HUMAN RIGHTS THAT INFLUENCE THE MENTALLY ILL PATIENT IN SOUTH AFRICAN MEDICAL LAW: A DISCUSSION OF SECTIONS 9; 27; 30 AND 31 OF THE CONSTITUTION*

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1 Introduction

People suffering from mental illness are among the most disadvantaged groups in society. They suffer severe personal distress and they are stigmatised, discriminated against, marginalised and often left vulnerable.[1] Stigma[2] has become an important concept in health law. It is widely accepted that certain diseases are disfavoured in society, leading to discrimination against people diagnosed with them. Burris[3] explains that this leads to the tendency to drive an epidemic underground, for example, to make it more difficult for voluntary public health programmes to reach and succeed among populations bent on concealing their diseases or risk status. The need to reduce stigma and its effects has been used to justify the passage of privacy and anti-discrimination law to protect people with disabilities. Stigma also insinuates itself into policy decisions, access to care, health insurance, employment discrimination, and research allocations and priorities.[4]

It is only a decade ago that South Africans were living and working in an oppressive and discriminatory system. As part of the national policy, health services were

* Sections 10 (human dignity); 12(2) (freedom and security of the person); and 14 (the right to privacy) have been discussed in a separate article. See Swanepoel 2011 THRHR. For an in-depth discussion on human rights that influence the mentally ill patient, see also Swanepoel Law, Psychiatry and Psychology 193-299.

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1 Orovwuje and Taylor "Mental health consumers" 95.

2 Stigmatisation is entirely contingent on having access to social, economic and political power that allows the identification of indifference, the construction of stereotypes, the separation of labelled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination. The term stigma is applied when elements of labelling, stereotyping, separation, status loss and discrimination co-occur in a power situation that allows them to unfold. See Link and Phelan 2006 Lancet 528.

3 Burris 2002 J L Med & Ethics 179.

4 Jamison 2006 *Lancet* 533.

fragmented along racial lines. Of all the medical specialities, psychiatry and psychology (the disciplines most influenced by the prevailing social and political climate) were the most criticised by the international community. The then psychiatric services were inspected by overseas groups and condemned. Concern was also expressed regarding the Royal College of Psychiatrists' continued silence on the political abuses of psychiatry in South Africa. In 1984 a call went out to the World Psychiatric Association to expel the "racist Society of Psychiatrists of South Africa" because of its collusion with apartheid. In 1987 a resolution was approved by the Royal College of Psychiatrists condemning racism and urging College members to support the Commonwealth Nassau Accord of October 1985, which recommended the discouragement of participation in South African cultural and scientific events except where these contributed towards the ending of apartheid or had no possible role in promoting it.[5]

The situation faced by people with mental illnesses in South Africa was and sometimes is characterised by levels of inequality and discrimination. Social, economic and political barriers interact to create conditions of underdevelopment, marginalisation and unequal access to resources. One of the central factors that contributed to these conditions is the failure of our society to recognise the rights of mentally disordered individuals as being equal to those of able-bodied persons. The policies and practices adopted by the apartheid government served not only to ignore these rights, but also to set up and maintain mechanisms which contributed to further abuse and discrimination. However, with the advent of democracy in South

5 Also note in this context that: “In response to the hideous violations of human rights in the past, the post-apartheid government established a Truth and Reconciliation Commission to promote national unity and reconciliation. The intention was to establish as far as possible the nature, causes and extent of gross human rights violations by granting amnesty to perpetrators who made full disclosures and by affording victims the opportunity to give accounts of their sufferings. For the nation as a whole, the Truth and Reconciliation Commission has had a positive and perhaps even therapeutic effect. There are a number of issues regarding the Truth and Reconciliation Commission that are of relevance to psychiatry. Both perpetrators and victims recounted almost unbelievable incidents of extreme emotional trauma. Mental health professionals provided advice regarding the manner in which testimony should be taken, and provided psychological support when necessary to those who testified. Truth and Reconciliation Commission staff members were trained in issues relevant to psychological support, and some of the Truth and Reconciliation Commission commissioners were mental health professionals.” See Emsley 2001 *Br J Psychiatry* 384. See also Jones "Prospects of a progressive mental health system" 1; Strous 2006 *Harv Rev Psychiatry* 30-37.

