

# **A Critical Evaluation of the Human Rights of Involuntary Mental Health Care Users**

**by**

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## **Abstract**

The regulation of mental health care has its roots in Roman law. The history of the regulation of mental health care may be described as belonging in the darker pages of history. Mental health laws in South Africa have moved from being centred around the detention of mentally ill persons to ultimately being centred on the protection of their rights. The Mental Health Care Act 17 of 2002 read with the Bill of Rights is the main legislation regulating mental health care in South Africa. The study critically evaluates the rights provided to involuntary mental health care users in terms of the Mental Health Care Act 17 of 2002 and the Bill of Rights in order to determine compliance with International Human Rights standard as provided in international instruments.

The study finds that the protection of rights of involuntary mental health care users does conform to the international human rights standards. The study also provides a comparison of the South African protection of rights of involuntary users to the United Kingdom mental health care regulation in order to determine whether there are any lessons to be learnt. The study recommends introduction of reforms in respect of institutions created to protect the rights of mentally ill persons in terms of the Mental Health Care Act 17 of 2002.

## Declaration

I declare that this dissertation hereby submitted to the Faculty of Law at the Mafikeng Campus of the North West University is my work and that all references have been acknowledged.

Student       Moffat Maitele Ndou

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## **List of Abbreviations**

BCLR	Butterworth Constitutional Law Reports
CC	Constitutional Court
CCMA	Commission for Conciliation, Mediation and Arbitration
CRPD	Convention on the Rights of Persons with Disabilities
EU	European Union
IJLP	International Journal of Law and Psychiatry
LLLA	The Lunacy and Leprosy Laws Amendment Act
MDA	Mental Disorder Act
MEC	Member of the Executive Council
MHA	Mental Health Act
MHCA	Mental Health Care Act
NLJ	New Law Journal
PAJA	Promotion of Administrative Justice Act
PEJ	Potchefstroom Electronic Journal
SA	South African Law Reports
SAJHR	South African Journal on Human Rights
SAJP	South African Journal of Psychiatry
SALJ	South African Law Journal
SAMJ	South African Medical Journal
UK	United Kingdom

UKMHA	United Kingdom Mental Health Act
UKTCEA	United Kingdom Tribunal, Courts and Enforcements Act
ZAKZHC	KwaZulu-Natal High Court
ZAWCHC	Western Cape High Court

## **Table of Cases**

### **South Africa**

1. *Chirwa v Transnet Limited and Others* 2008 (4) SA 367 (CC)
2. *De Lange v Smith NO* 1998(3) SA 785 (CC)
3. *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* (4502/10, 5825/14) [2014] ZAWCHC 135 (5 September 2014)
4. *Ex parte: G and SIXTY-SIX OTHERS* [2008] ZAKZHC 37
5. *Harksen v Lane NO* 1997 11 BCLR 1489 (CC)
6. *Kaunda and Others v President of the RSA and Others* (2) 2004 (10) BCLR 1009 (CC)
7. *Minister of Finance v Van Heerden* 2004 (6) 121 (CC)
8. *Penrice v Dickinson* 1945 A.D 6
9. *Rutland v Engelbrecht* 1957 (2) SA 338 (A)
10. *S V Dodo* 2001 (3) SA 382 (CC)
11. *S v Makwanyane* 1995 (3) SA 391 (CC)
12. *S v Petane* 1988 (3) SA 51 (C)
13. *S v Rudman* 1989 (3) SA 368 (E)
14. *S v Williams* 1995 (2) SACR 251 (CC)

### **United Kingdom**

1. *Pickering v Liverpool Daily Post and Echo Newspapers plc* 1990 1 ALL ER 335 (CA)
2. *Pickering v Liverpool Daily Post and Echo Newspapers plc* 1991 1 ALL ER 622 (HL)

3. *Regina v East London and the City of Mental Health NHS Trust and another (Respondents) ex Parte con Brandenburg (aka Hanley) (FC) (Appellant)* [2003] UKHL 58
4. *T & Ors v Mental Health Review Tribunal & Anor* [2002] EWHC 247 (Admin)

### **United States of America**

*Folartiga v Pena-Irala* 630 F.2d 876; 1980 U.S. App. LEXIS 16111

### **International Court of Justice**

1. *Legal Consequences for States of the continued Presence of South Africa in Namibia (South West Africa) notwithstanding Security Council Resolution 276* (1970) 171 ICJ Reports 16
2. *Nicaragua v USA* 1986 ICJ Reports 14
3. *North Sea Continental Shelf Cases* 2002 ICJ Reports 3

### **The African Commission**

*Purohit and Moore v Gambia* Communication No. 241/2001, Sixteenth Activity report 2002-2003, Annex VI

## **Table of Statutes**

### **South Africa**

1. Constitution of the Republic of South Africa, 1996
2. Mental Disorders Act 38 of 1916
3. Mental Health Act 18 of 1973
4. Mental Health Care Act 17 of 2002
5. The Legal Aid Act 22 of 1969

### **United Kingdom**

1. Tribunals, Courts and Enforcement Act 2007
2. United Kingdom Mental Capacity Act of 2005
3. United Kingdom Mental Health Act of 2007
4. United Kingdom Mental Health Care 1983

## **List of International Instruments**

1. Committee on the Rights of Persons with Disabilities Communication No. 1/2010, in which the committee had to decide whether there was any violation of the CRPD in respect of access to ATMs by persons with disabilities in Hungary.
2. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
3. Convention on the Elimination of all Forms of Discrimination against Women (1979)
4. Convention on the Rights of Persons with Disabilities (2007)
5. Convention on the Rights of Persons with Disabilities and the Optional Protocol (2006)
6. Convention on the Rights of the Child (1989)
7. International Convention on the Elimination of all Forms of Racial Discrimination (1966)
8. International Covenant on Civil and Political Rights (1966)
9. Second Optional Protocol and the International Covenant on Economic, Social and Cultural Rights (2008)
10. The Compendium of Key Human Rights Documents of the African Union (2005)
11. The Convention on the Rights of Persons with Disabilities (CRPD) (2007)
12. The Convention relating to the Status of Refugees (1951)
13. The United Nations Principles for the Protection of Persons with Mental Illness and for the improvement of Mental Health Care (1991)
14. United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993)
15. United Nations World Programme of Action concerning Disabled Persons (1983)

## 16. World Health Organization Mental Health Care Law: Ten Basic Principles (1996)

## Chapter 1: Introduction

### 1.1 Introduction

The regulation of mental health care has its roots in Roman law.<sup>1</sup> The history of regulation of mental health care is correctly described by Kruger as belonging in the darker pages of history.<sup>2</sup> In December 1908, Dr WJ Dodds, the Inspector of Lunatics Asylum at the Cape colony reported a large number of deaths among mentally ill patients detained at Robben Island lunatic asylum and the appalling conditions in which mentally ill patients were detained.<sup>3</sup> This serves as evidence of the appalling conditions in which mentally ill person were subjected to. Kruger<sup>4</sup> correctly summarises the history of mental health laws in South Africa as moving from being centred on the detention of mentally ill persons to ultimately being centered on their treatment.

The introduction of the Constitution of the Republic of South Africa<sup>5</sup> (the Constitution) and the Mental Health Care Act (MHCA)<sup>6</sup> completes the development of mental health laws in South Africa. With this introduction mental health laws moved from being centred on detention; to being centred on treatment and the protection of rights of mentally ill patients. A regulation of mental health care can be easily divided into three periods, namely, the pre-union era<sup>7</sup>, post union era<sup>8</sup> and the constitutional era.<sup>9</sup> The coming into force of the Constitution in 1996 meant that the provisions of any legislation had to conform to the provisions of the Bill of Rights<sup>10</sup> and International Law.<sup>11</sup>

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<sup>1</sup> Kruger *A Mental health law in South Africa* 1980 (Butterworth, Durban) at 1.

<sup>2</sup> *Ibid.*

<sup>3</sup> Lunacy in Cape Colony <http://www.jstor.org/stable/25280258> (accessed on 16 December 2014).

<sup>4</sup> Kruger *op cit* (n 1) at 1-28.

<sup>5</sup> 1996.

<sup>6</sup> 17 of 2002.

<sup>7</sup> This refers to an era in which every pre-union state had its own laws regarding the provision of mental health care and more emphasis was placed on protecting members of the community rather than treating patients.

<sup>8</sup> This refers to an era in which comprehensive statutes regulating mental health care in South Africa was first promulgated and the emphasis of these statutes were on the treatment of the patients, but little or no emphasis was placed on protecting the patients human rights.

<sup>9</sup> This refers to an era in which the statutes regulating mental health care in South Africa had to conform to the provision of the Bill of Rights and International Law.

<sup>10</sup> The Constitution is the Supreme law of the Republic of South Africa and every law must not be contrary to the provisions of the Bill of Rights. See s 2 of the Constitution of the Republic of South Africa, 1996.

<sup>11</sup> S 39(1) of the Constitution of the Republic of South Africa, 1996.

The Bill of Rights in the Constitution sets out rights and values to which South Africans subscribes to.<sup>12</sup> The Constitution provides that everyone has the right to have access to health care services.<sup>13</sup> This includes the right of access to mental health care services. The MHCA is the key statute dealing with the care, treatment and rehabilitation services for persons with mental illness or severe and profound intellectual disabilities.<sup>14</sup>

## 1.2 Background to the study

The first legislation in South Africa that comprehensively regulated mental health care was the Mental Disorders Act (MDA),<sup>15</sup> which came into operation on 1 November 1916. Prior to the MDA, each pre-union state<sup>16</sup> had its own laws relating to mental disorders.<sup>17</sup> These pre-union laws were repealed by the MDA.<sup>18</sup> The MDA remained in force until 27 March 1975, when the Mental Health Act<sup>19</sup> (MHA), came into operation. The MHA was repealed by the MHCA.<sup>20</sup>

The introduction of the MHCA was necessitated by the fact that the laws<sup>21</sup> then did not give effect to the rights provided in the Bill of Rights.<sup>22</sup> The reform was necessary in order to bring the standard of regulation in conformity with the international norms and standards.<sup>23</sup> The MHCA brought, *inter alia*, the following changes to mental health care regulation in South Africa:<sup>24</sup>

- The introduction of the Mental Health Review Board

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<sup>12</sup> Preamble to the Constitution of the Republic of South Africa, 1996.

<sup>13</sup> S 27 of the Constitution of the Republic of South Africa, 1996.

<sup>14</sup> Preamble to the Mental Health Care Act 17 of 2002.

<sup>15</sup> 38 of 1916.

<sup>16</sup> Pre-union state refers to the states that existed before South Africa became a Union (South Africa became a Union in 1910). The mental health laws of the following pre-union states that will be discussed in this study: the Cape Colony, Transvaal, Orange Free State and Natal.

<sup>17</sup> Section 1 of the Lunacy and Leprosy Laws Amendment Act 14 of 1914.

<sup>18</sup> The pre-union laws were first recognised by the Lunacy and Leprosy Laws Amendment Act 14 of 1914 and the later repealed by the Mental Disorder Act 38 of 1916. The Lunacy Act 1 of 1897 (in the Cape Colony), Proclamation 36 of 1902 (in Transvaal), Law 8 of 1891 (in Natal) and Ordinance 13 of 1906 (in Orange Free State).

<sup>19</sup> 18 of 1973.

<sup>20</sup> 17 of 2002.

<sup>21</sup> 18 of 1973.

<sup>22</sup> Allan A & Allan M: The right of mentally ill patients in South Africa to refuse treatment *SALJ* (1997) 578 at 578.

<sup>23</sup> *Ibid.*

<sup>24</sup> Freeman M: The new mental health legislation in South Africa- principles and practicalities: A view from the Department of Health 2002 *SAPR* (August) 4 at 5-7.

Each province of the Republic of South Africa must have at least one Mental Health Review Board (the Review Board).<sup>25</sup> A Review Board may be established for a single health establishment, a cluster of health establishments or all health establishments providing mental health care services in that province.<sup>26</sup> The Review Boards are accurately described, in *ex parte: G and Sixty-Six Others*,<sup>27</sup> as a new innovation aimed at ensuring that the cases of mental health care users are considered by an independent body which makes vital decisions in regard to the user's future.

- Introduction of the 72 hour treatment and assessment period

In terms of section 34 of the MHCA,<sup>28</sup> an inpatient involuntary user's physical and mental health status is assessed over a period of 72 hours to consider whether the involuntary services must be continued and, if so, whether services should be provided on an outpatient or inpatient basis.<sup>29</sup> Only if the head of the health establishment decides that further involuntary services on an inpatient basis is warranted, will the involuntary user be admitted to a mental health establishment until the board makes its decision.<sup>30</sup>

- Involuntary outpatients care

If the head of the health establishment is of the opinion that the mental health status of the user warrants further involuntary services on an outpatient basis, the head must discharge the user subject to the prescribed conditions or procedures relating to her outpatient services and inform the board of the decision in writing.<sup>31</sup>

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<sup>25</sup> S 18(1) of the Mental Health Care Act 17 of 2002.

<sup>26</sup> S 18(2).

<sup>27</sup> [2008] ZAKZHC 37 para 19.

<sup>28</sup> 17 of 2002.

<sup>29</sup> 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 basis is fit to be an outpatient, he must discharge the user according to the prescribed conditions or procedures and inform the board in writing. See s 34(5) of the Mental Health Care Act 17 of 2002. This decision may be reversed. 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 he has reason to believe that the user fails to comply with the terms and conditions of such discharge. See s 34(6) of the Mental Health Care Act 17 of 2002.

<sup>30</sup> S 34(2) of the Mental Health Care Act 17 of 2002.

<sup>31</sup> 34(5) of the Mental Health Care Act 17 of 2002.

## 1.3 Problem Statement and substantiation

### 1.3.1 Regulation of mental health care in South Africa

South Africa is a sovereign democratic state founded on the principle of human dignity, the achievement of equality and the advancement of human rights and freedoms, non-racialism and non-sexism.<sup>32</sup> The Bill of Rights guarantees the right of access to health care, which includes the right of access to mental health care.<sup>33</sup> The Bill of Rights further requires the equal treatment of every person within the Republic of South Africa and prohibits discrimination on the grounds of any person's disability.<sup>34</sup> Furthermore, every person deserves and has a right to be treated with dignity.<sup>35</sup>

South Africa has ratified and is bound by a number of international instruments which places an obligation on her to develop laws which are aimed at protecting the rights of mentally ill persons and to provide treatment to such persons with consideration of human rights issues.<sup>36</sup> The MHCA was enacted to provide for the care, treatment and rehabilitation services for mentally ill persons or persons with severe and profound intellectual disabilities.<sup>37</sup>

The achievement of equality is of paramount importance for a democratic state.<sup>38</sup> Swanepoel points out that mentally ill persons are among the most disadvantaged groups in society as they suffer severe personal distress, are stigmatised, discriminated against, marginalised and often left vulnerable.<sup>39</sup> The stigmatisation of mental illness may lead to violation of the right to equality and the right to human dignity of persons with mental illness. The study explores the right to equality<sup>40</sup> and human dignity, in

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<sup>32</sup> S 1(a) of the Constitution of the Republic of South Africa, 1996.

<sup>33</sup> S 27.

<sup>34</sup> S 9.

<sup>35</sup> S 10.

<sup>36</sup> The following international and regional instruments requires South Africa to enact legislation, regulating mental health care, which is aimed at providing health care and protect rights of mental ill persons: the Convention on the Rights of Persons with Disabilities came into force on 03 May 2008 and South Africa ratified it on 30 November 2007; the United Nations Principles for the Protection of Persons with Mental illness and for the improvement of Mental Health Care is a non-binding general assembly resolution which cannot be ratified; and the African Charter on Human and People's Rights came into force in October 1986 and South Africa ratified it on 9 July 1996.

<sup>37</sup> *Op cit* (n 14).

<sup>38</sup> *Minister of Finance v Van Heerden* 2004 (6) SA 121 (CC) para 22.

<sup>39</sup> [http://uir.unisa.ac.za/bitstream/handle/10500/3106/thesis\\_swanepoel\\_m.pdf](http://uir.unisa.ac.za/bitstream/handle/10500/3106/thesis_swanepoel_m.pdf) (accessed on 30 October 2014 (Swanepoel M Law, Psychiatry and Psychology: A selection of Constitutional, Medico-Legal and Liability Issues LLD Thesis 2009).

<sup>40</sup> As provided by section 9 of the Constitution of the Republic of South Africa.

order to determine whether the provisions regulating mental health complies with this principles underlying the Constitution of the Republic of South Africa.

Section 9 of the Constitution provides that everyone is equal before the law and has the right to equal protection and benefits of the law.<sup>41</sup> Discrimination on the basis of disability is prohibited.<sup>42</sup> Mental health care users are further protected in terms of section 10 of the MHCA, in that it prohibits unfair discrimination on the ground of mental illness. It is submitted that section 9 of the Constitution recognises that there may be conduct which amounts to fair discrimination and such conduct is not prohibited in terms of section 9 and only unfair discrimination is prohibited.

In *Harksen v Lane NO*,<sup>43</sup> the court decided that the following enquiry should be conducted to determine whether there is unfair discrimination:

(a) Does the provision differentiate between persons or any categories of persons? If so, does the differentiation bear a rational connection to a legitimate government purpose? If it does not then there is a violation of section 9(1)<sup>44</sup> of the Constitution. Even if it does bear a rational connection, it might nevertheless amount to discrimination if the differentiation amounts to an unfair discrimination.

(b) Does the differentiation amount to unfair discrimination? This requires a two stage approach:

(i) Firstly, does the differentiation amount to 'discrimination'? If it is on a specified ground, then discrimination will have been established. If it is not on a specified ground, then whether, objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of a person as human beings or to affect them adversely in a comparably serious manner.

(ii) If the differentiation amounts to a 'discrimination' does it amount to 'unfair discrimination'? If it has been found to have been on a specified ground, then unfairness will be presumed. If on an unspecified ground, unfairness will have to be established by the person alleging such unfairness. If at the end of this stage of the inquiry, the

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<sup>41</sup> S 9(1) of the Constitution of the Republic of South Africa, 1996.

<sup>42</sup> *Ibid.*

<sup>43</sup> 1997 11 BCLR 1489 (CC) para 53.

<sup>44</sup> Currie I & de Waal J *the Bill of Rights Handbook* 2005 (Juta, Durban) at 235-236.

differentiation is found not be unfair, then there will be no violation of section 9(3) and 9(4)<sup>45</sup> of the Constitution.

(c) If the discrimination is found to be unfair then a determination will have to be made as to whether the provision can be justified under the limitation clause (s 36 of the Constitution).

There are generally three forms of discrimination.<sup>46</sup> First, there is mere differentiation which only amounts to discrimination and in conflict with section 9(1) of the Constitution if it is not rationally connected to a legitimate government purpose.<sup>47</sup> Second, there is a differentiation which amounts to unfair discrimination and in conflict with section 9(3) and 9(4) of the Constitution regardless of whether the differentiation is rationally connected to a government purpose or not.<sup>48</sup> Third, there is a differentiation which amount to a fair discrimination.<sup>49</sup>

Section 10 of the Constitution provides that everyone has the inherent dignity and the right to have their dignity respected and protected. The Constitutional court has described the right to dignity as one of the most important human right.<sup>50</sup> The right to dignity is a foundation to many rights<sup>51</sup> contained in the Bill of Rights.<sup>52</sup> In simple terms, treating a person with dignity is an acknowledgement of the intrinsic worth of human beings, which is to treat every human being with respect.<sup>53</sup>

The MHCA gives effect, in more detail, to the rights provided in the Bill of Rights.<sup>54</sup> The objects of the MHCA is to regulate the 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

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<sup>45</sup> *Ibid.*

<sup>46</sup> *Ibid* at 237.

<sup>47</sup> *Ibid.*

<sup>48</sup> *Ibid.*

<sup>49</sup> *Ibid.* Discrimination will be fair if it can be justified in terms of the provision of s 36 of the Constitution of the Republic of South Africa, 1996.

<sup>50</sup> *S v Makwanyane* 1995 (3) SA 391 (CC) para 144.

<sup>51</sup> This includes the right to life and the right to equality.

<sup>52</sup> *Op cit* (n 50) para 328.

<sup>53</sup> *Ibid.*

<sup>54</sup> Kruger A "Mental Health and the Bill of rights" 3EB1 in *the Bill of Rights Compendium*.

within the limits of the available resources; and regulate access to and provide mental health.<sup>55</sup>

These rights are more specific than the ones provided in the Bill of Rights. The following rights are provided for in terms of the MHCA:

- a) Respect, human dignity and privacy.
- b) Consent to care, treatment and rehabilitation services and admission to health establishment.
- c) Protection against exploitation and abuse.
- d) Determination concerning mental status.
- e) Confidentiality.
- f) Intimate adult relationship.
- g) Right to representation.
- h) Discharge reports.
- i) Knowledge of rights.

The MHCA further regulates the detention and treatment of mental health care users (users),<sup>56</sup> and provides three categories of users, namely, voluntary mental health care users<sup>57</sup>, assisted mental health care users<sup>58</sup> and involuntary mental health care users.<sup>59</sup>

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<sup>55</sup> S 3 of the Mental Health Care Act 17 of 2002.

<sup>56</sup> Chapter V regulates the provision of mental health care to mental health care users and comprises of s 25 ( which regulates the treatment and rehabilitation of voluntary mental health care users), s 26 (which regulates the treatment and rehabilitation of mental health care users incapable of making informed decisions), s 27 (which regulates the treatment and rehabilitation of assisted mental health care users), s 28 (which regulates the initial assessment of assisted mental health care users), s 29 (which regulated the appeal of the decision to detain an assisted mental health care user), s 30 (which provides for periodic review and annual reports on the assisted mental health care user), s 31 (which provide for procedures in respect of a recovered assisted mental health care user), s 32 (which regulates the care, treatment and rehabilitation of involuntary mental health care user), s 33 (which regulates the application to obtain involuntary mental health care), s 34 (which provides for a 72 hours assessment), s 35 (which provides for appeals against the decision to detain an involuntary mental health care user), s 36 (which provides for the judicial review of the decision to detain an involuntary mental health care user), s 37 (which provides for periodic and annual report an involuntary mental health care user), s 38 ( which regulates the procedure regarding a recovered involuntary mental health care user), s 39 (which provides regulates the transfer of mental health care user to a maximum security facility) and s 40 (which provides for instances which require the intervention of the South African Police Service).

<sup>57</sup> S 25 of the Mental Health Care Act 17 of 2002.

<sup>58</sup> S 27.

<sup>59</sup> S 32.

The MHCA also makes provision for Mental Health Review Boards (Review Boards).<sup>60</sup> Their functions are, *inter alia*.<sup>61</sup>

- a) To consider appeals against decisions of the head of a health establishment.
- b) To make decisions with regard to assisted or involuntary users.
- c) To consider reviews and make decisions on assisted or involuntary users.
- d) To consider 72 hours assessments made by the head of a health establishment.
- e) To consider the transfer of users to a maximum security facility.

The Review Board must be constituted by not less than three and not more than five members and it must include a mental health care practitioner and a member of the community.<sup>62</sup> The other member must be a magistrate, an advocate or an attorney.<sup>63</sup>

### 1.3.2 The International Law Regulation of mental health care

- The Convention on the Rights of Persons with Disabilities (CRPD)<sup>64</sup>

The purpose of the Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.<sup>65</sup> The convention recognises the persons with disabilities to include persons with long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.<sup>66</sup> The convention is founded on the following principles:<sup>67</sup>

- 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;

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<sup>60</sup> S 18 of the Mental Health Care Act 17 of 2002.

<sup>61</sup> S19(1).

<sup>62</sup> S 20.

<sup>63</sup> *Ibid.*

<sup>64</sup> The convention was adopted by the United Nations on 13 December 2006. South Africa signed the Convention on 30 March 2007 and it ratified it on 30 November 2007.

<sup>65</sup> Art 1 of the CRPD.

<sup>66</sup> *Ibid.*

<sup>67</sup> Art 3 of the CRPD.

- 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.

The CRPD is an important international instrument with the Bill of Rights placing an obligation on South African courts to consider international law when interpreting the rights of any person.<sup>68</sup> The study considers the CRPD in order to determine whether South Africa is complying fully with its provisions.

- The United Nations Principles for the Protection of Persons with Mental Illness and for the improvement of Mental Health Care (The Principles)<sup>69</sup>

The Principles provide a comprehensive and detailed international statement of the rights of mentally ill persons.<sup>70</sup> The Principles are not binding on states. However, they are persuasive and provide guidance in national legislation. The Principles provide standards for care and treatment of mentally ill persons and create protections against arbitrary detention of mentally ill persons.<sup>71</sup> The principles apply to persons with mental disorders, whether or not they are detained and prohibit any form of discrimination which has the effect of nullifying or impairing the equal enjoyment of the provided.<sup>72</sup> In South Africa, the principles can be used to give content to the rights regulation of mental health care by the Constitution and the MHCA.<sup>73</sup> The study considers these principles in order to determine whether the current regulation of mental health care in South Africa conforms to these Principles and whether it gives effect to the principles as provided.

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<sup>68</sup> S 39 of the Constitution of the Republic of South Africa, 1996.

<sup>69</sup> The United Nations approved the principles without a vote on 17 December 1991.

<sup>70</sup> Kruger A *op cit* (n 54) at 3EB33.

<sup>71</sup> Principles 1.1, 1.2 and 3 of the The United Nations Principles for the Protection of Persons with Mental Illness and for the improvement of Mental Health Care.

<sup>72</sup> Principle 1.4.

<sup>73</sup> Kruger A *op cit* (n 54) at 3EB1.

The Principles and the CRPD<sup>74</sup> are not the only international instruments applicable to mental health care.<sup>75</sup> The provisions of the Universal Declaration of Human Rights<sup>76</sup> apply to every person, including mentally ill persons. The study briefly refers to these international instruments.

- The African Charter on Human and People's Rights (the African Charter)<sup>77</sup>

Article 16 of the African Charter on Human and People's Rights provides that:

'16.1 Every individual shall have the right to enjoy the best attainable state of physical and mental health.

16.2 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.'

It is submitted that article 16 does not provide a comprehensive protection of rights of mentally ill persons. However, the African Commission on Human and Peoples' Rights (the Commission) had the opportunity to give content to article 16 of the African Charter in respect of mental health care in *Purohit and Moore v Gambia Communication*.<sup>78</sup> The Commission found that human dignity is an inherent right to all human beings including mentally ill persons and every person must respect it.<sup>79</sup> The Commission recognised that African countries are faced with the problem of poverty which makes it difficult for them to achieve the full enjoyment of the rights contained in the African Charter. However, the Commission decided that article 16 of the African Charter places a duty on State Parties to the African Charter to take concrete and targeted steps, while taking

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<sup>74</sup> The Convention on the Rights of Persons with Disabilities.

<sup>75</sup> The Convention relating to the Status of Refugees (1951), International Convention on the Elimination of all Forms of Racial Discrimination (1966), International Covenant on Civil and Political Rights (1966), Convention on the Elimination of all Forms of Discrimination against Women (1979), Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984), Convention on the Rights of the Child (1989), Convention on the Rights of Persons with Disabilities and the Optional Protocol (2006), Convention on the Rights of Persons with Disabilities (2007), Second Optional Protocol and the International Covenant on Economic, Social and Cultural Rights (2008) also apply to mentally ill persons as they deal with mental issues and health issues in general. However they do not form part of the core issues that will be dealt with in this study.

<sup>76</sup> The Universal Declaration of Human Rights was adopted by the United Nations General Assembly in 1948.

<sup>77</sup> (1981/1986) (also known as the Banjul Charter), The African Charter on Human and People's Rights was adopted by the Organisation of African Unity in Nairobi, Kenya and came into force in October 1986. South Africa ratified the African Charter on Human and People's Rights.

<sup>78</sup> No. 241/2001, Sixteenth Activity report 2002-2003, Annex VI (Purohit).

<sup>79</sup> *Purohit and Moore v Gambia Communication* No. 241/2001, Sixteenth Activity report 2002-2003, Annex VI par 57. The case is also reported in the *Compendium of Key Human Documents of the African Union*, page 178.

full advantage of their available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.<sup>80</sup>

The African Charter is compared to the provisions relating to involuntary users in South Africa in order to determine whether the provisions relating to involuntary users conform to the international norms and standards. The Constitution requires the courts to consider international law in interpreting the Bill of Rights.<sup>81</sup> International law, as provided in the United Nations instruments and the regional instruments (in this study the African Charter) are important in interpreting the provisions of the Constitution and providing a standard in terms of which the MHCA can be measured against.

### 1.3.3 Regulation of mental health care in the United Kingdom

The United Kingdom's Mental Health Act<sup>82</sup> (UKMHA) as amended by the Mental Health Act<sup>83</sup> (UKMHA 2007) regulates the provision of mental health care in England and Wales. The UKMHA provides regulation for, *inter alia*, a Mental Health Review Tribunal (MHRT)<sup>84</sup> and Independent Mental Health Advocates (IMHA).<sup>85</sup>

The MHRT is empowered to adjudicate disputes about treatment by conducting independent reviews of patients diagnosed with mental disorders, who are detained in psychiatric hospitals or outpatients and who may be subject to involuntary treatment. The IMHA is appointed to assist people detained as mentally ill patients.

