A comparative discussion of the regulation of Mental Health Review Boards in South Africa and the Mental Health Review Tribunal in the United Kingdom

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Abstract

There is general dissatisfaction regarding the operation of review boards in South Africa. These boards are guided solely by the principle of legality in that they may act only if legally permitted to do so, the principle of natural justice in that they must allow all sides an opportunity to present their cases, and the general principles governing administrative action. There are no general procedural rules applicable to all review boards. Lessons could be learnt from the United Kingdom's Review Tribunal and the First-Tier Tribunal as they relate to mental health care. The United Kingdom Review Tribunals have rules of procedure and mechanisms aimed at case management. The Mental Health Care Act (MHCA) provides a right to legal representation for the mentally ill at the proceedings. This right does not extend to representation in any instances other than during the proceedings before a review board or any other court. The introduction of the Independent Mental Health Advocates (IMHAs) would strengthen the protection of rights of mental health care users in terms of the MHCA and the Constitution, in that mental health care users would be better informed of their rights and be able to access review boards.

INTRODUCTION

The introduction to the Mental Health Care Act[1] (MHCA) brought, inter alia, the following changes to mental health care regulation in South Africa:[2]

- the introduction of the Mental Health Review Board (MHRB);[3]

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1 17 of 2002.

2 Melvyn Freeman, 'The new mental health legislation in South Africa–principles and practicalities: A view from the department of health' (2002) August SAPR 4 at 5–7.

3 Mental Health Care Act 17 of 2002, s 18.

- the introduction of the 72-hour treatment and assessment period;[4] and
- involuntary outpatient care.[5]

This contribution provides a comparative discussion on mental health review boards in terms of the MHCA and the Mental Health Review Tribunal (MHRT) in the United Kingdom (UK). The UK has already dealt with the protection of the human rights of mental health care users[6] now facing South Africa. The comparative review focuses on the role of the bodies created under the mental health care laws in the United Kingdom and the lessons that South Africa can learn from that jurisdiction. The UK mental health laws are comparable to South African laws in many respects and it is often instructive to refer to the law of the UK.[7] However, before the review board and the MHRT are discussed, it is important to provide a brief discussion of the rights of care users whom the review boards are established primarily to protect.

RIGHTS OF MENTAL HEALTH CARE USERS

Defining mental health care users

The MHCA regulates the detention and treatment of care users. It identifies various categories of user, but here I limit my discussion to issues relating to voluntary care users, assisted care users, and involuntary users.[8]

Voluntary users

A person who voluntarily submits to a health establishment for care, treatment and rehabilitation services is entitled to appropriate care, treatment

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4 Ibid s 34.

5 Ibid s 32.

6 Mental health care user (hereafter care user) refers to 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:
(a) prospective user;
(b) the person's next of kin;
(c) a person authorised by any other law or court order to act on that person's behalf;
(d) an administrator appointed in terms of the MHCA; and
(e) an executor of that deceased person's estate.

7 Albert Kruger, *Mental health law in South Africa* (Butterworth 1980) 130. See also Joanna Jane Taylor, 'Appeals against assisted and involuntary admission under the Mental Health Care Act No 17 of 2002 in Region A Gauteng province South Africa between December 2004 and December 2011' (MMed Psychiatry dissertation, University of the Witwatersrand 2015) at 11–14.

8 The MHCA read with the Criminal Procedure Act 51 of 1977 also regulates the detention and treatment of state patients but these categories will not be the focus of this submission. It is accepted that the functioning of the Mental Health Review Boards does affect state patients, the interplay between the MHCA and the CPA requires that it be discussed as a separate topic.

and rehabilitation[9] or to be referred to an appropriate health establishment.[10] It is submitted that if a person volunteers to receive mental health care there is no need for him or her to apply for the care in that it is a right to which each person is entitled.

Assisted users

A care user may be provided with care services at a health establishment as an outpatient or inpatient without his or her consent if:[11]

- the head of the health establishment has approved the written application for care services;
- at the time of making the application there is a reasonable belief that the care user is suffering from mental illness,[12] or severe or profound mental disability, and requires care services for his or her health or safety, or for the health and safety of other people;
- at the time of making the application the care user was incapable of making an informed decision on the need for care services.

Procedure during application

The application for assisted care may be made by the spouse, next of kin, partner, associate, parent or guardian of the care user.[13] If the care user is under the age of eighteen, the application must be made by his or her parent (or guardian).[14] The application may be made by the health care provider if the parties who are authorised to make such an application are unwilling to do so.[15] The person making the application must have seen the care user within seven days before making such an application.[16] The written application may be withdrawn at any time.[17]

The form of the application

An application for the provision of assisted services must be made in writing, using form MHCA 04.[18] The applicant must set out the following on the form:[19]

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9 The overarching term 'care' or 'care services' is used hereafter to refer to 'care, treatment and rehabilitation services'.

10 Mental Health Care Act 17 of 2002, s 25.

11 Ibid s 26.

12 The term mental disorder is used interchangeably with mental illness to maintain the wording of different legislations.

13 Mental Health Care Act 17 of 2002, s 27(1)*(a)*.

14 Ibid s 27(1)*(a)*(i).

15 Ibid s 27(1)*(a)*(ii).

16 Mental Health Care Act 17 of 2002, s 27(1)*(b)*.

17 Ibid s 27(3).

18 Ibid s 27(1) read with reg 9(1).

19 Ibid s 27(2).

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

The procedure after the application is made

After receiving the application, the head of the health establishment must have the care user available to be examined by two mental health care practitioners.[20] The mental health care practitioner conducting the examination may not be the mental health care practitioner making the application, and one of the mental health care practitioners appointed to examine the care user must be qualified to conduct a physical examination.[21] The mental health care practitioners appointed to examine the care user must, after the completion of the examination, submit a report to the head of the health establishment concerned as to whether:[22]

- the care user qualifies to receive assisted care services; and
- he or she should receive assisted care services as an outpatient or inpatient.

If the findings of the two mental health care practitioners differ, the head of the health establishment must refer the matter to a different mental health care practitioner who must submit a report on whether the care user qualifies to receive assisted care services as an outpatient or an inpatient.[23] The head of the health establishment may approve the application only if two mental health care practitioners agree that the conditions for assisted care services exist,[24] but will only approve the application for inpatient care if:[25]

- the findings of two mental health care practitioners concur that the conditions for the provision of assisted inpatients care services exist; and

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20 MHCA (n 1), s 27(4)*(a)*.
21 MHCA (n 1), s 27(4)*(b)*.
22 MHCA (n 1), s 27(5).
23 Mental Health Care Act 17 of 2002, s 27(6).
24 MHCA (n 1), s 27(7).
25 MHCA (n 1), s 27(8).

- the head of the health establishment is satisfied that the restrictions and intrusion on the rights of the care user to movement, privacy, and dignity are proportionate to the care services required.

