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Review

The Evolution of Mental Health Legislation in South Africa: Towards a Rights-Based Approach

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Abstract: This contribution examines the human rights framework and legislative developments in South Africa on persons with mental illness, revealing that the initial focus of the legislation was on control and detention at the cost of the rights of mental health care users. Presently, under its Constitutional democracy, South Africa has progressive Mental Health Legislation focusing on the rights of mental health care users and the least restrictive means of treatment. The contribution considers the impact of the legislative developments on the human rights of mental health care users. There are, however, challenges with the implementation of the legislation most notably illustrated by the Life Esidimeni disaster where a mass deinstitutionalization project led to the loss of life. South Africa's revised Mental Health Policy Framework holds a renewed commitment to respect a mental health care user's right to dignity, integrity, privacy, and freedom of movement. This is one step closer to the realisation of the obligations created by the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The contribution considers the 2018 concluding observations by the United Nations Committee on the Rights of Persons with Disabilities, which lays bare areas where yet further improvement is needed in South Africa to eradicate all forms of discrimination against persons with disabilities and, in particular, persons with mental illness Areas where progress have been made are highlighted. South Africa has made steady progress but needs to intensify its efforts to domesticize the CRPD.

Keywords: South Africa; mental health care; mental health law; legislative developments; patient rights; Life Esidimeni; psychiatric patients; deinstitutionalization; disability rights; CRPD

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1. Introduction

Mental health law is a neglected field in South Africa with initial legislation largely focusing on confinement and "criminal insanity". However, significant advances have been made in this area of the law since the introduction of the Constitution of the Republic of South Africa, in 1996. The Mental Health Care Act 17 of 2002, enacted in 2004 to better regulate mental health care services and protect the rights of mental health care users highlights South Africa's commitment to providing its citizens with access to mental health care. South Africa's adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2007 and its optional protocol binds it to strive towards realising the rights of persons with disabilities, including persons with mental illness. Despite a robust legal framework, the rights of persons with mental illness remain vulnerable as is tragically illustrated by the Life Esidimeni disaster that took place in South Africa in 2016 where more than 140 mental health patients lost their lives in a deinstitutionalization project. This event called for a relook at the mental health legislative framework and for efforts

to domesticate the provisions in the CRPD to be intensified. Some developments have taken place to enhance the protection of the rights of persons with disabilities, including those with mental illness since the United Nations' Committee on the Rights of Persons with Disabilities issued its concluding observations in South Africa's country report in 2018 in which concerns about the protection of the rights of persons with disabilities were highlighted.

This contribution starts with an overview of the human rights framework within which the rights of persons with mental illness are promoted. This is followed by a discussion of the prevalence of mental illness in South Africa and the treatment of persons with disabilities in the past. An overview of the evolution of mental health legislation and the mental health policy framework is given highlighting the impact of the legal developments on human rights. Challenges with the implementation of the current legislation are highlighted. South Africa's progress in domesticating the provisions of the CRPD as regards the protection of the rights of persons with mental illness post the Life Esidimeni disaster is considered and areas where improvement is still needed are shown.

2. Human Rights Framework

This section highlights some legal instruments relevant to the protection of the rights of persons with mental illness. Details about the content of these instruments and how South Africa is faring in protecting the specific rights held there are discussed throughout the contribution.

The 1948 Universal Declaration on Human Rights (UDHR) states that all human beings are born free and equal in dignity and rights. It protects amongst others the right to be free from torture, and the right to life, liberty, and privacy. Although the rights of persons with mental illness are not mentioned specifically, provision is made for the right to health, including the right to security in cases of disability, which would then include mental illness (Section 25). The UDHR came into being during the apartheid era in South Africa (1948–1994) which practises violated most of the rights in the UDHR leading to South Africa not ratifying it. This translated into persons with mental illness not enjoying protection under the UDHR either (during the time that the 1916 Mental Disorders Act was in place as discussed below). Many of the principles and rights in the UDHR are, however, now incorporated in the South African Constitution of 1996.

The African Charter on Human and People's Rights (ACHPR), also known as the Banjul Charter (African Organisation of Unity 1981), guarantees several rights including the right to equality and equal protection under the law, and the right to a fair trial. It prohibits slavery, torture, and cruel or degrading punishment. Article 2 states that everyone shall be entitled to the rights in the charter without distinction of any kind such as race, sex, colour, religion, birth "or any status". The phrase "or any status" could be interpreted to include health status or disability status. The ACHPR states in Article 16 that every individual shall have the right to enjoy the best attainable state of physical and mental health and that state parties must ensure that individuals receive medical attention when they are sick. The specific mention of mental health in this context confirms the obligations of state parties to provide the necessary mental health care services—this is particularly lacking in South African correctional settings as discussed later in this contribution. Article 18(4) specifically makes provision for special measures to be put in place for the protection of those with disabilities in keeping with their "physical or moral needs". South Africa only acceded to the Charter in 1996 (the same year that its Constitution was adopted) with the reservation that the Charter should align with UN resolutions on the characterisation of Zionism. The Charter sets up a regional human rights system for Africa establishing the African Commission on Human and People's Rights. In 2005, the African Court on Human

and People's Rights was established to adjudicate human rights violations in Africa. The principles in the ACHPR are echoed in the South African Constitution of 1996.

South Africa ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2007. The CRPD applies to persons with mental illness as confirmed in Article 1 of the convention[1] setting out its purpose. State parties undertake to ensure and promote all human rights and fundamental freedoms for persons with disabilities without discrimination of any kind based on disability. To this end, state parties must adopt relevant legislation and other measures to protect the rights in the convention. Existing legislation may have to be amended or even abolished to stop discriminatory practises against persons with disabilities, and for the purposes of this research, people with mental illness. Some specific rights relevant to our purposes contained in the convention include the following: The right to equal recognition before the law (Article 12); the right to access to justice (Article 13); the right to liberty and security of the person (Article 14); the right to freedom from exploitation, violence and abuse (Article 16); the right to liberty of movement (Article 18); the right to live independently (Article 19); and the right to privacy (Article 20). State parties must recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination based on disability (Article 25).

At a national level, the Constitution of the Republic of South Africa 1996 (Government of South Africa 1996), is the supreme law of the land and law or conduct inconsistent with it is invalid. Chapter 2 of the Constitution (Sections 7 to 39) contains a Bill of Rights setting out the fundamental human rights. Rights relevant for purposes of our discussion such as the right to equality (Section 9), dignity (Section 10), freedom and security of the person (Section 12), the right to privacy (Section 14), and the rights of arrested and detained persons (Section 35) to name a few, will be elucidated and discussed through the contribution where relevant. Important to note at this stage is that the rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including; the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose, and the availability of less restrictive means to achieve the purpose. This test would arguably have to be applied every time a patient is detained against his/her will, especially the consideration of less restrictive ways of treatment. Lastly, it should be noted that Section 39(1)(b) states that when interpreting the Constitution, international law must be considered. That means that for our purposes, the CRPD must be considered when looking at a particular constitutional right.

3. South African Context

It is estimated that one in every six South Africans meets the diagnostic criteria for depression, anxiety, or substance abuse (Herman et al. 2009; Sorsdahl et al. 2023). In line with that, the mental health problem in South Africa appears to be more intense than the global average estimate, which is one in every eight people suffering from a mental illness (Sorsdahl et al. 2023). Social factors such as poverty, exposure to violence, substance abuse, and adverse childhood experiences increase the mental health burden in the South African context (Sorsdahl et al. 2023; Burns 2011; MHPF 2023). The high prevalence of HIV & AIDS in South Africa and associated mental health issues, especially in the later phases of the

[1] Article 1 of the CRPD reads: "The purpose of the present 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. Persons with disabilities 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".

illness, contribute to the number of persons with mental illness (Kelly et al. 2019; Landman and Landman 2014). It is currently estimated that 62% of persons living with HIV & AIDS also have a mental illness (MHPF 2023), which reflects an increase compared with the 43% estimated previously (Kelly et al. 2019). Furthermore, the prevalence of mental health issues in South Africa appears to be higher after the COVID-19 pandemic (Shisana et al. 2024). Substance abuse in South Africa is also adding to the number of persons with mental illness (MHPF 2023). Thus, currently, mental illness is the leading cause of disability-adjusted life years (DALYs) at 13.8% compared with 11.8% in the case of HIV (MHPF 2023).

Sadly, 75% of South Africans living with a common mental illness such as depression are not receiving any type of care (Marais and Peterson 2015; Sorsdahl et al. 2023). If persons with serious mental illness are added to this equation, the outcome is less than one out of ten persons in South Africa receiving the mental health care treatment they need (Sorsdahl et al. 2023). This is despite progressive mental health legislation and great advances that have been made in the field of mental health care, shifting the focus from control to care as explored below.

4. Historical Treatment of Persons with Mental Illness in South Africa

The cause of mental illness was historically thought to stem from evil, and a person with a mental illness was considered to be possessed by demons (Gillis 2012; Kruger 1980).