The study provides a comparison of the South African protection of rights of involuntary users to the United Kingdom mental health care regulation in order to determine whether there are any lessons to be learnt. The study focuses on the role of the MHRT and the IMHA as lessons that South Africa could learn from the United Kingdom.

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<sup>80</sup> *Ibid* para 84.

<sup>81</sup> S 39(1) of the Constitution of the Republic of South Africa, 1996.

<sup>82</sup> 1983.

<sup>83</sup> 2007.

<sup>84</sup> S 65 of the United Kingdom Mental Health Act 1983 as amended of the United Kingdom Mental Health Act 2007.

<sup>85</sup> S 130A of the United Kingdom Mental Health Act 1983 as amended by the United Kingdom Mental Health Act 2007.

### 1.3.4 Study Hypothesis

- Point of departure

The regulation of mental health care in South Africa was developed in line with International human rights developments in mental health care and the provisions of the Bill of Rights which guarantees the right to equality and human dignity.<sup>86</sup>

- Assumptions

- a) The mental health care regulation in South Africa must conform to the Bill of Rights and principles of International Human Rights Law.
- b) South Africa has a duty to reform its laws in conformity with the Constitution and International Law principles.<sup>87</sup>
- c) The current position in the United Kingdom may provide lessons for South Africa.

- Hypothesis

The protection of the human rights of involuntary users in South Africa conforms to the Bill of Rights and International Law standards regulating mental health care and the broader International Human Rights principles. However, there are minor reforms required to improve the quality of the protection of rights of involuntary users, which may be learnt from the United Kingdom.

### 1.4 Aims and Objectives of the study

The following are the aims and objectives of this study:

- a) To explore the legislative framework regulating the protection of human rights of involuntary users in South Africa.
- b) To critically evaluate the protection of human rights of involuntary users in terms of the Constitution,<sup>88</sup> National Legislation<sup>89</sup> and International Human Rights Law.<sup>90</sup>

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<sup>86</sup> S 39 of the Constitution of the Republic of South Africa, 1996.

<sup>87</sup> S 39(2) of the Constitution of the Republic of South Africa, 1996 requires every court, when interpreting any legislation, to promote the spirit, purport and objects of the Bill of Rights. The Constitution provides in terms of section 231(2) that an international agreement binds the Republic if it has been approved by resolution in both the National Assembly and the National Council of Provinces.

<sup>88</sup> The Constitution of the Republic of South Africa, 1996.

<sup>89</sup> The Mental Health Care Act 17 of 2002.

<sup>90</sup> International Instruments regulating the provision of mental health care which includes, the Convention on the Rights of Persons with Disabilities, the United Nations Principles for the Protection of Persons

- c) To analyse the legislative framework regulating mental health care in the United Kingdom in order to determine whether there are lessons to be learnt for South Africa.
- d) To provide recommendations regarding improvement of the protection of rights of involuntary users.

### 1.5 Research Questions

This study endeavoured to answer the following research questions:

Central question

- a) Does the protection of human rights of involuntary users in South Africa conform to the International Human Rights norms and standards in mental health care regulation?

Sub questions

- a) What are the provisions regulating the protection of the human rights of involuntary users in terms of the Constitution, International Human Rights Law and National Legislation?
- b) What are the lessons to be learnt from the United Kingdom?
- c) What are the measures to be taken to improve the protection of human rights of involuntary users?

### 1.6 Rationale and significance of the Study

According to Mouton,<sup>91</sup> the rationale of the study discusses the fundamental reasons to conduct a study on the proposed problem. This helps the researcher to outline the relevance and the importance of the study. The significance of the study establishes why the proposed research matters, and its important contribution on a new body of knowledge.<sup>92</sup>

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with Mental Illness and for the improvement of Mental Health Care and the African Charter on Human and People's Rights.

<sup>91</sup> Mouton J *Understanding Social Research* 2001 (Van Schaik, Pretoria) 101.

<sup>92</sup> *Ibid* at 151.

Translating the MHCA principles into practice has been difficult owing to practical deficiencies and lack of preparedness at service level.<sup>93</sup> Burns argues that the implementation of the MHCA has been hampered by lack of infrastructure, inadequate skills and poor support and skill.<sup>94</sup> The study will investigate whether this difficulty can be attributable to an inefficient legal regulation of mental health care in South Africa. The study further attempts to inquire, whether any reforms are required to correct the defects identified by the study.

## 1.7 Literature Review

There has not been any conclusive study critically evaluating the overall regulation of the protection of human rights of involuntary users for the purpose of comparing it to the International Human Rights standards.

A critical evaluation of the provisions regulating mental health care is important for identifying loopholes and areas that require reform. It is also necessary to conduct a comparative study to make sure that the provisions are as effective as possible in order to achieve their objectives. There are aspects of this study which have been researched; however, the study in its entirety has not been conclusively researched.

Kruger<sup>95</sup> provides a detailed history of South African mental health care laws. This includes, the regulation of mental health care in Roman law, Roman Dutch Law and the mental health laws in the pre-union and the Union of South Africa.<sup>96</sup> Gillis<sup>97</sup> provides the historical development of psychiatry in South Africa since 1652 and points out that the history of psychiatry has over the years developed from disregarding the rights of mentally ill persons to providing protection of their human rights. Gillis does not provide this history in the context of the human rights of involuntary users and does not provide a legal study.<sup>98</sup>

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<sup>93</sup> Burns J: Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice 2008 January vol 98 no 1 *SAMJ* 46.

<sup>94</sup> *Ibid.*

<sup>95</sup> Kruger A *op cit* (n 1).

<sup>96</sup> *Ibid.*

<sup>97</sup> Gillis L: The historical development of psychiatry in South Africa since 1652 (2012) *SAJP* 78 at 78.

<sup>98</sup> *Ibid.*

Burns<sup>99</sup> argues that the implementation of the MHCA is hampered by lack of infrastructure, inadequate skills and poor support and skill. He<sup>100</sup> also argues that these problems undermine the successful implementation of the MHCA. He<sup>101</sup> does not critically analyse the content of the legislative framework regulating mental health care for the purpose of identifying areas that require reform, he merely identifies how the MHCA may be effectively implemented. A similar study was conducted by Freeman.<sup>102</sup>

Burns<sup>103</sup> further argues that the gap between the burden of mental illness and disability; and the relative lack of mental health care resources in South Africa is a human rights issue. Burns recognises that the provisions regulating mental health care may be providing protection for mentally ill persons but the unavailability of resources to implement the provisions, amount to a human rights issue.

This study does not describe ways that the MHCA can be effectively implemented with respect to the provision of resources and other technical requirements. The study is aimed at critically evaluating the protection of human rights of involuntary users in South Africa.

Various commentators have conducted studies regarding the provision of mental health care and the impact of the Bill of Rights. Armah<sup>104</sup> has conducted a study critically analysing the rights of women with psycho analysis, to access mental health care in South Africa and argues that the MHCA and the constitution guarantee the right to access mental health care. However, she points out that the implementation of these provisions is fraught with challenges which include lack of infrastructure, lack of resources and staff; and this affect the accessibility of mental health services in South Africa.<sup>105</sup> This study is not limited to the right to access mental health care. Furthermore, it is not restricted to any sex or gender. This study broadly considers the protection of the human rights of involuntary users.

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<sup>99</sup> Burns J: the mental health gap in South Africa – a Human Rights issue (2011) *The Equal Rights Review*, Vol. Six.

<sup>100</sup> *Ibid.*

<sup>101</sup> *Ibid.*

<sup>102</sup> Freeman M *op cit* (n 23) at 4.

<sup>103</sup> Burns J *op cit* (n 99).

<sup>104</sup> Armah B The right of women with psycho-social disabilities to access mental health care in South Africa: A critical analysis unpublished dissertation 2012 (University of Pretoria) 46.

<sup>105</sup> *Ibid.*

Haysom, Strous & Vogelmann examined the procedure for the compulsory confinement of mentally ill patients.<sup>106</sup> They suggested that the MHA regulation of the compulsory confinement of patients had to be amended to provide, *inter alia*, powers to magistrate and judges to inspect mental institutions to ensure that the mental institutions are providing services, right to legal representation and periodic review of patients.<sup>107</sup> The study was conducted in 1990 and in respect of the MHA. The current study is conducted in respect of the MHCA.

Swanepoel<sup>108</sup> argues that there is a need for optimised changes relating to the administration of mental health care in South Africa with regard to the right to equality,<sup>109</sup> the right to access health care services<sup>110</sup> and right to language, culture and religion.<sup>111</sup> The study looks at the specific rights of mentally ill patients and it is not limited to the rights of involuntary users, as is the case with the current study.

Allan and Allan argue that the right of mentally ill patients to refuse treatment in terms of the MHA was not clear.<sup>112</sup> The study conducted by the authors is only limited to the right to refuse treatment and it is done in respect of the MHA. No such study, it is assumed, has been conducted with reference of the MHCA. Therefore, the current study, *inter alia*, considers the right of involuntary users to refuse treatment but it is not limited to this. The study aims to evaluate the protection of the rights of involuntary mental health care users in order to determine whether it conforms to international law.

Swanepoel<sup>113</sup> argues that since 1994 many far-reaching improvements have been made to the South African health system. She<sup>114</sup> further provides a detailed discussion of sections 10,<sup>115</sup> 12(2)(b)<sup>116</sup> and 14<sup>117</sup> of the Constitution. However, the current study is not

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<sup>106</sup> Haysom N Strous M & Vogelmann L: The Mad Mrs Rochester Revisited: The Involuntary confinement of the mentally ill in South Africa 1990 *SAJHR* 6(3) 341.

<sup>107</sup> *Ibid.*

<sup>108</sup> Swanepoel M: Human Rights that Influence the Mentally Ill patient in South African Medical Law: A discussion of section 9; 27; 30 and 31 of the Constitution (2011) *PEJ* 41.

<sup>109</sup> S 10 of the Constitution of the Republic of South Africa, 1996.

<sup>110</sup> S 27.

<sup>111</sup> Ss 30 and 31.

<sup>112</sup> Allan A & Allan M: The right of mentally ill patients in South Africa to refuse treatment *SALJ* (1997) 724 at 736.

<sup>113</sup> Swanepoel M: A Selection of Constitutional Aspects that Impact on the Mentally Disordered Patient in South Africa 2011 *Obiter* 282 at 303.

<sup>114</sup> *Ibid.*

<sup>115</sup> Right to dignity.

<sup>116</sup> Freedom and security of the person.

<sup>117</sup> The right to privacy.

limited to these rights; the study provides a detailed evaluation of the human rights of involuntary users in South Africa.

Finstein<sup>118</sup> compares the MHCA to other mental health care legislation in the seven commonwealth jurisdictions. Finstein, tests the MHCA and other legislations on diagnosis, therapeutic aim, risk, capacity and review process. The study does not take into account the impact of the Bill of Rights on the regulation of mental health care; it merely focuses on the MHCA. Furthermore, the study does not spell out exactly how the MHCA fails to meet the international standard; the study merely gives scores in different categories.<sup>119</sup>

It is therefore submitted that this study provides an accurate legal comparison of the protection of the rights of involuntary users in South Africa.

## 1.8 Research Methodology

A research methodology is a way to find out the result of a given problem.<sup>120</sup> In research methodology, a researcher attempts to search the given problem systematically in his/her own way and finds answers to the given problem.<sup>121</sup> The use of a correct research methodology resolves problems that a researcher may experience in attempting to explore the research questions.<sup>122</sup> There are three approaches to research, namely, quantitative, qualitative and mixed methods.<sup>123</sup>

According to Mouton,<sup>124</sup> qualitative research refers to collecting, analysing, and interpreting data by observing what people do and say. Qualitative research is much more subjective than quantitative research and uses very different methods of collecting information, mainly individual, in-depth interviews and focus group.<sup>125</sup>

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<sup>118</sup> Finstein M *et al*: A comparison of mental health legislation from diverse commonwealth jurisdiction 2009 *IJLP* 32 147-155.

<sup>119</sup> *Ibid*.

<sup>120</sup> Sarantakos S *Social Research* 1998 (Macmillan, Basingstoke) 98.

<sup>121</sup> Goddard W & Melville S *Research Methodology: An Introduction* 2004 (Juta & Company, Lansdowne) 142.

<sup>122</sup> *Ibid* at 145.

<sup>123</sup> Creswell JW *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* 2003 (Thousand Oakes, London) 5.

<sup>124</sup> Mouton J *op cit* (n 91) at 3.

<sup>125</sup> Redman LV & Morry AVH: *The Romance of Research* 2009 (The Williams and Wilkins Co, Baltimore) 27.

The qualitative method investigates the why and how of decision making, not just what, where, and when; hence, smaller but focused samples are more often needed than large samples.<sup>126</sup>

In qualitative research, the research question which appears at the beginning of the study serves to indicate the purpose of the study.<sup>127</sup> The research question is specific because “qualitative researchers are devoted to understanding specifics of particular cases”.<sup>128</sup>

In qualitative research objective reality can never be fully understood or discovered, there exist many possible ways of looking at realities.<sup>129</sup>

Altogether qualitative methods aim to convey understanding, or attain clarification from data as an alternative from prior knowledge or theory.<sup>130</sup> Data in qualitative research can come from many sources, examples are interviews, photographs, texts, field notes, case studies, personal experiences, introspections, life stories, interviews, artefacts, cultural texts and productions, observational, historical, interactional and visual texts that describe routine and problematic moments and meanings in individuals’ lives.<sup>131</sup>

This study uses a qualitative approach to research. A qualitative approach is applied because the protection of involuntary users is examined and analysed in this study to enhance comprehension of this complex matter. This study is a theoretical assessment to understand the provision relating to the protection of human rights of involuntary users in South Africa. This study is library-based, descriptive, and analytical.

The methods of research are more specific and they are techniques of data collection.<sup>132</sup> Qualitative data is collected mainly by means of document analyses. In respect of the analyses of sources, different sources of different nature and type are consulted and compared in order to enhance validity of this study. The data that is collected includes

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<sup>126</sup> *Ibid at 30.*

<sup>127</sup> Leede PD: *Practical Research* 2001 (Pearson, United States) 125.

<sup>128</sup> Heppner PP & Heppner MJ: *Writing and publishing your thesis dissertation and research: a guide for helping professionals* 2004 (Brooks/Cole, USA) 138.

<sup>129</sup> *Ibid.*

<sup>130</sup> Richards L and Morse M: *Read me first for user's guide to qualitative methods* 3<sup>rd</sup> ed (Thousand Oakes, California) 73.

<sup>131</sup> *Ibid.*

<sup>132</sup> [http://www.sagepub.com/upm-data/10981\\_Chapter\\_1.pdf](http://www.sagepub.com/upm-data/10981_Chapter_1.pdf) (accessed on 20 June 2014).

publications produced by international organisations, by governments and by experts in the field.

The current study is conducted in the following manner:

a) Literature study

A literature review of the relevant South African law dealing with the protection of the human rights of involuntary users is conducted. The review includes a review of statutes and other legislation, international instruments, case law, common law, textbooks, and journal articles as well as electronic material obtained from various internet sites.

b) Legal Comparative study

The United Kingdom has dealt with the same issues regarding the protection of human rights of involuntary users that South Africa faces. The comparative review focuses on the challenges that South Africa has faced and how it has been dealt with in the United Kingdom. However, the study places emphasis on the role of the bodies created in terms of the mental health care laws in the United Kingdom and the lessons that South Africa can learn from that jurisdiction. The study focuses on the United Kingdom because mental health laws in the United Kingdom are comparable to South African laws in many respects and it is often instructive to refer to the law of the United Kingdom.<sup>133</sup> Primary sources are consulted in order to ensure the authenticity of this study.

## 1.9 Definition of concepts

- Mental health care user<sup>134</sup>

Mental health care user refers to 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:

(a) prospective user;

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<sup>133</sup> Kruger A *op cit* (n 1) at 30.

<sup>134</sup> S 1 of Mental Health Care Act 17 of 2002.

- (b) the person's next of kin;
- (c) a person authorised by any other law or court order to act on that person's behalf;
- (d) an administrator appointed in terms of the MHCA; and
- (e) an executor of that deceased person's estate.

- Involuntary mental health care user<sup>135</sup>

Involuntary mental health care user means a person receiving involuntary care, treatment and rehabilitation, being a person who, because of his or her mental health status, is incapable of making informed decisions and who refuses health intervention but requires such services for his or her own protection or for the protection of others.

- Mental health care practitioner<sup>136</sup>

Mental health care practitioner is a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services.

- Health establishment<sup>137</sup>

Health establishment is an institution, facility, building or place where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals.

- Head of a health establishment<sup>138</sup>

Head of a health establishment means a person who manages the health establishment concerned.

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<sup>135</sup> *Ibid.*

<sup>136</sup> *Ibid.*

<sup>137</sup> *Ibid.*

<sup>138</sup> *Ibid.*

- Mental illness<sup>139</sup>

Mental illness refers to a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis.

## 1.10 Chapter Outline

### Chapter 1

The chapter provides a general introduction to the study, background to the study, problem statement and substantiation, aims and objectives of the study, the research question, literature review, research methodology, definition of concepts and chapter outline.

### Chapter 2

Chapter two provides a detailed historical background of the regulation of mental health care in South Africa in order to put the study into perspective. This is done to give the historical, social, political and cultural context in which the present legislation is enacted.

### Chapter 3

Chapter three provides a brief description of the MHCA as it is the main legislation regulating mental health care in South Africa. It is important to understand the principles regulating mental health care in order to be able to determine the extent to which it conforms to International Human Rights principles.

The chapter also provides a description of how the Bill of Rights fits within the legislative framework regulating mental health care and the protection of the rights of involuntary users. In a constitutional state like South Africa the impact of the Bill of Rights on the MHCA is very important in understanding the regulation of mental health care. The chapter examines the rights of involuntary users in terms of the MHCA.

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<sup>139</sup> *Ibid* (n 138).

#### Chapter 4

Chapter four provides a description of International Law regarding the protection of human rights of involuntary users. A determination is made as to whether South Africa compares favourably with international norms and standards. The Chapter also explores the regulation of mental health care in the United Kingdom in order to determine whether there are any lessons to be learnt for South Africa.

#### Chapter 5

Chapter five provides the findings, conclusion and suggests recommendations regarding the introduction of Independent Mental Health Advocates and reforming the Mental Health Review Boards in a similar manner as the Mental Health Tribunals in the United Kingdom.

## CHAPTER 2: The historical background of mental health care regulation in South Africa

### 2.1 Introduction

According to Gillis,<sup>140</sup> the South African history of psychiatry stretches back to the first settlement by Europeans in the Cape of Good Hope in 1652. The first efforts to deal with mental illness in the Cape Colony were by the Dutch East India Company to early settlers and passing soldiers and sailors.<sup>141</sup> Gillis<sup>142</sup> further indicates that there are three developments falling into three phases with some overlaps. First, it was a period of expediency and restraint during the early stage; secondly, the psychiatric hospital era, which was under the rule of the British; thirdly, the modern period. According to Gillis<sup>143</sup>, the concept of mental illness as a disease only came about towards the end of the 18th century, and the term 'psychiatry' was coined by a French physician in 1808. Swartz<sup>144</sup> argues that there is evidence that colonial mental health care was characterised by institutionalised racist practices, and constructed scientific justifications for neglect of the black insane.

This chapter discusses the historical background of mental health care in South Africa. First, the position in the different colonies is discussed. Secondly, the position in the Union of South Africa is discussed. Thirdly, the influence of the constitution is briefly discussed. However, before these positions are discussed it is necessary to provide a brief history of the law relating to protection of involuntary users in terms of Roman law and Roman Dutch law. These positions are discussed mainly to determine the historical context of the protection of the human rights of involuntary users in South Africa.

### 2.2 Roman Law

The laws relating to mental health care followed the natural ways of the community and may be summed in a maxim, "*Si furiosus escit, agatum gentiliunque in eo pecuniaque*

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<sup>140</sup> Gillis L *op cit* (n 97) at 78.

<sup>141</sup> *Ibid.*

<sup>142</sup> *Ibid.*

<sup>143</sup> *Ibid.*

<sup>144</sup> Swart S: Colonial lunatic asylum archives: challenges to historiography <http://www.jstor.org/stable/41056612> (accessed on 24 June 2014).

*eius potestas esto*".<sup>145</sup> This maxim was taken to mean that the mentally ill person was in the custody of his closest male person or his or her clan.<sup>146</sup> This meant that the person in charge of the mentally ill person was automatically appointed. Kruger<sup>147</sup> argues that the interest of the family and the community were promoted above the rights of the mentally ill person and it appears that the right of the mentally ill person were never considered.

## 2.3 Roman Dutch Law

One of the developments in the mental health laws in Roman Dutch Law was that a curator or a person in charge of the mentally ill person was not automatically appointed and -mental illness was described in more details.<sup>148</sup> Roman Dutch law differentiated between 'insane' and 'mad' persons.<sup>149</sup> Insane persons were defined as persons who are tame and without violence, but lack the use of reason while a madman was defined as a person who was violently insane or who betray themselves by other clear tokens<sup>150</sup> of madness.<sup>151</sup>

The effect of insanity or being considered as a madman was as follows:<sup>152</sup>

- a) They had no authority to consent, no feelings, no perception or clear articulation and no mentality.
- b) They had no capacity to commit an offence and wrongdoing in others.
- c) They had no capacity to control themselves or their affairs.

Voet<sup>153</sup> goes further to consider insane persons and madman on the same footing as absent, dead, passive or sleeping persons.

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<sup>145</sup> Kruger *A op cit* (n 1) at 2.

<sup>146</sup> *Ibid.*

<sup>147</sup> *Ibid.*

<sup>148</sup> Kruger *A op cit* (n 1) at 5.

<sup>149</sup> Voet 27.10.3.

<sup>150</sup> Clear tokens of madness can be defined as 'a forward and threatening countenance, a gloomy brow, a wild expression, hurried footsteps, restless hands, changing of colour and frequent and deep-drawn sighs'. Voet 27.10.3.

<sup>151</sup> Voet 27.10.3.

<sup>152</sup> *Ibid.*

<sup>153</sup> *Ibid.*

A curator would be appointed by the provincial court of Holland or by the ordinary magistrates, depending upon which court the relatives of the patients approached,<sup>154</sup> but there was no need for an order of court for a person to be declared a madman or an insane person.<sup>155</sup> The relatives and friends of a dangerously insane person had to apply to the Court of Holland or a local court for a right to detain the person.<sup>156</sup> According to Kruger, mentally ill persons were better treated in Roman Dutch Law than in Roman Law as the detention of mentally ill persons had been legitimised but there were no mental hospital or any reasonable treatment.<sup>157</sup> They still had no structures dedicated to protecting mentally ill persons and it appears that the rights of mentally ill persons were never considered.

## 2.4 Pre-union States

Kruger<sup>158</sup> correctly summarises the position regarding regulation of mental health care in the pre-union states as follows:

The first group<sup>159</sup> of mental health laws provided that under certain circumstances a person could be brought before a magistrate, who could then, after calling in two medical practitioners, order his detention. The second group contained much more safeguards.

### 2.4.1 Cape Colony

During the 17<sup>th</sup> century there was no official provision for the treatment and detention of mentally ill persons.<sup>160</sup> The behaviourally disturbed were housed in a structure adjacent to the first Van Riebeeck fort.<sup>161</sup> In 1711, an apartment was added in the Cape Hospital, under the order of Commissioner Van Hoorn, for the confinement of mentally ill person and dangerous lunatics.<sup>162</sup> The first hospital was only built in 1818.<sup>163</sup> There were no express provisions authorising the confinement of mentally ill persons at the time, but it

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<sup>154</sup> Kruger A *op cit* (n 1) at 5 and Voet 27.10.10.

<sup>155</sup> Voet 27.10.3.

<sup>156</sup> Kruger A *op cit* (n 1) at 6.

<sup>157</sup> *Ibid* at 7.

<sup>158</sup> *Ibid* at 20-21.

<sup>159</sup> Kruger argues that there are two groups of acts regulating mental health care in the pre-union states.

<sup>160</sup> Kruger A *op cit* (n 1) at 8.

<sup>161</sup> Gillis L *op cit* (n 97) at 78.

<sup>162</sup> Kruger A *op cit* (n 1) at 8.

<sup>163</sup> Kruger A "Mental Health" in *LAWSA* vol 17(2) par 208.

was accepted that Roman Dutch Law provided authority for such confinement.<sup>164</sup> On 2 September 1866, the 1866 Circular<sup>165</sup> was issued by the Colonial office applicable to all the residents of the magistrate.<sup>166</sup> The 1866 Circular provided that the residents of the magistrate may apply for authority to send any mentally ill person to an asylum provided that the following requirements were complied with:<sup>167</sup>

- a) The application was brought in the form enclosed in the circular.
- b) The applicant had to state the following:
  - The personal particulars of the patient.
  - The duration of the existing attack.
  - Whether the patient was dangerous to others.
  - The cause of insanity if it was hereditary
- c) Two medical certificates of two duly licensed medical practitioners had to accompany the application. The two certificates had to specify the facts that the medical practitioner had observed and those that had been communicated by others.

Kruger<sup>168</sup> argues that there were no provisions authorising the issuing of the circular in the Cape Colony, and it is unlikely that the colonial office had the Roman Dutch Law confinement in mind. The mentally ill patients who were detained in these hospitals were not considered as patients, they were treated more as outcasts.<sup>169</sup> The living conditions in the early years were dreadful and the patients were usually kept in the dark insanitary cells.<sup>170</sup> However, some things improved in the mid-1860s.<sup>171</sup> In 1846, mentally ill persons were detained in Robben Island.<sup>172</sup> During the nineteenth century, the Cape Colony was served by four asylums, namely, Robben Island Infirmary, Grahamstown Asylum opened in 1875, Port Alfred Asylum in 1888 and Valkenberg

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<sup>164</sup> Kruger A *op cit* (n 1) at 8.

<sup>165</sup> Circular no 28 of 1866.

<sup>166</sup> Kruger A *op cit* (n 1) at 9.

<sup>167</sup> *Ibid.*

<sup>168</sup> Kruger A *op cit* (n 163).

<sup>169</sup> Kruger A *op cit* (n 1) at 10.

<sup>170</sup> Gillis A *op cit* (n 97) at 78.

<sup>171</sup> *Ibid.*

<sup>172</sup> Kruger A *op cit* (n 1) at 10.

Asylum was opened in 1891.<sup>173</sup> On 21 November 1879, Act 20 of 1879 was promulgated and section 1 of the act allowed a resident magistrate to call upon the help of two medical practitioners when a person is discovered under the circumstances indicating that the person is insane. The magistrate would grant an order directing that the person be taken up in a hospital or place of safe custody in the Colony if it was satisfied that:<sup>174</sup>

- a) the person was a dangerous insane; or
- b) the person was a dangerous idiot.

The Governor had the authority to:<sup>175</sup>

- a) Transfer persons to a mental institution.
- b) Discharge mentally ill persons on receipt of certificates from two medical practitioners that the person was no longer a dangerous insane or idiot.

The Act also provided the following safeguards in terms of section 9 and 10 of Act 20 of 1879:<sup>176</sup>

- a) The Supreme Court had the authority to order the immediate release of the person after finding that the person was not insane.
- b) The next of kin of the insane person could request that the Governor release the insane person in their care.

On 15 March 1892 the Lunacy Act<sup>177</sup> (the 1891 Lunacy Act), repealing Act 20 of 1879, was promulgated. In terms of section 27 of the 1891 Lunacy Act,<sup>178</sup> if a person was found under the circumstances showing that the person was of an unsound mind the magistrate could order that the person be detained in a hospital or other place until the person is discharged or moved to an asylum by the Governor, provided that:<sup>179</sup>

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<sup>173</sup> <http://www.jstor.org/stable/2637251> (accessed 24 June 2014).

<sup>174</sup> Kruger A *op cit* (n 1) at 13.

<sup>175</sup> *Ibid.*

<sup>176</sup> *Ibid.*

<sup>177</sup> 35 of 1891.

<sup>178</sup> *Ibid.*

<sup>179</sup> Kruger A *op cit* (n 1) at 15.

- a) The magistrate was satisfied that the person is a dangerous lunatic.
- b) The person was not a criminal lunatic.

The magistrate could also order that the person at large deemed to be a dangerous lunatic be brought before him or her and a constable must comply with this order.<sup>180</sup> The 1891 Lunacy Act provided the following safeguards:<sup>181</sup>

- a) A constable had to report to the magistrate that a lunatic was not been properly cared for.
- b) The magistrate could make a summary reception order in terms of which a lunatic may be detained for a period not exceeding one month and the Attorney General, a *curator ad litem*, would be granted an opportunity to investigate and report to a Judge in chamber and the Judge would make a finding.
- c) A relative or friend could apply to the magistrate to take the patient under his/her care.
- d) The relative or the detained person could apply to court for the reasons of the detention.