Africa, the authority of the *Constitution*[6] and Constitutional Court, the introduction of the Bill of Rights, the establishment of the Human Rights Commission and the enactment of the *Mental Health Care Act*[7] a more appropriate legislated infrastructure has been created in South Africa. This infrastructure addresses the past inequalities and attempts to ensure that the rights of all people, including mentally ill patients, are protected.[8]

The personalised nature of mental illness obscures from general view the intolerable burden of private and public distress that people with serious mental illness carry. Invariably the mentally ill person encounters rejection and humiliation that are in some way tantamount to a "second illness". The combination either disrupts or puts beyond reach the usual personal and social life stages of marriage, family life, raising children, sexual relationships, the choice of treatment, affordable housing, transportation, education and gainful employment. As a consequence of their lack financial and social support and their rejection from society, persons with mental illness tend to neglect themselves and their diet, and frequently delay seeking treatment.[9]

Because this is a contribution of limited scope, the focus here is placed on sections 9 (the equality clause), 27 (access to health care services), 30 and 31 (language, culture and religion) of the *Constitution*. Sections 10 (human dignity), 12(2) (freedom and security of the person), and 14 (the right to privacy) have been discussed in a separate article.[10]

6 The Constitution of the Republic of South Africa 1996 (hereafter referred to as the Constitution).
7 The *Mental Health Care Act* 17 of 2002 (hereafter referred to as the *Mental Health Care Act*).
8 Independent Living Institute 1997 www.independentliving.org. See also Swanepoel *Law, Psychiatry and Psychology* 4.
9 Orovwuje and Taylor "Mental health consumers" 95-96.
10 Swanepoel 2011 *THRHR* (to be published).

2 Section 9 of the *Constitution*: the equality clause[11]

Equality (non-discrimination) has a special place in the Bill of Rights, and sets its face against laws and practices that reinforce the subordination of disadvantaged and disabled groups.[12] Equality is also a dominant theme running through the Constitution. It is referred to expressly in the following sections:

- Section 9: "Everyone is equal before the law";
- Section 36: "In an open and democratic society based on freedom, and equality";
- Section 39: "When interpreting the Bill of Rights, a court, tribunal, or forum … must promote the values that underlie an open and democratic society based on human dignity, equality, and freedom."[13]

In *Harksen v Lane*[14] the determination of whether or not the equality clause may in fact be invoked requires an inquiry into the fact of whether or not there is differentiation between people or categories of people. If such a differentiation exists, it must be determined if there is a rational connection to a legitimate government purpose. The court went on to say that even if there is such a rational connection it might nevertheless still amount to discrimination.

11 Section 9 of the *Constitution* reads as follows: "(1) Everyone is equal before the law and has the right to equal protection and benefit of the law. (2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons or categories of persons, disadvantaged by unfair discrimination may be taken. (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth. (4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination. (5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair."

12 *Brink v Kitshoff NO* 1996 4 SA 197 (CC). See also *S v Makwanyane* 1995 3 SA 391 (CC).

13 See s 7(1) *Constitution*: "This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality, and freedom."

14 *Harksen v Lane* 1998 1 SA 300 (CC).

The second step is to distinguish if the differentiation amounts to unfair discrimination, which requires a three-stage analysis. Firstly, it must be established if the differentiation amounts to discrimination. The court was of the opinion that, if the allegation of unfair discrimination is not based on a listed ground, it must be resolved objectively if the ground is based on "attributes and characteristics which have the potential to impair the fundamental human dignity of persons as human beings or to affect them adversely in a comparably adverse manner." Secondly, it must be found that if it amounts to discrimination, such discrimination is unfair. If it is found to be on a listed ground (in this case disability), then the court will presume unfairness.[15] However, if it is found to be on an unspecified ground, the test of unfairness primarily focuses on the impact of the discrimination on the complainant and other people in the same situation.[16] Thirdly, if the discrimination is found to be unfair, it must be determined if it can be justified under the limitation clause.[17]

