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MENTAL HEALTH LAW PROFILE

Mental health and the law: a South African perspective

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Mental health law in South Africa has been dominated in recent times by the Mental Health Care Act 2002. This paper provides selective insights into specific aspects of that Act and highlights its impact on clinical practice within a broad clinical setting and in so doing suggests areas for review and revision.

Historical context, current legislation

The Mental Health Care Act 2002

The Mental Health Care Act 2002 (Act no. 17 of 2002), hereafter referred to as 'the Act', together with its regulations ushered in a new era for South African psychiatry by replacing the Mental Health Act of 1973. The Act was assented to on 28 October 2002, but commenced on 15 December 2004, taking many clinicians by surprise. In the wake of the implementation of the Constitution of the Republic of South Africa (promulgated in 1996, implemented in 1997) it was incumbent on law makers to ensure that all Acts of Parliament were amended and written so as to accord with the new Constitution (Constitution of the Republic of South Africa, 1996).

It has been noted that the Act is founded on the ten basic principles set out by the World Health Organization (WHO) guiding mental healthcare law (WHO, 1996; Landman & Landman, 2014). In essence, the era of a human rights-driven ethos in patient care had arrived. This is not to say that human rights were never previously a consideration, but the revised Act brought with it a raft of changes, not least of which was an explicit orientation towards what one might view as a more 'patient centred' approach to psychiatric care.

Challenges

In the aforementioned scenario, the patient became a 'user', more specifically a 'mental healthcare user', and the psychiatrist became a 'mental healthcare practitioner' (MHCP), together with other professionals, given that the procedures accompanying the Act permit medical practitioners with experience in psychiatry together with a range of allied health professionals (e.g. nurses, social workers and psychologists) a potential role in the assessment of mental state contributing to need for admission. The term 'user' has somewhat negative connotations, yet in attempting to be seemingly more egalitarian in the approach to care it was clearly felt that the word 'patient' conferred a status not befitting an individual seeking and requiring care. However, the word 'patient', derived from the Latin *patior* (to suffer), would appear to be precisely what a person seeking care is experiencing – suffering – with the medical practitioner's obligation being to assist in alleviating such suffering.

A further requirement of the Act was that 'users' be treated in the least restrictive manner possible and ultimately with the least discomfort and inconvenience, and so as close to their place of domicile as possible. This is a noble sentiment which no self-respecting practitioner would disagree with. It is hard to recall any South African psychiatrist wanting to have a 'user' stay in hospital care for one day longer than absolutely necessary, not least of all given the limited resources that characterise state psychiatry in South Africa.

The structure of mental health services in South Africa

The Act

Acute beds are at a premium, and longer-stay beds even more so. This of course raises a critical qualifier in the Act, namely that everything is dependent on resources (i.e. funding). In an ideal scenario the 'user' is assessed and treated locally, as envisaged by the Act .

Challenges

The requirements of the Act presume there is a functional primary healthcare clinic, with an appropriately trained family practitioner, who if

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required can either refer to the community healthcare clinic for a psychiatric assessment and opinion, retain the 'user' at that level, or refer onward to a district hospital, which ideally should have a functional psychiatric unit with the necessary facilities, staffing and access to medication. This would then obviate the need for 'users' to travel to distant regional and central hospitals, with in some instances onward referral to specialised psychiatric hospitals. While the Act proclaims, reality dictates. Until there are fully functional community services that operate as they should, such aforementioned sentiment – however laudable – remains work in progress. It should be noted that in terms of the National Health Act's 'Regulations relating to categories of hospitals', the specialist discipline of psychiatry is not included among those that should be represented at district hospital level (National Health Act, 2003). Ideally, referrals from district hospital onwards to successive levels of care should be on the basis of doctor–doctor referral, as opposed to casualty 'walk-ins' at whatever level.

The Act potentially provides for clinicians to hold government legally accountable for appropriate resource allocation to ensure service delivery within the parameters of the Act. However, appropriate resource allocation is ultimately about balancing competing interests and psychiatry is generally not viewed as a priority, notwithstanding the oft-quoted 'no health without mental health' (Prince *et al*, 2007) together with the increasingly cited contribution of mental illness to the global burden of disease (Prince *et al*, 2007; Whiteford *et al*, 2013). In this regard the emerging focus on public mental health (Wahlbeck, 2015), with epidemiology, social determinants of health/illness, patient advocacy and emphasis on wellness as important elements, is an area deserving of greater attention in specialist training and has in fact been recently introduced into the specialist training curriculum of the College of Psychiatrists within the Colleges of Medicine of South Africa (http://www.collegemedsa.ac.za).