On 25 May 1897 the Lunacy Act<sup>182</sup>, repealing the 1891 Lunacy Act was promulgated. According to Kruger<sup>183</sup> very few basic provisions and principles were affected by repealing the 1891 Lunacy Act.<sup>184</sup> Kruger<sup>185</sup> points at the introduction of provisions for voluntary patients as the main important addition to the regulation of mental health care at the Cape Colony. Kruger<sup>186</sup> summarises the development of mental health care laws in the Cape Colony as follows:

‘First the insane were detained by force and not treated at all, then they were detained and treated for hours and now they could voluntarily submit to treatment.’

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<sup>180</sup> *Ibid.*

<sup>181</sup> Kruger *A op cit* (n 1) at 16.

<sup>182</sup> 1 of 1897.

<sup>183</sup> Kruger *A op cit* (n 1) at 16.

<sup>184</sup> 35 of 1891.

<sup>185</sup> Kruger *A op cit* (n 1) at 16.

<sup>186</sup> *Ibid.*

## 2.4.2 Transvaal

Act 9 of 1894 (1894 Act) was enacted on 3 July 1894. Kruger<sup>187</sup> argues that the provisions of this act were similar to the 1891 Lunacy Act. It is important to note that section 3 of the 1894 Act provided that if a constable was satisfied that for public safety it was necessary that the person should be placed under care and control, he/she could apprehend such person and transport him/her to be detained for a period not longer than 48 hours.<sup>188</sup> Proclamation 36 of 1902 (The 1902 Proclamation), repealing the 1894 Act, was issued on 6 June 1902. The 1902 Proclamation contained the same provisions as the 1894 Act, with the exception of the following additions:<sup>189</sup>

- a) Application by family to detain a mentally ill person on an urgent basis for seven days.
- b) Introduction of voluntary patients.
- c) Circumstances under which mechanical means of bodily restraints were allowed.

## 2.4.3 Natal

Natal Law 1 of 1868 (the Natal Law) was promulgated on 22 September 1868. The purpose of the Natal Law was to make provisions for the safe custody of dangerously insane persons and for the care and custody of persons of unsound mind.<sup>190</sup> Kruger<sup>191</sup> states that the Natal Law is practically similar to Act 20 of 1879 in the Cape Colony. The Natal Law made it possible for the society to make an application to the Lieutenant Governor to examine a person as to his/her mental condition.<sup>192</sup> Persons detained in a lunatic asylum were afforded the liberty and the privilege of seeing their friends and legal advisors at all reasonable times.<sup>193</sup> Law 8 of 1891 (the Natal Law 8), repealing the Natal Law, was promulgated on 23 June 1891. The Natal Law 8 introduced a provision that in the absence of any agreement, the cost of maintenance of a lunatic in the asylum was charged against the estate of the lunatic.<sup>194</sup>

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<sup>187</sup> *Ibid* at 18.

<sup>188</sup> *Ibid*.

<sup>189</sup> *Ibid* at 19.

<sup>190</sup> *Ibid* at 16.

<sup>191</sup> *Ibid* at 17.

<sup>192</sup> *Ibid*.

<sup>193</sup> *Ibid*.

<sup>194</sup> *Ibid*.

#### 2.4.4 Orange Free State

Ordinance 16 of 1891<sup>195</sup> dealt with lunatics and pauper ill.<sup>196</sup> Kruger<sup>197</sup> states that, with the exception of the introductory provisions and the order of the sections, the provisions of Ordinance 16 of 1891 were exactly the same as the Natal Law and Act 20 of 1879 in the Cape Colony. Ordinance 16 of 1891 was repealed by Act 4 of 1893, which was promulgated on 20 May 1893. Act 4 of 1893 was the same as the 1891 Lunacy Act in the Cape Colony and the 1894 Act in the Transvaal.<sup>198</sup> Ordinance 13 of 1906 was promulgated on 9 March 1906.

#### 2.5 Union of South Africa

##### 2.5.1 The Lunacy and Leprosy Laws Amendment Act<sup>199</sup> (The LLLA)<sup>200</sup>

In 1910, South Africa became a union. The LLLA came into force on 22 June 1914 and it amended in certain respect certain laws in several provinces relating to lunatics and persons affected by leprosy. The effect of the LLLA was that the provincial acts were left intact and to a certain extent given extra-territorial power.<sup>201</sup> any warrant, order, certificates or report issued in terms of the lunatic and leprosy laws in the provinces were recognised in any other province, as if it was issued in that province.<sup>202</sup> Any warrant or order authorising the removal and detention of a person to any institution<sup>203</sup> was deemed to authorise the removal to and detention in any other institution in any part of the Union of South Africa.<sup>204</sup> The Minister (of the Interior)<sup>205</sup> had authority to transfer a person detained in any institution to other institutions, established for like

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<sup>195</sup> Chapter 94 of the Wetboek of the Orange Free State.

<sup>196</sup> Kruger A *op cit* (n 1) at 19.

<sup>197</sup> *Ibid* at 20.

<sup>198</sup> *Ibid*.

<sup>199</sup> 14 of 1914.

<sup>200</sup> The Act was assented to on 20 June 1914, but only came into force on 22 June 1914. The Act only had four sections.

<sup>201</sup> Kruger A *op cit* (n 1) at 21.

<sup>202</sup> S 1(1) of the Lunacy and Leprosy Law Amendment Act 14 of 1914.

<sup>203</sup> In terms of section 3 of the Lunacy and Leprosy Law Amendment Act 14 of 1914 institution means in respect of persons of unsound mind, an asylum as defined in any one of the provincial laws.

<sup>204</sup> S 1 (2) of the Lunacy and Leprosy Law Amendment Act 14 of 1914.

<sup>205</sup> Definition of "Minister" in terms of section 3 of the Lunacy and Leprosy Law Amendment Act 14 of 1914.

purposes, in the Union of South Africa.<sup>206</sup> In terms of section 2 of the LLLA, the Attorney-General was the official *curator ad litem* of the detained persons.

#### 2.5.2 The Mental Disorders Acts<sup>207</sup> (with 1944 and 1946 amendments) (the MDA)

On 1 November 1916, the MDA came into operation and its aim was to consolidate and amend the laws, relating to detention and treatment of mentally disordered and defective persons, in force in the several provinces of the Union of South Africa. The MDA applied to every person in respect of whom the provision were made and any person legally detained in any institution at the commencement of the MDA; and any order or warrant issued in terms of the previous acts remained in force.<sup>208</sup> The MDA defined a mentally disordered person or defective person as any person who as a result of mental disorder or disease or permanent defect of reason or mind.<sup>209</sup>

- a) was incapable of managing himself or his affairs; or
- b) required supervision, treatment and control.

The MDA differentiated between seven classes of mentally disordered or defective persons. The MDA provided for the following classes:<sup>210</sup>

- a) Class 1: A person suffering from mental disorder.
- b) Class 2: A person mentally infirm from age or decay of the faculties.
- c) Class 3: An idiot.
- d) Class 4: An imbecile.
- e) Class 5: A feeble minded person.
- f) Class 6: A socially defective person
- g) Class 7: An epileptic.

The MDA prohibited, with exceptions, the detention of any person as a patient without the authority of an order of a magistrate or an order of the court or a judge.<sup>211</sup> Any person over 21 years could make a written application in the prescribed form to the

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<sup>206</sup> S 1(3) of the Lunacy and Leprosy Law Amendment Act 14 of 1914.

<sup>207</sup> 38 of 1916.

<sup>208</sup> S 1 of the Mental Disorder Act 38 of 1916.

<sup>209</sup> S 2.

<sup>210</sup> S 3 and Kruger *A op cit* (n 1) at 22.

<sup>211</sup> S 4.

magistrate for a reception order and the application had to be accompanied by a medical certificate dated not earlier than seven days before the application.<sup>212</sup> The application had to state the grounds that the applicant relied on to believe that the person in respect of whom the application was made was mentally ill; the relation to the patient and if the applicant was not the spouse<sup>213</sup> or a close relative, the person had to give the reasons why the application was made by him or her and not the close relative or the spouse; and the applicant had to have personally seen the applicant seven days preceding the application.<sup>214</sup> The Magistrate would issue a reception order if it was satisfied that the patient was mentally disordered or defective and:<sup>215</sup>

- a) the patient was not under proper care, oversight or control;
- b) the patient was cruelly treated or neglected by any person having the care or charge of such person;
- c) the patient was of suicidal tendency or in any way dangerous to himself or others;
- d) the patient committed or attempted to commit any crime or offence or has acted in a manner offensive to public decency;
- e) the patient was an inebriated;
- f) the patient was in receipt of relief or assistance from public or charitable funds at the time of giving birth to an illegitimate child or when pregnant with such child; or
- g) the person having care or control of the persons had consented.

It was not necessary for the magistrate to hear the evidence of a medical practitioner.<sup>216</sup> A medical certificate was sufficient, but it had to be fourteen days old or less.<sup>217</sup> The magistrate had to be very careful in granting a reception order, all the provisions of the MDA had to be carefully adhered to.<sup>218</sup> The mentally ill patient could either be detained in an institution<sup>219</sup> or other place;<sup>220</sup> or in a dwelling of another person as a single patient.<sup>221</sup> A mentally ill patient could not be detained in an institution for a period

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<sup>212</sup> S 5 of the Mental Disorder Act 38 of 1916.

<sup>213</sup> S 5(2)(b) refer to a husband or a wife. The word spouse is used to mean husband or wife.

<sup>214</sup> S 6(2) of the Mental Disorder Act 38 of 1916.

<sup>215</sup> S 6(4).

<sup>216</sup> Medical practitioner in terms of the Mental Disorder Act means any medical practitioner duly registered as such under a law in force in any of the provinces of the Union.

<sup>217</sup> Ss 6 (7) and (8) of the Mental Disorder Act 38 of 1916.

<sup>218</sup> *Rutland v Engelbrecht* 1957 (2) SA 338 (A) 339F-G.

<sup>219</sup> The Institution must be licensed in terms of section 48.

<sup>220</sup> S 8 of the Mental Disorder Act 38 of 1916.

<sup>221</sup> S 7.

exceeding six months.<sup>222</sup> A mentally ill person could only be detained in a dwelling if the two medical practitioners certified that it would be safe and convenient that the patient be detained in the dwelling instead of an institution,<sup>223</sup> and after the magistrate or another person had examined the dwelling and he/she was satisfied that the owner of the dwelling was the right person to be in charge of the patient, and the dwelling and its surrounding was suitable to receive the patient.<sup>224</sup>

The MDA provided procedures for the detention of mentally ill patients in the case of urgency.<sup>225</sup> The following requirements had to be met before an urgent application was granted in terms of section 10 of the MDA:

- a) The detention had to be in the interest of the patient or in the public interest.<sup>226</sup>
- b) The application had to be verified by an affidavit or a solemn declaration.<sup>227</sup>
- c) The affidavit had to state on what grounds the applicant believed that the person in respect of whom the application was made was mentally ill; the relation to the patient and if the applicant is not the spouse or a close relative, the person had to give the reasons why the application was made by him/her and not a close relative or the spouse; the applicant had personally seen the patient seven days preceding the application; and that the application was urgent.<sup>228</sup>
- d) The application had to be accompanied by one medical certificate<sup>229</sup> and the medical practitioner had to have personally examined the patient not more than seven days before the application.<sup>230</sup>
- e) The application had to be signed by the spouse or a relation of the patient but if it was not signed by the mentioned parties, the applicant had to sign the application and explain the circumstances under which they sign the application.<sup>231</sup>
- f) The person signing the application had to be at least 21 years old and had personally seen the patient two days before the application.<sup>232</sup>

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<sup>222</sup> S 8(1) of the Mental Disorder Act 38 of 1916.

<sup>223</sup> S 7(2).

<sup>224</sup> S 7(3).

<sup>225</sup> S 9.

<sup>226</sup> S 9(1).

<sup>227</sup> *Ibid.*

<sup>228</sup> *Ibid.*

<sup>229</sup> *Ibid.*

<sup>230</sup> S 9(4).

<sup>231</sup> S 9(2).

<sup>232</sup> S 9(3).

The MDA authorised a policeman to apprehend and detain mentally ill persons in certain cases.<sup>233</sup> A policeman<sup>234</sup> was authorised to apprehend a person in any of the two cases. First, the policeman ought to have had a reason to believe that the person not wandering at large is mentally disordered or defective and a person in charge of such person had neglected him/her or is treating him or her cruelly; or the person acts contrary to public decency; or the person is not safely and properly supervised, cared for or controlled.<sup>235</sup> Secondly, the policeman ought to have had a reasonable belief that the person who is apparently mentally disordered or defective is a danger to himself or a danger to society; or he could not take care of himself and was wandering at large.<sup>236</sup> A policeman could apprehend a person deemed to be mentally ill and bring that person before a magistrate to be examined under the following circumstances:

- a) The magistrate had given an order, based on sworn information, for the apprehension of a person wandering at large and who was not able to take care of himself or was dangerous to others.<sup>237</sup>
- b) The magistrate had given an order for the apprehension of a person in respect of whom an application for a reception order had been made.<sup>238</sup>

The MDA provided guidelines in respect of mentally ill patients detained under the order of a magistrate. A patient could apply to the court, in person or through a *curator ad litem*<sup>239</sup> for an enquiry<sup>240</sup> into the cause and grounds of the detention.<sup>241</sup> Furthermore, a relative or a friend of the detained person could apply to a court for the enquiry into the person's mental condition and whether the reception order should have been

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<sup>233</sup> S 10 of the Mental Disorder Act 38 of 1916.

<sup>234</sup> In terms of the Mental Disorder Act, policeman includes an officer, non-commissioned officer, constable or trooper of any police force established by law or of any body of persons carrying out by law the functions of a police force, any inspector of natives or pass officer or any superintendent of a municipal native location or his assistants; and further includes such natives headmen as the Minister may designate in respect of natives; locations.

<sup>235</sup> S 10(1) of the Mental Disorder Act 38 of 1916.

<sup>236</sup> S 10(2).

<sup>237</sup> S 11.

<sup>238</sup> S 12.

<sup>239</sup> In terms of section 14, the Attorney-General of a province and a Solicitor-General of the Eastern district of the Cape of Good Hope are the official *curator ad litem*.

<sup>240</sup> Any inquiry held in terms of the Mental Disorder Act had to be done in terms of s 81 of the Mental Disorder Act, which provides the power to summon any person to appear before such court or a body holding an enquiry to testify under oath.

<sup>241</sup> S 19 of the Mental Disorder Act 38 of 1916.

granted.<sup>242</sup> The court had the discretion to make an order to which it deemed fitting in the circumstances of each case.<sup>243</sup> The MDA made provisions for periodical reports on the mental condition of the detained patient.<sup>244</sup> The person in charge of the institution was required to provide periodic reports to the Commissioner of Mentally Disordered and Defective Persons (Commissioner)<sup>245</sup> annually for the first three years of the detention of the mentally ill person, thereafter in the fifth year and then every five years.<sup>246</sup> The Commissioner had the discretion to order the discharge of the patient on the strength of the periodic report.<sup>247</sup>

Chapter II of the MDA<sup>248</sup> provides for provisions relating to mentally ill persons detained for a criminal offence. It is not necessary to discuss these provisions as they fall outside the scope of this study. The provisions of Chapter III,<sup>249</sup> Chapter IV<sup>250</sup> and Chapter V<sup>251</sup> are not discussed in this study as it falls outside the scope of this study.

Section 49 of the MDA<sup>252</sup> provides for the temporary detention of any person that the superintendent of any institution was satisfied that they are suffering from a mental disorder or defect and the person was likely to recover within a period of not more than twelve months after the admission in the institution. The person could only be detained as a temporary patient if an application, accompanied by statements by two medical practitioners indicating that they have examined the patient and the period within which the person was likely to recover, was made by a relative or a friend.<sup>253</sup> A patient detained in an institution on a temporary basis could not be detained in an institution for a period exceeding six months.<sup>254</sup> However, the Commissioner could authorise further detention of a patient provided the further detention was applied for by any person

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<sup>242</sup> S 20 of the Mental Disorder Act 38 of 1916.

<sup>243</sup> Ss 19 and 20.

<sup>244</sup> S 25.

<sup>245</sup> In terms of section 53(1), the Governor-General may appoint a medical practitioner, who is or has been a physician superintendent. The Commissioner had the duty to report to parliament.

<sup>246</sup> S 25(1) of the Mental Disorder Act 38 of 1916. Section 25(2) provides that the periodic report had to be submitted on the anniversary month of the detention of the mentally ill patient.

<sup>247</sup> S 25(3).

<sup>248</sup> S 27-42.

<sup>249</sup> S 43, which provides for the admission of patients from other states or territories in Africa.

<sup>250</sup> S 44, which provides provisions for persons voluntarily submitting to the treatment.

<sup>251</sup> S 45-47, which provides provisions for person residing in private dwellings.

<sup>252</sup> S 49.

<sup>253</sup> Ss 49(1), (3) and (4).

<sup>254</sup> S 50.

lawfully authorised to make such application and the further detention does not exceed six months.<sup>255</sup> The person detained as a temporary patient could apply to a magistrate to inquire on the grounds of his/her detention.<sup>256</sup> The detained person may be discharged on any of the following grounds:<sup>257</sup>

- a) A person detained in a mental hospital was certified by the physician superintendent to be fit to be discharged.
- b) A person detained in an institution was certified by a medical practitioner to be fit to be discharged.
- c) The Commissioner ordered the discharge of the detained person.
- d) The magistrate ordered the discharge of the person.
- e) The spouse<sup>258</sup> or guardian of the detained person or the person detained requested in writing that he be discharged.

The Minister (of Interior)<sup>259</sup> had the power to establish a hospital board<sup>260</sup> in respect of any institution or a mental hospital.<sup>261</sup> The hospital boards had the following powers:

- a) To visit the institution in respect of which it had been appointed and receive representations made by patients detained in the institution.<sup>262</sup>
- b) To make suggestions and observations regarding the welfare of patients detained in the institution or mental hospital in respect of which they have been appointed.<sup>263</sup>
- c) To make resolution to discharge patient, whether recovered or not, detained under lawful authority in an institution or mental hospital.<sup>264</sup>

Chapter IX<sup>265</sup> regulated the care and administration of the property of the mentally disordered or defective person. Chapter IX falls outside the scope of this study and therefore it is not necessary to discuss its provisions further. The MDA provided a

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<sup>255</sup> S 50(2) of the Mental Disorder Act 38 of 1916.

<sup>256</sup> S 51(2).

<sup>257</sup> S 51(1).

<sup>258</sup> S 51(1)(e) of the Mental Disorder Act 38 of 1916 makes reference to a wife or husband, therefore, the word spouse is used in that context

<sup>259</sup> Definition of Minister in terms of the Mental Disorder Act 38 of 1916.

<sup>260</sup> In terms of s 54 (1) of the Mental Disorder Act 38 of 1916, the Minister had to appoint three member to the hospital board, one member has to be a registered medical practitioner and one other member had to be an admitted advocate or attorney.

<sup>261</sup> S 54(1).

<sup>262</sup> S 55, The Visit had to be conducted once in every six months.

<sup>263</sup> S 56.

<sup>264</sup> S 59, the hospital boards did not have the authority to discharge mentally disordered or defective prisoners; or Governor-General decision patients.

<sup>265</sup> S 61-68.

number of offences and prescribed the penalties for such offences.<sup>266</sup> Any person who detained any other person outside the provisions of the MDA was guilty of an offence.<sup>267</sup> The following offences were further provided in terms of the MDA:<sup>268</sup>

- a) Any person who made false statements, false entries and wilful obstruction was guilty of an offence.<sup>269</sup>
- b) Any nurse or any person employed by the institution or mental hospital that mistreated patients was guilty of an offence.<sup>270</sup>
- c) Any person who incited a person to escape from the institution or mental hospital in which he was detained was guilty of an offence.<sup>271</sup>
- d) It was an offence to employ a male person to be in personal charge of a female patient.<sup>272</sup>
- e) It was an offence to have sexual intercourse with a female patient.<sup>273</sup>

The MDA provided a criminal and civil defence for any person who committed any act in pursuance or intended pursuance of the provisions of the MDA on the ground of want of jurisdiction or of mistakes of law or fact or on any ground if he had acted in good faith.<sup>274</sup>

The person also had any other defence available to him including the fact that he would be performing judicial functions.<sup>275</sup> The use of mechanical means of restraints was prohibited unless it was necessary for the purpose of surgical or medical treatment, or to prevent the patient hurting themselves.<sup>276</sup> The mechanical means of restraint was only allowed if the following requirements were complied with:<sup>277</sup>

- a) A medical certificate was signed describing the mechanical means of restrained to be used.

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<sup>266</sup> Chapter X of the Mental Disorder Act 38 1916.

<sup>267</sup> S 69(1).

<sup>268</sup> In terms of s 75(1), any person guilty of an offence and the penalty is not expressly provided shall upon conviction be liable for a fine not exceeding twenty pounds or to imprisonment not exceeding three months; and in terms of s 75(2) of the Mental Disorder Act every person who commits an offence in terms of s 69 to 72 and 74 of the Mental Disorder Act shall be liable upon conviction to a fine not exceeding one hundred pounds or imprisonment not exceeding two years or both.

<sup>269</sup> S 70 of the Mental Disorder Act 38 of 1916.

<sup>270</sup> S 71.

<sup>271</sup> S 72.

<sup>272</sup> S 73.

<sup>273</sup> S 75.

<sup>274</sup> S 76.

<sup>275</sup> S 76 (5), *Penrice v Dickinson* 1945 AD 6 at 15.

<sup>276</sup> S 77.

<sup>277</sup> *Ibid.*

- b) The medical certificate<sup>278</sup> must have been signed by a medical officer<sup>279</sup> or a medical attendant.<sup>280</sup>
- c) A record of the mechanical means of restraint used must be kept on a day to day basis and must be forwarded to the Commissioner at the end of the quarter.

The MDA provided a comprehensive regulation of the provision of mental health care in South Africa. The Act was amended by the Mental Disorder Amendment Act<sup>281</sup> and eventually repealed by the Mental Health Act<sup>282</sup> in 1973. In 1944 the administration of the statutes dealing with the regulation of mental health care was handed over from the Department of the Interior to the Department of Health.<sup>283</sup>

### 2.5.3 Mental Health Act<sup>284</sup>

After the assassination of Dr H F Verwoerd<sup>285</sup> on 6 September 1966 by a mentally disordered schizophrenic, a one man commission was appointed in the person of Mr Justice J T van Wyk.<sup>286</sup> Consequently and on the recommendation made by the commission, the President appointed a commission of inquiry, chaired by Mr Justice F Rumpff on 5 December 1966, to consider the responsibility of mentally deranged person and related matters (the Rumpff Commission).<sup>287</sup> The Rumpff Commission recommended, *inter alia*, that a commission of inquiry be appointed to revise the MDA.<sup>288</sup> On 9 June 1970 the President appointed the commission of inquiry, to revise the MDA, chaired by Mr Justice J T van Wyk (The van Wyk Commission).<sup>289</sup> The van Wyk Commission made recommendations which led to the enactment of the MHA.<sup>290</sup>

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<sup>278</sup> The medical certificates must be sent to the commissioner at the end of every quarter.

<sup>279</sup> In respect of a patient detained in an institution of a mental hospital.

<sup>280</sup> In respect of a patient detained as a single or private patient.

<sup>281</sup> 13 of 1946.

<sup>282</sup> 18 of 1973.

<sup>283</sup> Kruger A *op cit* (n 1) at 24.

<sup>284</sup> 18 of 1973.

<sup>285</sup> Dr Verwoerd was the Prime Minister of South Africa. He was stabbed to death by Demetrio Tsafendas, who later claimed he was told by a giant tapeworm inside of him to kill the Prime Minister. He was declared insane by state psychiatrists.

<sup>286</sup> Kruger A *op cit* (n 1) at 24.

<sup>287</sup> Cheetham RWS: Commission of inquiry into the Mental Disorders Act in relation to the problems of today 1970 SAMJ 1371 at 1371.

<sup>288</sup> *Ibid.*

<sup>289</sup> *Ibid* at 1372.

<sup>290</sup> *Ibid.*

- The provisions of the MHA

The purpose and object of the MHA was to provide for the reception, detention and treatment of persons who were mentally ill.<sup>291</sup> The MHA brought a change in regard to the definition of mental illness and the reception and detention of mentally ill persons.<sup>292</sup>

Mental illness was defined as any disorder or disability of the mind, and included any mental disease and any arrested or incomplete development of the mind.<sup>293</sup> Kruger<sup>294</sup> points out that Slovenko was correct in defining mental illness as a psychiatric or other disease which impaired a person's mental health. It is submitted that the legislature had moved away from defining mental ill persons as it was done in terms of the MDA and dealt away with the classifications of mentally disordered or defective persons that was defined in term of the MDA. The question of whether a person was mentally ill was solely a medical question,<sup>295</sup> the legal definition provided a guideline for psychiatrist to be able to diagnose, for the purpose of the MHA, any person suspected to be mentally ill. The MHA made provision for the detention of patients on a voluntary<sup>296</sup> or compulsory<sup>297</sup> manner in State and Provincial Institutions,<sup>298</sup> licensed institutions<sup>299</sup> and Private Dwellings. A person could be compulsorily detained if the magistrate has granted a reception order.<sup>300</sup> The MHA provided for the granting of a reception order in non-urgent cases, urgent cases and single care patients.<sup>301</sup> In a non-urgent application the following requirements had to be complied with:<sup>302</sup>

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<sup>291</sup> Long title of the Mental Health Act 18 of 1973.

<sup>292</sup> Kruger A *op cit* (n 1) at 46-50.

<sup>293</sup> S 1 of the Mental Health Act 18 of 1973.

<sup>294</sup> Kruger A *op cit* (n 1) at 49.

<sup>295</sup> Olmesdahl MCJ: *Furiosus Solo Furore Punitur* 1968 SALJ 272 at 278.

<sup>296</sup> S 3 of the Mental Health Act 18 of 1973.

<sup>297</sup> S 8.

<sup>298</sup> S 1 defines "institution" to mean a state psychiatric hospital or a provincial hospital or a half-way house at which provision has been made for the detention or treatment of persons who are mentally ill, and includes any other place designated by the Minister as a place for the reception and detention of two or more persons suffering from mental illness and in respect of which a licence has been granted under this Act.

<sup>299</sup> S 46(1) provides that the Minister of Health may issue licence to keep an institution for the reception and detention of mentally ill persons.

<sup>300</sup> S 11 provides that the reception order will be granted in respect of different application and only authorises the detention of a person for a period not exceeding forty-two days.

<sup>301</sup> The non-urgent application can be made in terms of s 8 of the Mental Health Act and Urgent applications could be made in terms of s 12 of the Mental Health Act and the application for single care patient may be made in terms of section 10 of the Mental Health Act.

<sup>302</sup> S 8.

- The Applicant<sup>303</sup>
  - a) The applicant had to be 18 years or older.
  - b) The applicant had to believe that any other person was suffering from mental illness to such a degree that he/she should be committed to an institution.
  - c) The applicant had to be a spouse or a relative of the person in respect of whom the application was made.
  - d) If the applicant was not the spouse or relative of the person in respect of whom the application was made, he/she had to explain why the application was made by him and not the spouse or a close relative.
- The Application<sup>304</sup>
  - a) The application had to be in writing to the magistrate of the district in which such other person was.
  - b) The application had to provide the grounds on which the applicant relied on, that the person was mentally ill to such a degree that he/she should be committed to an institution.
  - c) The application had to state the degree in which the applicant was related to the person in respect of whom the application was being made, and if the applicant was not the spouse or a near relative of such person, the reason why the application was being made by the applicant instead of the spouse or a near relative.
  - d) The application had to state that the applicant has personally seen the person in respect of whom the application was being made, within the seven days immediately prior to the date on which the application was signed.
  - e) The application had to be accompanied by an affidavit

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<sup>303</sup> S 9(1) of the Mental Health Act 18 of 1973.

<sup>304</sup> S 8(2).

The magistrate could grant a reception order after examining, with the assistance of two medical practitioners, the person in respect of whom the application is made.<sup>305</sup> The proceedings relating to the issue of a reception order could only be conducted in private.<sup>306</sup>

In an urgent application the following requirements had to be complied with:<sup>307</sup>

- The Applicant<sup>308</sup>
  - a) The applicant had to be 18 years or older.
  - b) The applicant had to bring the application for the welfare of a patient or had to be in the public interest that the patient be urgently placed under care and treatment in an institution.
- The Application<sup>309</sup>
  - a) The application had to be in writing to the magistrate of the district in which such other person was.
  - b) The application had to provide the grounds on which the applicant relied, that the person was mentally ill to such a degree that he should be committed to an institution.
  - c) The application had to state the degree in which the applicant was related to the person in respect of whom the application was being made, and if the applicant was not the spouse or a near relative of such person, the reason why the application was being made by the applicant instead of by the spouse or a near relative.
  - d) The application had to state that the applicant has personally seen the person in respect of whom the application was being made, within the two days immediately prior to the date on which the application was signed.
  - e) The application had to be accompanied by an affidavit.

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<sup>305</sup> S 9(1) of the Mental Health Act 18 of 1973.

<sup>306</sup> S 9(8).

<sup>307</sup> S 12.

<sup>308</sup> S 12(1).

