

Faraaz Mahomed and Michael Ashley Stein***

Summary

Stigma and associated discrimination against persons with psychosocial disabilities constitute a considerable barrier to the realisation of the highest attainable standard of health in South Africa, Africa, and further afield, constituting a significant human rights violation. This situation is evidenced and exacerbated by mental health as a whole remaining under-prioritised in law, policy and resource allocation. States parties to the Convention on the Rights of Persons with Disabilities (CRPD) have a duty to address stigma and discrimination through awareness raising and education. Some important commitments have been made in this respect, particularly at the policy level in South Africa. Nevertheless, and as demonstrated by tragic recent events, effective implementation remains lacking. This article lays out the obligations incumbent upon the South African government to address stigma and discrimination on the basis of psychosocial disability as a public health and human rights imperative by examining positive duties incorporated into international instruments and domestic law and policy. It further considers the role of political de-prioritisation of mental health and how this constitutes stigma of a systemic nature, using case law and examples of research and best practice from South Africa, Africa generally, and beyond. We conclude that South Africa is failing to meet its obligations to persons with psychosocial disabilities, and recommend that positive duties be emphasised in potential disability-specific legislation; high-level political commitment and co-ordination is

- * Visiting Research Fellow, Centre for Applied Legal Studies, University of the Witwatersrand, Johannesburg, South Africa; Harvard Law School Project on Disability.
** Extraordinary Professor, Centre for Human Rights, Faculty of Law, University of Pretoria, South Africa; Visiting Professor, Harvard Law School; Executive Director, Harvard Law School Project on Disability.
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secured for mental health; the CRPD's independent monitoring requirement is urgently fulfilled; and contextually-relevant interventions are crafted with the active participation of persons with psychosocial disabilities and their representative organisations.

1 Introduction

The World Health Organization (WHO) estimates that over 450 million people worldwide live with psychosocial disabilities,¹ a figure some experts believe to be a severe under-approximation.² Empirical certainty is especially challenging in South Africa where the overall accuracy of disability statistics has been the subject of significant debate due to unreliable, inconsistent and, at times, possibly biased measuring and reporting methods.³ Moreover, pervasive stigma and discrimination relating to persons with psychosocial disabilities in that state remain neglected by law and policy makers notwithstanding an urgent need to eliminate those prejudices and their consequences. Specifically, despite law and policy provisions that obligate South Africa to educate the public on psychosocial disabilities, and to undertake those education initiatives as part of a broader effort to prioritise mental health, no real progress has been made in the development and rollout of national awareness and stigma-reduction activities. As a consequence, mental health as a whole remains domestically de-prioritised and under-researched.

The article examines the need to address mental health stigma and its ramifications as human rights violations and public health challenges in the context of South Africa's broader obligation to ensure the full realisation of the rights of persons with psychosocial disabilities. In doing so, we consider the state's obligations under the Convention on the Rights of Persons with Disabilities (CRPD), and especially its domestic duties as encompassed in the Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA),⁴ the Draft National Disability Rights Policy (NDRP),⁵ and the National Mental Health Policy and Strategic Framework 2013-2020 (NMHPF).⁶

We argue that addressing stigma is both a public health and a human rights concern that is inadequately accounted for in existing laws and

- 1 WHO 'Mental disorders affect one in four people' http://www.who.int/whr/2001/media_centre/press_release/en/ (accessed 25 July 2017).
- 2 D Vigo et al 'Estimating the true global burden of mental illness' (2016) 3 *Lancet Psychiatry* 171-178.
- 3 K Foskett 'Intellectual disability in South Africa' (2014) <http://www.includid.org.za/Downloads/South%20Africa%20and%20Intellectual%20Disability.pdf> (accessed 25 July 2017).
- 4 Act 4 of 2000.
- 5 Draft National Disability Rights Policy, *Government Gazette* 38471, 16 February 2015.
- 6 Department of Health *National mental health policy and strategic framework 2013-2020* (2013).

policies. Although some South African laws and frameworks make mention of stigma and discrimination on the basis of psychosocial disability, or explicitly require the state to take steps to address this problem, existing protections nonetheless remain insufficient. To illustrate: the Mental Health Care Act⁷ lacks any positive obligation to foster inclusivity, while the provisions of PEPUDA, consciously designed to promote equality through public education,⁸ have yet to be activated. Lack of adequate resourcing and attendant capacity building, likewise, forms a significant impediment to meeting existing stigma reduction objectives, despite their inclusion in instruments such as the CRPD, NDRP and NMHPF. This demonstrated systemic failure to prioritise mental health in law and policy implementation amounts to stigma in its own right.

To comply with the CRPD as well as its own domestic legislation and policies, South Africa must undertake further actions. These can include high-level state intervention and inter-departmental co-ordination, adopting disability-specific legislation, and strengthening (while also making accountable) the South African Human Rights Commission (SAHRC) in its designated role as the state's CRPD-compliant independent monitoring mechanism. Using lessons from the rest of Africa as well as further afield, we consider how these recommendations might be best implemented for the benefit of persons with psychosocial disabilities in South Africa. Throughout the article we advocate for an African perspective which recognises that specific needs exist for South African persons with psychosocial disabilities, and that any contextually-relevant interventions must take those needs into account by including the active participation and consultation of those individuals and their representative disabled peoples' organisations (DPOs).⁹

2 Global, African and South African perspectives on Addressing Stigma

Stigma on the basis of psychosocial disability is a significant source of social marginalisation as well as a cruel and pervasive affront to human rights and individual dignity.¹⁰ This prejudice can dehumanise those affected and cast them as ineligible for fundamental rights,¹¹ including

7 Act 17 of 2002.

8 Ch 5 of the Act relates to the promotion of equality through, among other means, public education.

9 JE Lord & MA Stein 'Prospects and practices for CRPD implementation in Africa' (2014) 1 *African disability rights yearbook* 97.