According to Link and Phelan,[18] an insidious form of discrimination occurs when stigmatised individuals realise that a negative label has been applied to them and that other people are likely to view them as less trustworthy and intelligent and more dangerous and incompetent. According to this modified labelling theory, people who

15 Section 9(3) *Constitution*.

16 The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (hereafter referred to as the Promotion of Equality and Prevention of Unfair Discrimination Act), also contains a general prohibition provision, and states that "neither the state nor any person may unfairly discriminate against any person." See s 6. The strong link between human dignity and equality is also conceptualised in the value of ubuntu. Although not expressly mentioned in the Constitution, it was nevertheless recognised as a constitutional value in S v Makwanyane. See S v Makwanyane 1995 3 SA 391 (CC). This culture emphasises the fact that, in treating human beings with dignity, the state is required to act in a reasonable manner to eradicate poverty and is obliged to take steps to ensure the equal treatment of those who are vulnerable in society and have been historically deprived.

17 Section 36 of the *Constitution*. In *President of the Republic of South Africa v Hugo*, Kriegler J suggested that the factors that would or could justify interference with the right to equality under the limitation clause should be distinguished from those relevant to the enquiry as to whether or not there has been unfair discrimination under the equality clause. The former are concerned with justification, possibly notwithstanding unfairness, and the latter are concerned with fairness and with nothing else. See *President of the Republic of South Africa v Hugo* 1997 4 SA 1 (CC). In *Harksen v Lane* the Constitutional Court stated that the limitation analysis involves "a weighing of the purpose and effect of the provision in question and a determination as to the proportionality thereof in relation to the extent of its infringement of equality." See *Harksen v Lane* 1998 1 SA 300 (CC). See also Currie and De Waal *Bill of Rights Handbook* 238.

18 Link and Phelan 2006 *Lancet* 528. See also Link 1982 *Am Soc Rev* 212-215; Link 1987 *Am Soc Rev* 96-112.

have been hospitalised for mental illnesses may act less confidently and more defensively with others, or may simply avoid a threatening contact altogether. The result may be strained and uncomfortable social interactions, more constricted social networks, a compromised quality of life, low self-esteem, depressive symptoms, unemployment and a loss of income.

According to Jamison,[19] we need to better understand why stigma exists and he makes the following recommendations:

- We have to acknowledge upfront that untreated mental illnesses can be frightening and that it can be associated with violent acts. It should further be acknowledged that mental illness can have a powerful effect on those people close to it.
- Research is the greatest destigmatiser: We need to get people interested in the brain, and in the fact that these are very interesting disorders. We need to capture the imaginations of the young and explain that understanding the brain is the last great frontier. To make a disorder interesting is to some extent to help destigmatise it.
- Third, we need to start within our own clinical communities and have more honest and open discussions about impaired doctors, psychologists, nurses and other professionals. Unless we are willing to talk about how to deal with mental illness among professionals the problem is going to remain silent, creating more fear and more stigmatisation. We also need to standardise the teaching of the clinical science underlying these illnesses. Some of the stigma associated with mental illness exists because there has been so much bad teaching and inadequate treatment over the years. The stigma that those with psychiatric illness face is only truly understood by those who have been on the receiving end of it.[20]

19 Jamison 2006 *Lancet* 534.

20 Jamison explains that this stigmatisation became more painfully clear to him when he wrote *An unquiet mind,* that recounted his own experience with bipolar disorder: "I received thousands of letters from people. Most of them were supportive but many were exceedingly hostile. A striking number said that I deserved my illness because I was insufficiently Christian and that the devil had gotten hold of me. More prayer, not medication, was the only answer. Others were irate that I had continued my professional work, even though my illness was well-controlled. The most upsetting letters, however, were from doctors, psychologists, and nurses who wrote about their own mood disorders, suicide attempts, and substance misuse problems. All made the irrefutable point that it was disingenuous for hospitals and medical schools to expect health-care professionals to be straightforward about mental illness when their hospital privileges, referral sources, and licences to practice were on the line. This is undeniably true. The chairmen of my academic departments have been compassionate and supportive of my career. I am fortunate in this regard; most others in my situation are not. *Mental illness is as least as common in our colleagues as it is in the general public, which is to say it is common.* Suicide occurs far too often. We need to reach out to our colleagues. As mentors and educators we need to be proactive, we need to educate medical students, house staff, and graduate students about depression and other mental illnesses. We need to make it easy for them to get treatment. We need as well to educate them more effectively about how best to diagnose and treat mental

In the South African context it is stated in section 10 of the *Mental Health Care Act* that a mental health care user may not be unfairly discriminated against on the grounds of his or her mental health status. All mental health care users must receive the same standard of care, treatment and rehabilitation services.