The head of the health establishment must notify the applicant of its decision[26] and if he or she has approved the application for inpatient assisted care, he or she must cause the care user to be admitted to a health establishment or to be referred to a health establishment with appropriate facilities.[27]

If the head of the health establishment has reason to believe that an assisted user has recovered the capacity to make informed decisions, he or she must enquire of the assisted user whether he or she is willing to continue with care services.[28] If the assisted user consents to further care he or she is considered as a voluntary user.[29] If the assisted user does not consent to further care, the head of the establishment may discharge him or her if he or she is satisfied that user has recovered.[30] If the head of the establishment is satisfied that the person is still suffering from mental illness, he or she must advise the person who made the application for assisted care that he or she may make an application to detain the assisted user as an involuntary user.[31]

Involuntary users

Section 32 of the MHCA[32] allows for care of a person without consent if:

an application in writing is made to the head of the health establishment concerned to obtain the necessary services and the application is granted;

- there is a reasonable belief that the user has a mental illness of such a nature that he or she is likely to inflict serious harm on him- or herself or on others, or care is necessary for the protection of his or her financial interests or reputation; and
- at the time the application is made the user is incapable of making an informed decision on the need for care and is unwilling to receive the care required.

Who may apply?

The persons who may apply for care services for involuntary users correspond to those detailed above in regard to assisted care users.

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26 MHCA (n 1), s 27(9).
27 Ibid s 27(10).
28 Ibid s 31(1).
29 Ibid s 31(2).
30 Ibid s 31(2).
31 Mental Health Care Act 17 of 2002, s 31(1).
32 Act 17 of 2002.

The form of the application

An application for the provision of involuntary services must be made in writing, using form MHCA 04.[33] The same information required in the case of an assisted user (above) must be supplied.

The procedure after the application

Again, the post-application procedures outlined above in regard to a voluntary user also apply to the involuntary user save that if the head of the health establishment approves involuntary care services, he or she must cause the user to be admitted or referred to a health establishment within 48 hours.[34]

Seventy-two-hour assessment

After the head of a health establishment grants the application for involuntary services, he or she must:[35]

- ensure that the user is given appropriate care services;
- admit the user and request a medical practitioner and another mental health care practitioner to assess the physical and mental health status of the user for a period of 72 hours in the manner prescribed; and
- ensure that the practitioners also consider whether the involuntary services must be continued. If services must be provided, the practitioners must state whether this should be on an outpatient or inpatient basis.

Within 24 hours of the expiry of the 72-hour assessment period, the head of the health establishment must make the findings of the assessment available to the applicant.[36] After the completion of the assessment, the head of the establishment may:[37]

- immediately discharge the user if he or she is of the opinion that the status of the user does not warrant involuntary care services;
- discharge the user on an outpatient basis if the status of the user warrants further involuntary care services on an outpatient basis;[38]

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33 General Regulations of the Mental Health Care Act 17 of 2002, reg 10(1).

34 MHCA (n 1), s 33(9).

35 MHCA (n 1), s 34(1).

36 MHCA (n 1), s 34(2). Regulation 11(6) provides that form MHCA 06 must be used to submit the joint written report by the mental health care practitioners to the head of the mental health care establishment.

37 MHCA (n 1), s 34(3).

38 Reg 11(8) provides that if the head of the health establishment, following the 72-hours assessment, is of the opinion that the mental health status of the mental health care user warrants further involuntary services on an outpatient basis, he or she must inform the Mental Health Review Board in the form of form MHCA 09.

- request the review board to approve further involuntary care services on an inpatient basis if the status of the user warrant further involuntary care on an inpatient service.[39]

If the head of the health establishment requests the review board to approve further involuntary care services on an inpatient basis, the board must within thirty days give the interested parties an opportunity to make oral or written representations on the merits of the application.[40] The review board forwards the written decisions and the reasons to the applicant and the head of a health establishment.[41] If the review board decides to grant the request for further involuntary care it must refer the matter for automatic review to the High Court.[42]

THE INTERNATIONAL HUMAN RIGHTS LAW PRINCIPLES FORMING THE BASIS FOR THE MHCA

International human rights law requires that the following principles be complied with by national legislation.[43]

- The legislation should not only protect the rights of people with mental illness but should also aim to promote mental health and prevent mental illness.
- The legislation should embrace the principle of the least restrictive alternative, which requires that mentally ill persons are always offered treatment in settings that will least restrict their personal freedom and least affect their status and privileges in the community.
- The legislation should guarantee the confidentiality of all information on mentally ill people obtained during their treatment.
- The principle of voluntary and informed consent to treatment should be protected in the legislation.
- Involuntary admission to hospital should be allowed in exceptional cases and in very specific circumstances only. These exceptional circumstances should be outlined and incorporated into the legislation. Involuntary treatment should only be allowed in rare situations.

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39 Reg 11(9) provides that if the head of the health establishment, following the 72-hour assessment, is of the opinion that the mental health status of the mental health care user warrants further involuntary services on an inpatient basis, he or she must inform the Mental Health Review Board in the form of form MHCA 08.

40 Mental Health Care Act 17 of 2002, s 34(7)*(a)*.

41 Ibid s 34(7)*(b)*.

42 Ibid s 34(7)*(c)*.

43 See The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991), Universal Declaration of Human Rights, the United Nations Charter, Convention on the Rights of Persons with Disabilities (2007); Walter Ryder, *Mental Health Policy and Service Guidance Package* (WHO, 2003).

- The legislation should contain a provision for the appointment of an independent review body with specified composition, powers, and duties.
- Legislation should not be restricted to issues of mental health or even general health but should address issues of housing, education, employment, and general health, among other matters.

The drafter of the MHCA were also guided by the World Health Organisation's (WHO) 'Mental Health Care Law: Ten Basic Principles' (1996). The WHO, after conducting a study in a number of countries, compiled ten basic principles in mental health care law. The basic principles are not binding on countries; they are merely intended to be instructive or serve as guidelines for legislatures or policy-makers when dealing with mental health care law. The WHO identified the ten basic principles for mental health care laws set out below.

- Promotion of mental health and prevention of mental disorders.[44]
- Access to basic mental health care.[45]
- Mental health assessments in accordance with internationally accepted principles.[46]
- Provision of the least restrictive type of mental health care.[47]
- Self-determination.[48]
- The right to be assisted in the exercise of self-determination.[49]

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44 This entails ensuring that everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders. The principles suggest that in order to promote the principle, behaviours which contribute to enhancing and maintaining mental well-being must be promoted and actions to eliminate the causes of mental disorders must be identified and taken.

45 This principle entails that everyone in need should have access to basic mental health care. The mental health care provided must be of adequate quality, affordable and equitable, geographically accessible; available on a voluntary basis, as health care in general and it should be contingent upon the available human and logistical resources.

46 The principle provides that mental health assessments should only be conducted for purposes directly relating to mental illness or the consequences of mental illness. It is prohibited to refer to nonclinical criteria, such as political, economic, social, racial and religious grounds when assessing mental health. Assessment based only on past medical history of mental disorder is also prohibited.

47 It is required that everyone with mental illness should be provided with health care which is the least restrictive. States should be made to provide a community-based treatment.

48 Interference with the person's bodily integrity and liberty may only occur with consent. The consent must be given by the person involved or next of kin; it must be free and voluntary; it must be informed; and it must be documented in the patient's medical file.

