

1-1-2010

# An Analysis of South Africa's Mental Health Legislation

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## Recommended Citation

McCrea, Natalie Latoya. 2010. An Analysis of South Africa's Mental Health Legislation. National Law Forum.

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## **An Analysis of South Africa's Mental Health Legislation**

If one were to measure a society's health by its historical environment, then something can indeed be said of South Africa. This nation is known for its long abhorrent history with apartheid entrenched with a political and human rights struggle. In 1995, the world witnessed the evisceration of apartheid and the birth of a new democratic South Africa. In light of the struggle endured by a visible portion of the South African population, a question asked is, what about the forgotten and somewhat invisible individuals, those who suffer with mental illness. The purpose of this work is to discuss South Africa's mental health legislation, namely Mental Health Care Act, No. 17 [MHCA 2002], and conduct a comparative study with the African Banjul Charter, the UN Principles for the Protection of Persons with Mental Illness [MI Principles], and the World Health Organization Principles.

### **Historical Mental Health Legislation**

While South Africa has had numerous mental health statutes, our discussion will commence with the 1973 Act.

Mental Health Act 18 of 1973 [MHA 1973] grew out of a "public panic" that ensued after the assassination of then Prime Minister, Dr. Hendrik French Verwoerd by someone deemed to be mentally ill.<sup>[i]</sup> A Commission that inquired into his death concluded that many assassinations "are committed by mentally disordered persons."<sup>[ii]</sup> The Commission's conclusion spawned a proposed amendment, which eventually culminated into MHA 1973.<sup>[iii]</sup>

Scholars and psychiatrists have noted that MHA 1973 did not have an individual rights concern. Rather, its primary focus was on patient control and treatment, along with the "welfare and safety" of the society.<sup>[iv]</sup> The fact that this Act was propelled during the apartheid era cements the view that the human rights of the patients were not necessarily the priority. Specifically, MHA 1973 has been criticized because (i) it only required a reasonable degree of suspicion to be certified to a mental institution;<sup>[v]</sup> (ii) individuals could be denied their freedom and placed in a mental facility based on prejudices and vendettas.<sup>[vi]</sup> In fact, finding someone mentally incapable was sometimes utilized solely for political means in the apartheid era. Freedom fighters were often silenced by being placed in a mental facility; (iii) once deemed mentally ill and certified, patients went without the assistance of the law, and could spend a considerable amount of time in the mental institutions against their will<sup>[vii]</sup>; and (iv) patients did not have a significant right of appeal or representation.<sup>[viii]</sup>

According to the South Africa Federation for Mental Health, while MHA 1973 was in existence, it facilitated disproportionate mental health care based on race, with blacks receiving the least care. In effect, the MHA 1973 provisions did not promote personal autonomy, dignity or justice for individuals with mental illness. Instead, it highlighted a paternalistic principle which allowed mentally ill patients to be alienated, stigmatized and disempowered. It became apparent that MHA 1973 needed to be reconsidered and changed.

### **South Africa's Present Mental Health Legislation**

South Africa entered into a state of transition after the presidential election of Nelson Mandela in 1994. The nation was moving from a repressive regime into a new democratic era. According to the World Health Organization [WHO], Mandela's administration was particularly focused on ridding the nation of all apartheid polices, and instituting new ones that met the needs of groups previously disadvantaged.

The new South Africa adopted its Constitution with an accompanying Bill of Rights on May 8, 1996, which came into force on February 7, 1997. It became even more evident that MHA 1973 needed to be brought in step with the newly adopted principles of the South African Bill of Rights.<sup>[ix]</sup> Specifically, it needed to reflect the rights expounded in Chapter 2, §§§ 9, 10, and 12; recognizing respectively, issues of equality; the right to the respect and protection of

human dignity; and the freedom and security of person.

