CONSTITUTIONAL COURT OF SOUTH AFRICA

Case CCT 125/22

In the matter between:

MAKANA PEOPLE'S CENTRE	Applicant
and	
MINISTER OF HEALTH	First Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, EASTERN CAPE	Second Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, FREE STATE	Third Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, GAUTENG	Fourth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, KWAZULU-NATAL	Fifth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, LIMPOPO	Sixth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, MPUMALANGA	Seventh Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTH WEST	Eighth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTHERN CAPE	Ninth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, WESTERN CAPE	Tenth Respondent

Neutral citation: *Makana People's Centre v Minister of Health and Other*s [2023] ZACC 15

Coram: Zondo CJ, Maya DCJ,[*] Baqwa AJ, Kollapen J, Madlanga J, Majiedt J, Mathopo J, Mbatha AJ, Mhlantla J, Rogers J, and Tshiqi J

Judgment: Rogers J (unanimous)

Heard on: 10 November 2022

Decided on: 9 June 2023

Summary: Mental Health Care Act 17 of 2002 — sections 33-4 — statutory regime for involuntary admission and treatment — constitutional validity — section 12(1)(a) Bill of Rights — procedural safeguards for deprivation of liberty constitutionally compliant – sections 34 and 10 of Bill of Rights not infringed

Mental Health Care Act 17 of 2002 — Chapter IV — Mental Health Review Boards — constitutional validity of Chapter — Review Boards sufficiently independent

[*] Maya DCJ was present for part of the hearing, but did not participate in the final disposition of the case.

ORDER

On application for confirmation of an order of constitutional invalidity granted by the High Court of South Africa, Gauteng Division, Pretoria (High Court):

1. The declarations of constitutional invalidity by the High Court are not confirmed.
2. The costs orders made by the High Court are set aside and replaced with an order that the parties are to bear their own costs.
3. As a result of the orders in 1 and 2, the respondents' applications for leave to appeal fall away.
4. The parties are to bear their own costs in this Court.

JUDGMENT

ROGERS J (Zondo CJ, Baqwa AJ, Kollapen J, Madlanga J, Majiedt J, Mathopo J, Mbatha AJ, Mhlantla J and Tshiqi J concurring):

Introduction

[1] In May 2008 the United Nations (UN) Convention on the Rights of Persons with Disabilities[1] (CRPD) entered into force. The CRPD has been said to signal a change from medical and welfare (or charity) models of disability to a social model. The medical model sees disability as a medical condition from which a person suffers and which calls for medical treatment. The welfare model likewise focuses on the individual's impairment and views the state's role as being to care for those afflicted by disability by creating facilities and opportunities for them outside the mainstream of

[1] Convention on the Rights of Persons with Disabilities, 13 December 2006 (ratified by South Africa on 30 November 2007).

society. By contrast, the social model, which has non-discrimination as a core value, views the source of disability not as the individual's impairment but as barriers set up by society which hinder the individual's full and effective participation in the world on an equal basis with others. It is not the individual who needs to be cured or sequestered; it is society that must change.[2]

[2] In relation to the mentally ill, the CRPD – particularly as it has been understood by the UN's High Commissioner on Human Rights and the UN's Committee on the Rights of Persons with Disabilities – has profound implications for the domestic laws of State Parties, including South Africa. The implications are not confined to legislation on the treatment of the mentally ill. Capacity, criminal accountability and curatorship are among the subjects that may need to be reconsidered. Whether all of the CRPD's promises can be translated into workable legislation remains to be seen, not to mention the human and financial resources that might be needed.[3]

[3] In common with South Africa, the laws of most countries on the treatment of the mentally ill still follow the medical model, though with increasing emphasis on human rights and patient autonomy. The CRPD has spawned an abundant literature. Globally, the law on mental health is in a state of flux. In the present case, however, there is no challenge to the fundamental scheme of the legislation in issue, the Mental Health Care Act (Act).[4] The issues, while important, are quite modest in the context of the paradigm shift which the CRPD has been said to herald. They are (a) whether involuntary inpatient treatment should be subject to automatic independent review (for example, by

[2] Bartlett "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" (2012) 75 *Modern Law Review* 752 at 758-9.

[3] See, generally, Bartlett above n 2. Bartlett's article references the legislation in England and Wales. See also McSherry "Mental Health Laws: Where to from here?" (2014) 40 *Monash University Law Review* 175 (with reference to Australian law) and Swanepoel "Aspects of the Impact of the United Nations Convention on the Rights of Persons with Disabilities on South African Health Law: Section 1" (2020) 1 *Forensic Science International: Mind and Law* 100014 (with reference to South African law).

[4] 17 of 2002.

a judicial officer)[5] before or immediately following the decision to admit the person for involuntary treatment; and (b) whether the Mental Health Review Boards (Review Boards), which are created by the Act and which play an important role in authorising involuntary inpatient treatment, are sufficiently independent.

[4] This case is thus not about whether involuntary inpatient treatment is ever justified, or about the criteria which the Act sets for this to occur, or even about the procedure in general which the Act lays down. This case is also not about how the Act is being implemented in practice. Constitutionally compliant legislation may be implemented badly and constitutionally deficient legislation may be implemented humanely.[6]

[5] The applicant, Makana People's Centre (Makana), applied to the High Court of South Africa, Gauteng Division, Pretoria (High Court), to have certain provisions of the Act declared constitutionally invalid. The High Court granted the declarations. Makana

[5] In its founding affidavit in the High Court, Makana referred interchangeably to the need for an automatic "independent" review and an automatic "judicial" review. Its notice of motion, however, complained of the absence of an "automatic independent review" and the High Court made its declaration of invalidity in those terms.

[6] In the literature, writers often praise our Act while raising concerns about implementation and resource constraints: Burns "The Mental Health Care Gap in South Africa – a Human Rights Issue" (2011) 6 *The Equal Rights Review* 99 (when passed, our Act was "generally hailed as one of the most progressive pieces of mental health legislation in the world" (at 100) but it was implemented with inadequate planning and funding, a problem aggravated by "desperately inadequate" human resources, particularly a shortage and skewed distribution of psychiatrists (at 105-6)); Lund et al (Mental Health and Poverty Project) *Mental Health Policy Development and Implementation in South Africa: A situation analysis – Phase 1 Country Report*, 31 January 2008 (the Act is "consistent with international human rights standards" and as a key instrument of reform is a "highly appropriate and important milestone in the development of the mental health system in South Africa" (at 10), but policy implementation and service delivery identified as problematic); Kersop and Van den Berg "Obtaining Involuntary Mental Health Care in the South African Constitutional Dispensation" 2015 *Obiter* 679 (the Act is compliant with the Constitution but there have been failures in effective implementation, with one area of weakness being that Review Boards are reported to be understaffed, underfunded and ill-equipped to deal with their workload (at 699-700)); Moosa and Jeenah "Involuntary Treatment of Psychiatric Patients in South Africa (2008) 11 *African Journal of Psychiatry* 109 (the Act upholds users' rights but there are "numerous difficulties in the implementation of involuntary treatment within a health care service that is plagued by human resource and infrastructure constraints" (at 110)).

On implementation challenges, see also Petersen and Lund "Mental Health Service Delivery in South Africa from 2000 to 2010: One step forward, one step back" (2011) 101 *South African Medical Journal* 751; Schierenbeck et al "Barriers to Accessing and Receiving Mental Health Care in Eastern Cape, South Africa" (2013) 15 *Health and Human Rights* 110; Szabo and Kaliski "Mental Health and the Law: A South African perspective" (2017) 14 *British Journal of Psychiatry International* 69.

applies to this Court for their confirmation.[7] Makana is a not-for-profit organisation committed to uplifting the lives of the marginalised and previously disadvantaged in South Africa. Its mission is to advance the educational and socio-economic rights of South Africans in various ways, including public interest litigation. Makana brought the application in its own interest, in the interest of mental health care users unable to act in their own names and in the public interest.

[6] The first respondent in the High Court was the Minister of Health (Minister). The second to tenth respondents were the Members of the Executive Councils responsible for health in the nine provinces (MECs or Health MECs). They are similarly cited in this Court. The Minister and eight of the MECs (the second to ninth respondents) opposed Makana's application and were jointly represented in the High Court, as they are in this Court. The tenth respondent, the MEC for Health in the Western Cape (WC MEC), was separately represented in the High Court, as she is in this Court. The WC MEC abided the High Court's decision but filed explanatory affidavits.

[7] This was the High Court's order:

> "1. The scheme for the involuntary detention of a mental health care user created under sections 33-34 of the [Act] is declared to be inconsistent with the Constitution and therefore invalid, to the extent that it does not provide for automatic independent review prior to or immediately following the initial detention of a person involuntarily detained under the [Act].
>
> 2. In terms of section 34(7) and section 36 of the [Act], the Review Board and the Court respectively, may in their discretion, examine the mental health care user who is the subject of the review proceedings.

[7] In terms of sections 167(5) and 172(2)(b) of the Constitution, the High Court's declarations of constitutional invalidity have no force unless confirmed by this Court. In terms of section 172(2)(d), any person or organ of state with a sufficient interest may appeal such an order directly to this Court.

> 3. Chapter IV of the [Act] is declared to be inconsistent with the Constitution and invalid, to the extent that it fails to provide an adequate level of independence to the Mental Health Review Board(s).
>
> 4. The first and the tenth respondents are to pay the costs, jointly and severally, one paying the other to be absolved, including the costs of two counsel."

[8] Paragraphs 1 and 3 of the order contain the declarations which Makana asks this Court to confirm. The Minister and the eight MECs oppose confirmation. They also apply for leave to appeal the High Court's failure to limit the retrospective effect of its declarations and to suspend them for 24 months. Additionally, the Minister appeals the costs order against him.[8] Conditionally on this Court confirming the declarations of invalidity, the WC MEC likewise seeks leave to appeal on retrospectivity and suspension. The WC MEC also appeals the costs order made against her. The declaration in paragraph 2 of the High Court's order, which is not one of constitutional invalidity, is uncontentious. In what follows, any reference to the contentions and submissions made by the Minister should be understood as including the second to ninth respondents.

Statutory scheme

Preamble and objects

[9] The Act's preamble recognises, among other things, that the Constitution prohibits unfair discrimination against people with mental or other disabilities; that mental disorders and disabilities sometimes give rise to the need to protect the person or property of the patient or of members of the public; and that mental health care services should be provided in a way which promotes the maximum mental well-being of mental health care users and the communities in which they reside.

[10] The objects of the Act are set out in section 3. These include making the best possible mental health care, treatment and rehabilitation services available to the

[8] Although the notice of appeal was said to be against the whole of the High Court's judgment, these respondents do not seek to have paragraph 2 of the High Court's order reversed.

population "equitably, efficiently and in the best interest of mental health care users within the limits of the available resources".

Definitions

[11] The Act uses the expression "mental health care user" for a person receiving mental health care services. Save when quoting from the Act, I shall refer simply to a user.[9] The definition of "mental health care user" refers to a person receiving services at a "health establishment" aimed at enhancing the "mental health status" of the user.[10] The definition of "health establishment" includes community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals. The definition is not limited to facilities in the public sector. The "head of a health establishment" (head) is defined as the person who manages the establishment. The head may be, but does not have to be, a medical professional.

[12] A "mental health care practitioner" (MHC practitioner) is defined as meaning "a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services".

[13] The Act refers to the services which it regulates as "mental health care, treatment and rehabilitation services". For the sake of brevity, I shall simply refer to "treatment".

[9] The word "user" is also adopted in the National Health Act 61 of 2003. This terminology is consistent with that chosen by mental health advocacy groups such as the European Network of (Ex-) Users and Survivors of Psychiatry and the World Network of Users and Survivors of Psychiatry. "User" implies agency. "Patient" is seen as inconsistent with choice and as implying the use of the medical model: Rose and Lucas *The User and Survivor Movement in Europe* in Knapp et al (eds) *Mental Health Policy and Practice across Europe: The future direction of mental health care* (Open University Press, 2007) at 338. In keeping with the legislature's choice, I use the word "user", notwithstanding the reservations expressed in Szabo and Kaliski above n 6 at 69.

[10] "Mental health status" is defined as meaning "the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis".