49 In a case where the person cannot consent because of difficulty in understanding the implication of his/her decision, he/she should benefit from assistance by a knowledgeable third party.

- The availability of a review procedure.[50]
- An automatic periodical review mechanism.[51]
- Qualified decision-makers.[52]
- Respect for the rule of law.[53]

These basic principles are not binding on South Africa, but have been recognised in the MHCA.[54] They form the basis in terms of which the MHCA was enacted and provide an interpretative tool for the interpretation of its provisions.

THE RIGHTS OF MENTAL HEALTH CARE USERS IN TERMS OF THE MHCA READ WITH THE BILL OF RIGHTS

The MHCA reaffirms that every care user has the right to respect for his or her person, human dignity, and privacy.[55] It gives effect to human dignity, one of the most important rights in the Constitution of the Republic of South Africa, 1996 (the Constitution).[56] The right to dignity forms the foundation

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50 There should be a review procedure available easily and in a timely fashion for any decision made by official or representative decision-makers and by health care providers. In order to ensure this, it is required to have a review procedure and/or a permanent Review Board created by legislation and which is operational; and to establish a state-managed office of representatives for mental patients with legal and ombudsman-like services.

51 The principle provides that there should be an automatic review in the case of a decision affecting integrity (treatment) and/or liberty (hospitalisation) with a long-lasting impact.

52 Decision-makers should be competent; knowledgeable; independent and impartial.

53 Decisions should be made in keeping with the body of law in force in the jurisdiction involved and not on another basis nor on an arbitrary basis.

54 S 3 of the MHCA provides that: 'The objects of this Act are to – (a) regulate the mental health care in a manner that – (i) makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources; (ii) co-ordinates access to mental health care, treatment and rehabilitation services to various categories of mental health care users; and (iii) integrates the provision of mental health care services into the general health services environment; (b) regulate access to and provide mental health care, treatment and rehabilitation services to – (i) voluntary, assisted and involuntary mental health care users; (ii) State patients; and (iii) mentally ill prisoners; (c) clarify the rights and obligations of mental health care users and the obligations of mental health care providers; and (d) regulate the manner in which the property of persons with mental illness and persons with severe or profound intellectual disability may be dealt with by a court of law'. See also Adolph Landman and Willem Landman, *A Practitioner's Guide to the Mental Health Care Act* (Juta 2014) 3.

55 S 8 of the MHCA provides that: '(1) the person, human dignity and privacy of every mental health care user must be respected; (2) 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; (3) The care, treatment and rehabilitation services administered to a mental health care user must be proportionate to his or her mental health status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation.'

56 See *S v Makwanyane* [1995] 3 SA 391 (CC) para 144.

for a number of human rights contained in the Bill of Rights.[57] It is protected under the Constitution and is a value which informs the interpretation of most of the rights in the Constitution.[58]

Section 8 of the MHCA further secures for care users the right to privacy. In terms of section 14 of the Constitution the right to privacy includes the right not to have the person or person's home searched; the person's property searched; the person's possession seized; or the privacy of the person's communications infringed. The section is divided into two parts: first, the general protection of the right to privacy; and second, protection against specific infringements.[59] Section 8 of the MHCA, on the other hand, provides only a general protection for the right to privacy.[60]

In addition, section 8 provides that every care user must be provided with services that improve his or her mental capacity to develop to full potential and to facilitate his or her re-integration into community life.[61] The MHCA demands that persons suffering from a mental illness are not to be isolated from society unless this is necessary, or is for their protection or for the protection of others.[62] The prohibition on the abuse of care users is a further measure intended to protect their dignity.

The MHCA recognises and protects the right to autonomy.[63] However, the MHCA also acknowledges that there are situations in which the care user cannot, or will not, consent, even where treatment is very necessary. It is clear that a care user may be treated without his or her consent in two circumstances: where the treatment has been authorised by a court order or a review board; and where there is an emergency and, because

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57 Iain Currie and Johan de Waal, *The Bill of Rights Handbook* (Juta 2014) 250. See also *S v Dodo* [2001] 3 SA 382 (CC) where the court made the following finding regarding the need to respect and value human beings (at para 38): 'Human beings are not commodities to which a price can be attached; they are creatures with inherent and infinite worth; they ought to be treated as ends in themselves, never merely as means to an end'.

58 Currie and De Waal Ibid 252.

59 Ibid.

60 See *NM and Others v Smith and Others* [2007] 5 SA 250 (CC) para 34, where the court decided that the test to determine whether privacy is involved in any particular case is – that there must be a subjective expectation of the bearer of the right that something is a personal/private fact; and that society must consider the expectation to be reasonable. This is an objective test. The test does not define what private facts are. However, it has been accepted that private facts are those matters the disclosure of which will cause mental distress and injury to anyone possessed of ordinary feelings and intelligence in the same circumstances and in respect of which there is a will to keep them private.

61 Mental Health Care Act 17 of 2002, s 8(2).

62 General Regulations to the Mental Health Care Act Health Care Act 17 of 2002, reg 33.

63 S 9(1) of the MHCA provides that a mental health care user may be provided with care, treatment and rehabilitation services only if: the mental health care user has consented to the care, treatment and rehabilitation services or to admission; it is authorised by a court order or a Review Board; or any delay would lead to death or harm to the mental health care user or any other person; or causing serious damage to or loss of property belonging to the user or any other person.

of mental illness, any delay in providing services or admission may result in certain consequences. When a care user is treated by a mental health care practitioner or health establishment without his or her consent, and a delay would lead to death or harm to the care user or any other person; or where serious damage to or loss of property belonging to the user or any other person may occur, the mental health care practitioner or health establishment must report this fact to the relevant review board[64] and may not continue to provide services to the user concerned for longer than 24 hours unless an application for voluntary, assisted or involuntary mental health care is made within the 24-hour period.[65]

The MHCA recognises that there may be instances in which a care user may be subjected to treatment and operations for illness other than mental illness.[66] If a care user is capable of granting consent for treatment for a condition other than mental illness, the care user should grant such consent before the care or treatment is given to such user.[67] The MHCA also recognises that where the care user is unable to consent to treatment, such consent may be granted by a curator appointed by a court, a spouse, next-of-kin,[68] or in some instances, the head of the health establishment.[69]

The consent given by the party must comply with the following requirements:[70]

- the consenting party must have had knowledge and been aware of the nature and extent of the harm or risk;
- the consenting party must have appreciated and understood the nature and extent of the harm or risk;
- the consenting party must have consented to the harm or assumed the risk;
- the consent must be comprehensive, that is extending to the entire procedure, inclusive of all its consequences.

The MHCA makes it clear that a care user has a limited right to consent or refuse treatment, care, or rehabilitation in respect of his or her mental illness or any treatment other than for his or her mental illness.

