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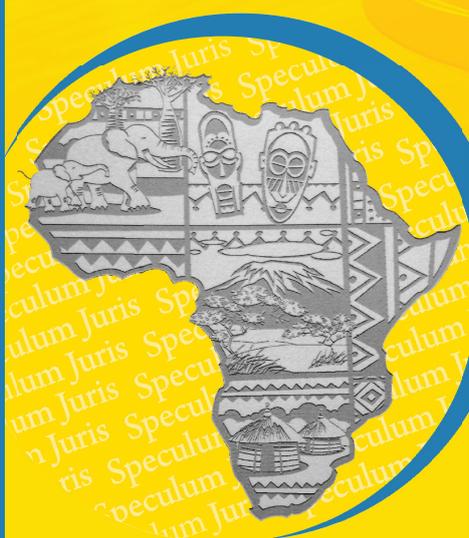
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The State of Psychiatric Health Care in South Africa 30 Years into Democracy

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Abstract

Mental health is recognised under the right to health in Article 12(1) of the International Covenant on Economic, Social and Cultural Rights. This article refers to the gross violation of mental health rights by the South African government, regarding the Life Esidimeni scandal that ended in tragedy. A failed de-institutionalisation policy implementation was to blame. The article further aims to assess the state of psychiatric health care in South Africa, 30 years into democracy. This milestone signifies a litmus test of how South Africa has advanced or not, in protecting the rights of people with mental disorders. An analysis of events after the Esidimeni tragedy suggests that the government must take more robust action to advance the rights of people in mental health care. The author highlights certain challenges towards ensuring that mental health institutions are considered in promoting the right to health. This article examines the theoretical foundations of mental health rights and the background of international and regional law approaches to mental health issues. The right to access to mental health services in South African jurisprudence and the law will be examined as well as the hurdles of implementing this policy. The Esidimeni tragedy and its aftermath will be discussed, followed by submissions and a conclusion.

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Keywords: mental health; deinstitutionalisation; Life Esidimeni; tragedy; human rights; dignity

1 INTRODUCTION

As South Africa celebrates 30 years of democracy, this cannot be separated from the importance of the constitutional right to health, which includes involuntary psychiatric health care. At this juncture, it is important to assess the importance of health care for individuals needing admission to psychiatric hospitals. What has the state done, and what is needed to be improved? 30 years later, horrific tragedies such as the Esidimeni scandal remain fresh in people's memories. The Life Esidimeni tragedy emanated from the death of 144 patients in private mental health facilities after being transferred from Life Esidimeni (a Life Care Subsidiary in the Gauteng province). An inquest into these deaths revealed that most of the cheaper private psychiatric facilities were severely under-resourced and were unlicensed. Has the Department of Health drawn lessons from this? Most probably not, from the assessment of the state of psychiatric institutions such as Northern Cape¹ and Eastern Cape,² just to name a few provinces in South Africa. These two provinces, like many others, are under-resourced to handle patients in need of psychiatric health care. This article argues that a human rights-based approach, fused with development approaches must be included in the state's mental health institutions in South Africa. It highlights further some challenges towards ensuring that mental health institutions are considered in promoting the right to health.

2 THEORETICAL FOUNDATIONS OF MENTAL HEALTH RIGHTS

According to the World Health Organisation, mental health is defined as “a state of mental well-being” which gives people the ability to be able to manage stress, fulfill their abilities, work and learn well and participate in the community.³ The WHO further states that mental health conditions can present as mental disorders and psycho-social disabilities. Chapman explains that the functional capabilities of human beings are made possible through the common inter-related rights to life, bodily health and bodily integrity.⁴ A human being should be able to live a normal lifespan instead of being reduced to a life not worth living.⁵ A human being must be in good health with decent meals and proper shelter. A human being should have bodily integrity that includes protection from any harm such as assault, verbal abuse and sexual abuse.⁶ This is also applicable to people who suffer from mental disorders, and, as such, it is important to protect people suffering from such disorders from being denied such rights as they are vulnerable to deprivation because they cannot comprehend their surroundings to the fullest of their mental

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- 1 Mochoari “Two Years Later, Kimberley Mental Health Hospital Still Not at Capacity” <https://www.spotlightnsp.co.za/2021/10/28/two-years-later-kimberley-mental-health-hospital-still-not-at-capacity/> (accessed 22-03-2024).
 - 2 Booyesen, Mahe-Poyo and Grant “The Experiences and Perceptions of Mental Health Service Provision at a Primary Health Centre in the Eastern Cape” 2021 *SAJP* 2; Sukeri “Regional Aspects of Long-term Public Sector Psychiatric Care in the Eastern Cape” 2017 *SAJP* 3.
 - 3 WHO “Mental Health-17 June 2022” https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response/?gad_source=1&gclid=Cj0KCQIA1K7BhC9ARIsAFZfEIs571osjMx_a3blZA3jEmUGaXxIqeY9U0y_KIOoCtKodeaADM28i0YaAq21EALw_wcB (accessed 20-12-2024)
 - 4 Chapman “The Foundations of a Human Right to Health: Human Rights and Bioethics in Dialogue” 2015 *HHRJ* 12.
 - 5 *Ibid.*
 - 6 *Ibid.*

faculties.

Chapman raises important questions relating to the feasibility of achieving the right to health. She asks, for instance, is health of special moral importance?⁷ When are health inequalities unjust?⁸ And how can health needs be achieved under resource constraints?⁹ To respond to the first question, Chapman answers by stating that good health is made possible by proper and functional healthcare systems, which in turn make people's goals and aspirations achievable because they are able to focus on their needs as their health needs are covered.¹⁰ When looking at this scenario from the perspective of mental health rights, the case could be made that a successful health system is better equipped to handle and care for those suffering from mental health disorders because problems are likely to be dealt with before they reach an advanced or chronic stage. When are health inequalities unjust? Chapman responds that inequalities in the health system are unfair and unjust when situations create unfairness or unjustness that can be avoided.¹¹ However, it is important to note that societal perceptions influence what is viewed as unfair or unjust. On the last question, which relates to an efficient but resource-strained health system, Chapman proposes a fair, deliberative process to strike a balance between available resources and reducing disagreements on resource distribution.¹²

Stier addresses issues relating to the normative nature of mental disorders. In one of his articles, he attempts to define what the relative norms that society perceives as mental disorder are.¹³ In the long run an affected person can be viewed as deviating from societal norms.¹⁴ This might lead to a feeling of rejection which could ultimately result in insanity.¹⁵ Stier is of the view that it is wrong to use norms of certain behaviours as a way of determining mental disorders.¹⁶ In conservative societies, for instance, regardless of an entrenched Constitution that protects freedom of expression and freedom of association, which might manifest in one being openly gay or professing an affinity to atheism, such expression might be condemned as abnormal.¹⁷ Individuals who deviate from the normative framework of a conservative society are vulnerable to depression, which, in the long run, can affect their mental state. Therefore, Stier concludes that a mental disorder could emanate from a host of factors outside of the limits of viewing such a mental disorder as a malfunctioning of the brain. The factors outside of this restricted view include substance abuse, brain injury, hereditary diseases and severe depression.¹⁸

This will be further demonstrated by exploring the attachment theory. According to this theory, obstacles in early relationships with primary caregivers can result in characteristic sequences in approaching relationships with others later in life.¹⁹ At the later stage of passing adolescence into adulthood, the individual may have a sense of insecurity if at some point in their early life they lost a parent or a close relative who was a primary caregiver.²⁰ This correlates with depression

7 *Ibid* 13.