The right to be protected against exploitation and abuse is enunciated in section 11 of this Act, which states that every person, body, organisation or health establishment providing care, treatment and rehabilitation services to a mental health care user must take steps to ensure that users are protected from exploitation, abuse and any degrading treatment. Users should not be subjected to any forced labour either. Care, treatment and rehabilitation services should not be used as punishment or for the convenience of other people. According to section 12 of the Act any determination concerning the mental health status of any person must be based on factors exclusively relevant to that person's mental health status, or to give effect to the *Criminal Procedure Act*, and not on socio-political or economic status, cultural or religious background or affinity.

In addition, the Ethical Code of Professional Conduct to which a psychologist shall adhere stipulates that:

> "A psychologist shall not impose on a client, employee, research participant, student, supervisee, trainee, or others over whom he or she has or had authority, any stereotypes of behaviour, values or roles related to age, belief, birth, conscience, colour, culture, disability, disease, ethnic and social origin, gender, language, marital status, pregnancy, race, religion, sexual orientation, socio-economic status or on any other basis proscribed by law.[21] A psychologist shall not engage in unfair discrimination based on age, belief, birth, colour, conscience, culture, disability, disease, ethnic and social origin, gender, language, marital

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illness in their patients. We as a profession also need to reach out to society to say that we will not tolerate the kind of pain and discrimination that has gone on for far too long. When I wrote my book I had no idea what the long term consequences of being public about my manic depressive illness would be. I assumed that they were bound to be better than continuing to be silent. I was tired of hiding and tired of the hypocrisy. I was tired of being held hostage to stigma and tired of perpetuating it. Now there is indeed no turning back and I find myself continuing to take solace in Robert Lowell's question, the one which had been at the heart of my decision to be public about my illness: 'Yet why not say what happened?'" (Own emphasis). See Jamison 2006 *Lancet* 534. See also in general Jamison *Unquiet Mind*.

21 The Ethical Code of Professional Conduct to which a psychologist shall adhere: s 12(1) *Mental Health Care Act* 17 of 2002.

> status, pregnancy, race, religion, sexual orientation, or socioeconomic status or on any other basis proscribed by law.[22]

Further, a psychologist has to make every effort to ensure that language-appropriate and culture-appropriate services are made available to a client and that acceptable standards of language proficiency are met in the provision of a service to a client whose mother tongue varies from that of such psychologist.[23]

3 Section 27 of the *Constitution*:[24] access to healthcare services

The translation of human rights into rights that transcend rhetoric is an enduring challenge for the community of nations. One of the challenges is to engage policy-makers and domestic courts in seeing how they might play a more effective role in promoting the realisation of the right to health care. The challenge also lies in developing new thinking about effective and feasible ways of implementing a right at a programmatic level so that it does not remain an abstract ideal that rarely rises above rhetoric.[25] Mental health care is among the most grossly neglected elements of the right to health care services, for example.[26]

Hunt[27] submits that states should take steps to ensure a full package of community-based physical and mental healthcare and support services conducive to health,

22 Section 12(2) *Mental Health Care Act* 17 of 2002.
23 Section 12(3) *Mental Health Care Act* 17 of 2002.
24 Section 27 of the *Constitution* reads as follows: "Health care, food, water, and social security. (1) Everyone has the right to have access to: (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment."
25 Cook and Ngwena (eds) International Library of Medicine xiii.
26 Hunt and Mesquita 2006 *Hum Rts Q* 333.
27 Hunt further argues that augmenting interventions to ensure the equality of opportunity for the enjoyment of the right to health will require training adequate numbers of professionals, including psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers, occupational therapists, speech therapists, behavioural therapists and caregivers in order to work toward the care and full integration of individuals with mental disabilities in the community. General practitioners and other primary care providers should be provided with essential mental healthcare and disability sensitisation training to enable them to provide front-line mental and physical healthcare to persons with mental disabilities. See Hunt and Mesquita 2006 *Hum Rts Q* 345.

