditions in facilities or other service related matters.²¹⁴ Kersop and Van den Berg state that Review Boards are placed in a precarious position by not being afforded sufficient powers to fulfil their statutory mandate, leading to frustration and friction with the mental health care sector.²¹⁵ The Review Boards have been created to facilitate supervision and accountability of care provision and to ensure that mental health care users are protected, especially during periods of vulnerability and are thus intended to be a mechanism for active monitoring and enforcement of mental health care users' personal rights.²¹⁶ Research has shown, however, that the functioning and power of these boards have been inadequate up to date and it has been suggested that the State needs to act urgently to restructure or standardise the Review Boards as an effective guardian of human rights for mental health care users.²¹⁷

Information systems required to routinely monitor and evaluate mental health services are largely inadequate.²¹⁸ There is a particular need to develop indicators of routine mental health service delivery at primary and secondary care level, and to integrate these indicators into the District Health Management Information System (DHIS).²¹⁹

²¹¹ *Ibid.*

²¹² Ramlall, Chipps and Mars (2010) SAMJ 668.

²¹³ *Ibid.*; Simpson and Chipps (2012) Social work 52.

²¹⁴ Janse van Rensburg (2007) Afr J Psychiatry 208.

²¹⁵ Kersop and Van den Berg (2015) Obiter 700.

²¹⁶ Kersop and Van den Berg (2015) Obiter 701.

²¹⁷ *Ibid.*

²¹⁸ Lund, c., Petersen, I., Kleintjies, S. Bhana, A. (2012) 'Mental Health Services in South Africa: Taking stock' African Journal of Psychiatry 15 402-405 404.

²¹⁹ *Ibid.*

Mental Health Review Boards are flooded with an administrative deluge created by the constant stream of uncontrolled paper work, and most Review Boards appear not to currently have the capacity to manage databases effectively or track the movement of users from the one facility to the other.²²⁰ It has also been reported that in 2011 Review Boards in some provinces like Limpopo have not even been appointed.²²¹ Janse van Rensburg states that Review Boards often seem to make “rubber stamp” decisions and only reject submissions if documents demonstrate administrative mistakes such as incorrect dates or incorrect numbering of routine periodical reports.²²² Such actions hold no real significance for the individual care user, or address any actual illegal or inappropriate admissions adequately or timeously.²²³

In a study by Janse van Rensburg it was found that data from the Mental Health Review Boards' database represented record entries and not users, meaning that several unrelated records may exist for the same user, or no record may exist for others.²²⁴ No overview of the total patients in any facility at a specific time was routinely obtained by the Review Boards, with the result that no conclusions could be drawn about the completeness of their records.²²⁵ Janse van Rensburg therefore states that it can therefore be assumed that responses by Review Boards may often be irrelevant, inappropriate and out-dated, based on the incomplete information that they may receive.²²⁶ Inadequate oversight of admission procedures and of the changing legal status of users is indicative of the poor capacity of the Review Boards to discover human rights or other violations.²²⁷ He recommends that while adequate clinical assessments and reports in support of applications for admission should continue to be ensured by clinicians, the quality of referral procedures and administrative record keeping must dramatically be improved and an effective tracking system must be ensured.²²⁸

²²⁰ Janse van Rensburg, ABR (2011) 'Available resources and human rights - a South African perspective' Afr J Psychiatry 14 173-175 173-175; Janse van Rensburg, ABR. (2011) 'Tracking the legal status of a cohort of inpatients on discharge from a 72-hour assessment unit' Afr J Psychiatry 14 318-320 320.

²²¹ Janse van Rensburg (2011) Afr J Psychiatry 14 173-175 173-175.

²²² *Ibid.*

²²³ *Ibid.*

²²⁴ Janse van Rensburg (2011) Afr J Psychiatry 14 318-320 320.

²²⁵ *Ibid.*

²²⁶ *Ibid.*

²²⁷ *Ibid.*

²²⁸ *Ibid.*

Information systems are generally weak in most mental health services.²²⁹ Lund *et al.* state that if the requirements of the MHCA are to provide mental health care in all “health establishments”, then both general and psychiatric hospitals need to develop information systems to monitor the care they deliver.²³⁰ The audit they conducted indicated that many general hospitals are not able to provide mental health data, in compliance with the MHCA. An immediate and practical solution to this problem is to expand current general health management information systems to include monitoring of mental health care.²³¹ The WHO has recently published guidelines for the development of Mental Health Information Systems that are linked to general health management information systems.²³² These guidelines could usefully be applied in a general review of mental health information systems in all provinces, which would be consistent with international trends and WHO recommendations for the integration of mental health into general health care.²³³ This is endorsed by South African national policy which recommends the integration of mental health into general health care, and the need for general hospitals to move in this direction.²³⁴

The United Nations Committee on the Rights of Persons with Disabilities expressed particular concern regarding poor monitoring of conditions and treatment of people in residential care, particularly in mental health institutions.²³⁵ Civil society stakeholders agree that the majority of Mental Health Review Boards appointed for all mental health hospitals as well as care and rehabilitation centres in all nine provinces are either dysfunctional or neglectful of carrying out their duties with regards monitoring human rights to ensure quality of care and in general do not respond to complaints with of ill treatment and torture which might occur.²³⁶

²²⁹ Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 399.

²³⁰ Lund, C., Stein, DJ., Flisher, AJ., Mehtar, S. (2007) 'Challenges faced by South African health services in implementing the Mental Health Care Act' 97 SAMJ 5 352-353 352.

²³¹ *Ibid.*

²³² World Health Organisation "Mental Health Policy and Service Guidance Package: Mental Health Information Systems" 2005; Lund, Stein, Flisher, Mehtar (2007) SAMJ 352.

²³³ Lund, Stein, Flisher, Mehtar (2007) SAMJ 352.

²³⁴ *Ibid.*

²³⁵ United Nations Committee on the Rights of Persons with Disabilities 'Consideration of reports submitted by States Parties under article 35 of the Convention: South Africa' (2015) 32.

²³⁶ United Nations Committee on the Rights of Persons with Disabilities (2015) 32.

6.7 Community care: Diagnosis and treatment of mental disorder

The Prevention of mental illness has not been as vigorously pursued in terms of the MHCA as was anticipated.²³⁷ Treating mental health problems as any other illness and within the same health system should reduce the stigma associated with mental health problems.²³⁸ Mental health care policy should aim to integrate comprehensive community-based mental health care services at the primary health care level in the least restrictive environment.²³⁹ The objective is "to make mental health services as much part of general health care as other health areas" and to replace custodial care with community-oriented alternatives for all but a small minority of people with mental health problems.²⁴⁰

The MHCA addresses this in two specific ways namely Section 3(a)(iii) which makes provision for the integration of mental health services into the general health environment, and Section 34 which makes provision for involuntary and assisted mental health care users to first be admitted for 72-hours observation at a local general hospital. Increasing access to care and the availability of local services reduces the need for premature or unnecessary transfers to psychiatric hospitals.²⁴¹ A strong system of community-based psychiatric services is necessary to ensure adequate care, treatment and rehabilitation, but new services have not been developed and existing ones have not been strengthened.²⁴²

Implementation of the Act has been haphazard and dominated by acute care with neglect of the promotion, prevention and rehabilitation components of care.²⁴³ The enforced integration of mental health into the general health system has been a welcome move that promotes de-stigmatization. Integration appears to have been focussed largely at district and regional hospital level to the neglect of community and Primary Health Care (PHC) services.²⁴⁴ A review of community psychiatric services in Southern Gauteng, revealed that primary health

²³⁷ Landman and Landman 4.

²³⁸ Simpson and Chipps (2012) Social work 51.

²³⁹ *Ibid.*

²⁴⁰ *Ibid*; Freeman M (2002) "New mental health legislation in South Africa – principles and practicalities: A view from the Department of Health" 5 S Afr Psychiatry Rev 3 4-8 7.

²⁴¹ Simpson and Chipps (2012) Social work 53.

²⁴² *Ibid.*

²⁴³ Ramlall (2012) Afr J Psychiatry 408.

²⁴⁴ *Ibid.*

clinicians played no active role in the management of the mentally ill with care being supplied mainly by mental health professionals.²⁴⁵ Insufficient numbers of community clinics failed to meet the local needs or fulfil the basic principles of community psychiatry as well as legislative and policy requirements.²⁴⁶ Much-needed transformation of community psychiatric services has not materialised.²⁴⁷

The establishment of halfway stations and step-down facilities has also not kept pace with demand.²⁴⁸ Freeman identified one of the key challenges to mental health care as inadequate community care and states that people roaming the streets with mental illness mostly do not need hospitalization but good community care instead.²⁴⁹ Hospitalisation of such people may not only constitute an abuse of their human rights but is more expensive than providing good community care, including housing and social support.²⁵⁰

6.8 The administrative burden of the MHCA: MHCA forms

The least popular, highly problematic and most controversial aspect of the MHCA has been its administrative burden in terms of paperwork.²⁵¹ The mountain of paperwork involved has challenged the administrative capacity of most hospitals that are unable to manage the paper trail.²⁵² Ramlall, Chipps and Mars found that 44% of hospitals were not forwarding their forms to the Mental Health Review Boards.²⁵³ Ramlall reported in 2012 that a proposal for a comprehensive revision of the forms has been submitted by the South African Society of

²⁴⁵ Moosa, MYH, Jeena, FY. (2008) "Community psychiatry: An audit of the services in southern Gauteng" 14 South African Journal of Psychiatry 236-43 38; Ramlall (2012) Afr J Psychiatry 408.

²⁴⁶ Moosa and Jeena (2008) South African Journal of Psychiatry 38; Ramlall (2012) Afr J Psychiatry 408.

²⁴⁷ Ramlall (2012) Afr J Psychiatry 408; Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjies, S., *et al.* (2009) "Planning for district mental health services in South Africa: a situational analysis of a rural district site" 24 Health Policy and Planning 2140-50.

²⁴⁸ Landman and Landman 6; Simpson and Chipps (2012) Social work 53.

²⁴⁹ Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

²⁵⁰ *Ibid.*

²⁵¹ Szabo, C (2006) 'The Mental Health Care Act: challenges and opportunities' S Afr Psychiatry Rev 9 1-5 5; Ramlall (2012) Afr J Psychiatry 409.

²⁵² Ramlall (2012) Afr J Psychiatry 409.

²⁵³ Ramlall, Chipps and Mars (2010) SAMJ 669.; Ramlall (2012) Afr J Psychiatry 409.

Psychiatrists (SASOP) and implementation of the changes is pending.²⁵⁴ To date, a comprehensive revision of the MHCA forms has not been implemented.

Szabo states that it is imperative however that appropriate staffing and materials are forthcoming in terms of clerical staff to facilitate the process of completion of forms.²⁵⁵ Currently there are no such dedicated personnel, so clinicians are tasked with this responsibility resulting in patient care time being taken up by paperwork.²⁵⁶ Szabo emphatically states that administrative inefficiency is inexcusable and that heads of Health Establishments should both understand their obligations and responsibilities in terms of the MHCA, as well as ensure that these are fulfilled.²⁵⁷ The implementation of an effective data management system has also been discussed in this thesis.

6.9 Mental health in the criminal justice system

Forensic psychiatry constitutes an important and significant field within the scope of state-employed psychiatrists.²⁵⁸ Janse van Rensburg states on behalf of the South African Society of Psychiatrists (SASOP) and the SASOP State Employed Special Interest Group (SESIG) that there are 3 groups of forensic patients, each with their own specific needs, problems and possible solutions, namely:²⁵⁹

1. Persons referred to designated hospitals for forensic psychiatric observation in terms of the CPA;
2. State Patients admitted to designated hospitals in terms of the MHCA; and
3. Mentally ill prisoners in terms of the MHCA.

²⁵⁴ Ramlall (2012) *Afr J Psychiatry* 409.

²⁵⁵ Szabo (2006) *A Afr Psychiatry Rev* 5

²⁵⁶ *Ibid.*

²⁵⁷ *Ibid.*

²⁵⁸ Janse van Rensburg, B. (ed.) (2012) 'The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) Position Statements on Psychiatric Care in the Public Sector' 18 *SAJP* 3 133-147 140.

²⁵⁹ *Ibid.*

Regarding the first group of persons referred for forensic observation in terms of the CPA, there are currently 10 observation units in the country and the main problem seems to be the long waiting list for admission to some of the units.²⁶⁰ There are also significant differences between the provinces in the manner in which observations are conducted, which leads to differences between the waiting lists.²⁶¹ An infrastructure task team assessed each observation site and found that not a single one met the standards of the Department of Health, and all had either to be replaced, newly built, or significantly altered.²⁶² SASOP and SESIG take the position that at least one observation unit should be established in each province, with satellite units within provinces to bring services closer to the people, and that observation units should be upgraded according to the standards set by the national Department of Health.²⁶³

Regarding State Patients, Janse van Rensburg states that most institutions catering for State Patients are well over capacity.²⁶⁴ SASOP and SESIG take the position that rehabilitation must be the emphasis of the care of State Patients and that institutions involved in their treatment should develop a uniform approach towards a rehabilitation programme.²⁶⁵

Regarding mentally ill prisoners, issues include the fact that the administrative process to place a prisoner into a mental health institution in terms of the MHCA is too complicated (this aspect has been discussed at length in Chapter 5).²⁶⁶ Psychiatric services in correctional facilities are very limited or nonexistent and should be addressed by interdepartmental negotiations.²⁶⁷ SASOP and SESIG take the position that attempts should be made to achieve changes to the MHCA to simplify the procedure of referral.²⁶⁸ An integral part of the realisation of the human rights of mental healthcare users is to ensure that the physical spaces

²⁶⁰ These are located at Weskoppies and Sterkfontein Hospitals (Gauteng, also serving Mpumalanga and North West); Free State Psychiatric Complex (also serving parts of Northern Cape); Komani (single observations only) and Fort England Hospital (Eastern Cape); Fort Napier Hospital (KwaZulu-Natal); Valkenberg Hospital (Western Cape and parts of Northern Cape); Thabamopo and Hayani Hospitals (Limpopo); and Bophelong Hospital (single observations only) (North West). Janse van Rensburg (ed.) (2012) SAJP 140.

²⁶¹ Janse van Rensburg (ed.) (2012) SAJP 140.

²⁶² *Ibid.*

²⁶³ *Ibid.*

²⁶⁴ *Ibid.*

²⁶⁵ *Ibid.*

²⁶⁶ *Ibid.*

²⁶⁷ *Ibid.*

²⁶⁸ *Ibid.*

and structure of facilities are aligned with the needs and functionality of a spectrum of mental healthcare users, including forensic psychiatric care users.²⁶⁹ It is also necessary to adequately protect public sector mental healthcare practitioners from assault and injury as a result of performing their clinical duties by ensuring that adequate security procedures are implemented, appropriate for the level of care that is required, and that appointed security staff members are appropriately trained and adequately equipped.²⁷⁰

6.9.1 Human resources and training

Very few practising psychiatrists in South Africa are actively involved in forensic psychiatry and according to a national survey in 2008, only 40 psychiatrists indicated a willingness to evaluate and report on accused referred from court.²⁷¹ A growing role for forensic practice in civil litigation has led to many psychiatrists in private practice becoming involved in such matters, mostly with no peer review or official regulation.²⁷² The College of Psychiatrists has recently introduced an examination for the diploma in forensic psychiatry, and subsequently the Health Professions Council of SA has accepted, by proclamation in the Government Gazette, that forensic psychiatry will be recognised formally as a sub-specialty in South Africa.²⁷³ In 2012 there were at least 10 psychiatrists whose practice is dedicated to forensic psychiatry, and some of the academic departments of psychiatry have introduced postgraduate programmes, and texts were being published to standardise the overall practice of forensic mental health.²⁷⁴

In a study on psychiatrists' participation in prosecutorial workshops, Kotze and De Wet concluded that mental health service providers can offer law professionals valuable training opportunities regarding the major mental illnesses and their treatment, course and prognosis.²⁷⁵ The results of their study indicate there is a need in South Africa for training of prosecutors in mental health topics, with the ultimate goal being to work towards a successful

²⁶⁹ Janse van Rensburg (ed.) (2012) SAJP 141.

²⁷⁰ *Ibid.*

²⁷¹ Ogulesi, Ogunwale, De Wet, Roos, Kaliski (2012) Afr J Psychiatry 5.

²⁷² *Ibid.*

²⁷³ *Ibid.*

²⁷⁴ *Ibid* 5; Kaliski, S. "Introduction" in Kaliski, S. (ed.) "Psycholegal assessment in South Africa" 2006 1-7.