10 BD Robbins & HL Friedman 'Social justice, human dignity and mental illness: A psychological perspective informed by personalist ethics' in CV Johnson & HL Friedman (eds) *The Praeger handbook of social justice and psychology* (2014) 67 71-72.

11 A Dhanda & T Narayan 'Mental health and human rights' (2007) 370 *Lancet* 1197-1198.

rights of access to health care facilities that (ironically) can help ameliorate those very same stigmatised and impairing conditions.¹² Discrimination can also play a role in perpetuating or causing 'socially-induced stress', at once a product and a recapitulation of the original structural and institutional biases that result in psychosocial impairments.¹³ In this sense, stigma and discrimination constitute a cyclical phenomenon, further alienating and oppressing those who have already been alienated and oppressed.

False attributions that consider psychosocial impairments as the product of witchcraft, supernatural possession or 'feeble-mindedness' have been demonstrated to be particularly significant impediments to accessing mental health care on the African continent.¹⁴ This barrier is exacerbated by negative attitudes among health care workers and a dearth of adequate treatment options, which in combination reinforce harmful stereotypes by leaving psychosocial disabilities untreated.¹⁵ In South Africa, much like the rest of the continent, the role of stigma as a rights violation and as an impediment to accessing responsive care continues to greatly impede individuals from seeking support, care or treatment.¹⁶ Similarly, a lack of adequate information and training on mental health issues causes some health care workers to feel unable or unwilling to render services to persons living with psychosocial disabilities.¹⁷ The result is that psychosocial disabilities often go untreated, that communities exclude people who could live fulfilling and productive lives in those communities, and that mental health continues to suffer a 'lack of ownership' as a policy priority.¹⁸

Stigma also hinders progress toward developing laws and policies relating to mental health in African countries, including South Africa.¹⁹ Thus, although Ghana enacted mental health legislation, and South Africa promulgated the NMHPF, the lack of implementation of the respective statutes continues to bar progress in each of these countries.²⁰ Ghana, for example, despite the promulgation of a national Mental Health Act in 2012, has yet to implement the law or prioritise mental health care in

12 S Cooper et al 'Viewing Uganda's mental health system through a human rights lens' (2010) 22 *International Review of Psychiatry* 578-583.

13 C Nelson 'Of egg shells and thin skulls: A consideration of racism-related mental illness impacting black women' (2006) 29 *International Journal of Law and Psychiatry* 128.

14 B Saraceno et al 'Barriers to improvement of mental health services in low-income and middle-income countries' (2007) 370 *Lancet* 1164-1174.

15 P Bartlett et al 'Mental health law in the community: Thinking about Africa' (2011) 5 *International Journal of Mental Health Systems* 21-24.

16 CO Egbe et al 'Psychiatric stigma and discrimination in South Africa: Perspectives from key stakeholders' (2014) 14 *BMC Psychiatry* 191.

17 R Kakuma et al 'Mental health stigma: What is being done to raise awareness and reduce stigma in South Africa?' (2010) 13 *African Journal of Psychiatry* 118-120.

18 AJ Flisher et al 'Mental health policy development and implementation in four African countries' (2007) 12 *Journal of Health Psychology* 505-516.

19 MA Omar et al 'Mental health policy process: A comparative study of Ghana, South Africa, Uganda and Zambia' (2010) 4 *International Journal of Mental Health Systems* 24.

20 GH Walker 'Ghana Mental Health Act 846 of 2012: A qualitative study of the challenges and priorities for implementation' (2015) 49 *Ghana Medical Journal* 266.

practice due to a lack of financial, human, and political resources.²¹ The next part considers incumbent obligations by South Africa to ensure that stigma is addressed.

3 South Africa's obligations to address stigma

South Africa ratified the CRPD in 2007.²² Further to the Constitution of the Republic of South Africa,²³ the act of ratification bound the state to honour the treaty's mandates. Amongst these obligations are requirements enumerated in article 8(1) that states break down stigma and positively educate their populations on issues relating to disability.²⁴ This legal duty is worth citing in full. States are charged:

- a. To raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;
- b. To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
- c. To promote awareness of the capabilities and contributions of persons with disabilities.

The responsibilities in article 8 have a direct bearing on all obligations arising under the CRPD, because each of the treaty's provisions must be read horizontally and holistically, including the non-discrimination and equality provisions (article 5).²⁵ Obviously connected duties relating to individual articles include equal access to health (article 25); provisions which guarantee the right to education (article 24) and to work (article 27); and the mandate for inclusion in the community (article 19). Put another way, countering the impact of stigma makes it vitally easier for people with psychosocial disabilities to seek care, attend school and university, pursue employment that is fair and dignified, and live where and with whom they wish.²⁶ Hence, numerous intersecting rationales support states alleviating stigma and discrimination, and restoring the dignity and fundamental freedoms of persons with psychosocial disabilities.

In domestic South African law, section 10 of the Mental Health Care Act prohibits discrimination on the basis of mental health status, but

21 Walker (n 20 above) 272.

22 CRPD 'List of ratifying states and regional integration organisations' <http://www.un.org/disabilities/convention/signature.shtml> (accessed 25 July 2017).

23 Sec 231 Constitution of the Republic of South Africa, 1996.

24 P Bartlett 'Stigma, human rights and the UN Convention on the Rights of Persons with Disabilities' in W Gaebel et al (eds) *The stigma of mental illness: End of the story?* (2017) 209-226.

