

New mental health legislation in South Africa - principles and practicalities: A view from the Department of Health

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Abstract

The Mental Health Care Act has been passed by parliament. There are a number of changes from the Mental Health Act (Act 18 of 1973) and this article outlines the basic principles of the new legislation and several of the procedural modifications which follow. The legislation has a strong human rights focus and addresses problems relating to current abuses of people with mental disabilities. The success of the legislation will be dependent on the commitment of all role-players to implement both the spirit and the letter of the law, and stakeholders are requested to become partners with the Department of Health in this important endeavour.

Update

New mental health legislation has been passed by parliament. Both the National Assembly and the National Council of Provinces voted to accept the legislation during the first part of 2002. However, the legislation will only be enacted once the Minister of Health has signed the regulations and once sufficient training has been done, and processes set up in provinces, for successful implementation of the Act. The regulations will be published during the second part of the year to ensure full public participation and comprehensive input from all stakeholders.

Introduction

Drafting mental health legislation which captures the essence of the South African constitution, which is internationally current and which incorporates the practical realities and the uniqueness of the South African context has been a complex task. Fortunately, the process has involved an inclusiveness and transparency which has not only greatly assisted the Department of Health in developing the content, but has resulted in legislation for which a broad constituency can (proudly I believe) take responsibility. This does not imply that there were no differences of opinion during the long consultation process, or that all stakeholders are now satisfied with each clause, but that positions have been reached which are broadly acceptable to all the important role players. Extensive inputs were received from inter alia consumer and family groups, NGOs, academics, practitioners as well as various government departments.

Of course the legislation has yet to be put to the practical test and some problems may well arise. However, if the response from parliament is indicative, South Africa can look forward to a mean-

ingful and positive change to the environment in which mental health services are provided, as well as significantly improved human rights and protection for the mentally disabled. In a largely unprecedented occurrence, the Bill was passed in the National Assembly (with a great deal of praise) by all parties other than the ACDP (African Christian Democratic Party). All provinces supported the Bill in the National Council of Provinces.

So what is the legislation about and how does it differ from the Act it replaces (Mental Health Act No 18 of 1973)?

While there are many objectives and perspectives from which the legislation can be viewed, I suggest that there are three basic tenets which capture its main essence. These are human rights and the protection of people with mental disabilities; an integrated approach to mental health care provision and the safety of the public.

Human rights and the protection of people with mental disabilities

Human rights are reflected in the Act in specifically stated rights clauses as well as through various procedural mechanisms.

Despite one legal viewpoint that "law should not be repeated" and that the constitution, with its emphasis on the rights of people with disabilities, covers the rights of people with mental disabilities, this Act includes a Chapter on Rights and Duties Relating to Mental Health Care Users. The Act specifies and contextualizes various rights which apply directly to people with mental disabilities and expands on these. Issues directly addressed are Respect, Human Dignity and Privacy; Consent to Care, Treatment and Rehabilitation services and Admission to Health Establishments; Unfair Discrimination; Exploitation and Abuse of mentally disabled people; Determinations concerning mental health status; Disclosure of information; Limitation on intimate adult relationships; Rights to representation; Rights to Discharge Reports and to have Knowledge of rights.

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This Chapter, and the legislation more generally, draws heavily on the United Nations General Assembly resolution (46/119) of 1991^a, Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care¹, the World Health Organisation's Guidelines for the Promotion of Human Rights of Persons with Mental Disorders^{2,3} and Mental Health Law: Ten Basic Principles⁴. Two key elements in these documents are that decisions should be taken "in the best interests" of the user and "in the least restrictive environment". These standards are central to this legislation.

The new rights and principles will undoubtedly mean that people dealing with users will have to consciously and consistently apply themselves to ensuring that rights are not infringed upon and that the best possible care, treatment and rehabilitation is provided - within the financial constraints available. If litigation is to be avoided, health professionals and health establishments will have to be particularly vigilant in carrying out their functions. The legislation is not intended to scare health workers and have them fearing their every move, but given past abuses of people with mental disabilities legislated rights were seen as a necessity.

Admission without consent

In addition to the rights above there are also a number of administrative and procedural processes which are as important in protecting individual's freedoms and rights as those outlined as "rights" per se. One of the key issues in mental health law is deciding under what circumstances (if any), and how, a person may be treated and admitted to a health establishment without their consent.