dignity and non-discrimination. The ideal package should include medication, psychotherapy, ambulatory services, hospital care for acute admissions, residential facilities, rehabilitation for persons with psychiatric disabilities, programmes to maximise the independence and skills of persons with mental illness, supported housing and employment, income support, inclusive and appropriate education for children with mental illness, and respite care for families looking after a person with a mental disability twenty-four hours a day. In this way, unnecessary institutionalisation can be avoided.

It was submitted by Fremouw[28] as early as in 1976 that the fact that a person has a mental disorder is not a crime. Therefore, if anyone is involuntarily restrained of his liberty because of a mental disorder, the state owes a duty to provide him or her with reasonable medical attention. If medical attention reasonably well adapted to his or her needs is not given, the person is not a patient but virtually a prisoner. The absence of treatment might draw the constitutionality of the mandatory section of access to health care services into question. It is also submitted by the author that failure to supply treatment may violate the equal protection clause. Indefinite confinement without treatment of one who has been found not criminally responsible may be so inhumane as to be cruel punishment.

Health care is generally considered to be a basic need. Section 27(1)(a) of the *Constitution* provides specifically that everyone has the right to have access to health care, including reproductive health care. This right is, however, limited internally by section 27(2), which provides that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights.[29] The *Constitution* does not guarantee a right to health, but only the qualified right of access to health care services. A further question that is of importance in understanding the right of access to health care services is that of the nature and level of care to which people are entitled.[30]

28 Fremouw "New right to treatment" 7, 9.
29 Sections 27(1)(a) and 27(2) *Constitution*.
30 For a detailed and valuable discussion of this right see in general Pearmain *Critical Analysis.*

In the case of *Soobramoney v Minister of Health Kwazulu-Natal*[31] the Constitutional Court had to interpret the scope and content of the right of access to health care services guaranteed under sections 27(1)(b) and 27(3). Mr Soobramoney, the appellant, was a 41-year old diabetic suffering from heart disease, vascular disease and irreversible chronic renal failure. His life could be prolonged by means of regular renal dialysis. He sought dialysis treatment from the Addington State Hospital in Durban. He was, however, not admitted to the dialysis programme of the hospital. Because the hospital did not have enough resources to provide dialysis treatment for all patients suffering from chronic renal failure, its policy was to automatically admit to the renal dialysis programme those suffering from acute renal failure that could be treated and remedied by renal dialysis. Patients suffering from irreversible chronic renal failure were not admitted automatically to the dialysis programme but according to a set of guidelines, which made the primary requirement for admission a patient's eligibility for a kidney transplant. A patient who was eligible for a transplant would be provided with dialysis treatment until an organ donor was found and a kidney transplant had been completed. According to the guidelines, patients were not eligible for kidney transplants unless free of significant vascular or cardiac disease. The appellant was therefore not eligible for a kidney transplant.

In July 1997 the appellant, relying on sections 27(3) and 11 of the *Constitution*,[32] made an urgent application to a local division of the High Court for an order directing the Addington Hospital to provide him with ongoing dialysis treatment and interdicting the respondent from refusing him admission to the renal unit of the hospital. The application was dismissed. The appellant appealed to the Constitutional Court.[33]

The court held that:

31 *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 1 SA 765 (CC). Renal dialysis is a procedure to preserve or extend someone's life when their kidneys have stopped functioning.

32 See the discussion of s 11 of the *Constitution.*

33 See *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 1 SA 765 (CC). See also Mubangizi 2003 *Obiter* 208; Van Oosten 1999 *De Jure* 11.