25 MA Stein 'Disability human rights' (2007) 95 *California Law Review* 75.

26 JK Burns 'Mental health and inequity: A human rights approach to inequality, discrimination and mental disability' (2013) 8 *Health and Human Rights Journal* 19.

imposes no penalties for its violation. nor does it incorporate positive duties and, instead, focuses largely on issues of legal capacity and institutionalisation.²⁷ Nevertheless, these elements of mental health law have a substantial role to play in improving the quality of life of persons with psychosocial disabilities. Indeed, in *De Vos*,²⁸ the Constitutional Court of South Africa characterised provisions allowing for the imprisonment of people with psychosocial disabilities prior to trial in terms reminiscent of ‘socially-induced stress’,²⁹ namely, that the practice ‘reinforces the stigma and marginalisation that people [living with psychosocial disabilities] are subjected to on a routine basis’.³⁰ Arguably, the same is true of involuntary institutionalisation which, while the subject of some necessary debate,³¹ has the potential to be routinely abused as well as abusive, thereby causing great harm, including unnecessary stigmatisation, in the process.³²

Similarly, as demonstrated in *Purohit & Another v The Gambia*,³³ the sole disability-related decision rendered by the African Commission for Human and Peoples’ Rights (African Commission), respect for the freedom of movement and association of people with psychosocial disabilities constituted a central component of the right to be free from discrimination itself. The Commission recognised that the right to appeal involuntary detention was essential for the assurance of the dignity of persons with psychosocial disabilities, while also asserting that laws which inadequately protected the rights of these persons constituted a failure to recognise their special needs and, therefore, amounted to discrimination.³⁴

3.1 Incorporating a positive obligation

Purohit likewise elaborated on the need for positive measures to integrate persons with psychosocial disabilities into society. The African Commission required The Gambia to ensure appropriate steps for inclusivity through law and policy designed to address discrimination and, in the process, advance associated rights such as the right to ‘a decent life, as normal and full as possible’.³⁵ Trenchantly, *Purohit* asserted the value of the right to health and required that its realisation be advanced positively

27 Sec 10 Mental Health Care Act (n 7 above).

28 *De Vos NO v Minister of Justice and Constitutional Development* 2015 (9) BCLR 1026 (CC).

29 Nelson (n 13 above) 128.

30 *De Vos* (n 28 above) para 46.

31 MC Freeman et al ‘Reversing hard-won victories in the name of human rights: A critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities’ (2015) 2 *Lancet Psychiatry* 844-850.

32 JE Lord & MA Stein ‘Contingent participation and coercive care: Feminist and communitarian theories consider disability and legal capacity’ in B McSherry & I Freckleton (eds) *Coercive care: Law and policy* (2013) 31.

33 (2003) AHRLR 96 (ACHPR 2003).

34 *Purohit* (n 33 above) paras 53-57.

35 *Purohit* para 61.

without 'discrimination of any kind'.³⁶ The decision, therefore, underscores the need for disability to be de-stigmatised in all spheres if discrimination is to be fully alleviated at individual, community, institutional and social levels. It also implies a positive and active state duty to seek a means of promoting inclusivity, whether in advancing the right to health care or in seeking to ensure access to the full spectrum of rights.³⁷

Aside from the Mental Health Care Act, no other form of disability-related legislation currently exists in South Africa. PEPUDA places a positive obligation on the state to promote the right to equality, including non-discrimination, on the basis of disability. Section 25(1)(a) of PEPUDA requires the state to 'develop awareness of fundamental rights' through, among other means, public information campaigns. Therefore, a significant obligation exists in respect of the promotion of the right to equality in South Africa, including through awareness raising and information dissemination. Yet this provision, along with the entire chapter of PEPUDA that deals with the promotion of the right to equality, remains in abeyance awaiting the signature into law of the President of South Africa, a situation that has persisted for over 17 years.³⁸

It is worth noting that two recent policy instruments have demonstrated a commitment to a rights-based approach to psychosocial disability and have included stigma reduction as part of these schemes. These policies, which emanated from different departments, are the National Disability Rights Policy (also known as the White Paper on the Rights of Persons with Disabilities), championed by a Directorate of the Department of Social Development (formerly the Department of Women, Children and People with Disabilities), which was approved in December 2015;³⁹ and the National Mental Health Policy and Strategic Framework 2013-2020, which is a product of the National Department of Health.⁴⁰ These are certainly important steps forward in the advancement of the rights of persons with psychosocial disabilities. Yet, as explored in the next section, notwithstanding considerable commitments on paper, the actual implementation of stigma reduction and public education initiatives have been less forthcoming.

36 *Purohit* para 84.

37 *Purohit* paras 78-81.

38 South African Human Rights Commission *Equality Round Table Report* (2015).

39 Draft National Disability Rights Policy (n 5 above); Western Cape Association for Persons with Disabilities 'Disability rights: A huge step forward' <http://www.wcapd.org.za/uncategorized/disability-rights-a-huge-step-forward/> (accessed 25 July 2017).

40 Department of Health (n 6 above).

4 Failure to address stigma

In 2013, South Africa issued its first progress report on the state's compliance with the provisions of the CRPD. The report noted in relation to article 8 that, despite awareness regarding the rights of disabled persons occupying a place of prominence in the state agenda, 'weaknesses in co-ordination, implementation and monitoring and evaluation have largely detracted from its effectiveness and impact'.⁴¹ This is a grim self-indictment of the inability of the South African government to mobilise resources and political will to support the rights of persons with disabilities. Two years later, South Africa's first periodic country report to the Committee on the Rights of Persons with Disabilities (the treaty body tasked with oversight of the CRPD) outlined a handful of activities aimed exclusively at officials in government departments as evidence of progress towards meeting the objectives of article 8.⁴² Such an approach belies the fact that the CRPD requires a much broader and societal approach to raising awareness and reducing stigma, and demonstrates that the country is failing to meet these obligations.

That South Africa has made numerous commitments to the reduction of stigma on the basis of psychosocial disability is indeed noteworthy. Yet, the lack of sound implementation and appropriate resourcing for such initiatives is amply borne out by the meagre advances reported in the country's CRPD report. Among the challenges identified in meeting this need is the lack of available resources to ensure sound implementation. Research conducted in 2009 assessed that 'there are not currently resources available for education to reduce stigma'.⁴³ Six years later, Marais and Petersen examined the extent of the country's implementation of the NMHPF, and found that resource allocation remained a challenge. Also contributing to administrative malaise was a lack of political impetus:

The mental health policy framework does not provide sufficient guidance on how stigma should be addressed, with provincial and district level respondents not being aware of any specific anti-stigma programmes for mental health and variations between provinces in terms of prioritising addressing stigma.⁴⁴

41 Department of Women, Children and People with Disabilities, South Africa *Baseline country report to the United Nations on the implementation of the Convention on the Rights of Persons with Disabilities* (2013).