Section 10 of the MHCA states that a person suffering from mental illness is entitled not to be unfairly discriminated against on the ground of his or her mental health status,[71] and that every such person has a right to

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64 MHCA, s 9(2)*(a)*.
65 MHCA, s 9(2)*(b)*.
66 General Regulations (n 33), reg 37.
67 General Regulations (n 33), reg 37(1).
68 General Regulations (n 33), reg 37(2).
69 General Regulations (n 33), reg 37(3).
70 *Castell v De Greef* [1994] 4 SA 408 (C) at 425.
71 Mental Health Care Act 17 of 2002, s 10(1).

receive services in accordance with standards equivalent to those applicable to other persons.[72] Policies and programmes aimed at promoting the mental health status of a person must be implemented taking into account the mental capacity of the person concerned.[73]

Section 9 of the Constitution prohibits discrimination in the following terms:

> (1) Everyone is equal before the law and has equal protection and benefit of the law.
> (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination may be taken.
> (3) The State may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
> (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.
> (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

In *Hoffmann v South African Airways*,[74] the court made the following finding regarding the prohibition of unfair discrimination:

> At the heart of the prohibition of unfair discrimination is the recognition that under our Constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against. The determining factor regarding the unfairness of the discrimination is its impact on the person discriminated against. Relevant considerations in this regard include the position of the victim of the discrimination in society, the purpose sought to be achieved by the discrimination, the extent to which the rights or interests of the victim of the discrimination have been affected, and whether the discrimination has impaired the human dignity of the victim.

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72 Ibid s 10(2).
73 Ibid s 10(3).
74 [2001] 1 SA 1 (CC) para 27.

The MHCA gives effect to the constitutional prohibition on discrimination and does so by prohibiting discrimination on the basis of a care user's mental health status.[75]

The MHCA places an obligation on the state to implement policies and programmes aimed at improving the mental health status of the care user.[76] These policies and programmes must be appropriate for the intended care user.

A care user has the right to a representative, including a legal representative, when he or she submits an application, lodges an appeal, or appears before a magistrate, judge, or review board, subject to the laws governing rights of appearance in a court of law.[77] This means that only a representative who is entitled to appear in the court concerned may represent the care user. An indigent care user is entitled to legal aid provided by the state in any proceeding instituted or conducted in terms of the MHCA subject to any condition fixed in terms of section 4(1)*(e)* of the Legal Aid South Africa Act 2014.[78]

A care user who is capable of giving informed consent to electro-convulsive treatment, must decide whether or not to have the treatment.[79] Electro-convulsive treatment must be performed by a medical practitioner with special training in mental health, and may only be carried out under a general anaesthetic administered in conjunction with a muscle relaxant.[80] A care user may not be subjected to this treatment more than once in 24 hours

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75 According to *Harksen v Lane NO* [1997] 11 BCLR 1489 (CC) para 53 the following enquiry should be conducted in determining whether a conduct amounts to an unfair discrimination: (a) Does the provision differentiate between persons or any categories of persons? If so, does the differentiation bear a relational connection to a legitimate government purpose? If it does not, then there is a violation of s 9(1) of the Constitution. Even if it does bear a rational connection, it might nevertheless amount to discrimination if the differentiation amounts to an unfair discrimination. (b) Does the differentiation amount to unfair discrimination? This requires a two stage approach: (i) Firstly, do the differentiation amount to 'discrimination'? If it is on a specified ground, then discrimination will have been established. If it is not on a specified ground, then whether, objectively, the ground is based on attributes and characteristics which have the potential to impair the fundamental human dignity of a person as human being or to affect them adversely in a comparably serious manner. (ii) If the differentiation amounts to a 'discrimination' does it amount to 'unfair discrimination'? If it has been found to have been on a specified ground, then unfairness will be presumed. If on an unspecified ground, unfairness will have to be established by the person alleging such unfairness. If at the end of this stage of the inquiry, the differentiation is found not to be unfair, then there will be no violation of s 9(3) and 9(4) of the Constitution. (c) If the discrimination is found to be unfair then a determination will have to be made as to whether the provision can be justified under the limitation clause (s 36 of the Constitution).

76 Mental Health Care Act 17 of 2002, s 10(3).

77 Ibid s 15(1).

78 MHCA (n 1), s 15(2).

79 Reg 33(3) read with reg 35(1) of the General Regulation of the Mental Health Care Act 17 of 2002.

80 General Regulations (n 33), reg 33(1).

and not on consecutive days.[81] Only the head of the establishment may perform the electro-convulsive treatment at a health establishment under the auspices of the state or a private health establishment.[82] Whenever electro-convulsive treatment is performed a register kept for that purpose must be completed and signed by the relevant medical practitioner and a transcript of the register must be submitted by the health establishment concerned to the review board on a quarterly basis on the form MHCA 47.[83]

A care user has a right not to be isolated as a form of punishment.[84] He or she may only be isolated to contain severely disturbed behaviour which is likely to cause harm to others.[85] While an involuntary care user is isolated, he or she must be observed at least every thirty minutes and the observation must be recorded in the clinical notes.[86] The clinical notes must be submitted by the health establishment concerned to the review board on a quarterly basis on form MHCA 48. Whenever isolation is applied the following must be complied with:[87]

- a register, signed by a medical practitioner, must be completed;
- the duration of and reasons for the isolation of the care user concerned must be outlined in the relevant register by the medical practitioner; and
- the head of the health establishment concerned must on a daily basis receive a report indicating all incidents of isolation.

Mechanical means of restraint may only be used if the pharmacological or other means of calming, physical means of restraint, or isolation of the user are inadequate to ensure that he or she does not harm him- or herself or others.[88] Mechanical means of restraint may be used in order to administer pharmacological treatment, but such means should be applied for a short period – ie, only the period necessary to effect the treatment – depending on the condition of the care user concerned.[89] The care user under restraint must be subject to observation at least every thirty minutes and such observation must be recorded in the clinical notes.[90]

Whenever a mechanical means of restraint is used, the register must be completed and signed by the relevant medical practitioner.[91] The form of

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81 General Regulations (n 33), reg 33(2).
82 General Regulations (n 33), reg 33(4).
83 General Regulations (n 33), reg 33(5).
84 General Regulations (n 33), reg 37(1).
85 Ibid.
86 General Regulations (n 33), reg 37(2).
87 General Regulations (n 33), reg 37(3).
88 General Regulations (n 33), reg 36(1).
89 General Regulations (n 33), reg 36(2).
90 General Regulations (n 33), reg 36(3).
91 General Regulations (n 33), reg 36(4)*(a)*.

mechanical means of restraint, the duration of the restraint, the times at which the user was observed and the reason for administering the means of restraint must be outlined by the medical practitioner in the register.[92] The head of the health establishment concerned must receive a daily report of all incidents involving the use of mechanical means of restraint.[93] The use of mechanical means of restraint as punishment is prohibited.[94]

MENTAL HEALTH REVIEW BOARDS UNDER THE MHCA

Establishment and composition

Each province in the Republic of South Africa must have at least one review board. The responsibility for establishing a review board or boards in a province rests with the member of the executive council responsible for health services in the province (the Health MEC).[95] A review board may be established for a single health establishment, a cluster of health establishments, or all health establishments providing mental health care services in that province.[96] The relevant provincial department must provide human and other resources to enable the review board to perform its administrative functions.[97]

