

OBTAINING INVOLUNTARY MENTAL HEALTH CARE IN THE SOUTH AFRICAN CONSTITUTIONAL DISPENSATION

Marike Kersop
LLB

Francois van den Berg
LLB LLM LLD
Lecturer, Faculty of Law
North-West University, Potchefstroom Campus

SUMMARY

The history of mental health care in South Africa has come a long way from the flawed past, where individuals who suffered from mental disabilities were treated like criminals and where social problems were blamed on and confused with mental deviance. While positive policy changes have undoubtedly been brought about by the Mental Health Care Act 17 of 2002 (MHCA), the question remains whether effect is truly being given to the upholding of rights envisaged by this Act and by the Constitution of the Republic of South Africa, 1996 (the Constitution). While substantive issues are admittedly of cardinal importance, especially when viewed in the light of the past, due process is something which cannot be disregarded when dealing with involuntary mental health care.

The aim of this contribution is to determine to what extent the MHCA upholds mental health care users' fundamental rights, as afforded by the Bill of Rights, specifically in the process of obtaining involuntary mental health care. This will be done against the background of the history of mental health legislation and its development in South Africa as well as the procedure by means of which involuntary mental health care must be obtained under current legislation. When scrutinising this procedure it will become clear that the MHCA requires the consideration of several factors when the decision concerning the provision of involuntary mental health care is made. It will subsequently become evident that the MHCA is transparent in terms of its procedure to obtain involuntary care, specifically regarding the administrative-law aspect thereof, and that it provides sufficient procedural and substantive protection for mental health care users' rights, in accordance with the Constitution.

1 INTRODUCTION

"The problem for all who care about others is how to reconcile respect for the free choices of others with real concern for their welfare when their choices appear to be self-destructive or self-harming."¹

¹ Fennell "Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder" 1990 17 *Journal of Law & Society* 29.

This statement neatly phrases a problem which is typically encountered by psychiatrists.² Their profession often requires making decisions contrary to the wishes of patients, since individuals suffering from mental disorder may at times lose the capacity to consent to care that could be to the advantage of themselves and others.³ Such treatment may, in fact, at times be explicitly refused by the individual in question.⁴ From a legal perspective, psychiatry is thus the treatment of persons who “already have, at least potentially, some limitation on their rights established by virtue of their illness”.⁵ The tension between autonomy and paternalism⁶ is thus very notable in relation to the treatment of mentally disordered individuals,⁷ especially in the case of involuntary treatment.⁸

Involuntary mental health care may be justified on the basis that the ethical principle of beneficence⁹ outweighs the principle of autonomy¹⁰ in

² A psychiatrist is a person who has earned a medical degree and then specialized in psychology. Psychiatrists are trained to investigate primarily the biological nature and causes of psychiatric disorders, and to diagnose and treat them as well. Psychiatry is thus the medical specialty devoted to the study and treatment of mental disorders. See Barlow and Durand *Abnormal Psychiatry: An Integrative Approach* (2009) 32 in this regard.

³ Hanlon, Tesfaye, Wondimagegn and Shibre “Ethical and Professional Challenges in Mental Health Care in Low- and Middle-income Countries” 2010 22 *International Review of Psychiatry* 245 246.

⁴ Swanepoel “A Selection of Constitutional Aspects that Impact on the Mentally Disordered Patient in South Africa” 2011 32 *Obiter* 282 287.

⁵ Ure *Mental Health Care in South Africa 1904 to 2004: Legislation Influencing Ethical Patient Care* (MSc-dissertation, University of Witwatersrand, 2009) 47.

⁶ “Paternalism” is described by Culver and Gert as follows: “A is acting paternalistically towards S if and only if A’s behaviour (correctly) indicates that A believes that: (1) his action is for S’s good; (2) he is qualified to act on S’s behalf; (3) his action involves violating a moral rule ... with regard to S; (4) S’s good justifies him in acting on S’s behalf independently of S’s past, present or immediately forthcoming ... consent; (5) S believes ... that he (S) generally knows what is for his own good.” See Culver and Gert “The Morality of Involuntary Hospitalization” in Spicker, Healy and Engelhardt (eds) *The Law-Medicine Relation: A Philosophical exploration* (1981) 160 in this regard.

⁷ Swanepoel 2011 32 *Obiter* 290; and Fennell 1990 17 *Journal of Law & Society* 29.

⁸ Moosa and Jeenah “Involuntary Treatment of Psychiatric Patients in South Africa” 2008 11 *African Journal of Psychiatry* 109; and Swanepoel 2011 32 *Obiter* 287.

⁹ According to Beauchamp “The Principle of Beneficence in Applied Ethics” 2 January 2008 <http://plato.stanford.edu/entries/principle-beneficence/> (accessed 2012-11-20), the principle of beneficence “refers to a normative statement of a moral obligation to act for the benefit of others, helping them to further their important and legitimate interests, often by preventing or removing possible harms”. Pantilat “Autonomy vs Beneficence” 2008 http://missinglink.ucsf.edu/lm/ethics/content%20pages/fast_fact_auton_bene.htm (accessed 2012-11-20) provides the following definition for beneficence: “action that is done for the benefit of others. Beneficent actions can be taken to help prevent or remove harms or to simply improve the situation of others.” According to Hanlon *et al* 2010 22 *International Review of Psychiatry* 246, providing treatment for mental disorder would be acting by virtue of this principle.

¹⁰ According to Pantilat http://missinglink.ucsf.edu/lm/ethics/content%20pages/fast_fact_auton_bene.htm, “autonomy is the ‘personal rule of the self that is free from both controlling interferences by others and from personal limitations that prevent meaningful choice’. Autonomous individuals act intentionally, with understanding, and without controlling influences.” Pantilat is furthermore of the opinion that “respect for autonomy is one of the fundamental guidelines of clinical ethics [and] physicians have an obligation to create the conditions necessary for autonomous choice in others”. The right of a mental health care user to refuse treatment will thus fall within the ambit of the principle of autonomy, according to Hanlon *et al* 2010 22 *International Review of Psychiatry* 246.

cases such as these.¹¹ Involuntary treatment may also be authorised by legislation, since the State may act by virtue of its *parens patriae*¹² powers to protect the innocent and vulnerable.¹³ However, due to the complex nature of mentally disordered individuals' vulnerability,¹⁴ mental health care users¹⁵ are at risk of exploitation.¹⁶ Indeed, mental health care users have been subjected to severe abuse in the past¹⁷ and continue to be discriminated against globally at present, especially when there is no mental health legislation to protect their rights.¹⁸ For this reason, laws that deprive individuals of their freedom in this regard "must provide for minimum substantive and procedural safeguards that protect mentally ill individuals' fundamental agency".¹⁹ Such laws should furthermore guarantee the rights to counsel, appeal, and review in relation to involuntary treatment.²⁰ As stated by Yamin and Rosenthal:²¹

"Suspicion of mental illness cannot mean untrammelled discretion to disregard due process concerns in detention. Whether or not ideological factors are at play, civil commitment laws must provide for minimum substantive and procedural protections that protect mentally ill individuals' fundamental agency."²²

The development and implementation of appropriate mental health legislation is thus imperative in eradicating exploitation, discrimination and abuse against this vulnerable group of people.²³ Since mental health care users

¹¹ Hanlon *et al* 2010 22 *International Review of Psychiatry* 246.

¹² "A doctrine that grants the inherent power and authority of the state to protect persons who are legally unable to act on their own behalf." In other words, the State's prerogative to act paternalistically towards its citizens. See Culver and Gert in Spicker *et al* (eds) *The Law-Medicine Relation* in this regard.

¹³ Swanepoel 2011 32 *Obiter* 290.

¹⁴ This is described in Ure *Mental Health Care in South Africa 1904 to 2004* 47: "[Mentally disordered individuals] require special consideration as a vulnerable group. The ethical position of the clinicians caring for this vulnerable group include the obligation to exercise clinical judgments orientated (ethically, morally, and legally) beyond or *exceeding ordinary patient care*. It is not appropriate, for example, for a surgeon in any field, to force a patient to undergo treatment they do not want. Mental health patients, however, can be forced, by virtue of potential harm to self or others to undergo incarceration or undergo involuntary treatment without recourse, often because of the symptoms present due to their illness" (authors' own emphasis).

¹⁵ According to s 1 of the Mental Health Care Act 17 of 2002, "mental health care user" has the following meaning: "a person receiving care, treatment and rehabilitation services ... aimed at enhancing the mental health status of a user, State patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions". The term "mental health care user" or simply "user" will thus be used throughout this paper instead of terms such as "patient" or "mentally disabled person", unless context deems the use of a different term necessary.

¹⁶ Hanlon *et al* 2010 *International Review of Psychiatry* 246.