42 Department of Social Development *First periodic country report on the United Nations Convention on the Rights of Persons with Disabilities* (2015).

43 M van der Merwe 'Psychiatry in distress: How far has South Africa progressed in supporting mental health?' <http://www.dailymaverick.co.za/article/2015-07-15-psychiatry-in-distress-how-far-has-south-africa-progressed-in-supporting-mental-health/#.WCkejdUrLIW> (accessed 25 July 2017).

44 DL Marais & I Petersen 'Health system governance to support integrated mental health care in South Africa: Challenges and opportunities' (2015) 9 *International Journal of Mental Health Systems* 1-21.

The lack of political knowledge, will or co-ordination that these authors refer to as stumbling blocks translates directly into an absence of political impetus to destigmatise mental health, regardless of the formal legal obligations and policy commitments to do so. While the promulgation of both the NDRP and the NMFPH illustrates that there is nominal political will to ensure that the rights of people living with psychosocial disabilities are advanced, this has not translated into the actual implementation of stigma reduction activities. Put another way, 'mental health is a priority on paper but not in practice'.⁴⁵ This failure speaks to a broader neglect – and essentially stigmatisation of its own kind – of psychosocial disability as an area for legal, political and administrative action, as illustrated further below.

5 Realising the obligation to address stigma

Notwithstanding public political commitments by South Africa to ameliorate stigma arising from psychosocial disability, a considerable and glaring gap exists as far as implementation is concerned. Ultimately, weak rights enforcement is not isolated to stigma reduction since mental health more generally remains a neglected issue country-wide, remaining 'low on the public sector agenda'.⁴⁶ Experts thus point to the entrenched stigmatisation of psychosocial disability as a primary 'excuse for inaction',⁴⁷ and among 'the chief obstacles' to improving mental health care.⁴⁸

The marginalisation of mental health as a public health or human rights concern is well illustrated by the fact that less than 5 per cent of South Africa's health budget is expended on assisting people with mental health needs.⁴⁹ In comparison with countries such as Zambia and Uganda, where less than 1 per cent of national budgets are expended on mental health, this proportion seems relatively generous. Nonetheless, the figure illustrates a very telling point about an urgent need for parity if care provision is to match the burden of disease relating to mental health.⁵⁰ *Purohit* may be instructive in this regard as well, with the African Commission encouraging states parties to the African Charter on Human and Peoples' Rights (African Charter) 'to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the

45 Walker (n 20 above).

46 AA Herman et al 'The South African stress and health (SASH) study: Twelve-month and lifetime prevalence of common mental disorders' (2009) 99 *South African Medical Journal* 339.

47 United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration *Mental health: A report of the surgeon-general* (1999) 3.

48 S Sturgeon 'Stigma and marginalisation: Structural violence and the impact on mental health' (2012) 48 *Social Work* 58 61 (citing Sartorius).

49 H Jack et al 'Closing the mental health treatment gap in South Africa: A review of costs and cost-effectiveness' (2014) 7 *Global Health Action* 10.

50 Omar et al (n 19 above) 26-28.

right to health is fully realised in all its aspects without discrimination of any kind'.⁵¹ Commentators interpret this to mean that mental health should comprise a significant proportion of the health budget, and that the failure to do so constitutes discrimination against those affected by psychosocial disability.⁵²

Indeed, the under-prioritisation of mental health in South Africa is a pervasive problem, as evidenced by the lack of reliable data. This problem has more recently proven to be deadly. Between March and December 2016, 94 psychiatric patients died after having been removed from institutionalised care and placed in unlicensed community settings which were found by the South African health Ombud to be 'unstructured, unpredictable and sub-standard' in what came to be known as the Gauteng Mental Health Marathon Project (GMHMP).⁵³ These transfers occurred after subsidies for institutionalisation had been cancelled due to an apparent lack of funds⁵⁴ and because of 'selective interpretation' of the NMHPF⁵⁵ which, in an effort to comply with article 19's enshrinement of the right to live in the community, calls for a systematic process of de-institutionalisation.⁵⁶ Instead, what occurred was a 'chaotic' process of transferring patients to under-resourced facilities with untrained staff.⁵⁷ This is clearly contrary to the state's obligations in terms of the CRPD, and calls into question not only the commitment of the South African government to address stigma and foster awareness of mental health in society, but more pointedly the commitment to recognise and prioritise mental health needs altogether.

The next part considers some potential formal and institutional remedies that can have the effect of addressing what amount to gross failures on the part of the state to meet its obligations.

6 Addressing South Africa's failure to meet its commitments

The CRPD, PEPUDA, NDRP and NMHPF evidence South Africa's binding legal obligations for reducing stigma towards and promoting the rights of individuals with psychosocial disabilities. The state has also made various other commitments through which it has expressed its intention to

51 *Purohit* (n 33 above) para 84.

52 M Anyidoho 'The right to health for mental health patients: African Commission' (2004) 1 *Housing and ESC Rights Quarterly* 4.

53 Office of the Health Ombud *The report into the circumstances surrounding the deaths of mentally-ill patients* (2017).

54 M Raborife 'Too many unanswered questions about Esidemeni 37' <http://www.news24.com/SouthAfrica/News/too-many-unanswered-questions-about-esidimeni-37-20161028> (accessed 25 July 2017).

55 Office of the Health Ombud (n 53 above) 1.

56 As above.

57 Office of the Health Ombud (n 53 above) 2.

meet these obligations. Therefore, it would be incumbent upon the South African government to consider the numerous challenges already identified and how these may be engaged with and alleviated. The following is an exploration of the mechanisms through which the advancement of public education and reduction of stigma relating to psychosocial disability might be accomplished.