Forensic mental health services

The Act

Defendants in the criminal courts can be referred to a forensic psychiatric hospital for a '30-day observation' (under the Criminal Procedures Act) to determine whether in the first instance they have a serious mental illness and, secondly, if they do, whether they are fit to stand trial and had criminal responsibility for their actions during the offence. These defendants consequently can be certified by the court under the Act as 'state patients', based on their suffering from a diagnosed mental disorder which impacted upon capacity either at the time of the alleged offence or during the court-mandated observation period. As 'state patients' they are admitted to forensic psychiatric facilities for an indefinite period (Zabow, 2006). Defendants accused of non-violent offences are generally referred to the general psychiatric service under a civil commitment, even though no legislation currently actually provides for a legal mechanism to formalise this referral. The courts have refused to allow non-violent defendants to be taken to primary healthcare facilities that ought to admit them in accordance with the requirements of the Act. Consequently, it has been necessary to devise an informal procedure that is not governed by the Act to expedite the admissions of this latter group directly to psychiatric hospitals.

After an accused person has been certified as a 'state patient' under section 41 of the Act he or she has to be transferred to a prison, still on remand, pending the submission of specified forms to the National Department of Health (NDoH) in Pretoria. The NDoH issues an order to transfer the state patient to a designated forensic psychiatric hospital. Not only does this take at least a month to complete, but in most provinces state patients have been left languishing in remand prison because the designated facility does not have beds to accommodate them. In the Western Cape (one of South Africa's nine provinces) the forensic mental health service has routinely ignored these requirements of the Act by admitting state patients directly from court. Again, the requirements of the Act are being ignored in order to effect a more humane result. It has long been observed that mental health clinicians flout mental health legislation when its requirements cannot be implemented practically (Appelbaum, 1994).

The Act also provides for a Byzantine process for referring prisoners who are mentally ill to high-secure wards in forensic psychiatric hospitals. If a prisoner is suspected of suffering from a serious mental illness this has to be reported to the commanding officer of the prison, who has to refer the prisoner to a psychiatrist. The report is submitted to a magistrate who then directs that another enquiry by up to two psychiatrists must be conducted to confirm the original submission. The court order for the transfer of the prisoner to a forensic unit is submitted to the NDoH in Pretoria (Gauteng Province), who thereafter has to issue an order for the prisoner's transfer to a designated facility. There is a dearth of psychiatrists working in prisons and therefore very few prisoners are transferred each year. The question arises as to whether such a process, and outcome, is in the spirit of the Act.

Processes and oversight

The Act

There are a number of notable elements that have certainly changed clinical practice. The administrative burden has increased significantly, specifically with regard to both assisted and involuntary treatment categories for 'users', noting that the third category of 'user' is voluntary. Patients can change status depending on clinical presentation and capacity to consent.

Challenges

In a sense, this categorisation is an important development. It ensures that assisted care (for

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patients not able to consent to admission but not refusing admission) and especially involuntary care (of patients refusing admission in the face of a clinical presentation mandating admission) are carefully thought through by the clinician – and ultimately defensible.

A host of documents require completion, commencing with the initial assessment, the requirement of a recommendation by the head of the health establishment (HHE) to continue with ongoing care, with such care comprising a 72-hour period of observation before involuntary status can be conferred (after completion of the necessary documentation by two independent mental healthcare practitioners), with onward referral if required to a site designated for involuntary admissions. Onward referral would then require completion of further documentation by the HHE and notification of such a decision to the local mental health review board (MHRB) – another notable new development.

The MHRB provides oversight and ensures that the rights of 'users' are respected and that the Act is implemented appropriately. In this regard, all users have the right to appeal their status, which upon receipt of the necessary and completed Mental Health Care Act (MHCA) form will lead to the necessary investigation, appeal process and recommendation/instruction to the clinician for ongoing status. The clinician is summoned to such an appeal to explain the decision, with the MHRB hearing from the 'user' and if necessary the family (who may be the ones who lodge the appeal). The MHRB comprises a number of members, none of whom need be a psychiatrist. Its decision is final, and the clinician has no right of appeal. The process and outcome can be a source of discomfort for the clinician, who, as noted, has no recourse once the MHRB has proclaimed.

Ever mindful of the potential for the misuse of psychiatry – as was the case within Soviet psychiatry, where opponents of government were detained as mentally ill (Chodoff, 1999) – one must accept that levels of oversight and administrative burden that require a step-wise process towards involuntary care are necessary to ensure that level of care is congruent with clinical need.

While the bulk of the Act deals with aspects of routine clinical care, it should be noted that the Act has 46 associated MHCA forms, constituting the procedures, covering a range of clinical activities, including registers for restraint/seclusion and electroconvulsive therapy. Forensic psychiatry, which has recently been designated as a sub-specialist discipline within the College of Psychiatrists (http://www.collegemedsa.ac.za), labours under the same bureaucratic processes.

Conclusion: looking ahead

The promulgation and implementation of the Mental Health Care Act 2002 represented a new era in mental health in South Africa. In line with the 1996 Constitution, the Act reflected the human rights orientation with the intention to ensure humane care with appropriate accountability. Revision of the Act was a political imperative. Notwithstanding the intent, implementation has brought challenges to the clinician. The administrative burden has been significant, more so with inadequate support to facilitate the myriad of processes inherent in the raft of procedures together with the necessary oversight. Adequate resource allocation has been, and remains, an issue. Repeated lobbying and submissions to have the Act modified have to date been met with bureaucratic inertia. As per a recent government gazette (General Notice, 2015), comments on the current Act and related procedures have been invited, with a view to possible revision.

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