Community-based mental health care for adults with psychosocial disabilities in South Africa through a right to health lens

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Thesis presented in fulfilment of the requirements for the degree of Master of Laws in the Faculty of Law at Stellenbosch University

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SUMMARY

There has been a shift, globally, from institutionalisation as the primary response to psychosocial disability, to community-based mental health care. This thesis sets out to determine the extent to which the legal and policy frameworks which govern community-based mental health care for adult persons with psychosocial disabilities in South Africa comply with constitutional and international law standards relevant to the right to health.

First, by analysing the right of access to health care services in section 27 of the South African Constitution, relevant normative standards for community-based mental health care are established. Further, the negative and positive constitutional obligations in respect of the right of access to health care services are discussed.

Following the analysis of constitutional norms and obligations, four key regional and international human rights instruments are analysed, with the right to health as the primary lens. A key part of this analysis is the consideration of two frameworks: the normative standards of “availability”, “accessibility”, “acceptability”, and “quality”; and the obligations to “respect”, “protect” and “fulfil”.

These constitutional and international law standards are then applied to evaluate the mental health care legislation, policy and practice relevant to community-based mental health care – specifically, the Mental Health Care Act 17 of 2002, the National Mental Health Policy Framework and Strategic Plan 2013-2020, and the White Paper on the Rights of Persons with Disabilities of 2016.

On the basis of this evaluation, this thesis finds that the framework does generally align with the constitutional and international law standards. However, the translation of this framework into practice is deficient in a number of ways. These deficiencies include: the absence of effective monitoring and information systems; insufficient resource allocation; the inequitable distribution of goods, facilities and services; a lack of clarity on the applicable standards for quality, ethical care; and poorly functioning oversight and accountability mechanisms. Consequently, this thesis concludes by making recommendations to improve the alignment of South Africa’s system of community-based mental health care with constitutional and international law standards.

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OPSOMMING

Wêreldwyd word institutionalisering, voorheen die primêre respons op psigososiale gestremdheid, vervang met ’n sisteem van gemeenskapsgebaseerde geestesgesondheidsorg. Hierdie tesis stel vas tot watter mate die wetlike en beleidsraamwerke wat gemeenskapsgebaseerde geestesgesondheidsorg vir volwassenes met psigososiale gestremdhede in Suid-Afrika reguleer, voldoen aan grondwetlike en internasionale reg standaarde wat van toepassing is op die reg op gesondheid.

Eerstens, deur die reg op toegang tot gesondheidsorg in artikel 27 van die Suid-Afrikaanse Grondwet te ontleed, word relevante norme vir gemeenskapsgebaseerde geestesgesondheidsorg vasgestel. Verder word die negatiewe en positiewe grondwetlike verpligtinge in verband met die reg op toegang tot gesondheidsorg vasgestel.

Na aanleiding van die analise van die grondwetlike norme en verpligtinge, word vier belangrike streeks- en internasionale menseregte-instrumente ontleed, met die reg op gesondheid as die primêre lens. ‘n Kern-aspek van hierdie analise is die oorweging van twee raamwerke: die normatiewe standaarde van “beskikbaarheid”, “toeganklikheid”, “aanvaarbaarheid” en “kwaliteit”; en die verpligtinge om die reg te “eerbiedig”, te “beskerm”, en te “verwesenlik”.

Hierdie grondwetlike en internasionale regstandaarde word dan toegepas om die wetgewing, beleid en praktyk wat verband hou met gemeenskapsgebaseerde geestesgesondheidsorg, te evalueer – naamlik, die Wet op Geestesgesondheidsorg 17 van 2002, die Nasionale Geestesgesondheidsorgbeleidsraamwerk en Strategiese Plan 2013-2020, en die Witskrif oor die Regte van Persone met Gestremdhede van 2016.

Na aanleiding van hierdie evaluasie, word daar bevind dat die raamwerk wel tot ’n groot mate in ooreenstemming is met die grondwetlike en internasionale reg standaarde. Daar word egter verder bevind dat daar ernstige tekortkominge is in terme van die implementering van hierdie raamwerk. Hierdie tekortkominge sluit in: die afwesigheid van effektiewe moniterings- en inligtingstelsels; onvoldoende hulpbrontoewysing; die ongelyke verspreiding van goedere, fasiliteite en dienste; onduidelikheid oor die toepaslike standaarde in verband met die kwaliteit en etiese

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vlakke van sorg; en swak funksionerende oorsig- en aanspreeklikheidsmeganismes. Gevolglik sluit hierdie tesis af deur aanbevelings te maak om Suid-Afrika se sisteem van gemeenskapsgebaseerde geestesgesondheidsorg in ooreenstemming te bring met grondwetlike en internasionale regstandaarde.

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To Alexander: I am beyond grateful to have you as my partner and best friend.

Aan my ouers, Bun en Suzette: dankie vir jul liefde en omgee.

Of the many lessons learned while writing this thesis, there is one truth I will never forget. That is, to be unmoved by the suffering of those most vulnerable, is not simply to be neutral. Where people are denied their fundamental human rights, indifference is no longer indifference. It is cruelty.

May we challenge ourselves to do more, to do better, to be better.

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ABBREVIATIONS AND SHORT TITLES

ACHPR	African Charter on Human and Peoples' Rights
African Commission	African Commission on Human and Peoples' Rights
African Court	African Court on Human and Peoples' Rights
African Disability Protocol	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa
CBMHC	Community-based mental health care
CESCR	Committee on Economic, Social and Cultural Rights
CRPD	Committee on the Rights of Persons with Disabilities
DPO	Disabled persons' organisation
Gauteng Mental Health Marathon Project	Marathon Project
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICS	Ideal Clinic Status
MHCA	Mental Health Care Act 17 of 2002
mhGAP	Mental Health Gap Action Programme
mhGAP Manual	mhGAP Operations Manual
Nairobi Guidelines	Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights
NGO	Non-governmental organisation
NMHPF	National Mental Health Policy Framework and Strategic Plan 2013-2020

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Parliamentarians' Handbook	Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol
PWD	Persons with disabilities
PWPSD	Persons with psychosocial disabilities
Review Board	Mental Health Review Board
SAHRC	South African Human Rights Commission
SALRC	South African Law Reform Commission
UN	United Nations
UN Disability Convention	Convention on the Rights of Persons with Disabilities
WHO	World Health Organization
WHO Action Plan	World Health Organization Mental Health Action Plan 2013-2020
WPRPD	White Paper on the Rights of Persons with Disabilities of 2016

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NOTE REGARDING REFERENCING STYLE

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CHAPTER 1: INTRODUCTION

1 1 Background and research problem

In 1699, "a small enclosed apartment for locking up the mad" was established near the Company Gardens in Cape Town.[1] This facility was one of the first of many colonial and apartheid era institutions designated to house those considered to be "lunatics", "madmen" or "insane".[2] The conditions of care and treatment at these facilities were questionable, particularly in the segregated facilities reserved for persons of colour. For example, a report by the Mental Hospitals Departmental Committee in 1937 observed overcrowding in dormitories for "non-Europeans", noting that, "it is not to be wondered at that in a recent instance a patient was murdered by a fellow patient in the next bed before the attendants could intervene."[3] More recently, mental health care was regulated by the Mental Health Act 18 of 1973. This legislation, which similarly favoured institutionalisation, has since been described as "unashamedly focused on control and treatment of patients", with health care professionals forced to be "both doctor and gaoler".[4]

However, starting in the 1970s, many states began to reject institutionalisation as the primary response to psychosocial disability.[5] Instead, systems of community-based mental health care ("CBMHC") were developed. The World Health Organization ("WHO") describes the key aims of CBMHC as follows:

> "Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings... using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres,

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[1] L Gillis "The historical development of psychiatry in South Africa since 1652" (2012) 18 *SAJP* 78 78.
[2] J Parle "Mental Illness, Psychiatry, and the South African State, 1800s to 2018" (2019) *Oxford Research Encyclopedia of African History* 1 2.
[3] J Louw "Building a Mental Hospital in Apartheid South Africa" (2019) 22 *Hist. Psychol.* 351 353.
[4] J K Burns "Implementation of the Mental Health Care Act (2002) at District Hospitals in South Africa: Translating Principles into Practice" (2008) 98 *SAMJ* 46 46.
[5] See World Health Organization Comprehensive Mental Health Action Plan 2013-2020 (adopted May 2013) 49: "Psychosocial disabilities refer to people who have received a mental health diagnosis, and who have experienced negative social factors including stigma, discrimination and exclusion. People living with psychosocial disabilities include ex-users, current users of the mental health care services, as well as persons that identify themselves as survivors of these services or with the psychosocial disability itself." Further, see F Mahomed "Stigma on the Basis of Psychosocial Disability: a Structural Human Rights Violation" (2016) 32 *SAJHR* 490 491, where the author notes that the term psychosocial disability "...correctly aims to shift the emphasis of a perceived 'impairment' to an environment that inadequately caters to the rights of a person with special needs".

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support of people with mental disorders living with their families, and supported housing."[6]

The WHO has further identified a number of services as being integral to a system of CBMHC, namely, crisis services, hospital-based services, community mental health services, outreach services, supported living services and peer support services.[7] The WHO has further emphasised that the term "CBMHC" does not simply refer to any care received near the user's community, but rather to a range of services of a specific nature:

> "However, what is also essential is that care and support is personalized, inclusive, comprehensive and rights-based, and actively contributes to independent living and community inclusion. Further, community-based mental health care is not a single entity but involves a range of services and interventions in order to provide for the different support needs of people, in particular crisis support, ongoing treatment and care, and community living and inclusion."[8]

To clarify what is understood under the term "CBMHC", the WHO has identified the "emerging network" of services in Peru as an example of good practice in the area of CBMHC. In the Peruvian National Plan for Mental Health, approved in 2006, the prioritisation of CBMHC was identified as one of four key objectives.[9] The Peruvian system of mental health care has since seen significant reform, as reported by the WHO in 2021.[10] The state has established "community mental health centres", where PWPSD can receive psychosocial and pharmacological treatment near their place of residence. Improvements have been made to the provision of mental health care at general primary health care centres, by providing training and supervision to non-specialised staff and by improving the systems for referral of PWPSD to community mental health centres. To decrease the number of PWPSD living in psychiatric hospitals, the state has invested in alternative accommodation, where mental health care is offered on a voluntary basis, aimed at improving the capacity of PWPSD to live and participate in their communities.

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[6] World Health Organization *Mental Health Action Plan 2013-2020* (adopted May 2013) 15.

[7] World Health Organization *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches"* (2021). Available: https://qualityrights.org/resources/promoting-person-centred-rights-based-community-mental-health-services/.

[8] 188.

[9] M Toyama, H Castillo, J Galea, L Brandt, M Mendoza, V Herrera, M Mitrani, Y Cutipe, V Cavero, F Diez-Canseco & J Miranda "Peruvian Mental Health Reform: A Framework for Scaling-up Mental Health Services" (2017) 6 *Int J Health Policy Manag* 501 503.

[10] World Health Organization *Guidance on Community Mental Health Services* (2021) 171-172.

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According to the WHO, community-based services such as these must be designed in line with a recovery approach.[11] In terms of this approach, the primary focus is to empower and support PWPSD, so they are able to lead a life that they find meaningful and take up roles that they consider to be fulfilling.[12] This is also the central aim of community-based rehabilitation, which is a component of CBMHC.[13] Community-based programmes fulfil a crucial function:

> "Further, given the barriers for people with disabilities accessing even clinic services, it is clear that if primary prevention fails and no rehabilitation is available, further preventive and health-promoting services become progressively less accessible, resulting in a downward spiral of ill health and disability."[14]

To avoid this "spiral", deinstitutionalisation initiatives must be accompanied by investment in rehabilitation and the other community-based services described above. In the absence of a functioning system of CBMHC, PWPSD who are discharged from institutions may experience relapse and readmission. Further, without a clear legislative and policy framework to govern CBMHC, treatment programmes which are harmful to PWPSD may continue to operate under the guise of being a form of CBMHC.

In the South African context, the most infamous recent initiative is the Gauteng Mental Health Marathon Project ("Marathon Project"). The Gauteng Department of Health terminated its contract with the Life Esidimeni facility, where a number of persons with psychosocial disabilities ("PWPSD") were receiving mental health care. What followed was the hurried, mass transfer of PWPSD from the Life Esidimeni facility to the custody of inappropriately equipped community-based health care providers. As a consequence, an estimated 144 PWPSD died. One of the first casualties of the Marathon Project was Deborah Phetla, who had been transferred to Takalani Home, a non-governmental organisation ("NGO"):

> "Mrs Maria Phetla testified that the post-mortem conducted on her daughter, Deborah, revealed that she had plastic and brown paper in her stomach. She also testified that

[11] In addition to the recovery approach, the WHO recommends the following criteria to be considered in the design of a system of CBMHC: respect for legal capacity; non-coercive practices; participation of PWPSD; and community inclusion. See World Health Organization *Guidance on Community Mental Health Services* (2021) 6-11.

[12] World Health Organization *Guidance on Community Mental Health Services* (2021) 10; World Health Organization *Community-Based Rehabilitation: CBR Guidelines* (2010) 1 14.

[13] World Health Organization *CBR Guidelines* (2010) 5.

[14] K Sherry "Disability and Rehabilitation: Essential Considerations for Equitable, Accessible and Poverty-Reducing Health Care in South Africa" (2014) *S. Afr. Health Rev* 89 93.

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> Deborah had been kept in solitary confinement in a small room and she suspects that the care givers at Takalani Home probably forgot to give her food, water and warm clothing."[15]

Despite the horrific circumstances of Deborah Phetla's death at such an early stage in the Marathon Project, the Project was not halted until a further 142 PWPSD had died as a result of neglect and abuse.[16] During the subsequent arbitration proceedings before former Deputy Chief Justice Dikgang Moseneke, the government officials who had initiated the Marathon Project testified that the termination of the contract with Life Esidimeni, and subsequent transfer of patients, was motivated by a commitment to deinstitutionalisation.[17] However, during the arbitration, it was found that the "claimed deinstitutionalisation was riddled with several defects",[18] echoing the findings of the Health Ombud that the Project had "defeated the very essence of community care".[19]

While the Marathon Project is thus not considered an example of CBMHC, it speaks to a structural issue, namely, the persistent disregard for and under-prioritisation of the human rights of PWPSD. The atrocities of the Marathon Project reflect the historical approach to mental health care described above, in terms of which PWPSD are not regarded as rights bearers, guaranteed certain freedoms and entitlements. Accordingly, the research problem that this study investigates is what the implications would be of a human rights-based approach to health care for PWPSD, and the extent to which the legal and policy framework which governs CBMHC for adult PWPSD in South Africa aligns with such a rights-based approach.

1 2 Research question, aims and hypotheses

The primary research question of this thesis is: to what extent do the legal and policy frameworks governing the shift to community-based mental health care for adult PWPSD in South Africa comply with constitutional and international law standards relevant to the right to health care? The primary hypothesis in this regard

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[15] *In the Arbitration between: Families of Mental Health Care Users Affected by the Gauteng Mental Marathon Project and National Minister of Health of the Republic of South Africa, Government of the Province of Gauteng, Premier of the Province of Gauteng, MEC for Health: Province of Gauteng before Justice Dikgang Moseneke* (2018) ("*Marathon Project Arbitration"*) para 88.
[16] Para 80.
[17] Para 27.
[18] Para 30.
[19] Office of the Health Ombud *The Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (2018) 18.

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is that, evaluated in light of the relevant constitutional and international law standards, there are a number of shortcomings in the legislative and policy framework, particularly in respect of its implementation. To engage further with this question, five key research aims have been identified, each with a corresponding hypothesis.

The first aim is to analyse section 27 of the Constitution of the Republic of South Africa, 1996 ("Constitution") in order to establish the normative standards applicable to the right of access to health care for PWPSD in South Africa, as well as the relevant obligations on the state. The corresponding hypothesis is that section 27 requires mental health care legislation, policy and practice to respect the human dignity of PWPSD, to promote their participation and integration in community life, and to acknowledge their status as vulnerable group. These normative factors should play a central role in evaluating the reasonableness of measures adopted to realise the right of access to health care services, the time frames for their implementation, and resource allocation for the realisation of the right.

The second aim is to analyse international human rights law in order to identify relevant international normative standards for CBMHC, as well as the corresponding state obligations. The corresponding hypothesis is that relevant international treaties, and their interpretation by the relevant supervisory organs, provide important normative standards relevant to a community-based system of health care for adults with psychosocial disabilities. These are the International Covenant on Economic, Social and Cultural Rights ("ICESCR"),[20] the Convention on the Rights of Persons with Disabilities ("UN Disability Convention"),[21] the African Charter on Human and Peoples' Rights ("ACHPR"),[22] and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa ("African Disability Protocol").[23]

The third aim is to analyse relevant features of South African mental health care legislation and policy applicable to CBMHC. The corresponding hypothesis is that key aspects of the regulatory framework relevant to community-based health care

[20] Adopted 16 December 1966, entered into force 3 January 1976, 993 UNTS 3.
[21] Adopted 13 December 2006, entered into force 3 May 2008, 2515 UNTS 3.
[22] Adopted 27 June 1981, entered into force 21 October 1986, 1520 UNTS 217.
[23] Adopted 29 January 2018, not yet entered into force.

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are contained in a disparate set of legislation, White Papers, policy and programme documents.

The fourth aim is to evaluate South African mental health care legislation, policy and practice in light of the relevant constitutional and international law standards. The guiding hypothesis in this respect is that the legislative and policy framework, and its translation into practice, fall short of a number of the constitutional and international law standards, including in respect of the allocation of resources as well as the involvement of PWPSD and their representative organisations in the development and monitoring of the system of CBMHC.

Finally, this thesis aims to recommend improvements to the current system of CBMHC in South Africa to promote better alignment with the relevant constitutional and international law standards. The relevant hypothesis is that constitutional and international human rights norms provide standards which can inform recommendations for improvements in the system of community-based health care services for adults with psychosocial disabilities in South Africa in a range of areas, including budgeting, policy, and legislation.

1 3 Scope of study

The scope of this research is delimited in five key respects. First, this research focuses only on adult PWPSD, and not children with psychosocial disabilities. While mental health care for children is undoubtedly essential, children's rights represent a highly specialised area of law, particularly in light of international and regional instruments focused on children's rights. This thesis aims to develop, first, an understanding of the relevant legal and policy frameworks as they apply to adult PWPSD.

Second, the right to health is the primary lens for this research. While psychosocial disability is a relevant research focus in respect of a number of socio-economic rights, this research focuses on the right to health. Other rights, such as the right to live independently in the community and the right to habilitation and rehabilitation, are referred to only insofar as they contribute to a clearer understanding of the normative standards and obligations flowing from the right to health.

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Third, in respect of the right to health, this thesis focuses primarily on the care dimensions of the rights to health whilst acknowledging their interconnections with the promotion and protection dimensions of health. The care dimensions of the right to health elaborated in this thesis will also be useful in elaborating on the promotion and prevention dimensions of the right to health. For example, appropriate care in a community setting overlaps with the dimension of prevention, as such care is essential to prevent PWPSD experiencing a relapse.

Fourth, the scope of this research is limited in respect of the three legislative and policy instruments identified for analysis and evaluation. The first of these is the Mental Health Care Act 17 of 2002 ("MHCA"), the primary mental health care legislation in South Africa. The second is the National Mental Health Policy Framework and Strategic Plan 2013-2020 ("NMHPF"). While this instrument has lapsed, no progress has been made in the development of a new policy.[24] Further, this instrument is both relevant and useful for this research, as the NMHPF and its implementation are the focus of the majority of recent literature on mental health care in South Africa. Finally, the White Paper on the Rights of Persons with Disabilities ("WPRPD") was selected, for its potential contribution in setting out the principles intended to guide the interpretation of the MHCA and NMHPF. The proposed National Health Insurance ("NHI") Bill is excluded from this research. Currently, the Bill contains little detail on CBMHC. Submissions from DPOs or persons working in the field of mental health care are yet to be considered.[25] Consequently, the implications that NHI may have for CBMHC cannot be easily ascertained at this point. Further, as the proposed NHI will build on existing legislation and policy, it was decided to analyse and evaluate, first, the three instruments identified above. NHI may present a relevant area of research in future.

Finally, this research will focus on four international human rights instruments in deriving normative standards and corresponding obligations in respect of CBMHC.

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[24] B Patel & L de Beer "Mind field: SA urgently needs a new mental health policy" (17-05-2021) *Daily Maverick* <https://www.dailymaverick.co.za/article/2021-05-17-mind-field-sa-urgently-needs-a-new-mental-health-policy> (accessed 10-10-2021).

[25] See, for example, S Kleintjes, D den Hollander, S Pillay & A Kramers-Olen "Strengthening the National Health Insurance Bill for Mental Health Needs: Response from the Psychological Society of South Africa" (2021) 51 *S Afr J Psychol* 134-146. The authors discuss a number of "core concerns related to the Bill", including improving, overall, the integration of mental health care into the Bill. Further, the authors comment: "Finally, we urge government to take seriously all submissions and commentary on the NHI Bill… We discovered in early March 2020 that our November 2019 submission was not officially captured, requiring a substantial back-and-forth process to rectify this…"

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The ICESCR, UN Disability Convention, ACHPR, and African Disability Rights Protocol, and the work of the relevant supervisory bodies, provide international and regional perspectives. Other instruments may provide opportunities for further research, particularly in respect of CBMHC for groups such as children, but these instruments are beyond the scope of this research.

1 4 Methodology and theoretical framework

How psychosocial disability is conceptualised determines which rights are afforded to PWPSD, the manner in which those rights are realised, and how urgent the realisation of those rights is deemed.[26] The shift from institutionalisation to CBMHC reflects a shift in conceptualisations of psychosocial disability: from a medical model to a social model and, finally, to a human rights-based model.[27]

The medical model frames disability as a deviation from the norm of able-bodiedness which requires rectification.[28] This model – alternatively termed the "personal tragedy theory" – is criticised for placing undue focus on individual impairment while neglecting the disabling effect of societal or institutional acts or omissions, thereby allowing the state to justify its failure to realise the rights of persons with disabilities ("PWD").[29]

The social model improves on the medical model, by drawing a distinction between "impairment" and "disability", with the latter referring to the barriers created by the failure of society and institutions to respond appropriately to impairment.[30] This model identifies such failures as a structural violation against PWD.[31] While

[26] S Braathen, A Munthali & L Grut "Explanatory Models for Disability: Perspectives of Health Providers Working in Malawi" (2015) 30 *Disabil. Soc.* 1382 1383.
[27] While these models were conceived to understand a broad range of disabilities, the models have also been applied to PWPSD in particular. See, for example: J Mulvany "Disability, Impairment or Illness? The Relevance of the Social Model of Disability to the Study of Mental Disorder" (2000) 22 *Social. Health Illn.* 582-601; P Beresford "Thinking About 'Mental Health': Towards a Social Model" (2002) 11 *J. Ment. Health* 581-584.
[28] T Degener "Disability in a Human Rights Context" (2016) 5 *Laws* 1 2; Beresford (2002) *J. Ment. Health* 582.
[29] Braathen et al (2015) *Disabil. Soc.* 1384; Watermeyer & Swartz "Introduction and Overview" in *Disability and Social Change: a South African Agenda* 1; C Ngwena "Interpreting Aspects of the Intersection between Disability, Discrimination and Equality: Lessons for the Employment Equity Act from Comparative Law" (2005) 16 *Stell LR* 210 221.
[30] Beresford (2002) *J. Ment. Health* 583; F Bhaba "Disability Equality Rights in South Africa: Concepts, Interpretation and the Transformative Imperative" (2009) 25 *SAJHR* 218 223.
[31] Bhabha (2009) *SAJHR* 223-224; M Priestley "Developing Disability Studies Programmes: the International Context" in B Watermeyer, L Swartz, T Lorenzo, M Schneider & M Priestley (eds) *Disability and Social Change: A South African Agenda* (2006) 19 22.

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more progressive than the medical model, the social model has also been criticised on the basis that the impairment-disability dichotomy risks overemphasising the role of social relations as a source of disempowerment and thereby fails to respond to the lived experiences of impairment.[32] Further, while the social model does provide a deeper understanding of disability, critics argue that the model does not provide sufficient guidance for the creation of mechanisms necessary to address the rights-based issues central to the experience of disability.[33]

While the social model has been described as "a model of disability", the human rights-based model has been characterised as "a model of disability *policy*".[34] In other words, the human rights-based model is more "prescriptive" in nature, rather than being mostly "descriptive" of the social dynamics relating to impairment and disability.[35] However, it must be noted that rights-based approaches have been criticised, including on the basis that they are often "fraught with definitional issues".[36] Consequently, the following paragraphs define the human rights-based model employed in this thesis, first, generally, and thereafter, in the context of CBMHC.

The human rights-based model of disability aims to provide a "roadmap for change", by enshrining a range of freedoms, entitlements, and protections as rights.[37] This model is founded on the universality of human dignity, as Quinn and Degener explain:

> "Human dignity is the anchor norm of human rights…The human rights model focuses on the inherent dignity of the human being and subsequently, but only if necessary, on the person's medical characteristics. It places the individual centre stage in all decisions affecting him/her and, most importantly, locates the main 'problem' outside the person and in society."[38]

While the human rights-based model thus also recognises the societal dimension of disability, it incorporates additional insights. These are: that impairment, in addition

[32] Degener (2016) *Laws* 7.
[33] Bhaba (2009) *SAJHR* 223-224; Degener (2016) *Laws* 12; A Samaha "What Good is the Social Model of Disability?" (2007) 74 *U Chi L Rev* 1251 1251.
[34] A Lawson & A Beckett "The Social and Human Rights Models of Disability: Towards a Complementarity Thesis" (2021) 25 *J. Hum. Rights* 348 364.
[35] 363-364.
[36] H Miller & R Redhead "Beyond 'Rights-Based Approaches'? Employing a Process and Outcomes Framework (2019) 23 *J. Hum. Rights* 699 699.
[37] T Degener "A Human Rights Model of Disability" in P Blanck & E Flynn (eds) *Routledge Handbook of Disability Law and Human Rights* *2016) 31 47.
[38] 34.

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to socially constructed barriers, is itself a relevant consideration in determining the needs of PWD; that impairment must be recognised as part of human diversity and variation; and that there is variation in the experience of impairment, including possible intersections with other forms of disadvantage.[39] On the basis of these foundational concepts, the human rights model advocates for disability mainstreaming,[40] active participation of PWD in decision-making, and an understanding of substantive equality[41] which promotes "empowerment, autonomy, inclusion, [and the] realisation of potential and dignity" for PWD.[42]

While these are the insights of the human rights-based model in the broader sense, this model also has clear application in terms of the provision of mental health care. The former UN Special Rapporteur on the Right to Health, Mr. Dainius Puras, has stated:

> "The starting point for a rights-based transformation must be to address the crisis of those left languishing in coercive health systems and those entering mental health systems with intellectual, cognitive or psychosocial disabilities and unable to access community-based support because the alternatives remain woefully underinvested and unavailable."[43]

This statement raises two key points. First, the use of the word "crisis" calls for serious and urgent consideration of the concerns of PWPSD who are subjected to fractured and failing mental health care systems. As Bilchitz and Mahomed also argue, the suffering experienced by PWPSD who are seeking or are subject to mental health care must be clearly reframed "as human rights violations", so that an appropriate and proportionate response is elicited from the state.[44] For this reason,

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[39] Degener (2016) *Laws* 6; A Broderick & D Ferri *International and European Disability Law and Policy: Text, Cases and Materials* (2019) 24-25.

[40] Disability mainstreaming requires that the interests of persons with disabilities are integrated into and represented in all human rights instruments and policies. See, for example K Skarstad & M Stein "Mainstreaming Disability in the United Nations Treaty Bodies" (2018) 17 *J. Hum. Rights* 1 2, where the authors state: "Such integrations... must reflect an understanding of human rights as applying equally to all individuals in contrast to being subject to disability-specific limitations."

[41] The value of substantive equality, applied as an interpretive tool, requires that past and present systemic disadvantage experienced by rights claimants be taken into account when determining the content of rights and when formulating remedies for human rights violations. See, for example: C Albertyn & B Goldblatt "Facing the Challenge of Transformation: Difficulties in the Development of a Jurisprudence of Equality" (1998) 14 *SAJHR* 248 250; S Liebenberg & B Goldblatt "The Interrelationship Between Equality and Socio-Economic Rights Under South Africa's Transformative Constitution" (2007) 23 *SAJHR* 335 350-358.

[42] Degener (2016) *Laws* 13; Bhabha (2009) *SAJHR* 238.

[43] UN Human Rights Council "Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health" (2020) GE.20-05623(E) para 53.

[44] D Bilchitz & F Mahomed "Special Cluster: The Intersection Between Mental Health and Human Rights" (2016) 32 *SAJHR* 406 406.

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this thesis adopts a right to health lens in evaluating South Africa's system of CBMHC.

Second, as is evident from statement of the Rapporteur, the human rights-based model calls for action on two fronts: to eliminate the harmful coercive practices which occur under the guise of providing "mental health care", and to ensure that the downscaling of such practices occurs while community-based services are scaled up. Without sufficient development of community-based services, institutionalisation may be the only form of mental health care available to PWPSD. Consequently, PWPSD who refuse institutionalisation will either be subject to forced institutionalisation or will not receive any form of mental health care. Dhanda criticises this "false dichotomy" which is created by the failure to invest in forms of mental health care located outside institutional settings:

> "Further, forced treatment cannot be placed in opposition to no treatment. The law should ensure a range of alternatives, so that a refusal of an invasive treatment or a particular service should not be read as a refusal of all treatment and services."[45]

The human rights-based model, as theoretical framework, is central to the methodology employed in this thesis. This thesis sets out, first, to identify relevant normative norms and obligations from constitutional and international human rights law.[46] The South African Constitution and the relevant international human rights instruments are interpreted with reference to the human rights-based understanding of disability set out above. By applying the human rights-based model, the aim is to interpret the relevant instruments in such a way that the widest possible range of protections and entitlements in respect of health care are extended to PWPSD. Thus, when South African mental health legislation, policy and practice are evaluated, the subsequent recommendations will be aimed at promoting those aspects central to a human rights-based approach, as set out earlier in this part.

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[45] A Dhanda "From Duality to Indivisibility: Mental Health Care and Human Rights" (2016) 32 *SAJHR* 438 453.

[46] This thesis focusses on the relevant constitutional norms and obligations, and the norms and obligations derived from key international human rights instruments. While a comparative study is beyond the scope of this thesis, comparison with foreign jurisdictions with progressive mental health care legislation and policy could be a promising area for further research. See further chapter 6 part 6 3.

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1 5 Overview of chapters

Chapter 2 analyses section 27 of the Constitution to establish a normative framework for the right of access to health care for PWPSD, as well as the corresponding obligations on the part of the state. This chapter will draw on case law and academic literature relating to socio-economic rights, including an analysis of relevant concepts such as reasonableness review, progressive realisation, and the availability of resources.