6.1 Emphasising mental health in policy and budgeting

Although we emphasise the significance of stigma reduction in relation to psychosocial disability, a broader issue that should also be addressed is the neglect of mental health as a public health concern. These challenges form part of the same larger and more systemic problem,⁵⁸ with social attitudes and public health policies coalescing to marginalise persons with psychosocial disabilities in numerous intersecting ways.⁵⁹ For instance, stigma obstructs the rehabilitation of individuals with psychosocial disabilities through de-prioritisation or a lack of co-ordination. Half of all African countries remain without a mental health policy, signalling that psychosocial impairment is a marginalised area of concern across the continent.⁶⁰ Similarly, the formulation of policies that subsequently remain unimplemented represents another form of de-prioritisation. It should, therefore, be noted that, while addressing stigma in public arenas requires one form of intervention, the prioritisation of mental health can in itself serve to alleviate stigma and, therefore, must be considered in the policy process alongside awareness-raising initiatives.

Emphasising mental health as an area of policy priority will require questioning the 'lack of ownership' identified by scholars⁶¹ and ensuring that this is addressed through the clear designation of officials whose mandate is the promotion of mental health in their respective policy agendas. This is particularly important for South Africa in the Departments of Health, Finance and Social Development, where issues of resourcing and budget constraints have been identified as impediments. Ensuring that mental health is advocated for within these institutional structures can significantly alter this situation, with a stronger emphasis being placed on the needs of those with psychosocial disabilities as a matter of regularity in all aspects of governance.

The continued neglect of mental health as a concern evidences stigma across institutions, and can be alleviated through the appointment of a task

58 United States Department of Health and Human Services (n 47 above); Omar et al (n 19 above); Walker (n 20 above).

59 PW Corrigan et al 'Structural levels of mental illness stigma and discrimination' (2004) 30 *Schizophrenia Bulletin* 481-491.

60 J Ssebunya et al 'Developing a national mental health policy: A case study from Uganda' (2012) 9 *PLoS Med* 10.

61 Flisher et al (n 18 above).

force advocating its prioritisation in government departments while centrally co-ordinating these efforts. This can have the effect of ensuring that mental health is given the necessary priority and also that psychosocial disability is made visible – is understood and demystified. Visibility, in turn, can have a significant impact in improving awareness,⁶² whether at the level of local communities and health establishments or, indeed, nationally, including amongst law makers themselves.

Inter-departmental co-ordination and the dovetailing of activities undertaken by the Departments of Health, Finance and Social Development can significantly advance what amounts to a common goal across ministries. Recognising that these departments place a significant emphasis on the advancement of the rights of persons with psychosocial disabilities, it seems reasonable to suggest that an inter-ministerial mechanism be implemented to harmonise unenforced schemes currently contained in NDRP and NMHPF. Considering that one of the barriers to addressing stigma has been identified as the insufficient allocation of resources,⁶³ avoiding duplication and resource pooling can significantly aid in the achievement of outcomes that advance both public health aspirations and disability rights objectives. Such a mechanism, therefore, requires high-level engagement in its composition. Clearly, the participation and input of other ministries, such as the Department of Justice and Correctional Services, the Department of Basic Education and others, is likewise needed.

6.1.1 Disability rights legislation concordant with the CRPD

Cabinet approval of the NDRP signals a significant shift in the desire to see the rights of persons with psychosocial disabilities realised. Still, the passage from White Paper status to the formulation of a Bill, and eventually a National Disability Rights Act, has significant advantages. Flynn, for example, notes that an impediment to the advancement of the rights of persons with disabilities in South Africa through policy has been the lack of enforcement and accountability mechanisms, which may be legislated for.⁶⁴ Similarly, Byrnes suggests that the provisions of the CRPD require specific legislation in order to meet the need for harmonisation of national laws with the Convention because of the numerous areas covered, ranging from issues of legal capacity to child protection and the prohibition of torture. As such, he suggests, the mere inclusion of a non-discrimination

62 R Warner 'Fields of intervention' in Gaebel et al (n 24 above) 435-450.

63 Herman et al (n 46 above).

64 E Flynn *From rhetoric to action: Implementing the UN Convention on the Rights of Persons with Disabilities* (2011).

provision or 'reading in' of disability into existing instruments, such as the Mental Health Care Act, is not likely to be sufficient.⁶⁵ Instead, an approach which addresses all disabilities in a manner that recognises the scale and the range of challenges faced would be preferable.

With regard to stigma reduction, an important advantage of legislation is the legal obligation placed on the state to promote the rights of persons with psychosocial disabilities. This is particularly important because of the fact that the promotional mandate incorporated in PEPUDA remains inactive. Such apathy has contributed to a lack of accountability on the part of the South African government to rigorously and diligently undertake initiatives aimed at the promotion of the right to equality.⁶⁶ While it is clear that there may be some need for greater elucidation of the relationship between proposed legislation and PEPUDA, there has been no indication that the latter will reach the stage of implementation. Further, the recent introduction of seemingly parallel pieces of legislation, such as the Women's Empowerment and Gender Equality Bill,⁶⁷ suggests that the political will to see Chapter 5 reach fruition may be lacking.

However, perhaps more importantly, articles 4(1)(a)-(e) of the CRPD recognises the need for harmonisation and appropriate auditing of existing legislative mechanisms in order to identify what gaps exist in the current legal framework and how the state may go about rectifying them.⁶⁸ The Department of Social Development has already embarked upon such a review, although the outcome is as yet unclear.⁶⁹ A comprehensive process that considers what specific needs exist and how legislation can best aid in the advancement of fundamental rights is a necessary first step. However, it must be followed by the development of legislation which places a specific emphasis on the obligation of the state to address stigma on the basis of psychosocial disability through, among other means, rights promotion, awareness raising and inter-departmental co-ordination.