¹⁷ Ure *Mental Health Care in South Africa 1904 to 2004* 49–50.

¹⁸ Hanlon *et al* 2010 22 *International Review of Psychiatry* 246.

¹⁹ Burns "The Mental Health Gap in South Africa – A Human Rights Issue" 2011 6 *The Equal Rights Review* 99 108; and Yamin and Rosenthal "Out of the Shadows: Using Human Rights Approaches to Secure Dignity and Well-being for People with Mental Disabilities" 2005 2 *Public Library of Science Medical Journal* 296 297.

²⁰ Burns 2011 6 *The Equal Rights Review* 108.

²¹ Yamin and Rosenthal 2005 2 *Public Library of Science Medical Journal* 297.

²² *Ibid.*

²³ Burns 2011 6 *The Equal Rights Review* 108.

may not always be in a position to safeguard their rights, particularly during periods of heightened vulnerability,²⁴ there should also be a “mechanism for active monitoring and enforcement of such rights”.²⁵ South Africa’s current mental health legislation, the Mental Health Care Act (MHCA),²⁶ has been hailed as “one of the most progressive pieces of mental health legislation in the world”,²⁷ but the question remains whether the MHCA contains the previously mentioned minimum substantive and procedural protection²⁸ which is necessary to safeguard mental health care users’ fundamental rights.²⁹

2 A LEGAL-HISTORICAL BACKGROUND OF MENTAL HEALTH CARE IN SOUTH AFRICA

2 1 Introduction

Before endeavouring an analysis of current mental health care legislation, it is necessary to provide a background in terms of which to contextualise said legislation. When taking the origin and development of mental health care into consideration, it is much easier to understand the legislator’s intention with the current MHCA – and to a certain extent much more difficult to criticise several aspects of the MHCA.³⁰ A brief legal historical overview of South Africa’s mental health care, with specific reference to legislation, will thus follow.³¹

2 2 The early years

The first South African mental health legislation to be enacted in the then South African Union was the Mental Disorders Act 38 of 1916, which was British-based.³² At this time there existed a Commissioner of Mental Health Disorders and Defective Persons (this title later changed to that of Commissioner of Mental Hygiene), namely Doctor JT Dunston, who played a pivotal role in the development of aforementioned Act.³³ Dunston held the position of Commissioner of Mental Hygiene from 1916 until 1951.³⁴ During this time he greatly influenced the development of scientific and medical

²⁴ *Ibid.*

²⁵ *Ibid.*

²⁶ 17 of 2002.

²⁷ Burns 2011 6 *The Equal Rights Review* 100.

²⁸ Burns 2011 6 *The Equal Rights Review* 108; and Yamin and Rosenthal 2005 2 *Public Library of Science Medical Journal* 297.

²⁹ Perlin and Szeli “Mental Health Law and Human Rights: Evolution and Contemporary Challenges” 2008 *New York Law School Legal Studies Research Paper Series* 8.

³⁰ *Ibid.*

³¹ Owing to space constraints, this discussion will be limited to the time period of 1910 until present, since 1910 was the year in which South Africa became a Union and it was under this Union that the first mental health care legislation was enacted.

³² Laurenson and Swartz “The Professionalization of Psychology within the Apartheid State 1948–1978” 2011 14 *History of Psychology* 249.

³³ Ure *Mental Health Care in South Africa 1904 to 2004* 22; and Mental Disorders Act 38 of 1916.

³⁴ Ure *Mental Health Care in South Africa 1904 to 2004* 22.

thinking regarding “deviants”, “idiots”, “imbeciles” and “the feebleminded”,³⁵ as referred to in the Mental Disorders Act.³⁶ Two concepts of moral management arose during this time: firstly, fear of the poor white Afrikaner as social impurity and secondly the concept of feeble-mindedness as a genetic contaminant.³⁷ Dunston was also the driving force behind the South African Mental Hygiene movement.³⁸

Another key role player in the development of South Africa’s mental health care was Doctor Hendrik F Verwoerd. Verwoerd’s training and exposure to mental health care was consistent with the European and American perspectives which supported his university education in psychology at the University of Stellenbosch.³⁹ This, amongst other things, caused Verwoerd to contrive social interventions for South Africa which was in line with what was being implemented elsewhere in the world at the time.⁴⁰

The era of the South African Union was a politically and socially complex time due to the difference in English and Afrikaner ideologies.⁴¹ To make matters worse, both these groups lacked an understanding of the customs of the indigenous people.⁴² During this time, the growing tendency was to cure social ills through science.⁴³

Up to the 1930s it was difficult to differentiate between social deviance and psychiatric illness, and social problems were often the cause for institutionalisation and psychiatric interventions.⁴⁴ This was a typical reflection of Western ideas interpreted locally in a colonial mentality.⁴⁵ As a result, mentally disordered persons were treated like criminals and deviants due to general medical ignorance of disease causation.⁴⁶

³⁵ Ure *Mental Health Care in South Africa 1904 to 2004* 23, 31.

³⁶ 38 of 1916.

³⁷ Ure *Mental Health Care in South Africa 1904 to 2004* 23. A feeble-minded person was defined by the Mental Disorders Act 38 of 1916 as follows: “a person in whose case there exists from birth or from an early age mental defectiveness ... so that he is incapable of competing on equal terms with his normal fellows or of managing himself and his affairs with ordinary prudence and who requires care, supervision and control for his own protection or for the protection of others or if he is a child, appears by reason of such defectiveness to be permanently incapable of receiving proper benefit from the education and training in a special school ... or in an ordinary school at which special classes have been established for the education and training of children who ... are unable to benefit sufficiently from the instruction and training given in the ordinary classes at such school”.

³⁸ Ure *Mental Health Care in South Africa 1904 to 2004* 13. “Mental Hygiene” was an umbrella term for the socially discriminatory practices which were exercised at this time as a result of the lack of differentiation between criminal and behavioural problems on the one hand and symptoms of actual mental illness on the other, since there were no clear medical definitions of mental illness outside of the perceived deviance of behaviour according to the religious practices or social norms of the times.

³⁹ Ure *Mental Health Care in South Africa 1904 to 2004* 24.

⁴⁰ *Ibid.*

⁴¹ Ure *Mental Health Care in South Africa 1904 to 2004* 13.

⁴² *Ibid.*

⁴³ Ure *Mental Health Care in South Africa 1904 to 2004* 13. This formed part of the Mental Hygiene movement.

⁴⁴ Ure *Mental Health Care in South Africa 1904 to 2004* 27.

⁴⁵ Ure *Mental Health Care in South Africa 1904 to 2004* 13.

⁴⁶ *Ibid.*

These practices and treatments were authorised by the Mental Disorders Act⁴⁷ and led to what would be considered in the contemporary South African society as the infringement of several fundamental rights.⁴⁸ However, since South Africa followed a system of parliamentary sovereignty at this time, the courts had no competence to test the substantive validity of any act of Parliament and thus these statutes continued to be in force for many years.⁴⁹

2.3 The apartheid era

1948 saw the first enactment of apartheid legislation by the newly elected National Party Government.⁵⁰ At this stage there wasn't much development regarding mental health care – the apartheid Government basically inherited the outdated colonial psychiatric system underpinned by the Mental Disorders Act⁵¹ as it was.⁵² The situation remained this way until the late 1960s, despite the apartheid Government's attempts to reform other aspects of the social setting.⁵³

This did not mean that there were no problems with the mental health system. Psychiatry was being abused to serve the purposes of apartheid⁵⁴ and the discrimination and racism against non-white patients was abhorrent.⁵⁵ Overcrowding of facilities was also very disconcerting at this stage.⁵⁶

There were, however, changes during the 1950s–1960s, albeit not any policy changes. The 1950s heralded the era of new therapies⁵⁷ which

⁴⁷ 38 of 1916.

⁴⁸ Chapter 2 of the Constitution. These rights include, *inter alia*, the right to equality, human dignity and freedom and security of the person.

⁴⁹ Currie and De Waal *New Constitutional and Administrative Law: Volume One* (2001) 45 and 48.

⁵⁰ Overy *Atlas of 20th Century History* (2005) 129 and 155; and Giliomee and Mbenga *Nuwe Geskiedenis van Suid-Afrika* (2007) 310.

⁵¹ 38 of 1916.

⁵² Laurenson and Swartz 2011 14 *History of Psychology* 249.

⁵³ *Ibid.*

⁵⁴ Such as the use of electric shock-eversion therapy in an attempt to convert homosexuals who were serving in the military to heterosexuals – see Laurenson and Swartz 2011 14 *History of Psychology* 250.