South Africa's new Mental Health Care Act (MHCA 2002) was passed in 2002 and promulgated on December 15, 2004.<sup>[x]</sup> It came in force in line with other positive international initiatives in mental health legislation, such as the London Mental Health Act 2007, The Scotland Mental Health (Care and Treatment) 2003, and the Jamaica Mental Health Act 1998. In effect, MCHA 2002 seeks to: (1) shift the system from a past custodial approach to one encouraging community care; (2) make certain that appropriate care, treatment and rehabilitation are provided at all levels of the health service; and (3) highlight that individuals with mental disabilities should not be discriminated against, stigmatized or abused.<sup>[xi]</sup>

## **MCHA 2002's Key Provisions**

Mental illness is defined under the Act as a "positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria" made by a mental health care practitioner authorized to make such diagnosis.<sup>[xii]</sup> The Act outlines the rights and duties to mental health patients, and highlights that their human dignity and privacy must be respected; that they should not be unfairly discriminated against because of their mental status; and that they should be protected from "exploitation, abuse and any degrading treatment" <sup>[xiii]</sup>

### **Involuntary Treatment:**

Regulation No. 27117 of 2004 governs MCHA 2002.<sup>[xiv]</sup> This Regulation and § 33 of the Act, states that in order to commence a proceeding to have someone involuntarily committed, "an application must be made to the Head of a Health Establishment (HHE) by a spouse, next of kin, partner, associate, parent or guardian", who must have seen the person within the past seven days.<sup>[xv]</sup> Once the application is received, the HHE must have the person examined by two mental health care practitioners who perform independent assessments of the patient, and must report their findings and recommendations.<sup>[xvi]</sup> If the assessments of the two practitioners are different, then the HHE must have the patient assessed by another practitioner.<sup>[xvii]</sup> The HHE can approve an application only if the two mental health care practitioners agree together that involuntary care is needed.<sup>[xviii]</sup>

MCHA 2002 is clear that only individuals suffering from mental illness are eligible for involuntary care.<sup>[xix]</sup> According to the Act, an involuntary mental health user "must be provided with care, treatment and rehabilitation at a health establishment if at the time of application, there is a reasonable belief that the mental health care user has a mental illness," and is likely to cause serious harm to their person or others.<sup>[xx]</sup>

If the HHE recommends involuntary care, treatment and rehabilitation, the patient must be admitted to a health establishment within 48 hours.<sup>[xxi]</sup> The HHE must then arrange for the assessment of the patient's physical and mental health status for 72 hours.<sup>[xxii]</sup> After the 72-hour assessment, based on the medical health care practitioner's reports, the HHE must decide if the patient requires further involuntary care, treatment and rehabilitation services as an inpatient. If the HHE determines that the patient does not require further treatment, care or rehabilitation, the patient must be discharged immediately, unless the patient gives consent to further care. Invariably, depending upon the HHE's determination, the patient can be discharged or have their status changed to a voluntary inpatient or outpatient. <sup>[xxiii]</sup>

### **Voluntary Treatment:**

MCHA 2002 directs that an individual who voluntarily submits to a mental health facility for care and treatment, and who consents to such care, is "entitled" to care and treatment, or referral.<sup>[xxiv]</sup>

### **Procedural Protections and Precautions:**

MCHA 2002 incorporates several procedures, and precautions to ensure that patient's rights are fully protected.

One notable precaution is that persons directed by the HHE to examine the prospective patient must be qualified mental health practitioners.[\[xxv\]](#)

Another important precaution and procedural protection is the establishment of the Mental Health Review Boards, which are to be constituted in every province.[\[xxvi\]](#) The primary aim of the Boards is to ensure that the rights of the prospective patients are not violated. The Boards must be comprised of one magistrate, one attorney, and a mental health practitioner.[\[xxvii\]](#) Where the HHE subjects an involuntary patient to the 72 hour assessment, and concludes that the patient should receive further involuntary care, treatment and rehabilitation, the HHE must submit a report within 7 days of the expiration of the 72-hour assessment requesting the Board to approve further involuntary care.[\[xxviii\]](#)

One striking element of the Act is that while the Board considers the HHE's decision to continue involuntary treatment, all (the applicant, the mental health providers), except for the reluctant patient is afforded the opportunity to present their representations to the Board.[\[xxix\]](#) Additionally, it is interesting that after the Board makes its deliberations, there is no mention of them sending a notification of the results to the potential patient. The Act, however, notes that decision letters are sent to the HHEs and the applicant who requested that the patient be treated.[\[xxx\]](#) Once the Board decides to adhere to the HHE's assessment that the involuntary patient should continue to be so treated, the Board must submit their decision for judicial review and send all documentations to the High Court for consideration of the matter. The Court has a month to consider.[\[xxxi\]](#)