The Bill asserts that a person should not be treated without his/her consent unless defined procedures have been adhered to. In the first instance an application, either for assisted or involuntary care, must be made to the head of a Health Establishment who must cause the person to be examined by two mental health care practitioners (and a third if there is disagreement). One of these practitioners must be qualified to conduct physical examinations. In the case of an application for assisted care the practitioners must establish whether the person is suffering from a mental illness or severe or profound intellectual disability which requires care, treatment and rehabilitation services for the user's health or safety/for the health and safety of others and that the person is incapable of making an informed decision on the need for such services. In an application for involuntary treatment, the criteria are that the person is likely to inflict serious harm to himself or herself or others or that care, treatment and rehabilitation is necessary for the protection of that person's financial interest or reputation. In addition the person must be incapable of making an informed decision and be unwilling to receive a health intervention.

If a decision is made that care should proceed, in the case of an assisted user the person should be informed of the decision, and, if inpatient care is approved, be admitted to a health establishment within five days. This decision must then be forwarded to a Mental Health Review Board who must consider each case and ensure that all the criteria for assisted care have

been met and that the best interests of the user are being served by the decision.

In the case of an involuntary user, if the decision is made that the person should be provided with further care and treatment, the head of the Health Establishment must cause the user to be admitted to a health establishment within 48 hours. The user will then be given appropriate care treatment and rehabilitation for a period of 72 hours. In this time the person will also be assessed (by a medical practitioner and another mental health care practitioner) to decide whether further care, treatment and rehabilitation is needed; and if so whether this should be as an inpatient or on an outpatient basis. The 72 hour assessment and treatment may be conducted at any health facility which has the facilities to do so and should most often be at a general hospital. If inpatient care is then recommended the person must be transferred to a designated psychiatric hospital. As in the scenario with respect to assisted users, the decision to provide involuntary care must be sent to a Mental Health Review Board for their consideration and decision. However, in involuntary decisions, the Review Board must, in addition, submit details of the decision to the registrar of the High Court for consideration.

With regard to both assisted and involuntary care, provision is made for the periodic reporting of each person's mental health status to the Mental Health Review Board in which reasons for the continuation of care without consent must be provided. These periodic reviews must be done after six months and then every year thereafter.

A third, and exceptional, process can be followed for care without consent in circumstances where, due to mental illness, any delay in providing care may result in the death or irreversible harm to the user or to others or that the user may cause serious damage to or loss of property. In such cases a health care provider or a health establishment may provide care for 24 hours. If further care is required in this time an application as described above must be made. The Review Board must be informed of any such admissions.

Readers familiar with the South African Mental Health Act of 1973 will have noticed a number of differences between the two pieces of legislation. I will refer to four of the important changes. Firstly, there is reference above to a "Mental health care practitioner". This is a new category of health worker which is defined in the Bill as "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". This category was primarily introduced to add much greater accessibility to critical mental health functions. It also ensures that mental health functions are carried out by people able and qualified to do so. The conditions under which different health workers may be classified as mental health practitioners will be outlined in regulations.

A second major change is the introduction of Mental Health Review Boards and the shift away from the role of magistrates in certification procedures. Review Boards will be set up by the MECs for Health in each province in respect of one or more health establishment(s) which provide mental health services. These Boards will consist of no fewer than three and no more than five members. The Review Board should consist of at least one mental health practitioner, one legal practitioner and one member of the community concerned. The Review Board

^a Despite this resolution being passed more than 10 years ago, from our research it appears that South Africa is only the second country to specifically include these rights as part of mental health legislation. (The first, we understand, being Jamaica).

may consult or obtain representation from any person or organisation necessary in order to carry out its functions.

A third significant change is the introduction of a 72 hour treatment and assessment period for involuntary users. The aim of this change is to allow people who fit the criteria for involuntary admission to be treated in the acute phase of their illness in a place as near to their homes as possible. In many instances, with treatment people recover considerably within a 72 hour period and it is unnecessary for them to have to go to a psychiatric hospital as a "certified patient" and experience the stigma and loss of dignity that this often implies.