⁵⁵ McCrea "An Analysis of South Africa's Mental Health Legislation" 2010 *National Law Forum* 1; and Ure *Mental Health Care in South Africa 1904 to 2004* 29. See also Ure *Mental Health Care in South Africa 1904 to 2004* 21 in this regard: "The Eurocentric view, shared in South Africa around the black African's 'primitive personality' – in vogue from around the 1900 to 1960 – was fundamental in how treatment modalities developed ... the African's 'primitive mind' (was) compared to that of the European insane community and those of children ... Africans who acted out of the prevailing social norms were perceived as irresponsible and immature rather than having symptoms of mental illness – symptoms of mental illness as perceived by the European community, that is."

⁵⁶ Ure *Mental Health Care in South Africa 1904 to 2004* 40; and Laurenson and Swartz 2011 14 *History of Psychology* 254.

⁵⁷ Ure *Mental Health Care in South Africa 1904 to 2004* 2; and Laurenson and Swartz 2011 14 *History of Psychology* 252. These therapies included neuroleptics, imipramine and inhibitors of monoamine oxidase. See also Lund, Kleintjies, Kakuma and Flisher "Public Sector Mental Health Systems in South Africa: Inter-provincial Comparisons and Policy Implications" 2010 45 *Social Psychiatry & Psychiatric Epidemiology* 393 394 in this regard.

provided the potential of the mental health system to shift from being custodial⁵⁸ to being curative.⁵⁹

Noticeable policy changes only came about after the assassination of Hendrik Verwoerd, the Prime Minister at this time, which took place in 1966.⁶⁰ The assassin, Dimitri Tsafendas, escaped the death penalty after being diagnosed as schizophrenic.⁶¹ This led directly to commissions of enquiry into the management of mental health services together with several official publications dealing with the question of mental health as such, followed by the new Mental Health Act 18 of 1973 – the first substantial revision of mental health legislation in almost 60 years.⁶²

While the revision of the mental health legislation was a step in the right direction in principle, the new Mental Health Act⁶³ did not promote personal autonomy, dignity or justice for people suffering from mental illness. Instead, this Act's⁶⁴ primary focus fell on patient control and treatment and society's best interest.⁶⁵

2 4 Post-apartheid until present

With the abolishment of apartheid in 1994⁶⁶ came a new constitutional dispensation based on a supreme Constitution.⁶⁷ The Constitution⁶⁸ could subsequently render any law or conduct that is inconsistent with the values or provisions of the Constitution, as invalid and of no force or effect.⁶⁹ The

⁵⁸ The custodial approach entailed the institutionalisation of patients with very slim chances of discharge. Institutionalisation itself was the treatment.

⁵⁹ The curative approach, on the other hand, offers the possibility of cure b.m.o medication and therapy rather than institutionalising patients for life. Institutionalisation is thus a means to the end, rather than the treatment itself.

⁶⁰ Laurenson and Swartz 2011 14 *History of Psychology* 255; and McCrea 2010 *National Law Forum* 1.

⁶¹ Laurenson and Swartz 2011 14 *History of Psychology* 256.

⁶² Laurenson and Swartz 2011 14 *History of Psychology* 249; and Ure *Mental Health Care in South Africa 1904 to 2004* 41.

⁶³ 18 of 1973.

⁶⁴ *Ibid.*

⁶⁵ McCrea 2010 *National Law Forum* 1. Specific points of criticism against the 1973 Act, listed by McCrea, are the following: "(i) it only required a reasonable degree of suspicion to be certified to a mental institution; (ii) individuals could be denied their freedom and placed in a mental facility based on prejudices and vendettas. In fact, finding someone mentally incapable was sometimes utilized solely for political means in the apartheid era. Freedom fighters were often silenced by being placed in a mental facility; (iii) once deemed mentally ill and certified, patients went without the assistance of the law, and could spend a considerable amount of time in the mental institutions against their will; and (iv) patients did not have a significant right of appeal or representation."

⁶⁶ Currie and De Waal *The Bill of Rights Handbook* (2005) 2 and 5; and Overy *Atlas of 20th Century History* 155. This occurred on 27 April of that year, when the first democratic election in South Africa took place and the Interim Constitution came into force. See also Giliomee and Mbenga *Nuwe Geskiedenis van Suid-Afrika* 408.

⁶⁷ Currie and De Waal *New Constitutional and Administrative Law* 64.

⁶⁸ The Constitution of the Republic of South Africa 200 of 1993 (the interim Constitution) which was later repealed and replaced by the Constitution of the Republic of South Africa, 1996 (the Constitution) in 1997.

⁶⁹ S4(1) of the interim Constitution; s 2 of the Constitution; and Currie and De Waal *New Constitutional and Administrative Law* 64.

courts were given the competence to declare such law or conduct as invalid – therefore providing the judicial authority the ability to now review legislation on substantive grounds.⁷⁰ This inevitably led to the repeal of several pieces of legislation which were not in line with the constitutional values, the “first politically important and publicly controversial” decision of the Constitutional Court being the abolishment of the death penalty⁷¹ in 1995 in the case of *S v Makwanyane*.⁷²

In the same year, a report⁷³ into conditions and allegations of abuse in mental institutions found that numerous forms of abuse and infringement upon fundamental rights were indeed taking place in these facilities.⁷⁴ In 1996, an international delegation was sent to South Africa to investigate the condition of mental health services, and it was found that these services had not been keeping up with international trends.⁷⁵ Several suggestions were made by said delegation and it became evident that the Mental Health Act⁷⁶ was in need of change.⁷⁷

The MHCA was eventually promulgated on 6 November 2002 as a reaction to rejection of institutionalism as an infringement upon fundamental right⁷⁸ and it became operational consistent with other international movements in mental health legislation.⁷⁹ It was also an attempt at providing a solution to the problem of psychiatric abuses in the past.⁸⁰ Some important differences between the 1973 Act⁸¹ and the new MHCA can be found in the wording of the respective Acts.⁸² An example of this is the name of the new MHCA which reflects the intention of moving away from mental health as legislative entity and replacing it with the concept of care.⁸³

The primary goals of the MHCA seem to be the shifting of the mental health care system from the custodial approach it had in the past to a system in which community care is encouraged, as well as ensuring that suitable care is provided to individuals within the mental health care system.⁸⁴ Above all, the MHCA seeks to give effect to the constitutional imperative to avoid discrimination against individuals with mental

⁷⁰ Currie and De Waal *The Bill of Rights Handbook* 2.

⁷¹ Currie and De Waal *New Constitutional and Administrative Law* 65.

⁷² 1995 (3) SA 391 (CC).

⁷³ Brought by the Mental Health and Substance Abuse Committee, 1995.

⁷⁴ Ure *Mental Health Care in South Africa 1904 to 2004* 47.

⁷⁵ Ure *Mental Health Care in South Africa 1904 to 2004* 48.

⁷⁶ 18 of 1973.

⁷⁷ McCrea 2010 *National Law Forum* 1; and Bonthuis “Involuntary Civil Commitment and the New Mental Health Bill” 2001 118 *SALJ* 667 667.

⁷⁸ Ure *Mental Health Care in South Africa 1904 to 2004* 48.

⁷⁹ McCrea 2010 *National Law Forum* 2; and Lund *et al* 2010 45 *Social Psychiatry & Psychiatric Epidemiology* 394.

⁸⁰ Ure *Mental Health Care in South Africa 1904 to 2004* 48.

⁸¹ 18 of 1973.

⁸² See Ure *Mental Health Care in South Africa 1904 to 2004* 48: “For example, the *Mental Health Act of 1973* was committed to the ‘reception, detention and treatment’ of psychiatric patients, and the new Act provides for the ‘care, treatment and rehabilitation’.”

⁸³ Ure *Mental Health Care in South Africa 1904 to 2004* 48.

⁸⁴ McCrea 2010 *National Law Forum* 2; Moosa and Jeenah 2008 11 *African Journal of Psychiatry* 110; Burns 2011 6 *The Equal Rights Review* 100; and Lund *et al* 2010 45 *Social Psychiatry & Psychiatric Epidemiology* 393.

disabilities,⁸⁵ and is deemed to be one of the “most progressive pieces of mental health legislation in the world”.⁸⁶

3 CONSTITUTIONAL ANALYSIS⁸⁷ OF THE MENTAL HEALTH CARE ACT⁸⁸

3 1 Introduction

As stated previously,⁸⁹ the Constitution has had an impact on mental health care legislation since it is the supreme law in South Africa and any conduct or legislation irreconcilable with it is invalid.⁹⁰ Included in the Constitution is the Bill of Rights,⁹¹ which applies to all law and is binding on, *inter alia*, the legislature and all organs of state,⁹² and instructs the State to use the power which is afforded to it by virtue of the Constitution in ways that do not infringe fundamental rights.⁹³ It is argued that last-mentioned should include efforts to promote “the greatest degree of self-determination and personal responsibility on the part of patients”.⁹⁴ In line with this, the National Health Act 61 of 2003 provides a legal framework, based on consent,⁹⁵ for the regulation of mental health.⁹⁶

The MHCA has introduced respect for individual autonomy as well as decreased coercion procedures in the management of the acute stages of mental illness.⁹⁷ The current system of involuntary treatment is a very big improvement on previous systems, since much greater respect for the

⁸⁵ *Ex Parte G KZP* (unreported) 2008-06-05 Case no 19/2007 par 6.