8 *Ibid*.

9 *Ibid*.

10 *Ibid* 14.

11 *Ibid*.

12 *Ibid* 13.

13 Stier "Normative Preconditions for the Assessment of Mental Disorder" 2015 *Frontiers in Psychology* 5.

14 *Ibid*.

15 *Ibid*.

16 *Ibid*.

17 *Ibid*.

18 *Ibid* 8.

19 Tew "Social Perspectives on Mental Distress" in Basset and Stickley (eds) *Learning About Mental Health Practice* (2008) 236.

20 *Ibid*.

and schizophrenia, which can lead to psychosis. As such, in many instances, people ignore or out of ignorance, have such mental conditions unmonitored resulting in possible insanity.²¹ It is, therefore, the role of the state to maintain checks and monitoring mechanisms at the primary diagnosis level for these types of conditions as a proactive and preventative approach in ensuring that the state fulfills its duties by ensuring it has a responsive health system.²²

Gostin and Gable make the case that international human rights are imperative as the backbone for recognising mental health rights.²³ It is the only law that has the power to check if mental health policies are consistent with basic human rights in a sovereign country.²⁴ It provides for protections that cannot be exterminated by a political process.²⁵ Therefore, people affected by mental disorders need not prove that they deserve privileges like other people.²⁶ The principle of human rights in mental disorders is based on the attacks and violations experienced by people living with mental disorders, wherein such individuals are discriminated against, live in inhumane conditions and do not have the same privileges as people those who do not suffer from mental illnesses.²⁷ Furthermore “mental health policies, programmes and practices can violate human rights”.²⁸ For instance, policies that do not provide support for community-based activities result in gross violations of human rights. People with mental disorders may be neglected from receiving essential needs that give them dignity and promote their well-being.

3 INTERNATIONAL AND REGIONAL LAW APPROACH ON MENTAL HEALTH ISSUES

It is posited that international human rights instruments are imperative in dealing with the right to mental health. This is so because they can be used as a gauge for checks and balances of domestic laws in various countries as to whether such domestic laws are compliant with basic human rights. Through a compilation of treaties, declarations and regional truces, the right to mental health is an embedded right that no government can deprive its citizens of, especially those affected by mental-related disorders. When looking at the position of South Africa, most of the major international human rights instruments pertaining to the right to health discussed below have been ratified or are consistent with SA law in terms of the Constitution.

The Universal Declaration of Human Rights (UDHR) in Article 25 states that amongst other essential rights everyone has the right to the highest standard of health and wellbeing.²⁹ The International Covenant on Economic, Social and Cultural Rights (ICESCR) describes in Article 12(1) that state parties must recognise the enjoyment to the highest attainable standard of physical and “mental health”.³⁰ ICESCR General Comment 14 reiterates Article 12(1) of the covenant on economic, social and cultural rights and it further reiterates the process of realising

21 *Ibid.*

22 *Ibid* 236.

23 Gostin and Gable “*Application of Human Rights Principles to Mental Health*” 2004 *Maryland Law Review* 22.

24 *Ibid.*

25 *Ibid.*

26 *Ibid.*

27 *Ibid.*

28 *Ibid* 27.

29 Universal Declaration of Human Rights art 25 (1); See also Braveman “Social Conditions, Health Equity and Human Rights” 2010 *Health and Human Rights Journal* 38, which states that access to health not only involves medical care but also the social and economic conditions essential for health.

30 International Covenant of Economic and Social and Cultural Rights art 12(1).

these rights through a step-by-step guide.³¹ The first paragraph of General Comment 14 on the ICESCR states that health is a fundamental right that is indispensable in exercising human rights.³² As such, the World Health Organisation (WHO) formulates health policies and nations implementing programmes developed by the WHO. In addition, nations can adopt specific legal instruments.³³ The report mentions four essential interrelated elements in realising the right to health. These elements are: availability, accessibility, acceptability and quality of health services.³⁴ This encompasses the provision of physical and mental health equally and timeously to give effect and meaning to the right to health. This includes the provision of essential drugs and appropriate mental health treatment and care.³⁵ Added to this is the availability, the acceptability and the quality of such health services.³⁶

The report indicates that coercive treatment in mental disorder cases must be subject to respect and adherence to the principles of the Protection of Persons with Mental Illness and Improvement of Mental Health Care (PPMIMHC).³⁷ Coercive treatment is employed to deal with critical mental illness in preventing any worsening of mental illness.³⁸ However it is strongly recommended that an option of voluntary treatment must be tried before using coercive treatment.³⁹ Another mandatory instrument that plays an important role in the rights of people suffering from mental disorders is the right to dignity, as encapsulated in the preamble of the International Covenant on Civil and Political Rights (ICCPR).⁴⁰ This right is also captured in Article 1 of the same covenant, wherein it is stated that “all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person”.⁴¹ Furthermore, this covenant refers to non-discriminatory practices on the status of persons, which, in this case, would include the person’s mental capacity.⁴²

The Convention on the Rights of Person with Disabilities (CRPD) and Optional Protocol in Article 1 states that 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.⁴³ CRPD goes on in Article 17 to mention that people with disabilities have a right to be respected in terms of their mental integrity on an equal basis with others.⁴⁴ Article 24(1)(b) speaks of the recognition of

31 See CESCR General Comment No.14: The Right to the Highest Attainable Standard Health (Article 12) in paragraph 2. See also Hunt and Mesquita “Mental Disabilities and the Human Right to the Highest Attainable Standard of Health” 2006 *Human Rights Quarterly* 332 341 submits that General Comment 14 is an authoritative source that describes the right to health in a succinct framework of norms and obligations that make up the right to health. For example, the right to health is meant to be realised through the supply of goods, services and conditions which are conducive to the highest attainable standard of physical and mental health. See also Murphy *Health and Human Rights* (2013) 44, says that in terms of General Comment No.14, it would be wrong for a state to justify non-compliance with General Comment No.14 and the core obligations set out.

32 *Ibid.*

33 *Ibid.*

34 *Ibid* para 12.

35 *Ibid* para 17.

36 *Ibid* para 12(b).

37 *Ibid* para 34.

38 Brekke, Clausen, Brodahl and Landheim, “Patients’ Experiences With Coercive Mental Health Treatment in Flexible Assertive Community Treatment: A Qualitative Study” (2023) *BMC Psychiatry* 2.

39 *Ibid* 2 .

40 International Covenant on Civil and Political Rights preamble.

41 *Ibid* See Article 1 of the International Covenant on Civil and Political Rights.

42 Article 26 of the International Covenant on Civil and Political Rights.

43 *Ibid* art 1.