<sup>309</sup> S 12(2)-(3).

f) The application had to be accompanied by a medical certificate relating to the mental condition of the patient, and by a statement that the matter was one of urgency.

Every person detained on an urgent basis may not be so detained for a period of more than ten days, unless the magistrate extends the period of detention.<sup>310</sup>

The superintendent of the institution to which a patient was admitted under an urgency application had to notify the magistrate of the district in which the institution was situated of such admission.<sup>311</sup> The magistrate had to proceed with the matter in the same manner as if the application had been made on a non-urgent basis, for the issue of a reception order.<sup>312</sup> Kruger<sup>313</sup> points out that the procedure in respect of the urgent application and non-urgent application for a reception order were the same; the only difference was the first step in the urgency proceedings. A medical practitioner could report any person, examined or treated by him, to the magistrate of the district in which such person was, if the medical practitioner was of the opinion that the person was mentally ill and a danger to others.<sup>314</sup>

The MHA empowered a police officer to make an application for a reception order in certain circumstances.<sup>315</sup> If a police officer reasonably believed that a person was mentally ill and neglected or ill-treated, he/she could apply for a reception order in respect of that person.<sup>316</sup> A police officer could also apply for a reception order in respect of a mentally ill person who was not under safe and proper supervision, care or control.<sup>317</sup> If a person was mentally ill and was wandering at large and was unable to take care of himself, a police officer could apply for a reception order in respect of such person.<sup>318</sup> However, if a police officer reasonably believed that the person was mentally ill and a danger to self or others, the police officer had to apprehend and detain the patient and report the matter to a magistrate.<sup>319</sup>

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<sup>310</sup> S 12(8) of the Mental Health Act 18 of 1973.

<sup>311</sup> S 12(5).

<sup>312</sup> *Ibid.*

<sup>313</sup> Kruger *A op cit* (n 1) at 69.

<sup>314</sup> S 13 of the Mental Health Act 18 of 1973.

<sup>315</sup> S 14.

<sup>316</sup> S 14 (1)(a)(i).

<sup>317</sup> S 14 (1)(a)(ii).

<sup>318</sup> S 14 (1)(b).

<sup>319</sup> S 14 (2).

When deciding to grant a reception order, a magistrate, could direct that the person be detained as a single patient.<sup>320</sup> Kruger<sup>321</sup> points out that theoretically the difference between a single patient and a compulsory detained patient was that the latter was detained in an institution and the former was detained in a private house. However, he further points out that in practice the provisions dealt with totally different patients.<sup>322</sup> In practice, most single patients were children and parents applied for single patient care in order to qualify for grants.<sup>323</sup> A magistrate could grant the reception order after examining the proposed householder and it was satisfied that the householder was a proper person to have charge of the patient and that his house and its surroundings were suitable for the reception and detention of the single patient.<sup>324</sup> The MHA provided a remedy to detained patients, in that they could approach, directly or through a *curator ad litem* the High Court for an enquiry into the reasons and grounds for his/her detention, and the court was empowered to make such order as it deems fit.<sup>325</sup>

The magistrate and the superintendent could submit, through a *curator ad litem*, a certificate and a report or further reports to the registrar of the court in whose area of jurisdiction in which the patient is being detained, and the registrar had to, and without delay, lay such certificate and report before a judge in chambers for consideration.<sup>326</sup> A judge in chambers could, after considering the certificate and report submitted by the magistrate and the superintendent, make an order to further discharge or order that the person remains detained.<sup>327</sup> Furthermore, a relative, guardian or friend could apply to court by petition for an enquiry into the mental condition of such person, whether or not a reception order had previously been issued, and the court could make such order as it deemed fit.<sup>328</sup>

It is submitted that the MHA provided an improvement in the protection of the human rights of involuntary users. However, it still fell short to properly protect involuntary

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<sup>320</sup> S 10, a patient would be detained as a single patient in private house and not in an institution.

<sup>321</sup> Kruger A *op cit* (n 1) at 70.

<sup>322</sup> *Ibid.*

<sup>323</sup> Kruger A *op cit* (n 1) at 43.

<sup>324</sup> S 10(3) of the Mental Health Act 18 of 1973.

<sup>325</sup> S 20.

<sup>326</sup> S 18.

<sup>327</sup> S 19.

<sup>328</sup> S 21.

users.<sup>329</sup> The knowledge and treatment of mental illness had considerably advanced and it was necessary to bring the laws into conformity with the development in the general field of psychiatry.<sup>330</sup>

## 2.6 The Impact of the Constitution on the regulation of mental health care

In 1993, a multi-party negotiation process at the World Trade Centre (Kempton park) culminated in the promulgation of the Constitution of the Republic of South Africa, 200 of 1993 (The Interim Constitution).<sup>331</sup> The Interim Constitution introduced the Bill of Rights which was further contained in the Constitution of the Republic of South Africa, 1996.<sup>332</sup> Eventually the Constitution was promulgated and it was based on the principles of constitutionalism; the rule of law; democracy and accountability; separation of powers and checks and balances; co-operative government and devolution of power.<sup>333</sup> The Constitution requires that legislation must comply with the principles underlying the Constitution and the Bill of Rights;<sup>334</sup> and necessitated a reform of various laws.<sup>335</sup> It is submitted that the MHCA was therefore enacted in order to bring the mental health laws in South Africa in conformity with the provisions of the Constitution. The influence of the Bill of Rights in the regulation of mental health laws and the framework of the MHCA are discussed in detail in chapter 3 of this study.

## 2.7 Conclusion

The history of South African mental health laws may be summarised as follows:

The mental health laws in South Africa moved from being centred on detention, to treatment and ultimately the protection of the rights of involuntary users (the treatment of mentally ill persons is a right protected by section 27 of the Constitution). During the pre-union era each pre-union state had its own laws regulating mental health and the

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<sup>329</sup> Allan A & Allan M: The right of mentally ill patients in South Africa to refuse treatment 1997 *SALJ* 578 at 578.

<sup>330</sup> *Ibid.*

<sup>331</sup> Devenish GE *The South African Constitution* 2005 (Lexis, Nexis Butterworths, Durban) 22, the Constitution of the Republic of South Africa Act 200 of 1993 came into force on 27 April 1994.

<sup>332</sup> Rautenbach IM and Malherbe EFJ *Constitutional Law* 4<sup>th</sup> ed 2004 (Lexis Nexis Butterworths, Durban) 292.

<sup>333</sup> Currie I & de Waal J *op cit* (n 44) at 7.

<sup>334</sup> S 2 of the Constitution of the Republic of South Africa.

<sup>335</sup> [http://r4d.dfid.gov.uk/PDF/Outputs/Disability/PolicyProject\\_legislation\\_sa\\_ex.pdf](http://r4d.dfid.gov.uk/PDF/Outputs/Disability/PolicyProject_legislation_sa_ex.pdf) (accessed on 24 June 2014).

detention of involuntary users. However, mentally ill persons were merely detained in order to remove them from the society, no treatment was provided and there was no regard for the protection of their rights. This trend continued until the MDA was promulgated as the first comprehensive legislation regulating mental health in the Union of South Africa. At that stage there was an attempt to treat mentally ill patients. When the MHA was promulgated in 1973, the mental health laws in South Africa were focused on the treatment of mentally ill persons and not just detention of such persons. The introduction of the Constitution meant that the rights of involuntary users had to be of paramount importance when detaining and treating involuntary users and this led to the promulgation of the MHCA. The mental health laws in South Africa became focussed on protecting the rights of mentally ill persons. This chapter was important in providing the context in which the current South African mental health laws have been promulgated. Chapter 3 provides a detailed description of the MHCA and the impact of the Bill of Rights as it is the main legislation regulating mental health care in South Africa.

## CHAPTER 3: The Legislative Framework of the Mental Health Care Act 17 of 2002

### 3.1 Introduction

The World Health Organisation (WHO)<sup>336</sup> provides the following ten basic principles as a guide to assist countries in developing mental health care laws:

- a) Promotion of mental health and prevention of mental disorders.
- b) Access to basic mental health care.
- c) Mental health assessments in accordance with internationally accepted principles.
- d) Provision for the least restrictive type of mental health care.
- e) Self-determination.
- f) Right to be assisted in the exercise of self-determination.
- g) Availability of review procedure.
- h) Automatic periodic review mechanism.
- i) Qualified decision maker.
- j) Respect for the rule of law.

The MHCA was promulgated in consideration of the guidelines provided above.<sup>337</sup> The MHCA creates the framework for caring for, treating mental illness and rehabilitating persons suffering from mental illness in South Africa both in the private and public sectors.<sup>338</sup> The MHCA recognises the following principles.<sup>339</sup>

- (a) Health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services.

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<sup>336</sup> WHO/MNH/MND/96.9 'Mental health care law: ten basic principles', Division of Mental Health and Prevention of Substance Abuse, World Health Organization, Geneva, 1996.

<sup>337</sup> Preamble to the Mental Health Care Act 38 of 2002.

<sup>338</sup> *Ibid.*

<sup>339</sup> *Ibid.*

- (b) The Constitution prohibits unfair discrimination of people on any ground, which includes mental health and other disabilities.
- (c) The person and property of a person with mental disorders or mental disabilities may, at times, require protection, and that members of the public and their property may similarly, in certain circumstances, require protection from people with mental disorders or mental disabilities.
- (d) There is a need to promote the provision of mental health care services in a manner that promotes the maximum mental well-being of users of mental health care services and the communities in which they reside.

## 3.2 Health establishments and mental health users

### 3.2.1 Mental health establishments

The MHCA defines a health establishment as an institution, facility, building or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals.<sup>340</sup> The health establishment is headed by a head of the establishment.<sup>341</sup>

The head of a provincial department of health must submit a list of health establishments in each district in the province that provide 72-hour assessments as contemplated in section 34 of the MHCA, to all health establishments under the auspices of the State, private health establishments within the province concerned, the police and the national department of health.<sup>342</sup> The MHCA differentiates between a private hospital and health establishment administered under the auspices of the State.<sup>343</sup> A private hospital means a hospital, which is not owned or funded by the State.<sup>344</sup> A health establishment administered under the auspices of the State means a

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<sup>340</sup> S 1 of the Mental Health Care Act 17 of 2002.

<sup>341</sup> S 14.

<sup>342</sup> Reg 12 of the General Regulations of the Mental Health Care Act 17 of 2002.

<sup>343</sup> Reg 1.

<sup>344</sup> *Ibid.*

public health establishment; or a health establishment contracted to and funded by the State to provide mental health care services on behalf of the State.<sup>345</sup>

A private hospital that wishes to admit assisted or involuntary users, must apply in writing to the national department of health for a licence to admit such users.<sup>346</sup> Before doing so, a private hospital must arrange with the applicable provincial department of health for the hospital to be inspected and audited by designated officials of the provincial department to determine whether the hospital is suitable to accommodate assisted and/or involuntary users or assisted and voluntary users, as the case may be.<sup>347</sup> The provincial department must stipulate clear conditions for granting the licence and the conditions must include:<sup>348</sup>

- 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.

Failure to comply with the stipulated conditions empowers the provincial department to withdraw the licence.<sup>349</sup> The head of the national department must (within 120 days of the Mental Health Care Act coming into place), with the concurrence of the head of the relevant provincial department, designate a health establishment or part of it as a psychiatric hospital or a care and rehabilitation centre and such designation may be revoked or varied.<sup>350</sup> A mental health establishment has the following duties when providing mental health care, treatment and rehabilitation services:

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<sup>345</sup> *Ibid.*

<sup>346</sup> Reg 42(2) of the General Regulations of the Mental Health Care Act 17 of 2002.

<sup>347</sup> Reg 42(3).

<sup>348</sup> Reg 42(5).

<sup>349</sup> Reg 42(6).

<sup>350</sup> S 5 of the Mental Health Care Act 17 of 2002.

- a) It must provide a care, treatment and rehabilitation services within its professional level or refer the mental health care user to a health establishment providing an appropriate level of mental care, treatment and rehabilitation services.<sup>351</sup>
- b) The health establishment may only give a mental health care user psychiatric medication for more than six months if it has been authorised by a mental health care practitioner.<sup>352</sup>
- c) A health establishment providing inpatient secondary level care and treatment may not admit a mental health care user for more than two months unless authorised by a mental health care practitioner in charge of the health establishment.<sup>353</sup>
- d) A health establishment must provide care, treatment and rehabilitation services in a manner that facilitates community care of mental health care users.<sup>354</sup>

### 3.2.2 Mental health care users

The MHCA regulates the detention and treatment of mental health care users, and provides three main categories of users, namely, voluntary mental health care users, assisted mental health care users and involuntary users. The MHCA read with the Criminal Procedure Act<sup>355</sup> also regulates the detention and treatment of state patients.

- Voluntary Users

A person who voluntarily submits 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.<sup>356</sup> It is submitted that if a person volunteers to receive mental health care, treatment and rehabilitation; there is no need to make any application, as it is a right that each person is entitled to.

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<sup>351</sup> S 6(1) of the Mental Health Care Act 17 of 2002.

<sup>352</sup> S 6(2).

<sup>353</sup> S 6(4).

<sup>354</sup> S 6(8).

<sup>355</sup> 51 of 1977.

<sup>356</sup> S 25.

- Assisted Users

A mental health care user may be provided with care, treatment and rehabilitation services at a health establishment as an outpatient or inpatient without his or her consent if:<sup>357</sup>

- a) The head of the health establishment has approved the written application for care, treatment and rehabilitation services.
- b) At the time of making the application there is a reasonable belief that the mental health care user is suffering from 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.
- c) At the time of making the application the mental health care user was incapable of making an informed decision on the need for the care, treatment and rehabilitation.

- Procedure during application

The application for assisted mental health care may be made by the spouse, next of kin, partner, associate, parent or guardian of the mental health care user.<sup>358</sup> If the mental health care user is under the age of 18, the application must be made by the parent of the mental health care user.<sup>359</sup> The application may be made by the health care provider if the parties who are authorised to make such an application are unwilling to do so.<sup>360</sup> The person making such an application must have seen the mental health care user within seven (7) days before making such an application.<sup>361</sup> The written application may be withdrawn at any time.<sup>362</sup>

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<sup>357</sup> S 26 of the Mental Health Care Act 17 of 2002.

<sup>358</sup> S 27(1)(a).

<sup>359</sup> S 27(1)(a)(i).

<sup>360</sup> S 27(1)(a)(ii).

<sup>361</sup> S 27(1)(b).

<sup>362</sup> S 27(3).

- The form of the application

An application for the provision of assisted services must be made in writing, using form MHCA 04.<sup>363</sup> The applicant must set out the following on form MHCA 04:<sup>364</sup>

- a) The relationship of the applicant to the mental health care user.
- b) The grounds on which the applicant believes the care, treatment and rehabilitation services is required.
- c) The date, time and place where the mental health care user was last seen by the applicant, which must be within seven (7) days of the application being made.
- d) If the applicant is a health care provider, the provider must state the reasons why he is making the application and what steps were taken to locate the relatives of the mental health care user in order to determine their capability or availability to make the application.

- The procedure after the application is made

The head of a health establishment must, after receiving the application, make available the mental health care user to be examined by two mental health care practitioners.<sup>365</sup> The mental health care practitioner conducting the examination may not be the mental health care practitioner making the application and one of the mental health care practitioners appointed to examine the mental health care users must be qualified to conduct a physical examination.<sup>366</sup> The mental health care practitioners appointed to examine the mental health care user must, after the completion of the examination, submit a report to the head of the health establishment concerned on whether-<sup>367</sup>

- a) the mental health care user qualifies to receive assisted care, treatment and rehabilitation services; and

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<sup>363</sup> S 27(1) read with reg 9(1).

<sup>364</sup> S 27(2) of the Mental Health Care 17 of 2002.

<sup>365</sup> S 27(4)(a).

<sup>366</sup> S 27(4)(b).

<sup>367</sup> S 27(5).

b) he/she should receive assisted care, treatment and rehabilitation services as an outpatient or inpatient.

If the finding of the two mental health care practitioners differs, the head of the health establishment will refer the matter to another mental health care practitioner who will submit a report on whether the mental health care user qualifies to receive assisted care, rehabilitation and treatment as an outpatient or an inpatient.<sup>368</sup> The head of the health establishment will approve the application only if two mental health care practitioners agree that the condition for assisted mental care, treatment and rehabilitation exist,<sup>369</sup> but it will only approve the application on the provision of assisted services as an inpatient if-<sup>370</sup>

a) the findings of two mental health care practitioners concur that the conditions for the provision of assisted inpatients care, treatment and rehabilitation exists; and

b) the head of the health establishment is satisfied that the restrictions and intrusion on the rights of the mental health care user to movement, privacy and dignity are proportionate to the care, treatment and rehabilitation services required.

The head of the health establishment must give notice to the applicant regarding its decision<sup>371</sup> and if it has approved the application for inpatient assisted care, treatment and rehabilitation it must cause the mental health care user to be admitted at a health establishment or to be referred to a health establishment with appropriate facilities.<sup>372</sup>

If the head of the health establishment has reasons to believe that an assisted user has recovered the capacity to make informed decisions, he or she must enquire from the assisted user whether the assisted user is willing to continue with care, treatment and rehabilitation services.<sup>373</sup> If the assisted user consents to further care, treatment and rehabilitation, he or she is considered as a voluntary user.<sup>374</sup> If the assisted user does not consent to further care, treatment and rehabilitation, the head of the establishment

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<sup>368</sup> S 27(6) of the Mental Health Care Act 17 of 2002.

<sup>369</sup> S 27(7).

<sup>370</sup> S 27(8).

<sup>371</sup> S 27(9).

<sup>372</sup> S 27(10).

<sup>373</sup> S 31(1).

<sup>374</sup> S 31(2).

may discharge the assisted user if it was satisfied that he/she has recovered.<sup>375</sup> If the head of the establishment is satisfied that the person is still suffering from mental illness, it must advise the person who made the application for assisted care, treatment and rehabilitation that he/she may make an application to detain the assisted user as an involuntary user.<sup>376</sup>

- Involuntary Users

Section 32 of the MHCA<sup>377</sup> allows for care, treatment and rehabilitation of a person without consent if-

- a) an application in writing is made to the head of the health establishment concerned to obtain the necessary services and the application is granted;
- b) there is a reasonable belief that the user has a mental illness of such a nature that the user is likely to inflict serious harm to himself or herself or others; or care, treatment and rehabilitation is necessary for the protection of his or her financial interests or reputation; and
- c) at the time the application is made the user is incapable of making an informed decision on the need for care, treatment and rehabilitation and is unwilling to receive the care, treatment and rehabilitation required.

- Who may apply?

The application for involuntary mental health care may be made by the spouse, next of kin, partner, associate, parent or guardian of the mental health care user.<sup>378</sup> If the mental health care user is under the age of 18, the application must be made by the parent of the mental health care user.<sup>379</sup> The application may be made by the health care provider if the parties who are authorised to make such an application are unwilling to do so.<sup>380</sup> The person making such an application must have seen the mental health

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<sup>375</sup> S 31(2) of the Mental Health Care Act 17 of 2002.

<sup>376</sup> S 31(1).

<sup>377</sup> 17 of 2002.

<sup>378</sup> S 33(1)(a) of the Mental Health Care Act 17 of 2002.

<sup>379</sup> S 33(1)(a)(i).

<sup>380</sup> S 33(1)(a)(ii).

care user within seven (7) days before making such an application.<sup>381</sup> The written application may be withdrawn at any time.<sup>382</sup>

- The form of the application

An application for the provision of involuntary services must be made in writing, using form MHCA 04.<sup>383</sup> The applicant must set out the following on form MHCA 04:<sup>384</sup>

- a) The relationship of the applicant to the mental health care user.
- b) The grounds on which the applicant believes the care, treatment and rehabilitation services is required.
- c) The date, time and place where the mental health care user was last seen by the applicant, which must be within seven days of the application being made.
- d) If the applicant is a mental health care provider, he/she must state the reasons why he/she is making the application and what steps were taken to locate the relatives of the mental health care user in order to determine their capability or availability to make the application.

- The procedure after the application

The head of a health establishment must, after receiving the application, cause the mental health care user to be examined by two mental health care practitioners.<sup>385</sup> The mental health care practitioner conducting the examination may not be the mental health care practitioner making the application and one of the mental health care practitioners appointed to examine the mental health care users must be qualified to conduct physical examinations.<sup>386</sup> The mental health care practitioners appointed to examine the mental health care user must, after the completion of the examination, submit a report to the head of the health establishment concerned on whether:<sup>387</sup>

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<sup>381</sup> S 33(b) of the Mental Health Care Act 17 of 2002.

<sup>382</sup> S 33(3).

<sup>383</sup> Reg 10(1) of the General Regulations of the Mental Health Care Act 17 of 2002.

<sup>384</sup> S 33(2) of the Mental Health Care Act 17 of 2002.

<sup>385</sup> S 33(4)(a).

<sup>386</sup> S 33(4)(b).

<sup>387</sup> S 33(5).

- a) the mental health care user qualifies to receive involuntary care, treatment and rehabilitation services; and
- b) he/she should receive involuntary care, treatment and rehabilitation services as an outpatient or inpatient.

If the finding of the two mental health care practitioners differs, the head of the health establishment will refer the matter to another mental health care practitioner who will submit a report on whether the mental health care user qualifies to receive involuntary care, rehabilitation and treatment as an outpatient or an inpatient.<sup>388</sup> The head of the health establishment will approve the application only if two mental health care practitioners agree that the condition for involuntary mental health care, treatment and rehabilitation exist.<sup>389</sup> If the head of the health establishment approves involuntary care, treatment and rehabilitation services, he/she must cause the user to be admitted or referred to a health establishment within 48 hours.<sup>390</sup>

- 72 Hours assessment

After the head of a health establishment grants the application for involuntary services, she/he must-<sup>391</sup>

- a) ensure that the user is given appropriate care, treatment and rehabilitation services;
- b) 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; and
- c) ensure that the practitioners also consider whether the involuntary services must be continued. If services must be provided the practitioners must state whether this should be on an outpatient or inpatient basis.

Within 24 hours of the expiry of the 72 hours assessment period, the head of the health establishment must make available the findings of the assessment to the applicant.<sup>392</sup>

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<sup>388</sup> S 33(6) of the Mental Health Care Act 17 of 2002.

<sup>389</sup> S 33(7).

<sup>390</sup> S 33(9).

<sup>391</sup> S 34(1).

<sup>392</sup> S 34(2).

The head of the establishment has the following options available to him/her after the expiry of the assessment.<sup>393</sup>

- a) Immediately discharge the user if he/she is of the opinion that the status of the user does not warrant involuntary care, treatment and rehabilitation services.
- b) Discharge the user on an outpatient basis if the status of the user warrants further involuntary care, treatment and rehabilitation basis.
- c) Request the Review Board to approve further involuntary care, treatment and rehabilitation services on an inpatient basis if the status of the user warrant further involuntary care, treatment, rehabilitation services on an inpatient service.

If the head of the health establishment requests the Review Board to approve further involuntary care, treatment and rehabilitation services on an inpatient basis, the Review Board must within 30 days give the interested parties an opportunity to make oral or written representations on the merits of the application.<sup>394</sup> The Review Board will forward the written decisions and the reasons to the applicant and the head of a health establishment;<sup>395</sup> and if the Review Board has decided to grant the request for further involuntary care, treatment and rehabilitation, it must refer the matter for an automatic review to the high court.<sup>396</sup>

- Intervention by South African Police Service (SAPS)

In terms of section 40 of the MHCA, if a member of the SAPS 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 himself or herself 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

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<sup>393</sup> S 34(3) of the Mental Health Care Act 17 of 2002.

<sup>394</sup> S 34(7)(a).

<sup>395</sup> S 34(7)(b).

<sup>396</sup> S 34(7)(c).

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.

If a mental health care practitioner, after the assessment of the user referred by a member of SAPS, is of the view that the person apprehended is due to mental illness likely to inflict serious harm to himself or herself or others, must admit the person to the health establishment for a period not exceeding 24 hours for an application for involuntary services to be made; or unlikely to cause harm, he or she must release the person immediately.<sup>397</sup> The application for involuntary services must be made within the 24 hour period after the person apprehended and such application has not been made, the mental health care user must be discharged.<sup>398</sup> It is submitted that the procedure for involuntary mental health care services, as provided in terms of section 33 of the MHCA applies in respect of mental health care users referred in terms of section 40 of the MHCA.

### 3.2.3 Mental Health Review Boards

- Establishment and Composition

Each province in the Republic of South Africa must have at least one Review Board. The responsibility for establishing a Review Board or Review Boards in a province rests with the Member of the Executive Council responsible for Health Services in the province (the Health MEC).<sup>399</sup> A Review Board may be established for a single health establishment, a cluster of health establishments or all health establishments providing mental health care services in that province.<sup>400</sup> The relevant provincial department must provide human and other resources to enable the Review Board to perform its administrative functions.<sup>401</sup>

The Review Board consists of no fewer than three persons and no more than five persons.<sup>402</sup> The members must be South African citizens.<sup>403</sup> They are appointed by the

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<sup>397</sup> S 40(2) of the Mental Health Care Act 17 of 2002.

<sup>398</sup> S 40(3).

<sup>399</sup> S 18(1).

<sup>400</sup> S 18(2).

<sup>401</sup> S 18(3).

<sup>402</sup> S 20(1).

<sup>403</sup> *Ibid.*

Health MEC of the province.<sup>404</sup> Each board must consist of at least one mental health care practitioner, a magistrate or an attorney or an advocate admitted in terms of the laws of the Republic of South Africa and a member of the community.<sup>405</sup> Before appointing any person to a Review Board, the Health MEC must publish a notice calling for nominees, stating the criteria for nominations and specifying a period within which nominations must be submitted.<sup>406</sup> The notice must be published in the Provincial Gazette and in any other widely circulating means of communication in that province.<sup>407</sup> The Health MEC must consider all nominations that are received and make an appointment.<sup>408</sup> The Health MEC must determine the term of office of members who are appointed to the board.<sup>409</sup> The terms of office may be staggered.<sup>410</sup> The fact that there is a vacancy at the time the Review Board takes a decision, does not affect the validity of such a decision.<sup>411</sup>

Any member of the Review Board may be removed from office by the Health MEC if<sup>412</sup>

- a) the member ceases to practise the profession in terms of which he or she was appointed;
- b) the member is unable to perform his/her duties effectively;
- c) the member was absent from two consecutive meetings of the Review Board without prior permission, except on good cause shown;
- d) the member ceases to be a South African citizen; or
- e) it is in the public interest to remove such a member.

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<sup>404</sup> *Ibid.*

<sup>405</sup> S 20(2) of the mental Health Care Act 17 of 2002.

<sup>406</sup> S 20(3).

<sup>407</sup> S 20(3).

<sup>408</sup> S 20(3)(c).

<sup>409</sup> S 20(4)(a).

<sup>410</sup> S 20(4)(b).

<sup>411</sup> S 22(3).

<sup>412</sup> S 21.

- Powers and functions of Review Boards

Section 19 of the MHCA,<sup>413</sup> provides the following powers and functions of the Review Board:

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

The MHCA further provides powers and functions to the Review Boards relating to receipt of information, reviews, appeals, requests and applications and monitoring. The Review Board also has the power to determine its own procedure for carrying on business.<sup>414</sup>

The Review Board is an independent body which has the oversight role and the responsibility to ensure that mental health care users are not detained without due regard for their human right.<sup>415</sup> Levinsohn DJP, in *G v Sixty-six Others*,<sup>416</sup> emphasises the role of review boards as follows:

[19] Now it will have become apparent from the abovementioned review of the legislation that the legislature clearly intended to introduce a regime which was compassionate and fully compatible with human rights and in particular the Constitution. The establishment of Review Boards was a new innovation and was aimed at ensuring

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<sup>413</sup> 17 of 2002.

<sup>414</sup> S 24(1) of the Mental Health Care Act 17 of 2002.

<sup>415</sup> *G v Sixty-six Others* (19/2007) [2008] ZAKZHC 37 (5 June 2008) para 17 to 19.

<sup>416</sup> ZAKZHC 37 (5 June 2008) paras 19, 39 and 40.

that the cases of mental health care users are considered by an independent body which obviously makes vital decisions in regard to the user's future. It goes without saying and is self-evident that the detention of a person in a mental institution on an involuntary basis is far-reaching involving as it does the deprivation of that person's liberty.

[39] In our view Review Boards are doing what the Act intended, and that is, to act as an independent objective body to investigate and report on decisions that have been made to admit users to institutions. They have supplanted the curator-ad-litem in the repealed Act and in our view perform a very practical function in the final assessment of a user's condition.

[40] When the matter is referred to the High Court there ought to be some record or minutes of what has transpired in the deliberations of the Review Board concerned. The reviewing judge will be concerned about whether the user has been properly apprised of his right to representation and whether he/she was able to understand the rights. A short report from the Board or from the health practitioner member would be of great assistance in allaying those concerns.'

It is submitted that the court correctly defined the Review Board as an independent body intended to ensure the protection of mental health care users. However, it may not be correct to define it as a *curator ad litem*. Landman and Landman<sup>417</sup> make the following argument regarding the legal nature of a Review Board:

'It would not, however, be entirely correct to regard a board as fulfilling the role of a *curator-ad-litem*. A board is itself the author of acts that may affect a user. When performing its functions a board does not purport to represent the user even though it would take into account the best interests of the user.