A fourth major difference is in "involuntary outpatient" care. There has been an international trend towards what is often termed "involuntary community committal". Though controversial and rejected by some consumers, it is included as it is regarded as an important component necessary for obtaining the objective of least restrictive environment. The alternatives should not be considered to be involuntary community care or no intervention, but rather involuntary inpatient versus involuntary outpatient care. In this regard the outpatient alternative is the less restrictive, and the better human rights alternative.

Discharge of State patients

The rights of people found by the courts to be unfit to stand trial is still a contentious issue worldwide. In this legislation rights are extended by inter alia the expansion of who can apply to a Judge for discharge. Whereas previously this was only the Directorate of Public Prosecutions (DPP) there are now a range of people who can make such application. These include the State patient him or herself, an administrator, the head of the health establishment at which the person is admitted, the medical practitioner responsible, a spouse, associate or next of kin of the person or any other person authorised to act on behalf of the person. Moreover, if there is a conflict of interest between the DPP and the State patient a legal practitioner can be appointed to assist in the processing of the application. There is also a considerable shortening in the period of periodic reporting of the mental health status of State patients. The periods will be after the first six months and every year thereafter.

An integrated approach to mental health care provision

The new legislation lays down the framework for integrated mental health care services with provision of mental health care, treatment and rehabilitation at primary, secondary and tertiary levels of the health service. In addition, every organ of State responsible for health services (and this includes private mental health provision contracted by the State) must co-ordinate its policies towards the promotion of community based care.

All health establishments must provide people requiring mental health care with the appropriate level of mental health intervention. If this is not possible they must refer the user to an appropriate establishment.

The objective is to make mental health services as much part of general health care as other health areas. Instead of verticalising mental health it must form part of an integrated service. On the other hand "specialised" services are required – of which psychiatric hospitals are one and, for example, day

care facilities may be another.

Different psychiatric hospitals will be designated to perform specified specialised functions. The legislation states that these should be restricted to care, treatment and rehabilitation for:- voluntary users into special programmes, assisted users, involuntary users, State patients, mentally ill prisoners, persons referred for psychiatric observation and people in chronic care. Care and rehabilitation centres, on the other hand, will conduct assessments of intellectual disabilities and provide care treatment and rehabilitation services to persons with severe and profound intellectual disabilities.

There is a strong international consensus, supported very strongly by the WHO⁵, that custodial care should be replaced by community oriented alternatives for all but a small minority of mentally ill and intellectually disabled people. This legislation reinforces South African mental health policy which promotes community care. It is anticipated that the legislation will assist provincial processes of moving people (and finances) from hospital care into comprehensive community care.

Protection of the public

When dealing with mental illness there are instances where there has to be a balancing between individual rights and rights of members of the public (including family members and health workers). The constitution of the Republic itself recognises that individual rights may at times need to be restricted, and while most people with mental illness are not violent or even prone to violence, there are exceptions and these have to be dealt with within the law. While most of the examples mentioned already strengthen the rights of users, this is not at the expense of other members of society.

Examples of restrictions of personal freedoms include involuntary admission per se; discharge and leave of absence of State patients; and regulations such as the use of seclusion and mechanical restraints.

If a person is deemed by a close relative or associate to be likely to "inflict serious harm to...others", he or she may be kept and treated without his/her consent. A member of the South African Police Service or a mental health care practitioner may also legally cause a person to be evaluated if they are thought to be mentally ill and a danger. Given that South Africa has had provision for involuntary detention on its statute books for some time does not minimise its significance - especially given that 25% of countries in the world have no mental health legislation at all⁶. The discharge of a State patient, (a person found by the court to be not guilty by reason of mental illness), has been somewhat eased by this legislation. Nonetheless, protection of the public against unwarranted discharge is still secure. So while, for example, application for discharge has been extensively widened to include a number of role players and not just the Directorate of Public Prosecutions, a High Court Judge still takes final responsibility based on weighing up various relevant factors.

Regulations dealing with seclusion and mechanical means of restraint and the limitations that are put on them, are often perceived as protecting the rights of the user. However, merely permitting such constraints of freedom is a protection for health workers and other members of the public – including other users. Such protections should never be taken for granted as they are an important part of the balancing of personal and public freedoms.