44 *Ibid* art 17.

the right to education for people affected by disabilities by making available systems capable of directing their mental and physical abilities to their full potential.⁴⁵ Finally, Article 26 of CRPD states that the state should ensure that it has “habilitation” and rehabilitation programmes that ensure that people affected by disabilities can integrate into society.⁴⁶

PPMIMHC is a non-binding instrument however, it is important in shaping mental health law and policy reform in South Africa. In PPMIMHC, principle 1 mentions the fundamental rights of mental freedoms and basic rights of persons with mental illness.⁴⁷ The charter states that all persons cannot be denied the right to best available mental health care, which is part of the health and social system.⁴⁸ Principle 1 further deals with issues pertaining to dignity, protection from all forms of abuse and non-discrimination of people with mental illness.⁴⁹ Principle 13 deals with the wellbeing of people with mental illness in as far as their conditions of living, recreation and integration into the community are concerned. Principle 14 goes on to deal with the adequacy of facilities and manpower in mental health institutions, as well as the avoidance of profiteering by private players when looking after people with mental disorders.⁵⁰ Jones argues that PPMIMHC is deficient in that it fails to adhere with respect to human rights. There is a lack of ingrained privilege depicted from this instrument in human rights protection. PPMIMHC gives medical professionals unlimited freedom to determine a person’s lack of mental incapacity, without following due processes.⁵¹

In the preamble of the WHO Constitution, health is described as “a state of complete physical, mental and social wellbeing and merely the absence of disease or infirmity”.⁵² Article 2(m) states that to achieve its objective, the function of the organisation shall be to foster activities in the field of mental health, particularly those that affect the harmony of human relations.⁵³

According to Sustainable Development Goal No 3, ensuring healthy lives and promoting wellbeing for all ages by 2030, there should be a reduction by one third of premature mortality from non-communicable diseases through the prevention and treatment as well as the promotion of mental health and wellbeing.⁵⁴

In Article 2 of the African Charter on Human and Peoples’ Rights (ACHPR), it is stated that individuals are guaranteed the right to enjoyment of rights and freedoms without distinction of amongst other rights such as “other status”.⁵⁵ Article 3, in turn, gives every individual equality and protection before the law.⁵⁶ Article 5 states that every individual has the right to dignity, which is inherent in human beings, and among other issues, no one may be subjected to cruel and degrading treatment.⁵⁷ Article 6 of the charter provides that every individual shall have

45 *Ibid* art 24(1)(b) in the Convention on the Rights of Person with Disabilities.

46 *Ibid*.

47 Principles for the Protection of Persons with Mental Illness and The Improvement of Mental Health Care Principle 1. It should be noted that these principles do not oblige States to be bound by them but however they serve as guide on the human rights approach to handling people with mental disabilities.

48 *Ibid*.

49 *Ibid*; see further paras 2, 3 and 4 of the same principles in Protection of Persons with Mental Illness and The Improvement of Mental Health Care.

50 Protection of Persons with Mental Illness and The Improvement of Mental Health Care Principle 14.

51 Jones “Can International Law Improve Mental Health? Some Thoughts on the Proposed Convention on the Rights of People with Disabilities” 2005 *International Journal of Law and Psychiatry*, 195–196.

52 Constitution of the World Health Organisation preamble.

53 *Ibid* art 2(m).

54 Sustainable Development Goals No. 3 in para 3.4.

55 ACHPR art 2.

56 *Ibid* art 3.

57 *Ibid* art 5.

the right to liberty and to security of his/her person and nobody may be deprived of his/her freedom except where the law states otherwise.⁵⁸ Article 16(1) states that everyone has the right to enjoy the best attainable state of physical and mental health.⁵⁹ Parties to the charter should ensure that measures are put in place to protect the health of their citizens and provide medical assistance in the event their citizens fall ill.⁶⁰ Article 18(4) provides that aged people with disabilities must have the right to special measures of protection in providing for their physical or moral needs.⁶¹ It is clear that there is an international and regional human rights system in place to ensure that the rights of persons with mental illness are covered. It is also evident that disability rights, which include mental health rights are found in a multiplicity of hard and soft law. These instruments are important because they place South Africa under a legal obligation to promote and protect psychiatric health care through law and policy. Furthermore, the key ratified instruments, namely the ICESCR, ICCPR, and CRPD, make it obligatory for South Africa to submit periodic reports on human rights compliance. Reporting on the state of psychiatric health care cannot be ignored or isolated from other health matters. However, the international and regional human rights system appears to be deficient in differentiating between the types of mental health.⁶² This implies that people with mental retardation, mental illness, mental disability, mental disorder and mental disability are all categorised as one group. Yet, in reality, these are different types of mental health issues. In order to bring clarity about the lack of differentiation in the international and regional human rights regime, this article takes a holistic view of all issues regarding mental health, because people with mental health issues could still have involuntary treatment imposed upon them, regardless of where they are on the spectrum, for instance, when they exhibit behaviour which is a danger to themselves or others, and they cannot make decisions about their own personal mental well-being. South Africa, as already mentioned above, has ratified these international instruments that interconnect with mental health issues.

4 ACCESS TO MENTAL SERVICES IN SOUTH AFRICAN JURISPRUDENCE AND LAW

4.1 Position of the South African Constitution on the Right to Health

Psychiatric health care services in South Africa fall under the Department of Health. This means that they are covered as a general right to health in both the Constitution and other supporting domestic legalisation and policies. The Constitution of South Africa refers to the right to health in section 27(1)(a) and in subsection (2) which mentions reasonable and other legislative measures within its resources to achieve the progressive realisation of each of these rights. Constitutional Court judgments on the right to health can be seen in the case of *Soobramoney v Minister of Health*.⁶³ In this case, the appellant was an unemployed man who had a critical irreversible condition of chronic renal failure.⁶⁴ The appellant was in need of urgent kidney dialysis, which he could not afford and he resorted to the state hospital in Durban, which had a limited number

58 *Ibid* art 6 .

59 *Ibid* art 16. See also Ssenyonjo *Economic, Social and Cultural Rights in International Law* 2 ed (2016)235 where the writer points out that this provision does not give a clear meaning to what “best attainable state of physical and mental health” entails nor does it give measure in which member states to the instrument must undertake to realise this right.

60 ACHPR art 16.

61 *Ibid* art 18(4).

62 Ventura “International Law, Mental Health and Human Rights” 2014 *The Centre for Civil & Human Rights University of Norte Dame* 7–9.

63 *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 1 SA 765 (CC).

64 *Ibid* para 1.

of kidney dialysis machines, some of which were in poor condition.⁶⁵ Thus, the hospital was in no position to provide him with the treatment he required.⁶⁶ It was for this reason, among others, that the appellant challenged his deprivation of emergency medical treatment as an infringement on the right to health in terms section 27(3) of the Constitution.⁶⁷ The applicant argued that this constituted a denial to the right to life in terms of section 11 in the Constitution.⁶⁸ In passing judgment, the Constitutional Court was cautious in not disputing that the appellant was in need of medical treatment.⁶⁹ The Court held that the need by the applicant to seek medical treatment was not considered urgent because his condition was not only irreversible, but it also depended on the availability of state resources.⁷⁰ In this instance, state resources were already stretched to accommodate patients with the appellant's condition.⁷¹ This judgment, interpreted contextually, implies that everyone in need of critical health services, including people with mental health issues, may be denied such treatment because the state does not have resources to accommodate their needs because of insufficient resources.

The South African Constitution, in section 39, requires that international and foreign law be considered when interpreting the Bill of Rights. A first point of reference relevant to the state of psychiatric health in South Africa is the case of *The Gambia: Purohit and Another v The Gambia*.⁷² Mental health advocates brought this case before the African Commission on Human and Peoples' Rights (ACHPR Commission). Briefly, the case touched on violations of Articles 2, 3, 5, 6, 7(1)(a) and (c), 13(1), 16 and 18(4) of the ACHPR and whether the Lunatic Detention Act in the Republic of Gambia was inconsistent with these provisions. In addition, the applicants contended that there was overcrowding in psychiatric units, no consent before admission of psychiatric patients, and no independent examination of living conditions, administration and management of hospitals. ACHPR Commission held that Articles 2, 3, 5, 6, 7(1)(a) and (c), 13(1), 16 and 18(4) had been violated by the respondent.⁷³ It is for this reason that the commission passed a recommendation that the government of Gambia repeal the Lunatic Detention Act and replace it with legislation appropriate and consistent with the values encapsulated in the ACHPR.⁷⁴ Furthermore, the commission stated that the respondent must provide medical care and adequate infrastructure for mental patients.⁷⁵ To ensure compliance, the commission requested that the respondent give feedback in the form of a periodic report to the commission on measures taken by the respondent in terms of progress made in realising the right to mental health care.⁷⁶ This case is significant because the commission confirmed that the right to health also encompasses access to mental health services. Furthermore, people with mental disabilities have their rights protected by ACPHR and the state should ensure that such

65 *Ibid* para 3.

