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# Aspects on the Constitutional Imperative and Domestic Legislation in Context of Mental Health Care Law in South Africa

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## ABSTRACT

The scope and purpose of this paper is to deal with the constitutional position and domestic legislation in the context of mental health care law in South Africa. Focus is placed on the constitutional[i] protection that exists for mentally ill patients in South Africa. A selective discussion of the Mental Health Care Act[ii] is also pivotal as the Act provides for the adequate care, treatment and rehabilitation services pertaining to mentally ill patients. The Mental Health Care Act also makes provision for a Mental Health Review Board that oversee the Mental Health Regulation in South Africa.

## Introduction

The impact of the Constitution of the Republic of South Africa, 1996 on mentally ill patients is threefold: First, the Constitution is considered to be the supreme law in South Africa,[3] and any legislation that is irreconcilable with it is invalid to the extent of the conflict. Second, according to the Constitution,[4] the Bill of Rights[5] applies to all law and binds the executive, legislature, judiciary and all organs of state. Every court, tribunal or forum must promote the spirit and objects contained in the Bill of Rights in the interpretation of legislation and the development of the common law. Third, the Bill of Rights instructs the state to use the power that the Constitution provides for in ways that do not violate fundamental rights.[6] The Bill of Rights declares many of the traditional human rights and has been praised as one of the best human rights instruments in the international context. South Africa has certainly made great strides in terms of its human rights awareness[7] or at least in terms of the Constitution and policies that address human rights.[8] There are specific fundamental human rights protected in the Bill of Rights that are applicable to the psychiatric profession and the mentally ill patient. The first is section 36 of the Constitution - the general limitation clause. If a court determines that a law or the conduct of a respondent impairs a fundamental right, it must be considered whether the infringement is nevertheless a justifiable limitation[9] of the right in question.[10]

The overall aim of the Mental Health Care Act[11] is the regulation of the mental health environment so as to provide mental health services in the best interest of the patient. The provision of care at all levels becomes the responsibility of the state. The Act promotes treatment in the least restrictive environment with active integration into general healthcare being required. Furthermore, respect for individual autonomy and decreased coercion procedures have been introduced in the management of the acute stages of illness.

The Act also addresses the potential and alleged malpractices in institutions and provides for prevention and detection.[12] This is related to reports of human rights abuses of those with mental illnesses, which required attention. Psychiatric hospitals' stigmatisation of patients used to occur.[13] This is an important aspect in terms of the Constitution, which requires that there be no discrimination toward persons with disabilities.[14] Mentally ill people have the right to be treated under the same professional and ethical standards as any other ill person. The National Health Act (The National Health Act 61 of 2003) further provides a legal framework, based on consent, for the regulation of mental health with regard to adults and children. These principles and domestic legislative provisions are discussed in more detail below.

## Research Methodologies

The following research methodologies are employed: A literature study of the Constitution, statutes, and case law as primary sources of law is followed. In addition, textbooks and writings of authors as secondary sources of law are utilised. Other sources include the internet and electronic databases.

THE CONSTITUTIONAL CONCEPT OF HUMAN RIGHTS[15]

The Constitution of the Republic of South Africa, 1996 contains a whole chapter (chapter 2) – The Bill of Rights, that deals with human rights. At the centre of the concept of human rights vests the idea that every person should be accorded a sense of value, worth and dignity and that every person (including the mentally ill person) should be protected from infringements and abuses of these fundamental rights, whether the infringements emanate from political states, authorities, or fellow human beings. In a general sense, human rights are understood as rights which belong to an individual as a consequence of being a human being and for no other reason.[16]

Fundamental rights and freedoms, as protected in the Bill of Rights, may be limited or restricted, and are therefore not absolute. Section 36, the general limitation clause, sets out specific criteria for the restriction of the fundamental rights in the Bill of Rights. However, given the importance of the rights and the total and irremediable negation of it caused by an infringement, the justification for a limitation would have to be exceptionally compelling.[17]

Therefore, where an infringement can be justified in an open and democratic society based on human dignity, equality and freedom, it will be constitutionally valid.

SECTION 10 OF THE CONSTITUTION: HUMAN DIGNITY[18]

In *Carmichele v Minister of Safety and Security*[19] it was said that human dignity is a central value of the objective, normative value system Chaskalson[20] in this regard wrote:

The affirmation of human dignity as a foundational value of the constitutional order places our legal order firmly in line with the development of constitutionalism in the aftermath of the Second World War.