A board is an organ of state exercising public powers and performing a public function in terms of an Act which may adversely affect the rights of a person and which has a direct external effect on the person. A board is therefore an administrative organ. A board is not a court of law. 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 for the decision.'

Landman and Landman<sup>418</sup> further argue that the composition of the Review Board emphasises the oversight role of the Review Boards. They breakdown the composition of the Review Board as follows:<sup>419</sup>

- a) The community member represents the interests of society in ensuring that mental health care users are treated with the expedition, dignity and expertise available.

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<sup>417</sup> Landman AA & Landman WJ *A Practitioner's Guide to the Mental Health Care Act 2014* (Juta, Cape Town) 209.

<sup>418</sup> *Ibid.*

<sup>419</sup> *Ibid.*

- b) The mental health care practitioner will chiefly ensure that the services afforded the user are appropriate for the situation, bearing in mind that this must be proportionate to the circumstances.
- c) The legal expert's primary role is to ensure that the rights, freedom and the liberties are honoured and observed or, where infringement is permissible, are infringed as little as is compatible with optimum treatment.

### 3.2.4 The impact of the Bill of Rights on mental health laws

It has always been required that laws ought to be just and reasonable; both in its matter, for it prescribes what is honourable and forbids what is base; and its form, for it preserves equality and binds the citizens equally.<sup>420</sup> Every person, whether healthy or ill, has basic human rights that are guaranteed by the Constitution.<sup>421</sup>

Swanepoel<sup>422</sup> points out that the Constitution has the following impact on mentally disordered persons:

- a) The Constitution is the supreme law in South Africa, and any legislation that is in conflict with it, is invalid to the extent of the conflict.
- b) The Bill of Rights applies to all law and binds the executive, legislature, judiciary and all organs of state.
- c) The Bill of Rights instructs the state to use the power that the Constitution provides for, in ways that do not violate fundamental rights.

The Bill of rights makes provisions for certain rights and such right applies to everyone including mentally ill persons. The Bill of Rights further prescribes instructions regarding the interpretation of these rights.<sup>423</sup> Section 39 of the Constitution provides that:

'39(1) when interpreting the bill of rights, a court, tribunal or forum:

- (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;

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<sup>420</sup> Voet 1.3.5.

<sup>421</sup> The Constitution of the Republic of South Africa, 1996.

<sup>422</sup> Swanepoel M *op cit* (n 113).

<sup>423</sup> S 39 of the Constitution of the Republic of South Africa, 1996.

(b) must consider international law; and

(c) may consider foreign law.

(2) When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit purport and objects of the Bill of Rights

(3) The Bill of Rights does not deny the existence of any other rights or freedoms that are recognised or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill of Rights.'

The importance of considering international law and foreign law was emphasised in *S v Makwanyane*.<sup>424</sup> The court made the following finding:<sup>425</sup>

'and for that purpose decisions of tribunals dealing with comparable instruments, such as the United Nations Committee of Human Rights, the inter-American Commission on Human Rights, and the European Court of Human rights, and in appropriate cases, reports of specialised agencies such as the International Labour Organisation may provide guidance as to the correct interpretation of particular provisions.'

Rautenbach and Malherbe<sup>426</sup> point out that when the meaning of the constitution is determined, the text of the Constitution as whole; the values that underlie an open and democratic society based on human dignity, equality and freedom; international laws; and foreign law must be considered. The Bill of Rights requires that every statute, including the MHCA, be interpreted in terms of the Bill of Rights.<sup>427</sup>

It is important to note that the Bill of Rights recognises that some rights might be in conflict and cannot be applied at the same time and therefore certain rights need to be limited.<sup>428</sup> The rights may be limited only by a law of general application and then only 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.<sup>429</sup> It must be shown that the law in question serves a constitutionally acceptable purpose and that there is sufficient proportionality between the harm done by the law

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<sup>424</sup> *Op cit* (n 50).

<sup>425</sup> *Op cit* (n 50) para 36-37.

<sup>426</sup> Rautenbach IM and Malherbe EFJ *op cit* (n 332).

<sup>427</sup> S 39(2) of the Constitution of the Republic of South Africa, 1996.

<sup>428</sup> S 36 of the Constitution of the Republic of South Africa, 1996.

<sup>429</sup> *Ibid*.

(the infringement of fundamental rights) and the benefits it is designed to achieve (the purposes of the law).<sup>430</sup>

Section 27 of the Constitution provides that:

‘27. Health care, food, water and social security.—(1) Everyone has the right to have access to—

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment.’

Section 27 prohibits the interference with the rights to access to health care and also place a duty on the state to take reasonable and other measures to achieve the progressive realisation of, *inter alia*, the right to health care.<sup>431</sup> Section 27 further provides that every person has a right to receive emergency medical treatment and such treatment may not be refused. In *Soobramoney v Minister of Health (Kwazulu-Natal)*,<sup>432</sup> the court made the following remarks regarding the provision of emergency health care:

‘Section 27(3) itself is couched in negative terms – it is a right not to be refused emergency treatment. The purpose of the right seems to be to ensure that treatment be given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities.’

But the right to emergency health care does not include the right to receive on-going treatment of an illness to prolong one’s life.<sup>433</sup>

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<sup>430</sup> *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* (4502/10, 5825/14) [2014] ZAWCHC 135 (5 September 2014).

<sup>431</sup> Ss 27(1) and (2).

<sup>432</sup> 1998 (1) SA 765 (CC) para 20.

<sup>433</sup> *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC) para 13.

Section 12(1) of the Constitution provides 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.'

Ackermann J, in *De Lange v Smith NO*,<sup>434</sup> made the following remark regarding the effect of section 12(1) of the Constitution:

'It can therefore be concluded that section 12(1), in entrenching the right to freedom and security of the person, entrenches the two different aspects of the right to freedom referred to above. The one that O'Regan J has, in the above-cited passages, called the right not to be deprived of liberty "for reasons that are not acceptable" or what may also conveniently be described as the substantive aspect of the protection of freedom, is given express entrenchment in section 12(1)(a) which protects individuals against deprivation of freedom "arbitrarily or without just cause". The other, which may be described as the procedural aspect of the protection of freedom, is implicit in section 12(1) as it was in section 11(1) of the interim Constitution.'

Section 12(1) provides protection to persons detained as involuntary mental health care users not to be detained for reasons that are not acceptable and without just cause. Bonthuys<sup>435</sup> argues that the rights provided to detained persons<sup>436</sup> should apply to persons detained as involuntary mental health care users. It is submitted that the Bill of Rights is very important in giving content to the right provided in terms of the MHCA.

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<sup>434</sup> 1998(3) SA 785 (CC).

<sup>435</sup> Bonthuys E: Involuntary Civil Commitment and the New Mental Health Care Bill (2001) 118 *SALJ* 667 at 683.

<sup>436</sup> Section 35(2) of the Constitution provides the following rights to detained persons: the right— (a) to be informed promptly of the reason for being detained; (b) to choose, and to consult with, a legal practitioner, and to be informed of this right promptly; (c) to have a legal practitioner assigned to the detained person by the state and at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly; (d) to challenge the lawfulness of the detention in person before a court and, if the detention is unlawful, to be released; (e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment; and (f) to communicate with, and be visited by, that person's— (i) spouse or partner; (ii) next of kin; (iii) chosen religious counsellor; and (iv) chosen medical practitioner.

### 3.2.5 The rights of involuntary mental health care users in terms of the MHCA

- Respect, human dignity and privacy

Section 8 of the MHCA provides the following:

'8. Respect, human dignity and privacy.—(1) The person, human dignity and privacy of every mental health care user must be respected.

(2) Every mental health care user must be provided with care, 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.

(3) The care, treatment and rehabilitation services administered to a mental health care user must be proportionate to his or her mental health status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation.'

The MHCA reaffirms that every user has the right to respect for his/her person, human dignity and privacy. The MHCA gives effect to one of the most important rights in the Constitution, human dignity.<sup>437</sup> The right to dignity is a foundation for a number of human rights contained in the Bill of Rights.<sup>438</sup> Ackerman J, in *S v Dodo*,<sup>439</sup> made the following finding regarding the need to respect and value human beings (at para 38):

'Human beings are not commodities to which a price can be attached; they are creatures with inherent and infinite worth; they ought to be treated as ends in themselves, never merely as means to an end.'

O'regan J, in *S v Makwanyane*,<sup>440</sup> recognised the importance of human dignity as a foundation to other human rights, when she stated that:

'[328] The right to dignity is enshrined in our Constitution in s 10:

"Every person shall have the right to respect for and protection of his or her dignity."

The importance of dignity as a founding value of the new Constitution cannot be overemphasised. Recognising a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern. This right therefore is the foundation of many of the other rights that are specifically entrenched in chap 3. As Brennan J held when speaking of forms of cruel and unusual punishments in the context of the American Constitution:

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<sup>437</sup> *S v Makwanyane* 1995 (3) SA 391(CC) para 144.

<sup>438</sup> Currie I & de Waal J *op cit* (n 44) at 274.

<sup>439</sup> 2001 (3) SA 382 (CC).

<sup>440</sup> 1995 (3) SA 391 (CC).

“The true significance of these punishments is that they treat members of the human race as non-humans, as objects to be toyed with and discarded. They are thus inconsistent with the fundamental premise of the clause that even the vilest criminal remains a human being possessed of common human dignity.” (*Furman v Georgia* 408 US 238 (1972) at 272-3.)

[329] Respect for the dignity of all human beings is particularly important in South Africa. For apartheid was a denial of a common humanity. Black people were refused respect and dignity and thereby the dignity of all South Africans was diminished. The new Constitution rejects this past and affirms the equal worth of all South Africans. Thus recognition and protection of human dignity is the touchstone of the new political order and is fundamental to the new Constitution.

[330] But human dignity is important to all democracies. In an aphorism coined by Ronald Dworkin, “Because we honour dignity, we demand democracy”. Its importance was recognised too by Cory J in *Kindler v Canada (Minister of Justice)* (1992) 6 CRR (2nd) 193 (SCC) at 237 in which he held that “(i)t is the dignity and importance of the individual which is the essence and the cornerstone of democratic government”.

The right to human dignity is a right protected in terms of the Constitution; furthermore, it is a value which informs the interpretation of most of the rights in the Constitution.<sup>441</sup>

Section 8 of the MHCA further provides the right to privacy to involuntary mental health care users. In terms of section 14 of the Constitution the right to privacy includes the right not to have the person or person’s home searched; the person’s property searched; the person possession seized; or the privacy of the person’s communication infringed. Section 14 provides two parts, the first being the general protection of the right to privacy and the second being the protections against specific infringements.<sup>442</sup> Section 8 of the MHCA only provides a general protection for a right to privacy.

The test to determine whether privacy is involved in any particular case is-<sup>443</sup>

- a) that there must be a subjective expectation of the bearer of the right that something is a personal/private facts; and
- b) that society must consider the expectation to be reasonable. This is an objective test.

The test does not define what private facts are. However, it has been accepted that private facts are those matters the disclosure of which will cause mental distress and

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<sup>441</sup> Currie I and de Waal J *op cit* (n 44) 275.

<sup>442</sup> *Ibid.*

<sup>443</sup> *NM and Others v Smith and Others* 2007 (5) SA 250 (CC) para 34.

injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep them private.<sup>444</sup>

In addition, section 8 provides that every involuntary mental health care user must be provided with services that improve his/her mental capacity to develop to full potential and to facilitate his/her re-integration back into community life.<sup>445</sup> The MHCA demands that persons suffering from a mental illness are not to be secluded and isolated from society unless necessary or for their protection and for the protection of others.<sup>446</sup> The prohibition on the abuse of mental health care users is a further measure intended to protect the dignity of a mental health care user.

- Consent to care, treatment and rehabilitation services

Section 9(1) of the MHCA provides that a mental health care user may be provided with care, treatment and rehabilitation services only if:

- a) the mental health care user has consented to the care, treatment and rehabilitation services or to admission;
- b) it is authorised by a court order or a Review Board; or
- c) any delay would lead to death or harm to the mental health care user or any other person; or causing serious damage to or loss of property belonging to the user or any other person.

The MHCA recognises and protects the right to autonomy. However, it is submitted that the MHCA also acknowledges that there are situations when the mental health care user cannot, or will not, consent, even where treatment is very necessary. It is clear that an involuntary mental health care user may be treated without his/her consent in two circumstances: where the treatment has been authorised by a court order or a Review Board, or where there is an emergency and, because of mental illness, any delay in providing services or admission may result in certain consequences. When a mental health care user is treated by a mental health care practitioner or health establishment without her consent and a delay would lead to death or harm to an involuntary mental

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<sup>444</sup> *Ibid.*

<sup>445</sup> S 8(2) of the Mental Health Care Act 17 of 2002.

<sup>446</sup> Reg 33 of the General Regulation of the Mental Health Care Act 17 of 2002.

health care user or any other person; or causing serious damage to or loss of property belonging to the user or any other person, the mental health care practitioner or health establishment must report this fact to the relevant Review Board,<sup>447</sup> and may not continue to provide services to the user concerned for longer than 24 hours unless an application for voluntary, assisted, or involuntary mental health care is made within the 24-hour period.<sup>448</sup>

The MHCA recognises that there may be instances in which an involuntary mental health care user may be subjected to treatment and operations for illness other than mental illness.<sup>449</sup> If an involuntary mental health care user is capable of granting consent for treatment other than mental illness, the user should grant such consent before the care or treatment is granted to such user.<sup>450</sup> The MHCA also recognises that where the user is unable to give consent for treatment, such consent may be granted by a curator appointed by a court, a spouse, next of kin<sup>451</sup> or in some instances the head of the health establishment.<sup>452</sup>

The consent given by the party must comply with the following requirements:<sup>453</sup>

- 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 extending to the entire transaction, inclusive of all its consequences.

The MHCA makes it clear that an involuntary mental health care user has a limited right to consent or refuse treatment, care or rehabilitation in respect of his/her mental illness or any other treatment other than his or her mental illness.

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<sup>447</sup> S 9(2)(a) of the Mental Health Care Act 17 of 2002.

<sup>448</sup> S 9(2)(b).

<sup>449</sup> Reg 37 of the General Regulations of the Mental Health Care Act 17 of 2002.

<sup>450</sup> Reg 37(1).

<sup>451</sup> Reg 37(2).

<sup>452</sup> Reg 37(3).

<sup>453</sup> *Castell v De Greef* 1994 (4) SA 408 (C) 425.

- Protection against unfair discrimination

Section 10 of the MHCA states that a person suffering from mental illness is entitled not to be unfairly discriminated against on the grounds of her mental health status<sup>454</sup> and every such person has a right to receive services according to standards that are equivalent to those applicable to other persons.<sup>455</sup> Policies and programmes that are aimed at promoting the mental health status of a person must be implemented taking into account the mental capacity of the person concerned.<sup>456</sup>

Section 9 of the Constitution prohibits discrimination in the following terms:

(1) Everyone is equal before the law and has 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.

(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.'

In *Hoffmann v South African Airways*,<sup>457</sup> the court made the following finding regarding the prohibition of unfair discrimination:

'At the heart of the prohibition of unfair discrimination is the recognition that under our Constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against. The determining factor regarding the unfairness of the discrimination is its impact on the person discriminated against. Relevant considerations in this regard include the position of the victim of the discrimination in society, the purpose sought to be achieved by the discrimination, the extent to which the rights or interests of the victim of the discrimination have been affected, and whether the discrimination has impaired the human dignity of the victim.'

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<sup>454</sup> S 10(1) of the Mental Health Act 17 of 2002.

<sup>455</sup> S 10(2).

<sup>456</sup> S 10(3).

<sup>457</sup> 2001 (1) SA 1 (CC) para 27.

The MHCA gives effect to the constitutional prohibition on discrimination and does so by prohibiting discrimination on the ground of a mental health care user's mental health status. According to *Harksen v Lane NO*,<sup>458</sup> the following enquiry should be conducted in determining whether a conduct amounts to an unfair discrimination:

(a) Does the provision differentiate between persons or any categories of persons? If so, does the differentiation bear a relational connection to a legitimate government purpose? If it does not then there is a violation of section 9(1)<sup>459</sup> of the Constitution. Even if it does bear a rational connection, it might nevertheless amount to discrimination if the differentiation amounts to an unfair discrimination.

(b) Does the differentiation amount to unfair discrimination? This requires a two stage approach:

(i) Firstly, does the differentiation amount to 'discrimination'? If it is on a specified ground, then discrimination will have been established. If it is not on a specified ground, then whether, objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of a person as human being or to affect them adversely in a comparably serious manner.

(ii) If the differentiation amounts to a 'discrimination' does it amount to 'unfair discrimination'? If it has been found to have been on a specified ground, then unfairness will be presumed. If on an unspecified ground, unfairness will have to be established by the person alleging such unfairness. If at the end of this stage of the inquiry, the differentiation is found not to be unfair, then there will be no violation of section 9 (3) and 9 (4) of the Constitution.<sup>460</sup>

(c) If the discrimination is found to be unfair then a determination will have to be made as to whether the provision can be justified under the limitation clause (s 36 of the Constitution of the Republic of South Africa).

There are generally three forms of discrimination.<sup>461</sup> First, there is mere differentiation which only amounts to discrimination and is in conflict with section 9(1) of the

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<sup>458</sup> 1997 11 BCLR 1489 (CC) para 53.

<sup>459</sup> Currie I & de Waal J *op cit* (n 44) 235-236.

<sup>460</sup> Currie I & de Waal J *op cit* (n 44).

<sup>461</sup> Currie I & de Waal J *op cit* (n 44) 237.

Constitution if it is not rationally connected to a legitimate government purpose.<sup>462</sup> Second, there is a differentiation which amounts to unfair discrimination and in conflict with section 9(3) and 9(4) of the Constitution regardless of whether the differentiation is rationally connected to a government purpose or not.<sup>463</sup> Third, there is a differentiation which amount to a fair discrimination.<sup>464</sup>

The MHCA places an obligation on the state to implement policies and programmes aimed at improving the mental health status of the mental health care user.<sup>465</sup> The policies and programmes aimed at promoting the mental health status of a person must be appropriate for the intended mental health care user.

- Protection against exploitation and abuse

Section 11 of the MHCA provides that every person suffering from mental illness has a right:

- a) not to be exploited, abused or suffer degrading treatment;
- b) not to be subjected to forced labour; and
- c) to services, provided these are not used as punishment, or for the convenience of other people.

Any person witnessing any form of abuse set out above must report it in the prescribed manner.<sup>466</sup> Section 12(1)(e) of the Constitution prohibits the cruel, inhuman or degrading treatment or punishment of any person. The rights provided in terms of section 11 of the MHCA are an extension of the right to dignity.<sup>467</sup> Whether the mentally ill person is subjected to exploitation, abuse, degrading treatment or forced labour, the dignity of the user is infringed.<sup>468</sup> The words exploited, abused and degrading treatment are not defined in the MHCA. However, the definition of degrading treatment in terms of the Constitution provides direction. Punishment is degrading if it causes feelings of fear

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<sup>462</sup> *Ibid.*

<sup>463</sup> *Ibid.*

<sup>464</sup> *Ibid.* Discrimination will be fair if it can be justified in terms of the provision of s 36 of the Constitution of the Republic of South Africa, 1996.

<sup>465</sup> S 10(3).

<sup>466</sup> S 11(2) of the Mental Health Care Act 17 of 2002. The person must report this fact to the board on form MHCA 02, or lay a charge with the South African Police Service.

<sup>467</sup> *Op cit* (n 50).

<sup>468</sup> *S v Dodo* 2001 (3) SA 382 (CC) para 35.

anguish and inferiority capable of humiliating and debasing the victims and possibly breaking their physical or moral resistance.<sup>469</sup> Some practices are inherently degrading.<sup>470</sup> Section 13 of the Constitution provides that no one may be subjected to slavery, servitude or forced labour.

- Determination concerning mental status

The MHCA prohibits the determination of mental health status on irrelevant factors.

Section 12 of the MHCA, provides that:

(1) 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.

(2) 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.'

Any determination or diagnosis of the mental health status of any person must be based on factors exclusively relevant to that person's mental health status.

- Confidentiality

A mental health care practitioner or health establishment may not disclose any information that an involuntary mental health care user is entitled to keep confidential in terms of any other law.<sup>471</sup> But this obligation to keep the information confidential is not absolute. The head of the national health department, a head of a provincial department of health or the head of a health establishment may disclose this information if failure to do so would seriously prejudice the health of the user or that of other persons.<sup>472</sup> A mental health care user has the right to access information in her health records. A mental health care provider may temporarily deny a mental health care user access to information contained in their health records, if disclosure of that information is likely to:<sup>473</sup>

a) seriously prejudice the user; or

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<sup>469</sup> Woolman S *Constitutional Law of South Africa* 2<sup>nd</sup> ed 2008(Juta, Durban) at 40-68.

<sup>470</sup> *S v Williams* 1995 (2) SACR 251 (CC) para 40.

<sup>471</sup> S 13(1) of the Mental Health Care Act 17 of 2002.

<sup>472</sup> S 13(2).

<sup>473</sup> S 13(3).

b) cause the user to conduct him or herself in a manner that may seriously prejudice him or her or the health of other people.

- Intimate adult relationship

The general rule is that there is no limit on a mental health care user having intimate adult relationships. The right to intimate adult relationship is subject to conditions applicable to providing care, treatment and rehabilitation services in health establishments.<sup>474</sup> 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.<sup>475</sup>

- Right to representation

A mental health care user has the right to a representative, including a legal representative, when the user is submitting an application, lodging an appeal, or appearing before a magistrate, judge or a Review Board, subject to the laws governing rights of appearances at a court of law.<sup>476</sup> This means that only a representative who is entitled to appear in the court concerned may do so. 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 the MHCA subject to any condition fixed in terms of section 3(d) of the Legal Aid Act, 22 of 1969.<sup>477</sup>

- Discharge reports

The head of a health establishment must, in a prescribed form, issue a discharge report to the user who was admitted for purposes of receiving care, treatment and rehabilitation services.<sup>478</sup>

- Knowledge of rights

Every mental health care provider must, before administering any care, treatment and rehabilitation services, inform a mental health care user in an appropriate manner of his

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<sup>474</sup> S 14 of the Mental Health Care Act 17 of 2002.

<sup>475</sup> *Ibid.*

<sup>476</sup> S 15(1).

<sup>477</sup> S 15(2).

<sup>478</sup> S 16.

or her rights, unless the user has been admitted without consent in terms of section 9(1)(c) of the MHCA.

- Rights regarding electro-convulsive treatment

An involuntary mental health care user who is capable of giving informed consent to electro-convulsive treatment, must decide whether to have electro-convulsive treatment or not.<sup>479</sup> Electro-convulsive treatment must be conducted by a medical practitioner with special training in mental health and may only be carried out under a general anaesthetic together with a muscle relaxant.<sup>480</sup> An involuntary mental health care user may not be subjected to this treatment more than once in 24 hours and not on consecutive days.<sup>481</sup> Only the head of the establishment may perform the electro-convulsive treatment at a health establishment under the auspices of the state or a private health establishment.<sup>482</sup> Whenever electro-convulsive treatment is performed a register kept for that purpose must be signed and completed by the relevant medical practitioner and a transcript of the register must be submitted by the health establishment concerned to the review board on a quarterly basis in the form of form MHCA 47 of the Annexure.<sup>483</sup>

- Right not to be secluded

An involuntary mental health care user has a right not to be secluded as a form of punishment.<sup>484</sup> He/she may only be secluded to contain severely disturbed behaviour, which is likely to cause harm to others.<sup>485</sup> While an involuntary mental health care user is secluded, he or she must be observed at least every 30 minutes and that observation should be recorded in the clinical notes.<sup>486</sup> The clinical notes must be submitted by the health establishment concerned to the Review Board on a quarterly basis in the form of

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<sup>479</sup> Reg 33(3) read with reg 35(1) of the General Regulation of the Mental Health Care Act 17 of 2002.

<sup>480</sup> Reg 33(1).

<sup>481</sup> Reg 33(2).

<sup>482</sup> Reg 33(4).

<sup>483</sup> Reg 33(5).

<sup>484</sup> Reg 37(1).

<sup>485</sup> *Ibid.*

<sup>486</sup> Reg 37(2).

form MHCA 48 of the Annexure. Whenever seclusion is utilised the following must be complied with:<sup>487</sup>

- a) a register, signed by a medical practitioner, must be completed;
  - b) the time period that an involuntary mental health care user concerned needed to be secluded and the reason for secluding that user must be outlined and the seclusion must be outlined in the relevant register by the medical practitioner; and
  - c) the head of the health establishment concerned must on a daily basis receive a report indicating all incidents of seclusion.
- Right not to be mechanically restrained

Mechanical means of restraint may only be used if the pharmacological or other means of calming, physical means of restraint or seclusion of the user are inadequate to ensure that the user does not harm themselves or others.<sup>488</sup> Mechanical means of restraint may be used in order to administer pharmacological treatment, but such means should be applied for a short period, depending on the condition of the mental health care user concerned, as is necessary to effect the treatment.<sup>489</sup> The mental health care user under restraint must be subject to observation at least every 30 minutes and such observations should be recorded in the clinical notes.<sup>490</sup>

Whenever a mechanical means of restraint is utilised, the register must be signed and completed by the relevant medical practitioner.<sup>491</sup> The form of mechanical means of restraint, the time period used, the times when the user was observed and the reason for administering the means of restraint must be outlined by the medical practitioner in the register.<sup>492</sup> The head of the health establishment concerned must receive a report, on a daily basis, of all incidents involving the use of mechanical means of restraint.<sup>493</sup> The use of mechanical means of restraint as punishment is prohibited.<sup>494</sup>

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<sup>487</sup> Reg 37(3) of the General Regulation of the Mental Health Care Act 17 of 2002.

<sup>488</sup> Reg 36(1).

<sup>489</sup> Reg 36(2).

<sup>490</sup> Reg 36(3).

<sup>491</sup> Reg 36(4)(a).

<sup>492</sup> Reg 33(4)(b).

<sup>493</sup> Reg 33(4)(c).

<sup>494</sup> Reg 33(5).

- Right to treatment or operations for illnesses other than mental illness

An involuntary mental health care user who is capable of giving informed consent to treatment or an operation, must decide whether to have treatment or an operation or not.<sup>495</sup> A curator, if a court has appointed one, a spouse, next of kin, a parent or guardian, a child over the age of 18, a brother or sister, or a partner or associate, may consent to the treatment or operation of an involuntary mental health care user deemed to be incapable of giving consent to the treatment or operation.<sup>496</sup> The head of the establishment may grant consent for the treatment or operation if:<sup>497</sup>

- a) none of the persons authorised to give consent are available and unsuccessful attempts have been made to locate them and this has been confirmed in writing;
- b) the relevant alternatives have been discussed with the head of the health establishment or the head of the licensed facility concerned above and that head is satisfied that the most appropriate intervention is to be performed; and
- c) the medical practitioner who is going to perform that operation recommends the treatment or operation.

An involuntary mental health care user's consent, where it may be given, and the information regarding the replacement of consent must be documented in the clinical record of the user concerned before the treatment is administered or the operation is performed.<sup>498</sup>

- Rights regarding psychosurgery

Psychosurgery may only be performed on an involuntary mental health care user who is capable of giving informed consent for such surgery.<sup>499</sup> Before any psychosurgery is performed on an involuntary mental health care user, a medical report must be constructed and signed by at least two independent psychiatrists and it must state whether in their opinion, all mental health treatment previously applied has failed and

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<sup>495</sup> Reg 35(1) of the General Regulation of the Mental Health Care Act 17 of 2002.

<sup>496</sup> Reg 35(2).

<sup>497</sup> Reg 35(3).

<sup>498</sup> Reg 35(4).

<sup>499</sup> Reg 32(1).

psychosurgery is necessary.<sup>500</sup> Psycho-surgery may only be performed by a registered neuro-surgeon who has agreed to perform the operation.<sup>501</sup>

### 3.3 Conclusion

The MHCA<sup>502</sup> provides a comprehensive regulation of the rights of involuntary mental health care users and other mental health care users in South Africa. The MHCA should be interpreted taking into account the provisions of the Bill of Rights. The MHCA also provides mechanisms in terms of which the rights of mental health care users may be protected.

It is submitted that the MHCA was promulgated taking into account the provisions of the Constitution. The MHCA provides detailed provisions aimed at protecting the rights of involuntary mental health care users, but gives effect to the provisions of the Constitution. It is further submitted that the MHCA conforms to the provisions of the Bill of Rights.

The following chapter provides a discussion on International law, particularly international instruments dealing with the protection of rights of involuntary mental health care users, and the law in the United Kingdom as it relates to South African law in respect of involuntary mental health care users.

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<sup>500</sup> Reg 32(2) of the General Regulation of the Mental Health Care Act 17 of 2002.

<sup>501</sup> Reg 32(3).