Chapter IV - Mental Health Review Boards

[14] The establishment of Review Boards is dealt with in Chapter IV of the Act (sections 18-24), which the High Court declared unconstitutional to the extent that it failed to provide an adequate level of independence for Review Boards.

[15] The heads of provincial health departments must establish one or more Review Boards for their provinces. A Review Board may be established for a single health establishment, a cluster of health establishments or all health establishments in the province.[11] The provincial department must make human and other resources available to the Review Board to enable it to perform its administrative functions.[12]

[16] A Review Board consists of at least three and no more than five South African citizens appointed by the MEC. The Review Board must at least include an MHC practitioner; a magistrate, attorney or advocate; and a member of the community concerned.[13] Appointments must be preceded by a public invitation for nominees setting out the criteria for nomination.[14] The MEC must determine the members' terms of office.[15] The remuneration, travelling expenses, subsistence allowance and other allowances payable to a Review Board member who is not in the full-time employment of the state must be determined by the Health MEC with the concurrence of the MEC responsible for finance (Finance MEC). These amounts must be appropriated out of the monies of the relevant provincial legislature.[16]

[17] The MEC may remove a Review Board member on one or more of the grounds listed in section 21, but only after an enquiry. The grounds are—

[11] Section 18(1) and (2). As at April 2019 there were more than 20 Review Boards in South Africa: Swanepoel and Mahomed "Involuntary Admission and Treatment of Mentally Ill Patients – the Role and Accountability of Mental Health Review Boards" (2021) 14 *South African Journal of Bioethics and Law* 89 at 90.

[12] Section 18(3).

[13] Section 20(1) and (2).

[14] Section 20(3).

[15] Section 20(4).

[16] Section 23.

"(a) ceasing to practise the profession in terms of which he or she was appointed;

(b) inability to perform his or her duties effectively;

(c) absence from two consecutive meetings of the Review Board without prior permission, except on good cause shown;

(d) ceasing to be a South African citizen; or

(e) public interest."

[18] The powers and functions of Review Boards are summarised in section 19(1). It is convenient to deal with them later, in the context of the particular provisions in relation to which they arise.[17] When performing its functions, a Review Board may "consult or obtain representations from any person, including a person or body with expertise".[18] If the Review Board is considering a matter that involves a health establishment at which one of its members is an MHC practitioner, that practitioner may not be involved in the consideration of the matter.[19]

Chapter III – rights and duties relating to users

[19] Chapter III of the Act (sections 7-17) deals with rights and duties relating to users. The best interests of users must be regarded in exercising the rights and performing the duties set out in the chapter.[20] The person, human dignity and privacy of every user must be respected.[21] A user must be provided with services that improve the user's mental capacity "to develop to full potential and to facilitate his or her

[17] Section 19(1) of the Act, when read in the context of the Act as a whole, is not an independent source of power but a summary of the powers conferred on Review Boards by other provisions. The power to consider appeals against decisions of the head (section 19(1)(a)) refers to the appellate powers conferred by sections 29 and 35. The power to make decisions on assisted or involuntary treatment (section 19(1)(b)) and the power to consider 72-hour reviews (section 19(1)(d)) refer to the decisions regulated by sections 28 and 34. The power to consider reviews and make decisions on assisted and involuntary users (section 19(1)(c)) refers to the periodic reviews and decision-making regulated by sections 30 and 37. The power to consider transfers of users to maximum security facilities (section 19(1)(e)) refers to the powers conferred by sections 39, 43 and 54. The power to consider periodic reports on the mental health status of mentally ill prisoners (section 19(1)(f)) refers to the powers conferred by section 55.

[18] Section 19(2).

[19] Section 24(3).

[20] Section 7(2).

[21] Section 8(1).

integration into community life".[22] Treatment must be "proportionate" to the user's mental health status and should "intrude only as little as possible" to give effect to the appropriate treatment.[23]

[20] The provision of treatment to and the admission of a user can take place in one of three circumstances: if the user has consented; if the treatment or admission is authorised by a court order or a Review Board; or if delay could result in the "death or irreversible harm" to the user or in the user "inflicting serious harm to himself or herself or others" or "causing serious damage to or loss of property belonging to him or her or others".[24] In the first and second situations, the health care provider must, before providing any treatment, inform the user in an appropriate way of his or her rights.[25] In the third situation, the circumstances must be reported to the relevant Review Board in the prescribed manner and treatment may not be continued for longer than 24 hours unless an application is made in terms of Chapter V.[26]

[21] Unfair discrimination against users on the grounds of their mental health status is prohibited, and the treatment they receive must be according to standards equivalent to those applicable to other health care users.[27] Those involved in the provision of treatment must take steps to ensure that users are protected from all forms of exploitation and abuse, and anyone witnessing such behaviour must report it in the prescribed way.[28] The determination of a user's mental health status must be based exclusively on factors relevant to mental health.[29] Confidentiality must be observed.[30]

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[22] Section 8(2).

[23] Section 8(3).

[24] Section 9(1).

[25] Section 17. These rights would include the right to legal representation conferred by section 15.

[26] Section 9(2).

[27] Section 10(1) and (2).

[28] Section 11.

[29] Section 12. Socio-political or economic status, cultural or religious background or affinity are excluded as relevant factors.

[30] Section 13(1).

[22] In terms of section 15, a user is entitled to a representative, including a legal representative, when submitting an application or lodging an appeal or appearing before a Magistrate, Judge or Review Board. An indigent user is entitled to legal aid provided by the state.

Chapter V – voluntary, assisted and involuntary treatment

[23] Chapter V of the Act (sections 25-40) regulates three categories of treatment: "voluntary", "assisted" and "involuntary". The recipients of the second and third categories are correspondingly defined as an "assisted mental health care user" and an "involuntary mental health care user". "Voluntary" treatment is treatment to which the user has consented. "Assisted" treatment is the provision of treatment to persons "incapable of making informed decisions due to their mental health status and who do not refuse the health interventions". "Involuntary" treatment is the provision of treatment to people "incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others".

[24] Assisted treatment is dealt with in sections 25 to 31, and involuntary treatment in sections 32 to 38. The regimes share some features. Since the focus of this case is involuntary treatment, I shall not deal in detail with assisted treatment.

Involuntary treatment

[25] A user must be provided with involuntary treatment if three conditions are satisfied: (a) that an application for such treatment is made to the head and granted; (b) that, at the time of the application, there is a reasonable belief that the user has a mental illness of such a nature that the user is "likely to inflict serious harm to himself or herself or others", or that treatment is "necessary for the protection of the financial interests or reputation" of the user; and (c) that at the time of the application the user is

incapable of making an informed decision on the need for treatment and is unwilling to receive the required treatment.[31]

[26] For ease of reference, I shall number the steps in the statutory process.[32] The High Court declared sections 33 and 34 constitutionally invalid for failing to provide for automatic independent review prior to or immediately following the start of involuntary detention. The key features of sections 33 and 34 are captured in steps 1 to 8.

[27] Step 1: An application for the involuntary treatment of adults must ordinarily be made by a user's spouse, next of kin, partner, associate,[33] parent or guardian. The application may, however, be made by a health care provider if the persons eligible to be applicants are unwilling, incapable or not available to make the application. If the user is under the age of 18, the application can be made only by the parent or guardian. Whoever makes the application must have seen the user within the last seven days.[34]

[28] An application, in prescribed form,[35] must set out the applicant's relationship to the user; the grounds on which the applicant believes treatment to be required; and the most recent time and place where the applicant saw the user. If the applicant is a health care provider, the latter must give reasons why they are making the application and the steps taken to locate the user's relatives to determine their capability or availability to make the application.[36]

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[31] Section 32.

[32] The forms to be used in these procedures and certain other details are contained in the General Regulations promulgated in terms of the Act: General Regulations, GNR 1467 *GG* 27117, 15 December 2004, as amended (Regulations).

[33] "Associate" is defined in section 1 as meaning "a person with a substantial or material interest in the well-being of a mental health care user or a person who is insubstantial contact with the user".

[34] Section 33(1).

[35] The prescribed form for an application is MHCA 04 annexed to the Regulations.

[36] Section 33(2)(b).

[29] Step 2: The head must, on receipt of the application, cause the user to be examined by two MHC practitioners. At least one of them must be "qualified to conduct physical examinations".[37]

[30] Step 3: The head must then decide whether to grant or refuse the application. The head can only approve the application if the reports of two practitioners concur that conditions for involuntary treatment exist.[38] If the head approves the application, the head must notify the applicant[39] and must cause the user to be admitted within 48 hours or must refer the user to another appropriate health establishment.[40]

[31] Step 4: Upon admission, the head must ensure that the user is given appropriate treatment. The head must also request a medical practitioner and another MHC practitioner to assess the user's physical and mental health status for a period of 72 hours. These two practitioners must also consider whether involuntary treatment should be continued and whether treatment should be provided on an outpatient or inpatient basis.[41] Within 24 hours after the expiry of the 72-hour assessment, the head must make the assessment findings available to the applicant.[42]

[32] Step 5: Based on the 72-hour assessment, the head can reach one of three decisions, namely that the user's mental health status (a) does not warrant involuntary treatment, in which case the user must be discharged immediately, unless the user

[37] Section 33(4). If the findings of the two MHC practitioners differ, the head must cause the patient to be examined by a third MHC practitioner, who must submit a report to the head: section 33(6). The prescribed form for the practitioners' findings is MHCA 05.

[38] Section 33(7).

[39] Section 33(8). The prescribed notification by the head to the applicant is form MHCA 07.

[40] Section 33(9).

[41] Section 34(1). The prescribed form for the 72-hour assessments is form MHCA 06. In terms of regulation 11, the medical practitioner conducting a 72-hour assessment may determine the user's treatment programme and must make a provisional diagnosis and initiate treatment as soon as possible. The medical practitioner must monitor the user's condition closely and give a written report to the head at least every 24 hours during the 72-hour assessment. The two practitioners must each submit their written reports (in accordance with form MHCA 06) to the head within 12 hours after the expiry of the 72-hour period. During the 72-hour assessment, the head may discharge a user or reclassify the treatment as voluntary if the user's mental condition warrants it.

[42] Section 34(2).

consents to treatment;[43] (b) warrants further involuntary treatment on an outpatient basis, in which case the head must discharge the user on prescribed conditions;[44] or (c) warrants further involuntary treatment on an inpatient basis.[45]

[33] Step 6: If the head concludes that further involuntary inpatient treatment is warranted, the head must, within seven days after expiry of the 72-hour assessment, submit a written request to the Review Board to approve this treatment. The request must be accompanied by the initial application, the head's notification to the applicant, the 72-hour assessment reports, and the head's basis for the request.[46] The head must give notice to the applicant of the date these documents were submitted to the Review Board.[47]

[34] Pending the Review Board's decision, the user must be treated in a psychiatric hospital, if necessary by transferring the user to such a hospital.[48] The user may, however, be discharged on an outpatient basis if at any stage the head considers that the user is fit to be so treated.[49]

[35] Step 7: Within 30 days of receipt of the documents, the Review Board must consider the request and make its decision. This includes giving the following persons an opportunity to make oral or written representations: the applicant; the MHC practitioners who conducted the initial assessment; an independent MHC practitioner, if any; and the head.[50] The Review Board must send its decision, with reasons, to the applicant and the head.[51]

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[43] Section 34(3)(a).

[44] Section 34(3)(b).

[45] Section 34(3)(c).

[46] Section 34(3)(c)(i). The prescribed form for the head's request is form MHCA 09.

[47] Section 34(3)(c)(ii).

[48] Section 34(4).

[49] Section 34(5).

[50] Section 34(7)(a).

[51] Section 34(7)(b). The prescribed form for this notification is MHCA 14.