Chapter 3 analyses international human rights law to establish normative standards for CBMHC. The primary international instruments in this analysis are the ICESCR, the UN Disability Convention, the ACHPR, and the African Disability Rights Protocol. The proposed thesis also draws on: General Comments of the Committee on Economic, Social and Cultural Rights ("CESCR"); General Comments of the Committee on the Rights of Persons with Disabilities ("CRPD"), and decisions by the CRPD under the Optional Protocol to the Convention on the Rights of Persons with Disabilities; and decisions by the African Commission on Human and Peoples' Rights ("African Commission"). These sources are supplemented by documents authored by the WHO, and critically analysed with reference to academic literature.

Chapter 4 identifies the provisions and principles relevant to CBMHC in select legislative and policy instruments: the MHCA, the NMHPF and the WPRPD.

Chapter 5 applies the constitutional and international law standards and jurisprudence identified in chapters 2 and 3 to evaluate mental health care legislation, policy and practice.

Chapter 6 summarises the findings of earlier chapters and makes recommendations as to possible improvements to the legal and policy framework regulating CBMHC for PWPSD in South Africa, to promote alignment with the aforementioned constitutional and international law standards

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CHAPTER 2: HEALTH CARE AS A HUMAN RIGHT: CONSTITUTIONAL NORMS AND STATE OBLIGATIONS

2 1 Introduction

In his seminal article on transformative constitutionalism, Klare writes that the Constitution is a transformative text, which not only establishes political rights but also contains a strong commitment to social justice. He further contends:

> "Implicit [in the Constitution] is an understanding that foundational law is not and cannot be neutral with respect to the distribution of social and economic power and of opportunities for people to experience self-realization."[47]

Goods and services obtained by way of socio-economic rights do not only have material value, but also create the conditions where people are able to exercise other rights and to pursue their goals.[48] In this regard, access to health care services has a key role to play. The South African Human Rights Commission ("SAHRC") has described health as "a necessary condition" for the exercise of all fundamental human rights.[49] For PWPSD, for whom psychosocial disability may pose an obstacle to the exercise of a range of constitutionally guaranteed rights, the enshrinement of the right of access to health care services in section 27 of the Constitution holds promise.

However, the potential of section 27 for PWPSD depends first and foremost on how the right is interpreted. Therefore, the aim of this chapter is to analyse section 27 in order to determine the normative standards applicable to the right of access to health care services for PWPSD, and to establish the corresponding negative and positive obligations on the State.

2 2 The normative content of the right of access to health care services

Before setting out the State's obligations in respect of section 27, the normative content of the right will be analysed. To illustrate why such an analysis is necessary, this part first considers criticisms of the South African Constitutional Court's limited

[47] K Klare "Legal Culture and Transformative Constitutionalism" (1998) 14 *SAJHR* 146 154.
[48] S Liebenberg "The Value of Human Dignity in Interpreting Socio-Economic Rights" (2005) 21 *SAJHR* 1 2, 13. D Bilchitz "Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-Economic Rights Jurisprudence" (2003) 19 *SAJHR* 1 11.
[49] South African Human Rights Commission *Public Inquiry: Access to Health Care Services* (2009) 17.

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engagement with the normative content of socio-economic rights.[50] Thereafter, the constitutional values of human dignity, freedom and equality will be discussed, to develop an understanding of the normative content of the right of access to health care services, particularly in the context of psychosocial disability.

The Constitutional Court makes use of the model of reasonableness review, derived from the duty to "take reasonable legislative and other measures", as set out in, *inter alia*, section 27(2) of the Constitution. In *Government of the Republic of South Africa v Grootboom* ("*Grootboom*"), the Court held that the state must adopt reasonable measures which are "capable of facilitating the realisation of the right".[51] The criticism of the Court's application of this model is that the Court proceduralises the interpretation of socio-economic rights. In terms of this approach, the Court does not engage sufficiently with the substantive content of the right, but rather evaluates the measures taken by the state in light of procedural considerations. According to Brand, the Court thus focusses on "structural good governance standards such as legality (rationality and non-arbitrariness), coherence, coordination and inclusivity in government policy formulation and decision-making".[52]

According to Pieterse, the consequence of a proceduralised approach to interpretation is that the Court fails to consider and address the severe material deprivation experienced by the claimants before the Court.[53] For example, Liebenberg criticises the approach of the Court in *Mazibuko v City of Johannesburg*,[54] which lacks meaningful consideration of the content and values underpinning the right of access to sufficient water.[55] Bilchitz similarly observes that there is a "virtual absence of any analysis" of the content of the right of access to

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[50] M Pieterse "Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services" (2006) 22 *SAJHR* 473 487; S van der Berg "Meaningful Engagement: Proceduralising Socio-Economic Rights Further or Infusing Administrative Law with Substance?" (2013) 29 *SAJHR* 376 382; S Liebenberg *Socio-Economic Rights: Adjudication under a Transformative Constitution* (2010) 176-177.

[51] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 41. In assessing the reasonableness of measures taken by the state, the Court considers a number of criteria, which are discussed in greater detail later in this chapter. See further part 2 4 2 of this chapter.

[52] D Brand "The Proceduralisation of South African Socio-Economic Rights Jurisprudence, or 'What are Socio-Economic Rights For?'" in H Botha, A van der Walt & J van der Walt (eds) *Rights and Democracy: In a Transformative Constitution* (2003) 33 36.

[53] M Pieterse "Eating Socio-Economic Rights: The Usefulness of Rights Talk in Alleviating Social Hardship Revisited" (2007) 29 *Hum. Rights Q.* 796 812. See also S Liebenberg "The Value of Freedom in Interpreting Socio-Economic Rights" (2008) 1 *Acta Juridica* 149 154.

[54] 2010 4 SA 1 (CC).

[55] Liebenberg *Socio-Economic Rights* 467.

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health care services in *Minister of Health v Treatment Action Campaign* ("*Treatment Action Campaign*").[56] Currie thus argues:

> "The trouble is that interpreting rights in the way the Constitutional Court has done leaves them empty. They are not a right to anything of substance, only to reasonableness in the measures the state has decided to adopt."[57]

Consequently, it is essential to determine the end goal towards which the steps taken by the State should be directed. This part therefore aims to develop an understanding of the normative content of the right of access to health care services, as informed by the constitutional values. Section 39(1)(a) of the Constitution provides that the rights in the Bill of Rights must be interpreted to promote the constitutional values of human dignity, equality, and freedom. These values are interrelated and should not be viewed as if each has a compartmentalised impact on the interpretation of rights.[58] Therefore, applied holistically as interpretive tools, the constitutional values can shed light on the purposes which underpin each of the rights in the Bill of Rights.[59]

In respect of the application of the constitutional values to the interpretation of socio-economic rights, the point of departure is the following passage from *Soobramoney v Minister of Health, KwaZulu-Natal* ("*Soobramoney*"):

> "These conditions [of socio-economic deprivation] already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring."[60]

Further, in both *Grootboom*[61] and *Khosa and Others v Minister of Social Development; Mahlaule and Another v Minister of Social Development*,[62] the Court held that socio-economic rights are entrenched "because we value human beings and want to ensure they are afforded their basic needs".[63] In these cases, the Court frames the realisation of the constitutional values as being inextricably intertwined with the realisation of socio-economic rights. The Court in *Grootboom* further states:

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[56] 2002 5 SA 721; Bilchitz (2003) *SAJHR* 6.
[57] Quoted in Pieterse (2007) *Hum. Rights Q.* 812.
[58] *Sidumo and Another v Rustenburg Platinum Mines Ltd and Others* 2008 2 SA 24 (CC) para 149.
[59] Liebenberg *Socio-Economic Rights* 50.
[60] 1998 1 SA 765 (CC).
[61] 2001 1 SA 46 (CC) para 44.
[62] 2004 6 SA 505 (CC) para 52.
[63] Own emphasis.

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> "There can be no doubt that human dignity, freedom and equality, the foundational values of our society, are denied those who have no food, clothing or shelter… The realisation of these rights is also key to the advancement of race and gender equality and the evolution of a society in which men and women are equally able to achieve their full potential."[64]

These constitutional values call for more than just basic needs fulfilment. The relevant values, particularly of human dignity, freedom and equality, imply that people should have access to the material goods and services needed to pursue their goals and to be able to function as equals in society.[65] The link between the effective realisation of socio-economic rights and the ability to seek personal fulfilment is highly relevant for PWD, as Bhabha argues:

> "The interests of people with disabilities are most acutely affected in the social and economic arena; they are most vulnerable in employment, health, education and social services – all areas of life which cut to the core of a person's being in the world and one's potential to live a meaningful life".[66]

Therefore, as noted earlier in this chapter,[67] the inclusion of the right of access to health care services in the Constitution has particular significance for PWPSD. However, it is crucial that the values which guide the interpretation of this right, are not understood in terms of the medical model.[68] Rather, the values must be understood in light of the human rights-based model, which, as noted in the previous chapter, aims to extend the widest possible range of protections and entitlements in respect of health care to PWPSD. For example, the judgments referred to earlier noted that socio-economic rights must be realised because "we *value* human beings", with reference to the value of human dignity. However, human dignity has been a contested matter in the case of psychosocial disability. For example, PWPSD may lack (at times or permanently) the capacity for rational agency required by Kant's understanding of human dignity, or some of the listed capabilities proposed by Nussbaum.[69] In this regard, Bilchitz proposes an alternative, inclusive understanding

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[64] 2001 1 SA 46 (CC) para 23.
[65] This interpretation is supported by the commitment expressed in the Preamble to the Constitution, to "[i]mprove the quality of life of all citizens and free the potential of each person". See further: Liebenberg (2005) *SAJHR* 23; Bilchitz (2003) *SAJHR* 11; Liebenberg (2008) *Acta Juridica* 155; S Liebenberg & B Goldblatt "The Interrelationship Between Equality and Socio-Economic Rights Under South Africa's Transformative Constitution" (2007) 23 335 342-242; Klare (1998) *SAJHR* 153.
[66] Bhabha (2009) *SAJHR* 219.
[67] See part 2 1 of this chapter.
[68] See chapter one part 1 4.
[69] D Bilchitz "Dignity, Fundamental Rights and Legal Capacity: Moving Beyond the Paradigm Set by the General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities" (2016) 32 *SAJHR* 410 426, 430.

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of human dignity based on "experiential value" and "purposive value."[70] This reconceptualisation has practical significance for the interpretation of socio-economic rights, particularly in terms of the allocation of resources. Bilchitz explains:

> "With this understanding of these two key sources of value, it is possible to recognise that there are certain conditions and resources which are necessary for all individuals to live a valuable life in these terms, irrespective of the purposes or experiences specific individuals value."[71]

The acceptance of impairment as part of human variation and diversity, as required in terms of the human rights-based model, is key to ensuring that PWPSD can exercise their rights on an equal basis. However, stigma has severely hindered the realisation of the rights of PWPSD, historically viewed as a danger or burden to society. For example, in 1952, South Africa hosted the National Conference for Handicapped Persons, where delegates were instructed to devise solutions to keep PWD from "becoming a parasite to the nation".[72] As Mahomed explains, the power of stigma lies in "its capacity to dehumanise the sufferer and, by implication, supposedly to render human rights inapplicable".[73] In respect of the interpretation of the right of access to health care services for PWPSD, the constitutional value of equality is thus highly relevant. However, it is not sufficient to state, in the abstract, that the value of equality also applies to PWPSD. As Bhabha notes:

> "In other words, the transformation imperative likely demands more than lofty pronouncements about the equality and dignity of disabled persons. It also necessitates measures not only to remedy discrimination, but also to re-orient the underlying societal structures that contribute to systemic material deprivation and to the exclusion of people with disabilities."[74]

Furthermore, the value of equality – particularly, substantive equality – calls for an interpretation of the right of access to health care services which is responsive to the fact that PWPSD are not a homogeneous group.[75] While it is important to acknowledge group-based disadvantage, a value-driven interpretation must take into

[70] Bilchitz (2016) *SAJHR* 430-433. He argues that human beings should be valued based on their ability to experience the world (whether they do so actively or passively, independently or with a degree of dependency) and/or their ability to develop and pursue any of a wide range of purposes.
[71] 431.
[72] J Fagin *Global Influences and Resistance Within: Inclusive Practices and South Africa's Apartheid Government* MA thesis, Loyola University Chicago (2011) 8.
[73] Mahomed (2016) *SAJHR* 492.
[74] Bhabha (2009) *SAJHR* 241.
[75] M Heap, T Lorenzo & J Thomas "'We've Moved Away From Disability As a Health Issue, It's a Human Rights Issue': Reflecting on 10 Years of the Right to Equality in South Africa' (2009) 24 *Disabil Soc* 857 865.

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account that individual experiences of disability may be affected by a wide range of intersecting identities and statuses such as, race, gender or socio-economic class.[76] Crucially, it must be acknowledged that PWD may experience compounded vulnerability when various stigmatised identities intersect with disability.[77] Multiple studies have found a close relationship between disability, poverty, race, and gender as grounds of disadvantage and marginalisation.[78] For example, in South Africa, Black women with disabilities are "the most likely to be poor, destitute, malnourished and illiterate".[79]

By acknowledging the structural stigma which has historically left mental health care under-prioritised, the constitutional values act as a counter to the proceduralisation of socio-economic rights, Thereby, stronger protections and entitlements in respect of health care for PWPSD are created. For example, Liebenberg writes:

> "In terms of the relational concept of human dignity I have sought to develop, dignity fails to be protected when the standard of justification demanded of government in respect of a failure to fulfil basic needs is low. A response that is not proportionate to the nature of the deprivation and its impact communicates a message that the affected group is not worthy of equal respect and concern."[80]

The constitutional values thus serve to create an understanding of the substantive end goals against which the State's chosen means must be measured, rather than focussing only procedural concerns. The following parts discuss the obligations imposed on the State by section 27 of the Constitution, starting with the negative obligations.

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[76] Mulvany (2000) 22 586-587; Bhabha (2009) *SAJHR* 233.
[77] K R Bogart "Ableism Special Issue Introduction" (2019) 75 *JSI* 650 652.
[78] N Mkhize & M J Kometsi "Community Access to Mental Health Services: Lessons and Recommendations" (2013) *SAHR* 103 106, W Nell, E de Crom, H Coetzee & E van Eeden "The Psychosocial Well-Being of a 'Forgotten' South African Community: The Case of Ndumo, KwaZulu-Natal" (2015) 25 *J Psychol Afr* 171 177; S Skeen, S Kleintjes, C Lund, I Petersen, A Bhana & A Flisher "'Mental Health is Everybody's Business': Roles for an Intersectoral Approach in South Africa" (2010) 22 *Int Rev Psychiatry* 611 611; I Grobbelaar-Du Plessis "African Women with Disabilities: The Victims of Multilayered Discrimination" (2007) 22 *SAPL* 405 420.
[79] Grobbelaar-Du Plessis (2007) *SAPL* 407.
[80] S Liebenberg "The Value of Human Dignity in Interpreting Socio-Economic Rights" in A van der Walt (ed) *Theories of Social and Economic Justice* (2009) 141 161. It must be noted that the author was not writing on the topic of socio-economic rights in the particular context of disability.

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2 3 The negative obligations imposed on the State by section 27 of the Constitution

Early on in its jurisprudence, the Constitutional Court established that the State bears negative constitutional obligations in respect of socio-economic rights.[81] These are derived from the State's duty to "respect" the rights in the Bill of Rights, as provided for in section 7(2) of the Constitution.[82] The seminal case in respect of this obligation is *Jaftha v Schoeman; Van Rooyen v Stoltz*, where the Court stated the following, in the context of housing rights:

> "It is not necessary in this case to delineate all the circumstances in which a measure will constitute a violation of the negative obligations imposed by the Constitution. However, in the light of the conception of adequate housing described above I conclude that, at the very least, any measure which permits a person to be deprived of existing access to adequate housing, limits the rights protected in section 26(1)." [83]

This Court expanded its understanding of the negative obligation in *Governing Body of the Juma Musjid Primary School v Essay NO and Others*, by stating that a violation occurs where there is "a failure to respect the existing protection of the right by taking measures that diminish that protection".[84] It could be argued that discharging PWPSD from mental health care institutions without ensuring that an appropriate system of CBMHC is in place, breaches the negative duty by diminishing the current enjoyment of the right of access to health care services. Furthermore, Liebenberg, in discussing the impact of fiscal consolidation measures on the realisation of socio-economic rights, cautions that "drastic retrogressive measures" could have the effect of "completely depriving people of their existing access to socio-economic rights", thereby amounting to a violation of the negative duty.[85]

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[81] *In re: Certification of the Constitution of the Republic of* South Africa 1996 4 SA 744 (CC) para 78; *Governing Body of the Juma Musjid Primary School and Others v Essay NO and Others* 2011 8 BCLR 761 (CC) para 58, *Jaftha v Schoeman and Others; Van Rooyen v Stoltz and Others* 2005 2 SA 140 (CC) paras 33-34, *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 34, *Mazibuko and Others v City of Johannesburg and Others* 2020 4 SA 1 (CC) para 47; *Khosa and Others v Minister of Social Development and Others; Mahlaule and Another v Minister of Social Development* 2004 6 SA 505 (CC) para 27; *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) para 46.

[82] B Slade *International law in the interpretation of section 25 and 26 of the Constitution* LLM thesis, Stellenbosch University (2010) 92; M Dafel "The Negative Obligation of the Housing Right: An Analysis of the Duties to Respect and Protect" (2013) 29 *SAJHR* 591 597; *Governing Body of the Juma Musjid Primary School and Others v Essay NO and Others* 2011 8 BCLR 761 (CC) para 58.

[83] 2005 2 SA 140 (CC) para 34.

[84] 2011 8 BCLR 761 (CC) para 58.

[85] S Liebenberg "Austerity in the Midst of a Pandemic: Pursuing Accountability through the Socio-Economic Rights Doctrine of Non-Retrogression" (2021) *SAJHR* 1 19.

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To classify obligations as either strictly positive or negative is a challenging task, as health care for PWPSD is multi-faceted issue, which is affected by a range of determinants. Nevertheless, the way the obligations in favour of PWPSD are framed could have significant consequences should relief be sought through the courts. The negative obligation represents a comparatively "strong obligation" in relation to socio-economic rights, as it is not qualified in the same terms as positive obligations, namely, with reference to reasonableness, progressive realisation, and the availability of resources.[86] If the State fails to act in accordance with its negative obligation, it is considered a *prima facie* violation of, in this case, section 27 of the Constitution.[87] The State then bears the burden of justifying the infringement in terms of section 36 of the Constitution, a "more rigorous, and far less deferential justification analysis" than applied in the context of positive duties.[88] Thus, it could be beneficial to frame certain aspects of CBMHC as part of the negative obligations of the right of access to health care services.

2 4 The positive obligations imposed on the State by section 27 of the Constitution

2 4 1 Introduction

In addition to the negative obligations discussed above, section 7(2) of the Constitution imposes positive duties on the State in relation to all rights in the Bill of Rights – namely, to "protect", "promote", and "fulfil".[89] First, the duty to *protect* entails preventing third parties from infringing on a right, interfering with the enjoyment of a right, or limiting rights-bearers' capacity to enjoy the right.[90] Second, the duty to *promote* requires the State to raise awareness of the right in question, including disseminating information on how the right may be accessed or enforced.[91] Third,

[86] S Liebenberg "*Grootboom* and the Seduction of the Negative/Positive Duties Dichotomy" (2011) 26 *SAPL* 37 40-41; Dafel (2013) *SAJHR* 596. T
[87] Liebenberg (2011) *SAPL* 41.
[88] Dafel (2013) *SAJHR* 596; Liebenberg (2011) *SAPL* 41.
[89] The CESCR includes the duty to promote a subdivision of the duty to fulfil, alongside the duties to "facilitate" and "provide". Regardless of the exact categorisation, there appears to be consensus that the duty to promote relates mainly to the dissemination of information related to rights. See UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 37.
[90] P de Vos & W Freedman (eds) *South African Constitutional Law in Context* (2014) 672; Liebenberg *Socio-Economic Rights* 84.
[91] De Vos & Freedman *South African Constitutional Law* 672; Liebenberg *Socio-Economic Rights* 85; C Heyns & D Brand "Introduction to Socio-Economic Rights in the South African Constitution" (1998) 2 *LDD* 153 158.

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the duty to *fulfil* calls for the adoption of "appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right".[92]

Further, in relation to the right of access to health care services in particular, section 27(2) imposes a qualified positive duty:

> "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights [enshrined in section 27(1)]."

Section 27(2) thus establishes three core qualifiers to the State's positive duty in relation to the right of access to health care services: "reasonableness", "progressive realisation", and "the availability of resources". These three qualifiers are discussed in the parts that follow.

2 4 2 Reasonableness

In *Grootboom,*[93] the Constitutional Court developed the "reasonableness review" model, which is applied in socio-economic rights adjudication to determine whether the state's chosen means are "reasonably capable of facilitating the realisation of the rights in question".[94] This inquiry does not entail that the Court consider whether "other more desirable or favourable measures" could have been used to promote the realisation of the relevant right.[95] While the State thus retains a degree of discretion in developing programmes aimed at realising socio-economic rights, such a programme will be considered reasonable and pass constitutional muster only if certain criteria are met. Crucially, the programme must not only be reasonably conceived but also reasonably implemented.[96] Thus, the following considerations apply not only to the socio-economic rights programme as designed, but also as it is applied in practice.

The first reasonableness criterion discussed in this part, is the requirement that the implementation of socio-economic rights programmes must be responsive "to the

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[92] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 33.
[93] 2001 1 SA 46 (CC).
[94] Liebenberg (2006) *Stell LR* 22.
[95] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 41; *Khosa v Minister of Social Development; Mahlaule v Minister of Social Development* 2004 6 SA 505 (CC) para 48.
[96] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 42.

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urgency of the situations it is intended to address".[97] Accordingly, the State must ensure that the needs "of those in crisis" are provided for in the short-term.[98] The Court in *Grootboom* made it clear that the vulnerability of the affected group is a crucial consideration in the reasonableness enquiry:

> "To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right."[99]

In the absence of appropriate mental health care, PWPSD are at risk of facing neglect and abuse, particularly if deinstitutionalisation initiatives are not accompanied by appropriate and timely investment in CBMHC. In South Africa, the failed Marathon Project serves as a highly relevant example, with the affected PWPSD referred to as "utterly vulnerable" by the Arbitrator, former Deputy Chief Justice Dikgang Moseneke.[100] Whether the vulnerability of this group is appropriately considered in the development and implementation of socio-economic rights programmes can be a matter of life-or-death.

This requirement that there must be short term provision for those in desperate need, is closely linked to the concept of "minimum core obligations", which has been defined by the CESCR as imposing a duty on the state to satisfy "minimum essential levels" of a right.[101] In particular, the CESCR has stated that States will violate their minimum core obligations if "any significant number of individuals is deprived of… essential primary health care".[102] In both *Grootboom*[103] and *Treatment Action Campaign*,[104] the Constitutional Court rejected the notion that minimum core constitutes an independent cause of action, but indicated that the minimum core of a right could, under appropriate circumstances, constitute a relevant consideration in the reasonableness enquiry. Building on this possibility, it is arguable that the minimum core concept, particularly as recognised in international human rights law, can play a role interpreting the state's obligations in respect of health care for

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[97] 2001 1 SA 46 (CC) para 67.
[98] Para 64.
[99] Para 44.
[100] *Marathon Project Arbitration* para 1.
[101] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art. 2, para. 1 of the Covenant)" (1990) E/1991/23 para 10.
[102] Para 10.
[103] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 33.
[104] 2002 5 SA 721 (CC) para 34.

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PWPSD. The concept of minimum core could strengthen the basis for holding the state to account for the measures it takes (or fails to take) in respect of the provision of CBMHC, as a form of essential primary health care.

The second criterion in respect of reasonableness is that the programme in question “ensures that appropriate financial and human resources are available”.[105] This issue is highly relevant in the context of the shift from institutionalisation to CBMHC, as deinstitutionalisation measures implemented without sufficient investment in CBMHC may impact negatively on the availability and quality of mental health care.[106] Owing to the centrality of mental health care to a person’s overall well-being, a failure to ensure sufficient allocation of resources to CBMHC may have severe consequences for PWPSD. Insufficient community-based support for PWPSD has been linked to cycles of relapse and readmission to psychiatric institutions, referred to as a “revolving-door” pattern of care.[107] Such relapses may also result in unemployment, deterioration of physical health, social exclusion, homelessness, or even imprisonment as a result of anti-social behaviour associated with untreated mental health diagnoses.[108] At worst, deinstitutionalisation initiatives which are unaccompanied by sufficient resource allocation for CBMHC may lead to the death of PWPSD.

The third reasonableness criterion is the clear allocation of responsibilities in respect of the socio-economic rights programme to the various spheres of government.[109] This is also closely linked to the requirement that the programme must be well co-ordinated, comprehensive, and coherent.[110] As a range of social determinants and structures affect the realisation of the right of access to health care services for PWPSD, an intersectoral approach is called for. Thus, co-ordination of responsibilities across national, provincial, and local levels of government is key, as well across various government departments. For example, Skeen *et al* highlight that

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[105] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 39.
[106] C Spivakovsky, L Steele & P Weller (eds) *The Legacies of Institutionalisation: Disability, Law and Policy in the ‘Deinstitutionalised’ Community* (2020) 1; L Jonker *Resilience factors in families living with a member with a mental disorder* M.Psych. thesis, Stellenbosch University (2006) 3.
[107] I Petersen & C Lund “Mental Health Service Delivery in South Africa from 2000 to 2010: One Step Forward, One Step Back” (2011) 101 *SAMJ 751* 756.
[108] A L Pillay “Is Deinstitutionalisation a Cheap Alternative to Chronic Mental Health Care?” (2017) 47 *S Afr J Psychol* 141 144; S Skeen et al (2010) *Int Rev Psychiatry* 611,
[109] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 39.
[110] Paras 40-41.

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the South African Police Service is a key actor, whose actions have in some cases proven to be detrimental to the human dignity of PWPSD.[111] In one interview conducted by Skeen *et al*, a district police officer described the approach to the transportation of PWPSD who experience mental health crises:

> "We do not treat them in any special way, we handcuff them just like anyone who has done something wrong and if we have to take them to hospital, we take them there and take our handcuffs back once they have injected him."[112]

The final criterion to be considered in the reasonableness enquiry, is that of "meaningful engagement" between the state and those who claim the realisation of rights.[113] While concepts pertaining to engagement and mediation were noted in earlier judgments,[114] the concept of meaningful engagement first saw significant development in *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street, Johannesburg v City of Johannesburg*.[115] Meaningful engagement has the practical function of providing the state with insights into the needs and concerns to be addressed.[116] Further, meaningful engagement recognises participants as "active stakeholders rather than just passive recipients of socio-economic goods and services".[117] The description of this process as "self-determination in action" by Justice Khampepe, in the context of an extra-curial lecture, points to the potential of meaningful engagement for PWPSD, a historically disempowered and marginalised group.[118]

Chenwi and Tissington set out a number of requirements for the process of meaningful engagement, including that it must be "structured, coordinated, consistent and comprehensive", and should include engagement at "individual and

[111] Skeen *et al* (2010) *Int Rev Psychiatry* 614.
[112] 614.
[113] *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes* 2010 3 SA 454 (CC) para 238.
[114] See, for example, *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 87; *Minister of Public Works v Kyalami Ridge Environmental Association* 2001 3 SA 1151 (CC) para 111; *President of the Republic of South Africa and Another v Modderklip Boerdery (Pty) Ltd* 2005 5 SA 3 (CC) para 31; *Port Elizabeth Municipality v Various Occupiers* 2005 1 SA 217 (CC) para 39.
[115] 2008 3 SA 208 (CC).
[116] L Chenwi "'Meaningful Engagement' in the Realisation of Socio-Economic Rights: The South African Experience" (2011) 26 *SAPL* 126 155; *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street, Johannesburg v City of Johannesburg* 2008 3 SA 208 (CC) para 15.
[117] Chenwi (2011) *SAPL* 129.
[118] S Khampepe "Meaningful Participation as Transformative Process: The Challenges of Institutional Change in South Africa's Constitutional Democracy" (2016) 3 *Stell LR* 441 447.

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collective" levels.[119] Further, the Constitutional Court has cautioned against a "top-down" approach to meaningful engagement, whereby the affected parties are merely informed about the decisions which have already been made without prior consultation.[120]

However, it must be noted that the above criteria were developed in the context of housing rights. In the context of mental health care, there are additional complexities which require special measures. A significant barrier is stigma on the basis of psychosocial disability, which Mahomed refers to as a "phenomenon of systematic dehumanisation".[121] On the basis of their mental health status, PWPSD have historically been barred from making decisions even on matters which directly affect their own lives.[122] Their exclusion from decision-making processes occurs either by an express denial of their legal capacity,[123] or by a failure to implement measures to ensure that engagement is truly meaningful and empowering.[124] For example, Kleintjes *et al* have observed a "hit and run" approach to engagement between policy makers and PWPSD:

> "Policy makers are often driven by demands for urgent solutions, leaving little time for pre-consultation capacity development of participants. Less capacitated stakeholders may be left behind or given token acknowledgement within time-pressured consultation activities."[125]

This approach reveals the persistent disregard for the human dignity of PWPSD, contrary to the human rights-based model. The Constitution also calls for respect for human dignity across diverse groups, as noted by Sachs J in *National Coalition for Gay and Lesbian Equality v Minister of Justice*:

> "What the Constitution requires is that the law and public institutions acknowledge the variability of human beings and affirm equal respect and concern that should be shown to

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[119] L Chenwi & K Tissington *Engaging Meaningfully with Government on Socio-Economic Rights: A Focus on the Right to Housing* (2010) 9.
[120] *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes* 2010 3 SA 454 (CC) para 378; Chenwi & Tissington *Engaging Meaningfully* 10.
[121] Mahomed (2016) *SAJHR* 493.
[122] S Kleintjes, C Lund & L Swartz "Barriers to the Participation of People with Psychosocial Disability in Mental Health Policy Development in South Africa: A Qualitative Study of Perspectives of Policy Makers, Professionals, Religious Leaders and Academics" (2013) 13 *BMC International Health and Human Rights* 1 1.
[123] See further chapter three part 3 5 5 for a discussion of legal capacity, in the context of involuntary treatment.
[124] S Kleintjes, C Lund, L Swartz, A Flisher & The MHAPP Research Programme Consortium "Mental Health Care User Participation in Mental Health Policy Development and Implementation in South Africa" (2010) 22 *Int Rev Psychiatry* 568 573.
[125] 575.