The aforementioned concerns are somewhat ameliorated by the Act's provision that mental health care users have a right to legal representation, and to appeal to the Board about the decisions of the HHE to continue involuntary treatment.[\[xxxii\]](#) One problem, however, is that the HHE's decision in favor of involuntary care is not submitted to the patient, but to the applicant. Since the reluctant patient was not notified of the HHE's decision in the first place, it is rather difficult for the patient to submit an appeal. If the Board finds for the reluctant patient, s/he must be released immediately. If the Board finds in favor of the HHE's decision, the Board must submit their decision to the High Court for judicial review.[\[xxxiii\]](#)

Another important procedural protection applicable to both voluntary and involuntary mental patients is that their conditions must be periodically reviewed, and annual reports must be submitted to the Board for review.[\[xxxiv\]](#)

### **MHCA 2002 Compliance with Other Human Rights Principles**

The African Banjul Charter on Human and People's Rights was ratified by South Africa on June 9, 1996, and accordingly, its principles are binding on South Africa. The Charter calls for the protection of the dignity of mental health patients; their equality before the law; their right not to be deprived of their liberty and security; and the right to obtain good mental health. [Articles 5, 3, 6, 16, respectively]. Some of these proscriptions were called to the forefront before the African Commission on Human and Peoples' Rights in the landmark case, *Purohit and Moore v. Gambia* No. 241/2001 (2003). The Commission held that all states party to the Banjul Charter should guard and protect the rights of the mentally disabled to dignity and the enjoyment of life.[\[xxxv\]](#)

South Africa's MHCA 2002 recognizes and subscribes to the importance of protecting individuals with mental illness.[\[xxxvi\]](#) The Act further recognizes that this protection is called for in the state Constitution. There is a clear indication that South Africa wants to protect the rights and interests of the mentally ill.[\[xxxvii\]](#) The human dignity and respect principles evoked in *Purohit* are enforced and protected in §§8, 10 and 11 of the Act.

### **The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)**[\[xxxviii\]](#)

As illustrated below, MHCA 2002 comports with many of the tenets of the United Nations' MI Principles:

Chapter III of the Act is a reflection of MI Principle 1 enumerating some basic rights for the mentally ill, such as

respect for human dignity and privacy;<sup>[xxxix]</sup> the consent to care factor;<sup>[xl]</sup> and rules against discrimination, exploitation and abuse.<sup>[xli]</sup> MI Principle 4 is reflected in Section 12 of the Act. Specifically, similar to the MI Principles, MHCA 2002 § 12 directs that a determination of an individual's mental health status should not be based on their socio-political, cultural or economic background. The MI Principle of Notice of Rights (Principle 12) can be found in § 17 of the Act providing that mental health patients must be informed of their rights before any administration of care or treatment. The Act follows MI Principle 16 on involuntary admission in that it considers the dangerousness factor before committing an individual involuntarily. The Act, like Principle 16, recognizes the importance of the concurrence of two mental health practitioners, and that involuntary preliminary treatment should be brief pending a review.<sup>[xlj]</sup> Additionally, both the Act and the MI Principles contain provisions for the creation of Review Boards [Principle 17; MHCA § 18]. They both also have provisions for periodical reviews of involuntary patients [Principle 17, MHCA § 30]; and the right of the patient to appeal [Principle 17, MHCA §29]. The MI Principle of monitoring is reflected in the Act in the form of judicial reviews in §§ 34, 35, 36 and 37.

## **The World Health Organization Principles**

According to the WHO, South Africa's MHCA 2002 "is consistent with international human rights standards...and appears to be a highly appropriate and important milestone in the development of the mental health system in South Africa."<sup>[xljii]</sup>

Many of the principles reflected in MHCA 2002 are in line with the WHO's concept that the aim of a mental health legislation is to "protect, promote, and improve" the lives of the mentally ill.<sup>[xljiv]</sup> Significantly, WHO's concepts are reflected in a number of the Act's principles, namely that mental health services should offer care, treatment and rehabilitation; and that recipients should be treated with the least possible restriction on their freedom.