66 *Ibid* para 6.

67 *Ibid* para 7.

68 *Ibid* para 7.

69 *Ibid* para 22.

70 *Ibid* para 25.

71 *Ibid* para 24.

72 *The Gambia: Purohit v The Gambia* (2003) AHRLR 96 (ACHPR 2003).

73 *Ibid* judgment.

74 *Ibid*. See also Olowu *An Integrative Rights-Based Approach to Human Development in Africa* (2010) 157 where the writer confirms it is not in dispute that the Commission held that they were violations but however Commission had a duty to explain what possible remedies beyond legislative reform would be appropriate to deal with rights of people with mental disorders. The writer recommends that since progressive realisation is alien to the ACHPR obligations of states should be assessed on positive acts and negative omissions.

75 *The Gambia: Purohit* judgment.

76 *Ibid*. Ssenyonjo *Economic, Social and Cultural Rights in International Law* 2 ed (2016) 238 submits that this judgement is significant because the commission relied on the ICESCR and the General comments of the CESCR in developing a normative content of the right to health under the ACHPR.

rights are protected.

The right to health in South African jurisprudence can also be seen in the case of *Minister of Health v Treatment Action Campaign*.⁷⁷ This case dealt with the contestation of government's refusal to make the antiretroviral drug, Nevirapine, available in the public health sector and setting up a timeframe for a national programme to prevent mother-to-child transmission of HIV.⁷⁸ The court had to determine whether the measures taken in respect of the prevention of mother-to-child transmission of HIV were reasonable.⁷⁹ The court established that government policy was inconsistent with the Constitution.⁸⁰ Therefore, the court ordered that restrictions on the availability of Nevirapine by the government, be replaced with a policy that made the drug readily available in all hospitals and clinics for expectant mothers.⁸¹ The case is significant in showing the importance of the state in taking reasonable measures towards enforcing the right to health.

In a nutshell the essence of relating these two cases to the right to mental health care is to show that the state must take reasonable legislative, and other measures, in realising the right to health. Legislation alone is not enough, it requires the state to exhaust all means within its available resources to make such legislation a practical reality. The right to health in South Africa goes hand in hand with the right to dignity, encapsulated in sections 1(a), 7(1) and 10 of the Constitution.

4 2 Mental Health Care Act No 17 of 2002

The aim of the Act is to cater for the treatment and rehabilitation of persons who are mentally ill and it sets out the process of admission of such persons.⁸² The Act further sets out the administration of the decision-making process for mental health institutions and repealing laws that are no longer in line with mental health rights.⁸³ The Act aims to regulate mental health care, medical care and rehabilitation services for the population equitably and efficiently in the interests of the health sector.⁸⁴ The Act goes on to mention co-ordinating access to mental health care, treatment and rehabilitation⁸⁵ and integration for the provision of mental health care

77 *Minister of Health v Treatment Action Campaign* 2002 5 SA 721 (CC) para 18. See also Jones and Chingore "Health Right: Politics, Places and the Need for Sites for Rights" in Cousins, Dugard *et al.* (eds) *Socio-Economic Rights in South Africa: Symbols or Substance?* (2014) 232 it is stated that the case draws a fine line between negative and positive obligations of right to health, there still appears to be a disconnection between the rights-based approach and instances of government enacting positive duties in the discourse of policy making.

78 *Minister of Health* para 18.

79 *Ibid* para 93.

80 *Ibid* para 135.

81 *Ibid* 135. See also Liebenberg *Socio-Economic Rights Adjudication under a Transformative Constitution* 2 ed (2016) 141–142. She argues that although the state must make progressive realisation of the right to health this case has its own flaws in that there is almost no attempt by the constitutional court to attempt to construe a meaning that fully protects the rights to health protected in the constitution. In assessing the budgetary limitations facing health departments, there was no reference to the budgetary implications on realising a human rights-based approach on health rights. This creates unclear guidance by courts on how the state should allocate adequate budgets for issues of priority such as health. See also Ssenyongo "The Influence of the International Covenant on Economic, Social and Cultural Rights in Africa" (2017) NILR 279. The writer observes that both the cases of Grootboom and Treatment Action campaign show that the courts were reluctant to rely on General Comment No.3 and 14 as sources of justifying socio-economic rights. Thus, the court in both cases held there was no obligation on the state to provide minimum essential services to those who needed them, such can only be provided on a progressive basis.

82 Mental Health Care Act 17 of 2002 preamble.

83 *Ibid*.

84 Mental Health Care Act 17 of 2002 s 3(a)(i).

85 *Ibid*.

services in the general health services department.⁸⁶ This Act refers to the implementation of policies and measures by the state that ensure provision of mental health care and treatment.⁸⁷ Promotion of community-based care, treatment and rehabilitation, are in the interests of mental health care users, and improve the health care of the general population.⁸⁸ “Mental health care users” in this case refers to a person receiving treatment, rehabilitation services or care in order to improve the status of their mental health. The Act refers to respect, human dignity and privacy for people suffering from mental health disorders,⁸⁹ which is in line with sections 9 and 14 of the South African Constitution.⁹⁰ The Act makes mention that consent of admission in mental health institutions will only be disregarded if there is a court order and when a patient is not in a position to give consent, for instance when not being in such a mental hospital would cause harm to themselves.⁹¹

The Act mentions that there shall be no unfair discrimination against mental health users, based on their mental status, and mental health care users shall be accorded services on par with any health user in state institutions.⁹² This also includes the making of policies that relate to the mental health status of persons concerned.⁹³ The rest of the Act deals with the administrative and appeal procedures of handling mental health care users in as far as their rights are concerned. Section 26 makes mention that, where a mental health user cannot give consent to his admission to a mental health institution, they will have to go through an administrative procedure of notification to the health establishment as an outpatient or inpatient.⁹⁴ Treatment or rehabilitation will only be provided upon full assessment.⁹⁵

4 3 Social Assistance Act 13 of 2004

The purpose of this law is to render social assistance to persons with no means of supporting themselves, owing to a host of factors, such as lack of capacity.⁹⁶ The law relates to mental health rights, which are dealt with in section 7(a), and pertains to caregivers or parents of individuals or children suffering from physical or mental disability receiving grant money.⁹⁷ In section 9(a), it is stated that a person may receive a grant if his mental or physical disability renders him unfit to gain employment, enter a profession or render a service of an income.⁹⁸ Noting that psychiatric institutions may lack essential medication and other resources to fully rehabilitate mental health users, this act prejudices mental health users admitted in state psychiatric hospitals. It prohibits such mental health users from receiving disability grants while detained in these institutions. Such a grant would be useful in helping mental health users accumulate unused grants to be in a position to restart their lives after being released from the institution and also live dignified lives. Rather than being dependent on their families who might not be in a position to host them

86 *Ibid* section 3 (a) (iii).