There was no distinction between different types of mental illnesses and all persons with mental illness were considered dangerous (Kruger 1980). For the duration of an affected person's incapacity, they were therefore automatically placed in the care and under the control of a "curator" (Kruger 1980). The main aim of appointing a curator was to protect the interests of society and the families involved. The rights of the mentally ill person received no consideration in that context (Kruger 1980). While the practice of appointing a curator continued under Roman-Dutch law, an appointment was only made on application to the court and a mentally ill person could apply for amendment of the order if they felt aggrieved by it (Kruger 1980).

Under Roman-Dutch law, a mentally ill person could be confined if they were considered "dangerously insane" (Kruger 1980), and they were treated no differently than criminals (Parle 2019). The focus was on safety and controlling violent and disruptive behaviour since treatment for different mental illnesses did not exist at the time (Gillis 2012). There were no guidelines on confinement and there was no control over how a mentally ill person was treated while confined (Kruger 1980).[2] Such a person became an outcast with little regard for their human rights (Kruger 1980). One could say that treatment for the mentally ill was inhumane and amounted to torture at the time (Kruger 1980). Today, this would amount to a clear violation of the right to dignity and the right to be free from torture and cruel, inhuman, or degrading treatment or punishment contained in Article 15 of the CRPD.

During the apartheid years in South Africa between 1948 and 1994, human rights abuses were recorded in psychiatric settings, especially concerning non-white South Africans (Kersop and Van den Berg 2015) Initial legislation was British-based (Kersop and Van den Berg 2015), bringing with it unique challenges as its implementation in a country consisting of various cultures and nationalities was often misaligned with the mental

[2] Kruger A. *Mental Health Law in South Africa* (Kruger 1980) at 7 discusses the case of Hendryntje Cract, a mentally ill woman charged with infanticide. On 8 November 1723, Hendryntjie's mother succeeded with an application to have her confined. She was absolved of the charges against her because of her mental condition but was ordered to confinement for the rest of her life. During her confinement, she was kept in a cage on the premises of Jeroen van Soelen who was paid to take care of her. It is reported that Van Soelen had to beat Hendryntje until she got scared of him to control her. She was kept on his premises for a year and a half until her mother took her back because of the costs of the confinement on Van Soelen's premises.

health needs of the population. Social problems were often used as reasons for institutionalisation and psychiatric interventions (Kersop and Van den Berg 2015). Apartheid-era policies furthermore resulted in psychiatric services being focused in urban areas and predominantly intended for white individuals (Simpson and Chipps 2012). These practises violated the dignity and equality of Black South African persons with mental illness. Unfortunately, there have also been more recent reports of human rights abuses in psychiatric settings in democratic South Africa with its Constitution aimed at protecting human rights, which is cause of great concern. Such abuses have been recorded by researchers (Simpson and Chipps 2012) and are evidenced by the Life Esidimeni deinstitutionalization disaster discussed later in this contribution.

Regarding institutions where mental health care was provided, the first hospital for civilians in South Africa was built in 1818 in the Cape (Kruger 1980), with a portion of the hospital allocated to the mentally ill (Gillis 2012; Kruger 1980). Such persons were treated there until they were moved to a "convict station" on Robben Island during the 1830s and 1840s (Gillis 2012; Kruger 1980).[3] It was not unusual for mentally ill persons to be treated like criminals (Kersop and Van den Berg 2015; Gillis 2012) and detained with convicted offenders (Kruger 1980). In 1867, a temporary "lunatic asylum" was erected in Natal (a province in South Africa at the time) after a request to have lunatics from that area detained at Robben Island was denied (Kruger 1980). That institution held 589 patients in 1910 when South Africa became a Union (Minde 1975). On 20 February 1891, Valkenberg Hospital opened in the then Cape Province. It could accommodate 36 mentally ill persons who were moved there from Robben Island (Kruger 1980). In 1910, there were 428 patients at Valkenberg Hospital (Minde 1975). In the province of Transvaal, the first patient was admitted to the Krankzinnigengesticht, now known as Weskoppies Hospital, on 27 January 1892 (Kruger 1980). The institution held 712 patients in 1910 (Minde 1975). On 1 January 1910, there were 3624 patients in eight mental institutions across South Africa (Minde 1975).

However, the capacity of these institutions soon became problematic with beds being placed in corridors, on verandas and in dining rooms (Gillis 2012; Minde 1975). It is reported that the beds were placed so close together in the dormitories that patients could scarcely get into them (Minde 1975). The problem grew to the point where in 1911, 781 patients in the Cape Province were transferred to jails for different periods until suitable accommodation could be found for them (Minde 1975).

In 1913, a committee was appointed to inquire into the adequacy of mental hospital accommodation. It made several helpful recommendations, but the implementation thereof was hampered by the outbreak of war in 1914 (Minde 1975).

In an attempt to manage the capacity of these institutions, and due to severe financial constraints of the state after the war, in 1931 an order was issued that magistrates were to direct that only "violent and dangerous patients in urgent need of institutional treatment" were to be admitted to the institutions (Minde 1975). While that did reduce the number of admissions, it was considered therapeutically and economically disastrous because curable cases would be refused admission until they were beyond help, resulting in life-long treatment costing the state more in the long run (Minde 1975). This practice was not in the interest of mental health patients and would certainly by today's standards constitute a violation of Article 25 of the CPRD which guarantees the highest attainable standard of health without discrimination based on disability.

The overcrowding problem improved with the establishment of, amongst others, Fort Napier Hospital in Natal in 1927 (Minde 1975). In 1936, the lack of capacity at mental hospitals reached disastrous proportions yet again in that there were 1534 patients for

[3] Gillis (2012) at 78 states the move took place in 1836, while Kruger A., *Mental Health Law in South Africa* (Kruger 1980) at 11 states it took place in 1846.

whom there were no available beds in a mental hospital (Minde 1975). Slight relief came when Sterkfontein Mental Hospital opened in Krugersdorp in the province of Transvaal in 1943. The capacity created at the newly established institution was nonetheless soon depleted due to taking in patients from other overcrowded institutions (Minde 1975).

In December 1969, there were 18 institutions across South Africa housing 23238 patients (Minde 1975). At present, there are reported to be 24 psychiatric hospitals across South Africa (Sorsdahl et al. 2023).

Initially, each province had its own legislation on the detention of the mentally ill (Kruger 1980).[4] The Mental Disorders Act 38 of 1916, which came into force on 1 November 1916, served to consolidate provincial legislation on the detention and treatment of "mentally disordered and defective persons" (Minde 1975; Kruger 1980), and brought about uniformity among provinces. However, the legislation was riddled with provisions on segregation, employing policies that ensured separate facilities for Black South Africans, a clear violation of equality and dignity. Fortunately, that changed when the first democratic government took power in 1994 (Gillis 2012), with mental health legislation undergoing significant change and development since then. An overview of pertinent pieces of legislation follows to illustrate the positive developments that emerged.

5. Legislative Developments

5.1. Introduction

The rights of persons with mental illness have not received the attention they deserved in the past (Landman and Landman 2014). The 1950s was labelled as the era of "new therapies", bringing with it the potential for the mental health care system to be transformed from custodial to curative (Kersop and Van den Berg 2015). That was followed by a worldwide shift in focus to the promotion of positive mental health in the early 1960s (Cheetham 1970). South Africa's attention was also drawn to its mental health care legislation during the time, not due to the worldwide mental health focus, but because of the assassination of Dr H F Verwoerd (who was prime minister at the time) in September 1966 by Demitrio Tsafendas, an individual with schizophrenia (Kruger 1980; Strydom et al. 2011). That event prompted the appointment in December 1966 of the Rumpff Commission of Inquiry under the chairmanship of the Honourable Mr Justice F Rumpff, tasked to investigate the criminal responsibility of "mentally deranged" persons in South Africa (Kruger 1980). That resulted in the first revision of mental health legislation in almost 60 years (Kersop and Van den Berg 2015) since the Mental Disorders Act came into force in 1916. The Act was later revised to include all aspects of mental health (Strydom et al. 2011).

Three significant pieces of mental health care legislation are discussed below to illustrate the progression of mental health laws. The Mental Disorders Act 38 of 1916 is discussed first, followed by the Mental Health Act 18 of 1973 (Mental Health Act 1973) and then the Mental Health Care Act 17 of 2002.

5.2. Mental Disorders Act 38 of 1916

The Mental Disorders Act 38 of 1916 (in this section referred to as the 1916 Act) dealt with seven categories of mentally ill persons, using terminology such as "idiot",[5]

[4] See Kruger A. *Mental Health Law in South Africa* (Kruger 1980) at 12–21 for a summary of the various legislative provisions in the Cape, Natal, Transvaal, and the Orange Free State before South Africa became a Union.