The review board consists of no fewer than three and no more than five persons.[98] The members must be South African citizens.[99] They are appointed by the Health MEC of the province.[100] Each board must consist of at least one mental health care practitioner, a magistrate, attorney or advocate admitted in terms of the law of the Republic of South Africa, and a member of the community.[101] Before appointing any person to a review board, the Health MEC must publish a notice calling for nominations, stating the criteria for nomination, and specifying a period within which nominations must be submitted.[102] The notice must be published in the *Provincial Gazette* and in any other widely circulating means of communication in that province.[103] The Health MEC must consider all nominations received and make an appointment.[104] The Health MEC must determine the term of office of members appointed to the board.[105] The terms of office may be

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92 General Regulations (n 33), reg 33(4)*(b)*.
93 General Regulations (n 33), reg 33(4)(*c*).
94 General Regulations (n 33), reg 33(5).
95 MHCA (n 1), s 18(1).
96 MHCA (n 1), s 18(2).
97 MHCA (n 1), s 18(3).
98 MHCA (n 1), s 20(1).
99 Ibid.
100 Ibid.
101 MHCA (n 1), s20(2).
102 MHCA (n 1), s 20(3).
103 MHCA (n 1), s 20(3).
104 MHCA (n 1), s 20(3)*(c)*.
105 MHCA (n 1), s 20(4)*(a)*.

staggered.[106] The fact that there is a vacancy at the time the review board takes a decision, does not affect the validity of such a decision.[107]

Any member of the review board may be removed from office by the Health MEC if:[108]

- the member ceases to practise the profession on the basis of which he or she was appointed;
- the member is unable to perform his or her duties effectively;
- the member has been absent from two consecutive meetings of the review board without prior permission, except on good cause shown;
- the member ceases to be a South African citizen; or
- it is in the public interest to remove the member.

Powers and functions of review boards

Section 19 of the MHCA[109] lists the following powers and functions of a review board:

- consider appeals against decisions of the head of a health establishment;
- make decisions with regard to assisted or involuntary care services;
- consider reviews and make decisions on assisted or involuntary care users;
- consider 72-hour assessments made by the head of the health establishment and decide on the further provision of involuntary care services;
- consider applications for transfer of mental health care users to maximum security facilities; and
- consider periodic reports on the mental health status of the care users.

It is important to provide a detailed discussion of these powers and functions. Only the powers and functions as they relate to appeals, applications for transfer and periodic reports are discussed in what follows as the other powers have been considered above.

Consider appeals against decisions of the head of a health establishment

The review board has the power to consider appeals against the decision of the head of the health establishment on involuntary care services.[110] The

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106 MHCA (n 1), s 20(4)*(b)*.
107 MHCA (n 1), s 22(3).
108 MHCA (n 1), s 21.
109 Act 17 of 2002.
110 MHCA (n 1), s 35. The appeal must be made by a user, spouse, next of kin, partner, associate, parent or guardian and it must be made within thirty days of the date of the written notice issued by the head of the health establishment informing the applicant and giving reasons on whether to provide involuntary services or assisted services.

appeal must contain the facts and grounds on which the appeal is based.[111] After receiving the appeal, section 35(2) of the MHCA imposes the following duties and functions on the review board:[112]

- it must, through its secretariat, ensure that all documents are obtained from the head of the establishment within thirty days after receipt of the notice of appeal and delivered to the members of the review board at least one week prior to the appeal.[113]
- it must, through its secretariat and within thirty days after receipt of the notice of appeal, in writing and by registered mail inform all the relevant parties[114] of the date of the appeal[115] and whether written or oral representation, as appropriate, must be made to the review board.[116]
- it must consider the appeal within thirty days and send a written notice of its decision and the reasons for such decision to all the relevant parties.[117]

If the review board upholds the appeal, all care services administered to the care user must be stopped and any admitted care user must be discharged by the head of the health establishment unless the care user consents to the care services.[118]

It is submitted that the procedure to be followed for appeals in terms of the MHCA does not present a problem. However, there might be an issue regarding the fact that the MHCA does not give the parties the choice to make oral or written representation. Landman and Landman,[119] commenting on this issue, make the following valuable observation:

> The regulation seemingly removes the choice from the appellant and others and locates it within the secretariat acting under the instructions of the board. The regulations constitute delegated legislation and the rule is that a delegated legislature has no power to restrict the wording of the empowering

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111 MHCA (n 1), s 35(1)*(b)*. See reg 13 and 14 which provides that the appeal must be made in terms of form MHCA 15. The appeal may be made to the Review Board directly or submitted to the head of the health establishment and he/she must immediately submit the appeal to the Review Board.

112 The Review Board must comply with such duties within thirty days of the receipt of the notice of appeal.

113 MHCA, s 35(2)*(a)* and reg 15(1).

114 The appellant, the applicant, the mental health practitioners, an independent mental health care practitioner and the head of the health establishment. See MHCA, s 35(2)*(b)*.

115 The date of the hearing must be given at least two weeks before the date of such hearing. See General Regulations (n 33), reg 15(4).

116 MHCA, s 35(2)*(b)* and reg 15(2).

117 MHCA, s 35(2)*(c)* and *(d)*.

118 MHCA, s 35(3).

119 Landman and Landman, *A Practitioner's Guide to the Mental Health Care Act* (Juta 2014) 123.

enactment. Should the board only require information on a medical or technical aspect it may be appropriate to invite only written representations. But, given the low literacy status of a substantial portion of the population, insistence on written representation may deny the appellant and others a right to make any meaningful representations. There is also the therapeutic dimension that the opportunity to make an oral representation affords an appellant. Even if the regulation validly restricts the user, in some cases, to written representations, a high court may hold that the user was not given a fair hearing. Generally it would seem fair to allow an involuntary user to appear in person, whether represented or not, before a board that has the power to ameliorate her situation.

It is important that the review board consider all the relevant circumstances before requesting written representations.

The decision of the review board will be based on an inquiry as to whether:[120]

- there is a reasonable belief that the user is suffering a mental illness;
- the care user requires care services for his safety or the safety of others
- the care user is capable of making an informed decision on the need for care;
- the care user should receive care services as an outpatient or inpatient.

Consider applications for transfer of mental health care users to maximum security facilities.

The Mental Health Review Board (MHRB) will grant an application[121] for transfer of a care user to a maximum security facility if:

- the head of the health establishment applies to the review board for an order for the transfer of an assisted of involuntary care user because he or she has previously absconded or attempted to abscond, or inflicted or is likely to inflict harm on others in the health establishment;[122]
- the head of the health establishment applies for an order to transfer a state patient because he or she has or is likely to inflict harm on others;[123]
- the head of the health establishment applies for an order to transfer a mentally ill prisoner because, he or she previously absconded or attempted to abscond; or inflicted or is likely to inflict harm to any other person in the health establishment.[124]

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120 Ibid at 124.
121 The application must be made in terms of form MHCA 19. See reg 22.
122 MHCA (n 1), s 39(1).
123 Ibid s 43(3)–(4).
124 Ibid s 54(2).