<sup>502</sup> 17 of 2002

## CHAPTER 4: Protection of human rights of involuntary users in International law and the United Kingdom

### 4.1 Introduction

Section 39 of the Constitution provides that when interpreting law, the court must consider International law and may consider foreign law. Section 39 is considered an interpretative tool which provides the foundational principle in the interpretation of statutes.<sup>503</sup> This Chapter considers the provisions of International law as it relates to the human rights of involuntary mental health care users. The provisions in terms of the international conventions and regional conventions are considered. The provisions of the regulation of mental health care in the United Kingdom will also be considered. This is necessary for comparative purposes and it is allowed in terms of section 39 of the Bill of Rights to consider foreign law. However, the study will focus on the points which may be important for implementation in South Africa.

### 4.2 International Human Rights of Involuntary Mental Health Care Users

Until 1945, International law was largely concerned with states and the relations between states.<sup>504</sup> The United Nations (which was the League of Nations at the time) was guided by a principle that intervention in the domestic affairs of the state was prohibited.<sup>505</sup> This led to the United Nations being unable to intervene in the atrocities committed by the state against its nationals.<sup>506</sup> That changed after the Nuremberg trial,<sup>507</sup> national leaders could no longer claim immunity on the basis that intervention on the domestic affairs of the state was prohibited.<sup>508</sup> It is now a well-established principle that a state cannot invoke its municipal legislation as a reason for avoiding its international obligations.<sup>509</sup> National leaders can be charged with violations of rights of

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<sup>503</sup> Burns Y *Administrative Law* 4<sup>th</sup> ed 2013 (Lexis Nexis, Durban) 22.

<sup>504</sup> Dugard J *International Law: A South African Perspective* 3<sup>rd</sup> ed 2005 (Juta, Lansdowne) at 309.

<sup>505</sup> *Ibid.*

<sup>506</sup> *Ibid.*

<sup>507</sup> In 1945 (after the Second World War), the USA, USSR, the UK and France established an international military tribunal to prosecute the major Nazi leaders for crimes against humanity, crimes against peace and war crimes.

<sup>508</sup> Smith RKM *Textbook on International Human Rights* 2<sup>nd</sup> ed 2005 (Oxford, New York) at 27.

<sup>509</sup> Jennings R and Watts A: *Oppenheim's International law* vol 1 9<sup>th</sup> ed 1992 (Longman Group, Essex) at 931.

individuals and the international community has the power to intervene in the violation of rights within a state.

#### 4.2.1 The United Nations Charter

The League of Nations was replaced by the United Nations and the Charter of the United Nations (the United Nations Charter) was adopted by the General Assembly in San Francisco in 1945, but entered into force on 24 October 1945.<sup>510</sup> The preamble of the United Nations Charter makes it clear that the United Nations is determined to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small. The most important articles for International Human Rights Law are articles 55 and 56 of the United Nations Charter.<sup>511</sup> Article 55 of the United Nations Charter provides that:

'With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

- a) higher standards of living, full employment, and conditions of economic and social progress and development;
- b) solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
- c) universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.'

Article 56 provides that:

'All Members pledge themselves to take joint and separate action in cooperation with the Organization for the achievement of the purposes set forth in Article 55.'

Dugard<sup>512</sup> points out that there are a number of defects in the human rights clause in the United Nations Charter. First, they are vague and give no indication of the rights protected, apart from that of discrimination. Secondly, no enforcement mechanism is provided for, unless the denial of human rights amount to a threat to international peace. Thirdly, it is not clear that the clauses create any legal obligations for states. Fourthly, there is a conflict between the human rights clauses and article 2(7) of the United Nations Charter. Article 2(7) of the United Nations Charter provides that:

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<sup>510</sup> *Ibid* at 26.

<sup>511</sup> Dugard *J op cit* (n 504) at 310.

<sup>512</sup> *Ibid* at 311.

'Nothing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of any state or shall require the Members to submit such matters to settlement under the present Charter; but this principle shall not prejudice the application of enforcement measures under Chapter VII.'

Until 1971, South Africa and other states questioned the legal status of the human rights provisions in the United Nations Charter.<sup>513</sup> The International Court of Justice resolved this matter and decided that the denial of fundamental human rights was a flagrant violation of the purpose and principles of the charter.<sup>514</sup>

The human rights provisions in the UN Charter place an obligation on states to advocate and to observe the human rights of all individuals, including mentally ill persons.<sup>515</sup> The provisions of the UN Charter are important in establishing the international standard in the protection of the rights of mentally ill persons. The UN Charter, together with other international instruments discussed in this study, form the basis of the international standard against which the protection of the rights of mentally ill persons in South Africa is compared with, for the purpose of determining whether South Africa complies with international human rights law.

The protection of human rights of mentally ill persons in South Africa complies with the provision of the UN Charter. A detailed discussion of how the protection of the rights of mentally ill person in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.2.2 Universal Declaration of Human Rights

In 1946, the Economic and Social Council of the United Nations established a Commission on Human Rights and its first task in drafting the international Bill of Rights, was to draft the Universal Declaration of Human Rights.<sup>516</sup> The declaration was adopted by the United Nations on 10 December 1948 and South Africa abstained from the voting of its adoption.<sup>517</sup> The Universal Declaration of Human Rights is not a treaty but a recommendatory resolution of the General Assembly and therefore not legally binding

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<sup>513</sup> *Ibid* at 313.

<sup>514</sup> Legal Consequences for States of the continued Presence of South Africa in Namibia (South West Africa) notwithstanding Security Council Resolution 276 (1970) 171 ICJ Reports 16 at 57.

<sup>515</sup> Gostin LO & Gable L: Human Rights of Persons with Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health (2004) 63 *Md. L. Rev.* 20 at 31.

<sup>516</sup> Dugard J *op cit* (n 504) at 314.

<sup>517</sup> *Ibid*.

on states.<sup>518</sup> Although not binding, it has guided the organs of the United Nations in their interpretation and application of the human rights clauses in the United Nations Charter and it has served as a model for national Bills of Rights.<sup>519</sup> It is widely accepted that the Universal Declaration form part of international customary law.<sup>520</sup> South African courts have cautioned against easily regarding the Universal Declaration as part of International Customary Law. In *S v Petane*,<sup>521</sup> the court made the following remark:

'The Universal Declaration on Human Rights may be taken as an example in this respect. It has been asserted that in the course of time its provisions have grown into rules of customary international law. This view is often substantiated by citing abstract statements by states supporting the Declaration or reference to the Declaration in subsequent resolutions or treaties. Sometimes it is pointed out that its provisions have been incorporated in national constitutions. But what if states making statements like these or drawing up their constitutions in conformity with the Universal Declaration at the same time treat their nationals in a manner which constitute a flagrant violation of its very provisions, for instance, by not combating large-scale disappearances, by practising torture, or by imprisoning people for long periods of time without a fair trial? Even if abstract statements or formal provisions in a constitution are considered a state practice, they have at any rate to be weighed against concrete act like ones mentioned.'

In *S v Rudman*,<sup>522</sup> the court refused to recognise the Universal Declaration of Human Rights as part of international customary law. The court made the following remark:

'However laudable the ideals which have inspired the Universal Declaration of Human Rights, the International Covenant of Civil and Political Rights and the European and American conventions they do not form part of customary international law.'

Dugard<sup>523</sup> argues that some of the provisions of the Universal Declaration, such as that of non-discrimination, the right to a fair trial and the prohibition on torture, are part of international customary law despite the fact that they may not be always observed, because they comply with the requirements of *corpus* and *usus*.

In Legal Consequences for States of the continued Presence of South Africa in Namibia (South West Africa) notwithstanding Security Council Resolution 276,<sup>524</sup> the following opinion was made with regard to the obligatory nature of the Universal Declaration of Human Rights:

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<sup>518</sup> *Ibid.*

<sup>519</sup> *Ibid.*

<sup>520</sup> *Ibid.*

<sup>521</sup> 1988 (3) SA 51 (C).

<sup>522</sup> 1989 (3) SA 368 (E) at 376A-B.

<sup>523</sup> Dugard *J op cit* (n 504) at 315.

<sup>524</sup> (1970) 171 ICJ Reports 16 at 57.

'In the preamble the General Assembly declares itself "Convinced that the administration of the Mandated Territory by South Africa has been conducted in a manner contrary" to the two basic international instruments directly imposing obligations upon South Africa, the Mandate and the Charter of the United Nations, as well as to the Universal Declaration of Human Rights.'

It is submitted that the fact that the Universal Declaration was mentioned indicates recognition as part of international customary law. In *Folartiga v Pena-Irala*,<sup>525</sup> the court made the following remarks, which indicate the recognition of some of the provisions of the Universal Declaration as part of customary international law:

'While this broad mandate has been held not to be wholly self-executing, *Hitai v. Immigration and Naturalization Service*, 343 F.2d 466, 468 (2d Cir. 1965), this observation alone does not end our inquiry. (9) For although there is no universal agreement as to the precise extent of the "human rights and fundamental freedoms" guaranteed to all by the Charter, there is at present no dissent from the view that the guaranties include, at a bare minimum, the right to be free from torture. This prohibition has become part of customary international law, as evidenced and defined by the Universal Declaration of Human Rights, General Assembly Resolution 217 (III)(A) (Dec. 10, 1948) which states, in the plainest of terms, "no one shall be subjected to torture." (10) The General Assembly has declared that the Charter precepts embodied in this Universal Declaration "constitute basic principles of international law." G.A.Res. 2625 (XXV) (Oct. 24, 1970).'

Smith<sup>526</sup> correctly recognises the declaration as a valuable framework of human rights which many subsequent international instruments expand into legally binding text. The Universal Declaration recognises the inherent dignity and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world.<sup>527</sup> The United Nations reaffirms its faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom.<sup>528</sup> The Universal Declaration of Human Rights is considered 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

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<sup>525</sup> 630 F.2d 876; 1980 U.S. App. LEXIS 16111.

<sup>526</sup> Smith RKM *op cit* (n 508) at 39.

<sup>527</sup> Preamble to the Universal Declaration of Human Rights.

<sup>528</sup> *Ibid*.

recognition and observance, both among the peoples of member states themselves and among the peoples of territories under their jurisdiction.<sup>529</sup>

Article 1 recognises that all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. Any distinction on the listed grounds<sup>530</sup> is prohibited.<sup>531</sup> The Declaration provides everyone with a right to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.<sup>532</sup> Arbitrary interference with his privacy, family, home or correspondence, or attacks upon a person's honour and reputation is prohibited and everyone has the right to be protected by law against such interference or attacks.<sup>533</sup> Everyone has the freedom of movement within the state.<sup>534</sup> Every person has the right to a standard of living adequate for their health and well-being, and that of his family, including food, clothing, and 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.<sup>535</sup> The following articles are also relevant to mental health care users:

'Article 3: Everyone has the right to life, liberty and security of person.

Article 4: No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6: Everyone has the right to recognition everywhere as a person before the law.

Article 7: 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 8: Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.'

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<sup>529</sup> *Ibid.*

<sup>530</sup> The following grounds are listed in art 2 of the Universal Declaration of Human Rights: race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

<sup>531</sup> Art 2 of the Universal Declaration of Human Rights.

<sup>532</sup> Art 10.

<sup>533</sup> Art 12.

<sup>534</sup> Art 13(1).

<sup>535</sup> Art 25(1).

Nothing in the Universal Declaration of Human Rights allows for the violation of the rights provided.<sup>536</sup>

It is submitted that certain provisions of the Universal Declaration of Human Rights are recognised as part of international customary law. South Africa has an obligation to observe and comply with international customary law. The provisions of the Universal Declaration of Human Rights protect the rights of every individual including mentally ill persons. The Universal Declaration of Human Rights, together with other international instruments discussed in this study, form the basis of the international standard. The protection of human rights of mentally ill persons in South Africa complies with the provision of the Universal Declaration of Human Rights. A detailed discussion of how the protection of the rights of mentally ill persons in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.2.3 United Nations World Programme of Action concerning Disabled Persons (Programme)

In 1983 the United Nations met in New York and declared the period between 1983 and 1992 as a decade of disabled persons. The objective of the programme was to promote effective measures for prevention of disability, rehabilitation and the realisation of the goals of 'full participation' of disabled persons in social life and development, and of 'equality'.<sup>537</sup> The Programme provided for the Prevention,<sup>538</sup> Rehabilitation<sup>539</sup> and the Equalisation of opportunity<sup>540</sup> for the disabled.

The programme is not a binding document, but it does provide a historical context of the rights of persons with disabilities in international law. The programme is structured as

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<sup>536</sup> Art 30 of the Universal Declaration of Human Rights.

<sup>537</sup> United Nations World Programme of Action concerning Disabled Persons I-A-1.

<sup>538</sup> *Prevention* means measures aimed at preventing the onset of mental, physical and sensory impairments (primary prevention) or at preventing impairment, when it has occurred, from having negative physical, psychological and social consequences.

<sup>539</sup> *Rehabilitation* means a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her/him with the tools to change her/his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example by technical aids) and other measures intended to facilitate social adjustment or readjustment.

<sup>540</sup> *Equalisation of opportunities* means the process through which the general system of society, such as the physical and cultural environment, housing and transportation, social and health services, educational and work opportunities, cultural and social life, including sports and recreational facilities, are made accessible to all.

policy document for the United Nations. South Africa is not bound to follow this programme. It is submitted that the programme does not form the basis of the international standard but, it provides a historical context, in interpretation of international instruments and municipal law.

#### 4.2.4 United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care<sup>541</sup>

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (the Principles) are not legally binding on states, but they reflect international agreement on good practice in the field of mental health.<sup>542</sup>

The Principles codify a set of basic rights that the international community consider to be inviolable in the care and treatment of mentally ill persons.<sup>543</sup> The principles provide rules in respect of the definition of mental illness; the protection of confidentiality; standards of care and treatment, including involuntary admission and consent to treatment; rights of persons with mental disorders in mental health facilities; protection of minors; provision of resources for mental health facilities; role of community and culture; review mechanisms providing for the protection of the rights of offenders with mental disorders; procedural safeguards protecting the rights of persons with mental disorders.<sup>544</sup>

The Principles apply without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth or any other ground. The Principles recognise that the rights provided may be limited only by law and the limitation must be necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.<sup>545</sup>

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<sup>541</sup> Adopted by General Assembly resolution 46/119 of 17 December 1991.

<sup>542</sup> Funk M: *Mental health Legislation and Human Rights* 2003 (WHO) at 3.

<sup>543</sup> *Ibid* at 15.

<sup>544</sup> *Ibid* at 17.

<sup>545</sup> General Limitation Clause of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

Every person has the right to the best available mental health care, which shall be part of the health and social care system.<sup>546</sup> The Principles require that every person with mental illness be treated with humanity and respect for the inherent dignity of the human person.<sup>547</sup> Any form of exploitation of mentally ill persons and degrading treatment is prohibited.<sup>548</sup> Any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights on the ground of mental illness is prohibited.<sup>549</sup> However, the principles do not prohibit any special measures solely to protect the rights, or secure the advancement, of persons with mental illness.<sup>550</sup> Furthermore, any distinction, exclusion or preference undertaken in accordance with the provisions of the Principles and necessary to protect the human rights of a person with a mental illness or of other individuals is not prohibited.<sup>551</sup> The principles recognise that every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.<sup>552</sup> Every person with mental illness is entitled to be assisted if he lacks the capacity to make such decisions by themselves.<sup>553</sup>

Every person with mental illness has the right to live and work, as far as possible, in the community.<sup>554</sup> The Principles provide that the determination of mental illness shall only be made on internationally accepted standards and shall not be made on the basis of political, economic or social status; or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.<sup>555</sup> No examination may be conducted on any person for purposes of determining mental

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<sup>546</sup> Principle 1.1 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

<sup>547</sup> Principle 1.2.

<sup>548</sup> Principle 1.3.

<sup>549</sup> Principle 1.4.

<sup>550</sup> *Ibid.*

<sup>551</sup> *Ibid.*

<sup>552</sup> Principle 1.5.

<sup>553</sup> Principle 1.6.

<sup>554</sup> Principle 3.

<sup>555</sup> Principle 4.

illness unless done in terms of the domestic laws of that country.<sup>556</sup> The principles recognise that the right to confidentiality would apply to any person to whom such right apply.<sup>557</sup>

The treatment of persons with mental illness must be done, as far as possible, in the community in which they live in or as near from the community as possible and the treatment must be suited to the person's cultural background.<sup>558</sup> Every mentally ill person 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 mentally ill persons; and shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.<sup>559</sup> Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.<sup>560</sup> 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 qualified professional staff.<sup>561</sup> Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners.<sup>562</sup> The treatment of every patient shall be directed towards preserving and enhancing personal autonomy of the mentally ill person.<sup>563</sup>

The Principles prohibit the treatment of any mentally ill person without his/her informed consent except where a proposed plan of treatment is given to a mentally ill person who is held as an involuntary patient,<sup>564</sup> a patient who has a personal representative who is

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<sup>556</sup> Principle 5 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

<sup>557</sup> Principle 6.

<sup>558</sup> Principle 7.

<sup>559</sup> Principle 8.

<sup>560</sup> Principle 9.1.

<sup>561</sup> Principle 9.2.

<sup>562</sup> Principle 9.3.

<sup>563</sup> Principle 9.4.

<sup>564</sup> Principle 11.6. the patient may be given the treatment plan if: the patient was, at the relevant time, held as an involuntary patient; An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and the independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

empowered by law to consent to treatment for the patient,<sup>565</sup> if a qualified mental health practitioner authorised by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons,<sup>566</sup> a major medical procedure is performed on a mentally ill person who cannot give consent provided the procedure is authorised after an independent review;<sup>567</sup> or a patient who cannot give informed consent has been admitted for clinical trial authorised after an independent review.<sup>568</sup>

The Principles define informed consent as consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on: the diagnostic assessment; the purpose, method, likely duration and expected benefit of the proposed treatment; alternative modes of treatment, including those less intrusive; and possible pain or discomfort, risks and side-effects of the proposed treatment.<sup>569</sup> A patient has the right to refuse or stop treatment, except where his/her consent is not required, and the consequences for refusing or stopping such treatment must be explained to him/her.<sup>570</sup> A mentally ill person has the right to choose who must be present when he/she grants such consent.<sup>571</sup> The right to informed consent cannot be waived and when a party attempt to waive such a right he/she must be explained to, that treatment cannot be given without informed consent.<sup>572</sup>

Physical restraint or involuntary seclusion of a patient is prohibited except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.<sup>573</sup> The physical restraint or involuntary seclusion shall not be prolonged beyond the period which is strictly necessary for this purpose.<sup>574</sup> All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall

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<sup>565</sup> Principle 11.7 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

<sup>566</sup> Principle 11.8.

<sup>567</sup> Principle 11.13.

<sup>568</sup> Principle 11.15.

<sup>569</sup> Principle 11.2.

<sup>570</sup> Principle 11.4.

<sup>571</sup> Principle 11.3.

<sup>572</sup> Principle 11.5.

<sup>573</sup> Principle 11.11.

<sup>574</sup> *Ibid.*

be recorded in the patient's medical record.<sup>575</sup> A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close, and regular supervision of qualified members of the staff.<sup>576</sup> A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.<sup>577</sup> Sterilisation of mentally ill persons is prohibited.<sup>578</sup>

Psychosurgery and other intrusive and irreversible treatments for mental illness are prohibited on an involuntary patient in a mental health facility.<sup>579</sup> Such procedures may be performed on other patients provided the domestic laws of that country allows; the patient has given informed consent; and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.<sup>580</sup> A mentally ill person admitted as a patient has a right to be informed of all his rights and if he does not have the capacity to understand the explanation of this right, they may be explained to his/her personal representative; and a mentally ill person who has the necessary capacity has the right to appoint someone to represent him and such person must be informed of their rights.<sup>581</sup>

A mentally ill person admitted in a mental health facility has the following rights:<sup>582</sup>

- a) The right to full respect for his or her: recognition everywhere as a person before the law; privacy; freedom of communication; and freedom of religion or belief.
- b) The right to environment and living conditions as close as possible to those of the normal life of persons of similar age and in particular shall include: facilities for recreational and leisure activities; facilities for education; facilities to purchase or receive items for daily living, recreation and communication; facilities, and encouragement to use such facilities.
- c) Right not to be subjected to forced labour.

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<sup>575</sup> *Ibid.*

<sup>576</sup> *Ibid.*

<sup>577</sup> *Ibid.*

<sup>578</sup> Principle 11.12 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

<sup>579</sup> Principle 11.14.

<sup>580</sup> *Ibid.*

<sup>581</sup> Principle 12.

<sup>582</sup> Principle 13.

d) Right not to be exploited.

As a general rule, the detention of mentally ill persons, as involuntary patients, should be avoided and every patient who is not admitted as an involuntary patient has the right to leave the mental health facility at any time.<sup>583</sup> A mentally ill person may be admitted in a mental health facility as an involuntary patient if he/she has a mental illness; and because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or in the case of a person whose mental illness is severe and whose judgment is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the Principle of the least restrictive alternative.<sup>584</sup> The facility must have been designated to admit involuntary patients by a competent authority prescribed by domestic law.<sup>585</sup> Involuntary admission must initially be done for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body.<sup>586</sup> The grounds of the admission must be communicated to the patient without delay.<sup>587</sup> The fact of the admission and the grounds for it shall also be communicated promptly and in detail to the Review Body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.<sup>588</sup>

The Principles makes provision for Review Bodies which must be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law.<sup>589</sup> The Review Body has the following powers and functions:

a) To review the decision to admit or retain a person as an involuntary patient in accordance with simple and expeditious procedures as specified by domestic law.<sup>590</sup>

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<sup>583</sup> Principle 15 the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

<sup>584</sup> Principle 16.1.

<sup>585</sup> Principle 16.3.

<sup>586</sup> Principle 16.2.

<sup>587</sup> *Ibid.*

<sup>588</sup> *Ibid.*

<sup>589</sup> Principle 17.1.

<sup>590</sup> Principle 17.2.

b) To conduct periodical reviews of the cases of involuntary patients at reasonable intervals as specified by domestic law.<sup>591</sup>

If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person.<sup>592</sup> A patient or a personal representative has a right to appeal, to a higher court, against the decision to admit or detain a mentally ill person as an involuntary patient.<sup>593</sup> A mentally ill person has the right to choose and appoint a counsel to represent him/her at a hearing or appeal.<sup>594</sup>

A patient has a right to have access to the information concerning his/her health and personal records maintained by a mental health facility.<sup>595</sup> This right may be limited in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others.<sup>596</sup> When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.<sup>597</sup> Patients and former patients have the right to complain through procedures prescribed by domestic laws.<sup>598</sup>

States are required to ensure that appropriate mechanisms are in force to promote compliance with the Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.<sup>599</sup> States are further required to implement the Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.<sup>600</sup> The principles do not limit any existing rights and no party can rely on it to limit any existing right.<sup>601</sup>

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<sup>591</sup> Principle 17.3 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

<sup>592</sup> Principle 17.6.

<sup>593</sup> Principle 17.7.

<sup>594</sup> Principle 18.1.

<sup>595</sup> Principle 19.1.

<sup>596</sup> *Ibid.*

<sup>597</sup> *Ibid.*

<sup>598</sup> Principle 21.

<sup>599</sup> Principle 22.

<sup>600</sup> Principle 23.1.

<sup>601</sup> Principle 25.

The Principles provide protection to mentally ill persons. It is submitted that they form the basis for the MHCA. It provides a basis in terms of which the provisions of the MHCA and other provisions of international instruments may be interpreted. It is further submitted that South Africa has no obligation to comply with these principles, but it may be required to comply as some of these principles are part of international customary law. South Africa complies with these principles. A detailed discussion of how the protection of the rights of mentally ill person in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.2.5 United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) (Standard Rules)

On 4 March 1994 the United Nations adopted the Standard Rules. The Standard Rules are not compulsory or binding. The purpose of the Standard Rules is to ensure that persons with disabilities, as members of their societies, may exercise the same rights and obligations as others.<sup>602</sup> The standard rules on the equalization of opportunities for persons with disabilities were created based on the United Nations Decade on Disabled Persons. The Standard Rules provides that 'disability' 'summarises a great number of different functional limitations occurring in any population in any country of the world.'<sup>603</sup> People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness.<sup>604</sup> Such impairments, conditions or illnesses may be permanent or transitory in nature.<sup>605</sup>

The Standard Rules are important in defining the international standard in the protection of rights of involuntary mental health care users. Although the Standard Rules are not binding, they may become international customary rules when they are applied by a great number of states with the intention of respecting a rule in international law. They imply a strong moral and political commitment on behalf of states to take action for the equalization of opportunities for persons with disabilities.<sup>606</sup>

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<sup>602</sup> United Nations R 48/96: Standard Rules on the Equalization of Opportunities for Persons with Disabilities para 15

<sup>603</sup> United Nations R 48/96: Standard Rules on the Equalization of Opportunities for Persons with Disabilities para 17

<sup>604</sup> *Ibid.*

<sup>605</sup> *Ibid.*

<sup>606</sup> United Nations R 48/96: Standard Rules on the Equalization of Opportunities for Persons with Disabilities par 14.

The purpose of the Standard Rules is to ensure persons with disabilities may exercise the same rights and obligations as others.<sup>607</sup>

It is submitted that the rules provide a basis in terms of which the provisions of the MHCA and other provisions of international instruments may be interpreted. It is further submitted that South Africa conforms to these Standard Rules. A detailed discussion of how the protection of the rights of mentally ill person in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.2.6 World Health Organization Mental Health Care Law: Ten Basic Principles (1996).

The World Health Organisation, after conducting a study in a number of countries, compiled ten basic principles in mental health care law.<sup>608</sup> The basic principles are not binding on countries; they are merely intended to be instructive or guidelines for legislatures or policy makers in mental health care law. The World Health Organisation decided that the following principles are the ten basic principles of mental health care laws:<sup>609</sup>

- Promotion of Mental Health and Prevention of Mental Disorders

This entails ensuring that everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders. The principles suggest that in order to promote the principle, behaviours which contribute to enhancing and maintaining mental well-being must be promoted and actions to eliminate the causes of mental disorders must be identified and taken.

- Access to Basic Mental Health Care

This principle entails that everyone in need should have access to basic mental health care. The mental health care provided must be of adequate quality, affordable and equitable, geographically accessible; available on a voluntary basis, as health care in general and it should be contingent upon the available human and logistical resources.

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<sup>607</sup> United Nation R 48/96: Standard Rules on the Equalization of Opportunities for Persons with Disabilities par 15.

<sup>608</sup> Mental Health Care Law: Ten Basic Principles.

<sup>609</sup> *Ibid.*

- **Mental Health Assessments in Accordance with Internationally Accepted Principles**

The principle provides that mental health assessments should only be conducted for purposes directly relating to mental illness or the consequences of mental illness. It is prohibited to refer to nonclinical criteria, such as political, economic, social, racial and religious grounds when assessing mental health. Assessment based only on past medical history of mental disorder is also prohibited.

- **Provision of the Least Restrictive Type of Mental Health Care**

It is required that everyone with mental illness should be provided with health care which is the least restrictive. States should be made to provide a community based treatment.

- **Self-Determination**

Interference with the person's bodily integrity and liberty may only occur with consent. The consent must be given by the person involved or next of kin; it must be free and voluntary; it must be informed; and it must be documented in the patient's medical file.

- **Right to be Assisted in the Exercise of Self-Determination**

In a case where the person cannot consent because of difficulty in understanding the implication of his/her decision, he/she should benefit from assistance by a knowledgeable third party.

- **Availability of Review Procedure**

There should be a review procedure available easily and in a timely fashion for any decision made by official or representative decision-makers and by health care providers. In order to ensure this, it is required to have a review procedure and/or a permanent Review Board created by legislation and which is operational; and to establish a state-managed office of representatives for mental patients with legal and ombudsman-like services

- Automatic Periodical Review Mechanism

The principle provides that there should be an automatic review in the case of a decision affecting integrity (treatment) and/or liberty (hospitalisation) with a long-lasting impact.

- Qualified Decision-Maker

Decision makers should be competent; knowledgeable; independent and impartial.

- Respect of the Rule of Law

Decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis.

These ten principles form a basis for an introduction to the MHCA.<sup>610</sup> These basic principles are not binding on the South Africa, but have been recognised in the MHCA. It is submitted that the principles provide an interpretative tool in terms of which the provisions of the MHCA may be interpreted. A detailed discussion of how the protection of the rights of mentally ill person in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.2.7 Convention on the Rights of Persons with Disabilities and the Optional Protocol (CRPD)<sup>611</sup>

The CRPD came into force on 03 May 2008, and it is the first binding international instrument on disability.<sup>612</sup> It is the first human rights treaty of the 21st century which cleverly combines civil and political rights as well as economic, social and cultural rights under an overarching theory of non-discrimination.<sup>613</sup> The Optional Protocol to the CRPD is a separate treaty which establishes a complaints procedure and an inquiry procedure.<sup>614</sup> The purpose of the CRPD is to promote, protect and ensure the full and

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<sup>610</sup> Landman AA & Landman WJ *op cit* (417) 3.

<sup>611</sup> It is a multilateral convention adopted by the United Nations General Assembly in 2006. It entered into force in 2008. It requires State parties to protect the rights of people with disabilities. South Africa ratified it on 30 November 2007.