[5] Refers to a person so deeply defective in mind from birth or from an early age as to render them unable to guard themselves against common physical dangers. Such persons belong in class 3 of the Mental Disorders Act 38 of 1916.

"imbecile"[6] and "feeble-minded person".[7] A person suffering from epilepsy, referred to as an "epileptic", was also deemed to be mentally ill or a mentally defective person (Kruger 1980). The 1916 Act further referred to an accused person with a mental illness as "mentally disordered or defective" (Mental Disorders Act 1916). The terminology in itself was indicative of a lack of respect for the dignity of a person with mental illness. The focus of the 1916 Act was on custodial care (Simpson and Chipps 2012). A Magistrate had to issue a reception order for a person to be declared "mentally disordered or defective" after which they were detained in an institution earmarked for the specific category of mental illness (Section 8 of the 1916 Act). The police could apply for a reception order if a person was suspected of being mentally ill (Section 10 of the 1916 Act). A report on the mental state of the patient had to be filed with the Commission annually for the first three years of detention, then again in the fifth year, and then every 5 years (Section 25 of the 1916 Act). The 1916 Act further had provisions regarding the management of the property of a person treated under a reception order (chapter ix of the 1916 Act). The focus was very much on controlling the movements and property of the mentally ill person. Detention in this fashion, clearly limited the mentally ill person's freedom of movement (liberty) and the right to self-determination.

If an accused person was unfit to stand trial or not criminally responsible due to a mental illness, they could be detained in a gaol or institution pending the decision of the Governor-General (Mental Disorders Act 1916; Kruger 1980). Such detention could last for significant periods. The 1916 Act provided for reports on the mental state of the accused to be filed in the same intervals as those for a person under a reception order but no provision was made for an appeal against a decision to be detained based on mental illness. This exposed mentally ill accused persons to the risk of being detained for unreasonably long periods while it was being decided whether they had a mental illness. The mentally ill person's access to justice was limited through the lack of an appeal process. The 1916 Act did, however, provide for the withdrawal or abandonment of charges against an accused before an order for observation (s 29bis of the 1916 Act).

Where a person was treated by his/her family whilst mentally ill, this had to be reported to the Magistrate who could condone such an arrangement for 6 months. If the condition persisted after 6 months, the procedure for a reception order had to be initiated to have the person admitted to a psychiatric institution (Section 39 and 40 of the 1916 Act). This is in contrast with the emphasis on the right of a mentally ill person to decide where and with whom they want to live as currently protected in the CRPD (Article 19(a)).

Patients were generally better cared for after the inception of the 1916 Act, but the custodial orientation towards persons with mental illness remained (Gillis 2012). The lack of provisions for voluntary mental health care confirms that the focus of this legislation was not on treatment. Mechanical restraint was permissible (Section 77) and long periods of detention were rife. Even though the 1916 Act emphasised the fact that any instances of neglect or maltreatment of a mentally ill person must be reported (Sections 47 and 71 of the 1916 Act), the implementation of the 1916 Act amounted to what would, today, be labelled as serious human rights violations (Kersop and Van den Berg 2015) under both the South African Constitution and the CRPD.

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[6] This referred to mental deficiency not amounting to idiocy and formed class 4 of the Mental Disorders Act 38 of 1916.

[7] These seven categories are: "mentally disordered; mentally infirm; idiots; imbeciles; feeble-minded persons; moral imbeciles; and epileptics". A person was mentally defective to such an extent that they could not compete on equal terms with their "normal" fellows.

The Van Wyk Commission of Inquiry under the chairmanship of the Honourable Mr Justice J T van Wyk was appointed to investigate a revision of the 1916 Act (Strydom et al. 2011). During the inquiry to revise the 1916 Act, the Commission commented that

> It is today generally recognized that persons suffering from mental illness should as far as possible be admitted to mental hospitals in the same way as any other person suffering from an illness is admitted to an ordinary hospital (Van Wyk 1972)

The above illustrates the shift in focus from pure custodial measures to the concept of treatment.

It is noteworthy that the then Department of Prisons was also represented in the Commission in that it reflected an acknowledgement that many afflicted with a mental illness were confined in prison. The Van Wyk Commission's report contained draft legislation that resulted in the Mental Health Act 18 of 1973. Commissions of inquiry to investigate problems relevant to psychopathy and drug and alcohol abuse were also established, and the findings of those commissions were subsequently considered in the drafting of the Mental Health Act 18 of 1973 (Cheetham 1970).

5.3. Mental Health Act 18 of 1973

The 1916 Act discussed above governed the treatment of mentally ill persons until the Mental Health Act 18 of 1973 (in this section referred to as the 1973 Act) came into operation on 27 March 1975. The 1973 Act differed radically (Minde 1975) from its predecessor, as is reflected boldly in the name of the Act, namely that the focus became health rather than disorder, and care rather than detention. The seven classes or categories of persons with mental illness set out in the 1916 Act were done away with and the general term "mental illness" was used instead (Minde 1975). Section 1 of the 1973 Act defined Mental illness as any disorder or disability of the mind and included any mental disease, any arrested or incomplete development of the mind, and any psychopathic disorder.

Chapter 1 of the 1973 Act stressed the fact that a patient needing mental health care could be admitted much like a patient with a physical ailment with their consent (Minde 1975). That was in line with the observation of the Van Wyk Commission when the provisions of the 1916 Act were reviewed, as discussed above.

Section 3 of the 1973 Act made provision for "voluntary patients" who requested treatment and could consent thereto to be discharged on request (s 5[a] of the 1973 Act). Section 4 provided for "patients by consent" who were patients unable to consent but not opposed to treatment. The application for treatment would be brought by a third party such as a family member. Such patients could be discharged on application by the third party who requested the treatment initially if a medical practitioner certified that the person was fit to be released or by order of the court (s 5[b] of the 1973 Act). Section 7 made provision for outpatient care for patients who, in the opinion of the superintendent of the relevant institution, are likely to benefit from such care and voluntarily submit to it. Voluntary patients and patients by consent could, however, be detained against their will should a reception order be brought in terms of Section 8 or an application be brought for their treatment in an institution in case of an emergency where it is expedient for the welfare of a patient or is in the public interest that the patient be forthwith placed under care and treatment in an institution (Section 12 of the 1973 Act). The introduction of the patient-by-consent category, as well as outpatient care, illustrates the change in emphasis from custody to care since similar provisions were lacking in the 1916 Act. It is also a step towards acknowledging the right to freedom of movement (liberty) and the right to bodily integrity as provided for in the Constitution since 1996.

Section 11 of the 1973 Act stated that a reception order could be made by a court for a person with a mental illness to be detained in an institution for up to 42 (forty-two) days,

While Section 20 allowed for a person detained under a reception order to apply to court asking for the reasons for their detention, they could, however, not apply to be released (Kruger 1980), thus limiting access to justice and freedom of movement. The mental state of a patient was reviewed every six months, during which review the release of the patient could be ordered if a medical practitioner recommended it (s 25 of the 1973 Act). When a person detained under a reception order was certified as dangerous, they had to be detained at a maximum-security facility (s 27 of the 1973 Act). Chapter 4 of the 1973 Act dealt with state patients and mentally ill prisoners. It also contained provisions for the administration of a mentally ill person's estate.

Although the 1973 Act was an improvement on the 1916 Act (Simpson and Chipps 2012), it did not promote the autonomy of and justice for the person with mental illness but rather focused on patient control and societal interests (Kersop and Van den Berg 2015). The focus was still more on community safety than on the human rights of the mentally ill person (Simpson and Chipps 2012). The 1973 Act also did not contain sufficient appeal provisions (Simpson and Chipps 2012). It was furthermore reported that the Act was used as a political weapon to silence freedom fighters during the apartheid era, since being certified mentally ill left a person so classified without the aid of the law (as they had no right to legal representation), and allowed for the person to be detained in an asylum (Kersop and Van den Berg 2015). It is plain to see how these practises would constitute a violation of the right to access to justice and to be considered equal before the law as currently protected in Articles 12 and 13 of the CRPD.

The Mental Health Care Act 17 of 2002 eventually introduced an era of patient autonomy, as discussed below. The Constitution forms the basis of this new legislation, expanding on fundamental human rights such as dignity and bodily integrity enshrined in the Bill of Rights in Chapter 2 of the Constitution.

5.4. Mental Health Care Act 17 of 2002

5.4.1. Introduction and Background

The above Mental Health Act was repealed in its entirety by the Mental Health Care Act 17 of 2002 (in this contribution referred to as the MHCA) that came into effect in December 2004 and still applies today. The preamble to the MHCA recognises an individual's constitutional right not to be discriminated against based on mental illness or any other disability, and records "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" (MHCA 2002). The MHCA has introduced a shift away from custodial care to a human-rights-based approach (Simpson and Chipps 2012; Kleintjies and Schneider 2023). With these high aspirations, the MHCA has been labelled as one of the "most progressive pieces of mental health legislation in the world" (Burns 2011; Kersop and Van den Berg 2015).