⁸⁶ Burns 2011 6 *The Equal Rights Review* 100.

⁸⁷ Substantive fundamental rights have already been the focus of various pieces of academic literature and will subsequently not be discussed. Instead, a discussion of section 33 of the Constitution and the validity of the MHCA under this particular section will be initiated, focusing on the administration of the procedure to obtain involuntary care under the MHCA. S 36 of the Constitution, which deals with the limitation of rights, cannot be discussed due to space constraints.

⁸⁸ 17 of 2002.

⁸⁹ In Chapter 2.

⁹⁰ S 2 of the Constitution.

⁹¹ Chapter 2 of the Constitution, comprising s 7–39.

⁹² S 39 of the Constitution; and Swanepoel 2011 32 *Obiter* 282.

⁹³ Swanepoel 2011 32 *Obiter* 282–283; and s 39(2) of the Constitution.

⁹⁴ Swanepoel 2011 32 *Obiter* 284.

⁹⁵ The National Health Act 61 of 2003 provides no definition for the term “consent”. S 7(3) of said Act, however, reads as follows: “For the purposes of this section ‘informed consent’ means consent for the provision of a specified health service given by a person with legal capacity to do so and who has been informed as contemplated in section 6” (s 6, deals with the user having full knowledge). According to Hanlon *et al* 2010 22 *International Review of Psychiatry* 248, “informed consent implies that a person is fully informed about the potential benefits and risks of a treatment, and that they are free to make a decision without coercion. Informed consent relies upon an individual having capacity in regard to the particular issue.” S 9(1)(a) of the MHCA states that a health-care provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if the user has consented to care, treatment and rehabilitation services or to admission. There are, however, exceptions to this, as listed in subsections (b) and (c) of s 9(1), which will then form the topic of this discussion, since this excludes the user’s consent.

⁹⁶ Swanepoel 2011 32 *Obiter* 284.

⁹⁷ *Ibid.*

fundamental rights of mental health care users have been introduced in this regard.⁹⁸ Critics, however, suggest that the new legislation has been developed for less noble purposes. It has been argued that the MHCA was promulgated as a preventative measure by the Government in order to reduce the possibility of litigation, in addition to an attempt to “keep up, at least superficially, with mental health trends around the world”.⁹⁹ This may seem like wild allegations, but further investigation reveals some truth in it. An example to illustrate this would be that the MHCA affords mental health care users the right to appeal to a Review Board¹⁰⁰ about decisions to continue involuntary treatment. However, the decision in favour of involuntary care is submitted to the person who applied for involuntary treatment of the mental health care user – not to the mental health care user himself/herself. Since the mental health care user is never directly notified of the decision, it is rather difficult for him/her to submit an appeal.¹⁰¹

This leads one to ponder to what extent the mental health care user’s dignity is protected and whether fair administrative action takes place in the case of involuntary treatment. A short exposition of the process of the application for involuntary treatment will subsequently be given, which will be followed by a discussion of the right to fair administrative action together with an analysis of the process.

3 2 What does involuntary treatment¹⁰² entail?

A health-care provider or a health establishment¹⁰³ may provide treatment to a mental health care user as provided for in the MHCA under the following circumstances: firstly if the user has given consent to such treatment, secondly if the treatment was authorised by a court order or Review Board¹⁰⁴ or thirdly if delay of such treatment would result in either the death or irreversible harm to the user’s health, or the infliction of serious harm to the

⁹⁸ Moosa and Jeenah 2008 11 *African Journal of Psychiatry* 109. For purposes of this discussion, only involuntary treatment as described in ss 32-36 of the MHCA will be discussed.

⁹⁹ Ure *Mental Health Care in South Africa 1904 to 2004* 49–50.

¹⁰⁰ Chapter IV of the MHCA provides for the establishment of a Review Board for health establishment providing mental health care. There must be at least one such Review Board in each province (see s 18(2) of the MHCA). The Review Board’s functions and powers include, amongst other, considering appeals against decisions of the head of a health establishment, making decisions with regard to assisted or involuntary mental health care, considering reviews and make decisions on assisted or involuntary mental health care users and considering 72-hours’ assessment made by the head of the health establishment, and make decisions to provide further involuntary care, treatment and rehabilitation (see s 19(1) of the MHCA in this regard). The Mental Review boards must consist of three to five members each which must include a mental health care practitioner, a magistrate, attorney or advocate and a member of the community concerned (s 20(2) of the MHCA).

¹⁰¹ McCrea 2010 *National Law Forum* 3.

¹⁰² Throughout the MHCA, the phrase “care, treatment and rehabilitation or admission” (or derivations thereof) are used. For both the author and reader’s convenience, the umbrella term “treatment” will be used, except where a specific reference to one of the terms is essential.

¹⁰³ Which will forthwith simply be referred to as an “establishment” in the main text for the sake of convenience.

¹⁰⁴ As provided for in Chapter IV of the MHCA. See fn 22 above in this regard.

user's person or property or to anybody else's person or property, by the user.¹⁰⁵

In terms of section 1 of the MHCA,¹⁰⁶ "involuntary treatment" entails the following:

"[T]he provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others ..."¹⁰⁷

This clearly excludes consent, and thus only includes the last two of the three listed circumstances as mentioned above, that is, subsections (b) and (c) of section 9(1) of the MHCA.¹⁰⁸ If care, treatment and rehabilitation services or admission takes place in terms of subsection (c), it must be reported in writing in the prescribed manner to the relevant Review Board.¹⁰⁹ Such care, treatment and rehabilitation services may not be provided to the user concerned for longer than 24 hours unless an application in terms of Chapter V of the MHCA¹¹⁰ is made within the 24-hour period.¹¹¹ Furthermore, a mental health care user *must* be provided with care, treatment and rehabilitation services *without his or her consent* if:¹¹²

- "(a) an application in writing is made to the head of the health establishment concerned to obtain the necessary care, treatment and rehabilitation services and the application is granted;
- (b) at the time of making the application, there is reasonable belief that the mental health care user has a mental illness of such a nature that –
 - (i) the user is likely to inflict serious harm to himself or herself or others; or
 - (ii) care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user; and
- (c) at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services and is unwilling to receive the care, treatment and rehabilitation required."¹¹³

¹⁰⁵ S 9(1) of the MHCA, which reads as follows: "A health care provider or a health establishment may provide care, treatment and rehabilitation services to or admit a mental health care user only if – (a) the user has consented to the care, treatment and rehabilitation services or to admission; (b) authorised by a court order or a Review Board; or (c) due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the – (i) death or irreversible harm to the health of the user; (ii) user inflicting serious harm to himself or herself or others; or (iii) user causing serious damage to or loss of property belonging to him or her or others."

¹⁰⁶ S 1 of the MHCA.

¹⁰⁷ *Ibid.*

¹⁰⁸ S 9 of the MHCA.

¹⁰⁹ Reg 8 in GN R1467 in GG 27117 of 2004-12-15.

¹¹⁰ S 25–40 of the MHCA. For purposes of this discussion, however, the focus will fall only on s 32–36.

¹¹¹ S 9(2) of the MHCA; and Swanepoel 2011 32 *Obiter* 293.

¹¹² S 32(1) of the MHCA; and Swanepoel 2011 32 *Obiter* 293–295, authors' own emphasis.

¹¹³ S 32(1) of the MHCA.

3 2 1 Procedure to obtain involuntary treatment

The procedure to obtain involuntary treatment is set out in sections 32–36 of the MHCA.¹¹⁴ This forms part of Chapter V of the MHCA, which regulates assisted,¹¹⁵ involuntary¹¹⁶ and voluntary¹¹⁷ mental health care. As already mentioned, a mental health care user may not be provided with treatment without his or her consent, save for certain exceptions.¹¹⁸ Thus, if involuntary treatment or admission is sought, a written application must be made to the head of the establishment concerned and this must be approved.¹¹⁹ There must be a reasonable belief at the time of making the application that the mental health care user is suffering from a mental illness or disability, and treatment is necessary for his or her health or safety, or for the health and safety of other people.¹²⁰ A further requirement is that the mental health care user must be incapable of making an informed decision regarding the need for treatment and is unwilling to receive the required treatment.¹²¹

An application for involuntary treatment can be brought only by a very specific group of persons.¹²² Furthermore, the person making the application must have seen the mental health care user within the past seven days.¹²³ Once the head of the establishment receives the application, the mental health care user must be examined by two mental health care practitioners.¹²⁴ These two practitioners must perform independent assessments of the mental health care user, and must report their findings and recommendations to the head of the establishment.¹²⁵ If the two practitioners' assessments do not correlate, the head of the establishment must have the mental health care user assessed by another mental health

¹¹⁴ Ss 32–36 of the MHCA.