## **Concerns with the New Mental Health Care Legislation**

Despite the fact that MHCA 2002 represents a major milestone in South Africa's history, the WHO has noted that it does not appear to be enough to bring forward major reforms greatly needed in South Africa's mental health system.<sup>[xljv]</sup> In fact scholars have commented that the system is plagued with human resource constraints and infrastructure restraints, and thus implementation of the Act's requirement in community and district hospitals is problematic.<sup>[xljvi]</sup> According to Moosa, South Africa has a limited amount of specialized psychiatric hospitals, and those that are available are ill equipped to properly abide by the 72-hour provision. Additionally, many South African psychiatric hospitals do not separate the patients by age groups; and there is a significant lack of beds.<sup>[xljvii]</sup> Other problematic areas that undermine the Acts successful implementation are lack of proper training, inadequate skills; and a lack of proper understanding of the Act.<sup>[xljviii]</sup>

## **Conclusion**

South Africa's new mental health care act is an important instrument implemented to advocate for the best interest of mental health care users. Although there are problems, one must remember that the nation had a horrid past, and remnants of the past system are still ingrained therein. The redeeming factor is that South Africa has made the step to correct the deficiency and has moved towards enabling its citizens to have access to obtaining optimal mental health care.

[i] Nicholas Haysom, Martin Strous, and Lloyd Vogleman, *The Mad Mrs. Rochester Revisited: The involuntary confinement of the mentally ill in South Africa*, 6 SAJHR 341, 343 (1990).

[ii] *Id.*

[iii] *Id.*

[iv] Burns, JK *Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating*

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*principles into practice*, S Afr Med J 2008; 98 46-49.

[v] *Id.*

[vi] *Id.*

[vii] *Id.*

[viii] *Id.*

[ix] Bonthuys, Elsje, *Involuntary Civil Commitment and the New Mental Health Bill*, 118 SALJ 667 (2001).

[x] Mental Health Care Act 17 of 2002 (S.Afr.), <http://www.info.gov.za/view/DownloadFileAction?id=68051>

[xi] MYH Moosa and FY Jeenah, *Involuntary treatment of psychiatric patients in South Africa*, 11(2)Afr Journal of Psychiatry, 109, 110 (2008).

[xii] Mental Health Care Act 17 of 2002 Chapter 1, § xxi (S. Afr.).

[xiii] *Id.* at Chapter 3, §§§ 8, 10 and 11.

[xiv] <http://www.info.gov.za/gazette/notices/2004/27117.pdf>

[xv] Mental Health Care Act 17 of 2002 §33 (1,2) (S. Afr.).

[xvi] *Id.* at § 33(4,5).

[xvii] *Id.* at § 33(6).

[xviii] *Id.* at §33(7).

[xix] *Id.* at § 32.

[xx] *Id.*

[xxi] *Id.* at §33(9).

[xxii] *Id.* at § 34.

[xxiii] *Id.* at §34(3).

[xxiv] *Id.* at §§ 25, 26.

[xxv] *Id.* at §27(4), §33(4).

[xxvi] *Id.* at § 18.

[xxvii] *Id.* at § 20.

[xxviii] *Id.* at §34(3)(c).

[xxix] *Id.* at §34(7)(a).

[xxx] *Id.* at §34(7)(b).

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[xxx] *Id.* at §34(7)(c).

[xxxii] *Id.* at §§ 15, 35.

[xxxiii] *Id.* at §35(3)(4).

[xxxiv] *Id.* at §§30, 37.

[xxxv] Michael L. Perlin, Arlene S. Kanter, Mary P. Treuthart, Eva Szeli & Kris Gledhill, *INTERNATIONAL HUMAN RIGHTS and COMPARATIVE MENTAL DISABILITY LAW* 840-841 (Michael L. Perlin eds., 2006).

[xxxvi] Mental Health Care Act 17 of 2002 Preamble (S. Afr).

[xxxvii] *Id.* at §4(c)(d).

[xxxviii] The Protection of Persons with Mental Illness and the Improvement of Mental Health Care, G.A. Res. 46/119, U.N. Doc. A/Res/46/119 (Dec 17, 1991).

[xxxix] Mental Health Care Act 17 of 2002 §§8, 13 (S. Afr).

[xl] *Id.* at §9.

[xli] *Id.* at §§10, 11.

[xlii] *Id.* at §§26, 33.

[xliii] WHO, *Mental Health Policy Development and Implementation in South Africa: A Situation Analysis*, 10 [January 31, 2008].

[xliv] *Id.*

[xlv] *Id.*

[xlvi] MYH Moosa and FY Jeenah, *Involuntary treatment of psychiatric patients in South Africa*, 11(2)Afr Journal of Psychiatry, 109, 110 (2008).

[xlvii] *Id.*

[xlviii] Burns, JK *Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice*, S Afr Med J 2008; 98 46-49.

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