He continues to say that as an abstract value common to the core values of our Constitution, dignity informs the content of all the concrete rights and plays a role in the balancing process necessary to bring different rights and values into harmony. It too, however, must find place in the constitutional order. O'Regan J remarked in *S v Makwanyane*[21] that recognising a right to dignity is an acknowledgment of the intrinsic worth of human beings: Human beings are entitled to be treated as worthy of respect and concern. This right is therefore the foundation of many of the other rights that are specifically entrenched in the Bill of Rights.

## Human dignity and the use of physical restraints for and seclusion of mentally ill patients[22]

It has been said that how a society treats its least well-off members says a lot about its humanity. Sometimes mentally ill people are treated with extreme measures that they do not want, for example, electroconvulsive therapy and unwanted medication with very serious risks and side effects. In addition, their liberty and dignity are taken away - sometimes for many years. There are many mentally ill people who are treated, who do not want to be treated. The question then arises: When should we

treat those who do not want to be treated and when should we respect their choices?[23]

According to Levenson,[24] (2007) physical restraints and seclusion may be required for confused, medically unstable patients, especially when chemical restraint is ineffective or contraindicative. Confused medically ill patients often climb over bed rails risking falls, which may result in fractures and head trauma. The stringent legal regulation of physical restraints has increased during the past decade, yet courts have generally held that restraints are appropriate when a patient presents a risk of harm to themselves or others and a less restrictive alternative is not available. While it should be acknowledged that physical restraints have been overused in the past, some argue that there are times when these restraints are the safest and most humane option. A full range of alternatives for preventing harm in confused medically ill patients, and for respecting their dignity, should be considered, keeping in mind that there are clinical and legal risks both in inappropriately using and foregoing restraints.

With regard to seclusion of mentally ill patients,[25] there are, according to Saks,[26] at least two theories of how seclusion is directly therapeutic: First, the patient is separated from stressful interpersonal relations and is so permitted to reconstitute and to feel more settled. Second, seclusion is therapeutic because of the destimulation it provides. The idea is that patients, especially psychotic ones, have a real problem with overstimulation. They have, as it were, lost their ability to filter out unnecessary detail. Therefore, placing a patient in a bare room with no stimuli to distract, impinge on and overwhelm him or her, can be most therapeutic. It is submitted that should less restrictive means be available to achieve the same putative therapeutic ends; seclusion should not be justified as a means of therapy.

The rights and duties of persons, bodies or institutions are set out in Chapter 3 of the Mental Health Care Act[27] and are in addition to any rights and duties that they may have in terms of any other law. According to section 8 of the Mental Health Care Act, the person, human dignity and privacy of every mental health care user[28] must be respected. Every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life. A mental health care user must receive care, treatment and rehabilitation services to the degree appropriate to his or her mental health status.

In addition, the Ethical Code of Professional Conduct to which a Psychologist shall adhere stipulates that:[29] "A psychologist shall respect the dignity and worth of a client and shall strive for the preservation and protection of fundamental human rights in all professional conduct."

SECTION 12(1) OF THE CONSTITUTION: FREEDOM AND SECURITY OF THE PERSON AND SECTION 35: ARRESTED, DETAINED AND ACCUSED PERSONS[30]

**Introductory remarks**

Section 12(1) states:

"Everyone has the right to freedom and security of the person, which includes the right: (a) not to be deprived of freedom arbitrarily or without just cause; (b) not to be detained without trial; (c) to be free from all forms of violence from either public or private sources; (d) not to be tortured in any way; and (e) not to be treated or punished in a cruel, inhuman or degrading way."

When a person is deprived of physical freedom, s 12(1) guarantees both substantive and procedural protection.[31] The substantive component requires the state to have good reasons for depriving someone of their freedom and the procedural component requires the deprivation to take place in accordance with fair procedures. O'Regan J described these components as follows:

… [T]wo different aspects of freedom: the first is concerned particularly with the reasons for which the state may deprive someone of freedom; and the second is concerned with the manner whereby a person is deprived of freedom. … [O]ur Constitution recognises that both aspects are important in a democracy: the state may not deprive its citizens of liberty for reasons that are not acceptable, nor when it deprives its citizens of freedom for acceptable reasons, may it do so in a manner which is procedurally unfair.