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all as they are. At the very least, what is statistically normal ceases to be the basis for establishing what is legally normative. More broadly speaking, the scope of what is constitutionally normal is expanded to include the widest range of perspectives and to acknowledge, accommodate and accept the largest spread of difference."[126]

Furthermore, the failure to engage meaningfully may result in less effective socio-economic rights programmes, as policymakers lack accurate information on the needs and interests which the programme must address. The failure to engage can even have deadly consequences, as was the case in the Marathon Project. There was no meaningful engagement with PWPSD or DPOs prior to the transfer from the Life Esidimeni facility. Following the transfer, even after a number of PWPSD had died, the inputs of representative organisations were still ignored.[127] Consequently, effective, empowering and inclusive mechanisms for meaningful engagement of PWPSD and their representative organisations are thus crucial.

The above criteria are used to evaluate the reasonableness of measures taken by the state, in respect of both the conception and implementation of socio-economic rights programmes. The next part further explores the nature of the state's obligations in respect of section 27, by discussing the second qualifier, progressive realisation.

2 4 3 Progressive realisation

The qualifier of progressive realisation[128] serves as a "necessary flexibility device", which is responsive to the fact that the State cannot realise socio-economic rights in full within a brief timespan.[129] Nevertheless, progressive realisation requires the State to show demonstrable progress towards the goal of the full realisation of the right in question, through taking "deliberate, concrete" steps and moving "as

[126] 1999 1 SA 6 (CC) para 134. Although the case did not directly concern disability-related issues, this passage has been considered in the context of disability studies. See, for example, C Ngwena "Developing Juridical Method for Overcoming Status Subordination in Disablism: The Place of Transformative Epistemologies" (2014) 30 *SAJHR* 275 282.

[127] *Marathon Project Arbitration* para 83; Office of the Health Ombud *The Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (2018) 29.

[128] This part refers to progressive realisation as interpreted by the CESCR, as the Constitutional Court has stated: "Although the Committee's analysis is intended to explain the scope of States Parties' obligations under the Covenant [ICESCR], it is also helpful in plumbing the meaning of 'progressive realisation' in the context of our Constitution. The meaning ascribed to the phrase is in harmony with the context in which the phrase is used in our Constitution and there is no reason not to accept that it bears the same meaning in the Constitution as in the document from which it was so clearly derived." See *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 45.

[129] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23) para 9.

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expeditiously and effectively as possible".[130] According to the CESCR, this is a "continuing obligation".[131] On this basis, Bilchitz argues that the Court in *Soobramoney* neglected to consider the State's obligation in respect of progressively realising access to dialysis:

> "If rights are bridges [between the ideal and the real], particular balancing decisions in the here and now are not enough; decision-making bodies must work to ensure that structures for the future improvement of rights realization are put in place."[132]

Such improvement would, according to the Court in *Grootboom*, entail that access to socio-economic rights is extended "not only to a larger number of people but to a wider range of people as time progresses".[133] Particularly, improved access for those groups facing extreme marginalisation and disadvantage is required.[134] The CESCR has, in this regard, identified PWD as a group which is deserving of "appropriate preferential treatment".[135] Such groups must also be timeously informed of the plans and programmes in place for the realisation of their rights.[136]

The obligation to realise progressively further entails improving the quality of available socio-economic goods and services.[137] Chenwi thus notes that, as progressive realisation must be aimed at achieving the *full* realisation of the right, the state's obligation to realise rights progressively respect entails more than meeting the "minimum essential levels" which constitute the minimum core of a particular right.[138]

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[130] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23) para 9; UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 39.
[131] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 31.
[132] D Bilchitz "Fundamental Rights as Bridging Concepts: Straddling the Boundary Between Ideal Justice and an Imperfect Reality" (2018) 40 *Hum. Rights Q.* 119 136.
[133] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 45.
[134] L Chenwi *Monitoring the Progressive Realisation of Socio-Economic Rights: Lessons from the United Nations Committee on Economic, Social and Cultural Rights and the South African Constitutional Court* (2010) 20.
[135] UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22 para 9.
[136] *President of the Republic of South Africa and Another v Modderklip Boerdery (Pty) Ltd* 2005 5 SA 3 (CC) para 49.
[137] Liebenberg *Socio-Economic Rights* 188.
[138] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art. 2, para. 1 of the Covenant)" (1990) E/1991/23 para 10. Chenwi illustrates this point with reference to the CESCR's interpretation of the right to education, observing that "states must not only *prioritise* the provision of *free primary education* but must also take concrete

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A further duty imposed by the obligation to realise progressively, is that the state must monitor progress made towards the full realisation of rights, including by establishing "right to health indicators and benchmarks".[139] Effective monitoring of progress also allows for the revision and adaptation of socio-economic rights programmes, which is another key obligation imposed by the duty to realise progressively.[140] The CESCR has further stated, in the context of the right to health under the ICESCR, that the revision of such programmes must be transparent and include the participation of the affected groups.[141]

Finally, the duty to realise progressively also introduces strict justificatory standards for the introduction of "deliberately retrogressive measures".[142] The CESCR has formulated the doctrine of non-retrogression as follows:

> "If any deliberately retrogressive measures are taken, the State Party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources."[143]

The CESCR, in the context of social security rights, stated that the following aspects would have to be considered in evaluating whether retrogressive measures are justified: whether alternative measures were properly considered; if "genuine participation of affected groups" took place in the process leading up to the decision to institute retrogressive measures; whether the measures would lead to the deprivation of "the minimum essential level" of a right for an individual or group; and

steps towards achieving *free secondary and higher education*". See Chenwi *Monitoring Progressive Realisation* 20.

[139] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 43(f).

[140] Chenwi *Monitoring Progressive Realisation* 22; *Mazibuko and Others v City of Johannesburg and Others* 2020 4 SA 1 (CC) paras 40 and 67.

[141] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 43(f).

[142] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art. 2, para. 1 of the Covenant)" (1990) E/1991/23 para 9; UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 32.

[143] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 32.

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whether the retrogressive measure were independently reviewed at a national level.[144]

It is clear that the concept of progressive realisation must not be interpreted to have the effect of "depriving the obligation of all meaningful content".[145] As this part has clarified the State's obligations in respect of the progressive realisation of socio-economic rights, the next part discusses the final qualifier, the availability of resources.

2 4 4 The availability of resources

The Court in *Treatment Action Campaign* acknowledges: "There are many pressing demands on the public purse".[146] The availability of resources as qualifier serves to recognise the reality of resource constraints faced by the State. However, resource constraints cannot be invoked to justify any and all failures of the State to meet its positive obligations. In this part, four key aspects relating to resource availability and socio-economic rights are discussed.

First, the Constitution does not impose an obligation which expects "the State to do more than its available resources permit".[147] Thus, the availability of resources must be considered when the reasonableness of the measures taken by the state is assessed.[148] As a consequence, resource constraints may also determine the time frame for the realisation of a right.[149]

The second key point is that resource constraints may require the State to "differentiate between categories of people and to prioritise", and that such differentiation must be subject to scrutiny.[150] As the Court noted in *Grootboom*, and as discussed earlier in this chapter, the State's chosen measures must not lose sight of the needs of persons most vulnerable.[151] Thus, while the rate at which a right is

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[144] UN Committee on Economic, Social and Cultural Rights General Comment 19: "The right to social security (Art. 9 of the Covenant)" (2007) GE.08-40397 (E) para 42.
[145] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art. 2, para. 1 of the Covenant)" (1990) E/1991/23 para 9.
[146] 2002 5 SA 721 (CC) para 37.
[147] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 46.
[148] Para 47.
[149] Para 46.
[150] *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd* 2012 2 SA 104 (CC) para 86.
[151] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 44; *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd* 2012 2 SA 104 (CC) para 90.

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realised may be affected by resource constraints, the measures taken must still be responsive to the extent of deprivation or denial of rights faced by disadvantaged groups.

Third, as held by former Deputy Chief Justice Dikgang Moseneke in the Marathon Project arbitration proceedings, resource constraints cannot be invoked to justify the State's failure to meet its constitutional obligations if the State determined its budget "according to a mistaken understanding of its constitutional and statutory obligation".[152] This confirms the Court's approach in *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd,* where Van der Westhuizen J further notes that a failure by the state to budget appropriately, or at all, does not constitute a valid justification for the failure to fulfil its constitutional obligations.[153]

Finally, it must be noted that this qualifier may be exploited by the State if the discourse around socio-economic rights continues to be depoliticised.[154] According to Pieterse, the allocation of resources is determined by a series of deliberate political and administrative decisions, but depoliticisation instead frames unjust resource allocations to health care as a type of unavoidable tragedy.[155] As a consequence, the State can more easily evade accountability for its failure to allocate sufficient resources.[156] In this respect, the approach of the Constitutional Court in *Soobramoney* has been criticised, particularly the judgment of Sachs J. He states:

> "It is precisely here, where scarce artificial life-prolonging resources have to be called upon, that tragic medical choices have to be made… Courts are not the proper place to resolve the agonising personal and medical problems that underlie these choices."[157]

The judgment reflects a particular form of depoliticisation, namely, "personalisation", in which needs are framed as arising purely from the personal

[152] *Marathon Project Arbitration* para 41.
[153] 2012 2 SA 104 (CC) para 74.
[154] Brand describes depoliticisation as "a tendency to talk about [people's needs] in such a way that they are bracketed as non-political, not subject to or not capable of being subjected to political contestation". See D Brand "The 'Politics of Need Interpretation' and the Adjudication of Socio-Economic Rights Claims in South Africa" in AJ van der Walt (ed) *Theories of Social and Economic Justice* (2005) 17 18.
[155] M Pieterse "Health Care Rights, Resources and Rationing" (2007) 124 *SALJ* 514 517.
[156] 515.
[157] 1998 1 SA 765 (CC) paras 57-58.

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"faults" of rights-claimants.[158] As argued by Pieterse, depoliticisation attempts to disguise "the often highly controversial and questionable principles and assumptions" which underpin the decisions which allow for, or bar, access to health care.[159] Stereotypes, such as the supposed misfortune inherent to the experience of impairment, allow the state to shift the "blame" for the socio-economic hardship experienced by PWPSD. In doing so, the state also absolves itself of further responsibility for alleviating such hardship.[160] The medical model of disability has a clear link with personalisation, as is evident from the fact that it is often alternatively referred to as the "personal tragedy" model.[161] Such stereotyping significantly hinders the realisation of the rights of PWPSD, as explained by Watermeyer and Swartz:

> "When confronted with the notion of 'disability', our minds do not turn instinctually to an exploration of possible modes of systematic discrimination and disadvantage. Rather we remain strongly attached to modes of attribution which prize the explanatory system of the body, in accounting for the inequalities we see."[162]

The implications of personalisation in the realm of health care can be severe, as evidenced by Brand's powerful summary of the above-mentioned judgment of Sachs J: "Questions of death are private, not political."[163] The problem of depoliticisation must be acknowledged, as it may prove to be an obstacle to the development of a system of CBMHC which is appropriately resourced and reflective of a human rights-based approach.

2 5 Conclusion

This chapter set out to establish the constitutional norms and state obligations applicable to health care. It was first established that, if the interpretation of socio-

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[158] Brand "The Politics of Need Interpretation" in *Theories of Social and Economic Justice* 20.
[159] M Pieterse *Can Rights Cure?* (2014) 97.
[160] Brand illustrates this with reference to the stereotype that poor people are "lazy or lack entrepreneurial vigour", a belief that caused a government spokesperson to state that implementing social assistance programmes would be a "handout" that would cause "a culture of dependency" among poor people. See Brand "The Politics of Need Interpretation" in *Theories of Social and Economic Justice* 18.
[161] J Morris "Feminism and Disability" (1993) 43 *Feminist Review* 57 68; M A Jackson "Models of Disability and Human Rights: Informing the Improvement of Built Environment Accessibility for People with Disability at Neighborhood Scale" (2018) 7 *Laws* 1 4; R Kayess & P French "Out of Darkness into Light – Introducing the Convention on the Rights of Persons with Disabilities" (2008) 8 *Hum. Rts. L. Rev.* 1 5.
[162] B Watermeyer & L Swartz "Introduction and Overview" in B Watermeyer, L Swartz, T Lorenzo, M Schneider & M Priestley (eds) *Disability and Social Change: A South African Agenda* (2006) 1 1.
[163] D Brand *Courts, Socio-Economic Rights and Transformative Politics* LLD dissertation, Stellenbosch University (2009) 143.

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economic rights is proceduralised, this may prove to be an obstacle to the realisation of the right of access to health care for PWPSD. However, adopting a specific value-based approach can help illuminate the purposes which underpin the right of access to health care services. Particularly, when the constitutional values are conceptualised to be inclusive of PWPSD, the rights in the Bill of Rights can be interpreted to encompass as wide a range of entitlements and freedoms for PWPSD as possible. Consequently, it is possible to determine the substantive end goals against which efforts to realise the right of access to health care services should be measured.

Second, it was established that, if the State were to interfere with the existing enjoyment of the right of access to health care services, it could amount to a violation of the negative obligation imposed by section 27. Particularly, if the State promotes deinstitutionalisation without scaling up CBMHC, it may be considered a negative violation, triggering the State's duty to justify such a deprivations according to the stringent proportionality inquiry of the general limitations clause, section 36. Further, it was noted that the classification of a particular aspect of CBMHC as being part of the negative obligation is not simply an abstract matter, but has practical significance: the stricter justificatory standards applicable to negative rights may make it easier to hold the state to account before a court.

Thereafter, the focus shifted to the state's positive obligations in terms of section 27 of the Constitution and the qualifiers to these obligations. The first qualifier, reasonableness, has been developed by the Court into the reasonableness review model. This model introduces criteria which are crucial to the development and implementation of a programme of CBMHC for PWPSD. First, the need to provide for urgent needs in the short-term was discussed. This requirement was linked to the concept of minimum core obligations, which may aid in the interpretation of the state's obligations, despite not being recognised as an independent cause of action by the Constitutional Court. Second, the allocation of appropriate resources was identified as a criterion which is of particular relevance to deinstitutionalisation initiatives, which must be accompanied by sufficient investment in CBMHC. The third criterion is the clear allocation of responsibilities to various spheres of government, which is crucial to address the range of determinants which impact on psychosocial disability. Finally, this part highlighted the significance of meaningful engagement for

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PWPSD, who have historically been disregarded in decision-making processes. These criteria serve to clarify the obligations of the state in respect of health care for PWPSD.

In the discussion of progressive realisation, it was noted that this qualifier presents the state with a measure of flexibility in light of difficulties in realising rights within a short time frame. However, the qualifier must not be interpreted so that the right can no longer give effect to its underlying purposes. Thus, the importance of the *full* realisation of the right as the ultimate goal was highlighted. It was noted that this would require a greater number and a wider range of persons to benefit from improvements in the access to and quality of the right. In this regard, special measures must be adopted to ameliorate the situation of disadvantaged and marginalised groups. Furthermore, a system for monitoring progress in the realisation of the right must be established, to allow for the relevant programmes to be revised as needed. Such revision requires a participatory approach. Finally, the discussion of progressive realisation concluded with a brief overview of the doctrine of non-retrogression, including that it sets a strict justificatory standard, which calls for the consideration of a number of factors.

In respect of the third qualifier, the availability of resources, it was noted that resource constraints cannot be called upon as to justify a state's failure to budget appropriately and in line with its constitutional obligations. The relevance of the vulnerability of PWPSD as a group was emphasised, and linked to the reasonableness consideration which calls for the degree of denial of a right not to be left out of account. Further, a link was drawn between insufficient resource allocation for mental health care and the depoliticisation of the needs and interests of PWPSD. The relevance of this line of critique is that justifications based on depoliticisation, which align with the medical model of disability, may be invoked by the state to attempt to evade accountability in respect of the right of access to health care services for PWPSD.

The key norms and obligations identified in this chapter will later serve as the basis for evaluating the legislation, policy and practice relevant to the system of CBMHC for adult PWPSD in South Africa. The following chapter contributes further

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normative standards and obligations in respect of health care for PWPSD, by analysing select sources of international human rights law.

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CHAPTER 3: COMMUNITY-BASED MENTAL HEALTH CARE: INTERNATIONAL LAW STANDARDS AND OBLIGATIONS

3 1 Introduction

This chapter analyses relevant regional and international human rights instruments in order to derive standards applicable to health care for PWPSD, particularly CBMHC. Before determining these standards, the various ways in which international law can find application in South African domestic law are considered, as well as the status of the relevant international law sources. Thereafter, the following key international human rights instruments are analysed: the ICESCR, the UN Disability Convention; the ACHPR; and the African Disability Protocol. Further, key documents on mental health care authored by the WHO will also be analysed.

The precise structure of the analysis varies for each of these instruments, based on the structure and content of the instrument itself. In general, the point of departure is the nature of the obligations imposed by the instrument, followed by an analysis of the normative content and obligations imposed by particular provisions related to CBMHC.

3 2 The relevance of international human rights law

International law is relevant to South Africa within both the international and domestic spheres.

First, international agreements create international obligations between state parties. These international obligations were described by Ngcobo J in the minority judgment in *Glenister v President of the Republic of South Africa* as "an undertaking to take steps to comply with the substance of the agreement".[164] This interpretation aligns with Article 26 of the Vienna Convention on the Law of Treaties,[165] which provides that parties to a treaty must perform their obligations in good faith.

In addition to obligations on an international level, international law has implications for domestic law as regulated by the provisions of the South African Constitution. The first relevant provision in this regard is section 39(1)(b), which provides: "When interpreting the Bill of Rights, a court, tribunal or forum must

[164] 2011 (3) SA 347 (CC) para 91.
[165] Adopted 23 May 1969; entered into force 27 January 1980 1155 UNTS 331.

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consider international law." According to the precedent set by the South African Constitutional Court in *S v Makwanyane*, section 39(1)(b) includes both binding and non-binding international law.[166] So-called "soft" international law includes the General Comments of treaty bodies, which have been considered by the Constitutional Court in numerous cases.[167] Although General Comments are not legally binding, they constitute "persuasive sources of interpretation" of state obligations under the relevant international human rights instruments.[168] Other authoritative interpretations, decisions or commentaries by official monitoring or judicial bodies may similarly be considered.[169]

With reference to the jurisprudence of the CESCR, Liebenberg argues that reliance on section 39(1)(b) presents a "further avenue for deepening the synergies" between domestic and international law.[170] For example, if minimum core obligations and other core concepts developed by the CESCR are considered in the interpretation of socio-economic rights, then the current model of reasonableness review could be developed into "a more substantive model" for the evaluation of measures taken by the State.[171] However, it must still be noted that section 39(1)(b)

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[166] 1995 3 SA 391 (CC) para 35. See further, for example, *Mahlangu v Minister of Labour* 2021 2 SA 54 (CC) paras 11 and 194, where the Court referred to reports of the International Labour Organisation.

[167] For example: UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23) in *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 29; UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23) in *Mazibuko and Others v City of Johannesburg and Others* 2010 4 SA 1 (CC) para 40; UN Committee on Economic, Social and Cultural Rights General Comment 7: "The right to adequate housing (Art. 11.1 of the Covenant): forced evictions" (1997) E/1998/22 in *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes and Others* 2010 3 SA 454 (CC) para 232; UN Committee on Economic, Social and Cultural Rights General Comment 4: "The right to adequate housing (Art 11.1 of the Covenant" (1991) E/1992/23 in *Jaftha v Schoeman and Others; Van Rooyen v Stoltz and Others* 2005 2 SA 140 (CC) para 24; UN Committee on Economic, Social and Cultural Rights General Comment 13: "The right to education (Art. 13 of the Covenant)" (1999) E/C 12/1999/10 in *Governing Body of the Juma Musjid Primary School and Others v Essay NO and Others* 2011 8 BCLR 761 (CC) paras 40-41; UN Committee on Economic, Social and Cultural Rights General Comment 16: "The equal right of men and women to the enjoyment of all economic, social and cultural rights (Art. 3 of the Covenant)" (2005) E/C 12/2005/4 in *Mahlangu and Another v Minister of Labour and Others* 2021 2 SA 54 (CC) paras 40-41.

[168] S Liebenberg "South Africa and the International Covenant on Economic, Social and Cultural Rights: Deepening the Synergies" (2020) 3 *South African Judicial Education Journal* 12 26.

[169] For example, in *Sonke Gender Justice NPC v President of the Republic of South Africa* 2021 3 BCLR 269 (CC), the Constitutional Court referred to the Robben Island Guidelines for the Prohibition and Prevention of Torture in Africa, authored by the African Commission, as "a useful tool for interpreting the obligations in related binding instruments. See African Commission on Human and Peoples' Rights *Robben Island Guidelines for the Prohibition and Prevention of Torture in Africa*, 23 October 2002.

[170] Liebenberg (2020) *South African Judicial Education Journal* 39.

[171] See further chapter two part 2 4 2; Liebenberg (2020) *South African Judicial Education Journal* 32.

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is not intended to incorporate international agreements into the Constitution, or to create entirely new constitutional obligations.[172]

The second relevant provision regulating the status of international law in the domestic sphere is section 231 of the Constitution, which sets out distinct steps which must be followed before an international agreement can become law in South Africa. The national executive must sign the agreement in terms of section 231(1), the National Assembly and National Council of Provinces must approve the agreement in resolution in terms of section 231(2), and the agreement must then be enacted into law by national legislation in terms of section 231(4). Thus, without incorporation in terms of section 231(4), South Africa is bound by a ratified agreement on the international plane only.[173] The incorporation of international agreements in terms of section 231(4) simply creates "ordinary domestic statutory obligations", and cannot create new constitutional rights and obligations.[174]

If not incorporated in this manner, international law may still influence the interpretation of legislation, as section 233 of the Constitution provides:

> "When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law."

This duty to favour interpretations which are in line with international law does not only apply where there is ambiguity in a statute.[175] While this provision has not yet seen significant application in the adjudication of socio-economic rights, it holds promise as means of bringing the interpretation of domestic legislation in line with international human rights law.[176]

In the event that incorporation in terms of section 231 has not taken place, persons who wish to claim the protections afforded by international law must generally attempt to do so by relying on sections 39(1)(b) and 233 of the

[172] *Glenister v President of the Republic of South Africa and Others* 2011 3 SA 347 (CC) para 108.
[173] Section 231(3) provides certain exceptions: "An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time." A further exception is found in section 231(4), namely that "a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is in consistent with the Constitution or an Act of Parliament."
[174] *Glenister v President of the Republic of South Africa and Others* 2011 3 SA 347 (CC) para 181.
[175] Liebenberg (2020) *South African Judicial Education Journal* 29.
[176] 29.

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Constitution. In other words, while non-incorporation may hinder the direct application of international law in the domestic sphere, binding and non-binding international human rights instruments remain relevant as guides to the interpretation of the Bill of Rights and legislation.

3 3 The status of select sources of international law

In this part, a brief overview of the status of key international law sources is provided. The first of these, the ICESCR, was signed by South Africa on 3 October 1994, and ratified on 12 January 2015. South Africa has not signed or ratified the Optional Protocol to the ICESCR.[177] In its Concluding Observations on the initial report of South Africa, adopted on 12 October 2018, the CESCR described the South African Constitution as "particularly progressive in the area of economic, social and cultural rights".[178] However, the CESCR recommended reform which would allow for provisions in the Covenant to be "directly invoked before domestic courts".[179]

South Africa signed both the UN Disability Convention and its accompanying Optional Protocol[180] on 30 March 2007 and ratified both instruments on 30 November 2007. On 9 December 2020, the South African Law Reform Commission ("SALRC") published an issue paper which called for comments on a broad range of issues related to the proposed domestication of the Convention.[181] The period for comments, initially set to close on 31 May 2021, was extended to 30 June 2021. The Convention could thus be incorporated as national legislation, instead of only being relevant as guides to the interpretation of the Bill of Rights and domestic legislation. However, the proposed timeline for such incorporation is uncertain.

South Africa acceded to the ACHPR on 9 July 1996. In 2016, the African Commission adopted Concluding Observations on South Africa's report submitted in

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[177] Adopted 5 March 2009, entered into force 5 May 2013.
[178] UN Committee on Economic, Social and Cultural Rights *Concluding observations of the initial report of South Africa as adopted by the Committee at its 64th session,* 24 September – 12 October 2018 para 4.
[179] Para 5.
[180] Adopted 13 December 2006; entered into force 3 May 2008.
[181] SALRC *Issue Paper No 39: Domestication of the United Nations Convention on the Rights of Persons with Disabilities* (148/2020).

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accordance with Article 62 of the ACHPR.[182] The African Commission commended South Africa for its adoption of a range of laws and policies, and the establishment of human rights-based institutions, which promote the rights guaranteed under the ACHPR within the domestic sphere.[183]

South Africa signed the African Disability Protocol on 29 April 2019, but has not ratified the instrument. The Protocol has not been ratified by a minimum of fifteen member states, as required by Article 38 of the Protocol, and has therefore not yet entered into force. However, once the instrument enters into force, Article 18 of the Vienna Convention on the Law of Treaties would apply. In terms of this provision, a State's signature indicates an undertaking to act in good faith and not in a way that would defeat the object and purpose of the treaty.

Finally, key documents authored by the WHO will be discussed. While these documents are not binding in nature, they may still hold relevance as guides to interpretation in terms of sections 39(1)(b) and 233 of the Constitution, as discussed in the previous section.

3 4 The International Covenant on Economic, Social and Cultural Rights

3 4 1 Introduction

The ICESCR and the accompanying General Comments by the CESCR have contributed significantly to setting international law standards in relation to health, including for PWPSD. In respect of mental health care, the central provision in the ICESCR is Article 12.1, which provides:

> "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

The CESCR has expressly stated that Article 12 does not constitute "a right to be *healthy*".[184] The phrasing of this provision – referring to "the highest attainable standard" – acknowledges that there are limits to the powers of the State in relation

[182] African Commission on Human and Peoples' Rights *Concluding observations and recommendations on the combined second periodic report under the African Charter on Human and Peoples' Rights and the initial report under the Protocol to the African Charter on the Rights of Women in Africa of the Republic of South Africa as adopted by the Commission at its 58th Ordinary Session, 6 – 20 April 2016*.

[183] Paras 10-12.

[184] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 8.

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to health.[185] For example, the impact of Article 12.1 is limited by every individual's biology, and a State cannot guard individuals against every single risk to their health.[186] The provision nonetheless encompasses a range of freedoms and entitlements, with corresponding obligations on the part of States Parties. The analysis of these freedoms, entitlements, and state obligations, is structured in three main parts. First, the general nature of States Parties obligations is considered. Second, the normative content of the right will be considered in terms of the "AAAQ" framework, founded on the elements of "availability", "accessibility", "acceptability", and "quality".[187] Thereafter, the analysis focuses on the "RPF" framework, which elaborates on State obligations in relation to health with reference to the duties to "respect", "protect" and "fulfil".[188]

3 4 2 The general nature of States Parties' obligations

The broad obligations of States Parties in terms of the ICESCR are found in Article 2.1, which provides:

> "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

There are three concepts which are central to understanding the duties imposed by Article 2.1, namely, progressive realisation, minimum core obligations, and resource constraints. The first of these, progressive realisation, has already been discussed in the previous chapter.[189] The second relevant concept is "minimum core obligations", described as the duty on States Parties to satisfy "minimum essential levels of each of the rights" in the ICESCR.[190] In relation to Article 12, the CESCR has listed a wide range of "core obligations", including:

> "(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; [and]
>
> ...

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[185] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 9.
[186] Para 9.
[187] Para 12.
[188] Para 33.
[189] See further chapter 2 part 2 4 3.
[190] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23 para 10.

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(e) To ensure equitable distribution of all health facilities, goods and services..."[191]

While "resource constraints" must also be taken into account when assessing whether a State has discharged its obligations in terms of the minimum core of a right,[192] the State bears the burden of proving that "...every effort has been made to use all resources that are at its disposal in an effort to satisfy, as a matter of priority, these minimum obligations".[193] An additional consideration, the use of maximum available resources, is thus also introduced by the ICESCR.

It must further be noted that certain obligations will exist irrespective of resource constraints, including monitoring the progress made in the realisation of rights and developing socio-economic rights programmes.[194] Further, resource constraints may not be raised as a justification for the failure to realise the rights of vulnerable groups, including PWD, who must be protected even during times of extreme resource constraints through the creation of "relatively low-cost targeted programmes".[195]

3 4 3 The AAAQ framework

According to CESCR, the right to health comprises the following four "interrelated and essential elements": "availability", "accessibility", "acceptability", and "quality".[196] These four elements, referred to as the AAAQ framework, indicate the normative

[191] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 43. Further, in para 4, the CESCR states that the right to health "...extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment". However, Yamin argues that the right to health should not be seen to "swallow all other rights on which it is interdependent" but that this passage by the CESCR should rather be viewed as an acknowledgement of the fact that health is affected by a wide range of factors. See A Yamin "The right to health" in J Dugard, B Porter, D Ikawa & L Chenwi (eds) *Research Handbook on Economic, Social and Cultural Rights as Human Rights* (2020) 159 165.

[192] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23 para 10.

[193] *Marcia Cecilia Trujillo Calero v Ecuador*, Communication No. 10/2015, Views adopted by the Committee on the Rights of Persons with Disabilities under the Optional Protocol to the Covenant at its sixty-third session (12 – 29 March 2018) para 14.3.

[194] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23 para 11.

[195] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23 para 12; UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22) para 10.

[196] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 12.

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standards which the State must meet in order to fulfil its obligations in respect of the right to health.

The first of these four attributes, availability, requires that health facilities, goods and services are available in sufficient quantity.[197] While the facilities, goods and services may differ in nature from one State Party to another, depending on the "developmental level" of the State, the attribute of availability at the very least demands adequate health care facilities, such as clinics and hospitals, and trained health care professionals.[198]

Secondly, health facilities, goods and services must be made accessible. Accessibility consists of four mutually-supporting components, of which the first is "non-discrimination". While disability is not expressly included as a prohibited ground of discrimination in the ICESCR, the CESCR has confirmed that the inclusion of "other status" extends the protections of Article 2.2 to PWD.[199] Second, "physical accessibility" calls for health facilities, goods and services to be located within "safe physical reach for all sections of the population", in particular for PWD as a vulnerable group, and for persons living in rural areas.[200] Third, "economic accessibility" entails that health care services are affordable and that lower income households are not "disproportionately burdened with health expenses as compared to richer households".[201] The fourth and final component of the attribute of accessibility is "information accessibility", which requires that information relating to health concerns be made accessible, without violating the right to have one's personal health information be treated confidentially.[202]

The third attribute of the AAAQ framework requires that health facilities, goods and services are acceptable by adhering to medical ethics and affording appropriate respect to cultural differences, as well as the specific requirements arising from

[197] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 12(a).
[198] Para 12(a).
[199] UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22 para 5; UN Committee on Economic, Social and Cultural Rights General Comment 20: "Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)" (2009) E/C.12/GC/20 para 28.
[200] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 12(b).
[201] Para 12(b).
[202] Para 12(b).