¹¹⁵ In terms of s 1 of the MHCA, “assisted care, treatment and rehabilitation” means the provision of health interventions to people *incapable* of making informed decisions due to their mental health status and who *do not refuse* the health interventions (authors' own emphasis added).

¹¹⁶ In terms of s 1 of the MHCA, “involuntary care, treatment and rehabilitation” means the provision of health interventions to people *incapable* of making informed decisions due to their mental health status and who *refuse* health intervention but require such services for their own protection or for the protection of others (authors' own emphasis added).

¹¹⁷ In terms of s 1 of the MHCA, “voluntary care, treatment and rehabilitation” means the provision of health interventions to a person who gives consent to such interventions. When viewed together with the definitions of assisted and involuntary care, treatment and rehabilitation in footnotes 39 and 40 above, it seems that consent can only be provided by a person who is capable of making an informed decision.

¹¹⁸ As stipulated in s 9(1)(b) and 9(1)(c) of the MHCA.

¹¹⁹ S 26(a) of the MHCA.

¹²⁰ S 26(b)(i) of the MHCA.

¹²¹ Swanepoel 2011 32 *Obiter* 293–294.

¹²² The spouse, next of kin, partner, associate, parent or guardian of the mental health care user. See s 33(1)(a) of the MHCA; and McCrea 2010 *National Law Forum* 2 in this regard.

¹²³ S 33(1)(b) of the MHCA; and McCrea 2010 *National Law Forum* 2.

¹²⁴ In terms of S 1 of the MHCA a “mental health practitioner” means “a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services”.

¹²⁵ In terms of s 33(5), the report of the practitioners must include their findings on whether or not a risk as referred to in s 32(b) and 32(c) exist and whether or not a mental health care user must receive involuntary treatment.

practitioner who must submit a written report on the same aspects as the previous two practitioners.¹²⁶ The head of the establishment may only approve an application if two mental health care practitioners who submitted a report are in accordance that involuntary care is necessary.¹²⁷ The applicant must then be informed in writing of the head of the establishment's decision regarding involuntary treatment, together with reasons for the decision.¹²⁸

If involuntary treatment is approved, the user must be admitted to an appropriate establishment within 48 hours, where the head of the health-care establishment must see to it that the user receives the appropriate treatment.¹²⁹ A medical practitioner and another mental health care practitioner must then assess the user's physical and mental health over a period of 72 hours.¹³⁰ During this assessment the practitioners must consider whether the involuntary treatment must be continued, and if this is indeed the case, whether such treatment must be provided on an outpatient¹³¹ or inpatient¹³² basis.¹³³ The head of the health-care establishment will then use these reports to decide whether the user requires further involuntary treatment.¹³⁴ If the head of the establishment is of the opinion that no further involuntary treatment is necessary, the user must be discharged immediately unless the user consents to further care.¹³⁵ If further involuntary treatment on an outpatient is deemed to be necessary in terms of the report, the head of the establishment must discharge the user, subject to the conditions relating to the user's outpatient treatment and inform the Review Board of this.¹³⁶

If, however, the head of the establishment is of the opinion that further involuntary treatment on an inpatient basis is necessary in terms of the reports, he or she must submit a written request to the Review Board within seven days to approve further involuntary treatment on an inpatient basis.¹³⁷ Notice of the date on which the relevant documents were submitted to the Review Board must accordingly be given to the applicant.¹³⁸ If the establishment where the user underwent the 72 hour assessment is a psychiatric hospital, the user must be kept there pending the Review Board's

¹²⁶ S 33(6) of the MHCA.

¹²⁷ S 33(7) of the MHCA.

¹²⁸ S 33(8) of the MHCA.

¹²⁹ Ss 33(9) and 34(1)(a) of the MHCA.

¹³⁰ S 34(1)(b) of the MHCA; and McCrea 2010 *National Law Forum* 2.

¹³¹ Neither the MHCA nor the National Health Act 61 of 2003 provides a definition for the term "outpatient". It is defined by the Oxford Dictionary as "a patient who attends a hospital for treatment without staying there overnight." See Hornby *Oxford Advanced Learner's Dictionary of Current English* (2005) 1017.

¹³² Neither the MHCA nor the National Health Act 61 of 2003 provides a definition for the term "inpatient". It is defined by the Oxford Dictionary as "a patient who lives in hospital while under treatment." See Hornby *Oxford Advanced Learner's Dictionary of Current English* 733.

¹³³ S 34(1)(c) of the MHCA; and McCrea 2010 *National Law Forum* 2.

¹³⁴ S 34(3) of the MHCA; and McCrea 2010 *National Law Forum* 2.

¹³⁵ S 34(3)(a) of the MHCA; and McCrea 2010 *National Law Forum* 2.

¹³⁶ S 34(3)(b) of the MHCA. The Review Board must be informed if the user is discharged as an outpatient at any time after the 72 hour assessment period. See s 34(5)(b) in this regard.

¹³⁷ S 34(3)(c)(i) of the MHCA.

¹³⁸ S 34(3)(c)(ii) of the MHCA.

decision.¹³⁹ Alternatively, the user must be admitted to a psychiatric hospital until the Review Board makes a decision.¹⁴⁰

The Review Board has 30 days from the date of receipt of the request to consider it and give opportunities for representations of the merits of the request to be made¹⁴¹ and notify the applicant and head of the establishment of its decision in writing.¹⁴² If the Review Board decides to grant the request the necessary documents must also be submitted to the Registrar of a High Court for consideration by a High Court within these 30 days.¹⁴³ The High Court then makes the final decision whether further treatment is necessary or not and makes a court order to this effect.¹⁴⁴

If an appeal is lodged against the decision of the head of the establishment before a decision regarding further involuntary treatment is made by the Review Board, the review proceedings must be stopped to consider the appeal.¹⁴⁵ Such an appeal may be lodged by the user or any of the persons who may be an applicant in terms of section 33(1)(a),¹⁴⁶ and must be lodged within 30 days after having received notice of the date on which the relevant documents were submitted to the Review Board.¹⁴⁷ The Review Board must consider the appeal and notify the appellant, applicant, the head of the establishment concerned and head of the relevant provincial department of its decision and the reasons for such decision in writing within 30 days after having received notice of the appeal.¹⁴⁸ If the appeal is upheld, all treatment must be stopped and the user must be discharged by the head of the establishment.¹⁴⁹ If the appeal is not upheld, the Review Board must submit its decision¹⁵⁰ together with the documents it obtained to decide the appeal¹⁵¹ to the Registrar of a High Court for review by the High Court,¹⁵² which will once again make the final decision whether further treatment is necessary or not and give a court order to this effect.¹⁵³

¹³⁹ S 34(4)(a) of the MHCA.

¹⁴⁰ S 34(4)(b) of the MHCA.

¹⁴¹ S 34(7)(a) of the MHCA. Representations of the merits of the request can be oral or in writing, and may be submitted by the applicant, a mental health practitioner or the head of the health establishment concerned.

¹⁴² S 34(7)(b) of the MHCA.

¹⁴³ S 34(7)(c) of the MHCA.

¹⁴⁴ S 36 of the MHCA.

¹⁴⁵ S 34(8) of the MHCA.

¹⁴⁶ That is, the spouse, next of kin, partner, associate, parent or guardian of a mental health care user, or if none of the aforementioned are able or willing to be an applicant, a health-care provider.

¹⁴⁷ S 35(1)(a) of the MHCA.

¹⁴⁸ S 35(2)(c) and 35(2)(d) of the MHCA. Before making its decision regarding the appeal, however, the Review Board must obtain a copy of the original application for involuntary treatment together with copies of the notice which was given to the applicant regarding the initial admission to a health-care facility and the reports submitted by the mental health care practitioners after the 72-hour assessment period in this health establishment. The appellant and applicant as well as mental health care practitioners must also be given an opportunity to make representations on the merits of the appeal. See s 35(2)(a) and 35(2)(b) in this regard.

¹⁴⁹ S 35(3) of the MHCA.

¹⁵⁰ In terms of s 35(2)(d) of the MHCA.

¹⁵¹ In terms of s 35(2)(a) of the MHCA.

¹⁵² S 35(4) of the MHCA.

¹⁵³ S 36 of the MHCA.