[36] Step 8: If the Review Board decides to grant the head's request, it must, within the same 30-day period, send the documents it received from the head and its decision to the Registrar of the High Court.[52]

[37] Step 9: If the Review Board sends the papers to the High Court, the latter must consider the papers; may obtain information from any relevant person; and must then order either that the user be further hospitalised (and, if necessary, that the user's financial affairs be managed and administered according to Chapter VIII) or immediately discharged.[53]

[38] Step 10: If the user is further hospitalised, the head must cause the user's mental health status to be reviewed after six months and thereafter every 12 months. The head must submit a summary report of each review to the Review Board, which must within 30 days consider the report; if necessary, obtain information from any relevant person; and notify its decision to the head. The head must comply with the Review Board's decision. If the user is discharged, the Registrar of the High Court must be notified.[54]

[39] Apart from these reviews, if the head considers, from personal observation or information obtained, including representations from the user, that the user is capable of making informed decisions, the head must ask the user whether they are willing to continue with treatment voluntarily. If yes, the user becomes a voluntary user. If no, and if the head is satisfied that the user no longer has a mental illness, the head must immediately discharge the user.[55]

[40] Intervening appeal: The steps summarised above assume that there has been no appeal against the initial decision to admit the user involuntarily. The Act provides,

[52] Section 34(7)(c).

[53] Section 36.

[54] Section 37.

[55] Section 38.

however, that within 30 days of the head having notified the applicant of the decision to admit the user, the user or the latter's spouse, next of kin, partner, associate, parent or guardian may appeal the head's decision to the Review Board.[56] Within 30 days after receipt of the notice of appeal, the Review Board must obtain the relevant documents from the head; give the various interested parties an opportunity to make written or oral representations; and send written notice of its decision to the appellant, the applicant, the head of the health establishment and the head of the relevant provincial department. The noting of an appeal displaces any pending automatic review.[57]

[41] If the Review Board upholds the appeal, all treatment must be stopped and the user must be discharged unless the latter consents to further treatment. If the Review Board dismisses the appeal, it must submit the relevant documents to the High Court for review.[58]

Assisted treatment

[42] If the head, based on an assessment of two MHC practitioners, decides that assisted inpatient treatment is warranted, the head must send the prescribed documentation to the Review Board which must make its decision within 30 days.[59] There is also a right of appeal to the Review Board.[60] For assisted users whose stay in a health establishment is lengthy, periodic reports must be sent to the Review Board for decision.[61]

[56] Section 35(1). The appeal document is form MHCA 15. The Regulations require the interested parties to be given at least two weeks' notice of the date of the appeal hearing. The Review Board may summon any person to appear as a witness and to produce documents: regulation 15(4) and (5).

[57] Section 34(8).

[58] Section 35(2) - (4).

[59] Sections 27 and 28.

[60] Section 29.

[61] Section 30.

Chapters VI and VII – State patients and mentally ill prisoners

[43] Chapters VI and VII regulate the provision of treatment to "State patients" and "mentally ill prisoners". The role of Review Boards here is limited. The Boards must take decisions about the transfer of patients to maximum security facilities.[62] In the case of mentally ill prisoners, the head must make periodic reports to the Review Board and the latter must make recommendations to the head about treatment plans and the return of patients to the prisons from which they were initially transferred.[63]

The High Court's judgment

[44] The High Court referred to evidence in Makana's founding papers about mental health care in South Africa, which Makana considered to be poor. This included evidence about the Life Esidimeni tragedy.[64] An arbitration award by retired Deputy Chief Justice Moseneke and a report by the Office of the Health Ombud found that the Gauteng Review Board had been "moribund, ineffective and without authority and without independence" and that its members were more concerned about protecting their financial benefits than carrying out their duties. The High Court also referred to a report by the South African Human Rights Commission (SAHRC), which spoke of a prolonged and systematic neglect of mental health. This report found that in KwaZulu-Natal most involuntary treatment applications were not submitted to the High Court due to mistakes and delayed submission. A similar problem was encountered in Mpumalanga.

The challenge to sections 33-4

[45] The High Court recorded Makana's contention as being that the detention of an involuntary user was prolonged and that it occurred without sufficient or prompt judicial

[62] Sections 43(3) and 54(2) respectively.

[63] Section 55.

[64] This tragedy resulted in the death of 144 users and trauma to hundreds more. According to the Ombud's report, the victims were assisted users. Dr Sutcliffe states that they were voluntary users but that is probably mistaken. At any rate, they were not involuntary users. The tragedy was not connected with shortcomings in the assessment and admission of the users but with a decision to transfer them from Life Esidimeni to non-governmental organisations which were not licensed or equipped to care for them.

oversight, given the late stage at which a Judge became involved. This regime was said to violate sections 10, 12 and 34 of the Constitution.[65] According to Makana, there should be an initial review of the detention, with the user's appearance before a judicial officer being the norm. This occurred in other contexts (for example, police arrests and the detention of illegal immigrants), even though the purpose of arrest or detention might serve a presumptively noble goal. The principle was that a person deprived of liberty must be brought before an independent arbiter, usually a court, before or immediately following the detention.

[46] The High Court cited *C v Department of Health*,[66] where this Court declared sections 151 and 152 of the Children's Act[67] constitutionally invalid for failing to provide for the automatic review of the removal by state officials of children from their family environment and their placement in temporary safe care. This was held to violate section 28 (children's rights) and section 34 of the Constitution. Although the provisions sought to cater for the best interests of children, there were insufficient safeguards against a wrong removal. This Court's remedy was to read into the sections a requirement that removals be reviewed by a Children's Court within 48 hours of the removal.

[47] The High Court recorded the Minister's characterisation of the Act as carefully drafted post-constitutional legislation which took full cognisance of users' vulnerability and the state's obligation to protect their fundamental rights. Courts were in no position to assess whether users suffer from a mental illness, and the priority should be the provision of treatment. The High Court observed, however, that the envisaged judicial review was one in which medical practitioners would provide expert evidence to assist the Court, without usurping the judicial function. The Minister had not explained why

[65] Those sections contain, respectively, the right to dignity; the right to freedom and security of the person; and the right to have legal disputes decided in a fair public hearing before a court or other impartial tribunal.

[66] *C v Department of Health and Social Development, Gauteng* [2012] ZACC 1; 2012 (2) SA 208 (CC); 2012 (4) BCLR 329 (CC).

[67] 38 of 2005.

a judicial review of the initial detention could not occur, if necessary in the absence of the user if the user was too unwell to be brought to court.

[48] The High Court rejected as misconceived the Minister's contention that, because the Act did not take away users' rights to approach the courts, their rights under section 34 of the Constitution were not violated. Involuntary users were in no position to make such an approach.

[49] The High Court regarded the evidence about the Life Esidimeni tragedy as illustrating the lack of proper safeguards in the statutory framework for involuntary treatment. It was not necessary for Makana to show that in every province users were exposed to untenable vulnerabilities. Accelerated judicial oversight, before or soon after detention, would not only benefit vulnerable users but serve to promote the positive obligations imposed on the state.

The independence of Review Boards

[50] In regard to Makana's complaint that Review Boards were not sufficiently independent, the High Court referred to *Glenister II*,[68] where this Court declared Chapter 6A of the South African Police Service Act[69] constitutionally invalid for failing to secure adequate independence for the Directorate of Priority Crime Investigation (DPCI). This Court held that the Constitution's scheme taken as a whole, and binding international law agreements, imposed a pressing duty on the state to set up a concrete, effective and independent mechanism to prevent and root out corruption. The DPCI did not meet the constitutional standard, because it was insufficiently insulated from political influence.

[68] *Glenister v President of the Republic of South Africa* [2011] ZACC 6; 2011 (3) SA 347 (CC); 2011 (7) BCLR 651 (CC). (The High Court mistakenly gave the citation of the earlier case, *Glenister v President of the Republic of South Africa* [2008] ZACC 19; 2009 (1) SA 287 (CC); 2009 (2) BCLR 136 (CC).)

[69] 68 of 1995.

[51] The High Court gave no further reasons for the order it made in respect of Chapter IV.

Justification for the limitation of rights

[52] The High Court said that a Judge had to make a "value judgment to give effect and meaning to constitutional rights and values". There were two "competing constitutional rights". On the one hand, withholding diagnosis and treatment until a judicial review occurred might infringe a user's right to life and right of access to health care services. On the other hand, the absence of a judicial review infringed the user's rights to freedom of movement and dignity. These rights had to be "weighed against the limitation clause".[70] The High Court's judgment does not, however, contain any analysis in the light of section 36 of the Constitution. One is left to infer that the High Court found the limitation of fundamental rights not to be justified.

Suspension of declarations of invalidity, and costs

[53] The High Court considered that it did not have the power to suspend the declarations of invalidity, because its declaration would in any event not take effect unless and until confirmed by this Court.

[54] The High Court noted that costs were in its discretion, to be exercised judicially. The High Court felt that costs should be awarded not only against the Minister but also against the WC MEC because the latter's explanatory affidavits were, so the High Court considered, irrelevant, unhelpful and unsolicited.

Makana's submissions in this Court

[55] Makana emphasises that its case is not about why users may be involuntarily detained but about how this happens. Its case is also not about whether particular functionaries in the mental health care system do their jobs well or badly. Its attack

[70] The High Court did not expressly mention section 36 of the Constitution, but the Court's paraphrasing shows that it had section 36 in mind.

calls for an objective assessment of the statute. If the Act on its own terms is constitutionally deficient, it cannot be saved by regulations or by constitutionally compliant implementation.

Sections 33-4

[56] Makana notes that the head of a health establishment is not required by law to be a medical doctor. The fact that in practice most heads are medical doctors is irrelevant. Makana also points to the wide definition of "MHC practitioner", which includes social workers and occupational therapists. As to time periods, Makana emphasises that an involuntary user may be detained for up to 70 days before the matter receives judicial attention.

[57] Although in the High Court Makana relied on section 10 as well, its focus in this Court is on sections 12(1) and 34. With reference to this Court's judgment in *De Vos*,[71] Makana submits that involuntary inpatient treatment is detention for purposes of section 12(1). Makana cites the liberty clause in Article 14 of the CRPD[72] and paragraph 13 of the Guidelines on Article 14 issued by the United Nations' Committee on the Rights of Persons with Disabilities.[73] According to paragraph 13, the—

> "involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty."

[58] Makana submits, with reference to judgments of this Court,[74] that the right guaranteed by section 12(1) of the Constitution has a substantive and procedural

[71] *De Vos N.O. v Minister of Justice and Constitutional Development* [2015] ZACC 21; 2015 (2) SACR 217 (CC); 2015 (9) BCLR 1026 (CC) at para 22.

[72] CRPD above n 1.

[73] Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, adopted by the United Nations' Committee on the Rights of Persons with Disabilities at its 14th session, held in September 2015.

[74] *De Lange v Smuts NO* [1998] ZACC 6; 1998 (3) SA 785 (CC); 1998 (7) BCLR 779 (CC) (*De Lange*) at para 22, citing *S v Coetzee* [1997] ZACC 2; 1997 (3) SA 527(CC); 1997 (4) BCLR 437 (CC).

component. The substantive component is about the acceptability of the reasons for detention. The procedural component is implicit in section 12(1), and has to do with the process for detaining a person. While Makana acknowledges that it may be acceptable to detain mentally ill persons in some circumstances, it challenges the justifiability of a scheme that allows detention for a long period without judicial oversight. According to Makana, the respondents have offered no scientific justification for this. Liberty is always urgent. The treatment of involuntary users contrasts unfavourably with persons arrested on suspicion of crime and as undocumented immigrants.

[59] Makana invokes judgments of this Court in support of the proposition that the procedural component of section 12(1) requires the interposition of an impartial arbiter, usually a judicial officer, between the individual and the state: *Nel*,[75] *Lawyers for Human Rights*[76] and *De Lange*,[77] among others. This was present in the Mental Health Act of 1973[78] (1973 Act), which stipulated that a patient could not be admitted involuntarily except with the approval of a Magistrate, assisted by two medical practitioners. The respondents have failed to explain why a similar procedure does not form part of the current Act.

[60] As to section 34 of the Constitution, Makana's first contention is that the Act does not make express provision for a user to ask for judicial intervention. There is no requirement that the user should be invited to challenge the admission judicially. Although the general principle is that any deprivation of liberty is unlawful unless justified by the state, the Act reverses this by placing the onus on users to approach a court to vindicate their freedom. This is exacerbated by the fact that users often are vulnerable people who are unlikely to have the ability or means to seek judicial redress.

[75] *Nel v Le Roux NO* [1996] ZACC 6; 1996 (3) SA 562 (CC); 1996 (4) BCLR 592 (CC) at para 14.