Section 35 states:[32]

(1) Everyone who is arrested for allegedly committing an offence has the right-
(a) to remain silent;
(b) to be informed promptly-
(i) of the right to remain silent; and
(ii) of the consequences of not remaining silent;
(c) not to be compelled to make any confession or admission that could be used in evidence against that person;
(d) to be brought before a court as soon as reasonably possible, but not later than-
(i) 48 hours after the arrest; or
(ii) the end of the first court day after the expiry of the 48 hours, if the 48 hours, expire outside ordinary court hours or on a day which is not an ordinary court day;
(e) at the first court appearance after being arrested, to be charged or to be informed of the reason for the detention to continue, or to be released and;
(f) to be released from detention if the interests of justice permit, subject to reasonable conditions.
(2) Everyone who is detained, including every sentenced prisoner, has the right-
(a) to be informed promptly of the reason for being detained;
(b) to choose, and to consult with, a legal practitioner, and to be informed of this right promptly;
(c) to have a legal practitioner assigned to the detained person by the state at state expense, if substantial injustice would otherwise result, and to be informed of this right promptly;
(d) to challenge the lawfulness of the detention in person before a court and, if the: detention is unlawful, to be released;
(e) to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment; and

(f) to communicate with, and be visited by, that person's
(i) spouse or partner;
(ii) next of kin;
(iii) chosen religious counsellor; and
(iv) chosen medical practitioner.

The influence of the Bill of Rights on the criminal justice system has been significant.[33] As mentioned above, it provides grounds for reviewing both the substantive and procedural content of the intricate web of laws shaping criminal justice as well as providing remedies for breaches of the Constitution. In doing so it has impacted on the content of law in addition to influencing the conduct of those who participate in the criminal justice system.[34]

In addition, the Ethical Code of Professional Conduct to which a Psychologist shall adhere stipulates that: "A psychologist shall never coerce a recipient of a psychological service into complying with the provision of such service nor shall he or she compel a client to give self-incriminating evidence via the use of psychological techniques or otherwise."

## The regulation of State patients and mentally ill prisoners in terms of the Mental Health Care Act[35]

Chapter 6 of the Mental Health Care Act regulates the position with regard to State patients. In terms of section 41, the head of the national department must, with the concurrence of the relevant heads of the provincial departments, designate health establishments, which may admit, care for, treat and provide rehabilitation services to State patients. Where a court issues an order in terms of the Criminal Procedure Act for a State patient to be admitted for mental health care, treatment and rehabilitation services, the Registrar or the Clerk of the court must send a copy of that order to the:

- Relevant official *curator ad litem*; and
- officer in charge of the detention centre where the State patient is or will be detained.

In terms of section 46(1) of the Mental Health Care Act, the head of a health establishment where a State patient is admitted or if on leave of absence or conditional discharge must cause the mental health status of the State patient to be reviewed after six months from the date on which care, treatment and rehabilitation services were commenced, and every 12 months thereafter. The review must make recommendations on:

- A plan for further care, treatment and rehabilitation service;
- the merits of granting leave of absence; or
- the discharge of the State patient.

Chapter 6 of the Act further regulates the transfer of State patients between designated health establishments; the position with regard to State patients who abscond; leave of absence from designated health establishments; the application for discharge of State patients; and the conditional discharge of State patients, amendments to conditions or the revocation of conditional discharge.

Chapter 7 of the Mental Health Care Act regulates the position with regard to mentally ill prisoners. In terms of section 49, the head of the national department must, with the concurrence of the heads of the provincial departments, designate health establishments which may admit, care for, treat and provide rehabilitation services to mentally ill prisoners. If it appears to the head of a prison through personal observation or from information provided that a prisoner may be mentally ill, the head of the prison must cause the mental health status of the prisoner to be enquired into by a psychiatrist or where a psychiatrist is not readily available, by a medical practitioner and a mental health care practitioner. The person conducting the enquiry must submit a written report to the head of the prison, and must specify in the report the mental health status of the prisoner; and a plan for the care, treatment and rehabilitation of that prisoner.

If the person conducting the enquiry referred to in section 50 finds that the mental illness of the convicted prisoner is of such a nature that the prisoner concerned could appropriately be cared for, treated and rehabilitated in the prison, the head of the prison must take the necessary steps to ensure that the required levels of care, treatment and rehabilitation services are provided to that prisoner.