²⁷⁵ Kotze and De Wet (2011) SAJP 116.

collaboration between the criminal justice and mental health systems.²⁷⁶ This requires a mutual understanding of each discipline's missions and methodologies, and training sessions provide an opportunity for reciprocal sensitisation between the different fields.²⁷⁷

6.9.2 Risk assessment

Section 77(6) and 78(6) of the CPA was discussed in Chapter 5 along with the indefinite detention of habitual and dangerous offenders, while involuntary mental health care users in Chapter 4. All of these provisions have in common the possibility of indefinite detention in a mental health establishment or prison based on, among other things, the determination of risk of dangerousness (to the mentally ill person themselves or to others) or the risk of reoffending. Risk assessment in context of South African forensic psychiatry was addressed by Roffey and Kaliski in an article in which they evaluate the importance of determining and managing risk against the inherently unpredictable and changeable notion of risk assessment.²⁷⁸ The authors mention a few methods of risk prediction, including actuarial methods such as the RRASOR (Rapid Risk Assessment for Sexual Offence Recidivism) actuarial instrument, and structured professional judgement (SPJ) instruments, such as the Historical-Clinical-Risk Management-20, or HCR-20 instrument.²⁷⁹ The drawbacks of actuarial methods of risk assessment include the fact that no clinical expertise is required to complete them, and that the best probability of risk they provide can only be valid for a particular population, but not necessarily for a specific individual.²⁸⁰ In pure actuarial instruments there is a complete reliance on historical factors, because statistical probabilities, expressed in quantitative terms, can only be formulated from accumulated data gained from past events.²⁸¹ SPJ instruments were developed to counter these limitations and include

²⁷⁶ *Ibid.*

²⁷⁷ *Ibid.*

²⁷⁸ Roffey, M., Kaliski, S. (2012) 'To predict or not to predict – that is the question' An exploration of risk assessment in the context of South African forensic psychiatry' *Afr J Psychiatry* 15227-233.

²⁷⁹ Roffey and Kaliski (2012) *Afr J Psychiatry* 228.

²⁸⁰ *Ibid.*

²⁸¹ *Ibid.*

assessment of dynamic and situational factors.²⁸² SJP's also include actuarial components, and whichever scale used produces a score that can be translated into a probability of risk.²⁸³

Assessment of the potential risk of harm to self, others or property is another area difficult to assess.²⁸⁴ No clinical assessment can provide a final measure of the outcome of a person's level of aggression, propensity for violence, or risk of harm to self or others and assessing clinicians can at best, take previous and present experiences into account to project the likelihood of possible future aggressive behaviour under similar conditions.²⁸⁵ While adequate pharmacological and behavioural treatments may reduce some aspects of the risk associated with this scenario, violent behaviour often depends on external environmental or situational variables, which are difficult to control or to predict.²⁸⁶

Main issues pertaining to risk assessment include the fact that risk assessment is a form of weighted prediction, which is more valid for groups and not individuals, which Roffey and Kaliski opine is not good enough for making important decisions, especially if there are thresholds for allowing or restricting someone's freedom.²⁸⁷ This argument is especially valid when a 100% risk of dangerousness cannot be established, and arbitrary lines have to be drawn in terms of the probability at which a mentally ill person will be deprived of their liberty.²⁸⁸ The instruments do not differentiate between types of violence or the type of circumstance under which violence is likely to be committed, and even the most reliable risk assessments are only valid for a few months.²⁸⁹ In addition in South Africa instruments for risk assessment are used that were developed in other countries, meaning that they may not

²⁸² *Ibid.*

²⁸³ *Ibid.*

²⁸⁴ Janse van Rensburg (2007) *Afr J Psychiatry* 208.

²⁸⁵ *Ibid*; Simon, RI. 'Ethics and Forensic Psychiatry' in Sadock, BJ. and Sadock, VA. (eds.) "Kaplan and Sadock's Comprehensive Textbook of Psychiatry" Volume 2 Seventh Edition Lippencott, Williams and Wilkens, Philadelphia 2000 3272 –3300.

²⁸⁶ Janse van Rensburg (2007) *Afr J Psychiatry* 208.

²⁸⁷ Roffey and Kaliski (2012) *Afr J Psychiatry* 228; Ryan, C., Nielsens, O., Paton, M., Large, M. (2010) 'Clinical decisions in psychiatry should not be based on risk assessment' *Australasian Psychiatry* 18 398-403 400.

²⁸⁸ Roffey and Kaliski (2012) *Afr J Psychiatry* 228; Ryan, Nielsen, Paton and Large (2010) *Australasian Psychiatry* 400.

²⁸⁹ Roffey and Kaliski (2012) *Afr J Psychiatry* 228; Ryan, Nielsen, Paton and Large (2010) *Australasian Psychiatry* 400; Mossman, D. (2000) "Commentary: Assessing the risk of violence - Are "accurate" predictions useful?" *Journal of the American Academy of Psychiatry and the Law* 3272-281.

capture culture specific variables.²⁹⁰ The authors state that risk assessment might only be useful in the short term and argue that at least some form of risk assessment, other than unstructured ones, should be used considering the fact that continued detention of dangerous patients should be justified using evidence-based instruments such as SJP's.²⁹¹ The authors further suggest that a better approach would be to regard risk management as the primary endeavour of such assessors, driven by iterative rounds of risk assessment and monitoring.²⁹²

6.10 Suggested solutions

Multiple recommendations have been made regarding the improvement of mental health services by various authors based on multiple studies, as has been collated in a systematic review by Petersen and Lund on mental health service delivery in South Africa from 2000 to 2010.²⁹³ Recommendations synthesised in the systematic review include:²⁹⁴

- Improved community-based rehabilitation and care facilities;²⁹⁵
- Training of MHCUs and service providers in users' rights, and establish programmes to improve attitudes and communication between service providers and users;²⁹⁶
- Improved infrastructure and specialist staff in general hospitals;²⁹⁷
- Improved training and support of primary health care doctors and nurses in the MHCA, emergency management and referral of cases;²⁹⁸

²⁹⁰ Roffey and Kaliski (2012) *Afr J Psychiatry* 228.

²⁹¹ *Ibid*; Marais, B., Subramaney, U. (2015) 'Forensic State Patients at Sterkfontein Hospital: A 3-year follow-up study' 21 *S Afr J Psychiatr* 3 86-92 91.

²⁹² Roffey and Kaliski (2012) *Afr J Psychiatry* 229; Marais and Subramaney (2015) *S Afr J Psychiatry* 91.

²⁹³ Petersen, I., Lund, C. (2011) 'Mental health service delivery in South Africa from 2000 to 2010: One step forward, one step back' *SAMJ* 101 751-757.

²⁹⁴ Petersen and Lund (2011) *SAMJ* 753-754.

²⁹⁵ Janse van Rensburg ABR. (2007) *African Journal of Psychiatry* 163; Janse van Rensburg ABR. (2010) "Diagnosis and treatment of schizophrenia in a general hospital based acute psychiatric ward" *African Journal of Psychiatry* 1 :204-210; Joska, JA., Flisher, AJ. (2007) "Needs and services at an in-patient psychotherapy unit" 10 *Afr J Psychiatry* 3 149-156; Lund C, Oosthuizen P, Flisher AJ, *et al.* (2010) "Pathways to inpatient mental health care among people with schizophrenia spectrum disorders in South Africa" 61 *Psychiatr Serv* 3 235-240.

²⁹⁶ Mayers, P., Keet, N., Winkler, G., Flisher, AJ. (2010) "Mental health service users' perceptions and experiences of sedation, seclusion and restraint" 56 *Int J Soc Psychiatry* 1 60-73.

²⁹⁷ Ramlall, Chipps and Mars (2010) *SAMJ* 671; Lund, C., Kleintjes, S., Kakuma, R., Flisher, AJ. (2010) "Public sector mental health systems in South Africa: interprovincial comparisons and policy implications" 45 *Soc Psychiatry Psychiatr Epidemiol* 3 393- 404.

- Training of security personnel and SAPS in the MHCA;²⁹⁹
- Improved information system to facilitate and monitor de-institutionalisation;³⁰⁰
- Ensure psychotropic medication is universally available at primary health care clinics;³⁰¹
- Scale up community-based care for adults and child and adolescent mental health services, in line with the recommended service resources and budgets, as per the national norms;³⁰²
- Need greater co-operation between the two systems of healing to promote culturally congruent services;³⁰³
- Increased training of traditional healers to promote mental health literacy;³⁰⁴
- Promote culturally appropriate care by public sector service providers;³⁰⁵

²⁹⁸ Temmingh, HS., Oosthuizen, PP. (2008) "Pathways to care and treatment delays in first and multi episode psychosis. Findings from a developing country" 43 Soc Psychiatry Psychiatr Epidemiol 9 727-735; Petersen, I., Bhana, A., Campbell-Hall, V., *et al.* (2009) "Planning for district mental health services in South Africa: a situational analysis of a rural district site" 24 Health Policy Plan 2 140-150; Van Deventer, C., Couper, I. (2008) "Evaluation of primary mental healthcare in North West Province - a qualitative view" 14 South African Journal of Psychiatry 4 136-140; Jonnson, G., Moosa, MYH., Jeenah, FH. (2009) "The Mental Health Care Act: Stakeholder compliance with Section 40 of the Act" 15 South African Journal of Psychiatry 2 37-42.

²⁹⁹ Lund, C., Oosthuizen, P., Flisher, AJ., *et al.* (2010) "Pathways to inpatient mental health care among people with schizophrenia spectrum disorders in South Africa" 61 Psychiatr Serv 3 235-240; Mayers, Keet, Winkler, Flisher (2010) Int J Soc Psychiatry 70-73.

³⁰⁰ Lund, C., Flisher, AJ. (2006) "Norms for mental health services in South Africa" 41 Soc Psychiatry Psychiatr Epidemiol 7 587-594; Lund, C., Flisher, AJ. (2009) "A model for community mental health services in South Africa" 14 Trop Med Int Health 9 1040-1047.

³⁰¹ Lund, Kleintjes, Kakuma, Flisher, MHaPP Research Programme Consortium (2010) Soc Psychiatry Psychiatr Epidemiol 400-404; Lund and Flisher (2006) Soc Psychiatry Psychiatr Epidemiol 591-594.

³⁰² Lund and Flisher (2006) Soc Psychiatry Psychiatr Epidemiol 591-594; Lund and Flisher (2009) Trop Med Int Health 1040-1047; Lund, C., Boyce, G., Flisher, AJ., Kafaar, Z., Dawes, A. (2009) "Scaling up child and adolescent mental health services in South Africa: human resource requirements and costs" 50 J Child Psychol Psychiatry 9 1121-1130.

³⁰³ Janse van Rensburg ABR. (2009) "A changed climate for mental health care delivery in South Africa" Afr J Psychiatry 12 157-165; Jones, LV. (2009) "Black South African psychiatric recipients: have they been overlooked under the recent democratization?" 24 Soc Work Public Health 1-2 76-88; Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., Flisher, AJ. (2010) "Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services" 47 Transcult Psychiatry 4 610-628; Sorsdahl, KR., Flisher, AJ., Wilson, Z., Stein, DJ. (2010) "Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa" 13 Afr J Psychiatry 4 284-290; Mkize, LP., Uys, LR. (2004) "Pathways to mental health care in KwaZulu-Natal" 27 Curationis 3 62-71; Sorsdahl, K., Stein, DJ., Flisher, AJ. (2010) "Traditional healer attitudes and beliefs regarding referral of the mentally ill to Western doctors in South Africa" 47 Transcult Psychiatry 4 591-609.

³⁰⁴ Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher (2010) Transcult Psychiatry 624-246; Sorsdahl, Flisher, Wilson, Stein, (2010) Afr J Psychiatry 288; Sorsdahl, Stein and Flisher (2010) Transcult Psychiatry 606-609.

³⁰⁵ Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher (2010) Transcult Psychiatry 626.

- Train more psychological service providers who speak African languages;³⁰⁶
- Psycho-educational programmes for families and communities;³⁰⁷ and
- Provide public education on which interventions are effective.³⁰⁸

Based on the results of a study by Marais and Subramaney in 2015 regarding a three year follow-up on State Patients at Sterkfontein Hospital, the following recommendations should be considered:³⁰⁹

- Improving outpatient community psychiatric services with a focus on treatment adherence strategies and early detection of treatment defaulters.³¹⁰ Improved treatment adherence would reduce the risk of relapse and recidivism of State Patients.³¹¹
- Improving other psychiatric community-based services (such as day-care services, residential placement facilities and vocational rehabilitation programmes), substance abuse rehabilitation programmes and community education regarding mental illness.
- The routine use of risk-assessment tools in forensic facilities is also recommended, to more objectively evaluate the risk of dangerousness and recidivism among State Patients, and appropriately manage the risk.
- Systems should also be enhanced or developed to monitor State Patients in forensic hospitals and in the community, including those who have absconded. The use of electronic databases, within the healthcare system, may be a way to achieve this.

³⁰⁶ Kilian, S., Swartz, L., Joska, J. (2010) "Competence of interpreters in a South African psychiatric hospital in translating key psychiatric terms" *61 Psychiatr Serv* 3 309-312; Swartz, L., Drennan, G. (2000) "The cultural construction of healing in the Truth and Reconciliation Commission: implications for mental health practice" *Ethn Health* 5 205-213.

³⁰⁷ Mavundla, TR., Toth, F., Mphelane, ML. (2009) "Caregiver experience in mental illness: a perspective from a rural community in South Africa" *18 Int J Ment Health Nurs* 5 357-367; Botha, UA., Koen, L., Niehaus, DJ. (2006) "Perceptions of a South African schizophrenia population with regards to community attitudes towards their illness" *41 Soc Psychiatry Psychiatr Epidemiol* 8 619-623.

³⁰⁸ Kakuma, Kleintjes, Lund, Drew, Green, Flisher (2010) *Afr J Psychiatry* 116-124.

³⁰⁹ Marais and Subramaney (2015) *S Afr J Psychiatry* 91.

³¹⁰ Such strategies have been described in the literature and include those that address treatment-related factors (reduced complexity of treatment regimens and the use of depot antipsychotics), patient-related factors (psycho education, reminder schedules, and pharmacy generated refill reminders), and healthcare-related factors (improved therapeutic alliance between healthcare provider and patients, reduced waiting times, telephone reminders, improved liaison between hospital and outpatient teams). Marais and Subramaney (2015) *S Afr J Psychiatry* 91.

³¹¹ Moosa, M., Jeenah, F., Kazadi, N. (2007) "Treatment adherence" *13 S Afr J Psychiatr* 2 40-45.

- Improved collaboration with the courts and SAPS is mandatory. SAPS 69 reports should be routinely submitted, by the SAPS to the courts, when individuals are referred for forensic observation. There should be complete compliance by the SAPS regarding promptly locating and returning absconded State Patients to the relevant health establishment, as per the MHCA. Electronic databases within the SAPS, which record whether a person is a State Patient, may also be useful to help to immediately identify State Patients in the community.

Simpson and Chipps state that social workers are ideally placed to play a major role in helping to entrench the rights of people with mental health problems. Because of their work with families in communities and their commitment to intervening “at points where people interact with their environments”.³¹² Social workers should be involved in the following aspects:³¹³

- Assist with the early identification of mental health problems and referral to appropriate resources;
- Raise public awareness about the treatment, care and rehabilitation of people with mental health problems;
- Work with consumer groups to advocate for improved services for people with mental health problems;
- Monitor the care, treatment and rehabilitation of individual clients and report human rights abuses immediately to the authorities.

Burns states that the solution is to accommodate the requirements of the MHCA in part through improvisation and in part through careful planning and suggests the following actions regarding infrastructure.³¹⁴

- At least 2% of beds in general wards at district hospitals should be made available for the care of mental health care users.

³¹² Simpson and Chipps (2012) Social work 54.

³¹³ *Ibid.*

³¹⁴ Burns (2008) South African Medical Journal 48.

- Every district hospital should have at least one seclusion room for the care of aggressive, disruptive mental health care users during 72-hour observation.
- Every district hospital should have a dedicated psychiatric outpatient clinic.

Regarding human resources Burns suggests:³¹⁵

- District hospitals should ensure that they have at least one medical officer with expertise in managing mental health care users and who is proficient in the practical application of the MHCA.
- District hospitals should have full-time psychiatric nurses and part-time occupational therapists, psychologists and social workers for psychiatric services.
- District hospitals should insist on outreach and support visits from regional or tertiary MHCPs.

Regarding education and training Burns suggests:³¹⁶

- District and community health workers require regular training updates on the MHCA 2002 and the use of MHCA forms. This must be repeated 6-monthly, as staff change regularly and the complexity of the Act requires refresher training. This is the responsibility of regional or tertiary MHCPs and the district office.
- Treatment protocols for managing mental disorders should be developed regionally for distribution to district and community level health workers.⁹ Regular training updates should be provided on these protocols.
- District hospitals should second medical officers for occasional periods to tertiary psychiatric hospitals for training in the management of mental disorders. The value of achieving such skills and qualifications (e.g. Diploma in Mental Health) cannot be over-estimated.

³¹⁵ *Ibid.*

³¹⁶ *Ibid.*

- Local SAPS and EMRS personnel should receive regular training in their roles regarding mental health care users and the requirements of the MHCA. This is the responsibility of the district office.

In addition, the following should be achieved:³¹⁷

- Copies of the MHCA and MHCA forms must be available at all district and community health institutions. This is the responsibility of institutional managers and the district office.
- A District Mental Health Forum should be established in every district, including health workers, administrators, SAPS and EMRS representatives, community organisations and mental health care user representatives.
- Regional or tertiary MHCPs have a responsibility to provide outreach consultation-liaison services, teaching and service development to secondary and primary services (monthly MHCP visits to district and regional hospitals).