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gender and age.[203] Furthermore, the aim must be to improve the health status of those who make use of the relevant facilities, goods and services.[204]

Finally, health facilities, goods and services must be "scientifically and medically appropriate and of good quality",[205] which includes the requirement that health care professionals must be appropriately skilled. The CESCR considers quality one of the "essential elements" of the right to health, which is interlinked with availability, accessibility, and acceptability.[206]

3 4 4 The RPF framework

The general obligations of States Parties in terms of Article 2(1) read with the AAAQ framework, give rise to specific obligations on the part of States Parties. The RPF framework has been used by the CESCR in its General Comments as a useful analytical framework for delineating the precise negative and positive duties imposed by the ICESCR on States Parties.[207]

The first component of the framework, the State's obligation *to respect*, prohibits it from interfering directly or indirectly with the enjoyment of the right, including refraining from implementing discriminatory practices which bar access to health care services.[208] In relation to mental health care, it is important to note that the CESCR considers the application of "coercive medical treatments" a violation of the State's obligation to respect the right to health, unless such treatment occurs "on an exceptional basis for the treatment of mental illness".[209] The CESCR further notes

[203] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 12(c).
[204] Para 12(c).
[205] Para 12(d).
[206] Para 12.
[207] The basis for this framework is the typology of obligations developed by Henry Shue in H Shue *Basic Rights: Subsistence, Affluence and US Foreign Policy* (1980). The CESCR has made extensive use of this framework. See for example: UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 33; UN Committee on Economic, Social and Cultural Rights General Comment 12: "The right to adequate food (art. 11)" E/C.12/1999/5 para 15; UN Committee on Economic, Social and Cultural Rights General Comment 19: "The right to social security (art. 9)" E/C.12/GC/19 para 43..
[208] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 34.
[209] Para 34.

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that exceptions of this kind may only take place subject to "specific and restrictive conditions".[210]

Second, the State has an obligation *to protect,* by preventing third parties from interfering with the enjoyment of the guarantees under Article 12, such as preventing the privatisation of health care from becoming an obstacle to the availability, accessibility, acceptability, and quality of health care.[211] A further key component of the obligation to protect, is the duty on the State to confirm that medical practitioners and health professionals are appropriately educated and skilled, and adhere to relevant ethical standards and codes of conduct.[212]

Third, the duty *to fulfil* – subdivided into duties *to facilitate, provide, and promote*[213] – requires the adoption of a wide range of measures, including those of a legislative, administrative, budgetary, judicial, and promotional nature, aimed at achieving the full realisation of the right.[214] In respect of PWD, the CESCR identifies the following general duties applicable to all States Parties: to monitor the extent of the issues faced by PWD in that State, to conceive and implement policies and programmes aimed at addressing such issues, and to budget appropriately for these initiatives.[215] In relation to the application of Article 12 to PWD in particular, the CESCR has emphasised the importance of health care and rehabilitation services which facilitate social reintegration and an "optimum level of independence and functioning".[216]

In addition to the obligations discussed above, it is also important to take note of the obligation of non-discrimination. The primary source of this obligation is Article 2.2 of the ICESCR, which provides:

> "The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

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[210] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 34.
[211] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The right to the highest attainable standard of health (Art. 12 of the Covenant)" (2000) E/C 12/2000/4 para 35.
[212] Para 35.
[213] Para 37.
[214] Para 33.
[215] UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22 para 13.
[216] Para 34.

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This provision does not expressly mention disability as a prohibited ground of discrimination. However, the CESCR has stated that disability is included through the mention of "other status".[217] Further, "health status", which includes mental health, also falls within the ambit of "other status".[218] While the primary lens for this thesis is the right to health, the obligation of non-discrimination is cross-cutting and will have a significant impact on the right to health for PWPSD. For example, in its General Comment on the rights of PWD under the ICESCR, the CESCR calls for the adoption of anti-discrimination legislation:

> "Such legislation should not only provide persons with disabilities with judicial remedies as far as possible and appropriate, but also provide for social policy programmes which enable persons with disabilities to live an integrated, self-determined and independent life".[219]

The CESCR has further stated that the obligation of anti-discrimination requires the allocation of sufficient resources to allow for PWD to participate on an equal basis in their communities.[220] Health status as a prohibited ground of discrimination also calls for the adoption of measures to combat stigma on the basis of psychosocial disability.[221] The obligation of non-discrimination is therefore key to an effective system of CBMHC.

3 4 5 Conclusion

When analysed with reference to the AAAQ and RPF frameworks, the ICESCR is undeniably a key source of international law standards and obligations applicable to health. Furthermore, the obligation of non-discrimination, as set out in the CESCR's General Comments, will also be a key point in the evaluation of South African mental health care legislation, policy and practice. However, as the ICESCR was not drafted with the rights of PWPSD as its central concern, this instrument provides limited guidance in relation to CBMHC for PWPSD in particular. It is thus necessary to

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[217] UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22 para 5; UN Committee on Economic, Social and Cultural Rights General Comment 20: "Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)" (2009) E/C.12/GC/20 para 28.
[218] UN Committee on Economic, Social and Cultural Rights General Comment 20: "Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)" (2009) E/C.12/GC/20 para 33.
[219] UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22 para 16.
[220] Para 17.
[221] UN Committee on Economic, Social and Cultural Rights General Comment 20: "Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2)" (2009) E/C.12/GC/20 para 33.

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supplement the obligations and standards set out in this part with those found in the UN Disability Convention.

3 5 The UN Convention on the Rights of Persons with Disabilities

3 5 1 Introduction

While various soft law instruments on the rights of PWD had been adopted prior to the adoption of the UN Disability Convention, the potential of these instruments to effect change was curbed by the fact that they were non-binding in nature.[222] Furthermore, many of these instruments have also been criticised for their adherence to the medical model of disability.[223] As the medical model strongly favours institutionalisation, the medicalisation[224] of disability has had a profound impact on the right to health of PWPSD in particular.[225]

The UN Disability Convention is thus a landmark instrument, as a binding treaty which is characterised by a "definitive abandonment of the medical model" in favour of a human rights-based understanding of disability.[226] This approach by the drafters of the UN Disability Convention in respect of defining "disability" is discussed in greater detail in the next part, to clarify the scope of the application of the Convention. Thereafter, the state obligations set out in Article 4 of the Convention are analysed, in order to provide a foundation for the analysis of Article 25 ("Health"), Article 26 ("Habilitation and rehabilitation"), and Article 19 ("Living independently and being included in the community"). As the right to health is the primary lens employed in this thesis, Article 25 of the Convention occupies a central place in the analysis which follows. However, it is argued that reading Article 25 in conjunction with Article 26 and Article 19 can contribute clearer standards for CBMHC for PWPSD. Finally, the issue of involuntary treatment of PWPSD is discussed, with

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[222] Kayess & French (2008) *Hum. Rts. L. Rev.* 16.
[223] See chapter one part 1 4.
[224] See R Garden "Disability and Narrative: New Directions for Medicine and the Medical Humanities" (2010) 36 *Med Hum* 70 72:

> "To a great extent, the differences and impairments that we call disability have historically been exclusively defined by medicine, through diagnosis and treatment and through the gatekeeping role in regard to benefits. This medicalisation of disability situates the problem in the individual and puts the solution for the problem in the hands of the clinician or team who diagnoses and treats, as well as assigning to the disabled person the responsibility to 'overcome' the impairment and strive to reach a standard of normalcy."

[225] J Hayes & E Hannold "The Road to Empowerment: A Historical Perspective on the Medicalization of Disability" (2007) 30 *J Health Hum Serv Adm* 352 363.
[226] Broderick & Ferri *International and European Disability Law and Policy* 60. For an in-depth analysis of the human rights-based approach to the Convention, see also Degener (2016) *Laws* 1-35.

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reference to the CRPD's interpretation of rights which intersect with the right to health, including Article 12 ("Equal recognition before the law"), Article 14 ("Liberty and security of person"), and Article 19.

3 5 2 Defining disability

The reconceptualisation of disability in terms of the human rights-based model can in part be attributed to the unprecedented level of participation by civil society representatives, particularly members of DPOs, during the negotiations leading up to the adoption of the UN Disability Convention.[227] During this period of negotiation, a contentious point was whether the Convention should include a definition of "disability", as some parties contended that a static definition would not be able to accommodate changing understandings of disability.[228] Others raised the concern that the decision not to include a definition would result in inconsistent application of the Convention, as States Parties would rely on various differing domestic definitions of disability.[229] The outcome of this debate is that "disability" is not defined in Article 2 ("Definitions"), but Article 1 ("Purpose") does include the following non-exhaustive list:

> "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

Similar wording is used in paragraph (e) of the Preamble to the Convention, in which "disability" is further described as "an evolving concept".[230] The CRPD made use of this paragraph to support the argument that the Convention is founded on the human rights-based model of disability.[231] The CRPD further stated that a condition which is initially understood to be illness, may later be considered an "impairment" for the purposes of the Convention, in the event that such illness is chronic or endures for an extended period of time.[232] To support this interpretation, the CRPD also cited paragraph (i) of the Preamble to the UN Disability Convention, which calls

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227 Broderick & Ferri *Disability Law and Policy* 60.
228 65.
229 66.
230 The full text of paragraph (e) reads: "Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others."
231 *S.C. v Brazil*, Communication No. 10/2013, Decision adopted by the Committee on the Rights of Persons with Disabilities at its twelfth session (15 September-3 October 2014) para 6.
232 Para 6.3.

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for recognition of the diversity of PWD.[233] In summary, both the wording of the Convention and the interpretation thereof by the CRPD indicate that the Convention can be applied to a broad class of persons, including PWPSD.

3 5 3 The general nature of States Parties' obligations

As the UN Disability Convention is intended to be "a complement to existing human rights treaties",[234] it is unsurprising that the Convention and the ICESCR impose the same broad categories of state obligations. The RPF framework employed in the earlier discussion of the ICESCR also applies to the Convention, as confirmed in the United Nations Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol ("Parliamentarians' Handbook"),[235] as well as in the General Comments of the CRPD.[236] Further, Article 4.2 of the UN Disability Convention and Article 2.1 of the ICESCR bear close similarities in formulation. Article 4.2 of the Convention provides:

> "With regard to economic, social and cultural rights, each State Party undertakes to take measures to the *maximum of its available resources* and, where needed, within the framework of international cooperation, *with a view to achieving progressively the full realization* of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law."[237]

With these similarities in the texts as a point of departure, the CRPD has also interpreted state obligations with reference to many of the same foundational concepts which underpin the obligations in the ICESCR. Progressive realisation in particular has been extensively developed by the CRPD, in line with the interpretations preferred by the CESCR. With express reference to General Comment 3 of the CESCR,[238] the CRPD has confirmed that steps taken to realise progressively the rights in the Convention must be "deliberate, concrete, targeted

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[233] *S.C. v Brazil*, Communication No. 10/2013, Decision adopted by the Committee on the Rights of Persons with Disabilities at its twelfth session (15 September-3 October 2014) para 6.3. As illustration of the combined impact of paragraphs (e) and (i) of the Preamble, and Article 1 of the Convention, see also para 7.6 of *X v Tanzania,* Communication No. 22/14, Views adopted by the Committee on the Rights of Persons with Disabilities at its eighteenth session (14 August-1 September 2017), where the Committee held that the application of the Convention extends to persons with albinism.
[234] United Nations *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* (2007) 5.
[235] 20.
[236] See, for example, UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) paras 47, 50 and 54.
[237] Own emphasis.
[238] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23.

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and use all appropriate means".[239] The CRPD has similarly noted that progressive realisation as referred to in the Convention implies the same strict justificatory standards which apply to retrogressive measures taken in respect of rights in the ICESCR.[240]

However, it must be noted that Article 12 is not subject to progressive realisation.[241] While the right to health is the primary lens for this thesis, it is acknowledged that the recognition of the legal capacity of PWPSD "on an equal basis with others in all aspects of life" impacts on the right to health. In particular, Article 12(4) imposes the obligation on States Parties to create "appropriate and effective safeguards", intended to respect and protect the autonomy of PWPSD. For example, measures which affect the exercise of legal capacity by PWPSD may only "apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body". These obligations are not subject to progressive realisation, but require immediate steps to be taken.[242]

The CRPD has also recognised the existence of minimum core obligations, including in the context of Article 28 ("Adequate standard of living and social protection")[243] and Article 19 ("Living independently and being included in the community").[244]

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[239] UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 41.
[240] UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 45; *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland carried out by the Committee on the Rights of Persons with Disabilities under article 6 of the Optional Protocol to the Convention* Report revised by the Committee at its sixteenth session (15 August-2 September 2016) para 46.
[241] UN Committee on the Rights of Persons with Disabilities General Comment 1: "Article 12: Equal recognition before the law" (2014) GE.14-03120 (E) para 12.
[242] Para 12.
[243] These include that "…persons with disabilities should not be discriminated against in the exercise of their right". See further *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland carried out by the Committee on the Rights of Persons with Disabilities under article 6 of the Optional Protocol to the Convention* Report revised by the Committee at its sixteenth session (15 August-2 September 2016) para 36.
[244] These include the "immediate obligation to eliminate discrimination against individuals or groups of persons with disabilities… [which] requires States parties to repeal or reform policies, laws and practices that prevent persons with disabilities from, for example, choosing their place of residence, securing affordable and accessible housing, renting accommodation or accessing such general mainstream facilities and services as their independence would require." See UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 45.

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While the UN Disability Convention mirrors the general state obligations imposed in terms of the ICESCR, this instrument does more than simply affirm, in an abstract sense, that rights already enshrined in other human rights instruments also apply to PWD.[245] Rather, according to Mégret, the Convention also reformulates these existing rights in order to clarify how they would apply to PWD.[246] In addition to "affirmation" and "reformulation", Mégret introduces two further functions of the UN Disability Convention, "extension" and "innovation", which he defines as follows:

> "In some cases, the Convention actually comes up with new categories of rights which significantly prolong a number of existing rights... Finally, the Convention also comes very close to creating new rights, rights that inhere in the experience of disability and are arguably, at the least in the particular form in which they are presented, specific to persons with disabilities..."

Megrét further contends that the Convention is consequently more prescriptive in respect of the means which should be used to implement the enshrined rights.[247] A key provision in this regard is Article 4.1, which encompasses a range of more specific undertakings on the part of State Parties. An important undertaking is the aim of eliminating discrimination against PWD, originating from any person or organisation or any "laws, regulations, customs and practices", in terms of Articles 4.1(b) and (e). In terms of Article 4.1(c), the interests of PWD must be mainstreamed, and considered in the development and implementation of all policies and programmes. Article 4.1(d) requires that States Parties must ensure that "public authorities and institutions" do not act in contravention of the Convention. Finally, in line with Article 4.1(i) all "professionals and staff" who work with PWD must receive training in respect of the rights contained in the Convention, to improve their capacity to contribute to the realisation of those rights.

These provisions, read with Article 4.2 of the UN Disability Convention and the interpretations of core concepts by the CRPD, provide clarity on the state obligations in relation to the socio-economic rights in the Convention.

3 5 4 Community-based mental health care: relevant provisions

In this section, three key provisions of the UN Disability Convention will be read together with the aim of deriving relevant standards for CBMHC: Article 25, the right

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[245] F Mégret "The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights" (2008) 30 *Hum. Rights Q* 1 10.
[246] 6.
[247] 13.

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to health; Article 26, the right to habilitation and rehabilitation; and Article 19, the right to living independently and being included in the community. While these must be viewed as mutually supportive and interrelated, the primary lens for this thesis, and the provision at the centre of the analysis in this section, is the right to health. The point of departure is thus Article 25, which provides:

> "States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation."

The "General principles" contained in Article 3 are key to the interpretation of all provisions in the UN Disability Convention.[248] Article 3(b) in particular has a profound impact on the interpretation of Article 25, as it establishes non-discrimination as a guiding principle. This principle is clearly reflected in subsections (a) to (f) of Article 25. For example, equality in accessibility features in nearly every subsection: non-discrimination is referred to in subsections (a), (d), (e), and (f); economic accessibility, or affordability, in subsection (a); physical accessibility in subsection (c); and information accessibility in subsection (d). In its Concluding Observations on the initial report of South Africa, the CRPD raised accessibility as a key concern in respect of the right to health, by referring to the unequal geographical distribution of health care facilities, persistent obstacles to the affordability of health care services, and shortcomings in respect of access to health-related information.[249]

Article 3(a), which calls for "respect for inherent dignity, individual autonomy... and independence of persons", also makes a crucial contribution to the interpretation of Article 25. In particular, Article 25(c) obliges States Parties to "[p]rovide these health services as close as possible to people's own communities, including in rural areas". Article 3(a) imbues Article 25(c) with a particular purpose, namely, to further the independence of PWD through CBMHC. The express inclusion of "health-related rehabilitation" in Article 25 also serves to create the conditions for PWD to enjoy

[248] Broderick & Ferri *Disability Law and Policy* 64.
[249] UN Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of South Africa as adopted by the Committee at its 20th session, 27 August – 21 September 2018* para 42.

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independence. The same purpose is outlined in Article 26, the right to habilitation and rehabilitation,[250] which provides:

> "States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to *attain and maintain maximum independence*, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life."[251]

Article 26 and Article 19, titled "Living independently and being included in the community", are closely linked.[252] Both provisions aid in the interpretation of Article 25, particularly Article 19, which has been described by the CRPD as "integral to the full implementation of the Convention".[253] Article 19 directly impacts the right to health, particularly mental health care, as the CRPD has interpreted Article 19 as imposing an obligation to institute measures to effect deinstitutionalisation.[254] The deinstitutionalisation imperative significantly influences the interpretation of the right to health in the case of PWPSD, as noted by the CRPD:

> "General health facilities and services [in terms of Article 25] must be available, accessible, adaptable and acceptable for persons with disabilities in their communities... The provision of nurses, physiotherapists, psychiatrists or psychologists, in hospitals as well as at home, is a part of health care and should not be seen as the fulfilment of a States Party's obligation under Article 19, but rather under Article 25."[255]

3 5 5 Involuntary treatment

In respect of involuntary treatment, a key provision in the UN Disability Convention is Article 25(d), which provides that health care must be provided "on the basis of free and informed consent". The right to consent to medical treatment in terms of Article 25 is, according to the CRPD, "inextricably linked" to the recognition of legal capacity in terms of Article 12.[256] The CRPD has stated that legal capacity

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[250] United Nations *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* (2007) 78: "Habilitation involves learning skills that will enable a person to function in society. These kinds of programmes usually target children born with disabilities. Rehabilitation means restoring capacity and ability. This generally applies to an adult who has to readapt to society after acquiring a disability."

[251] Own emphasis.

[252] UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 90.

[253] Para 6.

[254] *Inquiry concerning the United Kingdom of Great Britain and Northern Ireland carried out by the Committee on the Rights of Persons with Disabilities under article 6 of the Optional Protocol to the Convention* Report revised by the Committee at its sixteenth session (15 August-2 September 2016) para 9.

[255] UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 89.

[256] UN Committee on the Rights of Persons with Disabilities General Comment 1: "Article 12: Equal recognition before the law" (2014) GE.14-03120 (E) para 31.

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may not be denied on the basis of disability. Consequently, the legal and policy frameworks which govern mental health care should no longer allow for substitute decision-making.[257] Instead, PWPSD must be provided with support in the exercise of their legal capacity, in a manner that respects their rights, will and preferences.[258] Where their will and preferences cannot be determined, despite “significant efforts”, decisions which affect the individual must be based on the “best interpretation of will and preferences”.[259] This standard must be applied in place of the principle of “best interests”,[260] as the latter has been considered to be paternalistic and contrary to a human rights-based approach.

The CRPD has also linked the issue of involuntary treatment to Article 14, and considers involuntary commitment to an institution, and other forms of forced treatment, to be a violation of the right to liberty and security of person.[261] Further, in its General Comment on Article 19, the CRPD has called for an end to institutionalisation and involuntary treatment “in all its forms”.[262] A key point in respect of the link between forced treatment and institutionalisation, is how “institution” has been defined by the CRPD. The CRPD has urged States Parties to:

> “Recognise that an institution is any setting in which persons with disabilities cannot exercise their choice concerning living arrangements, and where persons with disabilities lack control and autonomy about their daily lives, irrespective of their size or the kind of services that are provided therein to persons with disabilities.”[263]

The denial of legal capacity allows for institutionalisation to remain “a pervasive and insidious problem”, as family members of PWPSD, or other parties, can consent to PWPSD being placed in institutions.[264] Consequently, to achieve

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[257] UN Committee on the Rights of Persons with Disabilities General Comment 1: “Article 12: Equal recognition before the law” (2014) GE.14-03120 (E) paras 7, 41.
[258] Para 17.
[259] Para 21.
[260] Para 21.
[261] UN Committee on the Rights of Persons with Disabilities *Report of the Committee on the Rights of Persons with Disabilities to the UN General Assembly at its 72nd session* (2017) A/72/55 Annex A paras 10-11.
[262] UN Committee on the Rights of Persons with Disabilities General Comment 5: “On living independently and being included in the community” (2017) GE.17-19008 (E) para 15(d).
[263] UN Committee on the Rights of Persons with Disabilities *Annotated Outline of Guidelines on Deinstitutionalization of Persons with Disabilities, including in Emergency Situations* (16 August – 14 September 2021) 2.
[264] UN Committee on the Rights of Persons with Disabilities General Comment 1: “Article 12: Equal recognition before the law” (2014) GE.14-03120 (E) para 46.

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deinstitutionalisation, the CRPD is of the view that the legal capacity of PWPSD must be recognised and laws which permit involuntary treatment must be abolished.[265]

3 5 6 Conclusion

In the UN Disability Convention, disability is conceptualised in line with a human rights-based approach. This instrument delivers a valuable contribution by, *inter alia*, providing for rights which respond directly to the experience of disability. In particular, the specific obligations arising from Article 25, read with Article 26 and Article 19, provide relevant standards for the provision of CBMHC. In summary, the CRPD recommends that deinstitutionalisation processes include the following:

> "…a comprehensive strategy and plan of actions, with reasonable timelines, benchmarks, human, technical and financial resources, and in the meantime establish a moratorium on new institutionalizations and re-institutionalizations, and ensure full respect of persons with disabilities' autonomy, will and preferences, and genuine choices to live in the community."[266]

3 6 The African Charter on Human and Peoples' Rights

3 6 1 Introduction

In Africa, mental health has historically been intertwined with the politics of race and culture. For example, during the colonial era, mental health diagnoses were an inescapably political matter, as the task of defining and determining "insanity" fell to colonial officials.[267] Psychiatry served to justify oppression by providing a pseudo-scientific basis for stereotypes, such as the notion that Africans do not suffer from depression owing to "an undeveloped sense of individuality".[268] Even in the post-colonial era, strife in Africa continues to impact on collective and individual mental

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[265] It must be noted that there have been obstacles to the translating into practice the CRPD's views on legal capacity, supported decision-making, and the prohibition on involuntary treatment. See, for example, F Mahomed, M Stein & V Patel "Involuntary Mental Health Treatment in the Era of the United Nations Convention on the Rights of Persons with Disabilities" (2018) 15 *PLoS Med* 1 5: "However, stakeholders were of the view that resource differentials necessitate a contextual approach, and there is a need for more research on supported decision-making models that can be applied to low-resource settings. Similarly, they felt that other areas, such as the 'will and preference' standard also require further theorizing, as there is very little conceptual or jurisprudential discourse on this approach."

[266] UN Committee on the Rights of Persons with Disabilities *Annotated Outline of Guidelines on Deinstitutionalization of Persons with Disabilities, including in Emergency Situations* (16 August – 14 September 2021) 7.

[267] E Akyeampong "A Historical Overview of Psychiatry in Africa" in E Akyeampong, A G Hill & A Kleinman (eds) *The culture of mental illness and psychiatric practice in Africa* (2015) 24 28.

[268] Quoted in L Swartz *Culture and mental health: a Southern African view* (1998) 170.

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health.[269] In the CRPD's regional consultations on deinstitutionalisation, participants also raised stigma on the basis of disability as a key concern, with PWDs being described as "forever children who need assistance in every aspect of their lives".[270] Participants in the consultations further identified a "lack of political will" in respect of disability-related issue as a significant obstacle.[271] Given this context, it is imperative that clear obligations and norms relating to health care are established at the African regional level.

3 6 2 The general nature of States Parties' obligations

In this part, the point of departure is the general State obligations imposed by the ACHPR in terms of Article 1, which provides:

> "The Member States of the Organization of African Unity parties to the present Charter shall recognize the rights, duties and freedoms enshrined in this Chapter and shall undertake to adopt legislative or other measures to give effect to them."

The obligations imposed by Article 1 can be better understood when read with the Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights ("Nairobi Guidelines"). The Nairobi Guidelines were adopted by the African Commission, in fulfilment of its mandate in Article 45(1)(b) of the ACHPR. Article 45(1)(b) provides:

> "The functions of the Commission shall be… to formulate and lay down, principles and rules aimed at solving legal problems relating to human and peoples' rights and fundamental freedoms upon which African Government may base their legislations."

In the Nairobi Guidelines, the African Commission classifies State obligations in terms of the following non-hierarchical duties: "to respect, protect, promote and fulfil".[272] While Article 1 calls for the adoption of "legislative *or* other measures", the African Commission considers the provision to impose an obligation to adopt "legislative *and* other measures", including in the realms of policy-making, budgeting

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[269] E Akyeampong, A G Hill & A Kleinman "Introduction" in E Akyeampong, A G Hill & A Kleinman (eds) *The culture of mental illness and psychiatric practice in Africa* (2015) 1 3-4; UN Committee on the Rights of Persons with Disabilities *Guidelines on Deinstitutionalization of Persons with Disabilities, including in Emergency Situations: Summary Note: Regional Consultation of Africa* (2021) 8.

[270] UN Committee on the Rights of Persons with Disabilities *Guidelines on Deinstitutionalization of Persons with Disabilities, including in Emergency Situations: Summary Note: Regional Consultation of Africa* (2021) 9.

[271] 2.

[272] African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (adopted 26 May 2010) 11.

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and initiatives to raise awareness.[273] In the Nairobi Guidelines, the African Commission also clarified the application of core concepts, including progressive realisation and minimum core.[274] According to the Commission, progressive realisation "has been implied into the Charter" and States Parties must "move as expeditiously and effectively as possible towards the full realisation of economic, social and cultural rights".[275] Further, the ACHPR does impose minimum core obligations, which exist irrespective of resource constraints.[276] States also bear a duty, even in the event of severe resource constraints, to prioritise the realisation of the rights of "members of vulnerable and disadvantaged groups".[277]

The African Commission has further identified a general obligation on the part of States Parties to guarantee four attributes in respect of every socio-economic right. These are: "availability"; "adequacy"; "physical and economic accessibility"; and "acceptability".[278] Despite some differences in formulation, these attributes largely correspond in substance to the those set out in the AAAQ framework employed by the CESCR, as discussed above. This framework must be borne in mind when analysing the provisions which govern CBMHC in the next part.

3 6 3 Community-based mental health care: relevant provisions

This part discusses select provisions of the ACHPR which provide relevant standards for CBMHC, with reference to the Nairobi Guidelines, and to the jurisprudence of the African Commission. The primary treaty provision for the analysis in this part is Article 16, which provides:

1. "Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

[273] L Chenwi "The African system" in J Dugard, B Porter, D Ikawa & L Chenwi (eds) *Research Handbook on Economic, Social and Cultural Rights as Human Rights* (2020) 27 33.
[274] 33.
[275] African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (adopted 26 May 2010) 12.
[276] 13.
[277] 13.
[278] 10.

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As with Article 12 of the CESCR, Article 16 does not constitute "the right to be healthy".[279] However, the provision does guarantee certain freedoms, including freedom from involuntary medical treatment, as well as entitlements, such as access to health facilities, goods and services without discrimination.[280] Article 16 has been interpreted by the African Commission to include special protection for vulnerable groups, including the following obligation on the part of the State:

> "Ensure provision of those specific health services needed by persons with psychosocial, intellectual and physical disabilities, including early diagnosis and access to humane and dignified care and treatment to enable their full enjoyment of life..."[281]

The Nairobi Guidelines further call for deinstitutionalisation, in favour of integrating mental health into general health care systems within communities.[282] The human rights of PWPSD who continue to reside in institutions must be respected, and the provision of health care within institutions must be regulated and monitored to prevent abusive practices against PWPSD.[283]

In addition to the Nairobi Guidelines, a prominent source for the interpretation of the right to health for PWPSD in the ACHPR is *Purohit and Moore v The Gambia* ("*Purohit*").[284] This communication of the African Commission concerned the Lunatics Detention Act, at the time the primary mental health legislation in the Gambia.[285] This Act provided for the detention of anyone deemed "an idiot or person of unsound mind".[286] The Act did not allow for any procedures for appeal or review of the mental health diagnosis, nor did it limit the periods for which patients could be detained.[287] The Commission found a violation of Article 16, on the following basis:

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[279] African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (adopted 26 May 2010) 24.
[280] 24.
[281] 27.
[282] 27.
[283] 27.
[284] *Purohit and Moore v The Gambia*, Communication No. 241/2001, Sixteenth Activity report of the African Commission on Human and Peoples' Rights 2002-2003, Annex VII.
[285] The Lunatics Detention Act was enacted in 1917 and had last been amended in 1964. As the African Commission states in *Purohit*, para 42: "There is no doubt that since 1964, there have been many developments in the field of human rights, particularly addressing the rights of persons with disabilities. As such, the LDA should have long been amended to bring it in line with the changed circumstances". As noted in part 3 6 1 of this chapter, the colonial influences on mental health care and approaches to psychosocial disability have persisted in many African countries.
[286] *Purohit and Moore v The Gambia*, Communication No. 241/2001, Sixteenth Activity report of the African Commission on Human and Peoples' Rights 2002-2003, Annex VII para 44.
[287] Paras 30-31.

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> "In the instant case, it is clear that the scheme of the LDA is lacking in terms of therapeutic objectives as well as provision of matching resources and programmes of treatment of persons with mental disabilities..."[288]

The Commission in *Purohit* also found a violation of article 18(4), which provides: "The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs." The inclusion of Article 18(4) in the ACHPR has been criticised on the grounds that it is worded so broadly that it cannot be easily enforced, particularly as the ACHPR does not contain a definition of "disability".[289] Further, the inclusion of both the aged and those with disabilities in the same provision disregards the differences in contexts and needs between the two groups. Nevertheless, in *Purohit*, the African Commission elaborated on the meaning of Article 18(4), stating that the special measures taken should empower PWPSD to "not only attain but also sustain their optimum level of independence".[290]

3 6 4 Conclusion

The ACHPR confirms the state obligations and normative standards for the right to health established in the ICESCR and UN Disability Convention, thereby affirming that these obligations and standards apply at a regional level. Further, when read with the Nairobi Guidelines and the African Commission's views in *Purohit*, the ACHPR provides a strong basis for CBMHC for PWPSD.