Few states explicitly set forth measures to be undertaken to reduce stigma and promote the rights of persons with disabilities in their domestic legislation. Malaysia's Persons with Disabilities Act of 2008, and Bangladesh's Rights and Protection of Persons with Disabilities Act of 2013, however, provide useful guidance in respect of addressing stigma

65 A Byrnes 'Disability discrimination law and the Asian Pacific region. Paper for the UNESCAP, social development division for the Asia-Pacific region' http://www.unescapsdd.org/files/documents/PUB_CRPD-Paper-III-Andrew-20110121.pdf (accessed 25 July 2017).

66 L Vetten 'Submission to the Portfolio Committee on women, children and people with disabilities on the Women Empowerment and Gender Equality Bill [B50-2013]' <http://pmg-assets.s3-website-eu-west-1.amazonaws.com/submissionwegebillparliament.pdf> (accessed 25 July 2017).

67 As above.

68 Byrnes (n 65 above).

69 Personal communication with official from the Department of Social Development, 26 November 2016.

through legislative mechanisms. Each of these laws uses national and district co-ordination committees to advise relevant government structures and to engage in awareness raising and information dissemination.⁷⁰ Such a model provides avenues for participation and oversight by persons with disabilities, while maintaining governmental implementation and resourcing obligations.

Even so, further concretising legislation can significantly enhance impact through, for example, the establishment of a stigma-reduction working group made up of public education experts who can report back on an annual basis to the Parliamentary Portfolio Committee on Women, Children and People with Disabilities. Such an approach has an added advantage of creating permanent structures with the dedicated purpose of advancing promotional objectives. Nor must such an approach be limited to the proposed legislation. It could draw upon the work of the NMHPF, to name an example, in ensuring that CRPD-guided and informed work is accurately motivated, implemented and monitored. Legislation and policy can be periodically evaluated for concordance with the CRPD, utilising a human rights assessment to examine mental health frameworks in Africa. Because currently no country on the continent (or indeed, the globe) is as yet fully compliant with the provisions of the CRPD, continuous examination can significantly aid in moving progress on this challenge.⁷¹

6.2 Research and capacity building

Stigma reduction is a relatively well-researched topic in the developed world, with numerous systematic studies illustrating that improving education, reducing social distance and intelligently targeting key stakeholders (such as healthcare workers) can have significant benefits.⁷² Yet, similar research in the developing world has only recently emerged.⁷³

70 Malaysia Persons with Disabilities Act, 2008; Bangladesh Rights and Protection of Persons with Disabilities Act, 2013.

71 N Drew et al 'Mental health law in Africa: Analysis from a human rights perspective' (2013) 12 *Journal of Public Mental Health* 10.

72 S Evans-Lacko et al 'The state of the art in European research on reducing social exclusion and stigma related to mental health: A systematic mapping of the literature' (2014) 29 *European Psychiatry* 382-389; D McDaid 'Countering the stigmatisation and discrimination of people with mental health problems in Europe' http://ec.europa.eu/health/archive/ph_determinants/life_style/mental/docs/stigma_paper_en.pdf (accessed 25 July 2017) 12-14.

73 A Alem et al 'Community-based mental health care in Africa: Mental health workers' views' (2008) 7 *World Psychiatry* 54; N Monteiro et al 'Policy perspectives and attitudes towards mental health treatment in rural Senegal' (2014) 8 *International Journal of Mental Health Systems* 9; J Crabb et al 'Attitudes towards mental illness in Malawi: A cross-sectional survey' (2012) 12 *BMC Public Health* 541; A Kapungwe et al 'Attitudes of primary health care providers towards people with mental illness: Evidence from two districts in Zambia' (2011) 14 *African Journal of Psychiatry* 290.

The relative successes of the Time to Change campaign in the United Kingdom⁷⁴ and Like Minds, Like Mine in New Zealand⁷⁵ provide important guidance in respect of the deconstruction of negative and false attributions. They also point out the need for private sector co-operation and the use of a variety of avenues for stigma reduction, including creative arts productions and the introduction of 'peer workers'.⁷⁶

Nonetheless, importing programmes from the global north wholesale without an acknowledgment of resource differentials and the specific contextual factors that lead to stigma and discrimination in the African context is not an appropriate solution. More empirically-grounded research is needed on the manner in which stigma can be combated, particularly in South Africa, where historically there have been a number of short-lived interventions that were not replicated or evaluated for their efficacy.⁷⁷ Similarly, awareness of mental health issues in many South African communities remains poor and requires targeted intervention aimed at literacy.⁷⁸ International models, many of which have been long-lasting and have undergone evaluation for their efficacy, can certainly be of significant utility,⁷⁹ but this must necessarily be accompanied by localised investigation.

Key obstacles to addressing public attitudes are the combined lack of evidence-based methods aimed at mitigating negative perceptions; an absence of capacity to carry out such initiatives once devised; and adequate policy co-ordination aimed at implementation.⁸⁰ The South African government, therefore, must accurately capture the capacity needs associated with goals contained in the NDRP and NMHPF if these programmes are to bear fruit. Addressing skills shortages as well as capital needs is likely to be an important consideration in the translation of political rhetoric into changes in actual lived experiences. It also is important to note that a significant amount of expertise already exists in the form of South Africa's DPOs and their umbrella body, the African Disability Forum, comprising DPOs from across the continent.⁸¹ The state, therefore, should ensure an approach that makes use of the expertise housed within these organisations to guide appropriate research functions and to inform the design and rollout of stigma-reducing activities.

74 C Henderson et al 'The time to change programme to reduce stigma and discrimination and its wider context' in Gaebel et al (n 24 above) 339-356.

75 R Cunningham et al 'Like minds, like mine: Seventeen years of countering stigma and discrimination against people with experience of mental distress' in Gaebel et al (n 24 above) 263-288.

76 Henderson et al (n 74 above); Cunningham et al (n 75 above).

77 Kakuma et al (n 17 above) 118-120.

78 Egbe et al (n 16 above).

79 H Stuart 'What has proven effective in anti-stigma programming?' in Gaebel et al (n 24 above) 497-514.

80 Marais & Petersen (n 37 above).

81 International Disability Alliance 'African Disability Forum' (2017) <http://www.internationaldisabilityalliance.org/african-disability-forum> (accessed 25 July 2017).