Lund *et al.* state that there is need for substantial new investment of resources to support 72-hour decentralized care in designated regional and district hospitals, and a need to strengthen identification and management of common mental disorders using task shifting within a stepped care approach at the primary health care facility level.³¹⁸ A key construct advocated by the WHO in scaling up services in resource constrained contexts is that of task shifting.³¹⁹ Task shifting is defined as “delegating tasks to existing or new cadres with either less training or narrowly tailored training”.³²⁰ Task-shifting may be a viable option to deliver mental health interventions in primary care and community-based programs particularly in resource-constrained environments, and should ideally also be accompanied by development of more highly trained personnel to provide support and supervision.³²¹ In this regard the use of guidelines such as those provided by the World Health Organization’s Mental Health Gap

³¹⁷ *Ibid.*

³¹⁸ Lund, Petersen, Kleintjies, Bhana (2012) *Afr J Psychiatry* 404.

³¹⁹ Sohrsdahl, Stein and Lund (2012) *Afr J Psychiatry* 168 169.

³²⁰ *Ibid.*

³²¹ *Ibid.*; Lund, Petersen, Kleintjies, Bhana (2012) *Afr J Psychiatry* 404.

Action Programme (mhGAP) Intervention Guide, which has been adapted for South Africa and integrated into set of clinical guidelines (Primary Care 101) is recommended.³²²

Public education is needed to improve mental health literacy and reduce stigma and discrimination.³²³ It is also essential that collaborative arrangements with traditional healers are established to promote culturally congruent care and referral systems between the two systems of healing.³²⁴ A nationally agreed minimum data set needs to be put in place and an information system established, in order to consistently monitor mental health service delivery and outcomes at provincial and district level.³²⁵ Janse van Rensburg calls for transparency and due planning and consideration in budgetary matters, and stresses the importance of assessing the extent and availability of resources, lest human rights be always subject to the alleged non-availability of resources.³²⁶ No process to ascertain if adequate resources were made available within given restraints and that resources are utilised in a way that upholds the human rights of users to have adequate access to services and treatment currently exists in the South African health system and although the principle can be regarded as formally legislated, no financial assessment or alignment with MHCA requirements of national or provincial budgets to evaluate the availability of mental health resources has yet been formally undertaken.³²⁷

Neglect of mental health will impact negatively on physical health as well as mental health given the high rates of co-morbidity, and it will also impact on education, productivity, and violence.³²⁸ Saxena and Skeen state that there is evidence that mental health interventions can improve economic outcomes,³²⁹ and given the links between mental health and various development indicators, it will be important to consider interventions to improve mental

³²² Lund, Petersen, Kleintjies, Bhana (2012) *Afr J Psychiatry* 404.

³²³ *Ibid.*

³²⁴ *Ibid.*

³²⁵ Lund, Kleintjies, Kakuma, Flisher, MHapp Research Programme Consortium (2010) *Social Psychiatry and Psychiatric Epidemiology* 403.

³²⁶ Janse van Rensburg (2007) *Afr J Psychiatry* 209.

³²⁷ *Ibid.*

³²⁸ Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

³²⁹ Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, *et al.* (2011) "Poverty and mental disorders: breaking the cycle in low-income and middle-income countries" *Lancet* 9801 1502–1514.

health within a developmental framework.³³⁰ A lack of progress in developmental targets within the country will continue to have a significant impact on mental health outcomes, while improving mental health at the population level would build individual, family and community level capacity in the country.³³¹ The health-promotion strategies of advocacy, communication, policy and legislative changes, community participation, and research and assessment can promote mental health together with physical health and productivity.³³²

The MHCA indicates that mental health care deserves parity with other health care issues and provides an opportunity to remind decision-makers of the importance of mental health, and to ensure that appropriate resources are allocated to improve the quality of mental health services and protect the human rights of people with mental disorders.³³³ Mental health needs to be prioritised so that it becomes part of not only the national but provincial annual performance plans.³³⁴

In the 2009 Report on the Public Inquiry on the Right to Health, the South African Human Rights Commission made a number of recommendations to ensure that all health care facilities should be physically accessible for persons with disabilities.³³⁵ The following progress has been recorded regarding these recommendations:³³⁶

1. Budget and resource allocations to mental healthcare should be reviewed and addressed accordingly. Due to the integrated nature of the budget it has been difficult to quantify expenditure for mental health services;
2. There should be substantial mental health research that clearly quantifies varying mental disabilities by region for resource allocation. The Department collaborates with various research institutions on mental health research;

³³⁰ Saxena and Skeen (2012) *Afr J Psychiatry* 400.

³³¹ *Ibid.*

³³² Herrman H., Swartz, L. (2007) 'Promotion of mental health in poorly resourced countries' *Lancet* 1195-1197 1196.

³³³ Lund, Stein, Flisher, Mehtar (2007) *SAMJ* 352.

³³⁴ Freeman, M. 'State of Mental Health and Mental Health Services in SA: Plans for way forward' briefing by the National Department of Health to the Select Committee on Social Resources of Parliament, 30 July 2013.

³³⁵ United Nations Committee on the Rights of Persons with Disabilities (2015) 51-52.

³³⁶ *Ibid.*

3. Mental healthcare facilities and services by trained staff should be available throughout the country at community level. Community-based services are developed by provinces incrementally as recommended by mental health policy;
4. There should be incentives to train and retain psychiatric staff in the public sector. The Minister of Health launched the Health Sector Human Resources Strategy 2012/13-2016/17 in October 2011. Training of mental health practitioners is a priority. The recently introduced “occupation specific dispensation” has improved retention of practitioners except in the case of psychiatric nurses, where there were problems with translation of the policy. This is being addressed through a review process;
5. There should be consistent access to prescribed medicine for persons with disabilities. Chronic medication for those who need monthly supplies is pre-packed and distributed monthly. There is also prescribed minimum benefits expected from medical schemes that address chronic medication;
6. Nursing staff should be trained on sensitivities and symptoms of different disabilities. Nurses’ training has incorporated a module on disability and nurses are placed in rehabilitation units during their training. There is on-going sensitivity training for health workers;
7. There should be awareness programmes at a community level which aim to eliminate discrimination and stigmatisation around mental health so that people with mental disabilities requiring treatment can access services. The Department provides financial resources for advocacy and creating public awareness on mental health through a National Treasury approved grant to the South African Federation for Mental Health. All health care points also conduct public education campaigns on dedicated dates and in months indicated in the health calendar;
8. There should be relevant considerations for clients with disabilities when issuing wheelchairs rather than a one-size-sits-all approach. All assistive devices in the Department are prescribed and fitted by appropriately-trained professionals. The Department also has seating specialists who train others on the science of seating. It is

acknowledged, as discussed under Article 26, that significant challenges remain with regards equal access;

9. Healthcare facilities should be technologically advanced so that new technologies are introduced as they emerge to facilitate the highest quality of health. The Department has embraced the use of technology in healthcare and many facilities have state of the art technology. For instance, more than 90% of all hearing aids issued as well as the diagnostic equipment is digital. Mayo Electrical Technology has been introduced for fitting artificial limbs in some larger centres in South Africa;
10. The code of conduct for healthcare staff should be monitored. The quality of services and implementation of policy should be monitored. The client feedback mechanism must be monitored. The Office of Standards Compliance will review all service standards, including conduct of healthcare personnel. The Health Professionals Council of South Africa (HPCSA) and the SA Nursing Council are responsible for disciplining errant practitioners and the public has direct access to these bodies;
11. Guidelines for the treatment of vulnerable groups and individuals should be developed to ensure acceptable quality of treatment for all health care users. As mentioned earlier, the guidelines are in place, but require review to ensure compliance with the CRPD and or strengthening their implementation and improving public access to them needs attention.

It is submitted that Section 66(1) and Section 68 of the MHCA provides a mechanism through which many objectives can be reached as outlined above to ensure the effective implementation of the Act. Section 66(1) of the MHCA provides for the issues the Minister may make regulations on after consultation with all relevant members of the Executive Council,³³⁷ and Section 68 provides for the procedures to be followed when making

³³⁷ The minister may make regulations on the following matters in terms of Section 66(1) of the MHCA:

- a) surgical procedures or medical or therapeutic treatment for mental health care users;
- b) setting of quality standards and norms for care, treatment and rehabilitation of mental health care users;
- c) establishment of maximum security facilities for mental health care users;

regulations. Section 68(2) provides that at any time before issuing regulations, discussions and consultations may be held with any interested group. Interested groups may include the SAFMH, SASOP, the HPCSA or any other parties with an interest in mental health care matters. Such interested groups may initiate a review of the law through advocacy, lobbying and petitioning of the Minister. Any regulation regarding State revenue or expenditure must be made with the concurrence of the Cabinet member responsible for finance,³³⁸ any regulation regarding the South African Police Service must be made with the concurrence of the Cabinet member responsible for safety and security,³³⁹ and any regulation regarding education must be made with the concurrence of the Cabinet member responsible for education.³⁴⁰ These provisions, along with the provisions of the Constitution regarding accountability in resource allocation,³⁴¹ as discussed above, creates a framework through

- d) seclusion of mental health care users and use of mechanical means of restraint;
- e) establishment of facilities for State Patients and mentally ill prisoners;
- f) observation, detention, care, treatment and rehabilitation of mental health care users referred to a health establishment by a court of law;
- g) expediting the processing of applications referred to in Chapter V;
- h) establishment of child, adolescent and geriatrics facilities to promote their mental health status and their admission, care, treatment and rehabilitation at health establishments;
- i) establishment and implementation of educational programmes for mental health care users admitted at health establishments;
- j) discharge or leave of absence of mental health care users on their recovery or on the application from spouses or associates;
- k) transfer, removal and transportation of mental health care users to a health establishment and the assistance by members of the South African Police Service in effecting a removal or transfer and conditions to be attached to such removal or transfer;
- l) books and records which must be kept at a health establishment in respect of a mental health care user and the entries which must be made therein, including the accounts, returns, reports, extracts, copies, statements, notices, documents and information which must be sent to the Minister;
- m) payment of maintenance costs and expenses incurred in connection with the transfer, detention, care, treatment and rehabilitation and maintenance of any mental health care user in health establishments administered under the auspices of State;
- n) estimated property value and annual income of a mentally ill person or person with severe or profound intellectual disability in respect of whom an administrator may be appointed;
- o) authorisation and licensing of health establishments administered under the auspices of the State, a non-governmental organisation or private body providing mental health care, treatment and rehabilitation services and conditions to be attached to such authorisation or licence;
- p) matters concerning the powers, functions, guidelines for exercising these powers and functions and reporting obligations of a Review Board;
- q) the period within which mental health care users may be kept in Police custody; and
- r) any matter necessary or expedient in order to achieve the objectives of this Act.

³³⁸ Section 68(4) of the MHCA.

³³⁹ Section 68(5) of the MHCA.

³⁴⁰ Section 68(6) of the MHCA.

³⁴¹ Section 214 which determines that *budget al.* locations must take into account, among other factors, the need to ensure effective basic service provision, developmental needs and the legal obligations of provincial and local government; and Section 184(3) which grants the South African Human Rights Commission powers to require

which the necessary inter-agency cooperation and collaboration may be achieved in order to ensure that the human rights of mental health care users are protected and respected through satisfactory resource allocation and regulation.

6.11 Conclusion

Saxena and Skeen iterate that mental health is intricately linked to the first six Millennium Development Goals which guide global development efforts.³⁴² The Millennium Development Goals are as follows:

- GOAL 1: Eradicate extreme poverty and hunger
- GOAL 2: Achieve universal primary education
- GOAL 3: Promote gender equality and empower women
- GOAL 4: Reduce child mortality
- GOAL 5: Improve maternal health
- GOAL 6: Combat HIV/AIDS, malaria and other diseases
- GOAL 7: Ensure environmental sustainability
- GOAL 8: Develop a global partnership for development

People living in poverty are at increased risk of developing mental health problems due to factors such as increased exposure to stress, and physical factors such as malnutrition, obstetric risks, and violence.³⁴³ Additionally, persons with mental illnesses are more likely to slide into poverty due to exclusion from social and economic opportunities, the high cost of accessing treatment, or the loss of employment due to diminished productivity.³⁴⁴ Research suggests that increasing levels of education may have a positive impact on mental health through improving one's social status, increasing earning capacity, or by providing protection

financial arms of government to report on their endeavours in pursuit of the progressive realisation of socio-economic rights.

³⁴² Saxena and Skeen (2012) *Afr J Psychiatry* 398; Burns J. K. (2009) "Mental health and inequity: a human rights approach to inequality, discrimination and mental disability" 11 *Health and Human Rights: An International Journal* 2 19-31 21.

³⁴³ Sohrsdahl, Stein and Lund (2012) *Afr J Psychiatry* 168; Saxena and Skeen (2012) *Afr J Psychiatry* 398.

³⁴⁴ Saxena and Skeen (2012) *Afr J Psychiatry* 398.

from mental disorders through optimal brain development during childhood.³⁴⁵ Regarding Goals 4, 5, and 6, the co-morbidity of physical health disorders and poor mental health was extensively explored by Prince *et al.*, under the often used phrase “no health without mental health”.³⁴⁶

The 2030 Agenda for Sustainable Development and Sustainable Development and the Sustainable Development Goals were adopted at the 70th Session of the UN General Assembly on Sept 25–27, 2015.³⁴⁷ The 2030 Agenda and the SDGs build on the lessons learned and the gaps identified in implementation of the Millennium Development Goals, as well as identifying newly emerging development challenges.³⁴⁸ The Millennium Development Goals made no express mention of mental health, while the Agenda and Sustainable Development and the Sustainable Development Goals have included mental health and disability in several paragraphs.³⁴⁹ Target 3.4 under Goal 3 (“to ensure healthy lives and promote wellbeing for all ages”), is to “reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing”, and target 3.5 is to “strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol”.³⁵⁰ Goals 4, 8, 10, and 11 include specific references to inclusion of people with disabilities, essential for protection and promotion of the rights of people with mental, intellectual, and psychosocial disabilities who have been among the most ostracised.³⁵¹

Considering the evidence discussed in this chapter, it is clear that the impact of the burden of disease of mental disorders is likely to have a devastating effect on the economic and social wellbeing of South Africa. Mental health concerns everyone and is not the preserve of health

³⁴⁵ Burns (2009) *Health and Human Rights: An International Journal* 21; Saxena and Skeen (2012) *Afr J Psychiatry* 398.

³⁴⁶ Prince M, Patel V, Saxena S, *et al.* (2007) 'No health without mental health' 370 *Lancet* 9590859-877.

³⁴⁷ Izutsu, T., Tsutsumi, A., Minas, H. Thornicroft, G., Patel, V and Ito, A. (2015) 'Mental health and wellbeing in the Sustainable Development Goals' *The Lancet* 2 1052-1054 1052.

³⁴⁸ *Ibid.*

³⁴⁹ *Ibid.*

³⁵⁰ *Ibid.*

³⁵¹ *Ibid.*

professionals and the health services.³⁵² There is therefore a need to establish parity for mental health services in South Africa, to use existing human and infrastructure resources as efficiently as possible, and to develop additional resources over time.³⁵³ Ramlall repeats the maxim that “policy without an implementation plan is not worth the paper it is written on”, and it is therefore against the yardstick of implementation that the success of the MHCA has to be measured.³⁵⁴ The lack of a funded implementation plan is evidence of the low priority accorded to mental health.³⁵⁵

This chapter serves to illustrate the fact that legislation by itself is not adequate to bring about the major reform required for the South African mental health system.³⁵⁶ Even if the suggested amendments to the MHCA and CPA were effected as discussed in Chapter 4 and Chapter 5, a lack of effective implementation renders the possible positive impact of the legislation moot. Where implementation of legislation aimed at protecting a vulnerable group of persons, such as mentally ill individuals, is not effectively implemented human rights violations are a manifest reality. The lack of proper infrastructure possibly violates the right to an environment that is not harmful to their health or wellbeing in terms of Section 24 of the Constitution, while detention in such facilities may amount to being treated in a cruel, inhuman or degrading way in violation of Section 12(1)(e) of the Constitution. The fact that resources regarding mental health care are not allocated on equal footing with other health issues violates the right to equality,³⁵⁷ dignity³⁵⁸ and access to healthcare.³⁵⁹

The training and registration of mental health care practitioners and the new Traditional Health Practitioners Act was discussed in Chapter 3. In light of the human resource challenged regarding sufficient training and availability of practitioners, government and the

³⁵² Herrman H., Swartz, L. (2007) 'Promotion of mental health in poorly resourced countries' *Lancet* 1195-1197 1196.

³⁵³ *Ibid* ; Sohrsdahl, Stein and Lund (2012) *Afr J Psychiatry* 168 169.

³⁵⁴ Ramlall (2012) *Afr J Psychiatry* 410.

³⁵⁵ *Ibid*.

³⁵⁶ Ramlall (2012) *Afr J Psychiatry* 410; Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, *et al.* (2008) "Mental Health policy development and implementation in South Africa: a situational analysis" Phase 1. Country Report. Cape Town: Mental Health and Poverty Project.