SECTION 28 OF THE CONSTITUTION: THE PROTECTION OF CHILDREN'S RIGHTS[36]

Section 28 sets out a range of rights that provide protection for children, which are additional to the protection they are given by other sections of the Bill of Rights. However, as important as these rights are, children's rights do not have a special status in the Bill of Rights. In *De Reuck v Director of Public Prosecutions*,[37] Epstein AJ held that "a child's best interests … is the single most important factor to be considered when balancing or weighing competing rights and interests concerning children. All competing rights must defer to the rights of children unless unjustifiable." This decision was overruled by the Constitutional Court in *De Reuck v Director of Public Prosecutions*. To say that section 28(2) of the Constitution "trumps" other provisions of the Bill of Rights is "alien to the approach adopted by this Court that constitutional rights are mutually interrelated and interdependent and form a single constitutional value system".

There are currently serious concerns about the placement, treatment and care of children in need of mental health care in South Africa. It is evident that there is a lack of guidelines, protocol and specialised expertise for the treatment of children in psychiatric institutions, leading to practices which are deeply concerning. Incidents of maltreatment and abuse of children admitted to psychiatric institutions are frequently reported. It has become clear that there are a wide variety of serious systematic problems at psychiatric institutions that require an urgent, holistic and comprehensive solution.

The above systematic problems relate, *inter alia*, to the following:[38]

- The criteria for admitting children in psychiatric institutions as well as the procedures followed for admission;
- whether children admitted to psychiatric institutions for observation are separated from institutionalised children who are receiving care on a continuing long-term basis;

- The staffing of the psychiatric wards, including:
  - Whether staff members are specifically trained to care for children and young people;
  - whether staff members in psychiatric wards are trained to care for children with special needs (such as autistic children); and
  - whether staff members receive continued training on how to care for children with psychiatric and/or special needs.
- The procedures followed by staff when an incident occurs, including:
  - Internal investigations to determine the cause of the incident and the course of action to remedy the situation;
  - disciplinary measures taken by staff to discipline children when they break the rules in a ward or cause an incident; and
  - notification of parents and family of children involved and/or injured in an incident.
- Safety measures to prevent children from absconding from the psychiatric institution and procedures followed by staff when children have absconded from the institution;
- The procedures followed to re-admit children who have absconded from a psychiatric institution, including:
  - Treatment of children by staff members when they are returned to the psychiatric institution;
  - appropriate measures to manage the behaviour of the children as well as the circumstances in which it would be necessary and appropriate to implement such measures; and
  - disciplinary measures for absconding, taken by staff against the children, with specific reference to placing children in seclusion.
  - The practice of placing children in seclusion with special reference to the following:
  - Guidelines for the staff and coherence to constitutional provisions on when and under which circumstances children may be placed in seclusion;
  - whether there is a register recording when children are placed in seclusion and if so, what information is entered in the register and whether such information is sufficient.
- The authority of staff to discipline children and the extent of such authority, including which measures are allowed and under which circumstances.

With reference to the matters listed above, the concern arises in South Africa that there are no clear, written policies in place which are adequate and appropriate; and that, to the extent that certain policies are in place, they are not adhered to consistently in practice, and that no measures or insufficient measures are taken when such policies are breached.

Child psychiatry training programmes have further encountered a number of administrative problems resulting from efforts to recognise, without isolating or submerging, the unique aspects of child psychiatry within existing departments of psychiatry. The intention is to question the validity of the concept of general psychiatry, which may be responsible for many of these administrative dilemmas. The author advances that child psychiatry actually represents a distinct field of practice, where training programs for children suffering from mental disorders should be integrated within departments of psychiatry through divisional administrative lines.[39]

In terms of section 9 of the Children's Act, (35 of 2008) the care, protection and well-being of a child in all matters concerning the standard that the child's best interest is of paramount importance, must be applied.

The Ethical Code of Professional Conduct to which a Psychologist shall adhere also safeguards the rights of children and stipulates that: "A psychologist shall be cognisant that a child's best interests are of paramount importance in every professional matter concerning direct or indirect psychological services to children." Further, a psychologist must take special care when dealing with children fourteen years of age and younger, and must at the beginning of a professional relationship, inform a child or a client who has a legal guardian or who is otherwise legally dependent, of the limits the law imposes on the right of confidentiality with respect to his or her communications with such psychologist.