South Africa's State Institutions Supporting Democracy – commonly referred to as Chapter 9s, and including the SAHRC and the Commission for the Protection and Promotion of Cultural, Religious and Linguistic Communities – also have a particularly important role to play in the realisation of the rights of persons with psychosocial disabilities. In terms of the Constitution and its enabling legislation, the SAHRC bears a clear mandate to promote the advancement of human rights, including those related to the community of persons with disabilities.⁸² Therefore, it is incumbent upon the government of South Africa and the SAHRC itself to ensure that this promotional mandate is fully carried out in respect of the rights of persons with psychosocial disabilities as well.⁸³

6.3 A (South) African perspective on stigma

As noted above, a considerable need exists for further investigation into stigma on the basis of psychosocial disability in South Africa and on the continent. This, in turn, requires that interventions, policies and laws must recognise the specific context in which they operate and seek to ensure relevance.⁸⁴ In the context of evolving mental health law, policy and practice, 'Africa presents particular challenges and opportunities'.⁸⁵ Among the unique structural factors experienced by the region are the significant shortage of specialised mental health professionals and the fact that, with the possible exception of South Africa, the institutionalisation of persons with psychosocial disabilities has not been a common occurrence.

In 2014, persons with psychosocial disabilities, non-governmental organisations (NGOs), policy makers, academics, research funders and service providers from Eastern, Western, Southern and Northern Africa and further afield, adopted the Declaration on Mental Health in Africa (Africa Declaration), a framework that broadly defines an agenda for serving the needs and advancing the rights of persons with psychosocial disabilities throughout the continent.⁸⁶ Sub-titled 'Moving to implementation', the pronouncement is worth quoting at length:

82 Sec 181 South African Constitution; South African Human Rights Commission Act 40 of 2013.

83 It is worth noting that an oversight function exists in relation to the SAHRC, whereby annual reporting to the Parliamentary Portfolio Committee on Justice and Correctional Services is required. Therefore, there is ample scope for ensuring that the SAHRC meets its promotional obligations and for holding the institution to account. To date, this has not been the case.

84 MA Stein & JE Lord 'Forging effective international agreements: Lessons from the UN Convention on the Rights of Persons with Disabilities' in J Heymann & A Cassola (eds) *Making equal rights real: Taking effective action to overcome global challenges* (2012) 27.

85 Bartlett (n 24 above) 21.

86 AS Daar et al 'Declaration on mental health in Africa: Moving to implementation' (2014) 7 *Global Health Action* 24589.

In communities in which persons with psychosocial disabilities live, and even in the health care system, the affected persons, their families, and caregivers are frequently stigmatised and experience social exclusion and discrimination; and it is often assumed that little can be done to address their circumstances. However, a growing body of scientific evidence shows that much can be done for treatment, at moderate additional costs, and with significant economic benefits to countries, while at the same time reducing suffering and improving, and often saving, the lives of those who are affected.⁸⁷

The Africa Declaration goes on to state that although challenging, the African health system may also present an opportunity for task, resource and knowledge sharing.⁸⁸ Regional and national efforts aimed at addressing stigma on the basis of psychosocial disability and advancing the rights of disabled persons generally, therefore, will need to recognise the specific challenges and opportunities that their context presents.

Meanwhile, in February 2016, the African Commission adopted the Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (African Draft Disability Protocol).⁸⁹ This instrument adds renewed impetus to efforts to ensure the mainstreaming of the rights of persons with disabilities into regional frameworks. It contains a specific non-discrimination provision, including what might be construed as a promotional mandate. Article 3, paragraph 3 of the African Draft Disability Protocol requires states parties to 'take steps to ensure that specific measures, as appropriate, are provided to persons with disabilities in order to promote equality and eliminate discrimination'. Yet, the article does not actually require states parties to advance rights through educative mechanisms, thus not fully recognising the need for societal shifts rather than merely the introduction of 'specific measures'. Therefore, it remains to be seen whether any explicit emphasis on the African context and the particular challenges faced by Africans with disabilities will be incorporated into the instrument. First published for comment in 2014,⁹⁰ the Draft Disability Protocol has not yet been finalised and there have been criticisms regarding its lack of contextual relevance.⁹¹ The instrument has also been critiqued for its under-emphasis on psychosocial disabilities, a state which is hoped will be rectified as the final version nears completion, adoption and, most importantly, resource allocation.⁹²

87 As above.

88 As above.

89 African Commission on Human and Peoples' Rights 'Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa' http://www.achpr.org/files/news/2016/04/d216/disability_protocol.pdf (accessed 25 July 2017).

90 L. Nkatha Murungi & E. Durojaye 'The sexual and reproductive health rights of women with disabilities in Africa: Linkages between the CRPD and the African Women's Protocol' (2015) 3 *African Disability Rights Yearbook* 3-30.

91 Personal communication with official from the Department of Social Development, 4 February 2017.

92 As above.

The marginalisation of psychosocial disability within continent-wide initiatives is also instructive for South Africa, where context-specific narratives and culturally-unique taboos likewise prevail. Despite the integration of a rights-based lens in the NDRP and NMHPF, an emphasis on specific sociocultural barriers to accessing care, and a focus on community and family-level stigma are not clearly captured. This is despite the fact that cultural, racial, gendered, ethnic, religious and traditional taboos play a significant part in the stigmatising process in South Africa.⁹³ Both societal stigma and self-stigma are informed by the context in which they occur, and will require interventions that reflect these contextual concerns if they are to be effective.⁹⁴ It, therefore, is imperative that a significant component of the research elaborated upon above considers the need for culturally-relevant methods of integrating persons with psychosocial disabilities and pay due mind to the specific opportunities characteristic of the African and South African context.⁹⁵ Civil society and DPOs – including the South African Federation for Mental Health, MindFreedom South Africa and the Pan-African Network of People with Psychosocial Disabilities – will have a central role to play in this process, bringing with them knowledge of conditions that government may very well not be exposed to. Their contributions, which in any case are required by article 4(3) of the CRPD, should be valued and encouraged.⁹⁶