³⁵⁷ Section 9 of the Constitution.

³⁵⁸ Section 10 of the Constitution.

³⁵⁹ Section 27(1) of the Constitution.

HPCSA is required to take the necessary steps to rectify the issues mentioned in this chapter. Insufficient staffing and training leads to an untenable situation where health care practitioners and the State contribute to the problem of infringing rights even whilst acting with the best intentions.

CHAPTER 7: RECOMMENDATIONS AND CONCLUSION

7.1 Scope and purpose of the study

This thesis set out to evaluate the legislative and regulatory framework regarding mentally ill persons against the backdrop of human rights, medicine and the aims of the criminal justice process. The focus of the study fell on the Mental Health Care Act 17 of 2002 (the ‘MHCA’), National Health Act 61 of 2003, Health Professions Act 56 of 1974, and Criminal Procedure Act 51 of 1977 (the ‘CPA’) and relevant regulations as far as they provide for the treatment, care and rehabilitation of mental health care users, State Patients, and mentally ill prisoners by mental health care practitioners within the public health system.

The main goal of the study was to investigate whether human rights infringements and the miscarriage of justice can be prevented by a South African legislative and policy framework that effectively regulates all aspects of mental health care. It is submitted that the effectiveness of legislation and policy can be measured by striking an acceptable balance between the competing interests of the state, the community, and the individual regarding compliance with constitutionally guaranteed human rights standards, science-based medicine and legal provisions and procedure; psychiatric and psychological principles and criminal law principles; and satisfactory practical implementation considering resource constraints.

Due to the fact that an analysis of legislation on its own does not portray an accurate picture of the lived experience of a mentally ill person in the mental health care and legal system, a desktop study of the practical implementation of mental health legislation and the state of affairs of the mental health care system was undertaken. Of particular significance was the review and critique of the MHCA forms, as they can be viewed as the bridge between the provisions and requirements contained in the MHCA and the practical implementation of those provisions. Where the MHCA forms are lacking in the information required to complete them, clarity, or other deficiencies, the goals of the legislator cannot be reached and the possibility of human rights abuses emerges. Similarly where mental health practitioners, Review Boards, and the SAPS are unaware of the implications of the MHCA, or insufficiently trained in completing the MHCA forms, and where there is a lack of accountability, the rights of mental health care users are compromised. It is submitted that this is the first study of its kind and scope and therefore delivers an original contribution to the literature from a novel

perspective with the aim of sparking discussion with its recommendations and proposals in order to facilitate positive change in legislation affecting mentally disordered individuals.

7.2 Synopsis

7.2.1 Chapter 1

In Chapter 1 the purpose of the study was contextualized with reference to the problems that exist in the interface between the legal system, the mental health care system, and branches of government responsible for the regulation and implementation of mental health matters. Some of the issues mentioned are: the fact that mental health care legislation is not properly implemented in practice; that MHCA forms used are not correctly completed by mental health care practitioners; that practitioners are insufficiently trained in the provisions of the MHCA; that there is disparity in the legal and mental health professions approach to and definition of mental disorder; and that deep-seated stigma and cultural beliefs that prevents some mentally ill persons from seeking treatment, leads to subpar care, treatment and rehabilitation, preventing the fulfillment of the full potential of persons with mental disorder as participants in and contributors to public life. The study was conducted in the interest of seeking solutions to these and other problems not mentioned here in order to prevent the abuse and further marginalization of mentally ill persons, who are a vulnerable group of people worthy of protection of, and advancement by, the law. A brief outline of the history of mental health care, mental health law, and criminal law and procedure is also given in the chapter. The central hypotheses of the thesis are stated, along with the research aims and methodology. A discussion of important terminology applied throughout the thesis is included, as well as an explanatory note regarding referencing.

7.2.2 Chapter 2

In this chapter a study of international human rights law as applicable to mentally ill persons was undertaken to establish their content and scope on a global stage. An exposition of the applicability and implementation of international treaties and conventions, international

customary law, and soft law in South Africa was given as regulated by section 39,¹ section 231,² Section 232,³ and section 233⁴ of the Constitution. Soft law instruments, such as the MI Principles and Standard Rules, were discussed as well as they are a valuable interpretive tool through which content and scope can be given to protected rights. International court decisions were also discussed regarding the rights of mentally ill persons.

The Constitution of the Republic of South Africa is the supreme law in the country and contains a Bill of Rights enshrining the human rights of its inhabitants, including mentally ill persons. The Constitution was discussed regarding the persons and institutions that are bound to it (which include the State, mental health practitioners, tertiary institutions, and Mental Health Review Boards), as well as the two step approach to be followed when determining whether a right in the Bill of Rights had justifiably infringed upon in terms of Section 36 of the Constitution.⁵ This entails the threshold and justification enquiries.

The content and scope of the following rights that all impact the mentally ill person were discussed to provide a reference framework against which it can be established whether legislation, law or conduct as discussed in the later chapters infringe upon a right guaranteed in the Bill of Rights:

¹ Courts must consider international law when making a decision.

² International treaties only become enforceable when the requirements of section 231 are met.

³ International customary law is automatically part of South African law.

⁴ Any interpretation of law should favour an outcome consistent with international law rather than contrary to it.

⁵ As discussed by the court in *S v Walters*, firstly it must be determined whether a right in the Bill of Rights had been infringed by the law or conduct by determining the scope and ambit of the right as well as the effect of the infringement. After this has been established it must be determined whether the violation was justifiable in terms of section 36 of the Constitution.

The rights in the Bill of Rights may be limited, according to Section 36 of the Constitution, only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:

- the nature of the right (entails the weighing up of the infringement of a right against the benefits sought by the limiting provision);
- the importance of the purpose of the limitation (reasonableness requires a worthwhile purpose);
- the nature and extent of the limitation (the effect of the limitation on the right is considered rather than the effect on the individual);
- the relation between the limitation and its purpose (the purpose must be reasonable and justifiable); and
- less restrictive means to achieve the purpose.

- The right to equality;
- The right to dignity;
- The right to life;
- The right to freedom and security of the person, and bodily and psychological integrity;
- The right to privacy;
- The right to freedom of religion, thought, belief and opinion;
- The rights of cultural, religious and linguistic communities;
- The right to an environment that is not harmful to health and well-being;
- The right to access to healthcare services;
- The right to just administrative action;
- The right to access to information;
- the rights of children; and
- the rights of arrested, detained and accused persons.

Important issues considered in this chapter include that of autonomy, competency in law, and informed consent, the right to access to health care and the adjudication of socio-economic issues. In the later chapters where it is established that a provision or conduct infringes upon a right, the factors mentioned in Section 36 is considered to determine the justifiability of the infringement. In each chapter where an infringement is not considered justifiable, recommendations are made as to steps to amend the legislation or rectify the conduct in order for it to be constitutionally valid.

Throughout the chapter reference is made to the MHCA and National Health Act provisions that give effect to and expand upon the rights in the Bill of Rights, as well as case law and the applicable considerations in international human rights law. In the chapter it was found that the legislature and policy-makers have a great capacity to translate rights guaranteed to mentally ill persons in the Constitution into their lived reality by creating a rights-based regulatory framework. The limitations of legislation-driven health care reform was also highlighted through discussion of socio-economic rights litigation and the limits placed on the judiciary through the doctrine of separation of powers and other issues affecting the legislature such as lack of political will and competing priorities. The legislature and judiciary can make abstract constitutional rights tangible by providing claimable entitlements to mentally ill persons.

7.2.3 Chapter 3

Chapter 3 presented a discussion of mental health care practice in South Africa. An overview of the differences between the legal and mental health care profession is important as an understanding of the fundamental differences in approach, legitimization, and purpose may facilitate the opening of better communication, cooperation and collaboration channels between the professions. The classification of mental disorders according to the DSM-5 and ICD-10 systems was discussed, as well as the use of such diagnoses in forensic settings. The different categories of mental disorders were discussed in order to lay the groundwork for determinations of mental status and capacity for purposes in law. The fact that the DSM-5 has done away with the multiaxial diagnostic system of its previous editions in favour of a nonaxial system that no longer differentiates between mental disorders and personality disorders has potentially interesting consequences for the determination of criminal liability. This was elaborated on in Chapter 5. The role of the mental health care practitioner in forensic environments as expert witness was also discussed in this chapter, as well as the liability of the expert witness and ethics in medical decision-making.

The health care system was discussed, especially pertaining to the integration of mental health care services in the general health care system and the influence of the National Health Act and MHCA. The regulation of mental health care practitioners was discussed, especially considering the Health Professions Act and the role of the HPCSA. The registration, training and continuous professional development of mental health practitioners was considered, also regarding the differences in psychologists and psychiatrists. The training and recognition of forensic mental health experts was an important point of enquiry considering that until recently there existed no training or qualifications for forensic mental health practitioners. The Traditional Health Practitioners Act and its controversial regulations were discussed especially as it applies to traditional health practitioners treating mentally ill persons and the question of whether the new Act and recognition of the rights of cultural and religious groups and the right to freedom of religion, culture and belief as entrenched in the Constitution lead to the conclusion that traditional health practitioners should be included in forensic and other assessment teams as mentioned in the MHCA and CPA. It was concluded that the influence of culture on the diagnosis and treatment of mental disorder in South Africa cannot be ignored and that a need exists for more inclusive health strategies that would enable the highest quality of care for mental health care users within their respective cultural context and

respectful of each individual's need in light of the fact that culture provides context to the mental state of every person.

7.2.4 Chapter 4

In Chapter 4 the MHCA was critically evaluated considering the objects of the Act, the rights contained in the Bill of Rights and the psychiatric and psychological principles that underlie mental health care. The provisions in the MHCA regarding voluntary, assisted and involuntary mental health care users were discussed and critiqued, and suggestions were made for their amendment in order for them to be constitutionally valid and in line with mental health care practice, as well as amendments ensuring internal logical consistency. Proposals for the amendment of the MHCA were discussed as well.

A main feature of this chapter was the critique of the MHCA forms in light of applicable human rights, science-based medicine, and mental health care practice considerations, and the requirements of the MHCA itself. Common problems with completion of the MHCA forms were first discussed, including the fact that practitioners complete forms with inappropriate terminology regarding diagnoses and symptoms, inaccurate record-keeping, and poor adherence to legal requirements. In the remainder of the chapter the MHCA forms were individually discussed as they apply to the different provisions in the MHCA (involuntary and assisted users, the SAPS, release, leave of absence and periodic reports) and recommendations as to their improvements were made continuously as necessary.

The mechanisms for accountability and transparency in the enforcement of the MHCA include the judiciary and Mental Health Review Boards, as well as administrative law procedures. These mechanisms were discussed with regard to the jurisdiction and purpose of the courts and the Review Boards respectively and whether each is the appropriate forum with sufficient empowerment to fulfill the goals of the legislator. The Review Boards' role and effectiveness in practice was discussed in Chapter 6. The SAPS was also discussed in this chapter with regard to their duties and functions as provided for in the MHCA pertaining to absconded mental health care users, the transfer of mental health care users, and mentally ill detainees in police cells and lockups. The proper training of police in the requirements of the MHCA and its forms and in recognizing mental disorder is imperative for the effective

implementation of the Act and prevention of human rights infringements where mentally ill persons are not treated in accordance with the correct procedures.

7.2.5 Chapter 5

In Chapter 5 the theories of punishment and criminal justice principles, such as the models of due process and crime control were discussed as an additional consideration to take into account when the validity of criminal law, the Criminal Procedure Act and the MHCA is evaluated as they pertain to mentally ill persons. The effect of mental disorder on the criminal liability of an accused person as a multiple defense was discussed. Mental disorder may negate the voluntariness of criminal conduct, the unlawfulness of the conduct, the criminal capacity of the defendant, as well as the element of fault. In addition where an accused is found to have criminal capacity despite the presence of a mental disorder, the CPA makes provision for considering diminished capacity which acts as a mitigating factor regarding sentencing. Whether mental disorder should be considered as a medical or legal term was discussed as well, and it was found that it should be viewed as a legal term given meaning through expert evidence by forensic mental health assessors. The ways in which different mental disorders may affect criminal capacity according to the degree of severity of the illness was also discussed, also considering the DSM-5 and the new nonaxial system that may have opened the door for a reconsideration of the criminal liability of persons with personality disorders, such as psychopathy.

Chapter 13 of the CPA was critically analysed to determine whether it is consistent with criminal justice principles and the theories of punishment, constitutionally protected human rights principles, and whether the provisions themselves are logically consistent. The fitness to stand trial, criminal capacity, and the report and panel for purposes of an enquiry into mental state were discussed. Case law, such as the recent *De Vos* judgment, was considered and recommendations made for the amendment of the CPA where necessary. The MHCA as it applies to State Patients (referred in terms of section 77 of 78 of the CPA) and mentally ill prisoners was discussed in this chapter, as well as the relevant MHCA forms. Suggestions for amendment were made where applicable.

7.2.6 Chapter 6

Chapter 6 considered the application of mental health law and the mental health care system in practice. The prevalence of mental illness was discussed to impress upon the reader the importance of a functional regulatory framework along with its effective implementation. The huge burden mental disorder places on the economic and social wellbeing of communities, and the resultant suffering that ensues in its wake is set to increase if proper counter measures are not taken. In South Africa there are multiple barriers to the effective implementation of mental health legislation, not least of which is the lack of resources faced by the mental health care system. In this chapter it was argued that the disproportionately low funding mental health services receive compared to other health services is unfair discrimination, and that mental disorders deserve parity with other disorders in the resources made available to their treatment. There is a critical shortage of mental health practitioners in public healthcare, and the infrastructure is insufficient and contributes to violations of the rights to an environment that is not harmful to health as well as undermining the right to access to healthcare. There is a worrying trend regarding the insufficient provision of mental health care services for children. Socio-economic rights jurisprudence was discussed in this chapter as well, especially pertaining to judicial deference by the courts to other branches of government. It was submitted that the judiciary has an important role to play in enforcing the right to access to healthcare and other socio-economic rights and that this role extends to circumstances involving resource allocation for mental health care services.

The implementation in practice of procedures regarding involuntary mental health care users was critiqued with regard to the lack of infrastructure where 72-hour assessments can be safely conducted in primary health care facilities. The effectiveness of Mental Health Review Boards was also discussed and suggestions made as to the improvement of the situation. The most controversial aspect of the MHCA is the administrative burden imposed by the multitude of forms to be completed by mental health care practitioners to the detriment of patient care due to time constraints. Suggestions were made for the easement of this particular burden, including the establishment and maintenance of a central information system and appointment of clerical staff. The lack of forensic mental health assessors and training programs for such assessors was an issue identified that needs attention, and the assessment of risk in cases where indefinite confinement might be imposed in terms of the CPA or MHCA was critiqued. The chapter included many suggestions for improvement of the current dire

situation, namely the poor implementation of mental health legislation, leading to human rights infringements.

7.3 Recommendations

The recommendations suggested in this chapter take the form of broad suggestions based on the arguments advanced in the thesis above, rather than in the form of a proposed legislative amendment act. The reasoning being that the recommendations are aimed at provoking debate and discussion, or further research, of the pertinent issues identified in the thesis, leading to a decision as to the correct form of action to be taken or amendment to be made after inputs from all stakeholders.

- Recommendation 1

The new nonaxial system of the DSM-5 has implications for the completion of MHCA forms and the completion of the forensic report in terms of section 79 of the CPA as it will be required of the practitioner to indicate not only the diagnosis pertaining to a mental health care user, but also the degree to which the disorder affects the functioning of the individual. This approach is more in line with the legal principles in determining capacity and mental status and it was submitted that training of practitioners in this approach will facilitate more effective communication with the judiciary and legal profession leading to more justifiable decision-making regarding mental health care users. Training of mental health care practitioners in this regard is necessary to ensure compliance with the MHCA and internationally accepted standards of diagnosis.

The nonaxial system also has potential consequences for the determination of criminal capacity as personality disorders are no longer considered separately from mental illnesses in the DSM-5. Diagnostic label is less important when determining criminal capacity than the degree to which a person's cognitive and conative abilities were affected at the time of commission of the offence. It is recommended that the courts consider this development in its decision-making and that further research on the topic is necessary. The importance of expert evidence when determining criminal capacity is underscored by this development.

- **Recommendation 2**

It is submitted that there can be no definition of mental illness that will account for all situations and contexts, and that in situations where mental illness becomes a pertinent topic where a legal outcome or decision is required, the only necessary definition of mental illness is to be found in the ever changing sciences of psychology and psychiatry. In order for the legal system to keep abreast of the constantly evolving nature of medical and scientific advancement, it needs to be flexible in accommodating changes and the accepted standards of the day. In order to keep this fluidity, mental illness or disorder for legal purposes remains an issue to be testified to by mental health experts making use of accepted diagnostic criteria, with sufficient knowledge and experience. It is submitted that for legal purposes it is only actually necessary to acknowledge that a mental disorder is a recognised affliction that may influence an individual's ability to actively participate in society in a productive manner, that it may influence a person's capacity to make decisions regarding their own lives, and that in certain cases it may lead to circumstances where an individual becomes a danger to themselves or others. The first step in forensic assessments by mental health care experts is to establish whether such an affliction exists, and the second step is to determine the extent to which it affects decisional capacity, dangerousness, or the ability to function within accepted parameters in society.