87 *Ibid* section 4.

88 *Ibid* section 4 (a-d).

89 *Ibid* section 8.

90 The South African Constitution ss 9 and 14.

91 Mental Health Care Act 17 of 2002 s 8.

92 *Ibid* s 10.

93 *Ibid*.

94 *Ibid*.

95 *Ibid*.

96 Social Assistance Act 13 of 2004.

97 *Ibid* s 7(a) .

98 *Ibid* s 9(a).

on release.

4 4 Older Persons Act 13 of 2006

This piece of legislation deals with the rights, wellbeing, safety and security of elderly people.⁹⁹ The Act makes mention of the inherent right to dignity and that such a right must be respected and protected.¹⁰⁰ The necessity for an environment conducive to the respect of the rights of elderly people is also stated in the law.¹⁰¹ Section 7(f) of the Act states that elderly persons should not be denied opportunities that promote their social, physical, mental and emotional wellbeing.¹⁰² Section 21(3)(a) notes that an older person may not be admitted to an old people's home, unless his mental condition renders him or her unfit to make a decision regarding their capacity to be admitted in such a home.¹⁰³ Section 21(5) points out that an elderly person must be asked for consent to admission to an old people's home regardless of mental state.¹⁰⁴ In section 25(5), it is outlined that an elderly person in need of care could be exposed to circumstances that may harm them physically or mentally or is in a state of physical, mental or social neglect.¹⁰⁵ This legislation, if used properly, could lessen cases of mental health users older than 65 being detained in psychiatric institutions. South Africa's has a growing elderly population, with the percentage of people older than 65, as of 2023, standing at 6.5 per cent of the national population of 63 million.¹⁰⁶ Older people are equally vulnerable to mental health problems because of loneliness, anxiety, sadness and diminished self-esteem. Thus, seeing conditions such as dementia can manifest into behaviours such as being violent, stubbornness and wandering away from home or with no fixed abode. State Mental health institutions may not be able to remedy this situation of taking care of elderly people with mental health conditions because of bed space incapacity.¹⁰⁷ Thus a remedy would be to implement the Older Persons Act, which strives to ensure that a community-based approach is in place rather than institutional care. Some elderly people with mental health disabilities may not have families to look after them or families may not be in a position to look after them. A community-based approach is beneficial in that elderly people do not forfeit their grants as a result of being kept in state mental health institutions as pointed out in the previous section. If homes could exist where their grants are used to get them their daily needs it would be ideal, thus decongesting the mental health institutions across South Africa and creating bed space for other mental health users on the waiting list, such as prisoners.

5 HURDLES BETWEEN LAW, POLICY AND PRACTICE IN REALISING THE RIGHT TO HEALTH IN SOUTH AFRICA

Access to involuntary mental health care over the past 30 years has presented a challenge, as already highlighted above. The right to health in the context of mental health has not been fully respected. In 2011, respected scholar Burns gave a lucid human rights approach to mental health

99 Older Persons Act 13 of 2006.

100 *Ibid.*

101 *Ibid.*

102 *Ibid s 7 (f)* of Act 13 of 2006.

103 *Ibid.*

104 *Ibid s 21(3)(a).*

105 Section 25(5) (g) and (h) of Act 13 of 2006.

106 Trading Economics, South Africa-Population Ages 65 and Above (% Of Total), [https://tradingeconomics.com/south-africa/population-ages-65-and-above-percent-of-total-wb-data.html#:~:text=Population%20ages%2065%20and%20above%20\(%25%20of%20total%20population\)%20in,compiled%20from%20officially%20recognized%20sources](https://tradingeconomics.com/south-africa/population-ages-65-and-above-percent-of-total-wb-data.html#:~:text=Population%20ages%2065%20and%20above%20(%25%20of%20total%20population)%20in,compiled%20from%20officially%20recognized%20sources).

107 Zizo Zikhali "SA Has Only 3 Psychiatrists Specialising in Old-age" 13 August 2018 <https://www.news24.com/life/sa-has-only-3-psychiatrists-specialising-in-old-age-20180813> (accessed 06-01-2025).

issues.¹⁰⁸ Burns details how most mental health facilities in South Africa are outdated, in a state of disrepair and are not suitable for human habitation.¹⁰⁹ Burns further argues that there is a serious shortage of personnel who are suitably trained to deal with psychiatric patients or issues of mental health.¹¹⁰ The community mental health system remains undeveloped and patients end up in institutionalised environments, with no hope of ever re-integrating into society.¹¹¹

The National Mental Health Policy Framework and Strategic Plan of 2013–2020 outlines the challenges facing mental health patients in South Africa and depicts a gap between mental health laws and policy. The policy framework mentions that mental health care continues to be inadequately funded in comparison to other health priorities of the nation.¹¹² Public ignorance, insufficient data on people with disabilities and poor hospital infrastructure built during the apartheid era and not maintained or updated, are some of the challenges identified in the framework.¹¹³ The little effort made by the state to take care of people suffering from mental disorders is confined to severe disorders, but disorders that are considered less severe, such as depression and anxiety, are not given much priority.¹¹⁴

The National Mental Health Policy Framework and Strategic Plan of 2013–2020 further explains that the situation appears to have gotten out of hand, in the sense that social and economic issues are the leading factors in mental illness.¹¹⁵ A combination of heredity neurological disorders, substance abuse and childhood environment, which disturb the normal development of a child, are contributing factors of mental illness in South Africa.¹¹⁶ High levels of poverty, as a result of South Africa's unequal society in which wealth is skewed along racial lines, have been cited as leading factors in the proliferation of mental disorders, especially depression among the poor who feel no hope of ever escaping the vicious circle of poverty.¹¹⁷

The National Mental Health Policy Framework and Strategic Plan of 2023-2030 (NMHPFSP 2023–2030) was introduced three years after the lapse of the NMHPFSP 2013–2020. The NMHPFSP 2023–2030 acknowledges the Life Esidemeni tragedy and how it is a stark reminder how the basic human rights of people living with mental illness have been violated.¹¹⁸ The framework laments on the lack of implementation of plans, shortage of staff and erratic budget allocations by treasury to mental health.¹¹⁹ The framework amongst other issues basically calls for better financing and planning of mental healthcare at all levels¹²⁰ by ensuring that all provinces have strengthened mental health institutions with resources being distributed equally¹²¹ and making sure that community-based mental health services are aligned with social

108 Burns “The Mental Health Gap in South Africa – A Human Rights Issue” (2011) *The Equal Rights Review* 99.

109 *Ibid* 104.

110 *Ibid*.

111 *Ibid*.

112 National Mental Health Policy Framework and Strategic Plan of 2013–2020, at 9.

113 *Ibid* .

114 *Ibid* 9.

115 *Ibid* 13.

116 *Ibid* .

117 *Ibid* .

118 *Ibid* .

119 *Ibid* .

120 *Ibid*.