The shift from control to care (Kersop and Van den Berg 2015) is clear from the MHCA objectives and its focus on autonomy and patient rights. One of the main goals of the MHCA is to make the best possible mental health care and rehabilitation services available to the population equitably (s 3[a][i] of the MHCA) and to clarify the rights and obligations of mental health care users and mental health care service providers (s 3[c] of the MHCA).

Chapter 3 of the MHCA contains a patient charter aimed at empowering mental health care users with knowledge of their rights. This patient charter is partially based on a 1991 United Nations resolution on the protection of persons with mental illness and the improvement of mental health care (Freeman 2002). The MHCA is further based on the World Health Organization's (WHO) Guidelines for the Promotion of Human Rights of Persons with Mental Disorders (Landman and Landman 2014). There is a duty on health

care workers to ensure that mental health care users are aware of their rights in terms of this Act (s 17 of the MHCA). The only exception is when the user is admitted in an emergency under Section 9 (1)(c) of the MHCA (Landman and Landman 2014).

The MHCA has introduced a rapid shift in focus from arbitrary decision-making about the treatment of the mentally ill to patient autonomy (Simpson and Chipps 2012). Autonomy is achieved by providing the least restrictive care. The MHCA's focus on the least restrictive method of treatment is most evident from the regulations governing electroconvulsive therapy, which now requires the user's consent, and psychosurgery (Landman and Landman 2014). The MHCA further provides that mechanical restraint may only be used for short periods, and only if chemical restraint is inadequate. If mechanical restraint is used, it must be monitored every 30 min and must be recorded in a register and reported to the relevant Review Board (Regulation 38 to the MHCA). This practice aligns with the right to bodily and psychological integrity in Section 12 (2) of the South African Constitution providing for the right to have security in and control over one's body and Article 17 of the CRPD providing for the mental and physical integrity of persons with disability. The mechanism of periodic reviews incorporated in the MHCA (e.g., s 37) supports the ideal of providing the least restrictive manner of treatment, as an involuntary user may be reclassified as an assisted or voluntary user if they regain the ability to provide informed consent to mental health care treatment and rehabilitation services (Landman and Landman 2014). For example, if they are reclassified as a voluntary user, they may be released on request. Their freedom of movement is no longer limited in any way.

An appeal process for those admitted as assisted or involuntary users ensures that mental health care users maintain their autonomy and remain involved in decisions about their treatment. An appeal against the decision to be treated as an involuntary mental health care user can be brought within 30 days of the decision of the Head of the Health Establishment to be so treated. If an appeal is lodged while the Review Board is considering the Head of the Health Establishment's decision for involuntary care, such review should be stopped, and the appeal must be heard (Section 34 (8) and 35 of the MHCA). These appeal provisions allowing the mentally ill person him/herself to appeal are aligned with the provisions of Article 12 of the CRPD, which states that a person with a disability has the right to equal recognition before the law. This provision of the CRPD entails that persons with mental illness should be provided with any support they may need to exercise their legal capacity.

In addition to the review and appeal procedures, the MHCA allows for the Head of the Health establishment to discharge an involuntary mental health care user or allow him/her to continue treatment voluntarily if s/he believes from personal observation, information obtained or on receipt of representations by the user, that s/he has regained his/her ability to make informed decisions, (Section 38 of the MHCA). These provisions ensure that the user is treated for the shortest possible time bolstering his/her constitutional right to freedom of movement (Section 21) and to have control over his/her body (Section 12).

The protection of the mental health care user's privacy is emphasised in the MHCA stating that information about the user may only be disclosed to third parties if non-disclosure would seriously prejudice the health of the mental health care user (s 12[2] of the MHCA). The privacy of the mental health care user is also considered during periodic review sessions in that less restrictive options of treatment should be considered that would be less intrusive on the user's privacy, dignity, and movement (s 37[2][c] of the MHCA), (Liebenberg 2010). The focus on privacy is in line with the protection of privacy in Section 14 of the Constitution and Article 22 of the CPRD which specifically requires state parties to protect the privacy of personal, health, and rehabilitation information of persons with disabilities on an equal basis with others. The National Health Act 61 of

2003 (National Health Act 2003) (Section 14) specifically states that information about a person's treatment may only be disclosed with his/her written consent or, in the absence thereof, under very specific conditions such as under a law of general application or a court order. The Protection of Personal Information Act 3 of 2013 (POPIA) (Protection of Personal Information Act 2013) classifies information about a person's medical treatment or health condition as special personal information that must be treated with the highest regard for its sensitive nature and requires extra protection when processed. The protection of health information is further regulated by the guidelines provided by the Health Professions Council of South Africa which prescribes rules to manage the relationship between doctor and patient. The Health Professions Council of South Africa's (HPCSA) guidelines aim to protect medical information against unauthorised modification, destruction, or access.

Section 10 of the MHCA contains a prohibition against unfair discrimination against mental health care users on the grounds of their mental health status, which is one of the major objectives of the MHCA (Kersop and Van den Berg 2015). That provision is an extension of the protection of equality as provided for in Section 9 of the Constitution, which prohibits unfair discrimination on specific grounds including race, gender, sex, pregnancy, marital status, ethnic, or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language, and birth. Mental illness would fall under disability. It also aligns with the prohibition against discrimination in Article 5 of the CRPD and the general obligations of member states as set out in Article 4 of the CRPD. Article 5(4) states, however, that specific measures that are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention. Special laws and protocols that, for example, provide for special treatment of persons with mental illness, will not be considered discriminatory as they aim to protect and strengthen their rights so that they can exercise those rights on equal footing with others.

In further support of ensuring that the mental health care user receives the least restrictive means of treatment, a 72 h assessment period has been introduced (s 34 of the MHCA), which entails assessment by two physicians, one of whom must be a mental health care worker, to determine whether involuntary treatment should be continued. An advantage of the 72 h assessment period is that it is long enough to allow someone who appeared mentally ill due to substance use to recover and be discharged (Burns n.d.). The 72 h are also long enough to exclude the possibility that the person might suffer from medical conditions other than a mental illness, such as meningitis, epilepsy delirium, or HIV (Burns n.d.). Once it has been confirmed during the 72 h assessment period that the person needs further involuntary care, they will forthwith be treated as such on an in- or outpatient basis. The decision must be approved by the relevant Review Board (s 34 of the MHCA). This 72 h assessment period adds to the aim of integrating mental health care services into all levels of health care and contributes to the move towards deinstitutionalization of mental health care users (Burns n.d.). There are currently 188 hospitals designated to conduct 72 h assessments across South Africa (Sorsdahl et al. 2023). Challenges with the implementation of the 72 h assessment periods have, however, been reported due to the lack of available beds at the designated hospitals (Sorsdahl et al. 2023). That leads to mental health patients being treated in general wards, leading to inadequate care for their mental health conditions.

A positive aspect of the MHCA is that it provides less restrictive treatment possibly closer to the place of residence of a mental health care user, which assists in information sharing and mental health promotion in communities (Burns n.d.). It also reduces overcrowding in mental health institutions and results in more time spent with patients, preventing premature discharge. That, in turn, addresses the revolving-door phenomenon

(Burns n.d.). Mental health care treatment and rehabilitation services are divided into five categories in the MHCA. A brief description of each category follows.

5.4.2. Categories of Mental Health Care Treatment and Rehabilitation Services in the MHCA

The category of mental health care treatment and rehabilitation services that a patient should receive is determined by the patient's ability to make an informed decision about the need for such services. Consideration is also given to whether the patient poses a risk to him/herself and others and whether treatment is necessary to prevent financial loss or further damage to his/her reputation (the latter applies to involuntary admissions only). The HPCSA's guidelines primarily deal with consent to medical treatment and not with obtaining consent for mental health treatment per se. The health practitioner(s) who assesses the patient upon an application for the relevant category of mental health care exercises his/her discretion regarding the patient's ability to consent as guided by the application forms published in the guidelines to the MHCA.

The least restrictive category is voluntary mental health care treatment and rehabilitation services (s 25 of the MHCA). That applies to mental health care users who can make an informed decision about their need for mental health care treatment and rehabilitation services, who can consent thereto and who understand the implications of the treatment. For example, such users would suffer from depression after a traumatic event and seek mental health care treatment at a mental health care establishment for a limited period. These users can be discharged on request.

Assisted mental health care treatment and rehabilitation services (s 26 of the MHCA) are for those users who are not able to make informed decisions about their need for mental health care treatment and rehabilitation services but require it for their safety or the safety of others. Such users would not be opposed to receiving mental health care treatment and would be discharged once they have regained their ability to make decisions about their need for mental health care treatment and rehabilitation services (s 31[3] of the MHCA).