3 3 The right to just administrative action

3 3 1 Does the decision regarding an application for involuntary treatment amount to administrative action?¹⁵⁴

In order to determine whether the abovementioned process amounts to administrative action, the definition of “administrative action” must first be examined.

Anything of possible concern to administrative law, besides the exercise of private powers, will be “administrative action” for purposes of the Constitution and is therefore subject to section 33 of the Constitution and, in most cases, to the Promotion of Administration of Justice Act 3 of 2000 (PAJA).¹⁵⁵ Administrative action is, in broad terms, the exercise of public powers by organs of State.¹⁵⁶ In terms of the PAJA, administrative action is defined as

“[A]ny decision taken, or any failure to take a decision, by an organ of state, when exercising a public power or performing a public function in terms of any legislation; or by a natural or juristic person, other than an organ of state, when exercising a public power or performing a public function in terms of an empowering provision, which adversely affects the rights of any person and which has a direct, external legal effect.”¹⁵⁷

To fully understand and apply this definition, certain of the terms contained therein need further attention. “Decision” means “any decision of an administrative nature made,¹⁵⁸ proposed to be made, or required to be made, as the case may be, under an empowering provision”.¹⁵⁹ This includes a decision relating to the making of an order or determination,¹⁶⁰ giving a direction, approval or consent,¹⁶¹ imposing a condition or restriction,¹⁶² and failure to take any such action.¹⁶³ Failure in this regard includes a refusal to take the decision.¹⁶⁴ “Organ of state” includes

¹⁵⁴ According to Currie and De Waal, “only once it has been ascertained whether particular conduct is administrative action, one can turn to the content of the administrative justice rights to establish the duties that the rights place on administrators”. See Currie and De Waal *The Bill of Rights Handbook* 650 in this regard.

¹⁵⁵ Currie and De Waal *The Bill of Rights Handbook* 646.

¹⁵⁶ Quinot *et al Administrative Justice* (2015) 83; and see also Currie and De Waal *The Bill of Rights Handbook* 650.

¹⁵⁷ S 1 of PAJA.

¹⁵⁸ The phrase “of an administrative nature” means that all forms of executive, legislative or judicial conduct is excluded. It can be described in broad terms as conduct connected with the daily business of the Government, such as the implementing of legislation. See Currie and De Waal *The Bill of Rights Handbook* 655; and Hoexter *Administrative Law in South Africa* (2007) 190 in this regard.

¹⁵⁹ S 1 of PAJA.

¹⁶⁰ Subsection (a).

¹⁶¹ Subsection (b).

¹⁶² Subsection (d).

¹⁶³ Subsection (g).

¹⁶⁴ S 1 of PAJA.

“[A]ny department of state or administration in the national, provincial or local sphere of government; or any other functionary or institution exercising a power or performing a function in terms of the Constitution or a provincial constitution; or exercising a public power or performing a public function in terms of any legislation.”¹⁶⁵

This definition clearly includes State hospitals and public mental health facilities,¹⁶⁶ which in turn fall under the definition of “health establishment” as provided for in the Mental Health Care Act.¹⁶⁷ The definition of “empowering provision” includes, amongst others, a law.¹⁶⁸ The MHCA thus qualifies as an empowering provision. An “administrator” is defined to be “an organ of state or any natural or juristic person taking administrative action”.¹⁶⁹

From the above it is apparent that the decision to grant an application for involuntary treatment or admission, or the refusal to grant such an application, does indeed amount to administrative action. The head of the health establishment to which an application is submitted will thus qualify as an administrator, as will the Review Board making the final decision. A private institution can also be an administrator in this sense,¹⁷⁰ since the decision to either grant or not grant an application for involuntary treatment or admission most certainly has a “direct, external legal effect”¹⁷¹ on an affected party.¹⁷²

3.3.2 *Analysis of procedure in the light of section 33 of the Constitution*

Section 33 of the Constitution reads as follows:

- “33(1) Everyone has the right to administrative action that is lawful, reasonable and procedurally fair.
- (2) Everyone whose rights have been adversely affected by administrative action has the right to be given written reasons.
- (3) National legislation must be enacted to give effect to these rights, and must –
 - (a) provide for the review of administrative action by a court or, where appropriate, an independent and impartial tribunal;
 - (b) impose a duty on the state to give effect to the rights in subsections (1) and (2); and

¹⁶⁵ *Ibid.*

¹⁶⁶ In terms of s 1 of the National Health Act 61 of 2003, which states that a public-health establishment is a health establishment that is owned or controlled by an organ of State.

¹⁶⁷ S 1 of the MHCA states that health establishments include “community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals”.

¹⁶⁸ S 1 of PAJA.

¹⁶⁹ *Ibid.*

¹⁷⁰ Hoexter *Administrative Law in South Africa* 182–183.

¹⁷¹ As provided for in S 1 of PAJA. This direct, external legal effect could include the infringement of the mental health care user’s right to freedom of movement (s 12 of the Constitution) or it could lie in the fact that his status has been affected (eg, being declared mentally incompetent). Not granting the application could lead to society’s right to safety and security being infringed if the application was brought under s 9(1)(c) of the MHCA.

¹⁷² Owing to space constraints, only the actions head of the health establishment and the Review Board will be discussed as administrative action, and not the actions of the mental health practitioners who make assessments in terms of s 33(5)(b) of the MHCA.

(c) promote an efficient administration.¹⁷³

The legislation required by section 33(3)¹⁷⁴ has been enacted¹⁷⁵ in the form of PAJA. What, then, is the status of the constitutional rights in section 33?¹⁷⁶ PAJA gives effect to the constitutional rights in section 33,¹⁷⁷ making the rights effective by providing an elaborated exposition of the rights to just administrative action and providing remedies to uphold these rights.¹⁷⁸ However, the constitutional right still exists independently of PAJA, but retreats to a background role since it is limited by PAJA.¹⁷⁹ The free-standing rights in sections 33(1) and (2) of the Constitution can therefore only be directly relied upon under exceptional circumstances.¹⁸⁰ One of these circumstances would be when the right to just administrative action is utilised to challenge legislation passed subsequent to PAJA, such as the MHCA, which contains an infringement of the right to administrative justice.¹⁸¹ What follows is thus a discussion of whether the procedure for involuntary care in terms of the MHCA, as has been described above, infringes upon the constitutional rights to administrative justice.¹⁸²

3.3.3(i) *The right to administrative action that is lawful, reasonable and procedurally fair*¹⁸³

Lawful administrative action under the Constitution basically means that administrators must “obey the law and must have authority in law for their decisions”.¹⁸⁴ An administrator cannot make a decision that is not permitted by law since this will amount to unlawful conduct, rendering the decision invalid.¹⁸⁵ The constitutional adoption of this well-known principle of the common law in the administrative-justice right does not add much to its content.¹⁸⁶ It does, however, fulfil the important function of preventing legislative “ouster clauses”.¹⁸⁷ As Currie and De Waal puts it:

¹⁷³ S 33 of the Constitution.

¹⁷⁴ S 33(3) of the Constitution.

¹⁷⁵ Currie and De Waal *The Bill of Rights Handbook* 647.

¹⁷⁶ Quinot *et al Administrative Justice* 76.

¹⁷⁷ S 33 of the Constitution.

¹⁷⁸ Currie and De Waal *The Bill of Rights Handbook* 647.

¹⁷⁹ The reason being that “Parliament elected to give effect to the rights in s 33 by enacting a general and comprehensive administrative-law code applicable to all instances of administrative action as defined by the Act”. See Currie and De Waal *Bill of Rights Handbook* 648 in this regard.

¹⁸⁰ Currie and De Waal *The Bill of Rights Handbook* 648.

¹⁸¹ Currie and De Waal *The Bill of Rights Handbook* 649.

¹⁸² Owing to space constraints, only the free-standing constitutional rights to just administrative action, and not the way in which PAJA gives effects to these rights, will be discussed.

¹⁸³ S 33(1) of the Constitution.

¹⁸⁴ Currie and De Waal *The Bill of Rights Handbook* 672.

¹⁸⁵ *Ibid.*

¹⁸⁶ *Ibid.*

¹⁸⁷ Ouster clauses are “provisions that seek to exclude or restrict the review jurisdiction of the courts, thereby permitting unlawful administrative action”. See Currie and De Waal *Bill of Rights Handbook* 672 in this regard.