121 *Ibid*.

integration programmes.¹²²

The framework states that mental disorders are a leading cause of disability adjusted life years (DALYs), accounting for 13.8 per cent of the disease burden in South Africa. DALYs refers to the “sum of years of life lost to due to premature mortality and the years lived with a disability as result of prevalent cases of the disease or health condition in a population”.¹²³ As most of the mental health budget is consumed by specialised psychiatric health hospitals, which are in the minority. There is a high readmission rate of patients within the three month period of being released, thus consuming 18 per cent of mental health expenditure.¹²⁴ The framework suggests mitigation measures such as primary health care on hazardous alcohol abuse, and pharmacological interventions for over-dependence on alcohol to prevent an influx of the already overwhelmed psychiatric hospitals. The framework states that a budget in the form of a grant has been made available to contract psychiatrists, psychologists and registered counsellors to augment access to mental health services.¹²⁵ De-institutionalisation is said to have improved, but, however, it lacks community-based services.¹²⁶ Community-based services as per the framework refer to three components comprising community residential care, day care services and outpatient services.¹²⁷

The framework makes mention of the National Health Insurance, which will make mental health care for all accessible.¹²⁸ Such accessibility will be made possible by adequate funding of the NHI, where mental health services are given equal treatment with other health conditions on a par with the impact of the disease. The NHI must include services of care that are cost effective.¹²⁹ Overall, the NHI will see the current Mental Health Care Act No 17 of 2002 amended to include accessible health insurance for people suffering from mental disorders.¹³⁰

6 LIFE ESIDIMENI TRAGEDY

On 29 September 2015, the head of the Gauteng Provincial Health terminated the Life Esidimeni contract.¹³¹ Thereafter, psychiatric patients in need of specialised care were moved out of Life Esidimeni psychiatric health facilities between October 2015 and June 2016, and into unregistered NGOs. A total of 1 711 patients were affected.¹³² The Gauteng Provincial Health Department handpicked various bogus NGOs around the province to accommodate the patients, with some patients returned into the care of their families.¹³³ Prior to the unilateral removal of the patients, relentless calls were made to the department to come up with a plan to protect the rights and needs of the patients. However, those calls went unanswered.¹³⁴ The department cited the deinstitutionalisation of mental health services, concern by the provincial treasury about the

122 *Ibid* National Mental Health Policy Framework 13.

123 Disability-adjusted Life Years (DALYs) <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158#:~:text=Mortality%20does%20not%20give%20a,Method%20of%20estimation> (accessed 07-01-2025)

124 National Mental Health Policy Framework 16.

125 *Ibid* 18.

126 *Ibid* 19.

127 *Ibid* 23

128 *Ibid* 25; National Health Insurance Act 20 of 2023 preamble.

129 *Ibid* 25.

130 National Health Insurance Act 20 of 2023 s 54(4)(h).

131 *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*, at para 24.

132 *Ibid* para 24.

133 *Ibid*.

134 *Ibid* para 26.

contract between Life Esidimeni with and the department and financial constraints as reasons for the unilateral decision to move the patients.¹³⁵

The second reason given by the department for terminating the Life Esidimeni contract was because of the concerns raised by the Auditor-general about its duration, but there was no corroborating evidence justifying this.¹³⁶ A third reason furnished for terminating the contract was cutting costs. However, evidence showed that, despite saving on costs, money was misappropriated and mismanaged.¹³⁷

The department justified moving the patients to NGOs on the grounds that it would halve its costs.¹³⁸ The NGOs were to receive a meagre amount for each patient and source the rest of the funds required to take care of the patients from donors and disability grants from the state.¹³⁹ However, this arrangement was not feasible and resulted in the deaths of 144 patients.¹⁴⁰

According to the Health Ombudsman's report into the matter, the 27 NGOs entrusted to care for patients did not have valid licences.¹⁴¹ The NGOs were overcrowded, poorly resourced, and lacked basics such as food and clean water. On the face of it, the department did not give any reasons for not buying existing facilities from Life Esidimeni, despite being given favourable payment plans.¹⁴² The chaotic transfer of the mental health patients from Life Esidimeni facilities to the NGOs at some point witnessed 950 patients being transferred at once for distribution proportionally to the 27 NGOs.¹⁴³

That information came to the attention of lobby groups such as the South African Depression and Anxiety Group, which raised concern about the patients' families not being notified of events.¹⁴⁴ The patients were transported in unfit vehicles for psychiatric patients and the patients' medical records were not handed over. This constituted a violation of the right to dignity and proper health.¹⁴⁵

6 1 Late Rolling Out of Funding

The department's late funding of the NGOs resulted in extremely poor conditions.¹⁴⁶ The testimonies of affected families indicated that food provided to patients was not suitable for human consumption and, in many instances, relatives would bring food for the patients.¹⁴⁷ Furthermore, testimonies indicated that, in some NGOs, the patients were placed in makeshift dormitories in open warehouses and garages, which did not have privacy, contained poor bedding and exposed the patients to the elements during cold spells.

Through the Gauteng Provincial Health Department, the state had a constitutional duty to realise the right to health for psychiatric patients and their families.¹⁴⁸ The deaths of most of the 144

135 *Ibid* para 27.

136 *Ibid* para 32.

137 *Ibid* para 34.

138 *Ibid* para 38.

139 *Ibid*.

140 *Ibid* .

141 *Ibid* para 42.

142 *Ibid*.

143 *Ibid* para 53.

144 *Ibid*.

145 *Ibid* paras 57 and 61.

146 *Ibid* para 63.

147 *Ibid*.

148 *Ibid* para 79.

patients were caused by negligence as there were indications that some died from preventable causes such as dehydration and pneumonia, chronic hepatitis, which causes liver failure, and brain injury, which is likely to have been the result of the patients not being monitored.¹⁴⁹ The breach of the right to dignity outlined in sections 1(a), 7(1) and 10 of the Constitution even occurred after the deaths of the patients as most families or close relatives were never notified in time about the passing of their loved ones. Most shocking was that, on notification, families found their deceased relatives in a state of decomposition in government mortuaries. Furthermore, the state did not offer the affected families any form of assistance with funeral expenses.¹⁵⁰

The presentation before the arbitration hearing indicated that the surviving patients appeared to be severely dehydrated, were found in curled or crouched positions as a result of pneumonia and most were in a filthy state because of not having been bathed or cleaned regularly.¹⁵¹ In most cases, the surviving patients appeared to be inappropriately dressed.¹⁵² Some of the patients were discharged prisoners and, as a result of their mental conditions, could not be kept in the penitentiary system. There are 44 reported cases of patients who, to this day, have not been found.¹⁵³

The arbitration concluded that the families who either lost their loved ones or relatives because of the reckless conduct of the state and the survivors who suffered inhumane torture, be adequately compensated in the form of either funeral costs in the amount of ZAR20 000 (about US\$1383.32), ZAR18 0000 in general damages (US\$12449.87) and ZARR1 000 000 in “constitutional damages” (US\$69165.96) for breaching sections 1(a), (c) and (d), 7, 12(1) (d) and (e), 27(1)(a) and (b) and 195 of the Constitution. The department had also violated the National Health Act 61 of 2003 and the Mental Health Care Act.¹⁵⁴

6 2 Non-consultation with Families and Non-compliance with Domestic Law, International and Regional Instruments

The Life Esidimeni tragedy depicts a case where the families of psychiatric patients were excluded in the transfer of their relatives to NGOs. This was in breach of the Mental Health Care Act¹⁵⁵ because there was never coordination, as set out in section 3(a)(iii) of the Mental Health Care Act.¹⁵⁶ The National Mental Health Policy Framework and Strategic Plan of 2013–2020, set up in terms of section 4 of the Mental Health Care Act,¹⁵⁷ proved to be cumbersome because de-institutionalisation ended in tragedy. The breach of the constitutional respect of dignity was identified by overwhelming evidence that the state could not deny. In the process, South Africa breached its international and regional obligations. South Africa was in contravention of section 12(1) of the ICESCR. Furthermore, the country breached the respect of privacy in mental facilities as set out in principle 13 of the PPPMI and the Improvement of Mental Health Care.¹⁵⁸ At the regional level, South Africa violated the ACHPR in Article 5 of the document,

149 *Ibid* para 85.