The third category is involuntary mental health care treatment and rehabilitation services (s 32 of the MHCA). Mental health care users in this category would be incapable of making an informed decision about their need for treatment and rehabilitation services but require it for their safety or the safety of others, or to prevent financial loss or further damage to their reputations. They would refuse to receive treatment and would thus be treated against their will (s 32 of the MHCA). Since this involuntary detention deprives the person of their liberty, just cause for such detention must be shown as per Article 14 of the CRPD and Section 12 (1(a) of the Constitution. To this end, a 72 h assessment would be conducted to determine whether involuntary care should be continued, and if so, if it should be on an in- or outpatient basis (s 34 of the MHCA). Involuntary outpatient care can be recommended by the head of the health establishment after the 72 h assessment period (Section 34(3) of the MHCA). According to the General Regulations to the MHCA (Regulation 18), the patient is provided with a list of conditions indicating which health establishment he should attend for mental health services and how often (Department of Health 2004). Should the patient not accept the stipulated conditions, s/he shall be treated on an in-patient basis. A patient may be transferred from inpatient to outpatient care and vice versa (Regulation 20). Outpatient care allows for treatment of the patient closer to his/her family and may be particularly apt where the family is supportive and understanding of the patient's condition and treatment needs. Involuntary outpatient care has been identified as one of the pertinent developments under this Act (Freeman 2002).

The Criminal Procedure Act 51 of 1977 (ss 77 and 78) provides for a criminal court to order that a mentally ill person found not criminally responsible and/or unfit to stand trial be "sentenced" for treatment as an involuntary mental health care user under the MHCA.

The court could not order the unconditional release of an accused found unfit to stand trial, even if they were found to have been involved in a non-violent crime or not to have committed it. The lack of such a provision was found to be unconstitutional (De Vos NO and Others v Minister of Justice And Constitutional Development 2015), and the court ordered the amendment of that Act so that it now allows for the release, conditionally or unconditionally, of an accused found unfit to stand trial in certain instances (Pienaar 2018). This development bolsters the mentally ill accused's right to freedom and security of the person (Section 12 of the Constitution and Article 14 of the CRPD).

Section 37 of the MHCA specifically deals with the review of the involuntary mental health care user's status by the head of a health establishment and provides for review six months after admission and thereafter every 12 months. During the review, consideration must be given to the ability of the user to express a need for further treatment, the possibility of the user inflicting self-harm or harm on others, and whether there are less restrictive services to be rendered that would have less of an impact on the user's privacy, dignity, and movement. Lastly, a plan for future treatment should be indicated (s 37[2] of the MHCA). The report on the user's status would then be considered by the relevant Review Board. If the Review Board decides that involuntary treatment is not warranted, all involuntary care must be stopped, and the user must be discharged unless they consent to further treatment (s 37[5] of the MHCA). Where a user is discharged, the Registrar of the High Court must be informed of such discharge (s 37[6] of the MHCA). Should the Review Board be in favour of involuntary care continuing, the decision would be subject to judicial review by the High Court. The latter must then order continued involuntary care or discharge of the user if there is no basis for continued involuntary care.

Mentally ill prisoners as a fourth category are dealt with in Chapter VII of the MHCA. They are persons detained in custody in any prison or who are being transferred from one prison to another. The category may include persons who are awaiting psychiatric assessment to determine fitness to stand trial or criminal capacity. However, the MHCA only provides for convicted prisoners in this category to receive mental health care treatment and rehabilitation services on an outpatient basis (s 52 of the MHCA). Those not yet convicted (including those out on bail, for instance) seem to be excluded from outpatient care.

The final category covers state patients. State patients are individuals who have been found unfit to stand trial or not criminally responsible due to mental illness under Sections 77 and 78 of the Criminal Procedure Act 51 of 1977, and who have been charged with and found to have been involved in murder, culpable homicide, rape, or any other act involving serious violence. Accused persons in this category are treated as state patients in terms of the MHCA (ss 42 and 47) that provide for treatment at a psychiatric institution until the judge in chambers orders their release. They may only apply for discharge once every 12 months (S v Pedro 2015; MHCA 2002). If the State Patient regains his ability to stand trial, the trial may continue although this is not always done due to the lapse of time (Pienaar 2018)

The different categories of treatment and rehabilitation in the MHCA acknowledge the advances in mental health treatment in that not all mental disorders are the same (as initially believed), and that they differ in how they affect a person's day-to-day life. The provisions for emergency admission in Section 9 of the MHCA acknowledge the devastating effect a mental illness can have on a person, and that interventions against an affected person's will may sometimes be justified, provided it is in their best interest and that of the community.

The 72 h assessment period, the patient rights charter and the short periods of review of the treatment of involuntary and assisted users, state patients, and mentally ill prisoners are significant advances included in the MHCA (Zabow 2006) that set it apart from its predecessors. These mechanisms alone enhance the rights of mental health users, specifically to ensure that they are not detained unnecessarily or for unreasonable periods. The

possibility of reclassifying a mental health care user to a less restrictive care category also helps to ensure that treatment intrudes as little as possible to give effect to the proper care, treatment and rehabilitation services (Department of Health 2012). Any violation of rights must be reported to a Review Board as discussed below.

5.4.3. Review Boards

Mental health Review Boards are established in terms of Chapter 4 of the MHCA to monitor the human rights of mental health care users in mental health care establishments (Landman and Landman 2014; Burns 2011).

The maltreatment of people with mental disabilities in the past was a strong motivation for the establishment of mental health Review Boards (Freeman 2002; Simpson and Chipps 2012). These boards serve as "watchdogs" against the abuse of the human rights of mental health care users, ensuring that they are not unnecessarily detained and not detained for unnecessarily long periods.

The powers of the boards are set out in Section 19 of the MHCA.[8] For example, they review the decisions of health establishment heads to treat persons as assisted or involuntary mental health care users (s 19 MHCA 2002). Complaints of exploitation and/or abuse must furthermore be lodged with and subsequently investigated by a Review Board (s 11 of the MHCA). As such, they provide an accountability mechanism within the South African mental health framework.

The Review Boards create a mechanism for mental health users to exercise their constitutional rights. The periodic reviews by Review Boards align with the right to just administrative action under Section 33 of the Constitution and for such actions to be reviewed. Section 34 of the Constitution guarantees access to the courts or an impartial tribunal or forum to resolve any dispute. The Review Board is such a forum where complaints about abuse and maltreatment can be lodged and appeals against decisions for treatment where the user is aggrieved by it. Section 35 of the Constitution deals with the rights of arrested, detained and accused persons. This provision applies to persons detained in mental health institutions and states that they have the right to know the reason for the detention (Section 35(2)a(a)) and to challenge it (Section 35(2)(d)). The appeal process to the Review Board gives effect to this right.

The establishment of Review Boards is further in line with the provisions of Article 16 of the CRPD as State Parties are tasked with ensuring that facilities and programs designed to serve persons with disabilities are monitored by independent bodies to ensure that Article 16 violations (exploitation, violence, and abuse) do not occur. The Review Board is a mechanism to fulfil this obligation under the CRPD.

Review boards follow a multidisciplinary approach as they consist of a lawyer, a psychologist, or psychiatrist and a community member (MHCA 2002). The introduction of these boards is labelled as one of the most important changes the MHCA has brought about (Freeman 2002).

However, these Review Boards have very little involvement in the criminal justice system. In terms of the MHCA, their only official involvement is the periodic review (every

[8] [Section 19 of the MHCA states the powers to be: (1) The Review Board must
(a) consider appeals against decisions of the head of a health establishment;
(b) take 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-h assessment made by the head of the health establishment and make decisions to provide further involuntary care, treatment and rehabilitation;
(e) consider applications for transfer of mental health care users to maximum security facilities; and
(f) consider periodic reports of the mental health status of mentally ill prisoners.

six months) of the mental state of a mentally ill prisoner (s 19 of the MHCA). They are not authorised to review a fitness finding by a court, nor are they involved in deciding the appropriate way to deal with a person who suffers from a mental illness in the criminal justice system. Unfortunately, Review Boards have generally been found to be ineffective (Simpson and Chipps 2012) in protecting the rights of mental health care users. Operational inefficiencies seem to hamper Review Boards from becoming involved when rights are violated (Burns 2011), and there have been calls for such boards to be restructured to enhance their functioning (Burns 2011; Kersop and Van den Berg 2015).

5.5. National Mental Health Policy Framework

South Africa's National Mental Health Policy Framework (MHPF) and Strategic Plan 2013–2020 and the most recent MHPF 2023–2030 guide national and provincial governments in mental health promotion, the prevention of mental illness, and mental illness care, treatment, and rehabilitation, and are aligned with the WHO's Mental Health Action Plan that embraces task sharing and the integration of mental health into primary health care services. The MHPF is a vital tool for the implementation of the MHCA (Marais and Peterson 2015). However, implementing legislation aided by the MHPF remains a challenge, as highlighted below.