“At a minimum, the right to lawful administrative action means that legislation cannot oust a court’s constitutional jurisdiction or deprive the courts of their review function to ensure the lawfulness of administrative action.”¹⁸⁸

When considering the procedure to obtain involuntary treatment as described in the MHCA, it is clear that no such “ouster clauses” exist in this particular piece of legislation. In fact, the MHCA makes explicit provision for review of the Review Board’s decision by the High Court.¹⁸⁹

The constitutional right to reasonable administrative action overrules the common-law position¹⁹⁰ which existed prior to enactment of the Constitution and simply requires that all administrative action must be reasonable.¹⁹¹ This implies that the court has a wide discretion as to what reasonableness entails, and it is likely that the courts will adopt a flexible standard regarding the meaning of reasonableness.¹⁹²

When viewed in this light, together with the rights to lawful and procedurally fair administrative action, it seems likely that the procedure to obtain involuntary treatment under the MHCA can indeed be regarded as reasonable.

Section 33 of the Constitution grants everyone the right to procedurally fair administrative action. This right entrenches, at the very least, the common-law right to natural justice¹⁹³ but is not limited to this.¹⁹⁴ Common law answers the question whether a hearing is required before a decision by considering whether the decision would have an individual or general impact.¹⁹⁵ It will thus depend on the circumstances of each given case whether a hearing is required.

¹⁸⁸ Currie and De Waal *The Bill of Rights Handbook* 672.

¹⁸⁹ S 35(4) and 36 of the MHCA.

¹⁹⁰ The common-law position regarding reasonableness in terms of administrative action comprised two closely linked doctrines. The first is the doctrine of symptomatic unreasonableness, according to which unreasonableness of a decision was material only if was a “symptom” of some other reviewable deficiency in a decision. The second doctrine holds that this effect can be possible only if the degree of unreasonableness is shockingly bad. See Currie and De Waal *The Bill of Rights Handbook* 674 in this regard.

¹⁹¹ S 33(1) of the Constitution.

¹⁹² S 24(d) of the Constitution of the Republic of South Africa 200 of 1993 (the interim Constitution), however, created a right to administrative action “which is justifiable in relation for the reasons given for it”. This formulation was considered by the Constitutional Court in the case of *Bel Porto School Governing Body v Premier of the Province, Western Cape* 2002 (3) SA 265 (CC). According to the minority decision, the right to administrative action that is justifiable in relation to the reasons given, “involves an element of substantive review – it relates not simply to procedure but to substance”. The majority judgment did not accept this interpretation and was of the opinion that “the intensity of review ... will depend upon the subject matter at hand”. Currie and De Waal is of the opinion that “it is difficult to treat the majority decision in *Bel Porto* as anything other than a heavy hint that the Constitutional Court is likely to adopt a flexible standard of reasonableness review in future cases”. See Currie and De Waal *The Bill of Rights Handbook* 675 in this regard.

¹⁹³ According to Currie and De Waal, the common-law rules of natural justice “are crystallised in two maxims: *audi alteram partem* (persons affected by a decision should be given a fair hearing by the decision maker prior to the making of the decision) and *nemo iudex in sua causa* (the decision making must be, and must be reasonably perceived to be, impartial)”. See Currie and De Waal *The Bill of Rights Handbook* 663 in this regard.

¹⁹⁴ Currie and De Waal *The Bill of Rights Handbook* 663.

¹⁹⁵ *Ibid.*

It was stated by the Constitutional Court in *Premier, Mpumalanga v Executive Committee, Association of Governing Bodies of State-Aided Schools, Eastern Transvaal*¹⁹⁶ that

“In determining what constitutes procedural fairness in a given case, a court should be slow to impose obligations upon government which will inhibit its ability to make and implement policy effectively (a principle well recognised in our common law and that of other countries).”¹⁹⁷

From the above mentioned it is clear that the object of the procedure to obtain involuntary treatment¹⁹⁸ should not be frustrated. This provides a very good reason why the user, in terms of whom the application is made, is not given a chance to “defend” him- or herself before the Review Board (except upon appeal).¹⁹⁹ The aim of the procedure is to provide care to individuals who need it, but who refuse to receive it, and to simultaneously protect society from potentially dangerous individuals. From a paternalistic point of view,²⁰⁰ it serves no purpose to apply the *audi alteram partem* rule, since the user does not have the capability to decide what is truly in his or her best interest,²⁰¹ while the medical practitioners who have examined the user on numerous occasions,²⁰² and who are acting in the user’s best interests, do.

The MHCA does, however, grant the user the right to appeal the head of the establishment’s decision.²⁰³ When compared to the paternalistic view as described above, this is what is referred to as a non-instrumental rationale for procedural fairness, where the purpose of fairness is simply to uphold an individual’s right to dignity by giving him or her an opportunity to partake in decisions affecting him or her.²⁰⁴

It thus appears as if the MHCA is trying to maintain a balance between the protection of mental health care users’ right to dignity and the upholding of mental health care users’ best interests in instances where these two objectives are irreconcilable.

3 3 3(ii) *The right to be given written reasons when rights have been adversely affected by administrative action*²⁰⁵

A general duty to provide reasons is a “significant new feature” of South African administrative law.²⁰⁶ The constitutional right to reasons is found in

¹⁹⁶ 1999 (2) SA 91 (CC).

¹⁹⁷ Par 41.

¹⁹⁸ Namely to provide mental health care users with the care they need whilst simultaneously protecting them and society – see s 32(1) of the MHCA.

¹⁹⁹ In terms of s 34(7)(a) of the MHCA, only representations of the merits of the request may be made before the Review Board.

²⁰⁰ As discussed in Chapter 1.

²⁰¹ This is one of the conditions required by s 32(1) of the MHCA to justify the involuntary care of a user.

²⁰² In terms of s 33(4) and 34(1)(b) of the MHCA.

²⁰³ S 35(1) of the MHCA.

²⁰⁴ As opposed to an instrumental rationale, where the purpose of procedural fairness is to improve the quality of decision-making. See Currie and De Waal *The Bill of Rights Handbook* 663 in this regard.

²⁰⁵ S 33(2) of the Constitution.

section 33(2) of the Constitution and section 5 of PAJA which give effect thereto. However, strictly speaking, PAJA does not implement a right to reasons but rather a “right to request reasons and a corresponding duty to provide reasons upon request”.²⁰⁷ Reasons may be requested only by a person who has not been given reasons for the action.²⁰⁸

The MHCA makes provision for the providing of reasons of the outcome of the procedure to obtain involuntary treatment. The applicant must be informed in writing of the head of the establishment’s decision regarding involuntary treatment, *together with reasons for the decision*.²⁰⁹ Furthermore, according to section 34(2) of the MHCA,²¹⁰ the head of the establishment must, within 24 hours after the expiry of the 72-hour assessment period, make available the findings of the assessment to the applicant.

4 AREAS OF CONCERN

From the discussion above it is clear that the South African legislative framework for involuntary mental health care has developed into a constitutionally sound system aimed at providing much needed mental health care, whilst promoting fundamental rights.²¹¹ This does not mean, however, that the existing system is infallible or might not lead to the unjustifiable limitation of patients’ rights. Therefore it is necessary to consider some areas of concern.

Involuntary mental health care is in the main reliant on effective clinical assessment in order to justify forcible or coerced treatment.²¹² In practice this is sometimes sorely lacking. The vast majority of involuntary mental health care admissions are channelled through hospital-casualty centres,²¹³ where an initial assessment is performed by medical clinicians, not psychologists or psychiatrists.²¹⁴ This evaluation is conducted merely in

²⁰⁶ When compared to the common-law position of the past. It was first introduced by s 24(c) of the Constitution of the Republic of South Africa 200 of 1993 (the Interim Constitution) in 1994. See Currie and De Waal *The Bill of Rights Handbook* 678 in this regard.

²⁰⁷ Currie and De Waal *The Bill of Rights Handbook* 678.

²⁰⁸ S 5(1) of PAJA. Currie and De Waal is of the opinion that this is applicable only to written reasons – if reasons have been provided orally at the time of the decision, a person should, according to them, still be able to request *written* reasons. See Currie and De Waal *The Bill of Rights Handbook* 682 in this regard.

²⁰⁹ S 33(8) of the MHCA (authors’ own emphasis).

²¹⁰ S 34(2) of the MHCA.

²¹¹ See the discussion in paragraph 3 above.

²¹² Janse van Rensburg “A Framework for Current Public Mental Health Care Practice in South Africa” 2007 10 *African Journal of Psychiatry* 205 207. See also Zabow “Competence and Decision-making: Ethics and Clinical Psychiatric Practice” 2008 1 *SAJBL* 61 62. Zabow contents that determining the competency of a patient to accept or refuse treatment is mainly based on a clinical assessment of the patient’s rationality and understanding of the situation.

²¹³ Schierenbeck *et al* “Barriers to Accessing and Receiving Mental Health Care in Eastern Cape, South Africa” 2013 15 *Health and Human Rights* 110 117.