<sup>612</sup> Quinn G "A Short Guide to the United Nations Convention on the Rights of Persons with Disabilities" in Quinn G and Waddington (eds) *European Year Book of Disability Law* (2009) 91.

<sup>613</sup> *Ibid.*

<sup>614</sup> *Ibid.*

equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities,<sup>615</sup> and to promote respect for their inherent dignity.

The CRPD imposes three obligations on every state bound by it, namely, the obligation to respect, protect and fulfil.<sup>616</sup> The obligations are defined as follows:<sup>617</sup> The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right. The obligation to protect requires states to take measures that prevent third parties from interfering with the right guaranteed. Finally, the obligation to fulfil requires states to adopt appropriate legislative, administrative, budgetary, judicial, and promotional and other measures towards the full realisation of the right guaranteed.

The obligations are reflected in article 4 of the CRPD and the following obligations are imposed on state parties:

- a) Adopting all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the CRPD.<sup>618</sup>
- b) Taking all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities.<sup>619</sup>
- c) Taking into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes.<sup>620</sup>
- d) Refraining from engaging in any act or practice that is inconsistent with the CRPD and to ensure that public authorities and institutions act in conformity with the CRPD.<sup>621</sup>

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<sup>615</sup> Article 1 of the CRPD defines Persons with disabilities, to include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

<sup>616</sup> Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000) at para 33.

<sup>617</sup> *Ibid*

<sup>618</sup> Art 4(1)(a) of the CRPD.

<sup>619</sup> Art 4(1)(b).

<sup>620</sup> Art 4(1)(c).

<sup>621</sup> Art 4(1)(d).

- e) Taking all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise.<sup>622</sup>
- f) Undertaking or promoting research and development of universally designed goods, services, equipment and facilities which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design<sup>623</sup> in the development of standards and guidelines.<sup>624</sup>
- g) Undertaking or promoting research and development of, and to promote the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost.<sup>625</sup>
- h) Providing accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities.<sup>626</sup>
- i) Promoting the training of professionals and staff working with persons with disabilities in the rights recognized in the CRPD so as to better provide the assistance and services guaranteed by those rights.<sup>627</sup>
- j) Ensuring progressive realisation of economic, social and cultural rights.<sup>628</sup>
- k) Involving persons with disability in the development and implementation of legislation and policies aimed at implementing the CPRD.<sup>629</sup>

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<sup>622</sup> Art 4(1)(e) of the CRPD.

<sup>623</sup> Universal design is defined as means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. "Universal design" shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

<sup>624</sup> Art 4(1)(f) of the CRPD.

<sup>625</sup> Art 4(1)(g).

<sup>626</sup> Art 4(1)(h).

<sup>627</sup> Art 4(1)(i).

<sup>628</sup> Art 4(2).

<sup>629</sup> Art 4(3).

Quinn<sup>630</sup> argues that the easiest way of rendering the rights contained in the CRPD accessible is to loosely categorise them into a cluster as follows: rights that protect the person; rights that restore autonomy, choice and independence; rights of access; and participation; liberty rights; and economic, social and cultural rights. It is submitted that Quinn's categorisation provides a simple way to explain the rights as provided in terms of the CRPD and this categorisation will be followed in this study. The rights contained in the CRPD must be interpreted against the principles of dignity; ability to choose; independence; non-discrimination; participation; full inclusion; respect for difference; acceptance of disability as part of everyday life; equality of opportunity; accessibility; equality of men and women; and respect for children.<sup>631</sup>

- Rights that protect the person

Quinn<sup>632</sup> points out that the rights include the right to life (Art 10), freedom from torture, inhuman or degrading treatment (Art 15), freedom from violence and exploitation (Art 16) and a right to integrity of the person (Art 17). It is submitted that the protection provided to mentally ill persons in situations of risks and humanitarian emergencies (Art 11) also fall within this category.

Mentally ill persons have the right to life on the same basis with others who are not disabled.<sup>633</sup> Quinn<sup>634</sup> points out that the right to life provided in terms of article 10 of the CRPD did not alter, add or subtract from existing International Human Rights law. In a case of an armed conflict, humanitarian emergencies and occurrence of disasters, disabled persons have the right to be protected.<sup>635</sup> Article 11 of the CRPD provides a link between International Human Rights Law and International Humanitarian Law. It places an obligation on states parties to take all necessary measures to ensure the protection and safety of persons with disabilities in situations of armed conflict and humanitarian emergencies and occurrence of natural disasters. Torture or cruel, inhuman or degrading treatment or punishment, in particular, subjecting a mentally ill

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<sup>630</sup> Quinn G *op cit* (n 612) at 104.

<sup>631</sup> Art 3 of the CRPD.

<sup>632</sup> Quinn G *op cit* (n 612) at 104.

<sup>633</sup> Art 10.

<sup>634</sup> Quinn G *op cit* (n 612) at 104.

<sup>635</sup> Art 11 of the CRPD.

person to medical and scientific experimentation is prohibited.<sup>636</sup> Article 15 further places a duty on the state parties to take effective legislative, administrative, judicial and other measures to prevent persons with disabilities from being subjected to torture or cruel, inhumane or degrading treatment or punishment.<sup>637</sup> Quinn<sup>638</sup> points out that an additional element was added in respect of person with disabilities in the normal formulation of the clause in other international instruments, in that the article specifically prohibits subjecting a disabled person to medical or scientific experimentation.

Article 16 of the CRPD provides the following duties on states parties in respect to the prevention of exploitation of persons with disabilities:

- a) Taking all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
- b) Taking all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, *inter alia*, appropriate forms of gender and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.
- c) Ensuring that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities in order to prevent the occurrence of all forms of exploitation, violence and abuse.
- d) Taking all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

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<sup>636</sup> Art 15(1) of the CRPD.

<sup>637</sup> Art 15 (2).

<sup>638</sup> Quinn *G op cit* (n 612) at 104.

e) Putting in place effective legislation and policies, including women and child focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Article 16 recognises that persons with disability may be exploited easily and that it is very important to protect the most vulnerable in our society against any form of exploitation.<sup>639</sup> Article 17 of the CRPD provides the right to respect for physical and mental integrity, to disabled persons, on the equal basis as persons without any form of disability. It is submitted that article 17 is a restatement of the rights provided in terms of articles 10, 15 and 16, as they effectively provide for the right to respect for a person's physical and mental integrity.

- Rights to autonomy, choice and independence

It is submitted that the rights protected in this category include, the right to equal recognition before the law (Art 12), the right to live independently and being included to the community (Art 19), freedom of expression and opinion, and access to information (Art 21), respect for privacy (Art 22), respect for home and family (Art 23) and work and employment (Art 27).

The CRPD recognises and places a duty on states to recognise people with disabilities as persons before the law; to provide them with the rights available to all other persons; and to provide financial and legal support.<sup>640</sup> Quinn<sup>641</sup> argues that article 12 engineers a profound shift to the fundamental approach under international law, in that it restores decision making autonomy of persons with disability. People with disability have the same rights as any other person, to live and participate in the community and this includes making sure that people with disabilities:<sup>642</sup>

a) can choose where to live and should not be forced to be detained in institutions they do not like;

b) have the choices on where and how to live in the community; and

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<sup>639</sup> Quinn G *op cit* (n 612) at 105.

<sup>640</sup> Art 12 of the CRPD.

<sup>641</sup> Quinn G *op cit* (n 612) at 105.

<sup>642</sup> Art 19 of the CRPD.

c) have access to the community facilities which have been adapted to their needs.

Person with disabilities have the right to freedom of expression and the right to give and receive information.<sup>643</sup> The states party to the CRPD have the duty to protect the privacy of person with disabilities and such privacy may not be contravened in any manner against the law.<sup>644</sup> Personal, health and rehabilitation information of persons with disability must be kept confidential in the same way as other people's rights are protected.<sup>645</sup> Persons with disability have the following rights regarding family.<sup>646</sup>

a) The right to marry and have a family.

b) The right to have children; and to decide when and how many children they should have.

c) The right in respect of adoption and guardianship, taking into account the interest of the child.

d) To raise their own children and not to have their children taken away on account of disability.

Persons with disability have the same rights to work and make a living from the work as other persons.<sup>647</sup> State parties to the CRPD have the duty to protect persons with disabilities from slavery and forced labour.<sup>648</sup> The state party to the CRPD further have a duty to ensure that persons with disabilities enjoy the same rights enjoyed by other persons.<sup>649</sup>

- Rights of access and Participation

It is submitted that the rights protected under this category include, general right to access (Art 9), access to justice (Art 13), right to habilitation and rehabilitation (Art 26), right to participate in political and public life (Art 29) and right to participation in cultural life, recreation, leisure and sport (Art 30). Article 9 places a duty on countries to

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<sup>643</sup> Art 21 of the CRPD.

<sup>644</sup> Art 22 (1).

<sup>645</sup> Art 22 (2).

<sup>646</sup> Art 23.

<sup>647</sup> Art 27 (1).

<sup>648</sup> Art 27 (2).

<sup>649</sup> Art 27 (1).

eliminate barriers that people with disabilities face in buildings, the outdoors, transport, information, communication and services, in both cities and the countryside. The states party to the CRPD have the following duties to ensure right of access to persons with disability.<sup>650</sup>

- a) Putting in place, and oversee minimum standards for accessibility for places and services that are open to public;
- b) Making sure that private businesses and organizations that are open to the public are accessible for people with disabilities;
- c) Training people who are involved in accessibility issues on what people with disabilities need when it comes to accessibility;
- d) Having Braille signs and easy to read and understand information in buildings open to the public;
- e) Providing help, such as readers, sign language interpreters and guides, so people with disabilities can access buildings open to the public;
- f) Providing other types of help as needed so people with disabilities can get access to information;
- g) Promoting access to new technologies for people with disabilities; and
- h) Making sure that accessibility is taken into account early on when looking for, and creating new technology.

Access to justice is afforded to persons with disabilities in the same manner as any other persons and it must be adjusted to suit such persons.<sup>651</sup> State parties to the CRPD have the duty to provide services that cover all areas of life, both in habilitation and rehabilitation.<sup>652</sup> The state party are further obligated to promote training programmes and the use of assistive devices and other types of aid as they relate to habilitation and rehabilitation.<sup>653</sup> Persons with disabilities have the right to participate in political and

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<sup>650</sup> Art 9 (2) of the CRPD.

<sup>651</sup> Art 13.

<sup>652</sup> Art 26 (1).

<sup>653</sup> Art 26 (2)-(3).

public life.<sup>654</sup> They have the right to participate in cultural life, recreation, leisure and sport, which entails:<sup>655</sup>

- a) Having access to literature and other writings in formats which they can access.
- b) Getting television programmes, film, theatre and other cultural activities in a way that they understand.
- c) Getting access to cultural performances and services such as libraries, museums, theatres and sites of national importance.

The state parties to the CRPD have the duty to ensure that these rights are realised and must put measures in place to ensure accessibility to cultural life, recreation, leisure and sport.<sup>656</sup>

- Liberty Rights

It is submitted that the rights protected in this category include, general right to liberty (Art14), freedom of movement and nationality (Art 18) and the right to personal mobility (Art 20).

The states party to the CRPD have the duty to ensure that people with disability have the same right to liberty and security as any other person and to ensure that these rights are not taken away without a reason because of the disability or in any way which is against the law.<sup>657</sup> If the right to liberty of any person without disability is taken away, the state must ensure that person is protected by law.<sup>658</sup> Any person with disability has the same rights as any other person to freedom of movement and nationality.<sup>659</sup> Children with disability have the right to be registered after they are born, a right to a name, nationality and the right to be raised by their parents.<sup>660</sup> Persons with disabilities have the right to move around with the greatest possible independence which includes:<sup>661</sup>

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<sup>654</sup> Art 29 of the CRPD.

<sup>655</sup> Art 30.

<sup>656</sup> Art 30(5).

<sup>657</sup> Art 14(1).

<sup>658</sup> Art 14(2).

<sup>659</sup> Art 18(1).

<sup>660</sup> Art 18(2).

<sup>661</sup> Art 20.

- a) To move around in a way they choose and in a way they can afford.
  - b) To access mobility aids and technology; training in mobility skills; and to ensure they are not expensive.
- Economic, Social and Cultural Rights

It is submitted that the rights protected in this category include, right to education (Art 24), the right to health (Art 25), the right to work and employment (Art 27) and the right to an adequate standard of living (Art 28).

Persons with disability are afforded the right to education and states party to the CRPD have the duty to ensure that that the education system at all levels accommodate persons with disability.<sup>662</sup> The educational system must work:<sup>663</sup>

- a) To make sure that every person develops their human potential, sense of dignity and self-worth, and respect for human rights, freedom and diversity.
- b) To develop persons with disabilities personality and talents to their fullest potential.
- c) To make sure persons with disabilities can be involved in society.

State parties to the CRPD have the duty to ensure that persons with disabilities learn social and life skills that enable them to attend school and be in the community.<sup>664</sup> State parties have the duty to ensure that persons with disability have access to vocational training, study in universities and lifelong learning like any other person.<sup>665</sup>

Persons with disability have the same right, as any other person, to quality health care, without discrimination because of disability.<sup>666</sup> The right to quality health includes:<sup>667</sup>

- a) Ensuring that persons with disability get the same free and affordable health care as other people.
- b) Protecting persons with disabilities from further disability.

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<sup>662</sup> Art 24(1) of the CRPD.

<sup>663</sup> *Ibid.*

<sup>664</sup> Art 24(3).

<sup>665</sup> Art 24(5).

<sup>666</sup> Art 25.

<sup>667</sup> *Ibid.*

- c) Providing health services to people in their own communities.
- d) Ensuring that persons with disabilities are not discriminated against in respect of health and health insurance and health workers are trained to provide the same quality of health as other people.

Persons with a disability have the same right to work and earn a living from work they choose as other people.<sup>668</sup> The states parties have the duty to pass laws needed to:<sup>669</sup>

- a) Stop discrimination on the basis of disability in all kinds of employment.
- b) Protect the rights of person with disabilities in respect of working conditions.
- c) Ensure that persons with disabilities have organisational rights in respect of employment.
- d) Ensure that persons with disability are equipped to pursue their careers.

State parties have a duty to ensure that people with disabilities are not held into slavery and forced labour.<sup>670</sup>

Persons with disabilities have the right to adequate standard of living for themselves and their families.<sup>671</sup> Persons with disabilities further have a right to social protection by their government without discrimination.<sup>672</sup>

The CRPD defines disability as including those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. South Africa is bound by the provisions of the CRPD. In interpreting the provisions of the MHCA, the provisions of the CRPD must be taken into account. It is submitted that CRPD is the main basis for the international standard for the protection of right of involuntary mental health care users. A detailed discussion of how the protection of the rights of mentally ill

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<sup>668</sup> Art 27 of the CRPD.

<sup>669</sup> *Ibid.*

<sup>670</sup> Art 27(2).

<sup>671</sup> Art 28(1).

<sup>672</sup> Art 28(2).

person in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.2.8 Additional protocol to the CRPD (The Additional Protocol)

The Additional Protocol makes provision for parties whose rights in terms of the CRPD have been violated by a state party to refer the matter to the Committee on the Rights of Persons with Disabilities.<sup>673</sup> The Additional protocol does not apply to countries that have not ratified it.<sup>674</sup> The Committee will not consider the following referrals.<sup>675</sup>

- a) An anonymous communication.
- b) A communication which amount to an abuse of the right and the provisions of the CRPD.
- c) The matter has already been, or is being considered by the committee or any other body in terms of International Law.
- d) The party has not exhausted all available domestic remedies, unless it has been prolonged unreasonably or no effective relief may be achieved.
- e) Ill-founded or not substantiated in communications.
- f) The facts occurred prior to the additional protocol came into force, unless it continued after the additional protocol came into force.

After the Committee receives a communication from a party, it must confidentially bring the communication to the attention of the state party and such state party must submit a written explanation or clarification and the remedy that may have been taken by the state.<sup>676</sup> The Committee will examine the communication behind closed door and is required to forward its suggestions and recommendations to the state party and the party who petitioned.<sup>677</sup> The Committee may, while considering the matter, request the

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<sup>673</sup> Art 1(1) of the Additional Protocol to the CRPD.

<sup>674</sup> Art 1(2).

<sup>675</sup> Art 2.

<sup>676</sup> Art 3.

<sup>677</sup> Art 5. See also Committee on the Rights of Persons with Disabilities Communication No. 1/2010, in which the committee had to decide whether there was any violation of the CRPD in respect of access to ATMs by persons with disabilities in Hungary.

state party to take interim measures and such interim measure do not imply a final determination of the matter.<sup>678</sup>

Article 6 provides the following procedure when considering a matter referred to the Committee:

- a) After the Committee gets trustworthy information about serious or widespread violations of rights in the CRPD, it may invite the country in question to participate in the reviewing of the information and to give its opinion on it.
- b) After reviewing all the information that it has, the Committee may select one or more of its members to urgently investigate the matter. If the country in question agrees, and if it is needed, it may make a visit to the country to investigate directly.
- c) The Committee will give the country in question the results of the investigation and any recommendations it has.
- d) The country in question will give its opinion on the results to the Committee within six months.
- e) The investigation will be confidential and the country in question will be asked to cooperate throughout the process.

#### 4.2.9 Customary International Law

There are two requirements for the existence of a custom; namely, settled practice and acceptance of an obligation to be bound.<sup>679</sup> In order to satisfy the requirement of settled practice, the conduct of the state must, in general, be consistent with such a rule and conduct. Inconsistent with rules should be treated as a violation of the rules and not recognition of a new rules.<sup>680</sup> The requirement of an acceptance of the obligation to be bound will be met if it is carried out in such a manner, which indicates a belief that the practice is rendered obligatory by the existence of a rule of law requiring it.<sup>681</sup> Resolutions made by the United Nations and other international organisation may not be binding. However if it satisfy the requirements of a custom, it will be binding on

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<sup>678</sup> Art 4 of the Additional Protocol to the CRPD.

<sup>679</sup> Dugard *J op cit* (n 504) at 29.

<sup>680</sup> *Nicaragua v USA* 1986 ICJ Reports 14 at 98.

<sup>681</sup> *North Sea Continental Shelf Cases* 2002 ICJ Reports 3 at 44.

states. Customary International Law also has a big role to play in the regulation of mental health and remains a source of International Human Rights Law. Various non-binding international instruments have certain provisions which are regarded as part of Customary International Law and apply to the regulation of mental health. Various non-binding international instruments contain provisions which become binding because they are recognised as part of Customary International Law. Involuntary mental health care users have various rights in terms of Customary International Law. South Africa complies with such customs. A detailed discussion of how the protection of the rights of mentally ill person in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.3 Regional protection of involuntary mental health care users

The Africa Charter provides protection to mentally ill persons and places an obligation on state parties to ensure the protection of mentally ill persons in that particular country.<sup>682</sup> Article 16 of the African Charter provides a right to every person to receive the best attainable state of physical and mental health, and state parties are required to take necessary measures to protect the health of its citizens and to provide medical attention to those who need it. Article 18(4) of the African Charter provides that disabled persons have the right to special measure of protection in keeping with their physical or moral needs. Furthermore, Article 2 of the African charter provides that:

'Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, or any other opinion, national or social origin, fortune, birth or other status.'

Article 3 of the African Charter provides that every person is equal before the law and entitled to equal protection of the law. Article 5 of the African Charter provides every individual a right to the respect of dignity inherent in a human being and to the recognition of his legal status and prohibits all forms of exploitation and degradation of human beings, particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment. Article 6 of the African Charter prohibits the arbitrary detention of persons and provides that everyone has the right to liberty and to the security of his person.

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<sup>682</sup> Art 16 and 18(4) of the African Charter.

These provisions were given content in *Purohit and Moore v The Gambia*.<sup>683</sup> It is important to provide a brief discussion of this case, as it will provide the context in terms of which the rights of mentally ill persons were decided. In this matter, the complaint was brought by mental health advocates on behalf of patients detained at a psychiatric unit of the Royal Victoria Hospital in terms of the mental health care laws of the Republic of Gambia. The complainant argued that the legislations governing mental health in Gambia were outdated, *inter alia*, because:

- a) It did not define a lunatic<sup>684</sup> or a mentally ill person.
- b) The legislations did not place safeguards during diagnosis, certification and detention of patients.
- c) There was no requirement for consent to treatment.
- d) There was no requirement for subsequent review of continued treatment.
- e) Detained patients were not allowed to vote.
- f) There was no provision for legal aid and the legislation did not provide a remedy for a violation of a mentally ill persons rights.

The African Commission after considering the provisions of the African Charter and taking into account the Principles for the Protection of Persons with Mental Illness and Improvement of mental health care made it clear that Gambia has not fulfilled its obligation with regard to its responsibility to mentally ill persons. The findings of the commission may be summarised with reference to paragraphs 82 and 83, in which the commission made the following finding:

'82. Under the Principles, "mental health care" includes analysis and diagnosis of person's mental condition and treatment, care and rehabilitation for a mental illness or suspected mental illness. The Principles envisage not just 'attainable standards', but the highest attainable standards of health care for the mentally ill at three levels. First, in the analysis and diagnosis of a person's mental condition; second, in the treatment of that mental condition and; thirdly, during the rehabilitation of a suspected or diagnosed person with mental health problems.

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<sup>683</sup> Communication 241/2001- 16<sup>th</sup> Annual Activity Report.

<sup>684</sup> The Gambian Lunatic Detention Act defined a lunatic to include an idiot and a person of unsound mind.

83. In the instant case, it is clear that the scheme of the LDA is lacking in terms of therapeutic objectives as well as provision of matching resources and programmes of treatment of persons with mental disabilities, a situation that the Respondent State does not deny but which never-the-less falls short of satisfying the requirements laid down in Articles 16 and 18(4) of the African Charter.<sup>685</sup>

Gambia was ordered to:

- a) Repeal the Lunatics Detention Act and replace it with a new legislative regime for mental health in The Gambia compatible with the African Charter on Human and Peoples' Rights and International Standards and Norms for the protection of mentally ill or disabled persons as soon as possible;
- b) Pending the repeal of the Lunatics Detention Act, to create an expert body to review the cases of all persons detained under the Lunatics Detention Act and make appropriate recommendations for their treatment or release;
- c) Provide adequate medical and material care for persons suffering from mental health problems in the territory of The Gambia;
- d) Report back to the African Commission when it submits its next periodic report in terms of Article 62 of the African Charter on measures taken to comply with the recommendations and directions of the African Commission in this decision.

The Mental Health and Poverty Project recommends, in respect of African countries that:<sup>685</sup>

- a) Laws must be reformed to reflect a shift in paradigm away from the involuntary treatment and towards the promotion of voluntary treatment and care.
- b) Mental health laws must play an important role in promoting access to good quality care by encouraging the development of community based mental health services and the integration of mental health into primary care and general hospitals, so that people are able to get the treatment that they require close to where they live, in line with international human rights standards including the right to health and the right to live independently and be included in the community.

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<sup>685</sup> Policy Brief: Developing Effective Mental Health Laws in Africa  
[http://www.who.int/mental\\_health/policy/development/MHPB7.pdf](http://www.who.int/mental_health/policy/development/MHPB7.pdf) (accessed on 15 January 2015)

c) Law can play an essential role in limiting the potential for abuse.

d) Clear statements on patients' and caregivers rights are needed which place the patient at the centre of the mental health system while giving caregivers the rights necessary to enhance patient care and health.

In *Kaunda and Others v President of the RSA and Others*,<sup>686</sup> The court made the following remarks regarding the obligation to comply with the provisions of the African charter:

'In construing the provisions of the Constitution we are enjoined to consider, amongst other things, international law. International law consists, inter alia, of the international human rights instruments to which the government is a party. These instruments are also relevant to the question whether there is a constitutional duty to provide diplomatic protection to nationals who are abroad. By ratifying the African Charter, the government "recognises the rights, duties and freedoms enshrined" in the African Charter, and it assumed the "duty to promote and protect human and peoples' rights and freedoms.'

South Africa is bound by the African Charter to ensure the protection of the rights of involuntary mental health care users. It is submitted that South Africa provides a comprehensive protection of the rights of mental health care users and it surpasses what is required in terms of the Africa Charter. The MHCA provides rights and mechanism to enforce such right, and this is not the same in the African Charter. However, the African Charter is considered together with other international instruments in order to establish the international standard in the protection of the rights of involuntary mental health care users. A detailed discussion of how the protection of the rights of mentally ill person in South Africa complies with the international standard is provided in chapter five of this study.

#### 4.4 Protection of involuntary mental health care users in the United Kingdom

In England and Wales the provision of mental health care is governed by the Mental Health Act (UKMHA),<sup>687</sup> which provides for the care and treatment of persons with mental disorders. The Mental Capacity Act<sup>688</sup> also applies to persons who lack capacity and enables care and treatment for mental and physical health conditions.<sup>689</sup> The Mental

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<sup>686</sup> 2004 (10) BCLR 1009 (CC) para 160.

<sup>687</sup> 1983.

<sup>688</sup> 2005.

<sup>689</sup> Spencer-Lane T: Mind over Matter (2012) *NLJ* 20.

Capacity Act is intended to make provision in connection with the Convention on the International Protection of Adults signed at the Hague on 13<sup>th</sup> January 2000. Therefore, the UKMA is the main legislation regulating the care and treatment of mentally ill persons and this study will be limited to its provisions.

The UKMHA applies to the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.<sup>690</sup> Mental disorder is defined as any disorder or disability of the mind, but it does not include a learning disability not associated with abnormally aggressive or seriously irresponsible conduct or dependence on drugs and alcohol.<sup>691</sup>

The UKMHA makes provision for admission of mentally disordered persons for purposes of assessment.<sup>692</sup> The mentally disordered person may only be detained for assessment for a period not exceeding 28 days;<sup>693</sup> he/she is suffering from mental disorder which warrants detention and the detention is done in the interest of the mentally disordered person or to protect other persons; and the application for assessment must be accompanied by a written recommendation by two medical practitioners.<sup>694</sup> An application to detain a mentally disordered person may be made in terms of section 3 of the UKMHA and it is required to prove that the person suffers from a mental disorder which requires treatment; the detention is necessary and appropriate medical treatment is available. The application for admission must be accompanied by written recommendations by two medical practitioners.<sup>695</sup> The UKMHA also recognises that in some instances an application for assessment may be made on an urgent basis<sup>696</sup> and in some instances it may be that an application may be made in respect of a patient already in hospital.<sup>697</sup> If the application for admission complies with the requirements it will be a sufficient authority to detain a mentally disordered person.<sup>698</sup>

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<sup>690</sup> S 1(1) of the UKMHA.

<sup>691</sup> Ss 1(2)-(4).

<sup>692</sup> S 2.

<sup>693</sup> S 2(4).

<sup>694</sup> S 2(2).

<sup>695</sup> S 3(3).

<sup>696</sup> S 4.

<sup>697</sup> S 5.

<sup>698</sup> S 6.

The UKMHA provides a system in terms of which detained patients may be discharged under supervision as outpatients and continue to receive medication.<sup>699</sup>

The starting point of the UKMHA is that a patient's consent is not required for any medical treatment given to him for mental disorder from which he is suffering.<sup>700</sup> However, the psychosurgery and electro-convulsive therapy may only be performed after the patient has consented to such treatment.<sup>701</sup> The treatment of a patient without consent must be medically necessary.<sup>702</sup> The following factors will be considered in determining the necessity to treat patient without consent:<sup>703</sup>

- a) How certain is it that the patient does suffer from a treatable disorder;
- b) How serious is the disorder;
- c) How serious a risk is presented to others;
- d) How likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition;
- e) How much alleviation is there likely to be;
- f) How likely is it that the treatment will have adverse consequences for the patient; and
- g) How severe may they be?

It is submitted that the UKMHA does not materially differ to the Mental Health Care Act 17 of 2002 in terms of the basic principles forming the basis of the two statutes and it is not necessary to discuss the UKMHA in more detail. However the provisions regarding the Mental Health Review Tribunal and the Independent Mental Health Care Advocates are very important and instructive for South Africa. Therefore, only the relevant provisions are discussed below.

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<sup>699</sup> S 17A of the UKMHA.

<sup>700</sup> S 63.

<sup>701</sup> Ss 57, 58 and 58A.

<sup>702</sup> Bartlett P: The Necessity Must be Convincingly Shown to Exist: Standards for Compulsory Treatment for Mental Disorder Under the Mental Health Act 1983 *Medical Law review* (2001) 19(4) 514 at 516

<sup>703</sup> *Ibid* at 532.

Section 65 of the UKMHA makes provision for the constitution of Mental Health Review Tribunals. The purpose of the tribunals is to deal with applications and references by and in respect of patients under the UKMHA.<sup>704</sup> The application may be made to the tribunal in respect of:<sup>705</sup>

- a) a patient admitted for assessment.
- b) a patient admitted for treatment.
- c) a detained patient in respect of whom, a community treatment order is made or revoked.