3 7 The African Disability Protocol

In the early 1990s, the Organisation of African Unity, as it then was, took steps to realise the rights of PWD by including disability-focussed provisions when drafting new human rights treaties.[291] However, the practice of including a lone disability-focussed provision in a human rights instrument did not prove effective.[292] The

[288] *Purohit and Moore v The Gambia*, Communication No. 241/2001, Sixteenth Activity report of the African Commission on Human and Peoples' Rights 2002-2003, Annex VII para 83.
[289] See, for example, S Kamga "A Call for a Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa" (2013) 21 *Afr. J. Int'l & Comp. L.* 219 238.
[290] *Purohit and Moore v The Gambia*, Communication No. 241/2001, Sixteenth Activity report of the African Commission on Human and Peoples' Rights 2002-2003, Annex VII para 81.
[291] K Appiagyei-Atua "A Comparative Analysis of the United Nations Convention on the Rights of Persons with Disability and the African Draft Protocol on the Rights of Persons with Disabilities" (2018) 21 *LDD* 153 157.
[292] For example, Article 23 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, titled "Special Protection of Women with Disabilities", calls for "specific measures commensurate with the needs" of women with disabilities. Kamga criticises this approach on the basis that a single provision of this kind cannot account for the wide range of interests in

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search for an alternative to this "piecemeal" incorporation of disability-focussed rights lead to adoption of the African Disability Rights Protocol. [293] The Protocol was adopted on 29 January 2018, but has no ratifications to date.

In this analysis of the Protocol, the focus is on the right to health, enshrined in Article 17(1), which provides: "Every person with a disability has the right to the highest attainable standard of health". While the term "disability" is not defined in the Protocol, Article 1 provides a non-exhaustive list of "persons with disabilities" which closely reflects the approach in the UN Disability Convention.[294] However, a key difference is that the African Disability Protocol does not limit its scope to "long-term" impairment only. Thus, in theory, a range of short-term or temporary impairments may entitle a person to protection under the Protocol. However, it must be noted that the African Commission and the African Court on Human and Peoples' Rights ("African Court") will only be able to provide authoritative interpretations of this and other relevant provisions once the African Disability Protocol has entered into force.[295]

In respect of the general obligations of state parties in terms of the Protocol, Article 4 provides the following:

> "States Parties shall take appropriate and effective measures, including policy, legislative, administrative, institutional and budgetary steps, to ensure, respect, promote, protect and fulfil the rights and dignity of persons with disabilities, without discrimination on the basis of disability..."

Article 17(2)(a) to (i) further describes a wide range of obligations on the part of the state in relation to health. These provisions largely mirror those in Article 25(2) of the Convention.[296] To determine standards for CBMHC in particular, Article 17 must

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question, nor does the broad wording allow for effective monitoring of a state's compliance with the duty imposed by this provision. See Kamga (2013) *Afr. J. Int'l & Comp. L.* 242.

[293] Appiagyei-Atua (2018) *LDD* 157.

[294] Article 1 of the Protocol provides: "'Persons with disabilities' include those who have physical, mental, psychosocial, intellectual, neurological, developmental or other sensory impairments which in interaction with environmental, attitudinal or other barriers hinder their full and effective participation in society on an equal basis with others."

[295] Article 34(3) provides: "In the implementation of this Protocol, the African Commission shall have the mandate to interpret the provisions of the Protocol in accordance with the African Charter." Further, Article 34(4) provides: "The African Commission may refer matters of interpretation and enforcement or any dispute arising from the application or implementation of this Protocol to the African Court on Human and Peoples' Rights."

[296] The exception is Article 17(2)(g) of the Protocol, which places a duty on the state to ensure that persons with disabilities "are provided with support in making health decisions, when needed". Article 25 of the UN Disability Convention does not contain an equivalent provision. In the absence of an authoritative interpretation, the scope of and rationale for Article 17(2)(g) of the African Disability Protocol is unclear at this point in time.

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be read with Article 14, "the right to live in the community". This provision imposes an obligation on the state to provide a range of support mechanisms in the community, such as rehabilitation services.[297] Furthermore, Article 18 places an obligation on the state to enable the independence of PWD, and their "full inclusion and participation in all aspects of life". Steps taken by State Parties to realise this right include "organising, strengthening and extending comprehensive habilitation[298] and rehabilitation services and programmes, particularly in the [area] of health....".

There was debate as to the desirability of adopting a regional disability rights treaty, owing to concerns that a regional instrument would merely duplicate the provisions of the UN Disability Convention.[299] However, Appiagyei-Atua notes that the African Disability Protocol does contain unique contributions which are grounded in the African cultural and historical context.[300] One such example is Article 11, which imposes an obligation in relation to "harmful practices" which exceeds the specificity and extent of the obligation in Article 8(b) of the UN Disability Convention.[301] Article 11 of the African Disability Protocol provides:

> "States Parties shall take all appropriate measures and offer appropriate support and assistance to victims of harmful practices, including legal sanctions, educational and advocacy campaigns, to eliminate harmful practices perpetrated on persons with disabilities, including witchcraft, abandonment, concealment, ritual killings or the association of disability with omens."

Through the elimination of harmful practices, this provision could help to create communities where PWPSD can safely reside and receive care. However, the scope of the application of this provision is unclear, pending interpretation by the African Commission or African Court.

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[297] According to Article 1 of the Protocol: "Rehabilitation means inpatient or outpatient health care services such as... psychiatric rehabilitation services that help a person keep, restore or improve skills and functioning for daily living and skills related to communication that have been lost or impaired because a person was sick, injured or disabled.".

[298] According to Article 1 of the Protocol: "Habilitation means inpatient or outpatient health care services... that address the competencies and abilities needed for optimal functioning to interaction with their environments."

[299] See, for example, Kamga (2013) *Afr. J. Int'l & Comp. L.* 219-249*,* as well as the response to Kamga by F Viljoen & J Biegon "The Feasibility and Desirability of an African Disability Rights Treaty: Further Norm-Elaboration or Firmer Norm-Implementation?" (2014) 30 *SAJHR* 345-365.

[300] Appiagyei-Atua (2018) *LDD* 174.

[301] Article 8(b) place an obligation on the state to "...combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life".

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3 8 Guidelines for mental health care from the World Health Organization

In addition to the four international instruments discussed above, documents authored by the WHO may also provide guidance in relation to health care for PWPSD, particularly on the practical measures which States need to adopt to implement the right effectively. In this section, an overview of five key documents is provided. The first of these is the Mental Health Gap Action Programme ("mhGAP"),[302] This document, published in 2008, identifies core areas in relation to mental health care which call for state action. These include: performing a comprehensive assessment of the mental health needs of the population;**[303]** developing legislative and policy frameworks which are grounded in the recognition of fundamental human rights;[304] ensuring that appropriate and sufficient human resources exist to furnish mental health care as envisioned in the legislative and policy frameworks;[305] and allocating sufficient financial resources for the project of scaling up mental health care services.[306]

A supplementary document, the mhGAP Operations Manual ("Manual"), was published in 2018.[307] The aim of this document is to provide assistance to district health managers[308] in reintegrating mental and physical health services.[309] In the Manual, possible obstacles to the realisation of this aim are identified.[310] While numerous examples are identified, many of these obstacles result from, or are aggravated by, an underlying issue, namely, the failure to prioritise mental health care as a crucial component of public health at district level.[311] A means of addressing this concern is to involve a wide range of stakeholders when developing, monitoring, and raising awareness of mental health care initiatives at district level.[312] A further counter to this problem is to increase collaboration between district

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[302] World Health Organization *Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders* (2008).
[303] 15.
[304] 16.
[305] 18.
[306] 18.
[307] World Health Organization *mhGAP Operations Manual* (2018).
[308] The Manual notes that "[t]he concept of a district differs by country (e.g. province or country) and by level of resources... We define 'district' as an administrative division below regional level." See World Health Organization *mhGAP Operations Manual* (2018) xiii. In the South African context, "district" could thus be interpreted to refer to provinces.
[309] World Health Organization *mhGAP Operations Manual* (2018) xiii.
[310] 3, 16 and 40.
[311] 3.
[312] 3.

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authorities and national policy-makers in order to revise the district-level approach to mental health care on a continuous basis, particularly in terms of the allocation of resources.[313]

Further practical guidance can be found in the WHO Mental Health Action Plan 2013-2020 ("WHO Action Plan").[314] This document is structured according to four overarching objectives, each accompanied by proposed actions to be undertaken by member states. These four broad objectives are: "to strengthen effective leadership and governance for mental health"; "to provide comprehensive, integrated and responsive mental health and social care services in community-based settings"; "to implement strategies for promotion and prevention in mental health"; and "to strengthen information systems, evidence and research for mental health".[315]

A significant contribution of the WHO Action Plan is thus its detailed description of steps which must be taken to promote CBMHC for PWPSD. These actions include: the creation of "a formalized structure and/or mechanism" for engagement with stakeholders, including PWPSD, during both the development and implementation stages of policies and legislation;[316] the development of human resources appropriate to the delivery of mental health care which is "evidence-based, culturally appropriate and human rights-oriented";[317] a proactive approach to identifying and supporting vulnerable groups who do not have sufficient access to mental health care services;[318] and the creation of monitoring and information systems to collect data on, *inter alia,* the prevalence of psychosocial disability and the extent to which national policy is successful in providing appropriate mental health care to various groups within the state.[319]

A fourth key document authored by the WHO, is titled "Community-Based Rehabilitation: CBR Guidelines".[320] In this document, the WHO advocates for rehabilitation which follows a recovery approach to psychosocial disability, described as follows:

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[313] World Health Organization *mhGAP Operations Manual* (2018) 3.
[314] World Health Organization *Mental Health Action Plan 2013-2020* (adopted May 2013).
[315] 10.
[316] 12.
[317] 15.
[318] 15.
[319] 18.
[320] World Health Organization *CBR Guidelines* (2010).

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"Recovery is a process of personal growth and transformation beyond suffering and exclusion – it is an empowering process emphasizing people's strengths and capabilities for living full and satisfying lives."[321]

Thus, community-based rehabilitation is aimed at empowering PWPSD and ensuring that they are able to take part in community life. A key step in community-based rehabilitation, is to ensure that resources within the community are mobilised and optimally applied. The WHO highlights a case study from rural India, where locals received training so they could contribute to the recovery and reintegration of PWPSD within the community. Their duties included identifying persons who could benefit from mental health care, arranging access for PWPSD to the outreach clinics, and educating community members on mental health to reduce stigma and encourage persons to take responsibility for their mental health.[322] Further, it must be noted that community-based rehabilitation is intended to be a cross-cutting strategy.[323] It must not be limited to the realm of health care, but also requires intersectoral collaboration, for example, in respect of housing, education, and labour.[324]

Finally, the WHO Quality Rights Initiative consists of a number of documents, each providing guidance in respect of a specific facet of mental health care. This part focusses on the document most relevant to CBMHC, titled "Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches".[325] This document is to be used to reform mental health care systems which still reflect "an entrenched overreliance on the biomedical model".[326] A number of reforms are recommended, such as the creation of effective monitoring and information systems, the development of universal standards to measure the quality of services, and improved accountability mechanisms for human rights violations.[327] Two cross-cutting themes emerge from the recommended reforms: resource allocation; and the participation of PWPSD and their representative organisations.

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[321] World Health Organization *CBR Guidelines* (2010) 10. For more on the recovery approach, see chapter one, part 1 1.
[322] World Health Organization *CBR Guidelines* (2010) 5.
[323] S Rule, A Roberts, P McLaren & S Philpott "South African Stakeholders' Knowledge of Community-Based Rehabilitation" (2019) 8 *African Journal of Disability* 1 6.
[324] World Health Organization *CBR Guidelines* (2010) 16.
[325] World Health Organization *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches"* (2021). Available: https://qualityrights.org/resources/promoting-person-centred-rights-based-community-mental-health-services/.
[326] xvii.
[327] 183.

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First, resource allocation and financing for mental health care must reflect a human rights-based approach to psychosocial disability.[328] Overall, the resources available for mental health care should be increased substantially.[329] Resources should be redistributed away from psychiatric hospitals into the community.[330] The closure of psychiatric institutions should be accompanied by appropriately resourced support for former residents, so they are able to "lead meaningful lives in the community".[331] Increased investment in the development of a "strong, trained multidisciplinary" community mental health workforce is required.[332]

Second, the document calls for increased participation of PWPSD and their representative organisations in all decision-making processes. Law- and policy-making processes in respect of mental health care should include "people with lived experience" and their representative organisations.[333] PWPSD should also be involved in a meaningful manner in the structures in place for monitoring and accountability in respect of the delivery of mental health care.[334]

This part illustrates that a human rights-based approach to mental health care requires more than "a token line of text or single paragraph" in legislation or policy documents.[335] A human rights-based approach calls for those systems which still reflect the medical model of disability to be dismantled. In close consultation with PWPSD, the State must develop as well as implement an effective system of CBMHC which promotes the human rights of PWPSD.

3 9 Conclusion

The aim of this chapter was to establish standards for CBMHC for PWPSD, based on key sources of international law. The first of these, the ICESCR, delivers an invaluable contribution. The concepts central to the AAAQ framework – availability, accessibility, acceptability and quality – generate normative standards for the right to health, while the RPF framework provides clarity on the range of measures which States Parties must undertake in order to realise these standards. While

[328] World Health Organization *Guidance on Community Mental Health Services* (2021) 182.
[329] 197.
[330] 187.
[331] 197.
[332] 182,
[333] 182.
[334] 187.
[335] 182

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sluggishness in incorporating the ICESCR in South African domestic law remains concerning, this instrument could still play an extensive role in interpreting the rights in the Bill of Rights in terms of section 39(1)(b) of the Constitution, and legislation in terms of section 231.

Building on the broad obligations imposed by the ICESCR, the UN Disability Convention contributes a more detailed list of actions to be undertaken by States Parties in relation to the right to health for PWPSD. The fact that the Convention is more specific and prescriptive in respect of the means of implementation will be useful when evaluating the measures taken to realise the rights of PWPSD in South Africa, and when making recommendations in the final chapter of this thesis. Furthermore, through the application of the right to health, in conjunction with the right to habilitation and rehabilitation and the right to living independently and being included in the community, the Convention establishes a clear imperative to effect deinstitutionalisation in favour of CBMHC. The CRPD has also unequivocally stated that involuntary treatment is contrary to the provisions and principles of the Convention.

The ACHPR delivers an important regional human rights law perspective. The right to health in the ACHPR was analysed in terms of availability, adequacy, physical and economic accessibility, and acceptability; these contribute relevant standards and largely correspond in substance to the AAAQ framework. Notably, the Nairobi Guidelines, which elaborate on the duties and standards contained in the ACHPR, frame the deinstitutionalisation of mental health care as a core component of the right to health.

In addition to the ACHPR, the African Disability Protocol was identified as a relevant regional instrument. While the Protocol does, to an extent, duplicate the provisions of the UN Disability Convention, the provisions of the Protocol may be interpreted differently to those in the Convention once the Protocol has entered into force.

Finally, the WHO provides further guidelines for the improvement of mental health care, including specific and practical steps which must be taken in relation to the creation of legislation and policy, budgeting, collaboration between various state organs and levels of state, data collection, and the involvement of stakeholders in

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initiatives related to mental health care. One of the key contributions found in these documents, is the detailed plan of action for the promotion of CBMHC for PWPSD, which will be useful in making recommendations for changes to South African mental health care legislation, policy and practice.

Overall, the analysis in this chapter delivered a range of normative standards and state obligations applicable to CBMHC for PWPSD. These standards and obligations, coupled with those identified in chapter 2, will form the basis of the evaluation of South African legislation, policy and practice and subsequent recommendations in later chapters.

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CHAPTER 4: COMMUNITY-BASED MENTAL HEALTH CARE IN SOUTH AFRICA: THE LEGISLATIVE AND POLICY FRAMEWORK

4 1 Introduction

As discussed in chapter one, institutionalisation is a deeply rooted practice in South Africa.[336] It is against this backdrop that the MHCA was adopted in 2002, followed by the NMHPF in 2013 and the WPRPD in 2016. These instruments are intended to reform a historically oppressive and discriminatory mental health system, including by implementing deinstitutionalisation and strengthening the system of CBMHC. This chapter aims to analyse the afore-mentioned three instruments with a view to identifying provisions and principles which are relevant to CBMHC for PWPSD.

4 2 The Mental Health Care Act 17 of 2002

4 2 1 Introduction

The MHCA was promulgated with the aim of aligning the system of mental health with a human rights-based approach. Burns argues**:**

> "Emanating from a new culture focusing on human rights within South Africa after the pivotal year of 1994, it was one of the legislations enacted to rid the country of its apartheid legacy. And with its history of mental health treatment, South Africa was in dire need of an act that reflected the new spirit."[337]

Efforts to align the system of mental health care with a human rights-based approach meant that the focus of mental health legislation was no longer the control of PWPSD. As Ramlall notes: "A critical word in the Act's title is 'care' – this must be our guiding ethos."[338] At the heart of the MHCA is the following object set out in section 3(a)(i):

> "... to regulate the mental health care in a manner that 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".

This provision contains crucial elements – quality, availability, equity, and efficiency. Section 3(a)(i) also introduces the "best interests" standard. Section 3 further sets out a range of objects, including: to regulate mental health care so as to

[336] See chapter one part 1 1.
[337] Burns (2008) *SAMJ* 47.
[338] S Ramlall "The Mental Health Care Act No 17 – South Africa. Trials and triumphs: 2002-2012" (2012) 15 *Afr J Psychiatry* 407 407.

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co-ordinate access to mental health care, treatment and rehabilitation for "various categories of mental health care users";[339] to integrate mental health care into "the general health care services environment";[340] and serving to "clarify the rights and obligations of mental health care users and the obligations of mental health care providers".[341]

These aims serve to contextualise this analysis, which is structured according to three themes. As noted in the discussion of the theoretical models of disability,[342] mental health care legislation is necessarily underpinned by a particular understanding of psychosocial disability. Thus, the point of departure is to analyse how psychosocial disability is conceptualised in the MHCA. Thereafter, select parts of the MHCA which promote CBMHC are analysed. Finally, a brief overview of the approach of the MHCA to involuntary care is conducted, as involuntary treatment has throughout South African history been located in some form of psychiatric institution. Given the focus of this thesis on the shift from institutionalisation to CBMHC, it is therefore appropriate to incorporate a brief consideration of how the MHCA regulates involuntary mental health care.

4 2 2 Psychosocial disability as conceptualised in the MHCA

As established earlier in this thesis, the extent of protections and freedoms afforded to PWPSD is determined in part by how psychosocial disability is understood.[343] The MHCA does not expressly refer to a specific theoretical model, nor does it make use of the term "psychosocial disability". Rather, a narrow definition of "mental illness"[344] is provided, which focusses on "diagnosis of a mental health related illness", thereby failing to acknowledge the disabling effect of external

[339] S3(a)(ii). This provision does not describe the "categories" to which it refers. However, s3(b) could provide an indication of the drafters' intention, as ss3(b)(i) to (iii) refer to "voluntary, assisted and involuntary mental health care users", "State patients", and "mentally ill prisoners".
[340] S3(a)(iii).
[341] S3(c).
[342] See chapter one part 1 4.
[343] See also, for example, the discussion of the Gambian Lunatics Detention Act in chapter three part 3 6 3. The Lunatics Detention Act applied to those deemed "an idiot or person of unsound mind", strongly implying that psychosocial disability necessarily diminishes a person's capacity to act autonomously. The Act was thus not aimed at providing appropriate care or rehabilitation, but rather employed institutionalisation as a means of controlling PWPSD. Consequently, it comes as no surprise that the Act contained no appeal or review mechanisms in respect of diagnosis, nor limitations on the duration of involuntary detention.
[344] S1: "'mental illness' means a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis."

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factors.[345] Other than a brief reference to "social" factors which may have an impact on mental well-being, the definition of "mental health status"[346] is similarly focussed on diagnosis. It is arguable that these definitions are reflective of the medical model.[347] However, the term, "mental health care user", which is the terminology generally used in the MHCA, holds greater promise. Section 1 contains the following definition of this term:

> "'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..."

The MHCA defines "rehabilitation" as "a process that facilitates an individual attaining an optimal level of independent functioning". These definitions are far more progressive than the definitions used in previous South African mental health legislation or policy. For example, the Lunacy Act 35 of 1891 applied to "lunatics", broadly defined as an "idiot or person of unsound mind incapable of managing himself or his own affairs".[348] The Mental Disorders Act 38 of 1916 applied to "idiots", "imbeciles" and persons who were "socially defective".[349] More recently, section 1 of the Mental Health Act 18 of 1973 defined "patient" as follows:

> "'Patient' means a person mentally ill to such a degree that it is necessary that he be detained, supervised, controlled and treated, and includes a person who is suspected of being or is alleged to be mentally ill to such a degree..."

Beyond the definitions of key terms, a relevant consideration is the range of protections enshrined in Chapter III of the MHCA, titled "Rights and duties relating to mental health care users". The cornerstone of Chapter III is section 8, which provides:

> (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.

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[345] See chapter one part 1 4.
[346] S1: "'mental health status' means the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis."
[347] See chapter one part 1 4.
[348] F Swanson *"Of Unsound Mind": A History of Three Eastern Cape Mental Institutions, 1875-1910* MA History thesis, University of Cape Town (2001) 110; M Minde "History of Mental Health Services in South Africa: Part II. During the British Occupation" (1974) 48 *S. Afr. Med. J.* 1629 1632.
[349] Parle (2019) *Oxford Research Encyclopedia of African History* 7.

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> (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."[350]

Section 8 can be seen as a guiding provision for the MHCA as a whole. Previously, mental health care was used as a means to control PWPSD, whereas section 8 of the MHCA reframes it in terms of respect for the human rights of PWPSD .[351] In addition to the protections set out in section 8, Chapter III affords mental health care users a range of other rights: freedom from non-consensual treatment, barring certain specific exceptions;[352] freedom from unfair discrimination in respect of the standard of mental health care received;[353] the right to non-disclosure of confidential information;[354] and the right to legal representation.[355] A further key provision is section 11, which prohibits "exploitation, abuse and any degrading treatment",[356] as well as the use of mental health care services "as punishment or for the convenience of other people".[357] These provisions in Chapter III establish that mental health care users are rights bearers, rather than disempowered subjects within the mental health care system.[358] Section 8 of the MHCA thus establishes an overarching framework of a human rights-based approach to psychosocial disability.

4 2 3 Community-based mental health care: relevant provisions

While the MHCA contains a number of provisions that can be viewed as promoting aims related to CBMHC, most of these do not expressly refer to CBMHC.[359] This section focusses on the three key provisions which speak more

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[350] S1 defines "rehabilitation" as: "a process that facilitates an individual attaining an optimal level of independent functioning".
[351] See also s3(a)(i), which states that one of the objects of the MHCA is to "make 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".
[352] S9: "Consent to care, treatment and rehabilitation services and admission to health establishments".
[353] S10 "Unfair discrimination".
[354] S13: "Disclosure of information".
[355] S15: "Right to representation".
[356] S11(1)(a).
[357] S11(1)(c).
[358] It must be noted that involuntary treatment remains a contentious topic. The provisions in the MHCA relating to involuntary treatment will be discussed in chapter four part 4 2 4 and evaluated in chapter five part 5 10.
[359] For example: The Preamble and s4(a) call for mental health care to be provided at primary, secondary and tertiary levels of care; s3(a)(iii) identifies the integration of mental health care into

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directly to CBMHC, namely, sections 4(b), 6(8) and 8. The first of these, section 4(b), provides:

> "Every organ of State responsible for health services must determine and co-ordinate the implementation of its policies and measures in a manner that promotes the provision of community-based care, treatment and rehabilitation services."

This provision is worded broadly to allow for a more detailed approach to be set out in mental health care policy, as will be discussed later in this chapter. Section 4(b) is not phrased in such broad terms that policymakers are left without sufficient guidance. However, the same cannot be said for section 6(8), which provides:

> "Persons providing care, treatment and rehabilitation services must provide such services in a manner that facilitates community care of mental health care users."

Section 1 defines "health care provider" as "a person providing health care services", which does not help to delineate the category of responsible persons referred to in section 6(8). Similarly, section 1 defines "health establishment" as including:

> "...institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals."

Section 6(8), read with section 1, is thus worded so broadly that the provision aims to hold an ambitiously wide range of persons accountable. Furthermore, section 6(8) does not clearly delineate the extent of the duty imposed on health care providers, despite the fact that section 3(c) provides that one of the key objects of the MHCA is to "clarify… the obligations of mental health care providers".

Finally, the third relevant provision in the MHCA, is section 8, titled "Respect, human dignity and privacy". As established in the previous, section 8 provides the basis for a human rights-based approach to mental health care. In respect of CBMHC in particular, section 8(2) and section 8(3) are relevant. Section 8(2) provides that mental health care must aim "...to facilitate his or her [the mental health carer user's] integration into community life". Section 8(3) calls for minimally intrusive treatment, which is proportionate to the mental health status of the mental health care user. These two provisions, when read with section 4(b), provide a firm

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general health care as an object of the MHCA; s1 defined "health establishment" to include "community health and rehabilitation centres", and "rehabilitation" is defined as "a process that facilitates an individual attaining an optimal level of independent functioning".

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foundation on which policymakers can build to develop a CBMHC approach for PWPSD, which aligns with a human rights-based approach.

4 2 4 Involuntary mental health care

. Parts of the MHCA reveal a tension between, on the one hand, respect for the autonomy of PWPSD and, on the other, concern for the harm that PWPSD may cause themselves or others.[360] The MHCA aims to address this tension by allowing for treatment without consent of the mental health care user, subject to strict adherence to the requirements and procedures set out in sections 32 to 35 of the MHCA.

In terms of section 32(a), an application for involuntary treatment must be made in writing to the head of the relevant health establishment. The application in terms of section 32 must be granted if the mental health care user is either "likely to inflict serious harm to himself or herself or others",[361] or if treatment is required in order to protect "the financial interests or reputation of the user".[362] In addition to either of these criteria needing to be present, the following is required in terms of section 32(c):

> "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… at the time of 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."

Section 33 provides further requirements relating to applications made in terms of section 32(a). It details the procedure to be followed by the head of the health establishment upon receiving such an application, including ordering an examination of the mental health care user in question by two mental health care practitioners. Section 33 further sets out the intended safeguards and procedures in detail. For example, section 33(6)(a) prescribes that a third mental health examiner must examine the mental health care user in the event that those practitioners appointed

[360] See, for example, the Preamble para 3, which states: "RECOGNISING that the person and property of a person with mental disorders or mental disabilities, may at times require protection and that members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities."
[361] S32(b(i).
[362] S32(b)(ii).

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initially deliver different findings as to whether the mental health care user must receive involuntary care.

A further intended safeguard is the 72-hour assessment period prescribed by section 34. In terms of this provision, a mental health care user admitted for involuntary treatment must, for 72 hours following admission, be observed and assessed by a medical practitioner and mental health practitioner. These two practitioners must report to the head of the health establishment on whether further involuntary treatment is warranted. A mental health care user or interested parties, such as the next of kin of a mental health care user, may appeal against the head of the health establishment's decision to a Mental Health Review Board ("Review Board").[363] Review Boards are bodies created by section 18 of the MHCA to handle the appeal and review of matters relating to involuntary treatment. In respect of involuntary care, the MHCA introduces various measures intended to protect against abuse and neglect of mental health care users within the mental health care system.

4 3 National Mental Health Policy Framework and Strategic Plan 2013-2020

4 3 1 Introduction

In the foreword to the NMHPF, the Minister of Health highlights a number of key challenges which prompted the organisation of provincial and national mental health summits. These challenges include the inequitable distribution of resources for mental health, the seriousness of co-morbidity between mental health diagnoses and other illnesses, and the "substantial gap between demand and supply of mental health services".[364] These summits culminated in the adoption of the "Ekurhuleni Declaration on Mental Health – April 2012", which would form the basis of the NMHPF.[365] In the foreword to the NMHPF, the policy is described by the Minister of Health as "an ambitious plan".[366] The process leading to the adoption of the policy was itself ambitious, with over 4000 stakeholders from a wide range of sectors consulted during provincial and national mental health summits, including

[363] See Chapter IV, s19 for the Powers and functions of the Review Board. In terms of section 20, the Review Board must consist of, at least: a mental health care practitioner; a magistrate, an attorney or advocate admitted in terms of terms of the law of the Republic; and a member of the community concerned. The Review Board must consist of at least three persons, and no more than five, who are South African citizens appointed by the Executive Council in each province.
[364] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 3.
[365] 48-51.
[366] 3.

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representatives from government, academic institutions, the WHO, advocacy groups, and traditional health practitioners.[367] The resulting document envisioned "improved mental health for all in South Africa" by its end date, 2020, through the achievement of the following mission:

> "From infancy to old age, the mental health and well-being of all South Africans will be enabled, through the provision of evidence-based, affordable and effective promotion, prevention, treatment and rehabilitation interventions. In partnerships between providers, users, carers and communities, the human rights of people with mental illness will be upheld; they will be provided with care and support; and they will be integrated into normal community life."[368]

Thus, in addition to transforming the mental health care system in line with standards such as affordability and effectivity, the mission of the NMHPF highlights inclusion of PWPSD in community life as a key aim.[369] This vision and mission serve as context for the analysis of the principles and commitments in the NMHPF relating to CBMHC. First, an overview of the relevant objectives, values and principles of the NMHPF is provided. Thereafter, the relevant "areas for action" identified in the NMHPF are discussed. Finally, the allocation of roles and responsibilities in realising the aims of the NMHPF are set out.

4 3 2 Objectives, values and principles

As a point of departure, the NMHPF identifies eight broad objectives. These objectives include: raising awareness in order to address stigma and discrimination on the basis of mental health status; increasing intersectoral collaboration to engage with the interrelated nature of poverty and poor mental health; establishing systems to monitor and evaluate the provision of mental health care; and ensuring the provision of evidence-based mental health care. The NMHPF contains two objectives specifically targeted at CBMHC, namely:

> "To scale up decentralized integrated primary mental health services, which include community-based care, PHC [primary health care] clinic care, and district hospital level care; [and]
>
> To empower local communities, especially mental health service users and carers, to participate in promoting mental wellbeing and recovery within their community."[370]

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[367] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 4.
[368] 19.
[369] 19.
[370] 19.