150 *Ibid* para 95 to 111.

151 *Ibid* para 115.

152 *Ibid*.

153 *Ibid* para 119.

154 *Ibid* para 226.

155 Mental Healthcare Act 17 of 2002.

156 *Ibid*.

157 *Ibid* s 3(a)(iii).

158 Principle 13 at Paragraph 1 of the Principles for the Protection of Persons With Mental Illness and the Improvement of Mental Health Care Principle 13.

emphasising the right to dignity and not being subjected to inhumane and degrading treatment.¹⁵⁹ The Esidimeni tragedy also shows breaches of Article 16, which deals with the right to physical and mental health, with special emphasis on people with disabilities in that they should have a measure of protection in keeping their physical and moral needs.¹⁶⁰ It is also important to note that the lack of reporting on the state of psychiatric health care by South Africa in terms of the ICESCR, ICCPR and CRPD indicate that there is still a long way to go in advancing the rights of people with mental health disabilities.

7 EVENTS SUBSEQUENT TO THE LIFE ESIDIMENI TRAGEDY

7.1 Investigations by the South African Health Ombudsman's in Eastern Cape Mental Health Services

Following the publicity of the Life Esidimeni tragedy, the South African Health Ombudsman conducted an investigation into the mistreatment of patients at Tower Psychiatric Hospital in Fort Beaufort, Eastern Cape. This situation was dubbed another Life Esidimeni saga, which emanated from a new publication in the report by a senior psychiatrist working in the hospital.¹⁶¹ Allegations submitted by an ex-member of staff who reported many deaths, torn clothing and poor quality of food were said to be unfounded.¹⁶² The allegation of the basic human rights of patients lacking dignity in single cells, which had damp conditions, with no toilets and no mattresses, was a well-known complaint and not disputed by anyone.¹⁶³ This was in clear violation of the Mental Health Care Act. The Ombudsmans recommended, amongst other issues, an urgent need to correct the systematic failures of the mental health care policy and delivery. This includes investigating and reviewing priorities regarding the roles of staff and improving human resources constraints by ensuring that enough occupational psychologists, social workers and occupational psychiatrists are available in the Eastern Cape Department of Health.¹⁶⁴

7.2 Makana People's Centre : Fairness of Involuntary Treatment

The Life Esidimeni tragedy influenced a Non-Profit Organisation, Makana People's Centre to institute a law suit in the Gauteng High Court. The law suit challenged the provisions of the Mental Health Care Act, relating to the involuntary treatment of individuals as being unconstitutional in *Makana People's Centre v Minister of Health*.¹⁶⁵ These provisions, namely sections 33 and 34, were said to be lacking in the provision of an independent review before a patient would undergo involuntary detention.¹⁶⁶ The applicants approached the Constitutional Court to confirm the order. The Constitutional court examined whether these provisions violated section 12 of the Constitution on non-deprivation of liberty without just cause of persons. Involuntary treatment is a form of deprivation of freedom under section 12(1)(a) of the Constitution.

Guided by the position of involuntary treatment in other nations and international law, the court stated that even though the laws of other nations are not consistent with South Africa's

159 African Charter on Human and Peoples' Rights art 5.

160 *Ibid* art 16.

161 Report on an Investigation into Allegations of Patient Mismanagement and Patient rights Violations at the Tower Psychiatric Hospital and Psychosocial Rehabilitation Centre.

162 *Ibid* paras 4.11 and 4.12.

163 *Ibid* para 4.13.

164 *Ibid* para 5.1.

165 *Makana People's Centre v Minister of Health* 2023 5 SA 1 (CC) (9) para 5.

166 *Ibid* para 26–36.

constitution, South African mental health care is consistent with international standards on involuntary detention.¹⁶⁷ South Africa's approach is unique because both the tribunal and a judge in a high court are involved in the process. The court held that sections 33 and 34 of the Mental Health Care Act were in dispute did not violate section 12(1)(a) of the constitution.

The case focused on administrative issues around people deemed to need psychiatric evaluation. The court was correct in judging that people who were brought in by family members, guardians and the state involuntarily, did not have their rights infringed. However, it is also felt that the court should have questioned the state of service people receive in government psychiatric hospitals. How does this overlap with dignity and protecting people with no capacities and freedoms? Is the service of evaluating and giving the necessary treatment guaranteed? In light of what has been pointed out in the report of the South African Society of Psychiatrists and scandals that have rocked Kimberley Mental hospital discussed below, this was a missed opportunity by the court to tackle or address these problems.

7 3 Scandals in Kimberley Mental Hospital

After the Esidimeni tragedy, the government expedited the building of the Kimberley Mental Hospital in Northern Cape Province which had been a white elephant for many years. This project took 16 years to complete and opened its doors in 2024, though it was officially opened by the Premier of Northern Cape in 2018.¹⁶⁸ The lack of funding was among the reasons for the delay in opening the hospital. Despite the hospital now being officially open, it has been rocked by mismanagement, through poor construction and no electricity for months. It is also said that the patients' families feel let down by the government for inadequate facilities.¹⁶⁹ It is stated that funding is not the main issue, but the Northern Cape Department of Health mismanages funds.

7 4 Procurement in Public Health Falling Victim to Vicious Endemic of Corruption

Procurement in state hospitals is marred by rampant corruption. For instance, it was reported in 2022 that five companies benefited from ZAR1 billion in irregular contracts at Tembisa Tertiary Hospital in Gauteng. As well as the COVID-19 PPE procurement amounting to 332 million rands. The beneficiaries of these contracts are politically connected individuals. In *Glenister v President of the Republic of South Africa*,¹⁷⁰ the court succinctly mentioned that corruption causes more harm to the poor, by diverting funds meant for development, thus compromising the government's capability to render basic services. In light of this corruption, on 1 September, the President of South Africa issued proclamation 136 of 2023.¹⁷¹ This was meant to allow the Special Investigative Unit to make concentrated investigations into allegations of corruption and maladministration in the Gauteng Department of Health and Tembisa Hospital Affairs. The investigation confirmed, amongst other issues, that fraudulent suppliers and service providers were getting payments from the hospital. The CEO of Tembisa Hospital was responsible for authorising irregular procurement and irregularities in the bid documents, determining successful and unsuccessful bidders. At the time of writing, the investigations are still ongoing,

167 *Ibid* para 186–187.

168 Mochoari, "Two Years Later, Kimberley Mental Health Hospital Still Not at Capacity" <https://www.spotlightnsp.co.za/2021/10/28/two-years-later-kimberley-mental-health-hospital-still-not-at-capacity/> (accessed 22-03-2024).

169 Goodall, "Kimberley Psychiatric Hospital: Its Like a Jungle" <https://www.ewn.co.za/2024/04/08/kimberley-psychiatric-hospital-its-like-a-jungle> (accessed 14-04-2024); See also Carte Blanche, "Psychiatric Care in shambles" https://www.youtube.com/watch?v=xqVpsgYrInw&t=619s&ab_channel=CarteBlanche (accessed 14 -04-2024).

170 *Glenister v President of the Republic of South Africa* 2011 3 SA 347 (CC).

171 *Government Gazette Proc 136 OF 2023, NO 49217 1 September 2023.*

and the report is yet to be released.