[76] *Lawyers for Human Rights v Minister of Home Affairs* [2017] ZACC 22; 2017 (5) SA 480 (CC); 2017 (10) BCLR 1242 (CC) at paras 35 and 40.

[77] *De Lange* above n 74 at paras 23 and 101.

[78] 18 of 1973.

[61] Makana's second contention is that the Act "relegates judicial supervision over detentions to a subsidiary role". The matter may only reach the High Court more than a month after detention has begun. Makana refers, by analogy, to the principle that section 34 of the Constitution requires judicial oversight before execution is levied against a debtor's home or before an emoluments attachment order is issued. It is not enough, in such cases, that a debtor can approach the court to challenge the warrant or attachment. Makana invokes *C v Department of Health*,[79] where this Court rejected an argument that the right of parents to bring legal proceedings to challenge the removal of a child met the requirements of section 34. Although access to courts was not denied, it was impaired and delayed, and the legislation unfairly placed the burden on the affected family to take action.[80]

[62] Makana submits, thus, that sections 33 and 34 of the Act limit users' rights guaranteed by sections 12(1) and 34 of the Constitution. The respondents have not discharged the burden of justifying the limitations, in particular the "less restrictive means" component of section 36 of the Constitution.[81] This is not a case where justification can be adjudicated merely on broad policy considerations and common sense.[82] The respondents' factual assertions are vague and unsubstantiated. They have not shown that prompt judicial oversight is incompatible with early diagnosis and treatment. Not all involuntary users present with immediate life-threatening conditions. Prompt judicial oversight is particularly important because the substantive grounds for involuntary admissions are fallible.

[79] Above n 66.

[80] Id at paras 28 and 37 per Skweyiya J and at paras 79 and 81 per Yacoob J.

[81] In regard to the nature of this burden, Makana cites *Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development* [2013] ZACC 35; 2014 (2) SA 168 (CC); 2013 (12) BCLR 1429 (CC) at para 84 and *Minister of Home Affairs v National Institute for Crime Prevention and the Re-Integration of Offenders* (*NICRO*) [2004] ZACC 10; 2005 (3) SA 280 (CC); 2004 (5) BCLR 445 (CC) at paras 35-6.

[82] *NICRO* id at para 36.

Chapter IV (Review Boards)

[63] Makana sources the requirement of the Review Boards' independence in sections 12(1) and 7(2) of the Constitution. The former requires the interposition of "an impartial entity, independent of the Executive and the Legislature" in order for detention to be authorised.[83] The latter requires the state to "respect, protect, promote and fulfil" the rights in the Bill of Rights, which include section 12(1). The state's duty is reinforced by the country's international law obligations. In order to meet the constitutional standard of independence, various factors must be considered, but according to this Court's judgment in *Sonke Gender Justice* "certain key markers have emerged, namely: structural independence, operational independence, and perceived independence".[84]

[64] Structural independence entails, among other things, financial independence. According to Makana, section 23 causes the Act to fall short, because the MEC determines the remuneration and other allowances of review board members who are not full-time state employees. The MEC's decision is not made subject to any prescribed criteria or guidelines. This could make members beholden to the MEC. It is irrelevant that an MEC might in practice follow a satisfactory process in setting remuneration and allowances.

[65] Operational independence entails control over and freedom from interference in matters such as the appointment and accountability of staff, and operational decisions.[85] Makana points to several alleged deficiencies in the Act in this regard: section 20(1), which gives the MEC a free hand in appointing Review Board members; section 20(4), which empowers the MEC to determine the term of office of Review Board members; and section 21, which allows the MEC to remove Review Board members on grounds

[83] The quoted phrase is from *Nel* above n 75 at para 14.

[84] *Sonke Gender Justice NPC v President of the Republic of South Africa* [2020] ZACC 26; 2021 (3) BCLR 269 (CC) at para 75.

[85] Makana cites *Sonke Gender Justice* id at para 77, a passage which in turn refers to *Glenister II* above n 68 at para 216.

which, in two instances, are wide and open to differing interpretations ("inability to perform his or her duties effectively" and "public interest").[86] Makana argues, with reference to *Glenister II*,[87] that it is no answer to say that the removal power is subject to the principle of legality. The right to bring an after-the-event challenge does not cure the statutory deficiency. The MEC's power, moreover, is not constrained by safeguards such as a veto by the legislature or an obligation to report removal to the legislature.[88] The minimum prescribed qualifications for two of the Review Board members, medical and legal respectively, are no guarantee of independence.

[66] The above deficiencies lead, according to Makana, to a general perception of a lack of independence on the part of Review Boards. And, finally, Makana argues that the lack of the required independence is not capable of being justified under section 36 of the Constitution, because the need for independence is not sourced in the Bill of Rights alone.

Just and equitable remedy, and costs

[67] At the hearing, Makana agreed with the respondents that a declaration of invalidity should be suspended for 24 months and should not have retrospective effect. Makana submits that the High Court's costs order against the WC MEC was justified, since she in truth adopted a partisan stance. The allegations in her papers were not helpful in determining the core issues in the case. In this Court, however, Makana seeks costs only against the Minister.[89]

[86] Makana refers to *Corruption Watch NPC v President of the Republic of South Africa; Nxasana v Corruption Watch NPC* [2018] ZACC 23; 2018 (2) SACR 442 (CC); 2018 (10) BCLR 1179 (CC) (*Corruption Watch*) at para 45, where this Court was critical of a statute which gave the President an unguided power, when suspending the National Director of Public Prosecutions (NDPP) or a Deputy NDPP, to determine whether the suspended official should receive remuneration during the period of suspension, and if so how much. Such a power was "susceptible to abuse" and might cause the officials to be rendered ""compliant". It was "a tool that should not be availed to the Executive".

[87] *Glenister II* above n 68 at para 247.

[88] Makana refers, in this regard, to *Glenister II* above n 68 at paragraph 225 and *McBride v Minister of Police* [2016] ZACC 30; 2016 (2) SACR 585 (CC); 2016 (11) BCLR 1398 (CC) at paras 39-40.

[89] Although in its written submissions Makana also sought costs in this Court against the WC MEC, we were told in oral argument that Makana no longer did so.

The Minister's submissions

Sections 33-4

[68] The Minister describes the Act as "progressive legislation which is constitutionally compliant". The Act emphasises human rights, and promotes greater access to mental health services and a community-based approach to mental health care delivery. Throughout the Act's processes, the rights of users are protected, with appropriate checks and balances. The Minister submits that the High Court in *Ex parte G*[90] was right to say that the Act is "fully compatible with human rights and the Constitution".[91]

[69] Mental illness requires early diagnosis and treatment to increase the prospects of quick and full recovery. In most cases this happens with consent, but in up to 5% of cases users need involuntary treatment. Withholding treatment until judicial review, or prioritising judicial review over diagnosis and treatment, infringes the user's right to life and of access to health care services. Users often present as emergencies, where prompt medical intervention is needed. Two competing rights are at stake: the right to life, and the right to freedom of movement. The Constitution does not recognise a hierarchy of rights.

[70] Various safeguards exist throughout the process of involuntary admission and treatment. There is the information that must be contained in the application and the requirement that the applicant should have seen the user within the last seven days. The head can only act on the recommendation of two MHC practitioners. As soon the involuntary user is admitted, there is a right of appeal to the Review Board. The time periods for the various processes up to the time the head must submit the case to the Review Board are proportionate in order to allow informed decisions to be made.

[90] *Ex parte G and Sixty-Six Others* [2008] ZAKZHC 37, unreported judgment of the High Court of South Africa, KwaZulu-Natal Provincial Division, Case No 19/2007 (5 June 2008).

[91] Id at para 19.

[71] As to Makana's complaint that the 30 days granted to the Review Board is too long, the Minister stresses that the Act does not compel the Review Board to wait 30 days before making a decision. Cases differ in nature and complexity. Sometimes the Review Board will need to obtain representations or interview the user or practitioners. In other cases, the Review Board may be able to make its decision within a day or two. There has to be flexibility.

[72] Insistence on an automatic independent review before or immediately after admission is impractical. The language of "detention" is misplaced in the context of involuntary treatment. The Minister submits that the High Court gave no justification for finding sections 33 and 34 to be unconstitutional and failed to engage with the justification exercise required by section 36 of the Constitution. Reliance on the Life Esidimeni reports was unfounded because the reports did not say that there was anything wrong with the Act. Limitations on the rights of involuntary users, where the purpose is to provide treatment, are reasonable and justifiable in an open and democratic society.

Chapter IV (Review Boards)

[73] The Minister cites a passage from *Ex parte G*, in which the Court said that the Review Board was "a new innovation and was aimed at ensuring that the cases of mental health care users are considered by an independent body which obviously makes vital decisions in regard to the user's future".[92] The Court found nothing wrong in the fact that the MEC appoints members to the Review Boards. As to the determination of remuneration and allowances, Makana fails to appreciate that this is "an objective process undertaken by Treasury using approved standard tools that measure the workload and level of decision-making". This happens with the concurrence of the Finance MEC. All statutory institutions need to be funded by the state.

[92] Id.

[74] What happened in Life Esidimeni was a dereliction of duty by the members of the Gauteng Review Board. This does not point to legislative defects. In *Van Rooyen*[93] this Court observed that any statutory power is capable of being abused. That possibility has no bearing on the constitutionality of the statute.[94]

Conclusion

[75] The Minister concludes by submitting that this Court should decline to confirm the High Court's declarations of constitutional invalidity; should uphold the Minister's appeal; and should award the Minister costs, including the costs of two counsel.

The WC MEC's submissions

Suspension and retrospectivity

[76] If this Court confirms the declarations of constitutional invalidity, the WC MEC submits that the declarations should not be retrospective and should be suspended for 24 months. On non-retrospectivity, the WC MEC argues that, if Parliament were to fail to remedy the constitutional defects during the period of suspension, the declaration of invalidity would come into force. Absent any qualification, the invalidity would have retrospective effect, thus rendering unlawful and invalid all steps taken in respect of involuntary users, and all decisions of the Review Boards, from when the Act came into force.

[77] Although suspension is no longer contentious, the MEC submits that we should dispel the uncertainty which the High Court's judgment has created about the competence of the High Court and Supreme Court of Appeal to suspend declarations of invalidity pending remedial legislation. This legal issue has practical ramifications beyond the confines of the present case. The MEC submits that the High Court's

[93] *S v Van Rooyen* [2002] ZACC 8; 2002 (5) SA 246 (CC); 2002 (8) BCLR 810 (CC).

[94] Id at para 37.

reasoning essentially copied a passage from this Court's judgment in *Prince*.[95] The MEC argues that the passage in *Prince* is a non-binding *obiter dictum* (something said in passing) which was more widely stated than was necessary for purposes of the dealing with the High Court's suspension order in that particular case. If the statement was not *obiter*, the MEC argues that we should overrule it.

The High Court's costs order against the WC MEC

[78] The High Court awarded costs against the WC MEC on the basis that her explanatory affidavit was supposedly unsolicited, irrelevant and useless. The WC MEC takes issue with this characterisation. However, in light of the conclusions I have reached on other issues, it is unnecessary to elaborate on the WC MEC's costs submissions.

The issues

[79] The issues for determination are the following:

(a) Do sections 33-4 of the MHC Act limit the rights of involuntary users guaranteed in sections 10, 12(1) and 34 of the Bill of Rights?

(b) If so, are the limits justified in terms of section 36 of the Bill of Rights?

(c) Is Chapter IV of the MHC Act constitutionally invalid for failing to provide adequate independence for the Review Boards?

(d) If the above questions are answered in favour of Makana, what just and equitable orders should this Court make in terms of section 172(1)(b), that is, in addition to confirming the High Court's declarations of invalidity?

(e) Was the High Court correct to find that it lacked competence to suspend its declarations of invalidity in terms of section 172(1)(b)?

(f) Did the High Court err in making the costs orders it did against the respondents?

(g) What is the appropriate costs order in this Court?