In respect of transfer of an assisted and an involuntary care user,[125] the review board must not approve the request for transfer if it is aimed at punishing the care user, or it is not satisfied that the mental health status of the care user warrants a transfer.[126] If the MHRB approves the request it must on the form MHCA 20 order the transfer of the care user.[127] The head of the health establishment must effect the transfer within fourteen days of receipt of form MHCA 20.[128]

Consider periodic reports on the mental health status of mental health care users

The MHCA provides that periodical reviews must be carried out and recorded on form MHCA 13 by the head of the health establishment.[129] The MHCA requires that the review be carried out in respect of an assisted and involuntary care users, state patients, and mentally ill prisoners.[130] I limit my discussion to the periodical reports in respect of assisted and involuntary care users.

The first review must be performed within six months of the commencement of the care services[131] and thereafter every twelve months.[132] The purpose of the review is to consider: the capacity of the care user to express himself or herself on the need for care services; whether the care user is likely to inflict serious harm on himself or herself or others; and whether there are other measures less restrictive or intrusive on the right of movement, privacy and dignity of the care user.[133]

The review board must, within thirty days of receipt of the form MHCA 13, consider the report – which includes obtaining information from any relevant person – and decide on the review using form MHCA 17.[134] If the MHRB decides that the assisted or involuntary care user should be discharged, all mental health services administered to the care user must be stopped and the care user, if admitted, must be discharged.[135] The registrar of the High Court must be informed of any discharge made in terms of this Act.

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125 For the procedure for transfer of state prisoners and mentally ill prisoners see MHCA, s 43 and s 54 respectively. See also reg 22–25

126 MHCA (n 1), s 39(3).

127 See MHCA, s 39(4) and reg 23(1).

128 MHCA, s 39(5).

129 General Regulations (n 33), reg 21.

130 Ibid reg 21(1).

131 Ibid reg 21(2)*(a)*

132 Ibid reg 22(2)*(b)–(c)*.

133 MHCA (n 1), s 37(2).

134 MHCA, s 37(4), s 30(4) and General Regulations (n 33), reg 21(4).

135 See MHCA, s 37(5) and s 30(5). The mental health care user may give consent to be detained as an assisted or involuntary mental health care user.

General remarks on the nature of the Mental Health Review Board

The MHCA further grants review boards powers and functions relating to the receipt of information, reviews, appeals, requests, applications, and monitoring. The review board also has the power to determine its own procedure for conducting its business.[136]

The review board is an independent body with an oversight role and the responsibility to ensure that care users are not detained without due regard for their human rights.[137] Levinsohn DJP, in *G v Sixty-six Others*,[138] emphasises the role of review boards as follows:

> [19] Now it will have become apparent from the abovementioned review of the legislation that the legislature clearly intended to introduce a regime which was compassionate and fully compatible with human rights and in particular the Constitution. The establishment of Review Boards was a new innovation and was aimed at ensuring that the cases of mental health care users are considered by an independent body which obviously makes vital decisions in regard to the user's future. It goes without saying and is self-evident that the detention of a person in a mental institution on an involuntary basis is far-reaching involving as it does the deprivation of that person's liberty.
>
> [39] In our view Review Boards are doing what the Act intended, and that is, to act as an independent objective body to investigate and report on decisions that have been made to admit users to institutions. They have supplanted the curator-ad-litem in the repealed Act and in our view perform a very practical function in the final assessment of a user's condition.
>
> [40] When the matter is referred to the High Court there ought to be some record or minutes of what has transpired in the deliberations of the Review Board concerned. The reviewing judge will be concerned about whether the user has been properly apprised of his right to representation and whether he/she was able to understand the rights. A short report from the Board or from the health practitioner member would be of great assistance in allaying those concerns.

It is submitted that the court correctly defined the review board as an independent body intended to ensure the protection of care users. However, it may not be correct to define it as a *curator ad litem*. Landman and Landman[139] make the following argument regarding the legal nature of a review board:

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136 MHCA (n 1), s 24(1).

137 *G v Sixty-six Others* (19/2007) [2008] ZAKZHC 37, (5 June 2008) paras 17–19.

138 Ibid paras 19, 39 and 40.

139 See Landman (n 131) at 209.

> It would not, however, be entirely correct to regard a board as fulfilling the role of a *curator-ad-litem*. A board is itself the author of acts that may affect a user. When performing its functions a board does not purport to represent the user even though it would take into account the best interests of the user.
>
> A board is an organ of state exercising public powers and performing a public function in terms of an Act which may adversely affect the rights of a person and which has a direct external effect on the person. A board is therefore an administrative organ. A board is not a court of law. The Constitution provides that everyone has the right to administrative action that is lawful, reasonable and procedurally fair. Everyone whose rights have been adversely affected by administrative action has the right to be given written reasons for the decision.

They[140] further argue that the composition of the review board emphasises its oversight role. They breakdown the composition of the review board as follows:[141]

- The community member represents the interests of society in ensuring that care users are treated with the expedition, dignity and expertise available.
- The mental health care practitioner will chiefly ensure that the services afforded the user are appropriate for the situation, bearing in mind that this must be proportionate to the circumstances.
- The legal expert's primary role is to ensure that the care user's rights, freedoms, and liberties are honoured and observed, or, where infringement is permitted, are infringed as little as is compatible with optimum treatment.

MENTAL HEALTH REVIEW TRIBUNAL IN THE UNITED KINGDOM

In England and Wales the provision of mental health care is governed by the Mental Health Act (UK-MHA),[142] which provides for the care and treatment of persons with a mental disorder. The Mental Capacity Act[143] also applies to persons who lack capacity and enables care and treatment for mental and physical health conditions.[144] The Mental Capacity Act is intended to incorporate the provisions of the Convention on the International Protection of Adults[145] into UK law. Consequently, the UK-MHA is the principal legislation regulating the care and treatment of mentally ill persons in the UK.

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140 Ibid.
141 Ibid.
142 1983.
143 2005.
144 Tim Spencer-Lane,'Mind Over Matter' (2012) NLJ 20.
145 Signed at The Hague on 13 January 2000.