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To achieve these objectives, several key values are identified, each supported by a number of more specific principles. The central value for this analysis is "Community care", which is based on five principles. First, mental health services should be provided close to the homes and places of work of mental health care users. Second, mental health care should be minimally restrictive. Third, mental health care should, as far as possible, make use of "local community-based resources". Fourth, inpatient care should be made use of only after consideration of "all avenues for outpatient and community-based residential care". Finally, CBMHC should be based on "a recovery model, with an emphasis on psychosocial rehabilitation". This is closely linked to the value of "Recovery", which is based on the following principle:

> "Service development and delivery should aim to build user capacity to return to, sustain and participate in satisfying roles of their choice in their community."

Various other values are identified in the NMHPF, including: accessibility and equity; efficiency and effectiveness in terms of the use of resources allocated to mental health care; a comprehensive approach which includes prevention, treatment, and rehabilitation; targeted protection for vulnerable groups, such as persons living in poverty; mainstreaming of mental health concerns in all public sector activities, including law- and policy-making, budgeting, and mechanisms used to monitor; and the participation of mental health care users in "the planning, delivery and evaluation of mental health services".[371]

4 3 3 Areas for action

The NMHPF identifies twelve areas of action intended to realise the objectives set out above, and to give effect to the associated values and principles.[372] This section highlights those areas most relevant to CBMHC. The first of these is the area for action titled "Organisation of services", in terms of which CBMHC is described as including community residential care[373] as well as both general health and specialist

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[371] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 19-21.

[372] Organisation of services; Financing; Promotion and prevention; Intersectoral collaboration; Advocacy; Human rights; Special populations; Quality improvement; Monitoring and evaluation; Human resources and training; Psychotropic medication; Research and evaluation of policy services.

[373] The policy does not define "community residential care", other than stating that it includes "assisted living and group homes". See National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 23.

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mental health support services.[374] This section of the NMHPF contains an undertaking to develop CBMHC services, including by allocating funding to relevant NGOs to provide community programmes and facilities. Such development must occur "before further downscaling of psychiatric hospitals can proceed".[375] Further measures to strengthen CBMHC systems through improved organisation include establishing rehabilitation programmes at community level in all districts by applying the "task-shifting approach",[376] and appointing teams of specialist mental health workers to support CBMHC workers.[377]

Second, in the area of "Financing", the NMHPF sets a number of goals to be realised by 2014. For example, a national budget should be set for each area for action set out in the NMHPF, and reviewed annually. A further key aim is that "strategic plans for mental health", including budgets, should be developed at provincial level in line with the NMHPF, with targets and strategies set out for each year.[378]

Third, in respect of "Quality improvement", the NMHPF sets out aims intended to have been achieved by 2014. Quality improvement in relation to mental health care should be aligned with general quality improvement activities under the auspices of the Department of Health. Facilities will be licensed and designated as mental health care facilities based on their adherence to quality improvement mechanisms. Guidelines to ensure the safety and effectivity of mental health care at regional and district facilities should be developed, as well as a system to monitor and evaluate mental health care at all levels which will contribute to the improvement of relevant policy and programmes.[379] This ties in with the area "Monitoring and evaluation", which calls for a "culture of information" to be cultivated, whereby information is collected, processed and applied to determine reform of policy and programmes.[380]

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[374] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 23.
[375] 23.
[376] "Task shifting:" is defined as: "The use of specialist mental health staff in training and supervisory roles to non-specialist health workers, as a mechanism for more efficient and effective care." National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 8.
[377] 23.
[378] 25.
[379] 28.
[380] 28.

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Finally, in terms of "Human resources and training", the NMHPF prescribes that all general health staff must receive "basic mental health training". Further, provincial Departments of Health are expected to expand their mental health workforce, as well as implement a task-shifting approach so non-specialist staff may provide mental health services under the supervision of mental health specialists.[381] This area for action, as well as those discussed above, are used as the basis for the designation of roles and responsibilities in the NMHPF.

4 3 4 Roles and responsibilities

The NMHPF assigns a wide range of responsibilities in relation to the areas for action to key role players, including in respect of CBMHC. The Minister of Health must promote, as a matter of priority, CBMHC within the psychosocial rehabilitation and recovery framework.[382] The provincial Departments of Health must establish a Mental Health Directorate in their respective provinces, which is responsible for CBMHC as well as hospital-based mental health services.[383] Further, these Departments are tasked with the licensing and regulation of CBMHC services by NGOs as well as for-profit organisations, including community residential care centres.[384] Finally, district health services must establish and maintain community-based rehabilitation programmes, staffed by trained community health workers.[385]

4 4 White Paper on the Rights of Persons with Disabilities

4 4 1 Introduction

The WPRPD was approved by Cabinet on the 9th of December, 2015.[386] Disability rights activists are expressly credited for their role in the development of the WPRPD, particularly their efforts to conduct "an extensive community-based consultative process".[387] The WPRPD sets "[a] free and just society inclusive of all persons with disabilities as equal citizens" as its vision, with "Inclusive and Equitable

[381] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 28.
[382] 29.
[383] 31.
[384] 32.
[385] 31.
[386] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016).
[387] 8.

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Socio-Economic Development" as its mission.[388] This document does not focus specifically on psychosocial disability or mental health care. However, it is undoubtedly relevant to health care for PWPSD, as one of its key aims is to "guide the review of all existing, and development of new, sectoral policies, programmes, budgets and reporting systems to bring these in line with both constitutional and international treaty obligations".[389] Further, some broader aims related to health care are identified during a discussion on the rights of PWD, including improving access to those health services required on the basis of disability.[390]

The social model[391] is declared to be the basis of the government's approach to all disability policy. However, the WPRPD further notes that this social model, as applied in the WPRPD, is based on "a rights-based, mainstreaming and 'life-cycle' approach".[392] The description of these three approaches as provided in the WPRPD present a significant degree of overlap with the human rights-based model, set out earlier in this thesis[393]. For example, the "rights-based" approach applied in the WPRPD is described as follows:

> "It reinforces human rights principles, such as universality, inalienability, indivisibility, equality and non-discrimination as the central core in the formulation, implementation, monitoring and evaluation of policies and programmes."[394]

The "mainstreaming" approach is defined as the centring of disability concerns in the development of "all policies, budgets, plans and programmes", including assessing the possible impact of any particular initiative on PWD.[395] Finally, the 'life cycle' approach focuses on the equitable provision of socio-economic services, having regard for the geographical location of all PWD, as well as the needs based on a person's age or particular category of disability.[396] Using these three approaches as a basis, the following sections provide an overview of the "strategic

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[388] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 42.
[389] 8.
[390] 33.
[391] See chapter one part 1 4.
[392] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 45.
[393] See chapter one part 1 4.
[394] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 45.
[395] As this White Paper does not focus exclusively on psychosocial disability or mental health care, the mainstreaming approach is mostly further defined in the document with reference to universal design with the aim of ensuring equality of access, and reasonable accommodation.
[396] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 46.

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pillars" identified in the WPRPD, which are relevant to CBMHC for PWPSD, as well as the corresponding roles and responsibilities.

4 4 2 Strategic pillars

The WPRPD introduces nine strategic pillars intended to realise the rights of PWD. Of these, Pillar 3, titled "Supporting Sustainable Integrated Community Life" speaks most directly to CBMHC.[397] In terms of this pillar, stigma must be addressed so that communities are more "socially cohesive" and accepting of PWD.[398] Further, in this section, the WPRPD notes the burden of care imposed in relation to relatives and community members with disabilities, particularly on women. Consequently, this pillar prescribes a multi-sectoral approach to support families by easing the burden of care, to be achieved by providing "economic and non-economic support measures at household and community level".[399] Finally, the pillar calls for programmes which support PWD in enjoying independent community living, including services responsive to those PWD with "complex and high needs for support".[400]

The other strategic pillars are not directly relevant to community living nor CBMHC, but do provide some relevant policy directives. Health care must comply with standards of affordability and accessibility, and be relevant to the particular needs of each person.[401] Mechanisms must also be developed to monitor the quality of care provided to PWPSD at institutions, to prevent neglect or abuse.[402] Further, steps must be taken to promote the participation of PWD in all levels of governance, including by developing "minimum norms and standards for consultation" with PWD and their representative organisations.[403] A final example is the aim of collecting data on disability prevalence and related matters disaggregated according to gender, age, income and occupation, to inform policy reform.[404]

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[397] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 70.
[398] 72.
[399] 75.
[400] 77.
[401] Pillar 4: Promoting and Supporting Empowerment of Persons with Disabilities.
[402] Pillar 2: Protecting the Rights of Persons at Risk of Compounded Marginalisation.
[403] Pillar 6: Strengthening the Representative Voice of Persons with Disabilities.
[404] Pillar 7: Building a Disability Equitable State Machinery. The White Paper notes that data should not only be collected in relation to the type of impairments people present with, but also "participation restriction" and "activity limitation" data, i.e. the extent to which persons with disabilities are able to participate and their capacity to function in society, so as to inform policy reform more accurately.

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4 4 3 Roles and responsibilities

Functions are prescribed for key role players, to ensure that the implementation of the WPRPD occurs in "a coordinated and accountable manner".[405] The WPRPD assigns roles to a wide range of role players, including academic institutions, the media and advertising industry, and the religious sector.[406] The widest range of responsibilities is assigned to executive authorities, who must, first, ensure that the directives under each strategic pillar are actualised into appropriately funded programmes. Such programmes also require consultation with PWD and their organisations through formalised platforms.[407] The WPRPD also calls on the President to establish "disability rights coordinating mechanisms" at national and provincial level, which will develop and co-ordinate programmes of action for a five-year term, as well as monitor compliance with and ensure reporting in terms of international treaties such as the UN Disability Convention.[408] Finally, executive authorities must ensure that disability interests are mainstreamed in their respective institutions, including by keeping accounting officers accountable for their tasks. The main task of accounting officers is to establish administrative systems to allow for the WPRPD to be implemented effectively, and for its implementation to be monitored.[409]

Most notably, such systems must guarantee that adequate resources – financial, human and material – are allocated to programmes which relate to disability interests.[410] Finally, legislatures are tasked with overseeing public institutions to ensure the full integration of the directives in the WPRPD into planning, budgeting and reporting activities.[411]

4 5 Conclusion

The current framework regulating mental health care in South Africa covers a wide range of principles and provisions relating to CBMHC. The NMHPF features CBMHC prominently, including in those sections outlining its main objectives, values and principles. Whereas the MHCA contains few provisions that speak directly to

[405] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 125.
[406] 129-132.
[407] 125.
[408] 127.
[409] 125.
[410] 126.
[411] 129.

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CBMHC, the NMHPF provides a more detailed account of relevant areas for action in respect of CBMHC, including organisation of services, financing, quality improvement, monitoring and evaluation, and human resources and training. Finally, broad roles in relation to CBMHC are assigned to the Minister of Health, provincial Departments of Health and district health services.

The WPRPD, while not dealing exclusively with health care or the rights of PWPSD, nevertheless includes a range of relevant policy directives that reinforce many of the CBMHC areas for action identified in the NMHPF. Furthermore, concerns which do not feature as prominently in the NMHPF are highlighted in the WPRPD, such as the need to lessen the burden of care disproportionately borne by women.

In the following chapter, the legislative and policy framework for CBMHC, and its implementation, will be evaluated to determine whether this framework is aligned to the constitutional and international human rights law standards identified in chapters 2 and 3 of this thesis.

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CHAPTER 5: MENTAL HEALTH CARE LEGISLATION, POLICY AND PRACTICE THROUGH A RIGHT TO HEALTH LENS

5 1 Introduction

In this chapter, the constitutional and international law standards identified in chapters 2 and 3, respectively, are applied to evaluate the legislative and policy framework which regulates CBMHC in South Africa. It has been established that the State's obligations extend beyond simply devising a programme for the realisation of a particular right. It is also accountable for the implementation thereof.[412] Thus, in this chapter, the translation of mental health care legislation and policy into practice is also evaluated in light of the aforementioned standards.

The standards identified in previous chapters are interdependent and cannot be viewed in isolation. For example, the allocation of resources will necessarily affect all facets of CBMHC, including the availability, accessibility, acceptability, and quality thereof.[413] Similarly, monitoring and information systems are key to identifying and addressing shortcomings in terms of the attributes represented in the AAAQ framework. Based on this interdependence between standards, as well as the paucity of recent and relevant data to assess the implementation of CBMHC,[414] there will be a significant degree of overlap in the evaluation of the various standards. Thus, to avoid repetition, the chapter is structured in terms of nine overarching themes, chosen on the basis that they are cross-cutting in nature. Under each theme, reference will be made to the various standards implicated.

The following themes are discussed: physical accessibility; quality and acceptability as key standards of care;[415] non-discrimination; monitoring and information systems; resource allocation; oversight and accountability mechanisms; meaningful engagement and participation; intersectoral collaboration; and involuntary treatment.

[412] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 42.
[413] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 12.
[414] See part 5 5 of this chapter.
[415] While quality and acceptability each constitute a standard in own right, these two are considered in the same section as there is significant overlap in the literature used to evaluate whether effect is given to these standards.

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5 2 Physical accessibility

The physical accessibility of health facilities, goods and services for all communities is a crucial human rights standard.[416] In particular, PWD and persons living in rural areas have been identified as vulnerable groups whose access to health care should be improved through the adoption of special, targeted measures.[417] CBMHC programmes must be coordinated, coherent and comprehensive, which includes ensuring that PWPSD in all communities can benefit equally from such programmes.[418] The requirement of physical accessibility is closely linked to the standard of non-discrimination, as well as the constitutional and international law requirements in respect of the resource allocation, which are also discussed in this chapter. This part considers whether the legislative and policy framework sufficiently provides for the equitable geographical distribution of CBMHC facilities, goods and services.

Section 3(a)(i) of the MHCA does provide that mental health care must be made available "equitably", while section 4(b) imposes an obligation on organs of state responsible for health services to promote community-based care. The NMHPF, through the inclusion of "accessibility and equity" and "community care" as key values, explicitly emphasises the need to provide access to mental health care to PWPSD in their communities, "regardless of geographic location".[419] Further, the NMHPF tasks the Minister of Health and provincial Departments of Health with ensuring equitable service provision of mental health care across provinces and districts.[420] The WPRPD acknowledges the barriers faced by PWD in rural or low-income areas, and requires socio-economic goods and services to be provided in such a way that community-level services and facilities are accessible on an equal basis for PWD.[421]

Historically, resources for health care have been inequitably distributed across South Africa, with rural areas left "deliberately underdeveloped" during colonial and

[416] See chapter three part 3 4 3, 3 5 3, 3 5 4, 3 6 2.
[417] See chapter three part 3 4 3.
[418] See chapter two part 2 4 2.
[419] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 20.
[420] 30.
[421] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016).46 and 77.

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apartheid rule.[422] Inequity in the distribution of financial as well as human resources across the country has persisted following the entry into force of the MHCA.[423] For example, in 2006, while the Western Cape and Gauteng reported 0,8 psychiatrists per 100 000 persons, no other province reported a number higher than 0,3.[424] On the basis of available data from the Free State and North West, the WHO established that the concentration of psychiatrists based in or near the largest urban centre was nearly four-fold the average concentration of psychiatrists nationwide.[425]

These inequities are still present following the adoption of the NMHPF and WPRPD. It was reported in 2019 that the Western Cape and Gauteng spent 7,5% and 6,2% of their total health budget on mental health care, respectively. Expenditure in provinces with a larger rural population was significantly lower: 2,8% in the Free State, 2,6% in Limpopo, and 1,7% in Mpumalanga.[426]

It is challenging to isolate the resources available for CBMHC specifically, as both the MHCA[427] and the NMHPF[428] provide that mental health care should be integrated into primary health care settings. The most relevant measure for primary health care settings is the Ideal Clinic Monitoring System.[429] Of the 211 elements considered to determine Ideal Clinic Status ("ICS"), only one relates expressly to mental health care, namely, the broad requirement that "patients have access to mental health services".[430] Thus, while ICS is an important measure for primary

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[422] R Vergunst "From Global to Local: Rural Mental Health in South Africa" (2018) 11 *Glob. Health Action* 1 2.
[423] Lund et al (2010) *Soc Pyschiat Epidemiol* 400; A Bhana, I Petersen, K Baillie & A Flisher "Implementing the World Health Report 2001 Recommendations for Integrating Mental Health into Primary Health Care: A Situation Analysis of Three African Countries: Ghana, South Africa and Uganda" (2010) 22 *Int Rev Psychiatry* 599 604-607; J Burns "Mental Health Services Funding and Development in KwaZulu-Natal: A Tale of Inequity and Neglect" (2010) 10 *SAMJ* 662 665.
[424] C Lund & A Flisher "Norms for Mental Health Services in South Africa" (2006) 41 *Soc Psychiatry Psychiatr Epidemiol* 587 588.
[425] World Health Organization *WHO-AIMS Report on Mental Health System in South Africa* (September 2007) 18.
[426] Docrat *et al* (2019) *Health Policy Plan* 712.
[427] S4(a) of the Mental Health Care Act 17 of 2002.
[428] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 19.
[429] "An Ideal Clinic is a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community." See Provincial Department of Health, Western Cape *Annual Report 2019/20* (2020) 35.
[430] National Department of Health *Ideal Clinic Definitions, Components and Checklists* (2017) 9.

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health care service delivery in general, the standard is not tailored for measuring mental health service delivery or CBMHC**.**

The distribution of human resources, in particular, remains inequitable, as found by De Kock and Pillay in a series of studies on the availability of human resources for mental health care in 160 public rural primary health care facilities.[431] Significant disparities were found in the distribution of psychiatrists, clinical psychologists, and mental health nurses across provinces, and between rural and urban areas. The authors report that 61% of public sector facilities in rural areas generally do not receive even a single monthly visit from a psychiatrist.[432] In 2014, the Gauteng public health sector was served by 232 clinical psychologists, despite there being only 36 public sector clinical psychologists in the Free State, 35 in Mpumalanga and 17 in the Northern Cape.[433] In the public sector, the national average is 2,6 clinical psychologists per 100 000, while the number drops to 0,47 per 100 000 for rural primary health care facilities.[434] At the 160 rural primary health care facilities surveyed, a total of 116 mental health nurses were employed, intended to provide services to approximately 17 million people.[435] Thus, for primary care in rural areas, there are 0,68 mental health nurses per 100 000 persons – a "woeful representation" compared to the national rate of 9,7 mental health nurses per 100 000.[436]

Thus, inequities in physical access to mental health resources persist in the post-apartheid era, with significant disparities across provinces, particularly on the basis of rural location. The success of the shift to CBMHC is, naturally, dependent on resources being physically accessible at community-level. While the legislative and policy framework acknowledges the need for equitable physical distribution of resources, significant progress has not been made on this front. The legislative and policy framework includes broad aims in this respect, but lacks clear steps to be taken to realise these aims. Measurable targets, for key aspects such as budgeting for CBMHC at provincial level, are also absent from the framework. Further, PWPSD

[431] J de Kock & B Pillay "Mental Health Nurses in South Africa's Public Rural Primary Care Settings: A Human Resource Crisis" (2016) 16 *Rural and Remote Health* 1-10; J de Kock & B Pillay "A Situation Analysis of Psychiatrists in South Africa's Rural Primary Health Care Settings" (2017) 9 *Afr J Prim Health Care Fam Med.* 1-6; J de Kock & B Pillay "A Situation Analysis of Clinical Psychology Services in South Africa's Public Rural Primary Care Settings" (2017) 47 *S Afr J Psychol* 260-270.
[432] De Kock & Pillay (2017) *Afr J Prim Health Care Fam Med.* 4.
[433] De Kock & Pillay (2017) *S Afr J Psychol* 264.
[434] 264.
[435] De Kock & Pillay (2016) *Rural and Remote Health* 2 and 4.
[436] 2 and 4.

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who live in rural areas are not targeted for special interventions to improve their access to mental health care. The current framework lacks the specificity required to realise the human rights standard of physical accessibility, and is not sufficiently co-ordinated, comprehensive, or coherent in its implementation.

5 3 Standards of care: quality and acceptability

The provision of mental health care in community-based settings must meet standards of acceptability and quality. First, the standard of acceptability requires that the provision of CBMHC aligns with medical ethics.[437] Second, the standard of quality requires that CBMHC is scientifically and medically appropriate.[438] In terms of these standards, CBMHC must be provided by trained and skilled staff, who deliver evidence-based services, in line with ethical standards of care.[439] The realisation of acceptable and quality CBMHC particularly calls for the State to meet its obligation to *protect*, i.e. to prevent the infringement of the rights of PWPSD by third parties.[440] Further, the State must adopt measures which are responsive to the needs of PWPSD as a vulnerable group.[441] To achieve this, the state must establish the following: clear norms for the provision of CBMHC; a system to monitor adherence to these norms and standards; [442] and mechanisms to ensure accountability for non-adherence.[443] This part focusses on the provision made for the first aspect, in the MHCA, the NMHPF and the WPRPD.

Section 66(1)(b) of the MHCA provides:

> "The Minister may, after consultation with all relevant members of the Executive Council, make regulations on setting of quality standards and norms for care, treatment and rehabilitation of mental health care users."

The General Regulations, published in 2004, include a chapter titled "Quality Standards and Norms".[444] However, in respect of CBMHC, this chapter does not provide benchmarks for aspects which are central to the quality or acceptability of care, such as the state of medical equipment, skills training for health care

[437] See chapter three part 3 4 3, 3 6 2.
[438] See chapter three part 3 4 3, 3 6 2, 3 8.
[439] See chapter three part 3 4 4, 3 5 3.
[440] See chapter two part 2 4 1; chapter three part 3 4 4, 3 5 3, 3 6 2.
[441] See chapter two part 2 4 2; chapter three part 3 4 2, 3 6 3.
[442] See part 5 5 of this chapter.
[443] See part 5 7 of this chapter.
[444] GN R1467 in GG 27177 of 15-12-2004.

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practitioners, or adherence to medical ethics.[445] Nevertheless, the General Regulations do contain an important development, the requirement in Regulation 43 that "community facilities" may only operate if licensed.[446] Such facilities must apply for a licence from the relevant provincial Department of Health, who must perform "at least an annual audit" at each facility.[447] The General Regulations further provide that the National Department of Health must stipulate the conditions for licenses, including the "service requirements" applicable to these facilities.[448] It is unclear whether the inclusion of "service requirements" is intended as a reference to the quality of care required of these facilities, as the term is not defined in the General Regulations or the MHCA. Thus, under the General Regulations, there was uncertainty as to the norms and standards to be met in order to be licensed.

The NMHPF notes the relevance of quality of care as a requirement for the licensing of facilities.[449] Further, the NMHPF requires that "quality improvement initiatives" for mental health care must be aligned with those initiatives already applicable to general health care.[450] In respect of acceptability, the provision of evidence-based mental health care is listed as part of the mission of the NMHPF, and as a key objective, with training for the delivery of "evidence-based psychosocial interventions" set to be achieved by 2015.[451] This aligns with the requirement in respect of quality, that health care should be "medically and scientifically appropriate".[452] However, the NMHPF does not refer to adherence to medical ethics as a consideration in the licensing of facilities which provide mental health care.

The absence of clear criteria for licensing of facilities emerged as a key issue in the investigations following the collapse of the Marathon Project. In his report on this failed deinstitutionalisation initiative, the Health Ombud noted that licensing

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[445] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 paras 12(c)-(d).
[446] Regulation 43(1)(a) in GN R1467 in GG 27177 of 15-12-2004. A community facility for the purposes of Regulation 43 is defined as: "Any service not directly run under the auspices of an organ of the State and which is not a designated hospital, but which provides residential or day-care facilities for 5 people or more with mental disorders…"
[447] Regulation 43(1)(a) - (b) in GN R1467 in GG 27177 of 15-12-2004.
[448] Regulation 43(2)(d) in GN R1467 in GG 27177 of 15-12-2004.
[449] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 29.
[450] 29.
[451] 19 and 28.
[452] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 12(d).

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procedures "…should form the first line of protection for the mentally ill".[453] The Health Ombud consequently recommended that the Minister of Health establish a task team to review the compliance of current licensing regulations and procedures with the legislative framework, including the MHCA.[454] The SAHRC report similarly noted the absence of "comprehensive guidelines" for the standards of care to be provided by NGOs and community-based organisations.[455]

A relevant development in this respect was the enactment of the "Policy guidelines for the licensing of residential and/or day care facilities for persons with mental illness and/or severe or profound intellectual disability" in 2018.[456] The document imposes the following requirement:

> "Before the HOD [Head of the relevant provincial Department of Health] grants or refuses a license, an Inspection Team in the District must conduct a physical inspection of the relevant residential care facility or day care facility and record the outcome in terms of Norms and Standards for Licensing of Residential and Day Care Facilities (Annexure B)."[457]

In Annexure B, norms and standards to be used for licensing are provided for the following areas: "facilities and infrastructure";[458] "clinical governance and clinical care";[459] "clinical support services";[460] and "governance and human resources".[461] While Annexure B is indicated as the relevant set of norms and standards for the granting of licenses, the renewal of licences is considered following an evaluation in terms of Annexure D.[462] Annexure D, titled "Assessment and Compliance Report for Residential and Day Care Facilities", is prescribed for use by Inspection Teams

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[453] Office of the Health Ombud *The Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (2018) 54.
[454] 54.
[455] SAHRC *Report on Mental Health Care* (2017) 9.
[456] Policy Guidelines for the Licensing of Residential and/or Day Care Facilities for Persons with Mental Illness and/or Severe or Profound Intellectual Disability in GG 41498 of 16-03-2018.
[457] Inspection Teams are composed of a psychiatric nurse, a medical practitioner/psychiatrist, occupational therapist, social worker, dietician, environmental health practitioner "and other relevant officials, as required". See Policy Guidelines for the Licensing of Residential and/or Day Care Facilities for Persons with Mental Illness and/or Severe or Profound Intellectual Disability in GG 41498 of 16-03-2018 144.
[458] For example, aspects such as sanitation, security features and the physical layout of the facility.
[459] For example, aspects such as the keeping of records and ensuring confidentiality of mental health care users' information.
[460] For example, aspects such as the appropriate administration of medicine and the state of medical equipment.
[461] For example, aspects such as registration of health professionals at the relevant statutory bodies, the appointment of an appropriate number of staff with a sufficiently wide range of skills, and the development of a quality assurance policy for each facility.
[462] Policy Guidelines for the Licensing of Residential and/or Day Care Facilities for Persons with Mental Illness and/or Severe or Profound Intellectual Disability in GG 41498 of 16-03-2018 145-146.

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when conducting quarterly inspections, and by provincial Departments of Health when conducting annual audits at each facility.[463] It is unclear why two sets of standards are prescribed, particularly as the Inspection Teams are tasked with using Annexure B as well as Annexure D, despite there being a degree of overlap between the contents of the two sets of standards. Onerous licensing requirements may also present an obstacle to the accessibility of CBMHC in the South African context, where community-based facilities are not provided with the resources and support to meet the relevant standards.

A further concern is the legal status of the 2018 Guidelines, a point which was also raised by interest groups[464] in response to the publication of similar guidelines in 2017.[465] It was argued that the enactment of policy in respect of licensing of such facilities was "inappropriate", as the Minister is expressly authorised in terms of section 66(1)(o) of the MHCA to make regulations on the matter. Rather, it was recommended that Regulation 43 of the General Regulations be amended, or new regulations which are in line with Regulation 43 be enacted.

Finally, it must be noted that the Guidelines regulate only two components of CBMHC: residential and day care facilities. The NMHPF identifies a third component to CBMHC, "outpatient services in primary health care and specialist mental health support".[466] These facilities which must provide CBMHC are not referred to in the 2018 Guidelines. Outpatient services were, in fact, expressly excluded from the scope of the guidelines published in 2017.[467] Consequently, the Guidelines 2018 are not intended to be used to assess whether facilities such as clinics, community health centres, and mobile facilities should be licensed to provide CBMHC. The norms and standards applicable to CBMHC provided at these facilities are not yet

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[463] Policy Guidelines for the Licensing of Residential and/or Day Care Facilities for Persons with Mental Illness and/or Severe or Profound Intellectual Disability in GG 41498 of 16-03-2018145-146.

[464] SECTION27, the Life Esidimeni Family Committee, the South African Depression and Anxiety Group, the South African Federation for Mental Health & the South African Society of Psychiatrists "Submission on Guidelines for the Licensing of Residential and Day Care Facilities for People with Mental and/or Intellectual Disabilities" (2017-07-28) <http://section27.org.za/wp-content/uploads/2018/06/Submission-on-Guidelines-for-Licensing-of-Residential-and-Day-Care-1.pdf> (accessed 02-11-2021).

[465] Policy Guidelines for the Licensing of Residential and Day Care Facilities for People with Mental Illness and/or Intellectual Disabilities in GG 40847 of 19-05-2017.

[466] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 23.

[467] Policy Guidelines for the Licensing of Residential and Day Care Facilities for People with Mental Illness and/or Intellectual Disabilities in GG 40847 of 19-05-2017.

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clear, as "community-based care" is also expressly excluded from the scope of the National Core Standards for Health Establishments in South Africa, published in 2011.[468]

In practice, the approach to regulating the quality and acceptability of CBMHC appears fragmented. The current guidelines do not extend to outpatient services. Even in the case of residential and day care facilities, the requirements are not coherently set out. This presents an obstacle to facilities seeking to comply with the requirements, and to the persons tasked with conducting assessments or inspections. While the centrality of the human rights and the bests interest of mental health care users is emphasised in the MHCA, NMHPF and WPRPD, the framework does not specify which ethical standards of care apply.

Overall, in respect of the standards for the quality and acceptability of care, the legislative and policy framework is not implemented effectively. The approach is not co-ordinated, coherent nor comprehensive.[469] Without clear standards, the framework offers weak protection from practices which are unethical, or medically inappropriate. PWPSD may be exposed to care which is subpar or ineffective, with potentially life-threatening consequences. In respect of the current framework, and its implementation, the State thereby fails in its obligation to take reasonable measures to protect PWPSD from having third parties infringe or diminish the enjoyment of the right to health.

5 4 Non-discrimination

Equality occupies a prominent place as one of the founding values in the South African Constitution,[470] while non-discrimination features as a general principle in all four relevant international human rights instruments.[471] In order to align with

[468] National Department of Health *National Core Standards for Health Establishments in South Africa* (2011) 9.
[469] See chapter two part 2 4 2.
[470] Preamble and s7(1) of the Constitution of the Republic of South Africa, 1996.
[471] Article 2(2) of the International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3; Article 3(b) of the Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3; Article 2 of the African Charter on Human and Peoples' Rights (adopted 27 June 1981 entered into force 21 October 1986) 1520 UNTS 217; Article 3(b) of the Protocol to the African Charter on

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constitutional and international normative standards, CBMHC must be accessible to all on an equal basis, in law and in fact.[472]

The MHCA, NMHPF and WPRPD are reflective of a human rights-based model, for which equality is the foundation. For example, the MHCA[473] prohibits unfair discrimination on the basis of psychosocial disability, and both the NMHPF[474] and WPRPD[475] include equality as a key principle intended to guide reforms in mental health. The legislative and policy framework thus acknowledges that PWPSD must benefit from the right of access to health care on an equal basis with persons who do not have a psychosocial disability.