6.4 Independent monitoring of implementation

A key innovation of the CRPD is its commitment to accountability and effective monitoring of outcomes through the inclusion of a provision in article 33(2) which requires the designation or strengthening of an independent monitoring mechanism (IMM).⁹⁷ The IMM plays a significant role in ensuring that the rights of persons with disabilities are advanced by functioning as a comprehensive evaluator of laws and policies across government departments, and by assessing the societal impact of these schemes.⁹⁸ A considerable role thus exists for IMMs in seeking to ensure that the provisions of the CRPD are adequately and diligently implemented. Article 33(3) further and explicitly requires that persons with

93 CO Egbe 'Experiences and effects of psychiatric stigma: Monologues of the stigmatisers and the stigmatised in an African setting' (2015) 10 *International Journal of Qualitative Studies on Health and Well-Being* 27954.

94 As above.

95 Bartlett (n 24 above) 21.

96 It is noted, as an illustrative example, that advocacy and reporting on the GMHMP were due to efforts by the Pan-African Network of People with Psychosocial Disabilities after government, courts, parliament, and the SAHRC declined to act.

97 MA Stein & JE Lord 'Monitoring the Committee on the Rights of Persons with Disabilities: Innovations, lost opportunities, and future potential' (2010) 31 *Human Rights Quarterly* 689.

98 G de Beco 'Article 33(2) of the UN Convention on the Rights of Persons with Disabilities: Another role for national human rights institutions?' (2011) 29 *Netherlands Quarterly of Human Rights* 87.

disabilities are equal participants in the monitoring process and that the state ensures the input of civil society and DPOs in such a practice. While South Africa has committed to the implementation of article 33 in an effort to promote transparency and accountability, the formal designation or strengthening of an IMM has not yet materialised.⁹⁹ This amounts to a failure on the part of the state to meet its obligations in terms of the CRPD and requires urgent rectification if South Africa is to be said to be meeting its responsibilities.¹⁰⁰

With regard to stigma reduction and the broader prioritisation of mental health, the IMM can play a significant role, not least in examining barriers to the implementation of existing policy objectives and lacunae in law which continue to result in the marginalisation of persons with disabilities. Monitoring the rollout of awareness-raising campaigns, providing training to DPOs and self-advocates, and ensuring regular and accountable meetings of the task force proposed above could also be important functions for the IMM. This, of course, requires substantial commitment on the part of the state to ensure adequate resourcing and capacitation of the mechanism, whether it takes the form of being housed in an existing institution such as the SAHRC (as is the case with countries such as Germany and Denmark), or whether it results in a broader conglomeration of bodies under an umbrella mechanism co-ordinated as an IMM (akin to Austria's Independent Monitoring Committee).¹⁰¹ In either instance, the significant upscaling of resources and technical expertise is needed for the IMM to be fit for purpose.

While these interventions are not the only actions needed to ensure that stigma relating to psychosocial disability is addressed in South Africa, they will go a long way in domesticating the provisions of international law into the country's legal landscape and, in the process, ensuring that mental health receives the visibility necessary to be addressed comprehensively and consistently. The provisions of the CRPD suggest that these interventions are the minimum threshold required for South Africa to meet its obligations, rather than being the 'ceiling' for which the state must strive, meaning that the emphasis must also be placed on an approach that is sustainable and that will be augmented as needed.

99 Personal communication with official from the South African Human Rights Commission, 27 November 2016.

100 Because the SAHRC Act of 2013 incorporates a mandate to monitor South Africa's compliance with international instruments, the argument was made that there was not a need for formal designation but that there was still a need for strengthening as per the CRPD.

101 UNHCHR *Study on the implementation of article 33 of the UN Convention on the Rights of Persons with Disabilities in Europe* (2013).

7 Conclusion

A study of the effects of stigma and concomitant discrimination relating to psychosocial disability in South Africa noted two major effects on those affected, namely, 'being unable to lead normal lives and a worsening state of health of the service user'.¹⁰² These outcomes violate human rights protections, are personally harmful, unnecessary and deeply troubling. They represent a failure to integrate people with psychosocial disabilities into broader South African society, and a clear failure to adequately protect persons with disabilities from discrimination and marginalisation as required by the CRPD.¹⁰³ The South African government is aware of this situation, and appears at least nominally committed to its alleviation. This is significant, and the development of both the NDRP and NMHPF is an important development. Nevertheless, it is through implementation that their progress will be judged.

The Africa Declaration notes the 'urgent need to address stigma, social exclusion and discrimination' as crucial for contributing to quality of life improvements for persons with psychosocial disabilities; further, that the broad community of stakeholders 'must play a major role in bringing about these positive changes'.¹⁰⁴ This is indeed a very significant recognition in its own right. Crucially, however, it is accompanied by an important acknowledgment of the 'urgent need for political vision, commitment, and leadership at the highest level to encourage national dialogue on mental health'.¹⁰⁵ Governments should take the lead, while working with and supporting an inclusive, cross-sectoral, multi-stakeholder approach that can effectively engage with and remedy conditions and social circumstances that enable or reinforce stigma and discrimination against persons with psychosocial disabilities.

We echo the Africa Declaration's call for commitment and action. This requires not only that government enact sound policies, following on the lead of the NDRP and NMHPF, but also strong and accountable institutions and adequately-resourced bureaucracies to carry them out. In the wake of the GMHMP, South Africa must commit never again to fail those living with psychosocial disabilities. Addressing stigma is one step it can and should take without delay.

102 Egbe et al (n 16 above) 6.

103 Arts 4(1)(a)-(e)CRPD.

104 Daar et al (n 86 above).

105 As above.