Although it is positive news that the President issued a proclamation investigating the procurement scandals in Tembisa Hospital, sadly, some whistle-blowers who inform state law enforcement agencies have lost their lives to hitmen or assassins, commonly known as *nkabis* in local vernacular, hired by corrupt officials or private individuals with illicitly gained wealth to silence and stop any prosecution.¹⁷² One such victim was the whistle-blower who raised red flags on the procurement in Tembisa Hospital. Babita Deokoran was gunned down outside her home in August 2021. The perpetrators of the crime were arrested and sentenced. The public is afraid to speak out on corruption as this is just one of the many incidents of whistleblowers losing their lives. There is also a need to uphold the rule of law and the justice system's independence, whereas public servants holding positions in the police, prosecution and 'the bench' in lower and higher courts are not compromised. For instance, the temptations of making criminal dockets disappear to acquit accused public officials and private individuals have benefited immensely from bogus tenders and other misappropriation of public funds at the municipal level. Witness protection of whistle-blowers, although provided in terms of the Witness Protection Act of 1998, is rather weak.¹⁷³ And poorly funded, thus leaving a lot of corrupt officials and businesses plundering state institutions to walk scot-free. Other legislation linked to whistle-blowing is the Protected Disclosures Act, which only protects witnesses against prejudice in the workplace but not threat to life. Calitz suggests legislators could consider adopting a statute which protects whistleblowers not only in organisations but also members of the public. It should further also include reversing the burden of proof.¹⁷⁴

7.5 Esidimani Inquest Outcome and Awaited Prosecution

At this stage, prosecution of those responsible is yet to be seen from the Life Esidimani inquest, which commenced in July 2021 in Gauteng Division of the High Court in Pretoria and was concluded in November 2023.¹⁷⁵ The former MEC for Health Qedani Mahlangu and former provincial head for mental health Dr Kgabo Manamela have been found "negligent and responsible" in an inquest by the Gauteng Division of the High Court in Pretoria on 11 July 2024.¹⁷⁶ Despite the fact that potential evidence could not be obtained because most of the deaths were recorded as natural, the court was satisfied with evidence produced in the form of medical opinions from experts.¹⁷⁷ The MEC had been warned about the condition of some of the mental health patients as not being in any physical or mental condition to be transferred to NGO homes. Despite knowing that these mental health patients were vulnerable, the MEC went against the advice of experts.¹⁷⁸ The entire purpose of the inquest was to re-instil public confidence in the implementation of the involuntary mental health care policy and prevent similar occurrences such as the Esidimani tragedy.¹⁷⁹ The inquest can be said to be commendable because it is part of justice for the families of the deceased who need closure. No details about the NPA's decision

172 Wright "Whistleblowers in South Africa have Some Protection, But Gaps Need Fixing" <https://theconversation.com/whistleblowers-in-south-africa-have-some-protection-but-gaps-need-fixing-183992> (accessed 01-04-2024).

173 Stoltz "Many Sacrifices, Little Protection for State Witnesses" <https://mg.co.za/news/2022-11-26-many-sacrifices-little-protection-for-state-witnesses/> (accessed 01-04-2024).

174 Calitz, "The Plight of South African Whistle-Blowers: Searching for Effective Protection" 2023 *Obiter* 857.

175 *Life Esidimani Inquest* (I001/21) [2024] ZAGPPHC 676; Pongweni, "Life Esidimani Inquest Draws to Close After Two Tears of Blame Shifting, Finger Point" <https://www.dailymaverick.co.za/article/2023-11-08-life-esidimani-inquest-dnears-end-after-2-years-of-blame-shifting/> (accessed 02-04-2024).

176 *Life Esidimani Inquest* para 575.

177 *Ibid* para 16.

178 *Ibid* para 545.

179 *Ibid* para 41.

were available at the time of writing.

8 SUBMISSIONS

South Africa has been progressive in as far as its health policy is concerned, with various precedents available. However, the South African system is deficient in creating a socio-economic rights-based approach to mental health, as seen during the 30 years into democracy. The mental health legislation deals mostly with the administrative aspect of admitting people to mental health institutions rather than advocating for more budget and necessary infrastructure for dealing with people with mental disorders.

The Life Esidimeni tragedy exposed the flawed and unprofessional manner in which the Gauteng Provincial Department of Health conducted itself in transferring people with severe mental disorders into private NGOs. The Life Esidimeni tragedy was a big setback in advancing the interests of people affected by mental disorders. Although an inquest found the MEC and the Provincial head in charge negligent and liable for most of the deaths, the families need closure, as the NPA is silent about proceeding to prosecute those held responsible. The period of the NMHPFSP 2013–2020 saw nearly three years without any robust framework to advance the interests of people with mental health issues. It is anticipated the NMHPFSP 2023–2030 that, supersedes the NMHPFSP 2013–2020, will be implemented in light of the already gloomy situation in other institutions such as Kimberley Northern Cape and Fort Beaufort, Eastern Cape. Development is yet to be seen in light of the NHI legislation and how it will impact the accommodation of mental health care. In order to avoid similar recurrences such as the Life Esidimeni tragedy and subsequent lawsuits by affected families of mental health users suing the Department of Health, it is important for the Department of Health to reflect and revisit its mental health policy regularly. This mitigates the possibility of being sued, thus resulting in huge legal costs incurred by the Department of Health in settling claims as an admission that it had acted in a negligent manner.

It is important again for drafters of the next Framework on mental health to take cognisance of directives issued by the Minister of Health after the Life Esidimeni tragedy. Such directives, if made into a uniform mental health framework, can make mental health policy more uniform and less defragmented into a multiplicity of policies and laws that address the issue from different angles.

Seeing that the President of South Africa has issued various proclamations on procurement in government departments at the provincial level, such proclamations must be made on the state of procurement of mental health services.

Procurement scandals in every government department seeking services are the order of the day. Psychiatric health services have also been affected by procurement scandals, as evidenced by the Life Esidimeni tragedy. How can we actually protect vulnerable people's freedoms with the dire state of inadequate health services and corruption? A solution would be to eliminate procurement processes in delicate areas overlapping with essential socio-economic rights such as the right to health. The courts are overstretched with medical negligence cases, which have a direct impact on how the budget for health is rolled out to various hospitals, inclusive of mental health institutions. Yes, the government is responsible for medical negligence, but it is important to recall the Soobromoney cases, which are presently outdated for the present situation on access to health. In light of all the scandals in the health sector, one can say the

progressive realisation of the right to health inclusive of psychiatric treatment, is compromised.

9 CONCLUSION

This article revealed that legislation and policy have not done enough to advance the rights of people with mental disorders. For instance, the Social Assistance Act and the Older Persons Act have not been used effectively towards decongesting mental health institutions. Furthermore, this needs political will on the part of the government to provide a larger budget annually, than in previous years to key role players in mental health. The article shows that health rights are inter-related with other rights such as food and decent places of habitation. Life Esidimeni exposed the lack of these. To avoid mishaps such as the Life Esidimeni saga in the future, it is submitted that legislation and policy must strike a balance between properly trained NGOs and other private players as an outsourced means by the government. At the same time, the government should ensure adequate and timely funding to NGOs and private players who render services. South Africa is a nation that follows the monist approach of incorporating international provisions into its legislation and expects more. It is recommended that South African courts construe a meaning with regard to compliance with Article 12 (1) of the ICSECR in line with ICESCR General Comment No14 in order to protect people's rights that have been infringed.