Given the ever-changing nature of science and the medical profession, as can be seen in the history and evolution of psychiatry and psychology, it makes more sense to allow for an expert witness through the ages to assist the court to come to a decision by testifying as to the most up to date medical knowledge of the day than, year by year, to change legal definitions in an attempt to keep up with medicine. A few *caveats* accompany this statement, namely that in order for this system to work, there must be proper training and registration systems in place to make sure that forensic mental health experts utilise standardised and accepted reliable methods of assessment. To ensure that the report generated is of the highest value to the fact-finder in court, experts must be trained in legal terminology, the legal process and legal language in order to facilitate the transfer of information accurately and smoothly. The second *caveat* if this system is to work is that legal professionals, especially fact-finders in court, must be trained in the art of reading and interpreting forensic reports so that the valuable information contained therein is properly considered, and in order for the interests of justice, the community and the patient to be respected.

- **Recommendation 3**

Public mental health must be developed as a core discipline to ensure sufficient numbers of qualified psychiatrists, psychologists and other mental health care practitioners in the public service. Formal training programs or examinations for forensic mental health in South Africa is still insufficient, apart from a certificate in forensic psychiatry as a sub-specialty as approved by the College of Medicine of South Africa in May 2010. It is recommended that this issue must be addressed by the legislator, tertiary institutions and HPCSA.

- **Recommendation 4**

It is submitted that that there should be a register of forensic psychiatrists and psychologists that are objective and involved on behalf of the court to find the truth, instead of opening up the possibility of bias and abuse. It is an untenable state of affairs that it is possible for a forensic expert charged with assessing the mental state of a person not to be called to testify where the testimony does not suit the case of the appointing party.

- **Recommendation 5**

It is submitted that the American position is helpful in considering liability of forensic assessors in South Africa. If the health care practitioner conducts an evaluation in a manner that worsens the examinee's mental health and the practitioner knew, or should have known, about information that would have cautioned against conducting the examination in that manner, liability might arise. Although the formulation and expression of an opinion are protected by witness immunity in the American legal system, the actual performance of the evaluation may not be covered if the examinee suffers harm as a result.

- **Recommendation 6**

The role of culture and religion in mental health care cannot be ignored in South Africa's multi-cultural and diverse climate. The individual cannot be separated from their cultural context. A better understanding by registered mental health care practitioners of the different culture groups their patients belong to will lead to better mental health care in practice, therefore training in this regard should be more comprehensive. While recognising that a large

majority of persons with mental disorder seek help from traditional health practitioners and recognising that everyone has the right to practice their culture, religion and belief of choice in terms of the Constitution, it must be stressed that vulnerable persons with mental disorders must be protected from practices that are potentially harmful.

Accessible training and health education initiatives aimed at mental health care practitioners and students, their patients, as well as cultural and religious practitioners is imperative. The effective implementation of the Traditional Health Practitioners Act will be a great step in the right direction in this instance. Equipping traditional healers to understand and effectively manage mental disorders in their communities will contribute towards better mental health care and the prevention of rights abuses. Stakeholder compliance and cooperation, as well as sufficient support and resources from the State will aid in this endeavour. It is submitted that it is not acceptable for the Act and regulations to be enacted without a plan regarding resource and budget allocation to aid in meeting its objectives. The objections from traditional health practitioners to the Act and its regulations cannot be ignored and engagement is necessary to address concerns.

The extent to which mental health care elements feature in the legal definition of traditional health practice, necessitates the consideration of whether the multidisciplinary mental health care team as provided for in the MHCA (that currently includes psychiatrists, psychologists, general medical practitioners, nurses, occupational therapists, and more) should be extended in order to include alternative or traditional practitioners as well. The next steps in the process of fully realising an integrated health system is to determine the role a traditional healer might play in forensic investigations and the treatment of mentally disordered prisoners and state patients. This issue deserves consideration by the legislator and it is submitted the inclusion of such practitioners in the assessment and treatment of mental disorders may be a way to truly give effect to the cultural and religious rights of South African citizens, as well as ensuring better mental health care provision.

- **Recommendation 7**

Mental health practitioners must be properly trained in the meaning and practical application of the requirement of informed consent. There is currently no standard form which exists in which practitioners are required to indicate whether informed consent has in fact been

obtained with reference to the requirements of informed consent. It is submitted that health establishments are permitted to mandate which consent forms are used and their format, but that especially in cases involving mentally ill patients who potentially lack the capacity to give informed consent, a standard form and requirements should be considered by the legislator.

It is submitted that the MHCA and its regulations should be amended to prescribe a minimum of information that should be included in the consent form to be used by voluntary mental health care users to ensure proper informed consent is obtained prior to admission. It is submitted that standard consent forms used for medical and surgical procedures might not contain sufficient information to indicate that the user did possess the necessary competence or capacity to make an informed decision in the light of their mental disorder, and that they were properly informed and understood the consequences of consent. The training of mental health care professionals in the specifics of informed consent is an important aspect of ensuring that valid consent is obtained and the HPCSA should mandate CPD training on the topic.

It is submitted that the following applies in situations where consent is withdrawn or where a voluntary user no longer possesses the capacity to give informed consent:

- In a situation where a voluntary mental health care user with the necessary capacity withdraws consent, the user is to be discharged.
- In a scenario where a voluntary mental health care user becomes incapable of giving valid consent, but does not protest to continued detainment, an application for admission as an assisted user must be made for continued detention to be lawful.
- In a situation where a user becomes incapable of consenting after their admission as a voluntary user and wishes to be discharged or refuses treatment, an application must be made for further involuntary detention to avoid their unlawful detention against their will.

- **Recommendation 8**

Proper training of mental health care practitioners in the requirements and provisions of the MHCA is imperative, as lack of knowledge in the aims and procedures of the Act will lead to

human rights infringements of mental health care users. Training of practitioners in the proper completion of the MHCA forms and proper record-keeping is also necessary to as to ensure compliance with the Act and to enable the Review Boards and judiciary to make appropriate decisions pertaining to users. Proper completion of the MHCA forms include the use of correct and specific terminology regarding symptoms and diagnoses, as well as indicating the degree to which a disorder affects the capabilities of the user in question. Vague terminology such as ‘lacking insight’, ‘unstable’ and ‘non-compliant’ are unacceptable as they are neither recognised diagnoses or symptoms. Additionally, a training program is necessary as to which practitioners are required to complete which forms, also clarifying the time frames involved in the process.

The definition in the MHCA of a ‘mental health care practitioner’ is broader than just referring to a psychologist or psychiatrist.⁶ This means that in primary health care establishments it is likely that the two mental health practitioners called upon to complete MHCA forms calling for two practitioners, and who decide whether a person will be admitted as assisted or involuntary user, might not be specialised in, or sufficiently trained to recognise, mental disorder. It is imperative that the training of mental health practitioners should therefore be of a high quality and that ongoing CPD training is mandated to keep practitioners abreast of the latest developments in mental health care. It is submitted that the practice of one practitioner completing two forms, or where one practitioner completes an assessment that is merely signed off by another, without completing an independent assessment and delivering an individual opinion, is not procedurally fair and would lead to an unlawful detention if detainment is effected on the grounds of the reports.

- **Recommendation 9**

The following issues have been identified regarding data on mental health care users:

⁶ Section 1 of the MHCA defines “mental health care practitioner” as “a psychiatrist, registered medical practitioner, nurse, clinical psychologist, occupational therapist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services.”

- Data regarding mental health care users is frequently unavailable in a format that makes it possible to track the transfer and changing legal status of users;
- Several entries in the Mental Health Review Board Database refer to the same user where no records exist for other users;
- So overview of the number of patients in a facility at a specific time is routinely obtained by the boards, making it impossible to draw conclusions about the completeness of records;
- There is under reporting of admissions in hospitals, forms might become lost and the review boards do not sufficiently follow up on the matter.

It is recommended that an effective and relevant tracking system, without which human rights of mental health care users will continue to be compromised, must be ensured. Section 19(2) of the MHCA provides that the Review Board may, when performing its functions, consult or obtain representations from any person, including a person or body with expertise. It is submitted that the MHCA does not expressly provide for the establishment of a national data tracking system of mental health care users and that legislation should be enacted on consultation with data capture experts in the healthcare environment that calls for an effective national system to be established. Failing this the Review Boards are not sufficiently empowered to exercise their duties as they do not have access to the necessary information. In order to prevent human rights abuses of mental health care users it is necessary that each mental health care establishment and its health care practitioners, as well as the Review Boards, are able to access patient records (including dates of admission, patient history and forthcoming dates for periodic review) to ensure that no individual patient falls through the cracks of the system.

- **Recommendation 10**

The common law rule applies that where functions are entrusted to a statutory body it may only act if all its members are present and the decision is unanimous. This is a problem for a Mental Health Review Board since its members may be absent for 6 months before removal from office. It is suggested that the legislator consider the amendment of the MHCA in order to make provision for the valid exercise of the Review Board's functions if not all members are present to prevent a backlog of issues to be decided upon and delay in resolving them,

such as the introduction of a quorum, by allowing the Review Board to expand its membership to more than 5 members, or by creating more Review Boards per area to deal with the case load should one Board be unavailable.

- **Recommendation 11**

Mental Health Review Boards lack the authority to enforce its own recommendations without it being ratified and reviewed by the already overburdened judiciary. A restructuring of the system might be a solution and it is recommended that a specialised high court that deals with mental health care matters be created to ensure speedy and expert review of decisions by the Review Boards and the settling of matters pertaining to the MHCA. This specialised court would lighten the case load on the court system and prevent infringements of mental health care users' rights by delivering judgement in a more efficient and expedient manner by members of the judiciary specialising in mental health care law. Alternatively the creation of a special independent mental health care tribunal that deals exclusively with issues pertaining to the MHCA and Review Boards would serve the same purpose.

- **Recommendation 12**

Section 10(1) and (2) of the National Health Act states that a health care provider must provide a user with a discharge report at the time of discharge from a health establishment containing such information as may be prescribed by the Minister with regard to the nature of the health service rendered, the prognosis of the user and the need for follow-up treatment. Section 10(3) states that a discharge report may be verbal in the case of an outpatient, but must be in writing in the case of an inpatient. It is submitted that the provision of a written discharge report for voluntary mental health care users should be compulsory, especially in the light of poor record keeping and the difficulty in gathering data on mental health care users from which statistics may be compiled to guide policy and resource allocation in the mental health care sector.

It is further submitted that the MHCA and its regulations should be amended to prescribe a minimum set of information that should be included in the consent form to be used by voluntary mental health care users to ensure proper informed consent is obtained prior to admission. It is submitted that standard consent forms used for medical and surgical

procedures might not contain sufficient information to indicate that the user did possess the necessary competence or capacity to make an informed decision in the light of their mental disorder, and that they were properly informed and understood the consequences of consent.

It is submitted that the following applies in situations where consent is withdrawn or where a voluntary user no longer possesses the capacity to give informed consent:

- In a situation where a voluntary mental health care user with the necessary capacity withdraws consent, the user is to be discharged.
- In a scenario where a voluntary mental health care user becomes incapable of giving valid consent, but does not protest to continued detainment, an application for admission as an assisted user must be made for in order for continued detention to be lawful.
- In a situation where a user becomes incapable of consenting after their admission as a voluntary user and wishes to be discharged or refuses treatment, an application must be made for further involuntary detention to avoid their unlawful detention against their will.

It is recognised that the potentially changeable nature of consent, the difficulties in determining whether a patient has capacity to consent or withdraw consent at different points during their treatment, and the logistical issues involved (regarding increased paperwork, lack of resources and human resources), might necessitate that in certain instances the mental health care practitioner make a judgement call regarding continuation of treatment. The question is raised whether consent to admission as a voluntary mental health care user should be viewed as a type of ‘umbrella consent’ covering situations where the user later loses the capacity to consent to further treatment, or whether consent is required for every aspect of treatment. It is submitted that it seems prudent that consent be obtained before every treatment event to prevent violation of the right to bodily and psychological integrity. To prevent human rights abuses it is recommended that the legislator and stakeholders step in to regulate such scenarios by prescribing standard protocols and criteria that should be met for certain courses of action to be lawful.

- **Recommendation 13**

When a user has been admitted as an assisted user, but later becomes resistant to treatment, it is submitted that they should be transferred from assisted to involuntary status. In this scenario there is no specified form in the MHCA to be used specifically, which allows for an indication of the reasons for the transfer (MHCA 06 which is used for application for involuntary admission does not fulfil this need). It is submitted that the MHCA and its regulations be amended to make provision for such a scenario and provide an appropriate form. It is further submitted that in the event of an assisted user becoming capable of consenting to or withdrawing consent to treatment, they should be either admitted as a voluntary user or discharged.

It is recognised that the potentially changeable nature of consent, the difficulties in determining whether a patient has capacity to consent or withdraw consent at different points during their treatment, and the logistical issues involved (regarding increased paperwork, lack of resources and human resources), might necessitate that in certain instances the mental health care practitioner make a judgement call regarding continuation of treatment. To prevent human rights abuses it is recommended that the legislator and stakeholders step in to regulate such scenarios by prescribing standard protocols and criteria that should be met for certain courses of action to be lawful.

- **Recommendation 14**

Regarding assisted mental health care users, in terms of section 27 of the MHCA, it is submitted that the MHCA does not specifically determine the time from which the 5 days should be counted, e.g. whether the 5 days is from the date of admission, the date the application has been made or from the date the head of the health establishment has made their decision. The MHCA also does not stipulate the timeframe within which the head of the head establishment must come to a decision or when they are considered to have received the application (when it has been delivered to their office, once it has been logged on a system of information capture, or when they actually become aware of it). In addition the MHCA does not specify a mechanism by which a follow up procedure to enforce the timeframe is created. The MHCA should be amended to provide for clarity and the prevention of unduly long periods of detention and decision-making that could infringe on users' rights.

It is further submitted that the MHCA and its regulations are lacking because it does not prescribe a specific procedure for withdrawal of the application for assisted care, treatment and rehabilitation. At the very least confusion and arbitrary treatment could be avoided if the MHCA were amended to prescribe a specific form and procedure for withdrawal of the application. The MHCA does not require the head of the establishment to inform the applicant if the application has been unsuccessful and this should be done as it is a serious omission from the act as the right to appeal the decision is provided for in section 29. It is suggested that although the MHCA does not expressly provide for it, the user must be properly informed of the decision to provide assisted care and that this is in line with section 35(2)(a) of the Constitution that provides that everyone who is detained has the right to be informed properly of the reason for being detained and that this right is limited only to the extent of the person not being able to understand.

It is submitted that if a person has regained the ability to make informed decisions and refuses further assisted care, it is against their rights to be detained for a period of 30 days in terms of section 31(3), (4) and (5) of the MHCA, in addition to not be informed of this decision if they are deemed to not pose a risk to themselves or others. The MHCA must be amended accordingly. It is submitted that if a user does not require further care to protect the safety of the user or others, then the 30 day period is untenable and that the user must be discharged and interested persons may bring an application for involuntary care if they so wish to do after the discharge and if the requirements are satisfied.

- **Recommendation 15**

It is submitted that if a person has regained the ability to make informed decisions and refuses further assisted care, it is against their rights to be detained for a period of 30 days in terms of section 31(3), (4) and (5) of the MHCA, in addition to not be informed of this decision if they are deemed to not pose a risk to themselves or others. The MHCA must be amended accordingly. It is submitted that if a user does not require further care to protect the safety of the user or others, then the 30 day period is untenable and that the user must be discharged and interested persons may bring an application for involuntary care if they so wish to do after the discharge and if the requirements are satisfied.

- **Recommendation 16**

Regarding admission as an involuntary user, Section 33(3) of the MHCA determines that an application for involuntary care, treatment and rehabilitation services may be withdrawn at any time. It can be argued that the application for involuntary care can only be withdrawn before the head of the health establishment makes a decision in terms of Section 33(7), as after that it no longer is an application.⁷ The procedure for withdrawal of the application for admission as an involuntary mental health care user is not specified in the MHCA, and as was discussed regarding assisted users it is submitted that the Act should be amended to make the procedure for withdrawal of an application clear and standardised.

- **Recommendation 17**

Section 33(4)(a) of the MHCA determines that the head of the health establishment concerned must cause the mental health care user to be examined by two mental health care practitioners. It is submitted that the practice of one practitioner completing two forms, or where one practitioner completes an assessment that is merely signed off by another without completing an independent assessment and delivering an individual opinion is not procedurally fair and would lead to an unlawful detention if detainment is effected on the grounds of the reports. It is submitted that the accountability mechanisms to ensure compliance with the MHCA provisions are insufficiently utilised to ensure that this practice does not happen. It is submitted that the MHCA does not determine what is meant with “on receipt of the application” or the timeframe within which the head of the health establishment must be made or should have been made aware of such an application. It is submitted that a system of record keeping and effective communication is imperative in ensuring that users’ needs are attended to as quick as possible and that users do not become “lost” in the system awaiting the necessary assessments and treatments.