[95] *Minister of Justice and Constitutional Development v Prince; National Director of Public Prosecutions v Rubin; National Director of Public Prosecutions v Acton* [2018] ZACC 30; 2018 (6) SA 393 (CC); 2018 (10) BCLR 1220 (CC) (*Prince*).at para 2. The High Court in the present case did not cite *Prince.*

[80] Most of what follows addresses the questions arising under issue (a), with particular focus on section 12(1) of the Bill of Rights. It will be necessary to consider the scope of the fundamental rights in question and to analyse whether sections 33-4 of the Act limit those rights. Since we must have regard to international law when interpreting those fundamental rights, I shall, as a preliminary matter, deal with some of the relevant international instruments, before turning to a separate consideration of sections 12(1), 34 and 10 of the Bill of Rights. I treat the fundamental rights in that order because it reflects the relative emphasis placed on them in argument. Although the independence of the Review Boards has been the subject of a discrete challenge targeting Chapter IV of the Act, their independence is also a relevant consideration in assessing whether sections 12(1) and 34 of the Bill of Rights are limited by sections 33-4 of the Act. For this reason, the independence of the Review Boards is discussed both in relation to issue (a) and issue (c).

[81] If issue (a) is answered against Makana, issue (b) falls away. If issue (c) is also answered against Makana, the High Court's declarations of constitutional invalidity would not be confirmed, and issue (d) would then not arise, and issue (f) would also fall away. Issue (e) would become moot, but it might still be desirable and in the interests of justice to resolve the question. Whatever the outcome of the preceding questions, issue (g) will remain for determination.

International law

[82] Before addressing the constitutional challenges, I must set out the terms of international instruments which bear on the subject. International law is relevant for two reasons. First, and as I later explain, section 12(1) of the Constitution implicitly guarantees that a deprivation of liberty shall not take place without a fair procedure. In terms of section 39(1)(b) of the Constitution, we must consider international law in interpreting the Bill of Rights. In the context of the present case, that means that international law is relevant in determining the constitutional content of a fair procedure. Second, insofar as the provisions of the Act allow for more than one

interpretation, we are required by section 233 of the Constitution to prefer an interpretation that accords with international law.[96]

Universal Declaration (1948) and African Charter (1981)

[83] Foundationally, the Universal Declaration of Human Rights[97] (UDHR) states that everyone has the right to liberty and security of the person.[98] No one may be subjected to arbitrary arrest, detention or exile.[99] Everyone is entitled, in full equality, to a fair and public hearing by an independent and impartial tribunal in the determination of their rights and obligations.[100] The African Charter on Human and Peoples' Rights[101] (African Charter), which likewise affirms the right to liberty and security of the person, states that nobody may be deprived of freedom "except for reasons and conditions previously laid down by law". In particular, nobody may be "arbitrarily arrested and detained".[102]

International Covenant on Civil and Political Rights (1996)

[84] Article 9(1) of the International Covenant on Civil and Political Rights[103] (ICCPR) provides that no one shall be deprived of liberty "except on such grounds and in accordance with such procedure as are established by law". Articles 9(3) and 9(4)

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[96] Section 233 provides:

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

[97] Universal Declaration of Human Rights, 10 December 1948.

[98] Article 3.

[99] Article 9.

[100] Article 10.

[101] African Charter on Human and Peoples' Rights, 27 June 1981 (ratified by South Africa on 9 July 1996).

[102] Article 6. In *Purohit & Another v The Gambia* (2003) AHRLR 96 (ACHPR) at para 68, the African Commission on Human and Peoples' Rights found that The Gambia's legislation for the involuntary detention of the mentally ill fell short of international standards but that this did not violate Article 6, because that Article "was not intended to cater for situations where persons in need of medical assistance or help are institutionalised". Whatever the merits of this view may be in relation to Article 6 (on which I am sceptical), I would not apply the same narrow approach to our section 12(1)(a).

[103] International Covenant on Civil and Political Rights, 16 December 1996 (ratified by South Africa on 10 December 1998).

distinguish between detention on a criminal charge and detention on other grounds. In the former case, the person must be brought promptly before a judicial officer. In the latter case, the detainee must have the right to bring legal proceedings to challenge the detention. Article 10(1) states that all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

[85] In terms of Article 14, everyone "shall be equal before the courts and tribunals". In the determination of their rights and obligations in a suit at law, "everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law".

UN Mental Health Principles (1991)

[86] In 1991 the UN General Assembly adopted a resolution setting out principles for the protection of persons with mental illness and the improvement of mental health care (MHC Principles).[104] The MHC Principles include the following. No person shall be compelled to undergo a medical examination with a view to determining whether they have a mental illness "except in accordance with a procedure authorised by domestic law".[105] Patients have the right to be treated and cared for "as far as possible" in the communities where they live.[106] Patients have the right to be treated "in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others".[107] Treatment must be "directed towards preserving and enhancing personal autonomy".[108]

[104] UN General Assembly Resolution 46/119 *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, 17 December 1991.

[105] Principle 5.

[106] Principle 7.

[107] Principle 9.1.

[108] Principle 9.4.

[87] The MHC Principles distinguish between treatment without consent and involuntary admission. As to the former, treatment may be given without a patient's consent if the following conditions are met—

> "(a) the patient is, at the relevant time, held as an involuntary patient;
> (b) an independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and
> (c) the independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs."[109]

[88] Treatment may also be given to a patient without informed consent if a qualified mental health practitioner authorised by law determines "that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons". Such treatment shall not be prolonged beyond the period that is "strictly necessary for this purpose".[110]

[89] Where a patient is treated involuntarily, the patient or the patient's personal representative or any interested person must have the right to appeal the treatment decision "to a judicial or other independent authority".[111]

[90] In regard to involuntary admission or retention, the general principle is that every effort must be made to avoid it.[112] Involuntary admission or retention is nevertheless permissible if a "qualified mental health practitioner authorised by law for that purpose" determines that the person has a mental illness and considers—

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[109] Principle 11.6. The MHC Principles define "independent authority", at paragraph (b) of Principle 11.6, as "a competent and independent authority prescribed by domestic law".

[110] Principle 11.8.

[111] Principle 11.16.

[112] Principle 15.1.

> "(a) that, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
>
> (b) that, in the case of a person whose mental illness is severe and whose judgment is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative."

In the case of (b), a second authorised mental health practitioner, independent of the first, should be consulted where possible.[113]

[91] Involuntary admission must "initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body". The grounds of admission or retention must be communicated to the patient without delay and also to the review body, to the patient's personal representative, if any, and (unless the patient objects) to the patient's family.[114]

[92] The review body must be a "judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law". The body must have the assistance of at least one independent mental health practitioner, whose advice must be taken into account.[115] A review of the admission or retention decision must take place "as soon as possible" after the decision and must be conducted "in accordance with simple and expeditious procedures as specified by domestic law".[116] The review body must conduct periodic reviews at

[113] Principle 16.1. The MHC Principles define "mental health practitioner" as meaning "a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care".

[114] Principle 16.2.

[115] Principle 17.1.

[116] Principle 17.2.

reasonable intervals specified by domestic law.[117] The patient must also have the right to apply to the review body for release.[118] The patient or the patient's personal representative or any interested person must have the right "to appeal to a higher court" against a decision that the patient be admitted to or retained in a mental health facility.[119]

[93] In general, (that is, not only in cases of involuntary admission),a patient must be entitled to choose and appoint counsel to represent him or her, including in any complaint procedure or appeal. If the patient does not secure such services, counsel must be made available without payment if the patient lacks sufficient means.[120] The patient, the patient's personal representative and counsel shall be entitled to attend and participate in any hearing.[121]

General Comment 35 on Article 9 of ICCRP (2014)

[94] In December 2014 the UN's Human Rights Committee (HR Committee) issued a General Comment on Article 9 of the ICCRP (HRC Comment).[122] The HRC Comment records that Article 9 does not enumerate all the permissible reasons for deprivation of liberty. Other regimes involving deprivation of liberty "must . . . be established by law and must be accompanied by procedures that prevent arbitrary detention".[123]

[95] In paragraph 19, the HR Committee emphasises the harm inherent in any deprivation of liberty "and also the particular harms that may result in situations of involuntary hospitalization". State Parties should provide adequate community-based

[117] Principle 17.3.

[118] Principle 17.4.

[119] Principle 17.7.

[120] Principle 18.1.

[121] Principle 18.5.

[122] Human Rights Committee General Comment No 35: Article 9 (Liberty and security of person), 16 December 2014.

[123] Id at para 11.

or alternative social-care services as less restrictive alternatives to confinement. The HR Committee continues:

> "The existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual . . . . Deprivation of liberty must be re-evaluated at appropriate intervals with regard to its continuing necessity."

Convention on the Rights of Persons with Disabilities (2006)

[96] The preamble to the CRPD[124] recognises that "disability is an evolving concept" and the importance for persons with disabilities "of their individual autonomy and independence, including the freedom to make their own choices". In terms of Article 1, 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".

[97] In Article 12(2) the State Parties recognise that persons with disabilities "enjoy legal capacity on an equal basis with others in all aspects of life". Article 12(3) requires State Parties to take "appropriate measures to provide access by persons with disabilities to the support that they require in exercising their legal capacity". Article 12(4) provides:

> "State Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to

[124] Above n 1.

> the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests."

[98] In terms of Article 13(1), State Parties must ensure "effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations".

[99] Article 14 is headed "Liberty and security of person" and reads thus:

> "1. State Parties shall ensure that persons with disabilities, on an equal basis with others:
>
> (a) Enjoy the right to liberty and security of person;
>
> (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
>
> 2. State Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation."

Guidelines on Article 14 of CRPD (2015)

[100] The UN's Committee on the Rights of Persons with Disabilities (RPD Committee) has issued Guidelines on Article 14 (RPD Guidelines).[125] The RPD Guidelines state that Article 14 is in essence a non-discrimination provision.[126] The RPD Guidelines contain a number of potentially far-reaching statements.

[125] Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, September 2015.

[126] Para 4.

[101] According to the RPD Committee, it is incompatible with Article 14 to detain persons on the grounds of their actual or perceived impairment, even if there are other grounds, including that the persons are "deemed dangerous to themselves or to others".[127] Persons with "intellectual or psychosocial impairments" are often considered dangerous when they resist treatment. Like everyone else, persons with disabilities are not entitled to pose a danger to others: "Legal systems based on the rule of law have criminal and other laws in place to deal with those matters."[128] The freedom to make one's own choices, established in Article 3 of the CRPD, "includes the freedom to take risks and make mistakes on an equal basis with others".[129]

[102] Involuntary commitment of persons with disabilities on health care grounds "contradicts the absolute ban on deprivation of liberty on the basis of impairments", and the RPD Committee has repeatedly said that State Parties should repeal such provisions. Involuntary commitment in health facilities "carries with it the denial of the person's legal capacity to decide about care, treatment, and admission to a hospital or institution".[130] State Parties have an obligation "to obtain the free and informed consent of persons with disabilities prior to any treatment". State Parties must not "permit substitute decision-makers to provide consent on behalf of persons with disabilities".[131] Decisions about medical and psychiatric treatment "must be based on a determination of the person's autonomy, will and preferences".[132]

[103] The RPD Committee has called for State Parties to ensure that persons with disabilities are "not denied the right to exercise their legal capacity on the basis of a third party's analysis of their 'best interests'". State Parties should refrain from the

[127] Para 6. See also para 13.

[128] Para 14.

[129] Para 15.

[130] Para 10.

[131] Para 11.

[132] Para 15.

practice of "denying legal capacity of persons with disabilities and detaining them in institutions against their will, either without their consent or with the consent of a substitute decision-maker", as this is an arbitrary deprivation of liberty.[133] Instead, "practices associated with 'best interests' determinations should be replaced by the standard of 'best interpretation of the will and preferences' of the person".[134]

[104] Despite these statements, the RPD Guidelines also has provisions about the conditions of detention of persons with disabilities, including seclusion and physical restraints, and about the monitoring of detention facilities.

[105] The RPD Guidelines state that persons with disabilities who are "arbitrarily or unlawfully deprived of their liberty" are entitled to "have access to justice to review the lawfulness of their detention, and to obtain appropriate redress and reparation". They must be promptly told about, and given access to, "appropriate support to exercise their legal capacity with respect to proceedings related to" their detention. Persons detained in a psychiatric hospital or similar institution "must be informed about ways in which they can effectively and promptly secure their release".[135]

African Disability Rights Protocol (2018)

[106] In January 2018 the African Union's Heads of State adopted a disability rights protocol to the African Charter[136] (African Protocol). It has not yet received the 15 ratifications needed for it to come into force. It has provisions broadly similar to the CRPD. Article 9 provides that State Parties must take appropriate and effective measures to ensure that persons with disabilities, on an equal basis with others, enjoy the right to liberty and security of the person "and are not deprived of their liberty

[133] Para 8.