Conclusion

The process of getting new mental health legislation to parliament and then made law, has been long but fruitful. Significant changes have been made and these now need to be implemented and, of course, tested. The Department of Health is optimistic that within the confines of our current knowledge the objectives of the legislation are correct, are captured and are implementable. However, as in getting to draft and passing the legislation partnerships were required, the same is true of implementation – only that now many more people will have to be brought in and made part of the changing mental health care environment.

References

- 1 United Nations. *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, General Assembly resolution (46/119) of 1991.
- 2 World Health Organisation. *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders*. WHO, Geneva, 1996.
- 3 World Health Organisation. *Mental Health Law: Ten Basic Principles*. WHO, Geneva, 1996.
- 4 World Health Organisation. *World Health Report: Mental Health: New Understanding, New Hope*. WHO, Geneva, 2001.
- 5 World Health Organisation. *Atlas: Mental Health Resources in the World*. WHO, Geneva 2001.

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COMMENTARY

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Every 30 years, or more, countries that have mental health legislation revise and re-enact it, usually following a spasm of outrage at prevailing practices. Often a seminal event, such as the assassination of a politician provokes this, or, as in post-apartheid South Africa tumultuous social change demands that legislation follow a new socio-political ethos. New mental health acts usually reflect an idealistic desire to be more humane, provide for greater accountability, and also to protect both the mentally ill and the community. Unfortunately, as Appelbaum (1) has concluded, radical changes in mental health legislation (depressingly) results in little change in actual practices. In his research he had found that countries and US States that had enacted widely differing, but intentionally humane, laws were in the end still admitting individuals who were deemed to be dangerous (whatever that means), and were bypassing the new legal mechanisms that were supposed to modify the practice of involuntary admission of mentally ill people.

South Africa's soon to be enacted Mental Health Care Act is a commendable attempt to ensure that the human rights of mentally ill individuals, who are usually cognitively impaired and otherwise vulnerable, are preserved. But will it work? Here are just a few considerations.

This is a country with meagre resources. Sophisticated and complicated laws are not easily implemented, even in developed countries. We are in danger of having one of the most advanced pieces of mental health legislation in the world, but scant means to use it.

Firstly the Act attempts to de-medicalise the management of mental illness. Patients are now called 'mental health users', and are managed by 'mental health practitioners or provider'. If the former is cognitively impaired he/she is called an 'assisted mental health care user', who may end up as an 'involuntary mental health care user' if he/she refuses help but needs it. Does terminology change reality? Unfortunately these politically correct terms have a faint echo of our apartheid past when black citizens were variously called 'natives', 'africans', and 'plurals' etc. Using terms that

are not in daily standard use rings false, and perhaps also have a ludicrous Orwellian echo.

Perhaps the Act's most significant achievements are the changes to the admission procedures. Under the present legislation families have to apply for involuntary admission through the Magistrate's courts, with non-psychiatric medical doctors' certificates at the ready. Now applications can be made directly to the heads of the mental health establishments (which now cease to be hospitals), and are then reviewed after admission by the Mental Health Review Boards. As wonderful as this latter innovation is, the question remains: how will enough competent (i.e. professionally educated) people be found to work on Review Boards? Consider this. Each of our busy psychiatric hospitals probably admits at least 50-80 individuals in a week. The Mental Health Review Boards are going to be very busy indeed. It will be a full time job. Are funds available to establish these full time posts?

Another commendable advance is the overt direction to manage mental illness predominantly in the community, including involuntary outpatient care. This probably also could apply to state patients, which would relieve the current pressure on inpatient facilities. Hopefully this will force the authorities to allocate more funding and resources for this. If they do not, the Act will mock its own existence.

Perhaps the most distressing aspect of the Act is that it will require a large bureaucracy. Mental health care practitioners will also become mental health care petitioners. Every application will probably require reams of reports and forms to be filled in (including the six monthly periodicals). Our colleagues in Canada and UK are well acquainted with these onerous tasks, and repeatedly complain that they have become less effective as clinicians. The patients see less of the clinicians, and the bureaucrats get to see more paper.

But, we must regard the Mental Health Care Act to be a significant advance, and thankfully like other pieces of legislation, can be changed, again. Even if it takes another 30 years.

Reference

- 1 Appelbaum PS. *Almost a revolution. Mental health law and the limits of change*. Oxford: Oxford University Press, 1994.

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