⁷ Landman and Landman 112.

- **Recommendation 18**

If the head of the health establishment approves involuntary care, treatment and rehabilitation services, they must within 48 hours cause the mental health care user to be admitted to that health establishment.⁸ It is submitted that the MHCA does not specify whether the 48 hours must be counted from the date the application is made or from the date the decision has been made by the head of the health establishment, nor does the MHCA specify a timeframe within which the decision must be made and that the MHCA should be amended to clarify the situation and prevent unduly long periods of detention without lawful admission.

- **Recommendation 19**

The head of the health establishment concerned must give notice in terms of Section 33(8) of the Act to the applicant in the form of form MHCA 07 of his or her decision concerning the application for involuntary care, treatment and rehabilitation in question and reasons thereof.⁹ It is not a requirement of the MHCA that the mental health care user be informed of the outcome of the decision to provide involuntary care or not, which is problematic as a successful appeal is not possible without receiving reasons for the decision. It is submitted that the MHCA must be amended in order to insure notice of the outcome of an application for involuntary care and the reasons for the decision be given to the mental health care user in addition to the applicant, to enable the user to use their right to appeal. The right to request written reasons where a person has been adversely affected by administrative action is also a requirement for just administrative action as set out in Section 5 of PAJA, so at the very least a mental health care user should be made aware that they are entitled to request reasons if none were given.

⁸ Section 33(9)(a) of the MHCA.

⁹ Regulation 10(7) of the General Regulations to the MHCA.

- **Recommendation 20**

Involuntary mental health care is reliant on effective clinical assessment to justify forcible or coerced treatment, though in practice this is sometimes sorely lacking and steps should be taken to rectify the situation. The accuracy of the type of informal psychological assessments utilised due to the nature of the circumstances of assessment regarding resource and time constraints, as discussed in Chapter 4, is questionable, and although this admission process is the start of an extensive process, an insufficient assessment could limit the rights of a person by means of an involuntary admission. It could be argued that clinical psychological evaluations, carried out during the observation period, should rectify the result of an incorrect admission assessment, but an unneeded involuntary admission would already constitute a traumatic and gross infringement on the rights of the person involuntarily detained. It can also be argued that the state has a duty not to infringe upon the rights of its citizens and that by not providing the necessary expertise in personnel and resources that it would be shirking that duty. In addition if a person is detained unlawfully, as in the case of an involuntary detention where no mental disorder is present, the person so detained may have a civil claim for damages if it can be proven the decision to detain them was taken by a person with insufficient expertise to make a decision in the matter.

- **Recommendation 21**

It is submitted that the MHCA is unsatisfactory regarding the timeframes imposed with regard to involuntary users. The fact that the head of the health establishment must inform the user of the outcome within 24 hours of the assessment after expiry of the 72 hour period, but has seven days to send MHCA 08 to the board to approve further involuntary services, and the board then has 30 days in which to approve it, is unacceptable. It is submitted that the submission of form MHCA 08 to the Review Board must also be done within 24 hours, as by that time the head of the health establishment already has the necessary information. This would expedite the process of review and ensure that a mental health care user is not unlawfully deprived of their liberty for longer than is absolutely necessary to finalise the matter. This would also enable the user or applicant to submit an appeal against the decision of the head of the health establishment to the Review Board speedily and enable the Board to reach a decision more quickly. The 30 day window within which the Review Board must reach its decision is a long time to be unlawfully deprived of liberty and it would be more

respectful of users' rights to shorten the timeframe, though the nature of the Review Board and the available resources in light of the workload imposed upon it indicate the 30 day period to be reasonable. It is submitted that the system record keeping and administration in mental health care establishments is imperative to ensure that the timeframes in the MHCA are adhered to. If the system is deficient, it leads to a lack of compliance and difficulty implementing legislative provisions.

- **Recommendation 22**

Neither the MHCA nor the National Health Act 61 of 2003 provides a definition for the term "outpatient". It is submitted that the MHCA should be amended to include definitions for the terms "inpatient" and "outpatient" in order to ensure no misunderstandings concerning the status and treatment of a mental health care user arises.

- **Recommendation 23**

The MHCA does not stipulate that specific consent must be obtained from voluntary users undergoing electro-convulsive treatment (ECT), nor a specific procedure to be followed where a user is incapable of consenting. It is recommended that the MHCA be amended to include specific procedures and standard forms to be completed in line with recommendations by Segal and Thom as discussed in Chapter 4.

- **Recommendation 24**

It is submitted that where users are secluded solely for their own safety, rather than the safety of others, it is necessary to consider whether the effect of the seclusion on their mental health would be negative or positive for the seclusion to be allowable in terms of the MHCA with its emphasis on the protection of rights. Also to be considered are resource constraints and infrastructure constraints that would influence the decision of practitioners on which mental health care users to separate from the rest of the hospital population for safety, as opposed to therapeutic, reasons. If a mental health care user is in danger from others due to their vulnerable state, it is the dangerous user that should be secluded instead. It is submitted that the MHCA should be amended to state that seclusion for the safety of a user, and not for the safety of others, is not allowable if the seclusion is likely to have a negative effect on the

mental state of the person. The mental health review board must make sure that this is complied with to guard against human rights infringements.

- **Recommendation 25**

It is submitted, that although the MHCA does not make a distinction between persons younger than 18 years and persons younger than 18, but older or younger than 12 years for purposes of consent to medical treatment, the Children's Act does make this distinction. As such it is strictly unnecessary to amend the MHCA to reflect this difference, due to the fact that the Children's Act takes precedence in its interpretation. It is further submitted that mental health care practitioners and other stakeholders that deal with the MHCA and with children as mental health care users may be familiar with the provisions of the MHCA as part of their work, but not with the Children's Act and the relatively complex workings of statutory interpretation. It would be prudent to amend the MHCA to make plain the difference in the inability of children under the age of 12 to consent to medical treatment, and the ability of children over the age of 12 but under the age of 18 to consent if they have the competence to make informed decisions. It is further submitted that the MHCA should specify categories of mental health care user in accordance with their age and consequently the manner in which they should be accommodated in treatment facilities, integrated with or separate from the general population in the facility in children's wards, especially pertaining to children who due to their young age are considered more vulnerable.

- **Recommendation 26**

There is no provision regarding leave of absence in the MHCA specifically pertaining to assisted or involuntary users and the regulations are the only place it is mentioned, Section 45 of the MHCA only pertains to leave of absence for State Patients. It is submitted that the MHCA should be amended to correctly reflect the aims of the legislator and include a provision on the leave of absence for assisted and involuntary users.

- **Recommendation 27**

The MHCA does not specifically provide that the head of the health establishment must provide the user with reasons, but should inform them in terms of Section 35(2)(a) of the

Constitution that guarantees the rights of detained persons, and includes the right to be informed properly of the reasons for being detained and can only be limited to the extent that the person is unable to understand the information. It is submitted that a provision to this effect must be explicitly added to the MHCA to prevent infringement of rights in line with the Constitution. Section 33 of the constitution that guarantees just administrative action also includes the right to be given written reasons.

- **Recommendation 28**

It is submitted that the timelines attached to periodic reviews in Sections 30(1) and 37(1) of the MHCA (6 months and 12 months) are too long, considering that the mental health status of a user may change on short notice. To prevent unlawful detainment once a user has recovered their mental health, it is necessary to impress upon mental health care practitioners that it is their duty to take positive steps for the review of a user's case once it becomes apparent that a user has recovered their mental health. It is furthermore submitted that periodic reviews are an integral mechanism by which the lawfulness of continued detainment is assessed and it is imperative that the system of record keeping is effective in ensuring periodic reviews happen within the required timeframes to prevent an infringement of rights and the possibility of liability for unlawful detention.

- **Recommendation 29**

Regarding Section 9(1), the MHCA does not clarify whether, when a person is admitted in emergent circumstances and an application for involuntary admission is brought within the 24 hour period, if the 72-hour assessment period starts anew from the time the application is brought or from the time of original admission. It is submitted that the MHCA should be amended to include a provision stipulating that the 72-hour assessment period required for an application of involuntary admission should start from the time the application is brought, not from the time the patient was admitted as emergency mental health care user, as the requirements under assessment are different.

- **Recommendation 30**

Section 35(2)(d) of the MHCA determines that the Review Board must send a written notice of its decision on an appeal in terms of Section 33, and the reasons for such decision to the appellant, applicant, the head of the health establishment concerned and head of the relevant provincial department. The MHCA does not require the Board to inform the user of the outcome of the appeal unless the user is the appellant, therefore it is recommended that the MHCA should be amended to make provision that the user should be informed as well.

- **Recommendation 31**

It is recommended, in line with the suggestions of Jonsson, Moosa and Jeenah, that the implementation of Section 40 of the MHCA may be improved by providing proper training for all stakeholders (the SAPS, mental health care practitioners, and students), making amendments to MHCA form 22 by adding check boxes to encourage the likelihood of all components of the form being completed appropriately, and increasing the quality of the partnerships and cooperation between stakeholders.

- **Recommendation 32**

The assistance of the police may be requested in terms of Section 40(4) of the MHCA if an assisted user needs to be transferred in terms of Section 27(10) of the MHCA and the police are obliged to transfer the user in the prescribed manner. It is problematic that Section 27(10) does not refer to a “transfer”, but rather that the head of a health establishment must cause an assisted user to be admitted the establishment or referred to another establishment.¹⁰ This may be interpreted as meaning that a referral from one establishment to another implies that a transfer is needed and that the help of the police may be required in terms of Section 40(4).¹¹ If the user has not yet been admitted, transfer in terms of Section 40(1) is more appropriate to apprehend the user and bring them to the establishment.¹² The police should be used sparingly

¹⁰ Landman and Landman 98.

¹¹ *Ibid.*

¹² *Ibid.*

and only in the circumstances mentioned in the MHCA, but the MHCA does not list exceptional circumstances as a requirement and the regulations may not limit the provision in an Act of Parliament, possibly creating scenarios where the police are unnecessarily involved.¹³ It is submitted that in instances where a mentally disordered person or mental health care user is not considered to be dangerous to themselves or others, it might be more prudent to investigate whether speciality ambulance units are a better option to use for the transfer of users who are not prisoners.

- **Recommendation 33**

The different ways in which mental state may function as a multiple defence in criminal law (affecting possible the voluntariness of conduct, unlawfulness, criminal capacity or fault of an accused), is often poorly understood among legal professionals and mental health care practitioners who function as expert witnesses alike (as discussed in Chapter 5). The differences between automatism and criminal capacity, as well as the exact parameters of criminal capacity, and the different forms of intention deserve clarification in legal and expert witness education. It is recommended that proper training in this regard should be implemented among the judiciary and law students, as well as being included in forensic expert witness training.

- **Recommendation 34**

It is recommended that criminal capacity remains a legal term to be given meaning by expert evidence and that an all-encompassing definition of mental illness that suits all situations is one that is impossible to achieve. In addition, if such a definition were contrived, it would not be feasible long term to accommodate the changeable nature of advancements in mental health care. Therefore the expert witness is, and will remain, an indispensable resource for the court in providing expert opinion on a matter outside the knowledge and expertise of the judiciary.

¹³ Landman and Landman 298.

- **Recommendation 35**

The most important difference between the new DSM-5 and the previous DSM-IV-TR is the abolishment of the multi-axial system of classification of disorders in favour of a uniaxial system. The multi-axial system differentiated between personality disorders and clinical conditions, whereas the new DSM-5 and its uniaxial system does not. It is submitted that a reconsideration of the legal position regarding personality disorders and criminal capacity is necessary. In determining whether a personality disorder would meet the legal criteria for negating criminal capacity and therefore liability, it is necessary to consider the test for criminal capacity in Section 78 of the CPA, which requires a mental illness or mental defect that affects the cognitive and conative abilities of the accused. The fact that personality disorders under the new DSM-5 are no longer separated from mental illness, as well as the inherent difficulties in conceptual boundaries, it might be prudent for the courts to consider rather the effect of a condition such as a personality disorder on the two legs of the test for incapacity, rather than focusing overly on the particular diagnostic label.

- **Recommendation 36**

Section 78(7) of the CPA makes provision for a plea of diminished capacity so that a mentally disordered person deemed to be criminally liable, but if their capacity to appreciate the wrongfulness of the act, or act in accordance with such an appreciation, was diminished by reason of mental illness or mental defect would have a lesser punishment imposed. It is recommended that in cases where a mental disorder or mental defect did not lead to a finding of incapacity, though the mental disorder is of a serious nature, the court must consider in making its order whether detention in a mental health care establishment would be advisable as opposed to a prison term.

- **Recommendation 37**

As discussed at length in Chapter 5, it is submitted that section 78(6)(a) of the CPA is not sufficiently clear due to the use of the word “or”. In reading the provision it states that if an accused was found to have committed the act in question while lacking criminal capacity that they should be found not guilty, and then continues to paragraph 78(6)(b) after an “or”, which indicates that that is the end of the matter and the only finding a court is authorised to make.

Section 78(6)(a) has however been interpreted to mean that the court will find the accused not guilty and in addition make one of the directives listed in Section 78(6)(b). It is submitted that the legislator would not have meant for a mentally ill accused person lacking criminal capacity to be declared not guilty, without making provision for discretionary special directives such as those listed in Section 78(6)(b), therefore it is recommended that Section 78(6) be amended to ensure clarity and legal certainty on the matter. The amendment should take the form of combining the wording of Section 78(6)(a) and (b) and only listing the discretionary objectives in Section 78(6)(b), as follows:

- c) “the court shall find the accused not guilty, *or if the court so finds after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside and find the accused not guilty, by reason of mental illness or intellectual disability, as the case may be; and*”
- d) “*the court shall direct: ...*”

It is submitted that Section 78(6) should be amended to include safeguards or standards against which the court must exercise their discretion to make an order for detention, namely that present mental disorder must be a requirement for detention otherwise release is the prudent directive to make. It must also be considered that Section 37 of the MHCA regarding involuntary detention requires that the mental health care user must be suffering from a mental disorder otherwise detention would be imprudent and unlawful.¹⁴ This implies that if an accused lacks criminal capacity due to mental defect and it does not fit into the medical conception of “mental disorder”, detention under Section 37 of such a person would be unwarranted and unlawful.

- **Recommendation 38**

It is recommended that the reverse onus requiring persons who plead criminal incapacity to prove that they are in fact incapacitated is not justified. The reverse onus should not be applicable to persons who allege criminal incapacity due to mental disorder or defect (while

¹⁴ Section 37 of the MHCA was discussed in Chapter 4.

not applying to other defences in criminal law), as it is an arbitrary and unjustified infringement of their right to a fair trial under Section 35 of the Constitution, as well as the right to equality enshrined in Section 9 of the Constitution. Section 78(1B) of the CPA infringes upon Section 9(1) of the Constitution as it differentiates between mentally ill accused persons by only reversing the onus only in defences of non-pathological criminal incapacity, and the differentiation is not justified, legitimate or rational.

- **Recommendation 39**

Regarding the report for purposes for Section 79 of the CPA, it is recommended that accountability measures regarding these aspects should be investigated and implemented, as well as comprehensive training programmes of all relevant parties:

It is submitted that it is not up to the expert witness to decide in which cases more careful scrutiny and elucidation is required, as it is for the court to decide on the ultimate issue based on all the evidence. It is the role of the expert witness as forensic assessor to commit the same attention to detail to each case. Though there is no strict format prescribed (other than that the report must be in writing),¹⁵ a report should always address the required legal issues with clarity, relevance and ethical content. A good report would be comprehensive, objective, instructional, unbiased and expressive of the level of confidence the expert has in the findings.¹⁶ It is submitted that a report that is vague and uses inexact terminology should be declared invalid.

It is submitted that it should be an express rule that an expert witness is acting as an aid to the court in the quest to find the truth and that it must be forbidden for the report of an expert witness to be "settled" by a legal practitioner, as the impartiality of the report is then called into question. In cases where a forensic mental health assessor is discovered to be acting as a "hired gun" by allowing their testimony to be tailored to the benefit of a particular party, it should be tantamount to perjury and the evidence should be disallowed as the credibility of

¹⁵ Section 79(3) of the CPA.

¹⁶ Erlacher and Reid 332.

the expert is called into question.

According to Section 79(5) of the CPA, if the persons conducting the relevant enquiry are not unanimous in their finding, such fact shall be mentioned in the report and each of such persons shall give his or her finding on the matter in question. It is unclear whether the members of the panel are required or allowed to confer with each other in order to reach consensus. Each member of the multi-disciplinary team conducts an enquiry and at some stage ought to present their findings in a case conference, when hypotheses are discussed and any further assessments planned, therefore the resulting report represents the consensus of the team. This can be criticised in that the court requires an objective finding from each expert and the consensual report may negate this objectivity when there are dissenting opinions and different views and issues of seniority in the profession or work environment. The report of each individual expert mandated to report on the accused should ideally be untainted by the opinion of another, to enable the court to make its own decision on the evidence presented.