The current legislative framework and the MHPF 2023–2030 promote the incorporation of mental health services into primary, secondary, and tertiary health care, including community care, which is in line with the WHO's recommendations (Sorsdahl et al. 2023). This will aid in making mental health services more available to those in need of it. The National Health Insurance Act might also assist in this regard.

5.6. National Health Insurance Act 20 of 2023

Recently, the National Health Insurance Act 20 of 2023 (hereafter in this contribution referred to as the NHI) has been signed into law to achieve universal access to quality health services in South Africa (National Health Insurance Act 2023). The NHI aims to bolster several constitutional rights, including the right to health care and the right to bodily integrity (ss 12 and 27 of the Constitution). Among other things, the intent is to provide free mental health care at the point of service, except for those who bypass the referral path (Shisana et al. 2024), and the hope is that the NHI will address the inequality in the private and public sectors regarding the availability and affordability of health services (Shisana et al. 2024). Regulations are currently awaited to see how the NHI will impact the delivery of mental health care services in South Africa.

6. Challenges with Implementing the Legislative Framework

6.1. Staff Shortage

South Africa's mental health legislation is relatively progressive (Sorsdahl et al. 2023). Its realisation is nevertheless seriously hampered by practical challenges (Docrat et al. 2019). There is a shortage of psychiatrists in South Africa with an estimated 0.31 public sector psychiatrists for every 100,000 uninsured individuals (Docrat et al. 2019; MHPF 2023; Sorsdahl et al. 2023). Although the availability of nurses in the mental health care space is satisfactory (albeit that not all of them may be psychiatric nurses), a shortage of auxiliary staff needed for rehabilitation purposes such as audiologists, occupational therapists and speech therapists has been reported (Docrat et al. 2019).[9] To address such staff shortages, a task-sharing model has been adopted in the country. That involves the

[9] The availability of auxiliary health workers, critical for rehabilitative care and support services for mental health care users, was found to be scarce with estimates of 1.53 public sector occupational therapists; 1.07 public sector speech therapists and audiologists and 1.83 social workers per 100,000 of the uninsured population.

formal redistribution of tasks typically performed by specialist mental health workers (e.g., psychiatrists, psychologists) to health workers without specialist training in mental health to increase access to mental health services (Sorsdahl et al. 2023). Access to mental health services is further hampered by the fact that most trained psychiatrists work in the private sector. They are also concentrated in the urban areas, leaving rural areas with a lack of mental health professionals (Shisana et al. 2024). Additionally, 50% of the public hospitals that offer mental health services do not have a psychiatrist and only 30% of such hospitals have clinical psychologists (Shisana et al. 2024). These figures threaten the Department of Health's vision as set out in the MHPF 2023–2030 to provide comprehensive, high-quality, integrated mental health promotion, prevention, care, treatment, and rehabilitation for all in South Africa by 2030.

6.2. Lack of Funding

Funding for mental health care services in South Africa comes from the government, private insurers, out-of-pocket payments by individuals, donor funding to NGOs, religious institutions, employers, schools, and universities (Shisana et al. 2024). With approximately 80% of the South African population not being on medical aid, the funding from these sources is, however, often insufficient (Shisana et al. 2024).

Primary and community health services are still underfunded and understaffed, meaning that many persons do not receive the mental health care they need (Shisana et al. 2024). In its 2023–2030 MHPF, the Department of Health acknowledged that mental health services in South Africa are underfunded. Only 5% of the total health budget (in some provinces it is less than that) is spent on mental health services, with 86% of that spent on inpatient psychiatric care (MHPF 2023). Patients who receive long periods of inpatient mental health care are often readmitted, driving up the cost per individual in the public health sector (Docrat et al. 2019). Especially readmissions within three months of discharge add significantly to such increases in expenditure (MHPF 2023).

Lack of funding furthermore results in mental health medicines found to be out of stock in public hospitals (Docrat et al. 2019), and concerns have been raised about psychiatric hospitals falling into disrepair, making them unsafe for human use (Burns 2011). Lack of funding for mental health services inevitably leads to the neglect of mental health care services compared to health services for other conditions. This situation threatens the Department of Health's vision to ensure that mental health care users receive care, treatment, and rehabilitation services according to standards equivalent to those applicable to any other health care user that improves his/her well-being and capacity (Department of Health 2012).

6.3. Delay in Providing Mental Health Services

Many South Africans approach traditional or religious healers first before seeking help at a mental health facility due to the lack of availability of treatment facilities within communities (Zingela et al. 2018). That contributes to delays in accessing psychiatric medication since a visit to a mental health facility often only follows a visit to such an alternative health care provider (Zingela et al. 2018). Due to the lack of staff in mental health facilities, the suggestion has been made to consider including traditional healers as primary health care practitioners since they are extensively used within communities and their services are generally more accessible and affordable (Kleintjies and Schneider 2023). The need for training of such service providers is paramount and attention must be given to reported instances of abuse by such practitioners (Zingela et al. 2018) before serious consideration could be given to this proposal.

Another suggestion to reduce possible delays in mental health care was that efforts to deliver telemedicine should be intensified, as that would enable trained lay counsellors to provide interventions under the supervision of qualified mental health professionals, thereby broadening the network of persons that can be reached with these services (Shisana et al. 2024).

Accused persons wait for long periods before they are assessed for fitness to stand trial or criminal capacity. Mental health treatment in correctional facilities where they wait is not readily available. There are a limited number of beds available in psychiatric hospitals authorised to conduct such assessments. Increasing capacity at such facilities could aid in reducing the waiting periods. Diversion of these accused persons can be considered as a way to get them into a treatment program as soon as possible (Pienaar 2021).

In 2007, South Africa signed and ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD), thereby committing the country to a new rights-based approach towards persons with disabilities, including mental illness (Burns 2011). Enacting legislation in the form of the MHCA, which serves such patients' best interests, has been a step in the right direction. Unfortunately, it has not been backed up with the necessary resources and funding. That places South Africa at risk of only paying lip service to the commitments in the CRPD. Details on how South Africa is fairing in terms of its obligations under the CRPD are included after a discussion of the Life Esidimeni disaster which sparked serious concern about the rights of persons with disabilities.

6.4. Life Esidimeni Disaster—Deinstitutionalisation

As part of the MHPF 2013–2020, more focus was placed on deinstitutionalization and creating community beds with relevant community health care services to ensure success in the moving of patients into community care. The MHPF 2013–2020 aimed to address some problems that arose during previous deinstitutionalization attempts where persons ended up in the criminal justice system and on the street, as they were released into communities that were not ready to receive them (Life Esidimeni Inquest 2024). Deinstitutionalization is indeed an important part of the rights-based approach to mental health care (SAHRC 2017). The MHPF 2013–2020 nonetheless contained a provision that advised against deinstitutionalization until proper community services were developed and put in place (Life Esidimeni Inquest 2024).

Despite the above provision, the Gauteng Department of Health terminated a service level agreement with the Life Esidimeni hospital group that provided mental health care services to patients for many years. Consequently, patients had to be moved from the group's hospitals to various community-based non-governmental organisations (NGOs) for the sake of deinstitutionalization. It was coined the "marathon project" (SAHRC 2017). The institutions were not properly licenced and were ill-equipped in terms of staffing and facilities to care for the affected individuals (SAHRC 2017; Life Esidimeni Inquest 2024). The move of the patients from Life Esidimeni hospitals was poorly planned and done in haste (SAHRC 2017), so much so that some patients were transferred from one NGO to the next without being properly discharged by a clinician (Life Esidimeni Arbitration 2018). That led to what is now known as the Life Esidimeni disaster in which 144 mental health care users lost their lives and hundreds were subjected to inhumane and undignified treatment. Many family members did not know where their mentally ill relatives had been moved to and were forced to go from NGO to NGO to try to find them. In one instance, it took four months for a woman to locate her mentally ill brother who had been moved from a Life Esidimeni hospital, only to find that he had passed away (Life Esidimeni Arbitration 2018). Patients were found by their family members in a state of dehydration, emaciated and, in some instances, even decomposed (Life Esidimeni Arbitration 2018). The transfer of

the patients from Life Esidimeni hospitals to NGOs that were not properly equipped to take them in and care for them violated their right to dignity (Section 10 of the Constitution), both while they were alive and after they had passed away, and violated the right to dignity of their family members, in the most shocking way, as found during the arbitration hearing (Life Esidimeni Arbitration 2018).

That disaster proved that the legislative framework was not as robust as had been hoped (Life Esidimeni Arbitration 2018). The issue was first investigated by the Office of the Health Ombud, which recommended arbitration between the government and the families of the mental health patients involved (Mokgoba 2017). The health Ombud is an independent body established under the National Health Amendment Act 2013 and reports to the Minister of Health. The first Ombud was appointed in June 2016. The Ombud's functions include promoting and protecting the health and safety of users of health services by investigating complaints in private and public health establishments relating to non-compliance with prescribed norms and standards.