- Obligations imposed on the state under section 27 of the *Constitution* were dependent upon the resources available for such purposes, and the corresponding rights themselves were limited by reason of the lack of resources.[34]
- The words "emergency medical treatment" in section 27(3) might possibly be open to a broad construction, which would include ongoing treatment of chronic illnesses for the purpose of prolonging life. But this was not their ordinary meaning and, if this had been the purpose that section 27(3) was intended to serve, one would have expected it to be expressed in positive and specific terms.
- As to the argument that section 27(3) should be construed consistently with the right to life entrenched in section 11 of the *Constitution* and that everyone requiring life-saving treatment who was unable to pay for such treatment himself was entitled to have the treatment provided at a state hospital without charge, such a construction of section 27 would make it substantially more difficult for the state to fulfil its primary obligations under sections 27(1) and (2) to provide health care services to "everyone" within its available resources. It would also have the consequence of prioritising the treatment of terminal illnesses over other forms of medical care and would reduce the resources available to the state for purposes such as preventative health care and medical treatment for persons suffering from illnesses or bodily infirmities that are not life-threatening.
- The purpose of section 27(3) seems to be to ensure that treatment is given in an emergency, and is not frustrated by reason of bureaucratic requirements or other formalities.
- Given that the appellant suffered from chronic renal failure and that to be kept alive by dialysis he would require such treatment two to three times a week, his condition was not an emergency calling for immediate remedial treatment.

34 "The Appellant's case must be seen in the context of the needs which the health services have to meet, for if the treatment has to be provided to the appellant it would also have to be provided to all other persons similarly placed … It would also put a great strain on the existing dialysis machines which are already showing signs of wear."

- Section 27(3) did therefore not apply to this situation. In the context of budget constraints and cutbacks in hospital services in KwaZulu-Natal, there were many more patients suffering from chronic renal failure than there were dialysis machines to treat such patients.
- The appellant's case had to be seen in the context of the needs that the health services had to meet. If treatment had to be provided to the appellant, it would also have had to be provided to all other persons similarly placed. If all the people in South Africa who suffer from chronic renal failure were to be provided with dialysis treatment, the cost of doing so would make substantial inroads into the health budget.

A court would be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with matters like these. The state has a constitutional duty to comply with the obligations imposed on it by section 27 of the *Constitution*. It was not shown in the *Soobramoney* case that the state's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constituted a breach of those obligations. Chaskalson P followed a holistic approach to the larger needs of society and did not focus on the specific needs of particular individuals within society.[35] The judgment in *Treatment Action Campaign*[36] further shows that the Constitutional Court will hold government to its constitutional duties, and that the government is also a servant of the *Constitution*.[37]

At the national level, many countries have an absence of sustained and independent monitoring of mental healthcare. All too frequently, abuses of the right to access to healthcare services and of other human rights go unnoticed. This is the case not only in large psychiatric hospitals but also in community-based settings.

35 The Constitutional Court also noted in this case that "(t)he provisions of the Bill of Rights should furthermore not be interpreted in a way which results in courts feeling themselves unduly pressurised by the fear of the gambling with the lives of claimants into ordering hospitals to furnish the most expensive and improbable procedures, thereby diverting scarce medical resources and prejudice the claims of others", as quoted in Mubangizi 2003 *Obiter* 208.

36 Treatment Action Campaign v Minister of Health 2002 5 SA 721 (CC).

37 See Mubangizi 2003 *Obiter* 214. For a discussion of private and state funding see Van Oosten 1999 *De Jure* 1-18. See also Davis and Cheadle *et al Fundamental Rights* 358.

Persons with mental illness, especially those who are institutionalised but also those living in the community, are often unable to access independent and effective accountability mechanisms when their human rights have been violated. This may arise for various reasons, including the severity of a condition; the absence of effective procedural safeguards, such as the provision of a personal representative for those deemed to lack legal capacity; a lack of access to legal aid; and a lack of awareness of their human rights and other entitlements. In some cases, there is no independent accountability mechanism in the first place.[38]

Because South Africa acknowledges access to health care services in its Constitution, it is submitted that these include adequate treatment services for mentally disordered patients, including adequate treatment in psychiatric institutions, or for example, electroconvulsive therapy, especially if these are the only treatments recognised as appropriate for the purpose and treatment. These therapies could benefit the health and well-being of many South Africans. As individuals have the right to refuse treatment, they also have the right to seek orthodox treatments, and if they suffer incapacity, the person's rights are protected by using proxies and substitute judgment.