- **Recommendation 40**

A statement made by an accused at the relevant enquiry shall not be admissible in evidence against the accused at criminal proceedings, except to the extent to which it may be relevant to the determination of the mental condition of the accused, in which event such statement shall be admissible.¹⁷ Regulation 41(1) of the General Regulations to the MHCA determines that a person referred by a court of law to a health establishment in terms of Section 79 of the Criminal Procedure Act, 1977 for observation, must be informed that a report will be submitted by a mental health care practitioner to the court of law and that they are under no obligation to divulge information. Regulation 41(1) of the MHCA does not stipulate who must inform the accused of this right. It is submitted that the MHCA should be amended to provide explicitly that the forensic assessor conducting the observation should inform the accused of this right. The accused should be advised that they do not have to divulge information, but also that information may not be used against them as evidence of their guilt, but only of their mental state. There are at present no forms prescribed in the MHCA or other

¹⁷ Section 79(7) of the CPA.

accountability measures in place to make sure the accused is informed of this right. It is suggested that Section 79(4) of the CPA should be amended to state that the report should also include a statement that the accused has been informed of this right, which must be signed by the accused, or their proxy or lawyer if the accused lacks the necessary capacity to understand. Such an amendment would ensure that there is less risk of infringing the right to privacy, as is guaranteed in Section 14 of the Constitution

- **Recommendation 41**

Section 42 of the MHCA provides for the admission of State Patients, and for the provision of care, treatment and rehabilitation services, although neither the CPA nor MHCA determines that these services must be provided on an involuntary basis. Landman argues that due to this gap in the CPA and MHCA there is no authority on which to force involuntary mental health care on State Patients, although once the State Patient is admitted on receipt of the order, even if it does not mandate treatment, the patient is provided with involuntary services on compulsory basis.¹⁸ As there is no provision in the CPA that authorises that a State Patient may be medicated and treated without consent, the common law and the provisions of the MHCA must provide guidance and may entitle a psychiatric hospital to treat a patient depending on the facts of each case, but this decision may be challenged after the fact. Landman states that the common law is not sufficient in this regard and that Section 32 of the MHCA must be referred to instead to ensure the treatment of the State Patient is sanctioned by law and does not amount to an assault.¹⁹ The admission of State Patients under Section 32 of the MHCA has the advantage of being subject to periodic review, as this does not happen at present due to Review Boards not having jurisdiction regarding State Patients.²⁰

It is submitted that to simply admit State Patients as involuntary users and not as State Patients would not be in line with the intention of the legislator, as Sections 77(6) and 78(6) of the CPA already contain provisions that allow an accused under particular circumstances to be admitted as an involuntary user, as discussed in Chapter 5. These circumstances generally

¹⁸ Landman and Landman 172.

¹⁹ Landman and Landman 173.

²⁰ *Ibid.*

refer to situations where a less serious crime has been committed,²¹ or where on balance of probabilities the offending conduct was not committed.²² In other circumstances the legislator explicitly makes provision for detention as a State Patient, which has its or particular provisions that differ from those regulating involuntary users.²³ It is recommended that the MHCA should be amended in that Section 42 should explicitly clarify that State Patients are to be admitted on an involuntary basis, thus as a special type of involuntary mental health care user with the necessary special provisions that differ from provisions regarding involuntary users.

- **Recommendation 42**

Regarding the Leave of Absence of State Patients as provided for in Section 45 of the MHCA, it is submitted that State Patients differ from involuntary users in the purpose of their detention and the fact that they might pose a risk to society. Therefore it seems illogical that an involuntary or assisted user may be granted a leave of absence of up to two months at a time, but a State Patient is allowed a leave of absence of up to six months at a time. Should leave of absence be deemed logical and in line with the purpose of the legislator in light of the purpose of detention of State Patients, it is submitted that leave of absence of State Patients should only be granted where it has explicitly been determined that they do not pose a risk to society, or a risk of reoffending. In light of the *Carmichele* case²⁴ it can be argued that the State has a duty to protect its citizens from harm, and therefore to consider the risk a State Patient may pose in deciding whether it is prudent to release them on a leave of absence. It must be considered that if a person is sufficiently recovered in their mental state to warrant a leave of absence, it might be a better course of action in cases involving State Patients to establish whether discharge is the appropriate decision instead. A Review Board does not have jurisdiction to order the discharge of a State Patient,²⁵ therefore it seems illogical that a health establishment would have jurisdiction to grant a leave of absence and the MHCA

²¹ Section 77(6) and 78(6) of the CPA.

²² Section 77(6) of the CPA.

²³ The provisions regarding transfer, discharge and leave of absence of State Patients are discussed in this chapter below.

²⁴ *Carmichele v Minister of Safety and Security* (CCT 48/00) [2001] ZACC 22; 2001 (4) SA 938 (CC); 2001 (10) BCLR 995 (CC).

²⁵ Section 47 of the MHCA regarding discharge of State Patients is discussed below in this chapter.

should be amended either to determine that a leave of absence is not applicable to State Patients, or that a leave of absence must be confirmed by a judge in chambers.

- **Recommendation 43**

The court in *S v Ramokoka*²⁶ held that Section 47 of the MHCA does not have an automatic review mechanism, so that a person detained in terms of Section 77(6) of the CPA remains detained until an application is made to a Judge in Chambers and the Judge orders the release. It is submitted that the MHCA should be amended to include an automatic review mechanism, in order to prevent a situation where a State Patient is detained whilst not suffering from a mental disorder as that would amount to arbitrary and unlawful detention in terms of Section 35 of the Constitution. Reference can be made to the case of *Young*, where the court held that if the procedure in terms of Section 77 or 78 had been meticulously followed in that an assessment and report in terms of Section 79 was carried out and compiled, a safeguard was already in place to establish whether a mental disorder was present or not.²⁷ As was discussed above, the CPA should be amended to include a provision that mandatory detention of State Patients may only be ordered in the presence of a mental disorder warranting compulsory treatment and detention.

- **Recommendation 44**

It is submitted that the timeframe of 30 days granted in terms of Section 47(3)(a)(i) of the MHCA to the *curator ad litem* in which to compile and submit a report to a judge in chambers regarding an application for discharge, amounts to an undue deprivation of freedom of the State Patient who remains in detention despite the possible existence of reasons that would render their continued detention unlawful. Additionally there is no mechanism to ensure that the 30 day period is adhered to, nor is it clear from when the 30 days should be counted (from the date of the application or the date of receipt of the report or the date the curator becomes aware of the report).

²⁶ 2006 (2) SACR 57 (WLD) par 12.

²⁷ (2015) JOL 32909 (KZP) par 15-19.

It is submitted that Section 47(4)(a) of the MHCA is fundamentally unfair in that it requires the outright rejection of an application for discharge by a State Patient if another application had been brought in the previous 12 months. It is submitted that this is an inordinate amount of time to be deprived of liberty when a State Patient may no longer be suffering from a mental disorder warranting their continued confinement. The section is possibly in breach of Section 35(2)(d) of the Constitution that provides that every detained person has the right to challenge the lawfulness of their detention; as well as Section 10 pertaining to human dignity; Section 9 protecting equality (especially since State Patients are treated differently from other mental health care users in this instance in a manner that does not seem justified in its reasoning); and Section 12 regarding arbitrary deprivation of liberty. The purpose of Section 47(4)(a) seems to be to prevent spurious applications for discharge that are continuously made without justification. If a State Patient is deemed to no longer have a mental illness, the application could contain a justification for submitting another application within a year or the MHCA should be amended to determine that if a mental health professional supports the application that it is permissible to apply again. It is further recommended that the MHCA should be amended to include guidance to the judge that considers such an application.

- **Recommendation 45**

It is submitted that the MHCA must be amended to reflect the same terminology as the Correctional Services Act²⁸ (the (“CSA”)) in order to clear up any confusion that might lead to unfair treatment of persons suffering from mental illness that are entitled to treatment but are refused or fall through the cracks due to a terminology discrepancy. The new CSA terminology that refers to inmates and to correction facilities are preferable and have fewer stigmas attached to them than “prisoner” and “prison”. It is further submitted that the MHCA must be amended to not only include convicted prisoners in its ambit. It is unacceptable that persons who are mentally ill would be denied or delayed treatment only because they are awaiting conviction or sentencing, as this would infringe upon their rights under Section 35 of the Constitution as detained persons, as well as the right to access to healthcare. Refusing mental health care based solely on the fact that the prisoner has not been convicted may

²⁸ Act 111 of 1998.

infringe upon the right to not be treated in a cruel and inhumane manner. It is submitted that the a mechanism is necessary to ensure that persons with mental disorders do not need to wait their turn in court before possibly being diverted as a State Patient, or sent for observation under Section 77 or 78 of the CPA. It would be preferable if such an assessment could be initiated after recommendation by the correctional facility as well.

The care, treatment and rehabilitation of prisoners with mental illness in prisons is obscured by the wording of Sections 51 and 52 of the MHCA, both of which refer to “convicted” prisoners who are referred to as "unsentenced prisoners” in the CSA. The effect of this wording is that it does not refer to awaiting trial prisoners.²⁹ It is submitted that the MHCA and CPA should be amended to accommodate awaiting trial prisoners and unconvicted prisoners. It is further submitted that an appeal process should be enacted to enable a mentally ill prisoner treated in prison under Section 51 to appeal the decision to not transfer them to a health establishment. It is submitted that Section 51 does not explicitly determine whether care, treatment and rehabilitation of mentally ill prisoners is to be provided on an involuntary basis and the MHCA should be amended to reflect this.

- **Recommendation 46**

The MHCA does not define the degree of severity or type of mental illness that can be treated in prison in terms of Section 51, and those who need to be transferred to designated health establishments after requesting a magistrate to cause an inquiry to be made (Sections 49 and 52). It is submitted that there should be guidelines as to which prisoners can be treated in prisons and which must be transferred to a health establishment. The MHCA and regulations must be amended to give clearer guidelines as to which prisoners warrant transfer for treatment and which do not, also considering the type of prison facilities and medical care on hand. It is also submitted that the longer process in terms of Section 52 of requesting a magistrate to decide whether it is appropriate to ask medical experts to assess the mental health status of a prisoner is not time or resource efficient. Additionally a magistrate does not have the required medical knowledge to make a decision on the mental state of the prisoner;

²⁹ Landman and Landman 193.

rather the head of prison should be able to commission the required mental health assessors personally. It is submitted that Section 52 does not explicitly determine whether care, treatment and rehabilitation of mentally ill prisoners is to be provided on an involuntary basis and the MHCA should be amended to reflect this.

- **Recommendation 47**

Section 58(1) determines that a mentally ill prisoner must, subject to Sections 58(2) and 58(3), be released from prison or a health establishment designated in terms of Section 49 at which the prisoner is detained on expiry of the term of imprisonment to which that prisoner was sentenced. At least 90 days before expiry of the term of imprisonment, an application may be made according to the relevant provisions in Chapter V to the head of the health establishment in which the mentally ill prisoner is detained for the provision of assisted or involuntary care, treatment and rehabilitation.³⁰ At least 30 days before the expiry of the term of imprisonment, an application may be made to a magistrate for the continued detention of a mentally ill prisoner in the designated health establishment where such prisoner was cared for, treated and rehabilitated pending the finalisation of the application referred to in Section 58(2).³¹ An application in terms of Section 58(3) of the Act must be made in the form of form MHCA 38.³² It is submitted that where the term of imprisonment expires before the application for assisted or involuntary care is approved, the prisoner should be released as their continued detention is no longer lawful, unless compelling reasons exist to continue detention such as the risk of harm to the prisoner or others; or where the mentally ill prisoner submits to treatment as a voluntary user.

- **Recommendation 48**

It is submitted regarding Section 46 of the MHCA and Regulation 21(2) of the General Regulations to the MHCA, that 12 months is too long a time between periodic reviews and that an order must be made on a case by case basis, especially if the State Patient suffers from

³⁰ Section 58(2) of the MHCA.

³¹ Section 58(3) of the MHCA.

³² Regulation 31 of the General Regulations to the MHCA.

a highly treatable form of mental illness. It amounts to arbitrary conduct if periodic reviews of State Patients happen in longer timeframes than that of other mental health care users, particularly as the rationale behind the delay is unjustified.

- **Recommendation 49**

Considering the evidence discussed in Chapter 6 regarding the application of mental health law in practice, it is clear that the impact of the burden of disease of mental disorders is likely to have a devastating effect on the economic and social wellbeing of South Africa. There is therefore a need to establish parity for mental health services in South Africa with general health services, to use existing human and infrastructure resources as efficiently as possible, and to develop additional resources. It is therefore against the yardstick of implementation that the success of the MHCA has to be measured. Legislation by itself is not adequate to bring about the major reform required for the South African mental health system.

Even if the suggested amendments to the MHCA and CPA were effected as recommended in this thesis, a lack of effective implementation renders the possible positive impact of the legislation moot. Where implementation of legislation aimed at protecting a vulnerable group of persons such as mentally ill individuals is not effectively implemented human rights violations are a manifest reality. The lack of proper infrastructure possibly violates the right to an environment that is not harmful to health or wellbeing in terms of Section 24 of the Constitution, while detention in such facilities may amount to being treated in a cruel, inhuman or degrading way in violation of Section 12(1)(e) of the Constitution. The fact that resources regarding mental health care are not allocated on equal footing with other health issues violates the right to equality, dignity, and access to healthcare.

In light of the human resource challenged regarding sufficient training and availability of practitioners, government and the HPCSA is required to take the necessary steps to rectify the issues mentioned in Chapter 6. Insufficient staffing and training leads to an untenable situation where health care practitioners and the State contribute to the problem of infringing rights even whilst acting with the best intentions.

- **Recommendation 50**

The least popular, highly problematic and most controversial aspect of the MHCA is its administrative burden in terms of paperwork, which has challenged the administrative capacity of most hospitals that are unable to manage the paper trail.³³ Ramlall, Chipps and Mars found that 44% of hospitals were not forwarding their forms to the Mental Health Review Boards.³⁴ Szabo states that it is imperative however that appropriate staffing and materials are forthcoming in terms of clerical staff to facilitate the process of completion of forms.³⁵ Currently there are no such dedicated personnel, so clinicians are tasked with this responsibility resulting in patient care time being taken up by paperwork.³⁶ Szabo emphatically states that administrative inefficiency is inexcusable and that heads of Health Establishments should both understand their obligations and responsibilities in terms of the MHCA, as well as ensure that these are fulfilled.³⁷

7.4 Recommendations regarding MHCA forms

- **Recommendation 1**

MHCA 04 is used for assisted and involuntary users, therefore the requirements for each separate category of user must be identifiable in the form and easily distinguishable, and mental health care practitioners must be adequately trained in the requirements of the MHCA to ensure proper completion of the form. It is submitted that the following checklist should serve as a guide to completion of the form:

- The applicant in both assisted and involuntary admissions must have seen the user within seven days prior to the application, failing that the application will be invalid.

³³ Ramlall (2012) Afr J Psychiatry 409.

³⁴Ramlall, Chipps and Mars (2010) SAMJ 669.; Ramlall (2012) Afr J Psychiatry 409.

³⁵ Szabo (2006) A Afr Psychiatry Rev 5

³⁶*Ibid.*

³⁷*Ibid.*

- It must be clearly noted which person made the application and that they have signed the form and, if possible, that they have given as much information on the history of the user as possible.
- If the user is under the age of 18 years, a parent or legal guardian must be the applicant. If the child is resistant to treatment, they must be admitted as an involuntary rather than assisted user.
- In the event that the applicant is the health care provider, it must be clearly noted which attempts to contact the user's next of kin have been made.
- It is insufficient to complete the form in vague language and to leave sections unanswered.

It is submitted that the form should be amended to clearly indicate whether assisted or involuntary care is applied for on the first page as. The form must also be amended to indicate clearly whether the user is refusing treatment or not. For purposes of application for involuntary detention, it is submitted that the form is lacking because it does not make provision for the applicant to indicate that the user is a danger to themselves or others and should be amended to include such a question in order to comply fully with the requirements of involuntary detention. It is submitted that MHCA 04 does not make provision for a practitioner to indicate the exact time of admission, which is needed to help calculate whether applicable time frames are complied with.

- **Recommendation 2**

It is submitted that MHCA 05 should be amended to include a checkbox requiring the practitioner to indicate their designated category (e.g. registered medical practitioner, occupational therapist, nurse, and the like as indicated in the definition of mental health care practitioner), as well as indicating whether they are qualified to conduct a physical examination. This provides important information regarding data of practitioners dealing with mental health care users in establishments for purposes of guiding policy, as well as providing information that could be useful in a review of the decision of the head of the health establishment or review board if it was based on the opinions of practitioners not specialised in diagnosing mental disorder.

It is submitted that the completion of the category “(a) General physical health” is not acceptable if it merely states that the health of the user is “good”, as more information is required. Alternatively the practitioner might refer in that section to attached medical records of the patient where assessments are indicated in more detail to avoid unnecessary duplication of writing. It is further submitted that in the category “Information on user received from other person(s)/family” it should be indicated whether such information was unavailable due to absence of such persons to question or where such persons were unhelpful or uninformed, instead of leaving the question blank. It is submitted that MHCA 05 does not make provision for a practitioner to indicate the exact time of completion, which is needed to help calculate whether applicable time frames are complied with.