[134] Para 23.

[135] Para 24.

[136] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, 30 January 2018.

unlawfully or arbitrarily".[137] The existence of a disability or perceived disability "shall in no case justify deprivation of liberty".[138] In the context of the right to access justice, Article 13(1) of the African Protocol is closely modelled on Article 13(1) of the CRPD.

European Convention on Human Rights (1950, as amended)

[107] Article 5(1) of the European Convention on Human Rights[139] (the European Convention) provides that no one shall be deprived of liberty "save in the following cases and in accordance with a procedure prescribed by law". Six cases are then listed, one of which is "the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants".[140] Articles 5(3) and 5(4) of the European Convention draw the same distinction as is found in articles 9(3) and 9(4) of the ICCPR between the requirement of a prompt automatic judicial review where a person is arrested or detained on a criminal charge and the entitlement to take proceedings in other cases of arrest or detention.

[108] In the context of involuntary inpatient treatment, the Registry of the European Court of Human Rights (ECtHR) has, in its Guide on Article 5 (EUR Guide),[141] provided the following useful summary with reference to the Court's case law:

> "An individual cannot be deprived of his liberty as being of 'unsound mind' unless the following three minimum conditions are satisfied:
>
> - the individual must be reliably shown, by objective medical expertise, to be of unsound mind, unless emergency detention is required;

[137] Article 9.2(a).

[138] Article 9.5.

[139] European Convention on Human Rights, 4 November 1950, as amended by Protocols Nos 11, 14 and 15, and as supplemented by Protocols Nos 1, 4, 6, 7, 12, 13 and 16.

[140] Article 5.1(e).

[141] Registry of the European Court of Human Rights "Guide on Article 5 of the European Convention on Human Rights: Right to liberty and security" (as at 31 August 2022).

- the individual's mental disorder must be of a kind to warrant compulsory confinement. The deprivation of liberty must be shown to have been necessary in the circumstances;
- the mental disorder, verified by objective medical evidence, must persist throughout the period of detention.

. . .

No deprivation of liberty of a person considered to be of unsound mind may be deemed in conformity with Article 5 § 1 (e) of the Convention if it has been ordered without seeking the opinion of a medical expert.

. . .

As to the second of the above conditions, the detention of a mentally disordered person may be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons.

. . .

The deprivation of liberty under Article 5 § 1(e) . . . has a dual function: on the one hand, the social function of protection, and on the other a therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form of therapy or course of treatment.

Article 5 § 1 (e) of the Convention also affords procedural safeguards related to the judicial decisions authorising a person's involuntary hospitalisation. The notion of 'lawfulness' requires a fair and proper procedure offering the person concerned sufficient protection against arbitrary deprivation of liberty.
The proceedings leading to the involuntary placement of an individual in a psychiatric facility must thus provide effective guarantees against arbitrariness given the vulnerability of individuals suffering from mental disorders and the need to adduce very weighty reasons to justify any restriction of their rights.

It is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation. This implies that an individual confined in a psychiatric institution should, unless there are special circumstances, receive legal assistance in the

> proceedings relating to the continuation, suspension or termination of his confinement."[142] (Citations of authority omitted.)

Observations on international instruments

[109] The MHC Principles plainly influenced the formulation of our Act.[143] The ICCPR would also have been part of the international law background. The CRPD, on the other hand, was adopted after the Act came into force.

[110] The CRPD provides that persons with disabilities may not be deprived of their liberty "unlawfully or arbitrarily" and that any deprivation of liberty must be "in conformity with the law".[144] These provisions are consistent with the UDHR, African Charter, ICCPR and MHC Principles. The CRPD goes on to state, however, that "the existence of a disability shall in no case justify a deprivation of liberty".[145] If this means that the mere existence of a disability cannot on its own be a justification for a deprivation of liberty, it would be uncontroversial. If it means, however, that the existence of a disability cannot justify a deprivation of liberty even where, because of the disability (for present purposes, a mental illness), the person is likely to cause serious harm to themselves or others, it would be a radical proposition. There are statements in the RPD Guidelines suggesting that the CRPD does indeed impose an absolute prohibition of this kind. The RPD Guidelines have been described by a New Zealand court as "controversial" and at odds with the HRC Comment I quoted earlier.[146]

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[142] Id at paras 117, 119, 120, 130, 131 and 132.

[143] See Freeman "New Mental Health Legislation in South Africa – Principles and Practicalities: A view from the Department of Health" (2002) 5(3) South African Psychiatry Review 4 at 5 who notes that two other influential instruments were the World Health Organisation's *Guidelines for the Promotion of Human Rights of Persons with Mental Disorders* 1996 and *Mental Health Law: Ten Basic Principles* 1996. See also McCrea "An Analysis of South Africa's Mental Health Legislation" *The National Law Review* (21 October 2010), available at https://www.natlawreview.com/article/analysis-south-africa-s-mental-health-legislation.

[144] CRPD above n 1 at Article 14(1)(b).

[145] Id.

[146] *M (CA677/2017) v Attorney-General (in respect of the Ministry of Health)* [2020] NZCA 311 at para 114. The RPD Guidelines on Article 14 repeat propositions set out 18 months earlier in the RPD Committee's *General Comment No 1: Article 12 – Equal recognition before the law*, April 2014. For a lively debate in South African journals on the RPD Committee's views about legal capacity and the implications of these views for (among other

[111] The RPD Guidelines envisage that a person whose decision-making ability is impaired may receive "support" in the exercise of their legal capacity, provided this is done in a way that respects the rights, and attempts to interpret the will and preferences, of the person.[147] The RPD Guidelines are unclear, however, on what is to be done where the person's mental disorder is so great that there is no reliable way of gauging the person's will and preferences.[148] Despite the categoric language of the RPD Guidelines, I have not come across any modern legal system which does not have a regime for involuntary inpatient treatment of mentally ill persons.[149] It is, however, unnecessary to further pursue this aspect of the interpretation of Article 14(1)(b) of the CRPD, because Makana's attack on the Act is not about the justifiability of involuntary inpatient detention as such but about the way in which it is done.

The merits of the constitutional challenges

[112] Makana's attacks on Chapter IV and on sections 33 and 34 cannot be considered separately from each other. The Review Boards play an important role in the regime for involuntary inpatient treatment. The adequacy of the regime, in particular the absence of earlier judicial involvement, may depend on whether the Review Boards are

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things) involuntary treatment, see Freeman et al "Reversing Hard Won Victories in the Name of Human Rights: A critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities" 2015 *Lancet Psychiatry* 1 and David Bilchitz "Dignity, Fundamental Rights and Legal Capacity: Moving beyond the paradigm set by the General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities" (2016) 32 *South African Journal on Human Rights* 410, both of which are critical of the RPD Committee's approach, and Dhanda "From Duality to Indivisibility: Mental health care and human rights" (2016) 32 *South African Journal on Human Rights* 438, which criticises Freeman et al, embraces the RPD Committee's ideas and argues for a paradigm shift in our thinking on these matters. Freeman et al question the absence of medical representation on the RPD Committee and cite material suggesting that many State Parties did not agree with the approach the Committee intended taking in its General Comment on Article 12.

[147] RPD Guidelines above n 125 at paras 15, 23 and 24.

[148] See, on this, Bartlett above n 2, who observes that the "big issue" which the CRPD leaves largely unexplained is "how the shift to a pure supported decision-making structure will work in practice" and how to deal with cases where the "intensity of support" which the person needs is so great as to raise fundamental questions about whether the decision is that of the person or of the supporter; and Bilchitz above n 146, who criticises the RPD Committee for ignoring reality by "assum[ing] through some kind of definitional fiat that *all* individuals are capable of a certain level of autonomy to make decisions about their lives" (at 411, emphasis in the original).

[149] Directly or through recent literature, I have considered the position in the United Kingdom; all the provinces and states of Canada, the United States and Australia; New Zealand, Germany, France, Spain, Ghana, Kenya and Zambia. See also the survey of 20 European countries summarised in *Stanev v Bulgaria* [2012] ECHR 46; (2012) 55 EHRR 22 at paras 91-5.

sufficiently independent. In written argument, Makana also submitted that the prompt automatic independent review for which it argues could be done by a Review Board, provided the Review Board was properly independent and provided the review happened sooner than is currently the case. Although Review Boards deal with other matters as well, their independence comes into sharpest focus in relation to involuntary inpatient treatment, since it entails a deprivation of liberty. I shall thus consider the Review Boards' independence as part of the assessment of the constitutionality of sections 33 and 34. I shall deal with residual aspects of the Review Boards' independence at the end of the judgment.

Section 12(1) of the Constitution

[113] In terms of section 12(1) of the Constitution, everyone has the right to "freedom and security of the person". This fundamental right includes the right "not to be deprived of freedom arbitrarily or without just cause" (section 12(1)(a)) and the right "not to be detained without trial" (section 12(1)(b)).

[114] Involuntary inpatient treatment is a deprivation of freedom for purposes of section 12(1)(a).[150] The user is not free to leave the health establishment. The health establishment, if it is a psychiatric hospital, must "*keep*, care for, treat and rehabilitate" the user pending the Review Board's decision; and if the establishment is not a psychiatric hospital, the user must be transferred to a psychiatric hospital.[151] If the user absconds, the head may call on the police to apprehend the user.[152] Where the user absconds or tries to abscond, the head may submit a request to the Review Board

[150] Compare *De Vos* above n 71 at para 22, citing *HL v The United Kingdom* [2004] ECHR 720; [2005] 40 EHRR 32 (*HL*). *De Vos* dealt with detention in terms of section 77(6)(a) of the Criminal Procedure Act read with sections 37 and 47 respectively of the Mental Health Care Act. *HL* dealt with the inpatient treatment of persons who, in terms of our Act, would be classified as assisted patients, that is, patients lacking capacity to make an informed decision but who do not resist treatment. The inpatient treatment of involuntary users is an *a fortiori* case of deprivation of liberty.

[151] Section 34(4)(a) of the Act (emphasis added).

[152] Id section 40(4).

for an order transferring the user to a health establishment with maximum security facilities.[153]

[115] The right conferred by section 12(1)(a) has a substantive and a procedural component. Substantively, the right not to be deprived of freedom "arbitrarily or without just cause" means that there must be an acceptable reason for the deprivation. Procedurally, there is an implicit right not to be deprived of freedom except by a fair process.[154] Because these substantive and procedural components are part of the definition of the right, a litigant who challenges legislation on the basis that it limits the right must show that the statute permits a deprivation of freedom without acceptable reason or without a fair process. If the challenger shows this, it is for the state respondent to justify the limitation in terms of section 36 of the Constitution.

[116] Although Makana alleged that involuntary inpatient treatment violated section 12(1)(b) as well, it did not argue that the "without trial" component of section 12(1)(b) added anything to the guarantee of procedural fairness implicit in section 12(1)(a). This Court has not finally settled the precise ambit of the prohibition against "detention without trial", in particular whether it is confined to detention for political ends.[155] Whatever the prohibition's ambit, involuntary inpatient treatment at a hospital cannot aptly described as "detention without trial". But if the wider meaning were preferred, "trial" should then be interpreted as requiring not a conventional trial before a court but a fair process such as is in any event implicit in section 12(1)(a).

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[153] Id section 39(1).

[154] *Mahlangu v Minister of Labour* [2020] ZACC 24; 2021 (2) SA 54 (CC); 2021 (1) BCLR 1 (CC) at para 28. See also *De Lange* above n 74 at paras 22-3, 120 and 143, *S v Boesak* [2000] ZACC 25; 2001 (1) SA 912 (CC); 2001 (1) BCLR 36 (CC) at para 37, *Zealand v Minister for Justice and Constitutional Development* [2008] ZACC 3; 2008 (4) SA 458 (CC); 2008 (6) BCLR 601 (CC) at para 33, *Malachi v Cape Dance Academy International (Pty) Ltd* [2010] ZACC 13; 2010 (6) SA 1 (CC); 2010 (11) BCLR 1116 (CC) at para 25 and *De Vos* above n 71 at paras 25-7.