4 Sections 30 and 31 of the *Constitution*: language, culture and religion

In terms of section 30 of the *Constitution*:

> Language and culture –
> Everyone has the right to use the language and to participate in the cultural life of their choice, but no one exercising these rights may do so in a manner inconsistent with any provision of the Bill of Rights.

In terms of section 31 of the *Constitution*:

> Cultural, religious and linguistic communities –
> (1) Persons belonging to a cultural, religious or linguistic community may not be denied the right, with other members of that community -
> (a) to enjoy their culture, practise their religion and use their language; and

38 Hunt and Mesquita 2006 *Hum Rts Q* 349.

(b) to form, join and maintain cultural, religious and linguistic associations and other organs of civil society.

(2) The rights in subsection (1) may not be exercised in a manner inconsistent with any provision of the Bill of Rights.

The relevance of these procedures lies therein that culture can have a strong influence on how individuals experience psychiatric disabilities and on care and support preferences. Every patient should have the right to treatment suited to his or her cultural background. For example, mental healthcare and support services for indigenous peoples or racial and ethnic minorities must be respectful of their cultures and traditions.[39]

5 Conclusion

According to Jamison,[40] the inability to discuss mental disorder in an informed and straightforward way, to deal with it as the major public health concern that it is, is unjustifiable. There is a very large group which he refers to of as "the silent successful." These are people who recover from mental illness but who are afraid to speak out. This reluctance is very understandable, very human, but it is unfortunate because it perpetuates the misperception that mental illness cannot and should not be treated and cured. What remains visible in the public eye are the newspaper accounts of violence, the homeless mentally disordered and the untreated illness in friends, family, and colleagues. What is not seen is all the truck drivers, secretaries, teachers, lawyers, physicians and government officials who have been successfully treated, who work, compete and succeed. The purpose of this contribution was therefore to discuss a selection of rights which are relevant to the mentally disordered patient in South Africa.

Hassim importantly notes that: "much remains to be done to implement policies and to ensure that the vision of the protection of the patient becomes a reality for people

39 Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles), GA Res 46/119, UN GAOR, UN Doc A/RES/46/119 (1991) Principle 7(3).

40 Jamison 2006 *Lancet* 533.

regardless of factors like mental disorder."[41] One has to agree with this view and fortunately, the *Constitution* and the *Mental Health Care Act* has already introduced important changes relating to the administration of mental healthcare in South Africa. These must however be optimised in the areas that have been discussed in this contribution.

41 Hassim et al (eds) Health and Democracy 25.

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List of abbreviations

Am Soc Rev	American Sociological Review
Br J Psychiatry	British Journal of Psychiatry
J L Med & Ethics	Journal of Law, Medicine and Ethics
Harv Rev Psychiatry	Harvard Review of Psychiatry
Hum Rts Q	Human Rights Quarterly

HUMAN RIGHTS THAT INFLUENCE THE MENTALLY ILL PATIENT IN SOUTH AFRICAN MEDICAL LAW: A DISCUSSION OF SECTIONS 9; 27; 30 AND 31 OF THE CONSTITUTION

M Swanepoel[*]

SUMMARY

The personalised nature of mental illness obscures from general view the intolerable burden of private and public distress that people with serious mental illness carry. Invariably the mentally ill person encounters rejection and humiliation that are in some way tantamount to a "second illness." The combination either disrupts or puts beyond reach the usual personal and social life stages of marriage, family life, raising children, sexual relationships, the choice of treatment, affordable housing, transportation, education and gainful employment. As a result of their lack of financial and social support and their experience of rejection from society, persons with mental illness tend to neglect themselves and their diet, and frequently delay seeking treatment. Against this background, this contribution critically focuses on the human rights that influence the mentally ill patient in South African medical law. Specific attention is paid to the relevance and meaning of sections 9 (the equality clause), 27 (access to health care services), 30 and 31 (language, culture and religion) of the *Constitution of the Republic of South Africa*, 1996.

KEYWORDS: Mentally ill person; medical law; human rights law; equality; health care services; language, culture and religion

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