The manager of the hospital is required to refer the patient's case to the tribunal six months after the admission for assessment or treatment.<sup>706</sup> The manager of the hospital is further required to submit the patient's case after three years since the case was considered by the tribunal or after the community order is revoked.<sup>707</sup> The Mental Health Tribunals have, *inter alia*, the following powers:

- a) To reduce periods for the submission of the patient's case by the manager of the hospital.<sup>708</sup>
- b) To direct the discharge of qualifying patients.<sup>709</sup> This function is regarded as its primary function.<sup>710</sup>

The Mental Health Review Tribunal is regarded as a court in the United Kingdom. In deciding the nature of the Mental Health Review Tribunal, the court of Appeal in *Pickering v Liverpool Daily Post and Echo Newspapers plc*,<sup>711</sup> made the following finding:

'If such a tribunal is not a 'court' for all purposes, the Human Rights Convention is not being complied with, since there is no indication that 'court' in the convention has any different meaning from that which it bears in English law. However, I have no doubt that in law a

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<sup>704</sup> S65 (1A) of the UKMHA.

<sup>705</sup> S 65.

<sup>706</sup> S 68 (2).

<sup>707</sup> S 68 (6).

<sup>708</sup> S 68A.

<sup>709</sup> S 72(1).

<sup>710</sup> *T & Ors v Mental Health Review Tribunal & Anor* [2002] EWHC 247 (Admin) (22nd February, 2002).

<sup>711</sup> 1990 1 ALL ER 335 (CA) at 341F-J. The decision was confirmed on appeal in *Pickering v Liverpool Daily Post and Echo Newspapers plc* 1991 1 ALL ER 622 (HL).

mental health review tribunal is a court. Contrary to what is stated in the Associated Newspaper Group case, it did not inherit an executive function. It was given a new and quite different function. I would only add that I can see no reason why, as the Divisional Court appears to have held, the touchstone for determining whether a body is a court should be its ability to deprive a citizen of his liberty. One of the oldest and most important duties of the High Court is to restore liberty to a citizen by means of a writ or order of habeas corpus. Nor do I appreciate the relevance of the fact that the patient has a right to renew his application every year in deciding whether or not such a tribunal is a court. In my judgment, in so far as *A-G v Associated Newspapers Group plc* [1989] 1 All ER 604, [1989] 1 WLR 322 decided that a mental health review tribunal was not a court, it was wrongly decided and should not be followed.'

The decision is supported in *Regina v East London and the City of Mental Health NHS Trust and another (Respondents) ex Parte con Brandenburg (aka Hanley) (FC) (Appellant)*.<sup>712</sup> In terms of clause 32.2 of the Code of Practice: UKMHA, a Mental Health Review Tribunal is regarded as an independent judicial body with the purpose of reviewing the cases of detained, conditionally discharged, and supervised community treatment patients under the UKMHA and to direct the discharge of any patients where it thinks it appropriate. The classification of the Mental Health Review Tribunal must be understood with reference to the Tribunals, Courts and Enforcement Act (UKTCEA).<sup>713</sup> The UKTCEA provides for a change in the tribunal system.<sup>714</sup> Section 3 of the UKTCEA provides for a First-Tier Tribunal and the Upper Tribunal, which is a superior court of record, which consist of Judges and other members. The UKTCEA consolidates all the tribunals and create one system regarding the proceedings of tribunals created in terms of any other law, including the UKMHA.<sup>715</sup> The functions of the Mental Health Review Tribunal for the region of England have been transferred to the First-Tier Tribunal and therefore regulated in terms of the provisions of the UKTCEA.<sup>716</sup> The Mental Health Review Tribunal for the region of Wales remains under the provisions of the UKMHA.<sup>717</sup>

The constitution of the Mental Health Review Tribunal consists of persons with legal experience, registered medical practitioners and persons that the Lord Chancellor considers to have suitable experience.<sup>718</sup> One of the legal members is appointed chairman of the Mental Health Review Tribunal.<sup>719</sup> Section 78A of the UKMHA makes

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<sup>712</sup> [2003] UKHL 58.

<sup>713</sup> 2007.

<sup>714</sup> S 3 of the UKTCEA.

<sup>715</sup> S 3(1).

<sup>716</sup> S 6 and Schedule 6 part 1 of the UKTCEA.

<sup>717</sup> S 78 of the UKMHA.

<sup>718</sup> S 1 of Schedule 2 to the UKMHA.

<sup>719</sup> S 3.

provision for an appeal to the Upper Tribunal. The appeal to the Upper Tribunal may be made on any point of law arising from a decision of the Mental Health Review Tribunal.<sup>720</sup>

The UKMHA makes provision for appointment of persons as Independent Mental Health Advocates to assist qualifying patients.<sup>721</sup> The person appointed to act as an Independent Mental Health Advocate must be independent from any person who is professionally concerned with the patient's medical treatment.<sup>722</sup> The functions of the Independent Mental Health Advocate include:<sup>723</sup>

- a) Helping a qualifying patient in obtaining and understanding the provisions of the UKMHA; the medical treatment given, proposed or discussed in respect of the patient and why it is given, proposed or discussed; the authority under which the medical treatment is given, proposed or discussed.
- b) Helping a qualifying patient in obtaining and understanding any rights available in terms of the UKMHA and represent the qualifying patient in exercising his/her right in terms of the UKMHA.
- c) Visiting and interviewing a patient privately and any person professionally connected to the qualifying patient in order to assist the qualifying patient.
- d) Requiring production and inspecting any records relating to a qualified patient's detention or treatment.

Independent Mental Health Advocates provide an additional safeguard for qualifying patients.<sup>724</sup> They are trained specifically to work within the framework of the UKMHA to meet the needs of patients.<sup>725</sup> The Independent Mental Health Advocates are not intended to replace any other services available to the patient, but are intended to operate together with the other services.<sup>726</sup> The Independent Mental Health Advocate may only be appointed for a person liable to be detained in terms of the UKMHA,

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<sup>720</sup> S 78A (1) of the UKMHA.

<sup>721</sup> S 130A(1).

<sup>722</sup> S 130A (4).

<sup>723</sup> S 130B.

<sup>724</sup> Clause 20.1 of the Code of Practice: The UKMHA.

<sup>725</sup> Clause 20.1.

<sup>726</sup> Clause 20.2 of the Code of Practice: The UKMHA.

subject to a guardianship under the UKMHA, a community patient and those who become qualifying patients in terms of section 130C(3) of the UKMHA.<sup>727</sup> Qualifying patients have the right to be informed that help is available in the form of Independent Mental Health Advocate and how to obtain the services of one.<sup>728</sup> The information must be given in writing to the qualifying patient.<sup>729</sup>

The main benefit of Independent Mental Health Advocates is ensuring mental health patients have a voice.<sup>730</sup> The following comments published in the September/October 2012 issue of the mental health today, illustrate the importance of having Independent Mental Health Advocates.<sup>731</sup>

'She came in to see me and started talking to me. She said "have you got a review?" and "what are your problems?" and went through everything with me... and so we started talking and as you're talking you start to think, oh yeah, I should say this.'

And

'It's not changed anything that's happening here at all... [But] it's made me feel better within myself because people are treating me as a human being and not a bit of dirt under their feet... It gives you confidence within yourself.'

The use of Independent Mental Health Advocates has been satisfactory.<sup>732</sup> However, there are certain issues which require improvements and those areas relate to the implementation rather than the overall structure of Independent Mental Health Advocates.<sup>733</sup> These issues relate to, *inter alia*, failure by responsible authority to give information regarding Independent Mental Health Advocate to some patients and lack of resources.<sup>734</sup> A patient may choose to end the support they are receiving from an Independent Mental Health Advocate at any time and may choose not to accept the services.<sup>735</sup>

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<sup>727</sup> S 130C of the UKMHA.

<sup>728</sup> S 130D(1).

<sup>729</sup> S 130D(5).

<sup>730</sup> (Mental Health Today September/October 2012) [http://www.uclan.ac.uk/research/explore/projects/assets/mental\\_health\\_wellbeing\\_mhrt\\_the\\_right\\_to\\_be\\_heard.pdf](http://www.uclan.ac.uk/research/explore/projects/assets/mental_health_wellbeing_mhrt_the_right_to_be_heard.pdf) (accessed on 10 December 2014).

<sup>731</sup> *Ibid.*

<sup>732</sup> *Ibid.*

<sup>733</sup> *Ibid.*

<sup>734</sup> Care Quality Commission Monitoring the Mental health Care Act 2010/2011 to be found at [http://www.cqc.org.uk/sites/default/files/documents/cqc\\_mha\\_report\\_2011\\_main\\_final.pdf](http://www.cqc.org.uk/sites/default/files/documents/cqc_mha_report_2011_main_final.pdf) (accessed on 10 December 2014).

<sup>735</sup> Clause 20.17 and 20.18 of the Code of Practice: The UKMHA.

## 4.5 Conclusion

There have been vast improvements and developments in the protection of the rights of mentally ill persons in International law since the formation of the UN. The introduction of the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care in 1991 signalled the need for a reform in the protection of mentally ill persons in domestic laws of each country. There is an obligation on each state to reform its laws to reflect the changes in International Law. The chapter provided a detailed discussion of the protection of rights of mentally ill persons and it also provided a brief synopsis of provisions of mental health care law in the United Kingdom which may be instructive for South Africa. The next chapter will provide a conclusion and make recommendations.

## Chapter 5: Conclusion and Recommendations

### 5.1 The Comparator

The central question of the study was to determine whether the South African Regulation of involuntary mental health care conforms to the international norms and standards. The International Human Rights norms and standards, as a comparator were explored in chapter four. However, it is important to provide a discussion of how the South African standard compares to the international norms and standards. It is not necessary to repeat the issues discussed above. Where necessary, repetitions will be made to clarify a point.

It is submitted that the International Human Rights standard requires that the following principles be complied with by national legislations:<sup>736</sup>

- a) The legislation should not only protect the rights of people with mental disorders but should also aim to promote mental health and prevent mental disorders.
- b) The legislation should embrace the principle of the least restrictive alternative, which requires that mentally ill persons are always offered treatment in settings that will least restrict their personal freedom and least affect their status and privileges in the community.
- c) The legislation should guarantee the confidentiality of all information on mentally ill people obtained during the treatment of such persons.
- d) The principle of voluntary and informed consent to treatment should be protected in the legislation.
- e) Involuntary admission to a hospital should be allowed in exceptional cases and in very specific circumstances. These exceptional circumstances should be outlined and laid in the legislation. Involuntary treatment should only be allowed in certain rare situations.

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<sup>736</sup> See the Principles, the Universal Declarations, the United Nations Charter and Ryder W *Mental Health Policy and Service Guidance Package* 2003 (WHO).

f) The legislation should contain a provision for the appointment of an independent review body with specified composition, powers and duties.

g) Legislation should not be restricted to issues of mental health or even general health it should address issues of housing, education, employment and general health, among other matters.

It is further submitted that the MHCA gives effect to the principles mentioned above. It is apparent as discussed below, how the MHCA gives effect to such provisions.

- Respect, human dignity and privacy

Section 8 of the MHCA read with the Constitution provides, in detail, the right to respect, human dignity and privacy. International Human Rights Law requires that this right be protected. This is apparent from the provisions of the United Nations Charter,<sup>737</sup> the Universal Declarations<sup>738</sup> and the CRPD.<sup>739</sup> Section 8 of the MHCA read with the Bill of Rights recognises these provisions of the international instruments and, it is submitted, provides for more than what has been provided in these international instruments. It has been discussed, in this study that the Constitutional Court has defined these rights and no uncertainty as to its application in mental health care may exist.

- Consent to care, treatment and rehabilitation services

It is submitted that the International Human Rights Law requires that interference with the person's bodily integrity is allowed only with the consent of that person. It is further submitted that it is an accepted standard in International Human Rights Law that patients may, with certain exceptions, only be treated for their mental illness with their informed consent.<sup>740</sup> Section 9(1) of the MHCA reaffirms this principle, treatment of mentally ill persons may only be provided, *inter alia* and with certain exceptions, when the mentally ill patient has consented to such treatment.

It is submitted that both the international norms and standards and the MHCA recognise and protects the right to autonomy. However, it is further, submitted that both the

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<sup>737</sup> See art 55 & 56 of the United Nations Charter.

<sup>738</sup> See art 1, 6 & 12 of the Universal Declarations.

<sup>739</sup> See art 17 & 22 of the CRPD.

<sup>740</sup> Principle 11 of the Principles.

international norms and standards and the MHCA also acknowledge that there are situations when a mentally ill patient cannot, or will not, consent, even where treatment is very necessary. The international norms and standards recognise the detention and treatment of patients on an involuntary basis.<sup>741</sup> Section 32 of the MHCA provides a procedure, which incorporates the safeguards provided in the Principles (principle 16 in particular), for the detention and treatment of mentally ill persons as involuntary users. It is submitted that the 72 hour assessment and the review of the decisions to detain a patient by the Review Board are some of the important elements of the MHCA which effectively brings the MHCA in conformity with the international norms and standards.

- Protection against unfair discrimination

It is submitted that the international norms and standards prohibits unfair discrimination on the ground of mental illness. Involuntary mental health care users have the same rights as any other user or any other person. The MHCA read with the Bill of Rights provides, in more detail that the international instruments, what the right to equal protection before the law and prohibition of unfair discriminations means. It is submitted that, essentially, involuntary mental health care users must be treated in the same manner as any other involuntary mental health care users, any other user or any other person regardless of his or her mental health status.

Both the MHCA, read with the Bill of Rights, and the international norms and standards recognises that the right to equality may be limited in certain instances. It is submitted that both the MHCA and the international norms and standards do not prohibit fair discrimination or mere differentiations. The international instruments leaves the limitation of the rights to domestic laws and it is submitted that the provisions of section 36 of the Constitution are very important in the limitation of rights and are an extension of what is required in the international norms and standards.

- Protection against exploitation and abuse

It is an international norm and standard that States must take, *inter alia*, legislative steps to ensure that involuntary mental health care users are not exploited and abused.<sup>742</sup>

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<sup>741</sup> Principle 16 of the Principles.

<sup>742</sup> Art 16 of the CRPD.

Section 11 of the MHCA provides that every person suffering from mental illness has a right not to be exploited, abused or suffer degrading treatment. Any person witnessing any form of abuse set out above must report it in the prescribed manner.<sup>743</sup> Both the MHCA, read with the Bill of Rights, and the international norms and standards prohibit the cruel, inhuman or degrading treatment or punishment of any person. It was discussed in this study that the provisions, and its interpretation in terms of case law, of the Bill of Rights are instructive in understanding what these rights mean and what is protected. The MHCA gives effect to these rights and does so in conformity with the international norms and standards.

- Determination concerning mental health status

It is submitted that the international norms and standards require that the assessment of mental health be done in accordance with the internationally accepted standards. Any assessment made on the basis of any factor not directly connected to the person's mental health is prohibited.<sup>744</sup> The MHCA recognises this principle and it is given effect in terms of section 12 of the MHCA.

- Confidentiality

Both the MHCA, read with the Bill of Rights, and the international norms and standards recognise that the disclosure of any information that an involuntary mental health care user is entitled to keep confidential in terms of any other law is prohibited. It is submitted that the right to confidentiality is not, nor intended to be an absolute right, it may be limited in certain instances.

- Intimate adult relationship

The general rule is that there is no limit on a mental health care user having intimate adult relationships. International Human Rights Law guarantees that mentally ill persons have a right to marry and have a family. The MHCA provides a limitation on the right to intimate relationship for involuntary mental health care users detained in a health

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<sup>743</sup> S 11(2) of the Mental Health Care Act 17 of 2002. The person must report this fact to the board on form MHCA 02, or lay a charge with the South African Police Service.

<sup>744</sup> Principle 4 of the Principles.

establishment.<sup>745</sup> The principles of section 36 of the Bill of Rights will be applicable and justify the limitation of this right in respect of involuntary mental health care users. Therefore, the international norms and standards have been met by this provision, as the MHCA does not prohibit the right of every mental health care user to intimate relations.

- Right to representation

It is accepted that the international norms and standards require that mentally ill persons have a right to appoint counsel to represent him or her and to receive assistance from a knowledgeable third party. An involuntary mental health care user has the right to a representative, including a legal representative. It is submitted that, although the MHCA makes provision for this right in conformity with the international norms and standards, it may strengthen the implementation of this right to introduce the system of Independent Mental Health Advocates as it is done in the United Kingdom. The study recommends the introduction of Independent Mental Health Advocates in South Africa.

- Discharge reports

The MHCA complies with the international norms and standards in providing this right.

- Knowledge of rights

The MHCA ensures that the rights provided are known to the involuntary mental health care users. It is submitted that, this further strengthens the regulation of the rights of involuntary mental health care users in South Africa and therefore ensuring that the rights are implemented.

- Right not to be secluded and not to be mechanically restrained

The international norms and standards prohibit the physical restraint or involuntary seclusion of mentally ill persons except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. The physical restraint or

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<sup>745</sup> S 14 of the Mental Health Care Act 17 of 2002.

involuntary seclusion is not to be prolonged beyond the period which is strictly necessary for this purpose.

The MHCA provides that an involuntary mental health care user has a right not to be secluded as a form of punishment. He/she may only be secluded to contain severely disturbed behaviour, which is likely to cause harm to others. The MHCA provides a strict procedure for the seclusion of mentally ill patients.

In terms of the MHCA, mechanical means of restraint may only be used if the pharmacological or other means of calming, physical means of restraint or seclusion of the user are inadequate to ensure that the user does not harm themselves or others. This is in accordance with the international norms.

- Rights regarding psychosurgery and electro-convulsive treatment

The international norms and standards prohibit the psychosurgery and other intrusive and irreversible treatments on an involuntary mental health care user, but not any other mental health care user who has consented to such treatment. The MHCA allows psychosurgery to be performed on an involuntary mental health care user who is capable of giving informed consent for such surgery. It is submitted that this is not in itself a contravention of the international norms and standards, as the MHCA provides for a strict procedure when providing psychosurgery.

The MHCA provides that an involuntary mental health care user, who is capable of giving informed consent to electro-convulsive treatment, has a right to decide whether to have electro-convulsive treatment or not. The MHCA provides a strict procedure in respect of which it must be complied with in providing electro-convulsive treatment.

- The Mental Health Review Board

The International norms and standards make provision for Review Bodies which must be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. The MHCA provides for the Mental Health Review Boards, which are independent and impartial bodies. Essentially, the functions of the Mental Health Review Board are, *inter alia*:

- a) To review the decision to admit or retain a person as an involuntary patient in accordance with simple and expeditious procedures as specified by domestic law.
- b) To conduct periodical reviews of the cases of involuntary patients at reasonable intervals as specified by domestic law.

It is submitted that the MHCA does conform to the international norms and standards in this regard. As argued below, the study recommends that the Mental Health Review Boards as they presently are, needs reform. The Mental Health Tribunals in the United Kingdom are instructive to South Africa, in reforming the Review Boards. A detailed discussion of why and how the Mental Health Review Boards should be reformed is provided below.

- General comment on the regulation standard of mental health care

The protection of a mentally ill person's right to liberty and the desire to protect and treat a mentally ill person the same way as any other person is the main theme that is common to all the international instruments regulating mental health care and the MHCA, read with the Bill of Rights. Involuntary mental health care is not prohibited, but strict requirements are required from the domestic law of the countries. It should also be noted that, the majority of the international instruments referred to, in order to establish the international norms and standards are non-binding. However, that is not an important factor because the MHCA makes this provisions binding by incorporating them in the MHCA. In order to fully understand the manner in which the MHCA makes provisions for the international norms and principles applicable to mental health care, the preamble to the MHCA provides clarity:

'RECOGNISING that health is a state of physical, mental and social well -being and that mental health services should be provided as part of primary, secondary and tertiary health services;  
RECOGNISING that the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), prohibits against unfair discrimination of people with mental or other disabilities;  
RECOGNISING that the person and property of a person with mental disorders or mental disabilities, may 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; and  
RECOGNISING 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 in which they reside.'

It is submitted that the basis of the MHCA is the international norms and standards, and it has regulated mental health care in a manner that conforms to the international instruments on mental health care and the international norms and standards.

## 5.2 Recommendations

The study recommends changes regarding the legal nature of the Mental Health Review Board and proposes the introduction of Independent Mental Health Advocates<sup>746</sup> to assist mental health care users by ensuring that the rights of mental health care users are protected.

The Mental Health Review Board is an independent body which is an organ of state exercising public power. The Mental Health Review Boards are not courts of law for any reason. There is a general dissatisfaction regarding the working of the Mental Health Review Boards in South Africa.<sup>747</sup> The Mental Health Review Boards are only guided by the principles of legality, in that it must act only if it is legally permitted to act; and the principle of natural justice, in that it must give all sides the opportunity to present their case.<sup>748</sup> There are no general rules of procedures applicable to all the Mental Health Review Boards. The general principles of Promotion of Administrative Justice Act<sup>749</sup> (PAJA) apply to all the Mental Health Review Boards.<sup>750</sup> Lessons could be learnt from the United Kingdom's Mental Health Review Tribunal and the First-Tier Tribunal as it relates to mental health care. The United Kingdom Mental Health Review Tribunals have rules of procedure and mechanisms aimed at case management.

There is a need for uniform rules of procedure applicable to all Mental Health Review Boards. The impression created with regard to Mental Health Review Boards in South Africa, is that they are free to formulate their own procedure, provided it complies with the rule of legality and natural justice. There need to be a transition from Mental Health Review Boards as they are to a creation of a review body which has procedural rules similar to the United Kingdom's Mental Health Review Tribunal and the First-Tier Tribunal as it relates to Mental Health Care.

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<sup>746</sup> The term may be different but the structure must be similar to that created in terms of the UKMHA in the United Kingdom.

<sup>747</sup> Bateman C: Dismal use of legal safety net for mental health patients. *SAMJ* 2012; 102(2):72.

<sup>748</sup> Landman AA & Landman WJ *op cit* (n 417) at 3.

<sup>749</sup> 3 of 2000.

<sup>750</sup> Landman AA & Landman WJ *op cit* (n 417) at 3.

The Mental Health Review Boards may also be modelled in a similar manner as the Commission for Conciliation, Mediation and Arbitration (CCMA). The CCMA is a dispute resolution body established in terms of the Labour Relations Act, 66 of 1995 (LRA) and the provisions of the PAJA do not apply to its decisions.<sup>751</sup>

The MHCA needs to enact uniform rules of procedure for the Mental Health Review Boards. This is necessary in order to ensure that there is legal certainty regarding the working of these Review Boards; and to ensure that all Review Boards work the same and there is no confusion regarding its functioning. It is therefore recommended that the United Kingdom Mental Health Review Tribunal, taking into account the nature of the CCMA, should be used as reference in creating new Mental Health Review Boards.

It has been found that there is a low level of contact between the mental health establishment and the Mental Health Review Boards; and in most cases the Mental Health Review Boards have not conducted visits to the mental health establishment to ensure that mentally ill persons detained are afforded their rights.<sup>752</sup> Bateman<sup>753</sup> makes the following observation regarding the situation in KwaZulu-Natal:

'In KwaZulu-Natal, a July 2009 review of 49 regional and district hospitals designated by the Act to admit, observe and treat mental health care patients (for 72 hours before admission to a psychiatric hospital) found them to have inadequate staff and infrastructure, high administrative loads and a low level of contact with review boards. Over 80% had not been visited by a review board in the preceding 6 months. KwaZulu-Natal had 25% of the acute psychiatric beds and 25% of the psychiatrists required to comply with national norms. There was "little evidence of government abiding by its public commitments to redress the inequities that characterise mental health services".'

The MHCA provides a right to legal representation in order to represent the mentally ill person in the proceedings. This right does not extend to representation in any other instances other than during the proceedings before a Mental Health Review Board or any other court.<sup>754</sup>

The study recommends the introduction of the Independent Mental Health Advocates, who will be responsible for assisting mentally ill persons detained in terms of the MHCA by informing them of their rights and ensuring that their rights are respected. The

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<sup>751</sup> *Chirwa v Transnet Limited and Others* 2008 (4) SA 367 (CC) at para 50.

<sup>752</sup> Bateman C: Dismal use of legal safety net for mental health patients. *SAMJ* 2012;102 (2):72.

<sup>753</sup> *Ibid.*

<sup>754</sup> S 3 of the Legal Aid Act 22 of 1969.

advocates must be independent to all institutions and should not replace legal representatives. This will ensure that the rights of mentally ill persons detained in the mental health establishment are protected and mentally ill persons are aware of their rights. The advocate may be a person qualified as a social worker and having knowledge of the MHCA.

### 5.3 Recommendation for further study

This study may be taken further by researching the manner in which the Mental Health Review Boards can be developed, considering the recommendations made with reference to the United Kingdom Mental Health Tribunal and the CCMA. This study may also be taken further by researching the introduction of independent Mental Health Advocates in South African law.

### 5.4 Conclusion

The aim and objectives of the study were to explore the law protecting the rights of involuntary mental health care users and consider whether it complies with the International Human Rights Law relating to the protection of rights in involuntary mental health care; and to consider whether there can be any lessons to be considered in the mental health care laws in the United Kingdom. The study had to consider the historical background of mental health care laws in South Africa in order to provide the context in respect of which the MHCA was enacted in 2002.

The mental health laws in South Africa were initially centred on detention and there was no interest in treating the mentally ill person who was detained. The mentally ill persons were merely detained in order to remove them from the society, no treatment was provided and there was no regard for the protection of their rights. This trend continued until the MDA was promulgated as the first comprehensive legislation regulating mental health in the Union of South Africa. At this stage there was an attempt to treat the patients. When the MHA was promulgated in 1973, the mental health laws in South Africa were focused on the treatment of mentally ill persons and not just detention of such persons. The introduction of the Constitution meant that the rights of involuntary users had to be of paramount importance when detaining and treating involuntary users and this led to the promulgation of the MHCA. The mental health laws in South Africa became focussed on protecting the rights of mentally ill persons.

The introduction of the Constitution and MHCA brought a comprehensive protection of rights of involuntary mental health care users. The MHCA was promulgated taking into account the ten basic principles adopted by the World Health Organisations in Geneva in 1996. The MHCA provides a comprehensive codification of specific rights aimed at protecting persons with mental illness, which includes involuntary mental health care users. The rights provided in the MHCA should be interpreted taking into account the provisions of the Bill of Rights. The MHCA has been modelled in terms of the principles of International Human Rights applicable to involuntary mental health care users.<sup>755</sup> The fact that the MHCA has to be interpreted in terms of the Bill of Rights makes the Bill of Rights and the MHCA the primary sources of rights of involuntary mental health care users.

It is submitted that the International Human Rights law in respect of mentally ill person is based on the protection of the person suffering from mental illness; restoring and protecting the person's autonomy, choice and independence; protecting the liberty of a person suffering from mental illness and if not possible, ensuring that the least restrictive means is adopted in treating mentally ill persons; protecting the right to access to mental health care; and the protection of economic, social and cultural rights.<sup>756</sup> It is further submitted that the mental health care: Ten Basic Principles may be regarded as a basis for International Human Rights Law instruments in respect of mental health care and the MHCA.

Both the International Human Rights principles relating to mental health care and the MHCA read with the Bill of Rights make provisions for:

- a) The promotion of mental health and prevention of mental illness.
- b) The promotion of access to basic mental health care.
- c) The assessment of mental health in accordance with internationally accepted standards.
- d) Promotion of the least restrictive type of mental health care.

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<sup>755</sup> Landman AA & Landman WJ *op cit* (n 417) at 3.

<sup>756</sup> Quinn G *op cit* (n 612) at 104.

- e) Promotion of independence and self-determination for persons suffering from mental illness.
- f) The availability of review procedure and judicial oversight to ensure protection of persons suffering from mental illness.

The provisions of the MHCA were comprehensively discussed in chapter three and the provision of International Human Rights Law in chapter four. Therefore, it is not necessary to repeat such provisions. In answering the research questions the following can be said:

- a) The protection of human rights of involuntary mental health care users in South Africa does conform to the International Human Rights standard in respect of mental health care. However the study recommends certain measures which will be vital in the protection of human rights.
- b) Chapter four and five of this study provided a detailed discussion of the provisions protecting the rights of involuntary mental health care users in terms of the MHCA, the Bill of Rights and International Human Rights Law.
- c) The lessons to be learnt from the United Kingdom and the measures to be taken to improve the protection of rights of involuntary mental health care users are the reformation of the Mental Health Review Boards into a judicial body; and the introduction of Independent Mental Health Advocates. The recommendation made may be implemented by the legislature or policy makers.

The problem that has been posed by this study was important to answer as it will lead to an improved regulation of mental health care; and ensuring that the structures created to ensure compliance and protection of the right of mentally ill persons are fully equipped to do so. This study attempted to provide a practical solution.

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EDITING OF A N LLM THESIS

TO WHOM IT MAY CONCERN

This serves to prove that I have edited Mr Ndou, M.M.'s thesis titled: **A CRITICAL EVALUATION OF THE HUMAN RIGHTS OF INVOLUNTARY MENTAL HEALTH CARE USERS.** The candidate corrected all language errors identified. The document is of acceptable linguistic and academic standard.

Yours Faithfully

A handwritten signature in black ink, appearing to read 'J.R. Moletsane', written over a dotted line.

J.R. Moletsane (English language lecturer)

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