[155] In *De Lange*, above n 74, there was a difference of opinion as to whether the expression should be given a wide or narrow meaning. Four members of the Court (in accordance with Ackermann J's judgment) gave the guarantee against detention without trial in section 12(1)(b) the same wide meaning it had received in the interim Constitution. Another four members of the Court said that detention without trial should be confined to detention of the kind that was notorious under the apartheid regime – detention designed to suppress resistance to the government. O'Regan J expressed no opinion on this issue. There was thus no majority in favour of either view.

The substantive component of section 12(1)(a)

[117] The Act permits involuntary treatment on the substantive grounds specified in section 32, which I summarised earlier.[156] Makana has not challenged the constitutionality of that section. Those grounds may thus for present purposes be regarded as acceptable reasons for involuntary treatment. They accord broadly with grounds for involuntary inpatient treatment in other countries.

[118] I should emphasise that, unlike the position in some countries, involuntary inpatient treatment in South Africa cannot be given merely because a user is likely to inflict harm on themselves or others or because treatment would be in their best interests. It is also necessary that the user be incapable of making an informed decision about the need for treatment. To this extent, user autonomy is respected. Where users are incapable of making an informed decision, it would often be reasonable to infer that if they were not incapacitated they would want to be treated and protected against causing harm to themselves or others. Such users might prefer to be treated at home but that can only happen if the family is willing and able to do so. Generally, an application for involuntary inpatient admission is made by a family member precisely because they are unable or unwilling to carry the burden of caring for the user.

The procedural component of section 12(1)(a)

The flexible concept of fair process

[119] Whether a process is fair depends on the nature and purpose of the deprivation of liberty. This view is supported by this Court's jurisprudence. *Nel*[157] dealt with the imprisonment of recalcitrant witnesses in terms of section 189(1) read with section 205 of the Criminal Procedure Act.[158] The relevant fundamental right was section 11(1) of the interim Constitution, which provided that every person shall have the right to

[156] See [25] above.

[157] Above n 75.

[158] 51 of 1977.

freedom and security of the person, "which shall include the right not to be detained without trial". The interim Constitution did not have the equivalent of section 12(1)(a) of the current Constitution, so the right "not to be detained without trial" had to do more work than its equivalent in the current Constitution. The Court refrained from laying down a rigid rule. The right not to be detained without trial would "not . . . in all circumstances" require a procedure duplicating the safeguards applicable at an accused person's trial, although "[i]n most cases" constitutionally compliant detention would require "the interposition of an impartial entity, independent of the executive and the legislature to act as arbiter between the individual and the state".[159]

[120] In similar vein, O'Regan J in her concurring judgment in *Bernstein*[160] said that "the nature of the fair process required in each case will depend on a variety of factors, including the ground upon which the deprivation of freedom is based".[161]

[121] In *Coetzee*,[162] decided under the interim Constitution, the Court was dealing with imprisonment for debt in terms of the Magistrates' Courts Act.[163] In his concurring judgment, Langa J emphasised the harshness of imprisonment as a punishment, its demoralising effect on the offender, and the deleterious effects of penal institutions.[164]

[122] *De Lange*,[165] decided under the current Constitution, also dealt with the coercive imprisonment of recalcitrant witnesses, in that case in terms of section 66(3) of the Insolvency Act.[166] There was considerable divergence among the members of the Court

[159] *Nel* above n 75 at para 14.

[160] *Bernstein v Bester NO* [1996] ZACC 2; 1996 (2) SA 751 (CC); 1996 (4) BCLR 449 (CC).

[161] Id at para 146.

[162] *Coetzee v Government of the Republic of South Africa, Matiso v Commanding Officer Port Elizabeth Prison* [1995] ZACC 7; 1995 (4) SA 631 (CC); 1995 (10) BCLR 1382 (CC).

[163] 32 of 1944.

[164] *Coetzee* above n 162 at para 33.

[165] Above n 74.

[166] 24 of 1936.

both on outcome and reasoning.[167] What weighed with all seven Justices who found section 66(3) to be unconstitutional was that the power of detention under consideration was a power to send a person to prison indefinitely for coercive purposes. Ackermann J, emphasising the separation of powers, said that "the power to commit an uncooperative witness to prison" was "within the very heartland of the judicial power and thus could not be exercised by non-judicial officers.[168] Although committal to prison under section 66(3) was not incarceration following upon a criminal conviction, it was, from the perspective of the imprisoned person, analogous.[169] He acknowledged that in other settings the interposition of a judicial officer before detention occurs might make the achievement of important and legitimate government goals impossible to achieve. He referred to the fact that, in the European Convention, certain forms of detention are excluded from the right to liberty and security of the person, including those based on health considerations.[170]

[123] Sachs J, who also focused on the separation of powers, considered that only judicial officers should have the power to send people to prison.[171] He confined this proposition to imprisonment "as a penalty to mark State reprobation".[172] It was not uncommon in democratic States for custodial powers to be conferred initially on persons who are not judicial officers where the purpose was not punishment but, for

[167] *De Lange* above n 74. Two members of the Court (Didcott J, with Kriegler J concurring) would have declined to hold section 66(3) of the Insolvency Act unconstitutional at all. Five members of the Court (Ackermann J, in whose judgment three members of the Court concurred, and Sachs J in a separate judgment) found section 66(3) unconstitutional only to the extent that it permitted a presiding officer who was not a Magistrate to imprison a recalcitrant witness. The other two members of the Court (Mokgoro J and O'Regan J in separate judgments) would have found section 66(3) unconstitutional even where the presiding officer at a creditors' meeting was a Magistrate.

Four members of the Court (in accordance with Ackermann J's judgment) gave the guarantee against detention without trial in section 12(1)(b) the same wide meaning it had received in the interim Constitution, and they thus considered that right to be implicated by section 66(3). Another four members of the Court said that detention without trial should be confined to detention of the kind that was notorious under the apartheid regime – detention designed to suppress resistance to the government. O'Regan J expressed no opinion on this issue.

[168] Id at paras 60-1.

[169] Id at para 74.

[170] Id at paras 100-1, read with fn 131 and para 45.

[171] Id at paras 174-5.

[172] Id at para 176.

example, immigration control "or dealing with severe health risks". In those cases, detention was "neither punishment for past defiance nor compulsion for future compliance but simply the only reasonable way in which a non-punitive objective of pressing public concern can be achieved". The authority to incarcerate for purposes of imposing penalties for past or continuing misconduct, by contrast, belonged to the judiciary alone.[173]

[124] Mokgoro J said that in terms of section 66(3) a person could be confined to prison in circumstances where the "usual safeguards that imprisonment would demand are not afforded to the examinee". The imprisonment could be for an indeterminate period. There was no process of automatic review. Imprisonment occurred in a summary fashion where there was inadequate time for preparation. There was no constitutional right to legal representation at state expense, "notwithstanding the fact that the imprisonment, something ordinarily reserved for criminal sanction, occurs".[174]

[125] O'Regan J emphasised, as she had done in *Bernstein*, that there was no rigid rule on the procedural safeguards required by section 12(1). That would "depend on the nature of the deprivation and its purpose".[175] The purpose of the power conferred by section 66(3) was to imprison the witness indefinitely until they comply. Indefinite imprisonment for coercive purposes could involve a significant inroad upon personal liberty.[176] A review of our own statutes and foreign jurisdictions showed that it was extremely rare for agencies exercising non-judicial functions (such as the presiding officer at a creditors' meeting) to be granted summary powers of imprisonment to coerce information from unwilling witnesses.[177] Like imprisonment for punitive purposes, indefinite imprisonment for coercive purposes was a form of detention

[173] Id.

[174] Id at para 133.

[175] Id at para 143.

[176] Id at para 147.

[177] Id at para 150 read with the review at paras 151-7.

requiring "thorough procedural safeguards".[178] It should only be imposed by a court of law or an independent and impartial institution of a similar character.[179]

[126] The distinction between detention in a hospital and in a prison was also drawn in *De Vos*.[180] Section 77(6)(a)(i) of the Criminal Procedure Act specified what a court was to do with an accused person who lacked mental capacity to stand trial but had probably committed a serious offence. The person was to be detained in a psychiatric hospital or a prison pending the decision of a Judge in terms of section 47 of the Mental Health Care Act. This Court held that the section was acceptable in relation to hospitalisation but not in relation to imprisonment. The primary purpose of keeping a person in hospital pending a decision in terms of section 47 was the provision of therapeutic treatment. Prisons lacked facilities to provide appropriate treatment. Accused persons with mental illnesses and intellectual disabilities had been historically disadvantaged and unfairly discriminated against. Keeping them in a prison "perpetuates hurtful and dangerous stereotypes", impairs their dignity and "reinforces the stigma and marginalisation that [they] are subjected to on a routine basis".[181]

[127] *Lawyers for Human Rights*[182] concerned the detention of illegal foreigners in terms of sections 34(1) of the Immigration Act.[183] That section empowered an administrative official to arrest and detain an illegal foreigner pending deportation. The power was not subject to objectively determinable conditions or guidelines for its exercise. The arrest and detention was said by this Court to depend entirely on the whim of an immigration officer. The Court concluded that the guarantee in section 12(1)(b) of the Constitution against detention without trial, and the right of a detainee in terms of section 35(2)(d) of the Constitution to challenge the lawfulness of the detention in

[178] Id at para 158.

[179] Id at para 162.

[180] Above n 71.

[181] Id at para 46.

[182] Above n 76.

[183] 13 of 2002.

court, were implicated. It was in this context that the Court found there to be a need for automatic judicial review. It did not suffice that the illegal foreigner could request an immigration officer to have the detention confirmed by a court warrant or that the detention could only be extended beyond 30 days by a court order. The detainee had no right to appear in court on either occasion. The immigration officer decided what information would be placed before the court if a warrant was requested. *Lawyers for Human Rights*, which concerned administrative detention based on wrongdoing (unlawful presence in South Africa), is not authority for the proposition that a fair process for involuntary inpatient treatment requires immediate and automatic judicial oversight.

[128] I have alluded to the distinction drawn in Articles 9(3) and (4) of the ICCPR and Articles 5(3) and (4) of the European Convention between the requirement of automatic judicial oversight in the case of arrest on a criminal charge and the requirement, in other cases, that the detained person should have a right to take legal proceedings. The European jurisprudence on involuntary inpatient treatment does not require there to be automatic judicial oversight. In *X v United Kingdom*,[184] decided with reference to England's Mental Health Act of 1959, the ECtHR acknowledged that the availability of the English remedy of habeas corpus might, in certain contexts, be sufficient compliance with Article 5(4) of the European Convention. In the context of *X v United Kingdom*, however, it was not an adequate remedy because the detention power involved a subjective discretion by the Home Secretary.[185] Although the patient's case could be assessed by a Mental Health Review Tribunal (MHRT), and although an MHRT could be regarded as a "court" for purposes of Article 5(4), the Secretary of State was not obliged to give effect to the MHRT's advice, so the MHRT remedy was also inadequate.[186]

[184] *X v United Kingdom* [1981] ECHR 6; (1982) 4 EHRR 188. This case concerned a decision by the Home Secretary to recall a conditionally released patient to a secure facility because the patient was displaying renewed symptoms of mental illness. The patient had earlier been hospitalised after being charged with a serious crime.

[185] Id at paras 57-8.

[186] Id at para 61.