The UK-MHA applies to the reception, care, and treatment of mentally disordered patients, the management of their property, and other related matters.[146] Mental disorder is defined as any disorder or disability of the mind, but does not include a learning disability not associated with abnormally aggressive or seriously irresponsible conduct or dependence on drugs and/or alcohol.[147]

The UK-MHA provides for the admission of mentally disordered persons for purposes of assessment.[148] The mentally disordered person may only be detained for assessment for a period not exceeding twenty-eight days.[149] It is permitted only if he or she is suffering from a mental disorder which warrants detention and the detention is in the interests of the mentally disordered person or is necessary to protect other persons. The application for assessment must be accompanied by a written recommendation from two medical practitioners.[150] An application to detain a mentally disordered person may be made in terms of section 3 of the UK-MHA and requires proof that: the person suffers from a mental disorder which requires treatment; the detention is necessary; and appropriate medical treatment is available. The application for admission must be accompanied by written recommendations from two medical practitioners.[151] The UK-MHA also recognises that in some instances an application for assessment may need to be made on an urgent basis[152] or in respect of a patient already in hospital.[153] If the application for admission complies with the requirements set out above, it will provide sufficient authority for the detention of the mentally disordered person.[154] The UK-MHA introduces a system in terms of which detained patients may be discharged under supervision for treatment on an outpatient basis with continued medication.[155]

The UK-MHA's point of departure is that a patient's consent is not required for any medical treatment for a mental disorder from which he or she is suffering.[156] However, psychosurgery and electro-convulsive therapy may only be performed if the patient has consented to such treatment.[157] The treatment of a patient without consent must be medically necessary.[158]

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146 UK-MHA, s 1(1).
147 Ibid s 1(2)–(4).
148 Ibid s 2.
149 Ibid s 2(4).
150 Ibid s 2(2).
151 Ibid s 3(3).
152 Ibid s 4.
153 Ibid s 5.
154 Ibid s 6.
155 Ibid s 17A.
156 Ibid s 63.
157 Ibid s 57, s 58 and s 58A.
158 Peter Bartlett, 'The Necessity Must be Convincingly Shown to Exist: Standard for Compulsory Treatment for Mental Disorder Under the Mental Health Act 1983' Medical Law Review (2001) 19(4) 514 at 516

The following factors will be considered in determining the necessity of treating a patient without consent:[159]

- how certain is it that the patient suffers from a treatable disorder;
- how serious is the disorder;
- how serious a risk is presented to others;
- how likely is it that, if the patient does suffer from such a disorder, the proposed treatment will alleviate the condition;
- how much alleviation is there likely to be;
- how likely is it that the treatment will have adverse consequences for the patient; and
- how severe may they be?

It is submitted that the UK-MHA does not differ materially from the South African Mental Health Care Act 17 of 2002 as regards basic principle and it is unnecessary to discuss the UK-MHA in greater detail. However, the provisions regarding the MHRT and the IMHA are very important and could prove useful in the South African context. I discuss only the relevant provision below.

Section 65 of the UK-MHA provides for the constitution of MHRTs to deal with applications and referrals by and in respect of patients under the UK-MHA.[160] The application may be made to the tribunal in respect of:[161]

- a patient admitted for assessment;
- a patient admitted for treatment; and
- a detained patient in respect of whom a community treatment order is made or revoked.

The manager of the hospital is required to refer the patient's case to the tribunal six months after his or her admission for assessment or treatment.[162] The manager of the hospital is also required to submit the patient's case after three years subsequent to the case having been considered by the tribunal, or after the community order has been revoked.[163] The MHRTs have, inter alia, the following powers:

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159 Ibid at 532.
160 UK-MHA, s 65(1 A).
161 Ibid s 65.
162 Ibid s 68(2).
163 Ibid s 68(6).

- to reduce the periods for the submission of the patient's case by the manager of the hospital;[164] and
- to direct the discharge of qualifying patients.[165] This is regarded as its primary function.[166]

The MHRT is regarded as a court in the United Kingdom. In deciding the nature of the MHRT the court of appeal made the following finding in *Pickering v Liverpool Daily Post and Echo Newspapers plc*:[167]

> If such a tribunal is not a 'court' for all purposes, the Human Rights Convention is not being complied with, since there is no indication that 'court' in the convention has any different meaning from that which it bears in English law. However, I have no doubt that in law a mental health review tribunal is a court. Contrary to what is stated in the Associated Newspaper Group case, it did not inherit an executive function. It was given a new and quite different function. I would only add that I can see no reason why, as the Divisional Court appears to have held, the touchstone for determining whether a body is a court should be its ability to deprive a citizen of his liberty. One of the oldest and most important duties of the High Court is to restore liberty to a citizen by means of a writ or order of habeas corpus. Nor do I appreciate the relevance of the fact that the patient has a right to renew his application every year in deciding whether or not such a tribunal is a court. In my judgment, in so far as A-G v Associated Newspapers Group plc [1989] 1 All ER 604, [1989] 1 WLR 322 decided that a mental health review tribunal was not a court, it was wrongly decided and should not be followed.

This decision is supported in *Regina v East London and the City of Mental Health NHS Trust and another (Respondents); ex Parte con Brandenburg (aka Hanley) (FC) (Appellant)*.[168] In terms of clause 32.2 of the Code of Practice: UK-MHA, an MHRT is regarded as an independent judicial body to review the cases of detained, conditionally discharged and supervised community treatment patients under the UK-MHA, and to direct the discharge of any patient as it considers appropriate. The classification of the MHRT must be understood with reference to the Tribunals, Courts and Enforcement Act (UK-TCEA).[169] The UK-TCEA provides for a change in the tribunal system.[170] Section 3 of the UK-TCEA provides for a First-

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164 Ibid s 68A.
165 Ibid s 72(1).
166 *T v Mental Health Review Tribunal* [2002] EWHC 247, (Admin) (22 February 2002).
167 [1990] 1 All ER 335 (CA) 341F–J. The decision was confirmed on appeal in *Pickering v Liverpool Daily Post* [1991] 1 All ER 622 (HL).
168 [2003] UKHL 58.
169 2007.
170 UKTCEA, s 3.

Tier Tribunal and the Upper Tribunal, which is a superior court of record consisting of judges and other members. The UK-TCEA consolidates all the tribunals and creates a single system for the proceedings of tribunals created in terms of any other law, including the UK-MHA.[171] The functions of the MHRT for the region of England have been transferred to the First-Tier Tribunal, and are therefore regulated under the UK-TCEA.[172] The MHRT for the region of Wales remains under the UK-MHA.[173]

The MHRT consists of persons with legal experience, registered medical practitioners, and persons whom the Lord Chancellor considers to have suitable experience.[174] One of the legal members is appointed chairman of the tribunal.[175] Section 78A of the UK-MHA provides for appeal to the Upper Tribunal on any point of law arising from a decision of the MHRT.[176]

The UK-MHA provides further for the appointment of persons as Independent Mental Health Advocates (IMHAs) to assist qualifying patients.[177] The person appointed to act as an IMHA must be independent of any person who is professionally concerned with the patient's medical treatment.[178] The functions of the IMHA include:[179]

- assisting a qualifying patient to obtain and understand the provisions of the UK-MHA, the medical treatment administered, proposed, or discussed in respect of the patient, and why it is given, proposed or discussed, and the authority under which the medical treatment is given, proposed or discussed;
- assisting a qualifying patient to obtain and understand any rights available in terms of the UK-MHA and representing him or her in the exercise of his or her rights in terms of the UK-MHA;
- visiting and interviewing a patient privately and any person professionally connected with the qualifying patient in order to assist the qualifying patient; and
- requiring the production of and inspecting any records relating to a qualified patient's detention or treatment.