ELECTRO CONVULSIVE THERAPY[40]

"There had been times when I'd wandered around in a daze for as long as two weeks after a shock treatment, living in that foggy, jumbled blur which is a whole lot like the ragged edge of sleep, that gray zone between light and dark, or between sleeping and waking or living and dying, where you know you're not unconscious any more but don't know yet what day it is or who you are or what's the use of coming back at all - for two weeks.[41]

When electroconvulsive therapy is mentioned in conversation it invokes strong reactions from scientists and laypeople alike. A swirl of controversy has always surrounded the use of shock treatment. Electroconvulsive therapy has undergone many changes since its creation in the early 1930's in Europe. (Newell) However, despite scientific innovations and legislative actions, South Africa and many other countries are not sufficiently protecting the mentally disordered patient's constitutional right to refuse such an invasive and controversial treatment.

The use of electroconvulsive therapy is not a highly regulated and legislated treatment in South Africa. Up until the introduction of the Mental Health Care Act, legislation and monitoring of the use of electroconvulsive therapy in South Africa had been conspicuous by its absence. Fortunately, the Mental Health Care Act has a potential impact on the practice of electroconvulsive therapy in a variety of ways. One of the major limitations of electroconvulsive therapy is the neurocognitive side-effects that accompany its administration. However, with recent research on the effects of changes in electrode placement and dosing strategies, it is possible to minimise these side effects in the majority of patients. Despite these recent advances in the practice of electroconvulsive therapy, it should remain a highly regulated and legislated treatment modality in South Africa.[42] According to Segal and Thom,[43] it has been shown that the more legislated the procedure becomes the less

frequently it is used. Their argument is that paternalistic psychiatrists are conducting electroconvulsive therapy on patients whose rights they are violating, by utilising inadequate procedures for obtaining informed consent, thus undermining autonomy. This treatment is also potentially harmful thus not adhering to the tenets of non-maleficence. Further, the increasing risk of litigation in the field of medicine played a role in the aforementioned phenomenon both as cause and effect. On the contrary, Jorgensen[44] argues that the stigma that electroconvulsive therapy suffered due to prior barbaric type applications in the past are largely historical, and most medical professionals should agree that electroconvulsive therapy is safe today, has very minimal side effects, is not inherently abusive, and no long-term detriments. Yet, with the increase in popularity and the safe applications, electroconvulsive therapy is still treated archaically under certain laws and legislative restraints will cause an indigent, elderly population to be deprived of this useful and sometimes solely effective treatment.

Individuals requiring electroconvulsive therapy fall within groups or categories. The group that is most non-controversial are those who have mental capacity and may either refuse or request electroconvulsive therapy. Such individuals have statutory, common law and constitutional protections of autonomy and self-determination. The more controversial group are those patients who are mentally incapacitated and either refused electroconvulsive therapy, requested electroconvulsive therapy or who have not expressed a decision either way.

In *Rompel v Botha*,[45] Neser J made the following statement:

> There is no doubt that a surgeon who intends operating on a patient must obtain the consent of the patient … I have no doubt that a patient should be informed of the serious risks he does run. If such dangers are not pointed out to him then, in my opinion, the consent to the treatment is not in reality consent – it is consent without knowledge of the possible injuries. On the evidence defendant did not notify plaintiff of the possible dangers, and even if plaintiff did consent to shock treatment he consented without knowledge of injuries which might be caused to him. I find accordingly that plaintiff did not consent to the shock treatment.

It is clear from the above that lawful medical interventions require the informed consent of the patient apart from the specific exceptions mentioned above. Therefore, a medical intervention without the required informed consent amounts to a violation of a person's physical integrity, and may amount to criminal assault, civil or criminal *injuria*, or result in an action for damages based on negligence.

Whether in the capacity or incapacity group, each group's autonomy interests should be afforded differently. A group of concern are those patients who were competent, but are now incapacitated. When these individuals enjoyed capacity, they may have either created medical advance directives that did not provide for mental health care decisions or they failed to provide directives at all. The category includes those who may have consented to electroconvulsive therapy before or who may have refused the treatments prior to losing capacity. Procedures are needed, which will protect the vulnerable individuals from the misuse of electroconvulsive therapy and at the same time continue to protect the incapacitated individual's rights and self-determination.