²¹⁴ Freeman “New Mental Health Legislation in South Africa – Principles and Practicalities: A View from Department of Health” 2002 *South African Psychiatry Review* 4 5; Janse van Rensburg *et al* “The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) Position Statements on Psychiatric Care in the Public Sector” 2012 18 *SAJP* 133 136.

order to determine whether the patient satisfies the criteria for involuntary treatment.²¹⁵ As emergency rooms are aimed at lifesaving treatment, stabilisation and referral,²¹⁶ these *quasi*-psychological evaluations are conducted by means of an unstructured, non-clinical interview,²¹⁷ mainly based on collateral information obtained from friends, family or alternative sources, such as the South African Police Service or ambulance personnel.²¹⁸ The accuracy of such informal psychological assessments is therefore questionable.²¹⁹ Although this admission process is merely a start of an extensive process,²²⁰ an insufficient assessment could very well limit the rights of a person by means of an involuntary admission. In its simplest form, an unneeded involuntary admission would ensure observation by restricting the movement of the patient, but may also include forcible administration of medication if the patient is subjectively found to be combative or seen posing a threat.²²¹

It could be argued that clinical psychological evaluations, carried out during the observation period,²²² should rectify the result of an incorrect admission assessment,²²³ but an unneeded involuntary admission would already constitute a traumatic and gross infringement on the rights of the patient. The long-term physical and psychological effect of being unjustly incarcerated and subjected to medical substances could amount to direct infringements on the rights contained in the Bill of Rights.²²⁴

In a similar fashion, Review Boards are also tasked with preventing unreasonable or unjustified involuntary treatment.²²⁵ These boards, however, do not inspire confidence. MHRBs are generally reported to be understaffed,

²¹⁵ Ss 32-36 of the MHCA.

²¹⁶ Wallis "Emergency Medicine" 2013 30 *CME* 400. See also Nkombua "The Practice of Medicine at District Hospital Emergency Room" 2008 50 *SA Fam Pract* 65 66: "The emergency room (casualty) is a 24-hour unit in the hospital where patients whose conditions needing emergency and urgent treatment are seen."

²¹⁷ Moosa and Jeenah 2008 11 *African Journal of Psychiatry* 111.

²¹⁸ Schierenbeck *et al* 2013 15 *Health and Human Rights* 114; Janse van Rensburg "Admission to an Acute Inpatient Psychiatric Unit" 2015 *Mental Health Matters* 47 49.

²¹⁹ Moosa and Jeenah 2008 11 *African Journal of Psychiatry* 111: "Most admissions are made on the basis of an unstructured clinical interview and historical information provided by the patient, families and/or social-sector service staff. Thus, all three informational contexts represent sources of bias that colour the admitting clinician's judgment."

²²⁰ See the discussion in paragraph 3 2 1 above.

²²¹ One must take note that most involuntary admissions for mental health care are accompanied by resistance from the patient. It is therefore possible for similar emotions to be present if a person, who does not fall within the ambit of the involuntary admission criteria, is confronted by the threat of being "incarcerated". In such an instance the patient's reaction might be viewed as clinical symptoms, rather than raw emotions. See Janse van Rensburg "Acute Mental Health Care and South African Mental Health Legislation" 2010 13 *African Journal of Psychiatry* 382 387 in this regard. The author provides examples of such medication, including zuclopenthixol acetate, clonazepam and lorazepam.

²²² As prescribed by s 34(b) and (c) of the MHCA.

²²³ Petersen and Lund "Mental Health Service Delivery in South Africa from 2000 to 2010: One Step Forward, One Step Back" 2011 101 *SAMJ* 751 751.

²²⁴ These rights includes s 10 (human dignity); and s 12(1) (freedom and security of the person) and s 12(2) (Bodily and psychological integrity) as contained in Chapter 2 of the Constitution.

²²⁵ Petersen and Lund 2011 101 *SAMJ* 752; and Freeman 2002 *South African Psychiatry Review* 5.

underfunded and ill-equipped to deal with their workload.²²⁶ Review Boards are furthermore placed in a precarious position by not being afforded sufficient powers to fulfil their statutory mandate, leading to frustration and friction with the mental health care sector. Research shows that MHRBs have also been inert to implement legislative measures at provincial and district levels.²²⁷

Involuntary mental health care in South Africa is therefore undermined by unstructured and non-evidence-based initial assessments and treatment,²²⁸ which might require *ex post facto* correction by psychiatric institutions and ineffective MHRBs. Without properly structured and standardised practices, the effective implementation of a constitutionally sound legislative framework for involuntary mental health care becomes increasingly difficult – if not impossible. With due regard to the principles of *trias politica*, these concerns should be dealt with by the relevant executive authority, at both national and provincial level, and should not frustrate the courts with applications for administrative review.

5 CONCLUSION AND RECOMMENDATIONS

It is clear that the current system of involuntary treatment is a great improvement on previous systems and that much greater respect for the fundamental rights²²⁹ of mental health care users have been introduced.²³⁰ The Constitution and the MHCA have also introduced significant changes regarding the administration of mental health care in South Africa and even though some paternalistic aspects remain, it seems that the Mental Health Care Act²³¹ is consistent with the values of the Constitution.²³²

The procedure to obtain involuntary treatment²³³ requires the meeting of several strict requirements before an individual may receive involuntary mental health care.²³⁴ The process is governed by steps which need to be followed in specific order.²³⁵ Since each case is judged on its own merits both by the Review Board²³⁶ and by the courts,²³⁷ it seems that the

²²⁶ Bateman “Dismal Use of Legal Safety Net for Mental Health Patients” 2012 102 *SAMJ* 68; Gray and Pillay “Health Legislation and Policy” 2006 *Health Legislation and Policy* 8; and Petersen and Lund 2011 101 *SAMJ* 752.

²²⁷ Bateman 2012 102 *SAMJ* 68; Lund, Stein, Flisher, Mehtar “Challenges Faced by South African Health Services in Implementing the Mental Health Care Act” 2007 97 *SAMJ* 352; Jacob *et al* “Mental health systems in countries: Where are we now?” 2007 370 *The Lancet* 1061 1074; and Draper *et al* “Mental Health Policy in South Africa: Development Process and Content” 2009 24 *Health Policy and Planning* 342 350.

²²⁸ This includes the under or over diagnosis of psychiatric conditions that will ultimately lead to under- or overtreatment of patients. All these instances entail unethical behaviour by mental health care workers and might even lead to legal liability. Lund *et al* 2007 97 *SAMJ* 352.

²²⁹ As set out in Chapter 2 of the Constitution.

²³⁰ Moosa and Jeenah 2008 11 *African Journal of Psychiatry* 109; and Lund *et al* 2010 45 *Social Psychiatry & Psychiatric Epidemiology* 393.

²³¹ *Ibid.*

²³² See Lund *et al* 2010 45 *Social Psychiatry & Psychiatric Epidemiology* 394 in this regard.

²³³ S 32–36 of the MHCA.

²³⁴ Found in s 26, 33 and 34 of the MHCA. See paragraph 3 2 1 under Chapter 3 of this article for a full discussion.

²³⁵ See paragraph 3 2 1 under Chapter 3 of this article for a full discussion.

²³⁶ S 34(7)(a) of the MHCA.

procedure which is followed in order to obtain involuntary treatment is fair and just when considered in the light of section 33 of the Constitution. However, even though the procedures in the MHCA are clear, research indicates that the effective implementation of certain aspects of this procedure is lacking.²³⁸

The Review Boards have been created to facilitate supervision and accountability of care provision and to ensure that mental health care users are protected, especially during periods of vulnerability.²³⁹ The Review Boards are thus intended to be a “mechanism for active monitoring and enforcement of rights”²⁴⁰ of mental health care users’ personal rights. Research has shown, however, that the functioning and power of these boards have been inadequate up to date. It has been suggested that the State needs to act urgently to restructure or standardise the Review Boards as “an effective guardian of human rights”²⁴¹ for mental health care users if this is to be “more than just a gesture.”²⁴²

The conclusion can thus be made that the MHCA provides sufficient procedural protection for mental health-care users’ rights, which is in accordance with the Constitution. What now remains to be done is the effective implementation thereof since research has shown that there is an urgent need to address weak policy implementation in this regard²⁴³ in order to ensure that the protection of mental health care users’ rights is not merely a “paper victory”.²⁴⁴

²³⁷ S 33(1) of the Constitution; and s 36 of the MHCA.

²³⁸ Hanlon *et al* 2010 22 *International Review of Psychiatry* 246.

²³⁹ Swanepoel 2011 32 *Obiter* 303.

²⁴⁰ Burns 2011 6 *The Equal Rights Review* 108.

²⁴¹ *Ibid.*

²⁴² *Ibid.*

²⁴³ Lund *et al* 2010 45 *Social Psychiatry & Psychiatric Epidemiology* 393.

²⁴⁴ Perlin and Szeli *New York Law School Legal Studies Research Paper Series* 8.