However, the evaluations conducted in this chapter show that there is much to be improved in respect of equality for PWPSD in practice. Mental health care in general, and particularly CBMHC, is not afforded parity with general health care. Resources also remain concentrated near urban centres, to the detriment of PWPSD who live in rural areas.

PWPSD are also at risk of receiving substandard care, in the absence of clear guidelines for the quality and acceptability of CBMHC. These deficiencies have the most severe impact on groups who face intersecting vulnerabilities. For example, Black mental health care users have historically had limited access to mental health care, and when receiving mental health care in an institutional setting, were more likely to experience human rights violations.[476] Women with psychosocial disabilities are also at risk of compounded marginalisation, as the CRPD has noted that this

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[472] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 12(b); African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (adopted 26 May 2010) 26; UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22) para 5; Article 25 of the Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3; Article 17(2) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (adopted 29 January 2018).

[473] S10.

[474] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 20.

[475] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 157.

[476] See, for example: Parle (2019) *Oxford Research Encyclopaedia of African History*; Swanson "'*Of Unsound Mind*'" (2001); Louw (2019) *Hist. Psychol.*

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group is "particularly exposed" to abuse in institutionalised care settings.[477] The legislative and policy framework must be responsive to the vulnerabilities experienced by certain PWPSD, but targeted interventions for such groups have not yet been practically realised, despite the urgency of the needs in question.

Reforms to address these inequities in care seem unlikely, without an appropriate monitoring and information system to identify inequalities, or accountability mechanisms which function effectively. It is apparent that there is still a long way to go in achieving equality, in fact, for PWPSD in respect of various facets of health care.

5 5 Monitoring and information systems

Constitutional and international law norms and standards require the establishment of monitoring and information systems for CBMHC. First, such systems are key to assessing whether CBMHC programmes have been reasonably implemented, rather than only being reasonably conceived.[478] Second, a key component of progressive realisation is the duty to monitor progress made in the realisation of the right; this duty to monitor exists irrespective of resource constraints.[479] Third, without monitoring and information systems, vulnerable groups cannot be easily identified for targeted interventions as required in terms of the model of reasonableness review[480] and international human rights law.[481] Finally, the legislative and policy framework can only be coherent and comprehensive, as required in terms of the reasonableness enquiry, if based on accurate and relevant data.[482]

While the MHCA does not make provision for the creation of monitoring or information systems for mental health care, the establishment of such a system is one of the key objectives of the NMHPF.[483] In terms of the NMHPF, from 2013, nationally agreed indicators must be established and integrated into district health

[477] UN Committee on the Rights of Persons with Disabilities General Comment 3: "On women and girls with disabilities" (2016) GE.16-20871 (E) para 55.
[478] See chapter two part 2 4.
[479] See chapter two part 2 4 3; chapter three part 3 4 2, 3 4 4.
[480] See chapter two part 2 4 2.
[481] See chapter three part 3 4 2, 3 6 2, 3 8.
[482] See chapter two part 2 4 2.
[483] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 18.

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information systems.[484] The NMHPF further expressly notes that the data gathered must be used to determine the extent to which the identified norms and standards for mental health care are met, and to inform further policy reform.[485] The Minister of Health and provincial Departments of Health are tasked with ensuring that such monitoring and evaluation occurs.[486] Provincial Mental Health Directorates must also train "provincial and district health information officers and mental health programme staff in all provinces, in the collection, processing, dissemination and use of mental health indicators".[487]

The WPRPD similarly emphasises the importance of monitoring and evaluation, through the inclusion of a strategic pillar that requires the collection, analysis, and reporting of data in respect of the implementation of the WPRPD.[488] A range of focus points for evaluation are identified, such as efficiency, effectiveness, and sustainability, which must be routinely monitored to allow for progress in each of these areas to be tracked over time.[489] The input of PWPSD and their representative groups, as stakeholders, is expressly included as a key source of data to be used to monitor implementation.[490] The WPRPD further identifies a number of broad outcomes and associated indicators used to measure progress towards these outcomes, However, the WPRPD contains no indicators relating to mental health care or CBMHC specifically.[491]

In line with the requirements of the NMHPF outlined above, indicators relating to mental health have been included in the database for the District Health Management Information System.[492] However, only a limited range of mental health indicators have been included, such as first-time admissions for mental health care, number of total mental health care visits at primary health care level, and involuntary admission rate.[493] This set of indicators has been criticised as being inadequate for

[484] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 28.
[485] 28.
[486] 29-30.
[487] 43.
[488] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 116.
[489] 116-118.
[490] 117-118.
[491] 120-123.
[492] National Department of Health *District Health Management Information System* (2011).
[493] National Department of Health *National Indicators Data Set* (2021).

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monitoring the usage of CBMHC or the quality of services rendered in community settings.[494] For example, the current set of indicators does not report on the prevalence of different mental health diagnoses in each community, the rates of relapse among PWPSD who seek care at CBMHC facilities, or the human resources allocated to CBMHC facilities relative to the size of the communities served.[495] Furthermore, as the data is not disaggregated according to diagnosis, gender, or socio-economic group, vulnerable groups cannot easily be identified for special measures.[496] In summary, the present set of indicators is insufficient to monitor the implementation of the current system of CBMHC, and factors which bar access to health care services for PWPSD remain largely unacknowledged. Consequently, there is insufficient information to guide legislative and policy reform which would align South Africa's system of CBMHC with constitutional and international law standards.

A further concern is the quality of data collected. While Standard Operating Procedures[497] for data collection have been published, under-resourced CBMHC facilities in practice still experience poor standardisation of tools and methods for data collection, which continues to affect the accuracy and reliability of data.[498] In these facilities, the required information is generally recorded by hand, as information capture technology is unavailable, or health care practitioners are not trained to capture information electronically.[499] The acquisition of information capture technology and development of computer literacy programmes are not prioritised. Other issues, such as improving infrastructure or acquiring essential medicines, are

[494] L Robertson, B Chiliza, B Janse van Rensburg & M Talatala "Towards Universal Health Coverage for People Living with Mental Illness in South Africa" (2018) *S. Afr. Health Rev.* 99 103; M Bimerew "Information Systems for Community Mental Health Services in South Africa" (2019) 11 *Int. J. Africa Nurs. Sci.* 1 1; Docrat *et al* (2019) *Health Policy Plan.* 708; Docrat *et al* (2019) *Int. J. Ment. Health Syst.* 4.

[495] Bimerew (2019) *Int. J. Africa Nurs. Sci.* 1; Docrat *et al* (2019) *Health Policy Plan.* 708; S Ahuja, T Mirzoev, C Lund, A Ofori-Atta, S Skeen & A Kufuor "Key Influences in the Design and Implementation of Mental Health Information Systems in Ghana and South Africa" (2016) 3 *GMH* 1 6.

[496] Bimerew (2019) *Int. J. Africa Nurs. Sci.* 3.

[497] National Department of Health *District Health Management Information System (DHMIS) Standard Operating Procedures: Facility Level* (2016).

[498] Bimerew (2019) *Int. J. Africa Nurs. Sci.* 3; M Bimerew, O Adejumo & M Korpela "Experiences of Community Nurses in Management of a District-based Mental Health Information System in the Western Cape, South Africa" (2014) 2 *Afr. J. Phys. Health Educ. Recreat. Dance* 431 432.

[499] Bimerew (2019) *Int. J. Africa Nurs. Sci.* 4; Bimerew (2014) *Afr. J. Phys. Health Educ. Recreat. Dance* 435; G Wright, D O'Mahony & L Cilliers "Electronic Health Information Systems for Public Health Care in South Africa: A Review of Current Operational Systems" (2017) 4 *J Health Inform Afric* 51 54; R English, T Masilela, P Barron & A Schönfeldt "Health Information Systems in South Africa" (2011) *S. Afr. Health Rev.* 81 85.

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viewed as more pressing.[500] Consequently, the process of data collection is not optimised, and the quality of data collected at community and district levels may be compromised.

The data collected at these levels must be analysed and the results used to inform decisions in respect of mental health care at provincial and national level. However, as mental health care is intended to be integrated into primary health care, provincial Departments of Health do not include distinct trends in mental health care or CBMHC in their annual reports. Generally, the reports note that mental health care forms part of primary health care, and then focus on the number of primary health care facilities which have attained ICS. ICS, as already noted, is not targeted at assessing a facility's capacity to provide mental health care.

It must be noted that some provincial Departments of Health do include additional information on mental health care in their annual reports. For example, for the year 2019/2020, KwaZulu-Natal featured "mental disorders screening rate",[501] the Western Cape reported on the addition of psychiatric beds in regional hospitals,[502] and Gauteng included the number of "new primary health care clients treated for mental health disorders".[503] However, as the inclusion of this information is not mandatory, comparisons across provinces, and even between different years for a single province, are not feasible.

Overall, while monitoring and information systems are generally overlooked in the MHCA, it must be noted that certain aspects of the policy framework do align with the required standards. These include: providing for the creation of a range of indicators;[504] requiring monitoring mechanisms at national and regional levels;[505] and calling for monitoring mechanisms to be inclusive of civil society, particularly PWD and their representative organisations.[506] However, there are serious deficiencies in

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[500] G Cline & J Luiz "Information Technology Systems in Public Sector Health Facilities in Developing Countries: The Case of South Africa" (2013) 13 *J. Med. Inform. Decis. Mak.* 1 2.
[501] Provincial Department of Health, KwaZulu-Natal *Annual Report 2019/20* (2020) 144.
[502] 32.
[503] Provincial Department of Health, Gauteng *Annual Report 2019/20* (2020) ii.
[504] African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (adopted 26 May 2010) 15.
[505] UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 52.
[506] Article 33(3) of the Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3.

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the alignment of monitoring and information systems, as implemented, with the relevant human rights standards for CBMHC. These include the fact that the chosen indicators are insufficient and inappropriate to monitor CBMHC, under-investment in tools and skills training for data collection, and poor data processing and reporting. The limited availability of resources cannot be invoked to justify these failures, as international human rights law requires parties to monitor and evaluate progress made in the realisation of socio-economic rights even in the event of resource scarcity. Overall, the state's failure to meet their obligations in this respect has severe consequences, as reforms and improvements in the provision of CBMHC depend on the collection of relevant and quality data.

5 6 Resource allocation

The allocation of adequate and appropriate resources by States Parties is fundamental to the realisation of all socio-economic rights.[507] In addition to financial resources, appropriate human resources must also be made available to realise the right to health for PWPSD.[508] Constitutional and international law standards further require that the vulnerability of PWPSD and the immediacy of their needs be addressed, even in the event of resource constraints, through the implementation of low-cost targeted programmes.[509] Further, to avoid a violation of the negative obligation to respect right of access to health care services, the State must not initiate deinstitutionalisation measures without sufficient investment in the facilities, goods and services intended to realise CBMHC.[510]

[507] *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 39; UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" E/1991/23 para 7; UN Committee on Economic, Social and Cultural Rights General Comment 14: "The Right to the Highest Attainable Standard of Health (Art. 12)" (2000) E/C.12/2000/4 para 13; UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22) para 13; African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (adopted 26 May 2010) 10; Article 4 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (adopted 29 January 2018); UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 54.
[508] See chapter two part 2 4 2; chapter three part 3 5 4, 3 8.
[509] See chapter two part 2 4 2, 2 4 3, 2 4 4; chapter three part 3 4 2, 3 6 2.
[510] See chapter two part 2 3.

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The MHCA,[511] NMHPF[512] and WPRPD[513] each qualify the state's duties in respect of the provision of MHC with reference to the availability of resources. In principle, this does align with the Constitution and the identified international human rights instruments, which contain similar qualifiers in respect of resource constraints. However, as will be discussed when the implementation of these instruments is evaluated, such qualifiers cannot be "quoted indiscriminately in the deliberation of whether resources are available or not".[514]

A key obligation on the part of the state, is to take "deliberate, concrete and targeted" steps to realise the right in question, including in respect of resource allocation.[515] Section 4 of the MHCA formulates the state's obligation to determine and implement policy in broad terms, without express reference to the obligation to budget appropriately. The failure to identify clear obligations for all relevant role players may account for the period of poor resource allocation which followed the entry into force of the MHCA, as the discussion of the implementation of the MHCA will show.

Greater detail is provided in the NMHPF, which provides that, by 2014, budgets for mental health care must be set at national and provincial level to meet the targets identified for each area for action.[516] Provincial strategies for mental health, including budgets, are to be reviewed annually.[517] In addition to ensuring that provincial budgets for mental health care are "keeping parity with other health conditions", provincial Departments of Health are also tasked with ensuring the equitable distribution of resources.[518] In respect of CBMHC, "local community-based resources should be mobilised wherever possible".[519]

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[511] S3 of the Mental Health Care Act 17 of 2002.
[512] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 21 and 25.
[513] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 3.
[514] A Janse van Rensburg "A Framework for Current Public Mental Health Care Practice in South Africa" (2007) 10 *Afr J Psychiatry* 205 208.
[515] UN Committee on Economic, Social and Cultural Rights General Comment 3: "The nature of States parties' obligations (art.1, para. 1 of the Covenant)" (1990) E/1991/23 para 2; UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 41.
[516] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 22-29.
[517] 25.
[518] 30.
[519] 20.

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The WPRPD calls for adequate allocation of resources for CBMHC across all provinces,[520] particularly in rural communities which may require additional financial investment.[521] Significantly, the WPRPD expressly requires existing budgets to be re-prioritised to ensure the mainstreaming of disability concerns, including mental health care, as well as the establishment of budgets for services required on the basis of disability.[522] Furthermore, the WPRPD includes targets for the period between 2015 and 2019, as well as 2020 to 2030, and identifies the state actor responsible for each target.[523]

Another key aspect of resource allocation is that the legislative and policy framework must be responsive to the vulnerability of PWPSD as a group even in the face of harsh resource constraints. The MHCA does not provide for special measures to realise access to mental health care in the event of resource constraints. The NMHPF does identify "protection against vulnerability", including on the basis of disability, as a guiding value which calls for targeted, "cost-effective interventions for mental health".[524] The WPRPD similarly calls for "targeted programmes and services" for PWD on the basis of their "diverse needs", while expressly acknowledging that these must be adequately resourced.[525]

To evaluate the translation of the above framework into practice, the point of departure is to evaluate resource allocation in the period following the promulgation of the MHCA. However, this evaluation is hindered by a lack of data on budgeting and expenditure at both national and provincial level. For example, in a report published in 2007, the WHO indicated that expenditure on mental health at national level in South Africa could not be determined, and that only three provinces were able to report on the percentage of the provincial budget allocated to mental health care.[526] A bleak picture was painted by the available data, as the Northern Cape,

[520] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 86.
[521] 108.
[522] 107.
[523] 165-190.
[524] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 14 and 24.
[525] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 107.
[526] Attributed to poor prioritisation of mental health, lack of effective monitoring and information systems, and that mental health care is integrated into the general health care budget. See World Health Organization *WHO-AIMS Report on Mental Health System in South Africa* (September 2007) 8-9.

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Mpumalanga, and North West reported that, respectively, 1%, 8%, and 5% of their health budget was allocated to mental health care.[527]

In respect of human resources, a report by the WHO found that 9,3 persons per 100 000 were employed by the Department of Health in facilities that provided mental health care, of which 0,28 were psychiatrists, 0,32 were psychologists, and 7,45 were nursing staff.[528] These numbers represent a significant decline since 1997, where 19,5 mental health workers were recorded per 100 000 persons.[529] This reduction could be considered a retrogressive measure, which has not been justified in terms of the strict standards which apply in terms of the doctrine of non-retrogression.[530] By way of comparison, in 2009, Lund and Flisher proposed a model for CBMHC in South Africa, in which even the "minimum recommended service provision" called for 35,4 mental health care providers per 100 000 persons, including 0,4 psychiatrists, 2,5 psychologists and a combined total of 13,3 general and psychiatric nurses.[531]

Literature published during the period following the adoption of the MHCA indicates a decrease in the provision of resources for mental health in most provinces.[532] A study conducted between 2002 and 2007 reported diminished funding for two-thirds of psychiatric hospitals surveyed in KwaZulu-Natal.[533] Between 2000 and 2005, the Eastern Cape reported a 27% decrease in the number of hospital beds, with Limpopo experiencing a 26% decrease and the Western Cape a 21% decrease.[534] A shortage of resources had a severe negative impact on one of the laudable innovations in the MHCA, the 72-hour assessment period for involuntary admissions. By 2010, the National Department of Health had designated 53% of hospitals across the country as having authorisation to provide a 72-hour assessment, despite not all of these having separate psychiatric units.[535] According

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[527] World Health Organization *WHO-AIMS Report on Mental Health System in South Africa* (September 2007) 9.
[528] 17.
[529] C Lund, S Kleintjes, R Kakuma & A Flisher "Public Sector Mental Health Systems in South Africa: Inter-provincial Comparisons and Policy Implications" (2010) 45 *Soc Pyschiat Epidemiol* 393 402.
[530] See chapter two part 2 4 3.
[531] C Lund & A Flisher "A Model for Community Mental Health Services in South Africa" (2009) 14 *Trop. Med. Int.* 1040 1045.
[532] Burns (2010) *SAMJ* 663.
[533] Petersen & Lund (2011) *SAMJ* 752.
[534] Lund et al (2010) *Soc Pyschiat Epidemiol* 397.
[535] 397.

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to Burns, poor infrastructure and lack of trained personnel to facilitate the assessment caused "suboptimal levels of care and occasional disasters", including mental health care users being heavily sedated for the safety of general health care patients accommodated in the same wards.[536]

In addition to continued under-resourcing of mental health care overall following the adoption of the MHCA, literature reveals poor allocation of resources to CBMHC in particular. This could be attributed to the fact that the MHCA does not expressly require CBMHC to be included in the health budgets at national or provincial level. In a review of literature on mental health service delivery between 2000 and 2010, Petersen and Lund reported a decrease in funding for tertiary psychiatric facilities. However, these cutbacks were not accompanied by increased investment in CBMHC.[537] This could, again, be considered contrary to the doctrine of non-retrogression. Of the 92 articles reviewed by Petersen and Lund, not one reported increased investment in CBMHC.[538] In the four provinces which could provide data on this matter for the report compiled by the WHO, the following percentage of mental health care expenditure was allocated to psychiatric institutions: 67% in Gauteng, 94% in the Northern Cape, 85% in Mpumalanga, and 99% in North West.[539]

The troubling trends in resource allocation were attributed in part to the absence of a national mental health policy.[540] However, even with the adoption of the NMHPF and the WPRPD, resource allocation for mental health care, and CBMHC in particular, remains a cause for concern.[541] Docrat *et al* found that, for the 2016/2017 financial year, national health expenditure for mental health amounted to 4,6% of the total health budget.[542] The WHO recommends that between 5% and 10% of the total health budget be allocated to mental health, which indicates that expenditure on mental health care in South Africa fell short of the WHO minimum recommended

[536] Burns (2008) *SAMJ* 47.
[537] Petersen & Lund (2011) *SAMJ* 752 and 756.
[538] 752.
[539] World Health Organization *WHO-AIMS Report on Mental Health System in South Africa* (September 2007) 9.
[540] Lund *et al* (2010) *Soc Pyschiat Epidemiol* 402.
[541] Docrat *et al* (2019) *Health Policy Plan.* 708; Docrat *et al* (2019) *Int. J. Ment. Health Syst.* 5.
[542] Docrat *et al* (2019) *Health Policy Plan.* 711.

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percentage.[543] In respect of resource allocation, several issues persisted following the adoption of the NMHPF and WPRPD. These include: the disproportionate allocation of resources to institutionalised care; insufficient investment in CBMHC; and inequities between resources made available in public and private mental health care sectors.

In respect of the first issue, overinvestment in institutionalised care, Docrat *et al* estimated in 2019 that 45% of total national expenditure on mental health was directed at psychiatric hospitals.[544] Despite commitments in the MHCA and the NMHPF to integrate mental health care into primary health care, mental health care offered at primary health care level accounted for only 7,9% of mental health expenditure at national level.[545] District hospitals remain underfunded, although these are designated in terms of the MHCA and NMHPF as the "first point of contact" for PWPSD seeking mental health care.[546] The National Department of Health report for the year 2018/2019 indicates that only three of the planned 15 district mental health teams were established, with "lack of financial resources" cited as the reason for the shortfall.[547] The report for the following year shows significant improvement, with 17 of the planned 20 teams established, although "shortages of resources" were referenced once more.[548]

A key function of district hospitals, as the first point of contact, is to facilitate the 72-hour assessment before referral for further specialised treatment. This task is frustrated by resource constraints, a problem which has persisted since this referral process was introduced by the MHCA.[549] However, Burns argues that the problem lies with implementation, including a lack of appropriate facilities and shortages of staff, and not "the idea or concept of an observation period".[550]

The second issue relates to the disproportionate allocation of resources to psychiatric institutions, while CBMHC remains underfunded. In 2017, the South

[543] Docrat *et al* (2019) *Health Policy Plan.* 716-717; World Health Organization *Dollars, DALYs and Decisions: Economic Aspects of the Mental Health System* (2006) 9.
[544] Docrat *et al* (2019) *Health Policy Plan.* 712.
[545] World Health Organization *Dollars, DALYs and Decisions: Economic Aspects of the Mental Health System* (2006) 9; Docrat *et al* (2019) *Health Policy Plan.* 712.
[546] Docrat *et al* (2019) *Int. J. Ment. Health Syst.* 5.
[547] National Department of Health *Annual report 2018/19* (2019) 35.
[548] National Department of Health *Annual report 2019/20* (2020) 37.
[549] Petersen & Lund (2011) *SAMJ* 752.
[550] Burns (2008) *SAMJ* 47.

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African Society of Psychiatrists reported that not one province had effectively implemented CBMHC.[551] According to Robertson *et al*, deinstitutionalisation is most commonly implemented in a "haphazard" manner, with CBMHC either seeing "erratic" development, or none whatsoever.[552] A key challenge in respect of human resources in particular, is to ensure that CBMHC workers and mental health care staff are provided with administrative and skills development support, as well as the necessary infrastructure.[553] Studies have also shown that PWPSD who present as violent or disruptive have been admitted to general health care settings, where, for lack of appropriate infrastructure and to protect other health care users, they have been forcibly secluded in "inadequately refurbished wards or medical isolation units".[554] Further, the MHCA and NMHPF impose additional obligations on mental health care workers, and this should be reflected in appropriate resource allocations for these additional obligations. For example, the procedural and reporting requirements in respect of the 72-hour assessment period preceding involuntary admission may place a considerable administrative burden on the heads of health establishments.[555]

In the absence of clear standards for funding for CBMHC at national, provincial and regional levels, tertiary psychiatric services and facilities are downscaled without the necessary investment in community-based health and support services.[556] In effect, "dehospitalisation" instead of properly co-ordinated deinstitutionalisation will occur. The impact of this is that PWPSD who are discharged do not receive the necessary support in their communities, and enter a cycle of relapse and readmission.[557] Failure to invest in CBMHC thus causes a so-called "revolving door" phenomenon, with an estimated 24% of mental health care users readmitted to inpatient care within three months of being discharged.[558]

Even where expenditure on institutionalised mental health care is reduced, these funds are not "ring-fenced" for CBMHC, which is, in fact, often mistakenly viewed as

[551] SAHRC *Report on Mental Health Care* (2017) 31.
[552] Robertson *et al* (2018) *S. Afr. Health Rev.* 101.
[553] Ramlall (2012) *Afr J Psychiatry;* Burns (2008) *SAMJ* 47.
[554] Ramlall (2012) *Afr J Psychiatry* 409.
[555] Petersen & Lund (2011) *SAMJ* 756.
[556] 752.
[557] 756.
[558] Patel & De Beer "Mind field: SA urgently needs a new mental health policy" *Daily Maverick.*

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a cost-saving measure.[559] The most striking example of this is the failed Marathon Project, in which 144 PWPSD died following a rushed deinstitutionalisation project initiated by the Gauteng Department of Health, allegedly as a means of cutting costs. The Marathon Project serves as a further example of where stereotypes were used to depoliticise and personalise an extreme health care crisis, which had resulted in part from the failure to allocate appropriate funding. In the arbitration proceedings, the Arbitrator, former Deputy Chief Justice Dikgang Moseneke, observes:

> "Another misinformation that emanated from Ms Mahlangu, Dr Selebano and Dr Manamela was that the deaths that occurred were not related to the move but ought to have been expected given the mental health status of the deceased. All three of them, in slightly varying formulations said, 'mental health care users die'."[560]

Even following the collapse of the Marathon Project, sufficient investment in CBMHC has not been realised. In the National Department of Health report for the year 2019/2020, statistics as to "clinic and community health centres" are grouped together, without expressly indicating their intended role in the provision of mental health care. Moreover, it is reported that 19 projects to "construct or revitalise" clinics and community health centres failed owing to "various contractual reasons".[561]

These deficiencies may also be exacerbated by the implementation of the fiscal consolidation programme adopted to compensate for the financial impact of the Covid-19 pandemic. In respect of health care, this programme envisions "large spending reductions", and "significant restructuring of provincial health services, with a focus on efficiency savings".[562] It is anticipated that the fiscal consolidation programme will have a negative impact on the availability and quality of mental health care, serving as a further example of retrogressive measures which do not meet the relevant justificatory standards.

The evaluation of the provisions and principles of the MHCA, NMHPF and WPRPD indicates that the legislative and policy framework is not sufficiently explicit in setting benchmarks for funding. While the MHCA provides very limited guidance on budgeting, particularly in respect of CBMHC, the NMHPF and WPRPD provide greater clarity, including on the roles of actors at national and provincial levels in

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[559] C Brooke-Sumner, C Lund & I Petersen "Bridging the Gap: Investigating Challenges and Way Forward for Intersectoral Provision of Psychosocial Rehabilitation in South Africa" (2016) 10 *Int. J. Ment. Health Syst.* 1 2.
[560] *Marathon Project Arbitration* para 86.
[561] National Department of Health *Annual Report 2019/20* (2020) 44.
[562] RSA *Medium Term Budget Policy Statement* (2020) 41.

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respect of budgeting. Unfortunately, these principles and provisions have not been effectively translated into practice. Following the promulgation of the MHCA, as well as the adoption of the NMHPF and WPRPD, mental health care remains underfunded, with limited investment in CBMHC. The evaluation also revealed clear inequity in resource allocation for mental health care across provinces, the rural-urban divide, and the public and private sectors, with the consequence that the standard of availability is not fulfilled.

5 7 Oversight and accountability mechanisms

It is essential that appropriate and effective safeguards for the protection of PWPSD from neglect and abuse are established, including oversight and regular review by "a competent, independent and impartial authority".[563] As has been noted, the obligation to create such safeguards is immediately realisable and not subject to progressive realisation.[564] The MHCA, NMHPF and WPRPD assign a duty to monitor compliance with the legislative and policy framework to various actors – from executive authorities, to the SAHRC, to Review Boards, to mental health care providers themselves. Further, the legislative and policy framework assigns responsibilities in respect of CBMHC, which often overlap in substance, to a similarly wide range of actors. In terms of Bovens' conceptual framework for accountability, the South African system of mental health care may thus be facing "the problem of many eyes" as well as "the problem of many hands".[565] The former entails that there are several forums, each applying their own set of standards, tasked with keeping an actor to account.[566] In terms of the latter, various actors could potentially be held accountable for an act or omission, or some part thereof.[567] In essence, there is uncertainty as to who is ultimately tasked with keeping who accountable, to what standards, and with what consequences. As a result, the issue of a "lack of ownership" arises in respect of the deficiencies in South Africa's system of CBMHC.[568]

[563] See chapter three part 3 5 3.
[564] See chapter three part 3 5 3.
[565] M Bovens "Analysing and Assessing Accountability: A Conceptual Framework" (2007) 13 *Eur. Law J.* 447-468.
[566] 455.
[567] 457.
[568] Mahomed (2016) *SAJHR* 507.

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In terms of the MHCA, Review Boards are tasked with preventing human rights violations against mental health care users. The NMHPF affirms the importance of their role in protecting mental health care users from abuse and accordingly requires appropriate resources to be allocated for the functioning of Review Boards.[569] However, the effectiveness of Review Boards was called into question in the investigations into the failed Marathon Project. In the Health Ombud's report, the Gauteng Review Board was described as "moribund, ineffective and without authority and without independence".[570] Similarly, in the arbitration proceedings, it was concluded that the Gauteng Review Board failed to act independently and perform its statutory duties.[571] However, this failure was attributed to the unethical conduct of the board members, and not deficiencies in the MHCA. As held by the Arbitrator, former Deputy Chief Justice, Dikgang Moseneke:

> "One fleeting reading of the legislation regulating the Review Board will show that Mrs Masondo [the chairperson] was less than truthful when she pleaded ignorance of the duties of the Review Board. She and her Review Board chose to bend over and comply with what the Department wanted to do in order to protect her appointment and remuneration at the expense of mental health care users and their families."[572]

In addition to the shortcomings of the Gauteng Review Board, the report by the SAHRC found numerous Review Boards across the country to be "dysfunctional".[573] A range of causes underlying the failure of Review Boards to perform their duties in terms of the MHCA were identified. Review Boards were underfunded in many provinces.[574] Board members were not always available to perform their duties, while some Review Boards struggled to fill vacancies.[575] Certain provinces, such as KwaZulu-Natal, the Eastern Cape and Mpumalanga, reported that incompetence or negligence in respect of the submission of documents to the High Court resulted in mental health care users being detained illegally in hospitals.[576] Review Boards were underutilised as mental health care users lack awareness of their rights and of Review Boards as a means through which to enforce their rights.[577] For example, it

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[569] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 26 and 34.
[570] Office of the Health Ombud *The Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province* (2018) 55.
[571] *Marathon Project Arbitration* paras 173-175.
[572] Para 175.
[573] SAHRC *Report on Mental Health Care* (2017) 20.
[574] 20, 37 and 44.
[575] 20 and 44.
[576] 41, 43 and 33.
[577] 41.

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was reported in 2017 that the Review Board serving the Eastern region of the Eastern Cape had not received an appeal in a span of five years.[578]

There are a number of other concerns in respect of the functioning of Review Boards. First, there is not uniformity in the rules of procedure across different Review Boards, due to section 24(1) of the MHCA providing that Review Boards "may determine their own procedures for conducting business".[579] Second, despite being the primary accountability mechanisms created by the MHCA, the MHCA does not empower Review Boards to institute sanctions against facilities which repeatedly commit human rights violations.[580] Third, Review Boards currently have a limited role in protecting mental health care users who make use of CBMHC services, despite the dire need for accountability mechanisms in this sector.[581] For example, in 2005, only 8% of community residential facilities had been visited to ascertain whether the human rights of mental health care users were being upheld, while 52% of mental hospitals and psychiatric inpatients units in general hospitals received such an assessment.[582]

The most recent annual reports of the provincial Departments of Health do not even include information on the number of Review Boards within their respective jurisdictions. The National Department of Health, in its 2019/2020 report, noted only that Review Boards had been established in each province.[583] The former UN Special Rapporteur has identified a link between information systems and effective accountability for the delivery of mental health. He recommended expanding the list of indicators used to monitor the delivery of mental health care, to include "performance indicators on the reduction of coercion, institutionalization and excessive medicalization".[584] Currently, owing to poor information systems, it is difficult to ascertain whether the functioning of Review Boards has improved.