INSTITUTIONALISATION OF THE MENTALLY ILL

Far from providing a supportive environment, institutional care settings for the mentally disordered are often where human rights abuses occur. This is particularly true in segregated services including residential psychiatric institutions and psychiatric wings of prisons. Persons with mental disorders are often inappropriately institutionalised on a long-term basis in psychiatric hospitals and other institutions.[46] While institutionalised, they may be vulnerable to being chained to soiled beds for long periods of time, violence and torture, the administration of treatment without informed consent, unmodified use of electro-convulsive therapy, grossly inadequate sanitation, and inadequate nutrition. Women are particularly vulnerable to sexual abuse and forced sterilisations. Persons from ethnic and racial minorities are often victims of discrimination in institutions and care systems. A lack of monitoring of psychiatric institutions and weak or nonexistent accountability structures allow these human rights abuses to flourish away from the public eye.[47]

In terms of the Mental Health Care Act, 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. it was authorised by a court order or a review board;
c. due to mental illness, any delay in providing care, treatment and rehabilitation services or admission may result in the death or irreversible harm to the health of the user; or
d. the user can inflict serious harm to himself or herself or others; or cause serious damage to or loss of property belonging to him or her or others.

Any person or health establishment that provides care, treatment and rehabilitation services to a mental health care user or admits the user in circumstances referred to in the Mental Health Care Act[48] must report this fact in writing in the prescribed manner to the relevant review board; and may not continue to provide care, treatment and rehabilitation services to the user concerned for longer than 24 hours unless an application in terms of Chapter V is made within the 24-hour period.

The Mental Health Care Act[49] regulates voluntary, assisted and involuntary mental health care. Subject to section 9(l)(c), a mental health care user may not be provided with assisted care, treatment and rehabilitation services at a health establishment as an outpatient or inpatient without his or her consent, unless a written application for care, treatment and rehabilitation services is made to the head of the health establishment

concerned and he approves it; and at the time of making the application there is a reasonable belief that the mental health care user is suffering from a mental illness or severe or profound mental disability, and requires care, treatment and rehabilitation services for his or her health or safety, or for the health and safety of other people; and the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services.

An application referred to in section 26[50] may only be made by the spouse, next of kin, partner, associate, parent or guardian of a mental health care user, but where the user is under the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user. If the spouse, next of kin, partner, associate, parent or guardian of the user is unwilling, incapable or not available to make such an application, the application may be made by a health care provider. The applicants referred to in paragraph (a) must have seen the mental health care user within seven days before making the application.

Such application must be made in the prescribed manner, and must set out the relationship of the applicant to the mental health care user; if the applicant is a health care provider, state the reasons why he is making the application; and what steps were taken to locate the relatives of the user in order to determine their capability or availability to make the application; set out grounds on which the applicant believes that care, treatment and rehabilitation services are required; and state the date, time and place where the user was last seen by the applicant within seven days before the application is made.

On receipt of the application, the head of a health establishment concerned must cause the mental health care user to be examined by two mental health care practitioners. Such mental health care practitioners must not be the persons making the application and at least one of them must be qualified to conduct physical examinations. On completion of the examination, the mental health care practitioners must submit their written findings to the head of the health establishment concerned on whether the circumstances referred to in section 26(b) are applicable; and the mental health care user should receive assisted care, treatment and rehabilitation services as an outpatient or inpatient.

A mental health care user must be provided with care, treatment and rehabilitation services without his or her consent at a health establishment on an outpatient or inpatient basis if:

a. An application is made in writing 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 the user is likely to inflict serious harm to himself or herself or others; or
c. care, treatment and rehabilitation of the user is necessary for the protection of the financial interests or reputation of the user; and 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.

## Conclusion

Even though there is quite a lot of discrimination against mentally ill patients a lot of steps have been taken to secure their human rights are adhered to.[51] The Constitution of the Republic of South Africa makes provision for equal treatment,[52] dignity rights,[53] the right to life,[54] security of the body[55] and access to health care services.[56] The Mental Health Review Boards were also created to be the watch dog over mental health in South Africa. This researched aimed to point out what is still needed to improve mental health care rights.

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[27] Mental Health Care Act 17 of 2002.
[28] A Mental Health Care User is defined in section 1 of the Mental Health Care Act as: "mental health care user" means a person receiving care, treatment and rehabilitation services or using a health service at a health establishment 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, and in certain circumstances may include-

prospective user;
the person's next of kin;
a person authorised by any other law or court order to act on that persons behalf;
an administrator appointed in terms of this Act; and
an executor of that deceased person's estate and "user" has a corresponding meaning;
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