IMHAs provide an additional safeguard for qualifying patients.[180] They are trained specifically to work within the framework of the UK-MHA to

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171 s 3(1).
172 UK-TCEA, s 6 and sch 6 pt 1.
173 UK-MHA, s 78.
174 UK-MHA, s 1 of sch 2.
175 s 3.
176 UK-MHA, s 78 A(1).
177 s 130 A(1).
178 s 130 A(4).
179 s 130 B.
180 Cl 20.1 of the Code of Practice: The UK-MHA.

meet the needs of patients.[181] Although they are not intended to replace any other services available to the patient, they operate together with the other services.[182] IMHA may only be appointed for a person liable to be detained in terms of the UK-MHA, subject to a guardianship under the UK-MHA, a community patient, and for qualifying patients in terms of section 130C(3) of the UK-MHA.[183] Qualifying patients have the right to be informed that help is available in the form of an IMHA and how to access these services.[184] The information must be given in writing to the qualifying patient.[185]

The main benefit of IMHAs is to ensure that mental health patients have a voice.[186] The following comments published in the September/October 2012 issue of *Mental Health Today*, highlight the importance of having IMHAs:[187]

> She came in to see me and started talking to me. She said 'have you got a review?' and 'what are your problems?' and went through everything with me… and so we started talking and as you're talking you start to think, oh yeah, I should say this.

And

> It's not changed anything that's happening here at all. [But] it's made me feel better within myself because people are treating me as a human being and not a bit of dirt under their feel. [I]t gives you confidence within yourself.

The use of IMHAs has been well received.[188] However, there are certain issues which require improvement but these relate to implementation rather than the overall structure of the IMHA system.[189] Notable in this regard are failure by the responsible authority to provide some patients with information regarding IHMAs and lack of resources.[190] A patient may choose to end the support they are receiving from an IMHA at any time, and may also elect not to accept the services.[191]

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181 Cl 20.1.
182 Cl 20.2.
183 UK-MHA, s 130 C.
184 Ibid s 130 D(1).
185 Ibid s 130 D(5).
186 Mental Health Today, 'The Right to be Heard: Independent Mental Health Advocacy Services in England' (*Mental Health Today,* September/ October 2012) <www.uclan.ac.uk/research/explore/projects/assets/mental_health_wellbeing_mht_the_right_to_be_heard.pdf> accessed 10 December 2015.
187 Ibid.
188 Ibid.
189 Ibid.
190 Care Quality Commission Monitoring the Mental Health Care Act Report 2010/2011 <www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf> accessed 2 May 2017.
191 Cl 20.17 and 20.18 of the Code of Practice: The UK-MHA.

CONCLUSION

An MHRB is an independent body which is classified as an organ of state exercising public power but is not recognised as a court of law. There is general dissatisfaction with the functioning of MHRBs in South Africa.[192] They are guided only by the principles of legality – in that they may only act if legally authorised to do so – and the principles of natural justice – insofar as they must give all sides the opportunity to present their cases. There are no general rules of procedure which apply to all the MHRBs. The general principles of the PAJA apply to all the MHRBs. Lessons could be learnt from the United Kingdom's MHRT and the First-Tier Tribunal as regards mental health care. In the UK, MHRTs operate under rules of procedure and mechanisms aimed at case management.

There is a need for uniform rules of procedure applicable to all MHRBs. The impression created with regard to MHRBs in South Africa, is that they are free to formulate their own procedure provided it complies with the rule of legality and natural justice. There needs to be a shift from MHRBs in their current form, to the establishment of a review body with procedural rules similar to those of the UK-MHRT and the First-Tier Tribunal as regards mental health care. The MHCA needs to enact uniform rules of procedure for the MHRBs in order to ensure their operation and that all

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[192] Chris Bateman 'Dismal use Of Legal Safety Net for Mental Health Patients' SAMJ 2012 102 (2) 72. See Taylor (n 7) 14 where she makes the following observation: 'A small body of research is growing that gives us an indication of how the MHRBs [Mental Health Review Boards] are functioning. Each Review Board operates independently and is responsible only for its own jurisdiction, so it is unwise to make generalisations, but observations thus far raise grave concerns about their capacity to safeguard rights. A survey of 49 designated psychiatric care facilities in KwaZulu-Natal published in 2010 elicited significant dissatisfaction with MHRB involvement in and oversight of mental health care. Observations include unacceptably long response times for review board decisions and a sense that "decisions of the medical staff at these hospitals were accepted by the Board without investigation, and that these hospitals lodged no complaints or appeals". The investigators also report a perception that the MHRBs have demonstrated a lack of concern for suboptimal conditions in the facilities under their jurisdiction, despite their 15 specified role in investigating "abuse, neglect, and exploitation" of MHCUs [Mental Health Care Users].' See also Suvira Ramlall 'The Mental Health Care Act No 17 – South Africa: Trials and Triumphs: 2002–2012' (*AJOL*, 2012) <http://www.ajol.info/index.php/ajpsy/article/view/83478/73514> accessed 9 September 2016. Ramlall stated that: 'Procedurally they [Mental Health Review Board] are expected to report directly to their provincial health ministers who refuse to meet with them. Activity levels vary with 80% of KZN hospitals not having had a single visit in a six month period. MHRBs were generally perceived as being unhelpful in addressing practical issues, difficult to communicate with and lacking power to meaningfully contribute to transformation of neglected services. Problems pertaining to poor clinician-review board relations ('obstructive and dismissive of clinicians'), remuneration, training, supervision and professional boundaries of MHRB members were highlighted. The limited powers accorded to the Board rendered them ineffective in summoning investigations in cases of abuse and exploitation. Despite these challenges, reports of well-functioning boards, committed to championing mental health and taking initiatives to promote and advocate for mental health bear testimony to their potential to fulfil their legislated responsibility if they were appropriately supported and resourced.'

review boards function uniformly. Therefore, it is recommended that the UK-MHRT model should serve as a point of reference in establishing a new MHRB system for South Africa.

It has been found that there is a low level of contact between the mental health establishment and the MHRBs and in many cases the boards have not visited the mental health establishments to ensure that mentally ill persons detained are afforded their rights.[193] Bateman[194] makes the following observation regarding the situation in Kwazulu-Natal:

> In KwaZulu-Natal, a July 2009 review of 49 regional and district hospitals designated by the Act to admit, observe and treat mental health care patients (for 72 hours before admission to a psychiatric hospital) found them to have inadequate staff and infrastructure, high administrative loads and a low level of contact with review boards. Over 80% had not been visited by a review board in the preceding 6 months. KwaZulu-Natal had 25% of the acute psychiatric beds and 25% of the psychiatrists required to comply with national norms. There was 'little evidence of government abiding by its public commitments to redress the inequities that characterise mental health services'.

The MHCA provides a right to legal representation for mentally ill persons in proceedings before an MHRB or a court of law. This right does not, however, extend to representation in any other instances.

The introduction of IMHAs who will be responsible for assisting mentally ill persons detained in terms of the MHCA by informing them of their rights and ensuring that their rights are respected, would be welcome and would strengthen the protection of the rights of mental health care users under the MHCA and the Constitution. These advocates must be independent of all institutions and should not replace legal representatives. This will ensure that the rights of mentally ill persons detained within the mental health establishment are protected and that they are aware of their rights. The advocate should be a qualified social worker well versed in the workings of the MHCA.

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193 Chris Bateman, (n 192).
194 Ibid.