- **Recommendation 3**

It is submitted that MHCA 06 should be amended to include a checkbox requiring the practitioner to indicate their designated category (e.g. registered medical practitioner, occupational therapist, nurse, and the like as indicated in the definition of mental health care practitioner), as well as indicating whether they are qualified to conduct a physical examination. It is submitted that the completion of the category “(a) General physical health” is not acceptable if it merely states that the health of the user is “good”, as more information is required. Alternatively the practitioner might refer in that section to attached medical records of the patient where assessments are indicated in more detail to avoid unnecessary duplication of writing. It is submitted that MHCA 06 does not make provision for a practitioner to indicate the exact time of completion, which is needed to help calculate whether applicable time frames are complied with.

- **Recommendation 4**

It is submitted that form MHCA 07 would be improved if amended to substitute check boxes in order for the head of the health establishment to indicate clearly their recommendation instead of having to underline or circle or delete phrases in the current form. If person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, which must also be submitted to the Review Board. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated

authority of the head of the health establishment. It is further submitted that the form be amended so that the word “...contemplated” be replaced with the words “...warranted in the circumstances”. It is submitted that MHCA 07 does not make provision for a practitioner to indicate the exact time of completion, which is needed to help calculate whether applicable time frames are complied with.

- **Recommendation 5**

It is submitted that form MHCA 08 would only be completed if the head of the health establishment felt that further involuntary care was warranted and if they were satisfied that the infringement of the user’s rights were necessary, therefore the form should be amended to remove the words “not satisfied”. The form should also be amended to include check boxes by which to indicate which attachments have been included. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, which must also be submitted to the Review Board. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment. It is further submitted that the form be amended so that the word “...contemplated” be replaced with the words “...warranted in the circumstances”.

- **Recommendation 6**

It is submitted that form MHCA 09 would only be completed if the head of the health establishment felt that further involuntary care was warranted and if they were satisfied that the infringement of the user’s rights were necessary, therefore the form should be amended to remove the words “not satisfied”. The form should also be amended to include check boxes by which to indicate which attachments have been included. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment. It is further submitted that the form be amended so that the word “...contemplated” be replaced with the words “...warranted in the circumstances”. MHCA 09 should be amended to add a question where

the head of the health establishment must provide reasons that outpatient services is recommended instead of inpatient services.

- **Recommendation 7**

It is submitted that MHCA 10 is sufficient in the information required and clarity in presentation. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 8**

It is submitted that MHCA 11 is sufficient in the information required and clarity in presentation. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 9**

It is submitted that MHCA 12 is sufficient in the information required and clarity in presentation, though the addition of check boxes through which the head of the health establishment may indicate which transfer is being effected, as well as to indicate the reason for transfer from outpatient to inpatient care is necessary. If a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 10**

It is submitted that MHCA 16 should be amended for comprehension and readability purposes by adding check boxes by which the court can clearly indicate what order it has made.

- **Recommendation 11**

Regarding MHCA 27, it is submitted that if a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, therefore it is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 12**

Regarding MHCA 28, it is submitted that if a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, therefore it is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 13**

It is submitted that MHCA 15 is satisfactory in the information required and clarity of presentation. If more space is required for the writing of reasons or facts provision should be made for the attachment of additional pages.

- **Recommendation 14**

It is submitted that MHCA 13 should be revised and amended in terms of general grammar and readability as there are numerous spelling and grammar mistakes. It is submitted that if a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, therefore it is submitted that the form should be amended to provide for the name of the head of the health establishment and for the

details of a person signing the form on the delegated authority of the head of the health establishment. Pertaining to less restrictive means of care, treatment and rehabilitation, the question should rather be amended to read “Are there any other less restrictive or intrusive measures of care, treatment and rehabilitation available that would serve the same purpose as the current treatment plan?”

- **Recommendation 15**

It is submitted that MHCA 03 should be amended by replacing the word “Comments” with “Reasons for discharge” for purposes of clarity in the information required. It is submitted that if a person other than the head of the health establishment completes and signs the form they must be properly authorised to do so by written delegation, therefore it is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 16**

It is submitted that MHCA 01 would be clearer and easier to complete if check boxes were inserted to enable a mental health care practitioner to check the reason for admission in terms of Section 9(1)(c). It is further submitted that the form MHCA 01 should be amended as it does not make provision for noting if and when an application for assisted mental health care was made as is provided for in Section 9(2) of the MHCA. It is submitted that MHCA 01 should be amended to include an option (d) stating that within 24 hours the user was referred for medical follow up and was not in need of further psychiatric care.³⁸ It is submitted that if a person other than the head of the health establishment completes and signs the form, they must be properly authorised to do so by written delegation and the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

³⁸As per the Gauteng Provincial Government Department of Health ‘Guidelines for the implementation of emergency, assisted, and involuntary care in accordance with the Mental Health Care Act No 17 of 2002’ 1-11 2.

- **Recommendation 17**

It is submitted that MHCA 01 would be clearer and easier to complete if check boxes were inserted to enable a mental health care practitioner to check the reason for admission in terms of Section 9(1)(c). It is further submitted that the form MHCA 01 should be amended as it does not make provision for noting if and when an application for assisted mental health care was made as is provided for in Section 9(2) of the MHCA. It is submitted that MHCA 01 should be amended to include an option (d) stating that within 24 hours the user was referred for medical follow up and was not in need of further psychiatric care.³⁹ It is submitted that if a person other than the head of the health establishment completes and signs the form, they must be properly authorised to do so by written delegation and the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 18**

It is submitted that the MHCA 14 form is unclear and can be improved upon by adding check boxes for the Review Board to check the issues that were in fact considered. A lack of check boxes makes it difficult to establish which of the four types of matter had been before the Board to decide upon. It appears from the current form that all aspects in the four different types of decision the form is used for has been considered simultaneously. The form therefore does not offer enough of an explanation of the information it considered to reach its decision, making it difficult to establish a causal nexus between the information considered, the decision reached, and the reasons for the decision.⁴⁰ This leads to insufficient information before an applicant on which to base an appeal and may lead to a court ruling on review that the decision of the Review Board was unreasonable and therefore not administratively just. It could also lead to a determination of unlawful detention if it cannot be ascertained whether the reasons for detention were authorised and justified in terms of the MHCA.

³⁹ As per the Gauteng Provincial Government Department of Health 'Guidelines for the implementation of emergency, assisted, and involuntary care in accordance with the Mental Health Care Act No 17 of 2002' 1-11 2.

⁴⁰ If a decision cannot be objectively justified it is not reasonable. Reasonableness is a ground for judicial review in terms of Section 6 of PAJA. The decision must be shown to be rationally connected to the reasons for the decision.

The form does not make provision for dates to be filled in to indicate when a decision by the head of the health establishment was taken (to ensure that the decision was referred to the Review Board within seven days as is determined in Section 28(2) of the MHCA), or to determine the dates on which the matter was considered by the Review Board and reported back to the head of the health establishment (to ensure that the 30 day period has been complied with as determined in Sections 28(3) and 29(2) of the MHCA). A lack of simple accountability measures, such as the recording of relevant dates, lead to insufficient data capturing, and a skewed picture of the efficiency of the Review Board and the implementation of the MHCA. If a mental health care user were denied their rights under the MHCA to have a decision reached speedily and an appeal considered within the required timeframes, it is an abuse of their human rights. Without expedient decision-making and communication, a mental health care user might be detained for longer time periods than required even when detention is no longer necessary, which would be an unlawful deprivation of their liberty. It is further submitted that the forms pertaining to initial review of a decision by a head of the health establishment, should physically differ from the forms used for an appeal to avoid seeming biased in contravention of the *nemo iudex*-rule and perhaps exposing the decision to judicial review in terms of Section 6 of PAJA.

- **Recommendation 19**

It is submitted that MHCA 17 is unclear and should be amended to improve comprehension and readability. The title of the form should be amended to clearly refer to periodic review as follows: “*Decision of Review Board following summary report of **periodic or annual** review on assisted or involuntary mental health care users and mentally ill prisoners...*”

It is submitted that the form can be improved for ease of completion and readability by adding check boxes to indicate clearly:

- a) Whether the form pertains to an annual report or periodic review;
- b) Which of the criteria have been considered, as well as adding additional writing space in which other criteria not mentioned that were considered can be added;
- c) Which person or persons have been requested to make oral or written submissions;
and
- d) Which conclusion or decision has been reached.

- **Recommendation 20**

. A person summonsed in the form of form MHCA 18 by the Review Board to appear before it as a witness, in terms of Regulation 15(6) and (7) of the General Regulations to the MHCA, to give evidence must be compensated by funds appropriated by the provincial department concerned for any reasonable expenses which such person may have incurred in order to attend the appeal hearing. The MHCA does not clarify the procedure by which the person summonsed is to be reimbursed, and it is submitted that this falls under the discretion of the Review Board to regulate their own procedures. It is submitted that MHCA 18 is presented clearly pertaining to appropriate and sufficient information to enable a person summonsed to appear before the Review Board to be aware of the matter at hand and what is required of them. However it would be prudent to insert text into the form informing the person summonsed that they may be compensated for reasonable costs associated with attending the hearing. This will ensure that the relevant person is fully aware of their rights as stated in the regulations, which may not be common knowledge.

- **Recommendation 21**

It is submitted that MHCA 22 should be amended to enable the police officer to indicate whether the reasonable belief stems either from personal observation, or from information obtained from a mental health care professional. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 22**

It is submitted that MHCA 25 is satisfactory regarding the information required to enable the SAPS to lawfully apprehend an absconded mental health care user. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 23**

It is submitted that MHCA 26 is satisfactory regarding the information required to enable the SAPS to lawfully apprehend an absconded mental health care user. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 24**

It is submitted that MHCA 19 must be amended to clearly indicate to which of the scenarios of transfer the request pertains to.⁴¹ It is further submitted that MHCA 19 is satisfactory regarding the information required. It is submitted that the form should be amended to provide for the name of the head of the health establishment and for the details of a person signing the form on the delegated authority of the head of the health establishment.

- **Recommendation 25**

It is submitted that MHCA 20 must be amended to clearly indicate to which of the scenarios of transfer the request pertains to.⁴² It is further submitted that MHCA 20 is satisfactory regarding the information required. It is submitted that the form should be amended to add check boxes to enable the Review Board to indicate clearly which points the Board have considered, and to add additional spaces to mention other information also considered.

⁴¹ Either:

- a) An assisted or involuntary mental health care user in terms of Section 39(1) of the MHCA to maximum security facilities;
- b) A State Patient between designated health establishments in terms of Section 43 of the MHCA; or
- c) A mentally ill prisoner between designated health establishments in terms of Section 54(2) of the MHCA

⁴² Either:

- a) An assisted or involuntary mental health care user in terms of Section 39(1) of the MHCA to maximum security facilities;
- b) A State Patient between designated health establishments in terms of Section 43 of the MHCA; or
- c) A mentally ill prisoner between designated health establishments in terms of Section 54(2) of the MHCA.

- **Recommendation 26**

It is submitted that MHCA 27 contains the necessary information for purposes of the MHCA as it currently stands. It should however be amended to include a reference to the judge in chambers who must sign off on the decision to grant a leave of absence. In addition, if the MHCA should be amended as is proposed above, it is submitted that form MHCA 27 should include a section where it can be indicated that the State Patient has been assessed and is deemed to not pose a risk to society or a risk of reoffending. If the MHCA is amended as suggested to determine that a leave of absence is not an appropriate mechanism for use in cases involving State Patients, MHCA 27 would no longer be applicable to them.

- **Recommendation 27**

It is submitted that MHCA 28 should be amended to include reference to a judge in chambers, in whose authority it should be to cancel leave of absence of a State Patient or to whom it should be applied for confirmation of cancellation. If the MHCA is amended as suggested to determine that a leave of absence is not an appropriate mechanism for use in cases involving State Patients, MHCA 28 would no longer apply to them.

- **Recommendation 28**

It is submitted that MHCA 29 should be amended so that after the indication of whether an application had been made in the previous 12 months, the form makes provision to indicate whether the mental state of the State Patient has improved to such an extent that continued detention is unwarranted, and also to indicate whether the application is supported by a mental health care practitioner if it was not brought by such a practitioner. In such a case the rest of the form can be completed, even though another application had been brought in the previous 12 months (as is in line with the suggested amendments to the MHCA above).

- **Recommendation 29**

It is submitted that MHCA 30 should be amended so that after the indication of whether an application had been made in the previous 12 months, the form makes provision to indicate whether the mental state of the State Patient has improved to such an extent that continued

detention is unwarranted, and also to indicate whether the application is supported by a mental health care practitioner if it was not brought by such a practitioner. In such a case the rest of the form can be completed, even though another application had been brought in the previous 12 months (as is in line with the suggested amendments to the MHCA above).

It is further submitted that MHCA 30 be amended to make provision for the mental health practitioners indicated in Section 47(2) and (3) to indicate their exact profession, to ensure that one of the practitioners is in fact a psychiatrist as is required in the MHCA. MHCA 30 should also provide for situations where a person other than the head of the health establishment signs off on the form on permission of the head of the establishment and provide a space to indicate as such. It is submitted that MHCA 30 does not make clear the date which the curator submitted the report to the judge in chambers, nor does it provide for a space to indicate that the submission happened within the 30 day timeframe and the form should be amended as such.

- **Recommendation 30**

It is submitted that MHCA 32 should be amended to provide that the person monitoring the State Patient must state their name and occupation and also the date that the next six-monthly report should be submitted, if applicable.

- **Recommendation 31**

It is submitted that MHCA 33, MHCA 34, and MHCA 35 are satisfactory in the information required and in the clarity of the presentation. It is however recommended that they should be amended in order that the details of a person other than the head of the health establishment must be provided where such a person was authorised to sign the form on behalf of the head.

- **Recommendation 32**

It is submitted that MHCA 37 should be amended to provide for check boxes where the magistrate can indicate clearly whether the prisoner should be transferred to a health establishment or whether they should be treated in prison. It is further submitted that the parts of MHCA 37 requiring the magistrate to make a pronouncement on mental state and on

treatment plans should be removed from, as it is not appropriate that the magistrate who is not a mental health care practitioner should make pronouncements on such matters. The magistrate should rather attach to MHCA 37 the reports of the mental health assessors charged with the enquiry to indicate the scientific and medical basis of the decision.

- **Recommendation 33**

It is submitted that MHCA 38 does not provide for sufficient information to enable a magistrate to authorise continued detention. MHCA 38 should be amended so that the applicant may indicate the reasons for the request, such as the likelihood of success of the application for assisted or involuntary care, the severity of the mental disorder and the risk posed to society and to the mentally ill prisoner should they be released.

- **Recommendation 34**

It is submitted that there are no clear guidelines in the MHCA or regulations regarding the circumstances in which a mentally ill prisoner must be transferred back prison in terms of Section 55 of the MHCA (such as recovery of mental status or manageability of the disorder in the prison setting) and the MHCA should be amended to that effect.

- **Recommendation 35**

It is submitted that MHCA 17 should be amended to provide for check boxes to enable the Review Board to indicate clearly which factors were considered, and to indicate which persons are requested to make representations. MHCA 17 should also be amended to provide for a space where the Board can indicate which additional factors not mentioned were considered in arriving at the decision. Furthermore, check boxes should be added to enable the Review Board to clearly indicate the decision concluded.

- **Recommendation 36**

It is submitted that MHCA 21 should be amended to provide for the details and designation of the person or body ordering the transfer in terms of Section 43(8) or 54(6) of the MHCA.

7.5 Future research

Suggested avenues for future research include:

- Research into the implementation of the MHCA in the public and private health sector regarding:
 - Training and continuing professional development of mental health care practitioners and other health care staff in the requirements and procedures of the MHCA and completion of MHCA forms;
 - Human resources infrastructure and its development to meet the needs of the population and prevent human rights violations due to insufficient numbers of qualified mental health care practitioners
- The development of postgraduate and continuing education training programmes for forensic mental health practitioners;
- The establishment of a register for forensic mental health practitioners;
- The refinement and simplification of the MHCA forms and methods of easing the administrative burden imposed by them;
- The effect of the DSM-5 and the introduction of the uniaxial system placing personality disorders on par with other mental disorders on the criminal law;
- Methods of improving the efficiency and impact of Mental Health Review Boards;
- The utilisation of administrative law mechanisms to ensure administrative fairness in mental health matters;
- The development of specialised courts to deal with mental health matters in terms of the MHCA;
- Research into the Traditional Health Practitioners Act and its regulations and their implementation, especially considering the controversial nature of the Act and the necessity of imposing a regulatory system;

7.6 Concluding remarks

Mental health is imperative for good overall health, without which a population suffers on various fronts. The social and economic wellbeing of the nation will benefit from an efficient mental health care system. The proper regulation of this system, and the implementation of such regulations, can be viewed as the foundation for meaningful change. The human rights of vulnerable mentally ill individuals will be more protected if the recommendations in this thesis are considered and if the necessary amendments to mental health laws and policy are made, leading to a more prosperous and healthy South Africa.

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