[578] SAHRC *Report on Mental Health Care* (2017) 41.
[579] M Ndou "A Comparative Discussion of the Regulation of Mental Health Review Boards in South Africa and the Mental Health Review Tribunal in the United Kingdom" (2017) 50 *CILSA* 56 82.
[580] Lund *et al* (2010) *Soc Pyschiat Epidemiol* 396.
[581] SAHRC *Report on Mental Health Care* (2017) 58 and 60.
[582] Lund *et al (*2010) *Soc Pyschiat Epidemiol* 396.
[583] National Department of Health *Annual Report 2019/20* (2020) 10.
[584] UN Human Rights Council "Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health" (2019) GE.19-06239(E) para 97(a).

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5 8 Meaningful engagement and participation

A key obligation on the state, is to ensure the participation of PWPSD and their representative groups in the development, implementation, and evaluation of the legislative and policy framework. In the earlier discussion of meaningful engagement as a consideration in the reasonableness enquiry, a number of key points were raised.[585] First, meaningful engagement between the state and PWPSD and their representative organisations has a practical function, namely, to shed light on the interests and needs to which the legislative and policy framework must be responsive.[586] Second, meaningful engagement allows PWPSD to play an active role in determining their socio-economic circumstances.[587] This function is of particular importance for PWPSD, as members of a historically disempowered group who have long borne the stigma of being disempowered recipients of welfare and charity.[588] Third, merely informing PWPSD of decisions which have already been made without their involvement, does not constitute meaningful engagement. [589]

Based on international and regional human rights law, five further considerations are important in this regard. First, the CRPD has strongly emphasised that consultation with PWPSD must be inclusive of all demographic groups, particularly those who face compounded marginalisation based on other characteristics, such as gender or sexual orientation.[590] Second, according to the CESCR, the participation of PWPSD and their representative organisations in development and implementation of policy requires the establishment of "national coordinating

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[585] See chapter two part 2 4 2.
[586] Chenwi (2011) *SAPL* 155; *Occupiers of 51 Olivia Road, Berea Township and 197 Main Street, Johannesburg v City of Johannesburg* 2008 3 SA 208 (CC) para 15.
[587] Chenwi (2011) *SAPL* 129.
[588] This view aligns with the charity model of disability, which bears many similarities with the medical model (see chapter one part 1 4). "The [charity] model is often seen as depicting PWDs as helpless, depressed and dependent on other people for care and protection, contributing to the preservation of harmful stereotypes and misconceptions about PWDs." See M Retief & R Letsosa "Models of Disability: A Brief Overview" (2018) 74 *Theological Studies* 1 6.
[589] *Residents of Joe Slovo Community, Western Cape v Thubelisha Homes* 2010 3 SA 454 (CC) para 378.
[590] For example, the CRPD has noted the worrying "lack of or insufficient participation of women with disabilities in decision-making processes…". See UN Committee on the Rights of Persons with Disabilities General Comment 3: "On women and girls with disabilities" (2016) GE.16-20871 (E) para 10. A further example is the imperative to "involve a diverse range of persons with disabilities" in consultation, including women, elderly persons, and PWPSD, as noted by the CRPD in respect of Article 19. See UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) paras 56 and 70.

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committees, or similar bodies".[591] Fourth, the state bears the obligation of providing sufficient "political and financial support", to ensure that consultation processes are effective.[592] Finally, the African Commission emphasises the importance of a participatory approach which engages persons at the local level, in order to "maximise community input", which will be key to the success of CBMHC.[593]

The need for a participatory approach is not reflected strongly in the MHCA. Section 66 empowers the Minister of Health to make regulations on a number of important matters. These include: to set standards for the quality of care;[594] to establish procedures for the seclusion or restraint of mental health care users;[595] to authorise or license NGOs to provide mental health care;[596] and to determine the span of time for which mental health care users may be kept in the custody of the South African Police Service.[597] These regulations may have a significant impact on the experience of mental health care users have, particularly in terms of the quality and acceptability of care. The involvement of PWPSD and their representative organisations is therefore crucial to ensuring a human rights-based approach to CBMHC. Section 68(1) of the MHCA does provide for a 30-day period comment, following the publication of draft regulations. Further, section 68(2) provides:

> "At any time before issuing regulations, discussions and consultations may be held with any interested group."

The fact that this is the sole provision relating to a participatory approach, is an indication of a serious deficiency in the MHCA. First, as a consequence of the use of the word "may", the Minister is not obligated to engage with the relevant parties. Second, reference is made to "any interested group", instead of singling out PWPSD and their representative groups as being the most important stakeholders to consult. The MHCA does not facilitate the meeting of the constitutional and international human rights standards in respect of engagement with and participation of PWPSD.

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[591] UN Committee on Economic, Social and Cultural Rights General Comment 5: "Persons with Disabilities" (1994) E/1995/22) ("General Comment 5 of the CESCR") para 14.

[592] African Commission on Human and Peoples' Rights *Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights* (adopted 26 May 2010) 15.

[593] 25.

[594] S66(1)(a).

[595] S66(1)(d).

[596] S66(1)(o).

[597] S66(1)(r).

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Despite these deficiencies in the MHCA, the process leading to the adoption of the NMHPF in 2013 included widespread consultation and participation of a range of stakeholders, including "advocacy and user organizations", during provincial and national mental health summits.[598] "Participation" is included in the NMHPF as one of its key values. This value calls for the involvement of mental health care users "in the planning, delivery and evaluation of mental health services".[599] This value is aligned with the principle that "self-help and advocacy groups should be encouraged".[600] This principle is formulated vaguely, to the extent that its potential impact is hindered in three respects. First, it is not clear what this obligation to "encourage" self-help and advocacy groups practically entails. For example, it is not specified whether this obligation requires further legislative or policy measures to create official structures or mechanisms for participation, or whether the obligation calls for the allocation of resources. Second, the responsible actors are not identified, making it impossible to ensure accountability for the non-adherence to this value. Third, monitoring and evaluation of progress made in this respect are frustrated by the lack of clear, measurable targets.

These problems are significant, as the NMHPF identifies "participation" only as a key value, and not one of the areas for action. Consequently, the approach to participation is fragmented, as it only features as a subsidiary step in other areas for action. For example, under "Advocacy", the Department of Health is tasked with engaging with "consumer and family associations in policy development and implementation, as well as the planning and monitoring of services".[601] However, the area for action titled "Monitoring and evaluation", which would be one of the most appropriate sections in which to include participation, makes no reference to the involvement of PWPSD or their representative organisations.[602]

The WPRPD provides a stronger basis for a participatory approach, with the strategic pillar titled, "Strengthening the Representative Voice of Persons with

[598] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 47.
[599] 20.
[600] 20.
[601] 27.
[602] 28.

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Disabilities".[603] The WPRPD expressly links this strategic pillar to relevant provisions in the UN Disability Convention, namely, Article 4, Article 29, and Article 33. As part of this strategic pillar, the WPRPD identifies five focus areas, each including a number of practical directives. For example, one focus area is aimed at "strengthening the diversity and capacity of DPOs and self-advocacy programmes". This aim will be achieved by meeting specific directives, such as providing funding and a supportive legislative framework for DPOs.[604] Another focus area is the "recognition of representative organisations of persons with disabilities". This area includes as directive the development of "minimum norms and standards for consultation of persons with disabilities".[605] In respect of this pillar and the associated focus areas and directives, the WPRPD assigns responsibilities to a number of role players, including directing that executive authorities should formalise consultation platforms for DPOs within their respective institutions.[606] Consequently, these focus areas and directives address some of the deficiencies in the MHCA and the NMHPF, particularly through the inclusion of clearly delineated actions, assigned to particular actors.

While the WPRPD compensates somewhat for the shortcomings of the MHCA and NMHPF, it has not been effectively implemented. In 2018, the CRPD criticised the state's failure to ensure the participation of PWPSD and their representative organisations.[607] Consequently, the CRPD recommended the establishment of "formal mechanisms to ensure effective and meaningful participation and consultation" with PWD and DPOs.[608] In respect of DPOs, the CRPD made two key recommendations. First, the state must allocate sufficient financial resources to support DPOs to function as representative organisations.[609] Second, the state must "ensure that accreditation procedures [for DPOs] are accessible and simplified at all levels of the national disability rights machinery".[610]

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[603] Pillar 6. See National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 99-104.
[604] 102.
[605] 102.
[606] 125.
[607] UN Committee on Economic, Social and Cultural Rights *Concluding observations of the initial report of South Africa as adopted by the Committee at its 64th session,* 24 September – 12 October 2018 paras 5-7 and 54-55.
[608] Para 7(a).
[609] Para 7(a).
[610] Para 55(c).

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In addition to these challenges, stigma on the basis of psychosocial disability remains a barrier to the participation of PWPSD. For example, the CRPD also recommended that public officials who engage in consultations with PWDs and DPOs, must undergo "regular training… on non-discrimination, dignity and respect" in their treatment of PWDs.[611] Misconceptions as to the capacity of PWPSD to deliver meaningful contributions also presents as an issue. For example, a study by Kleintjes *et al,* on the challenges to participation of PWPSD in decision-making processes, includes the following observation: "A few respondents had difficulty conceptualizing the idea of policy participation by people with psychosocial disability, as it was a novel idea for them."[612]

Thus, participation of PWPSD in the development, monitoring and evaluation of policy still faces a number of barriers. These include: the lack of formalised and effective structures for engagement with PWPSD and DPOs, inadequate support for DPOs as representative structures, stigma, the absence of participatory mechanisms tailored to accommodate PWPSD, and the failure to build the capacity of PWPSD to participate.

5 9 Intersectoral collaboration

Collaboration between spheres of government is a key consideration in the reasonableness enquiry, as is the requirement that a socio-economic rights programme must be well-coordinated, comprehensive, and coherent.[613] In the context of deinstitutionalisation initiatives in particular, the CRPD has stated that "a coordinated, cross-government approach" is required, including in the setting of appropriate budgets and ensuring "appropriate changes of attitude", in line with the human rights-based model.[614] An intersectoral approach to CBMHC is key, as psychosocial disability is affected by a range of determinants and structures. These

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[611] UN Committee on Economic, Social and Cultural Rights *Concluding observations of the initial report of South Africa as adopted by the Committee at its 64th session,* 24 September – 12 October 2018 para 7(b).
[612] Kleintjes et al (2013) *BMC International Health and Human Rights* 3.
[613] See chapter two part 2 4 2.
[614] UN Committee on the Rights of Persons with Disabilities General Comment 5: "On living independently and being included in the community" (2017) GE.17-19008 (E) para 58.

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determinants and structures do not fall solely within the realm of health care, nor only within the powers or functions of Departments of Health.[615]

The MHCA does not prescribe or regulate an intersectoral response to mental health care. However, in the NMHPF, one of the eight main objectives is to establish a "multi-sectoral" approach, with the aim of addressing "the vicious cycle of poverty and mental ill-health".[616] Further, "intersectoral collaboration" is listed as one of the twelve areas for action. In terms of this area for action, the Department of Health is set as the primary actor who must "engage" other sectors or state departments, as well as local government, to ensure the implementation of the NMHPF.[617] In particular, the Department of Social Development must be engaged by the Department of Health in order to address the severe impact of poverty on mental well-being. Recommended focus points for intersectoral collaboration include skills development programmes, the creation of opportunities for PWPSD to generate an income, and "housing support".[618] The Minister of Health is tasked with coordinating such an approach.[619] Further, to promote intersectoral collaboration, the NMHPF requires a "District Multi-Sectoral Forum" to be established,[620] as well as a "national multi-sectoral health commission" which will involve state departments[621] and non-profit organisations.[622]

The WPRPD assigns roles and responsibilities to a very wide range of actors, including executive authorities, legislatures, DPOs, academic institutions, the media, and the religious sector.[623] In respect of the strategic pillar titled "Supporting sustainable integrated community life", a number of directives reflect the need for a multi-sectoral approach. One such example is the directive to "plan for mitigating

[615] See chapter three part 3 8.
[616] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 19.
[617] 26.
[618] 26.
[619] 30.
[620] 31.
[621] The examples listed include the Departments of Health, Education, Social Development, Labour, Housing, and Agriculture.
[622] National Department of Health *National Mental Health Policy Framework and Strategic Plan 2013-2020* (2013) 38.
[623] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 124.

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family responsibilities in terms of caring and support for persons with disabilities", which expressly states that intersectoral collaboration is required.[624]

While the importance of intersectoral collaboration is clearly emphasised in both the NMHPF and the WPRPD, the translation of these instruments into practice has generally not been successful. In 2017, the SAHRC reported that intersectoral forums had not been launched in all provinces, and very little information on how existing forums were performing was available.[625] In the Eastern Cape, Mpumalanga, and the Western Cape, intersectoral forums had been launched, but these were created with substance abuse as sole focus.[626] While Brooke-Sumner *et al* report, in 2019, that intersectoral collaboration has seen "some progress at the national level", this remains sorely neglected at provincial and district levels.[627] The authors further report a lack of clarity in the division of key responsibilities, particularly in respect of creating the infrastructure necessary for community-based care.[628] This applies to even the most basic infrastructure, such as the provision of "converted cargo containers used for support groups [for psychosocial rehabilitation]".[629]

Thus, while intersectoral collaboration is promoted by the NMHPF and WPRPD, its implementation remains problematic, in the absence of a clear division of roles, with concrete targets which can be used to measure the progress made by each sector. Further, even where an obligation has been clearly matched to a particular sector or department, effective mechanisms have not been put in place to monitor their progress or hold them to account for failing in respect of their obligations, as established earlier in this chapter.

5 10 Involuntary treatment

As established earlier, involuntary treatment is considered contrary to the provisions and principles of the UN Disability Convention.[630] While the MHCA does include safeguards to prevent human rights abuses which may occur during

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[624] National Department of Social Development *White Paper on the Rights of Persons with Disabilities* (2016) 75.
[625] SAHRC *Report on Mental Health Care* (2017) 45.
[626] 42, 44 and 46.
[627] Brooke-Sumner *et al* (2016) *Int. J. Ment. Health Syst.* 3.
[628] 9.
[629] 9.
[630] See chapter three part 3 5 5.

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involuntary treatment,[631] to allow for involuntary treatment is not in alignment with the human rights-based model, as interpreted by the CPRPD. The CRPD has, in the context of Article 14 the UN Disability Convention, been critical of the fact that the MHCA allows for forced institutionalisation.[632] Further, the MHCA incorporates the "best interests" standard, while the CPRD has stated that, instead, the "best interpretation of will and preferences" of PWPSD is required in order to align with a human rights-based approach.[633] These discrepancies between the MHCA and the UN Disability Convention can be attributed to different approaches to legal capacity of PWPSD, as the CRPD has noted in its Concluding Observations on the initial report of South Africa.[634] A more detailed discussion of legal capacity falls outside the scope of this thesis. In respect of the primary lens, the right to health, it is sufficient to conclude that the inclusion of involuntary treatment in the MHCA is contrary to the UN Disability Convention.

5 11 Conclusion

In this chapter, the aim was to evaluate the legislative and policy framework, as well as its implementation, in light of constitutional and international law standards. First, it was established that the legislative and policy framework acknowledges the importance of physical accessibility. However, clear and measurable targets for improving physical accessibility were absent from the framework. As a consequence, the disparities in resource allocation for different areas persist, with resources concentrated in urban centres. In respect of PWPSD who live in rural areas, these deficiencies in physical accessibility link to the standard of availability, as well as the quality and acceptability of care.

Second, evaluating standards of care, particularly quality and acceptability, proved to be challenging, given the absence of proper monitoring and information systems. It was found that clear guidelines for all types of CBMHC facilities and services where lacking. CBMHC facilities require clarity on the applicable standards of care required for licensing, as well as support in meeting such standards. In the absence

[631] See chapter four part 4 2 4.
[632] UN Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of South Africa as adopted by the Committee at its 20th session, 27 August – 21 September 2018* para 26.
[633] Paras 22-23.
[634] Paras 22-23.

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of clear guidelines, targeted at ensuring the quality and acceptability of CBMHC, there is the risk that standards of care may deteriorate to such an extent that a repetition of the type of tragedy seen in the Marathon Project may occur.

Third, it was found that there is a great discrepancy between equality for PWPSD as in law, as opposed to the factual reality. Overall, mental health care is not afforded parity with general health care. PWPSD, particularly those in rural areas, do not enjoy equal access to mental health care in terms of the availability, accessibility, acceptability, or quality thereof. Inadequate provision is also made for groups who face further vulnerabilities, in addition to psychosocial disability.

Fourth, it was found that the applicable policies do provide for the establishment of monitoring and information systems, while such a provision is absent from the MHCA. Although the policy framework sets a range of requirements, these have not been implemented successfully. Key issues in this regard include the limited relevance that the current set of indicators has for CBMHC, and the failure to disaggregate the data collected according to relevant demographic attributes. In addition, there are concerns over the dubious quality of data collected, attributable to poor standardisation of data collection methods and insufficient training for health care practitioners who collect data. Overall, the current monitoring and information systems are too poorly coordinated and fragmented to deliver accurate insights which could inform legislative or policy reform

Fifth, resource allocation is a significant cause for concern. While the MHCA only briefly refers to budgeting for mental health care, the NMHPF and WPRPD provide greater detail in respect of obligations in respect of budgeting. These requirements set out in policy have not been translated into practice: mental health care overall remains underfunded, investment in CBMHC is lacking, significant disparities in resource allocation exist between provinces, and between rural and urban areas. Poor resource allocation was found to underpin deficiencies in a range of other standards, including the physical accessibility of facilities, goods, and services.

Sixth, accountability and oversight mechanisms are deficient. Review Boards are tasked with preventing such violations of the rights of PWPSD from occurring. However, it was found that many Review Boards were non-functioning, due to a range of reasons, most notably a lack of resources. Recent reports of the functioning

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of Review Boards, or even the number of Review Boards per province, were unavailable. Further, it was argued that Review Boards, tasked with ensuring accountability and the protection of the human rights of PWPSD, are underused in respect of CBMHC.

Mechanisms and structures for meaningful engagement with PWPSD and their representative organisations were also found to be lacking. The NMHPF formulates the obligations in respect of ensuring participation of PWPSD in a vague manner, to the extent that the obligation is essentially unenforceable. The WPRPD places greater emphasis on participation and representation of PWPSD, including practical directives which are more clearly formulated. However, in practice, a number of obstacles persist, such as a lack of support for DPOs as representatives for PWPSD, and harmful misconceptions as to the capacity of PWPSD to deliver worthwhile contributions as stakeholders.

Intersectoral collaboration was found to have a strong basis in the WPRPD and NMHPF, but less so in the MHCA. However, implementation has been sluggish, particularly in respect of the establishment of multi-sectoral forums. Further, some obligations are not clearly assigned to a particular sector or state department, which delays access to resources – particularly infrastructure – needed for CBMHC.

The inclusion of involuntary treatment, as well as the standard of "best interests", in the MHCA was found to be contrary to the UN Disability Convention and the human rights-based approach. These discrepancies can be traced to the fact that the MHCA follows a different approach to legal capacity than the interpretation preferred by the CRPD.

Overall, the principles, values and objectives put forth in the legislative and policy framework do align with the constitutional and international law standards – with the exception of the issue of involuntary treatment. However, many provisions in the MHCA, NMHPF and WPRPD lack the specificity required for successful implementation. For example, concrete benchmarks for mental health budgeting at provincial level are absent from the framework, as are detailed requirements for the envisioned monitoring and information systems.

The following chapter draws overall conclusions arising from this research. It also recommends reforms to improve the alignment of the legislative and policy

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framework for CBMHC with relevant constitutional and international human rights standards.

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CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6 1 Overview of the research

The aim of this research was to determine to what extent the legal and policy frameworks governing the shift to CBMHC for adult PWPSD in South Africa comply with constitutional and international human rights standards. The primary hypothesis in this respect was the legislative and policy frameworks do not fully align with these standards, particularly in respect of implementation. The research delivered three main findings in respect of this hypothesis. First, it was found that the legislative and policy framework generally aligns with the relevant standards, and reflects a human rights-based approach. A significant exception in this respect is that the legislative and policy framework allows for involuntary treatment, contrary to the UN Disability Convention. Second, the framework in certain instances lacks the detail and specificity which would be beneficial in ensuring effective implementation of the framework. Third, it was found that there are significant deficiencies in the translation of this framework into practice.

Chapter 2 analysed section 27 of the Constitution to establish the applicable constitutional normative standards, and negative and positive obligations on the state. It was established that the state's negative obligation requires it to refrain from interfering with or impairing the existing enjoyment of the right. In the context of the right of access to health care services for PWPSD, it may be considered a negative violation if deinstitutionalisation occurs without sufficient investment in a system of CBMHC. In respect of the positive obligations on the state, three qualifiers were discussed: reasonableness, progressive realisation, and the availability of resources. A number of criteria must be used to assess the reasonableness of a socio-economic rights programme, as conceived and implemented by the State. These criteria include: the vulnerability of the group in question and the consequent urgency of their needs; the allocation of sufficient resources; the clear allocation of responsibilities in respect of the realisation of the right; and meaningful engagement with the affected parties. Second, it was established that the duty to realise the right progressively requires relevant organs of state to show demonstrable progress, made as expeditiously and effectively as possible, towards the end goal of the full realisation of the right. Further, progressive realisation implies that progress should

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be monitored, and policies revised through a participatory approach, and strict justificatory standards apply should retrogressive measures be implemented. Third, it was noted that the availability of resources may affect the time frame for the realisation of the right. However, the programme must still be responsive to the vulnerability of PWPSD and the urgency of their need. Further, resource constraints cannot be invoked as a justification if the State has failed to budget appropriately, or without due consideration for its constitutional obligations.

Chapter 3 analysed international and regional human rights instruments pertaining to mental health care, with a specific focus on CBMHC. A crucial set of norms was identified, in the form of the AAAQ framework, as well as corresponding state obligations, in the form of the RPF framework. Furthermore, a particularly relevant and useful source in this chapter was the ACHPR, as interpreted with reference to the Nairobi Guidelines, which emphasises the relevance of deinstitutionalisation and CBMHC in Africa. Finally, chapter 3 referred to documents authored by the WHO, which provide more specific and practical measures and targets aimed at the realisation of CBMHC.

In Chapter 4, the legislative and policy frameworks, consisting of the MHCA, the NMHPF, and the WPRPD, were analysed. A number of principles and provisions relevant to CBMHC were identified.

In Chapter 5 the aforementioned constitutional and international standards were applied to evaluate the legislative and policy framework, as well as the implementation thereof. The framework was found to align, to an extent, with the constitutional and international law standards. However, the implementation thereof was generally deficient and poorly coordinated. In practice, the aims central to the human right-based approach are not realised.

6 2 Recommendations

As has been noted, this research concludes that the legislative and policy framework which governs CBMHC in South Africa does largely align with the relevant constitutional and international law standards, but this framework is not effectively translated into practice. The root of these deficiencies in the South African system of CBMHC is best summarised by the former United Nations Special Rapporteur on the Right to Health, Mr. Dainius Puras:

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> "The main obstacle for the realization of the right to mental health does not rest with individuals and their global burden of mental disorders, but rather in the structural, political and global burden of obstacles being produced by archaic, broken mental health systems."[635]

To promote alignment, in practice, with the relevant constitutional and international law standards, the South African system of CBMHC must see improvements in a number of key aspects. First, inequities in the physical distribution of infrastructure and human resources must be addressed. Clear and measurable targets for improved access to CBMHC goods, facilities and services must be set at national, provincial and regional levels. In particular, special measures for the scaling up of CBMHC in rural areas are called for.

Second, a clear and comprehensive set of standards for the provision CBMHC at all relevant facilities must be developed and consistently implemented. CBMHC facilities must receive the support necessary to meet these standards, particularly in respect of quality and ethically acceptable care.

Third, the principle of non-discrimination has not been sufficiently reflected in the translation of the legislative and policy framework into practice. Mental health care must be afforded parity with general health care; PWPSD living in rural areas must have access to the necessary resources on an equal basis with PWPSD in urban areas; and PWPSD must be included in decision-making processes. Overall, non-discrimination is a cross-cutting issue. This deficiency will only be addressed if concrete and measurable targets are set for, for example, the creation of formalised mechanisms for participation of PWPSD, and clear guidelines for budgeting at national and provincial levels.

Fourth, the state must invest in improved monitoring and information systems, so that accurate, relevant, and quality data can be collected to inform reforms to the system of CBMHC. This would include the expansion of the current set of universally applied indicators to enable the identification of relevant trends in the usage of CBMHC services, the disaggregation of data according to relevant demographic factors, the provision of physical resources and training for persons who collect and

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[635] UN Human Rights Council "Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health" (2020) GE.20-05623(E) para 83.

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process information, and an increased focus on ensuring that reforms are indeed informed by the data collected.

Fifth, the insufficient allocation of resources to CBMHC negatively impacts on all facets of mental health care, including the quality of care, the acceptability thereof in terms of ethical standards of care, and the availability thereof, particularly in rural areas. More resources should be made available for CBMHC in particular. The legislative and policy framework should set clear standards for budgeting for CBMHC, to avoid a fragmented approach across provinces. Further, deinstitutionalisation initiatives must be accompanied by deliberate development of and investment in the system of CBMHC.

Sixth, it is imperative that well-functioning accountability and oversight mechanisms exist to prevent human rights violations, or to ensure remedies or redress should violations occur. Review Boards are not inherently poorly equipped to perform these tasks, but sufficient resource investment is currently lacking. It is recommended that clearer guidelines for the support of Review Boards by the national and provincial governments are formulated.

Seventh, PWPSD and their representative organisations must be given a voice in the development of CBMHC programmes, as well as the monitoring of such programmes when implemented. While the current legislative and policy framework requires the creation of formalised structures for the participation of PWPSD, this has not yet been translated into practice. Structures for regular engagement of PWPSD and their representative organisations at national, provincial, and local levels are key to ensuring that the system of CBHMC responds appropriately to the needs of PWPSD.

The eight recommendation relates to intersectoral collaboration, which is required to address the range of determinants which affect the lived realities of PWPSD. The current framework assigns responsibilities to various state departments and other actors. However, these responsibilities could be delineated more clearly and with greater specificity. Concrete, measurable targets are required, accompanied by effective accountability mechanisms to ensure these targets are met.

Finally, to ensure alignment with the UN Disability Convention, PWPSD must no longer be subject to forced treatment. That the MHCA provides for involuntary

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treatment, and applies the "best interests" paradigm, is considered not to align with a human rights-based approach to psychosocial disability.

6 3 Areas for potential further research

First, as this thesis dealt only with adult PWPSD, a promising area for future research is the rights of children with psychosocial disabilities in the context of CBMHC. Such research could draw on international and regional human rights instruments focussed on the rights of children. Second, while the right to health was the primary lens for this thesis, other socio-economic rights could serve as the lens for future research on the shift to CBMHC. The right of access to housing, in particular, would be an appropriate and relevant area for research. Third, as the NMHPF has lapsed, it is anticipated that a new national mental health policy will be adopted. The constitutional and international normative standards identified in this thesis could serve as the basis for an evaluation of the new policy. Fourth, the implications of the proposed National Health Insurance for the system of CBMHC is another important and fruitful area for further study. Fifth, the impact of extended emergency situations such as the Covid-19 pandemic on deinstitutionalisation efforts could be investigated.[636] Finally, future research could undertake a comparative study with a foreign jurisdiction, particularly one with progressive mental health legislation and policy, to inform further recommendations to the South African system of CBMHC.[637]

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[636] See, for example: UN Committee on the Rights of Persons with Disabilities *Annotated Outline of Guidelines on Deinstitutionalization of Persons with Disabilities, including in Emergency Situations* (16 August – 14 September 2021) 3, where it is noted that "confinement in institutions, particularly during emergency situations, is an aggravated form of institutionalization". See further: Chair of the UN Committee on the Rights of Persons with Disabilities & Special Envoy of the UN Secretary-General on Disability and Accessibility *Joint Statement: Persons with Disabilities and Covid-19* (8 September 2021).

[637] The South African system of CBMHC could be compared to other countries which were studied as part of the Mental Health and Poverty Project, such as Ghana. See, for example: A Bhana, I Petersen, K Baillie, A Flisher & the MHAPP Research Programme Consortium "Implementing the World Health Report 2001 Recommendations for Integrating Mental Health into Primary Health Care: A Situation Analysis of Three African Countries: Ghana, South Africa and Uganda (2010) 22 *Int. Rev, Psychiatry* 599-610; S Ahuja, T Mirzoev, C Lund A Ofori-Atta, S Skeen & A Kufuor "Key Influences in the Design and Implementation of Mental Health Information Systems in Ghana and South Africa" (2016) 3 *Global Mental Health* 1-13. A further promising jurisdiction for comparison is Peru, which faces historical challenges similar to South Africa (such as the concentration of resources in urban areas), but has implemented progressive legislation promoting the integration of mental health care into primary health care and seen an overall increase in financial and human resources for mental health care. See, for example: Toyama et al (2017) *Int J Health Policy Manag* 501-508.

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6 4 Concluding reflections

> "Identity involves entering a community to draw strength from that community, and to give strength there, too… All of us with stigmatized identities face this question daily: How much to accommodate society by constraining ourselves, and how much to break the limits of what constitutes a valid life?"[638]

While the legislative and policy framework governing CMBHC largely aligns with the relevant constitutional and international law standards, there are serious deficiencies in the implementation of this framework. CBMHC remains severely underfunded, monitoring and information systems are ineffective, safeguards for the quality and acceptability of care are lacking, and there is insufficient engagement with PWPSD and their representative organisations. These and other deficiencies in respect of implementation have had severe consequences for PWPSD.

An effective system of CBMHC is, first and foremost, essential to the mental well-being of PWPSD. If developed and implemented in line with a human rights-based approach, CBMHC holds even greater promise in improving the lived realities of PWPSD. Access to acceptable, quality mental health care within a community setting can empower PWPSD to exercise a range of other rights, to pursue their interests and seek personal fulfilment, and to participate in their communities on an equal basis with others.

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[638] A Solomon "How the worst moments in our lives make us who we are" (01-03-2014) *TED* <https://www.ted.com/talks/andrew_solomon_how_the_worst_moments_in_our_lives_make_us_who_we_are?language=mfe> (accessed 02-11-2021).

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