Following the arbitration, the Gauteng Department of Health accepted responsibility for the disaster, leaving only the amount of compensation to be paid to the families to be decided. The government was subsequently ordered to pay ZAR 1,000,000 (one million rand) to each of the 144 claimants (the families of those who passed away) and the 1418 patients who survived but endured pain, suffering, and torture (Life Esidimeni Arbitration 2018). The damages were awarded for the government's "unjustifiable and reckless breach" of, among other things, the affected parties' right to dignity (Section 10 of the Constitution), right not to be tortured in any way (Section 12[1][d] of the Constitution), right not to be treated or punished in a cruel, inhuman, or degrading way (Section 12[1][e] of the Constitution), right to have access to sufficient food and water (Section 27[1][b] of the Constitution), and right to have access to health care (Section 27[1][a] of the Constitution). Multiple breaches of the National Health Act and the MHCA were also shown.

The Life Esidimeni disaster sparked a SAHRC investigation into the state of mental health care services in South Africa (Kleintjies and Schneider 2023). The Commission found that rural areas have particularly poor resources in terms of mental health services and that mental health services for children and forensic patients need particular attention (SAHRC 2017; Kleintjies and Schneider 2023). The SAHRC further found that the deinstitutionalization of mental health care users went contrary to the provisions of the MHPF in place at the time in that the latter contained a cautionary provision on deinstitutionalization without ensuring that proper services and support were in place (SAHRC 2017). The SAHRC described the Life Esidimeni tragedy as "one of the saddest and most unacceptable chapters in the history of the health care system in democratic South Africa" (Baloyi 2024).

Shortly after the arbitration, the Director of Public Prosecution was requested to institute criminal proceedings against the government officials in charge of the relevant department at the time but declined to prosecute. A suggestion followed for an inquest to be held into the deaths of the 141 mental health care users (Life Esidimeni Inquest 2024). The inquest was concluded in July 2024, finding the Minister of Health among others liable for the deaths of the patients. The court found that the termination of the Life Esidimeni contract and moving of mental health care users to ill-equipped and inexperienced mental health care NGOs despite warnings from mental health professionals and other stakeholders against such action, led to the deaths of mental health care users (Life Esidimeni Inquest 2024). Criminal charges may now be brought against those officials, although it has not yet been instituted.

The Life Esidimeni disaster occurred while the MHPF 2013–2020 and the MHCA were in place and serves as a reminder of how fundamental human rights such as the dignity and bodily integrity of people living with mental illness can be violated even when legislation

and policies are in place that aim to protect such rights (MHPF 2023). That stresses the importance of monitoring the implementation of relevant legislation and policies with the utmost appreciation and respect for the human rights of those living with mental illness. Such persons are often vulnerable due to their illness and are dependent on the government to provide much-needed care in conditions aligned with the ideal in the MHCA to provide those with mental illness with the best possible care.

The MHPF 2023–2030 acknowledges the gravity of the Life Esidimeni disaster and declares commitment to not let something like that happen again. It contains values and principles to ensure that the right to dignity, respect, non-discrimination, and autonomy are upheld in the mental health care setting (MHPF 2023). It also commits to developing community mental health care services before continuing with the downscaling of psychiatric hospitals (MHPF 2023), which should aid in avoiding a repetition of the Life Esidimeni disaster. The framework also provides for commitment to ensuring that community services follow safety and human rights standards and principles (MHPF 2023).

7. United Nations Observations on South Africa and Its Obligations Under the CRPD

Issues surrounding mental health featured prominently in the Concluding observations on the report of South Africa by the United Nations Committee on the Rights of Persons with Disabilities ("the Committee") in 2018 (United Nations 2018). The Committee is concerned about the increased number of persons with disabilities admitted to mental health care institutions, which almost doubled between 2015 and 2017 (United Nations 2018). This trend poses a threat to the liberty and security of the person as protected in Article 14 of the CRPD. The Life Esidimeni disaster had already taken place by the time the Committee made these observations, which placed mental health issues at centre stage. The discussion below will highlight the Committee's concerns and point out how South Africa is addressing these concerns, if at all.

The Committee commended South Africa for taking swift action regarding the Life Esidimeni disaster in instituting investigations and arbitrations, thereby setting a good example for other countries (United Nations 2018). The Committee is, however, concerned about the high number of unregulated and unsupervised institutions housing persons with disabilities, as evidenced during the Life Esidimeni disaster and the lack of concrete complaint mechanisms where Article 15 rights are violated (the right to freedom from torture and cruel, inhuman, or degrading treatment or punishment). The Committee recommends that legal provisions and concrete administrative measures be adopted to protect persons with disabilities, in particular persons with psychosocial or intellectual disabilities, from Article 15 violations. Measures should be adopted to support victims, by providing legal advice, information in accessible formats, counselling, and redress, including compensation and rehabilitation. The Committee recommends that the South African Human Rights Commission be empowered to monitor all settings and institutions where persons with disabilities are deprived of their liberty.

In response to these recommendations, guidelines for care centres for persons with intellectual disabilities have been published but concerns have been raised about how realistic they are since they set the same standards as those required for hospitals (Kleintjies and Schneider 2023; Sorsdahl et al. 2023). There are 355 licenced community-based mental health facilities in South Africa (Sorsdahl et al. 2023), mostly run by NGOs. The capacity of such facilities is unknown. Still, there is a need for more community-based mental health services that are accessible and culturally appropriate (Shisana et al. 2024). Legal measures to protect patients against Article 15 violations are contained in the MHCA and the Review Board and are in place to monitor human rights violations. These are

arguably not sufficient, as shown by the Life Esidimeni disaster. Regarding monitoring by the SAHRC, such monitoring activity was, for example, conducted in the North West province in February 2021 (Human Rights Commission 2021). The Disability Bill, discussed below, confirms the monitoring function of the SAHRC, as suggested by the Committee. Still lacking, however, appears to be specific measures to support victims, in terms of legal advice, information in accessible formats, counselling and redress, including compensation and rehabilitation for Article 15 violations.

Linked to Article 15 rights, is the right to live independently and be included in the community (Article 19). Deinstitutionalization can contribute towards achieving this. The Committee is concerned, however, that the Life Esidimeni disaster will deter institutions from pressing ahead with deinstitutionalization initiatives. They recommended that deinstitutionalization efforts should be intensified and that a national strategic and legislative framework on deinstitutionalization of persons with disabilities be developed, including all the necessary independent living community support services, to ensure that persons with disabilities are effectively included at all stages of the deinstitutionalization process. To address this, the 2023–2030 MHPF contains a cautionary note that deinstitutionalization should not proceed without having community services in place for this purpose. There is, however, no concrete or stand-alone deinstitutionalization plan outside of the MHPF. This framework will have to be revised since the United Nations published the Guidelines on deinstitutionalization, including in emergencies in 2022 (United Nations 2022). These guidelines call for all forms of institutionalisation of persons with disabilities to be stopped. South Africa's MHCA provides for institutionalisation in certain instances (involuntary inpatient care), posing a challenge with harmonising current practises with the ideal set out in the aforementioned guidelines. Concerns have been raised by scholars about the blanket ban on institutionalisation, especially for those who are unable to make decisions about the need for care and for whom institutionalisation is aimed at protecting them (Swanepoel 2020). This will require an overhaul of not only the policies but also the laws of the country. For such a policy to be realistic and effective, significant time and resources will have to be spent on preparing the industry for it and ensuring that community services are in place to achieve this ideal. This would be in line with the Committee's general recommendation that the Older Persons Act and the Mental Health Care Act be revised within a clear timeline to strengthen their conformity with the Convention.

Regarding equity and non-discrimination (Article 5 of the CRPD), the Committee noted its concern about the widespread discrimination, especially against persons with psychosocial or intellectual disabilities and persons with albinism. The Committee recommended the adoption of effective legislation and policies that will protect persons with disabilities from multiple and intersectional forms of discrimination. In addition, it recommended the establishment of effective mechanisms for persons with disabilities exposed to discrimination to obtain redress, including compensation, rehabilitation, and sanctions against the perpetrators. The Disability Bill addresses this issue by incorporating a prohibition on discrimination on the grounds of disability (which includes mental illness) and providing for compensation if discrimination indeed occurs.

Regarding the integrity of the person as protected in Article 17 of the CRPD, the Committee recommended amendments to the Sterilisation Act 44 of 1998 as well as the Choice on Termination of Pregnancy Act 92 of 1996 to remove provisions that allow for sterilisation and termination of pregnancy where substituted consent was allowed for women and girls with disabilities, especially those with psychosocial or intellectual disabilities (United Nations 2018). Challenges with the Sterilisation Act in the context of the CRPD have been highlighted (Swanepoel 2020). The Disability Bill, discussed below, states that a person with a disability may not be deprived of his/her fertility without his/her

consent (Section 27). This prohibition against the deprivation of fertility without informed consent as contained in the Disability Bill, takes precedence over legislation that states otherwise and will thus override the offending provision in the Sterilisation Act should the Bill be signed into law while the Sterilisation Act remains in its present form (Section 4 of the Disability Bill).

Physical and legislative barriers that prevent or make access to justice for persons with disabilities difficult concern the Committee. Access to justice is provided for in Article 13 of the CRPD. The lack of procedural accommodation makes it particularly difficult for persons with psychosocial or intellectual disabilities. The Committee is concerned about the lack of knowledge of the rights of persons with disabilities in the justice system and the fact that information about the justice processes is not available in accessible formats for persons with disabilities. The Committee recommends that legal safeguards be established to ensure the participation of persons with disabilities in all legal proceedings on an equal basis with others and ensure that procedural, gender, and age-appropriate accommodations based on free choice are provided for persons with disabilities in all judicial settings, police stations, and places of detention, including prisons. A further recommendation is to ensure that information about the justice system is available in accessible formats for persons with disabilities. This concern is addressed in the Disability Bill discussed in more detail below.

The need for the participation of persons with disabilities in all aspects of legislative and policy drafting regarding aspects that concern them was emphasised by the Committee. Various organisations such as the Disability Rights Advocacy Fund and the Disability Rights Fund have been set up to achieve this goal in the global South (Mahomed et al. 2025). In South Africa specifically, organisations such as the National Council of and for Persons with Disabilities (NCPD) play an integral role in striving towards providing persons with disabilities in South Africa with access to equitable opportunities and rights (NCPD n.d.). Regarding mental illness in particular, the Global Mental Health Peer Network (GMHPN), whose head office is based in South Africa, aims for persons with lived experience of mental illness to add to conversations as experts by virtue of their lived experience and to influence policies and practices regarding mental health (GMHPN n.d.).

The Committee emphasises the need for training of various officials such as judicial and law enforcement officials, including police and prison officials, on the right of all persons with disabilities to access justice (Article 13). This is a gap that has been identified in the South African criminal justice system (Pienaar 2021) that needs more attention. Training should also be provided to mental health professionals, law enforcement and correctional facility officials on respecting the rights to liberty and security of persons with disabilities (Article 14) in mental health facilities, prisons, and detention centres (United Nations 2018)

Promotion and Protection of Persons with Disabilities Bill

The South African Law Reform Commission recently published a Discussion paper containing the above draft legislation (Disability Bill) to regulate issues regarding disabilities across sectors. This is to enhance the domestication of the CRPD (South African Law Reform Commission 2024). The Bill specifically includes persons with mental illness as set out in the definitional section where "disability" and "person with disability" are defined to include mental and intellectual impairments. The Disability Bill aims to aid in transforming the law from a welfarist to a human rights model of disability in line with the Concluding observations made by the United Nations Committee as referred to above. The Bill addresses most of the concerns highlighted in the concluding observations as briefly explained below.

The Disability Bill contains a prohibition against discrimination in Section 26 and declares it an offence to discriminate against any person with a disability (Section 37). This offence is punishable with a fine of not more than ZAR 100,000 for individuals and/or imprisonment of up to 6 months. The fine can be up to ZAR 1,000,000 for entities.

The Bill specifically provides for access to justice with the help of trained personnel in the police, justice, and correctional systems (Section 6). This places an obligation on the relevant sectors to train their personnel on the human rights of persons with disabilities.

The Bill emphasises the right to live independently and be part of a community. The Bill in Section 13 confirms the right to live within the community and to receive community-based services on equal footing with others. This places an obligation on the state to develop community-based services also for mental illness so that such persons can live in their communities close to their homes so that they are not forced to live in a particular living arrangement such as a care centre for persons with, for example, intellectual disabilities.

The Bill states that there is an obligation to ensure that instances of violence exploitation and abuse against persons with disabilities are protected (Section 18). The Minister must make regulations wherein simplified procedures regarding lodging complaints about discrimination against persons with disabilities are set out. This ensures access to justice for those with disabilities. The Bill states that the SAHRC will monitor all facilities and programmes designed to serve persons with disabilities to prevent the occurrence and recurrence of all forms of exploitation, violence, and abuse (Section 40).

The Bill in Section 41 makes it compulsory for persons with disabilities to be actively involved, directly or through their representative organisations in all matters concerning them, including in the development and implementation of legislation and policies to implement the Convention. This echoes the unifying slogan "nothing about us without us" of the disability rights movement in South Africa, stemming from the belief that no policy or law which affects persons with disabilities should be developed or implemented without the input of the people it affects (Suleman and Hodgson 2014).

8. Conclusions

The prevalence of mental illness in South Africa is high and needs to be addressed with due consideration for the human rights of mental health care users as contained in the Constitution, the MHCA, and the CRPD.

In exploring the developments of South African law on mental health from the Mental Disorders Act of 1916 to the MHCA of 2002, it is clear that the rights of mentally ill persons are receiving more recognition, resulting in measures being put in place to protect these rights. Detention against a mentally ill person's will is no longer the default as it was in the 1800s, which is a significant step forward. It should ensure that the disregard for human rights in the mental health care setting prevalent during the apartheid era in South Africa is eradicated. Awareness about the past abuse of psychiatry or the inappropriate use of detention on alleged psychiatric grounds for political gain (as discussed earlier) is clear from the Department of Health's Policy Guidelines on the 72 h assessment of mental health care users where they specifically state that "Any determination concerning the mental status of any person must be based on factors exclusively relevant to that person's mental status, and not on sociopolitical or economic status, cultural or religious background or affinity" (Department of Health 2012). These guidelines, together with the rights enshrined in the Constitution and the patient charter in the MHCA, should help to ensure that psychiatric interventions are used for therapeutic purposes only.

Even though South Africa's MHCA has been lauded as one of the most progressive in the world, it falls short if measured against the CRPD, especially concerning, deinstitutionalisation, victim support, redress, and compensation in the case of human rights

violations. Of course, civil remedies can be instituted based on the user's constitutional rights, but more specific and concrete protection is needed. A concrete deinstitutionalization framework is needed in South Africa in line with the United Nations guidelines issued in 2022 to ensure that deinstitutionalization happens in a responsible and dignified manner. Deinstitutionalization without adequate community-based resources can have disastrous consequences, such as premature discharge, relapses (Sorsdahl et al. 2023), and in some instances even death, as shown by the Life Esidimeni disaster. Before pushing ahead with deinstitutionalization, community mental health care services must be put in place by providing specialist psychiatric services for people with severe mental illness, primary care for those with uncomplicated mental illness, and general health care for those with intellectual disabilities (Robertson et al. 2018).

The Life Esidimeni disaster left a terrible stain on the history of South Africa's health care service delivery and showed that a robust mental health legislative framework is not enough to prevent human rights violations and that more specific legislative measures and close monitoring are needed to safeguard mental health care users' rights.

South Africa's work in safeguarding the rights of persons with disabilities, particularly those with mental illness, is continuing in line with the recommendations of the United Nations Committee on the Rights of Persons with Disabilities. Specific legislative measures such as the NHI and the Disability Bill are in line with what the CRPD aims to achieve and are concrete steps taken by South Africa to ensure access to quality health care for all and to prevent discrimination against persons with disabilities across all sectors. The MHPF 2023–2030 identifies persons with HIV living with mental illness as a priority group (Shisana et al. 2024) for whom mental health care should be made accessible without obstacles. The mental health care system challenges in South Africa such as the lack of staffing and funding are, however, seriously crippling effective service delivery to this priority group and others in need of mental health care. The NHI offers an opportunity to achieve this and to increase access to mental health care services in South Africa (Shisana et al. 2024). The challenge, however, remains the effective implementation of the legislation for the benefit of all.

The SAHRC is now the monitoring body for facilities providing mental health care with a particular focus on preventing human rights violations in line with the concluding observations by the Committee and the provisions of the Disability Bill. It is submitted that strengthening bodies such as the Mental Health Review Boards could assist them in keeping a closer eye on the day-to-day delivery of mental health care services and intervening without delay whenever a mental health care user's rights appear to be violated. That could be a small but important step towards preventing an event resembling the Life Esidimeni disaster from ever happening again.

Both the concluding observations by the Committee and the Disability Bill highlight the importance of involving persons with lived experiences of mental illness when drafting and implementing legislation and policies concerning mental health care and other issues affecting their treatment and daily lives. This must be implemented across sectors, which should change how, for example, policy frameworks are compiled. Where persons with disabilities are already included in such processes, this recommendation by the Committee should help to intensify participation and ensure that it is meaningful.

South Africa must continue to incorporate the CRPD ideals and provisions into its national legislative framework supported by its Constitution and ensure that it filters through to its policies and protocols to strengthen the mental health care service industry. It may not, however, stop there. Effective implementation of these provisions is key to bringing about meaningful change.

New knowledge about the treatment of mental illness continues to influence legal developments. Because of this, interdisciplinary research on issues of mental health and the law is encouraged and should be intensified to ensure that legal frameworks are responsive to the mental health needs of society.

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