[129] *MH v Secretary of State*[187] concerned England's Mental Health Act of 1983 in the context of a patient who lacked capacity to bring legal proceedings. At issue was the alleged lack of a suitable remedy to secure the patient's release (a) during the initial 28-day period for assessment under which she was detained; (b) during the extended period from the expiry of the 28 days until the County Court decided an application by the authorities to displace the mother as the patient's "nearest relative". The House of Lords rejected the challenges. Lady Hale said that the distinction between automatic judicial oversight in terms of Article 5(3) and elective legal proceedings in terms of Article 5(4) was deliberate. The question was whether, in terms of Article 5(4), an elective remedy sufficed for patients who lacked capacity to initiate court proceedings.[188] According to Lady Hale, there were no Strasbourg cases which implied a requirement of judicial review in cases where patients are unable to make their own applications. There were many circumstances apart from lack of capacity which might hinder a person in bringing judicial proceedings; there was no warrant for singling out lack of capacity for special treatment.[189] If the patient truly lacked capacity to apply to the MHRT, the family would have standing to bring proceedings for judicial review or habeas corpus. Better still was their right to ask the Secretary of State to refer the case

[187] *MH v Secretary of State for the Department of Health* [2005] UKHL 60; [2006] 1 AC 441. In *MH v Secretary of State* the patient was involuntarily detained in hospital against her mother's wishes. This was in terms of section 2, which authorised an initial 28 days of detention for assessment. During the first 14 days, the patient (but not her nearest relative) could bring an application for release to the MHRT. Because the patient lacked legal capacity, she could not bring such an application. The mother, as the "nearest relative", had the right in terms of section 23 to issue a written order for the release of the patient. Such release could, however, be blocked by the responsible clinician issuing a report in terms of section 25 to the effect that the patient, if discharged, would be likely to act in a manner dangerous to others or herself. When the mother issued an order for the patient's release, she was met by a blocking report. A further complication arose when, towards the end of the 28-day period, the authorities brought an application in terms of section 29 to displace the mother as the "nearest relative". This had the effect of extending the initial period of detention until the County Court decided the displacement application. The primary issues in the case concerned the allegedly inadequate remedies available to secure the patient's release (a) in terms of section 2, during the initial 28-day period; (b) in terms of section 29, during the period from the expiry of the 28 days until the County Court decided the displacement application. The mother, as the nearest relative, had no statutory right, during these periods of detention, to bring an application to the MHRT. Such a right only existed once the patient had been admitted for treatment in terms of section 3.

[188] Id at para 22.

[189] Id at para 24.

to the MHRT in terms of section 67 of the Act. The Secretary of State would have to exercise that power compatibly with the European Convention.[190]

[130] When the case reached the ECtHR as *MH v United Kingdom*,[191] that Court said that the remedy guaranteed by Article 5(4) had to be accessible.[192] The ECtHR accepted that, in the case of a patient with legal capacity, the right to apply to the MHRT during the first 14 days of the 28-day period of initial detention would satisfy the requirement of Article 5(4).[193] Special safeguards were needed, however, where the patient lacked capacity to bring such an application. Although automatic judicial review was one possible mechanism, it was not necessarily the only one.[194] The remedy of habeas corpus was capable of constituting an adequate remedy.[195] However, the scheme of the English Act made an application to the MHRT the natural and obvious way of taking Article 5(4)-type proceedings, and it was unreasonable instead to expect the patient or her mother to have to take habeas corpus proceedings. The patient, however, lacked capacity to bring an application to the MHRT and the statute did not allow the mother, as her "nearest relative", to do so. So neither the patient nor the mother could avail themselves of the normal remedy granted by the Act.[196] Article 5(4) was thus violated.

[131] In regard to the extended initial detention in consequence of the pending displacement application in the County Court, the ECtHR said that, pursuant to a referral of the matter to the MHRT by the Secretary of State in terms of section 67, the patient's case had been heard by the MHRT about 30 days after the expiry of the initial detention. This was not an unreasonably long period to have been without judicial

[190] Id at para 27 and paras 29-32.

[191] *MH v United Kingdom* (2014) 58 EHRR 35; [2013] ECHR 1008.

[192] Id at para 76.

[193] Id at para 80.

[194] Id at para 82.

[195] Id at para 83.

[196] Id at paras 84-6.

control, so the patient had not been deprived of a speedy remedy as contemplated by Article 5(4).[197]

[132] The effect of these judgments is that, in the case of patients lacking capacity to initiate legal proceedings, the right of a nearest relative to make an application to a tribunal such as the MHRT is an adequate safeguard. Compliance with Article 9(4) of the ICCPR does not require an upfront automatic review either by a court or a tribunal. In England, the first automatic review by the MHRT takes place only six months after admission, and there is no automatic review by a court.

[133] Our law goes further in protecting a user's rights than the legislation considered in *X v United Kingdom* and *MH v Secretary of State*. First, in terms of our Act, the range of persons who may apply to the Review Board is much wider than the English "nearest relative". Second, those persons have an unfettered right to apply to the Review Board during the first 30 days following involuntary admission. Third, even if a family member or associate does not bring an application to the Review Board, involuntary inpatient treatment cannot be extended after the 72-hour assessment except on the authority of the Review Board, though of course the user will be involuntarily detained until the Review Board decides the case. So there is an automatic review process not later than about 30 days from the completion of the 72-hour review. Fourth, within another 30 days there is an automatic review by a Judge.

[134] Fifth, the Act does not take away ordinary judicial remedies, such as applications for declaratory orders, interdicts and review in terms of the Promotion of Administrative Justice Act[198] (PAJA). The grounds on which a user may be involuntarily admitted, as set out in sections 9(1)(c) and 32 of the Act, appear to be objectively justiciable. Our approach to constitutional standing is generous (an interested party could bring an application for the benefit of the user), as are the

[197] Id at paras 91 and 96.

[198] 3 of 2000.

grounds of PAJA review. Ordinary judicial proceedings in this country would not, therefore, suffer from the shortcomings of the habeas corpus procedure discussed in *X v United Kingdom*.

Involuntary treatment contrasted with penal/coercive imprisonment

[135] The deprivation of liberty that occurs when a user is subjected to involuntary inpatient treatment is different from penal or coercive detention in important respects:

(a) First, the grounds for deprivation do not lie in past events but in the user's current mental health status.

(b) Second, the user's mental health status is typically not static; it may get better or worse depending on the nature and course of the mental illness and the treatment provided.[199]

(c) Third, determining a user's mental health status is a matter for expert assessment. It is not something a judicial officer can reliably do without extensive expert assistance.

(d) Fourth, the detention takes place at a health establishment, not a prison.

(e) Finally, the object of the process is not detention as such but treatment. The deprivation of liberty is a necessary precondition for providing the treatment.

[136] These differentiating features lead me to conclude that the most effective procedural safeguards against unjustified involuntary inpatient treatment are those aimed at ensuring that the user's evolving condition is assessed over an appropriate period of time by multiple experts and responsible officials in proximity to the user. The more people involved in the assessment, the less the risk of a mistaken assessment. Proximity and expertise improve reliability.

[199] Compare *MB v Poland* [2021] ECHR 827, CE:ECHR:2021:1014JUD006015715 at para 63: "[T]he existence of a mental disorder warranting compulsory confinement must be reliably shown at the date of detention and throughout the detention, especially given the marked tendency of mental disorders to develop over time". In *MH v Secretary of State* above n 187 Lady Hale, at para 17, spoke of "the inherent changeability of mental disorders".

The Act's procedural safeguards

[137] The Act, in my view, contains effective procedural safeguards of this kind. I shall not repeat the statutory steps and intervening appeal right summarised earlier.[200] By the end of step 5,[201] the user will have been examined by at least two, and often by four, MHC practitioners, and the user's status will, on the strength of these practitioners' reports, have been assessed by a head on two separate occasions, three to five days apart.

[138] In regard to assessments by MHC practitioners, Makana is troubled by the inclusion, in the definition of "mental health care practitioner", of social workers and occupational therapists. I do not think the concern is justified. First, the inclusion is subject to the rider that the person must have been trained to provide prescribed mental health care, treatment and rehabilitation services. Second, MHC practitioners are not only involved in examination, diagnosis and medical treatment. Social workers and occupational therapists are likely to play an important part in other forms of therapy and care. South Africa is not alone in valuing the contribution of these professionals in mental health care.[202]

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[200] See [27] to [41] above.

[201] See [32] above.

[202] The MHC Principles above n 104 define "mental health practitioner" as meaning "a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care".

For the position in England, see Hinchliffe "Compulsory Mental Health Treatment: When should judges get involved?", speech delivered on 26 August 2017 (available at https://www.judiciary.uk/wp-content/uploads/2017/08/judge-mark-hinchliffe-compulsory-mental-health-treatment-hong-kong-20170829.pdf) at 6:

> "On the ground, AMHPs [Approved Mental Health Professionals] are approved by local social services authorities, and they include social workers, nurses, occupational therapists and psychologists. Medical practitioners, however, are expressly excluded as AMHPs – so that there will always be a mix of professional perspectives at the point when a decision is made regarding a patient's detention. And even though all the personnel involved may be employed by the same organisation (e.g. the National Health Service Trust) the skills and training required of AMHPs ensures that they provide an independent social perspective."

Judge Mark Hinchliffe is the Deputy Chamber President of the Health, Education and Social Care Chamber, First-tier Tribunal, with responsibility for the mental health jurisdiction, and a Judge of the Upper Tribunal (Administrative Appeals Chamber). In England, though not in Wales, this Chamber of the First-tier Tribunal has taken over the functions formerly performed by the Mental Health Review Tribunal.

In the State of Victoria, Australia, the Mental Health Act of 2014 defines "mental health practitioner" as meaning a registered psychologist, registered nurse, social worker or registered occupational therapist.

[139] Third, and most importantly, the various categories of MHC practitioners can only be deployed to do things within their fields of expertise. Section 6(1) requires a health establishment to provide users with "the appropriate level of mental health care, treatment and rehabilitation services within its professional scope of practice". If the establishment is unable to do so, it must refer the user to another suitable establishment. Assuming that social workers and occupational therapists are not qualified to assess a person's mental health status, it would be impermissible for them to be part of the initial or the 72-hour assessment.[203]

[140] In the initial assessment (step 2),[204] at least one of the practitioners must be a person qualified to conduct physical examinations. We do not have evidence about qualifications to conduct physical examinations. Given the purpose of physical examination in this setting, the statutory requirement should be interpreted to mean that the person must be qualified to conduct physical examinations for the purpose of assessing a person's mental health status. On the assumption that social workers and occupational therapists are not relevantly qualified, one of the initial practitioners must be a medical doctor or a psychiatric nurse or perhaps a psychologist. In the 72-hour assessment (step 4),[205] at least one of the two practitioners must be a medical doctor. And for reasons I have just explained, the other MHC practitioner would have to be a person relevantly qualified to assess a user's mental health status.

[141] Although the head (who is the decision-maker in steps 3 and 5)[206] does not have to be a medical doctor, he or she is unlikely to be in a senior position without some experience and a proper sense of responsibility in evaluating a user's need for

[203] It is thus necessarily implicit that if an application is made to an establishment which does not have suitably qualified professionals to conduct the assessments, the application will have to be redirected to another establishment. Regulation 10(b) of the Regulations gives effect to this necessary implication. It states that a health establishment that is unable to provide an examination contemplated in section 33(4) of the Act must refer an applicant to a health establishment within the closest proximity that provides that examination.

[204] See [29] above.

[205] See [31] above.

[206] See [30] and [32] above.

involuntary treatment.[207] If the health establishment to which the application was made is not equipped to treat the user, the user may have been transferred to another health establishment for purposes of the 72-hour assessment and further treatment,[208] in which case a second head would be involved in making the decision in step 5. It is also relevant to note that the head is not the final decision-maker on involuntary detention. At stage 3, the head merely decides that the user should be admitted for a 72-hour assessment. At stage 5, the head must form an opinion on involuntary inpatient treatment but his or her role is not to authorise this but to ask the Review Board to do so.

[142] If step 6 is reached,[209] the user's case receives the attention of the Review Board, consisting of at least a MHC practitioner, a lawyer and a community member. The MHC practitioner cannot be employed at the establishment from which the request comes. The members of the board must not only consider the assessments done at the earlier stages; they have investigative powers – they can interview the applicant, the user, the practitioners and the head.

[143] It is only in step 7,[210] after the user's case has been assessed by various practitioners and other persons in reasonable proximity to the user, that a Judge becomes involved. In many cases, the matter will never reach a Judge, because there will have been a sufficient improvement in the user's condition to enable the user to be discharged or reclassified. Statistics supplied by the Minister for the years 2019-2021 reflect that only 40% of involuntary applications reached the stage of the Review Boards and only 23% came before Judges.[211] The medical reports that serve before the Judge do not

[207] Regulation 3(1) of the Regulations provides that when the head makes a decision in terms of the Regulations that falls outside his or her scope of professional practice, he or she must act "after consultation with the mental health care practitioner that conducted the assessment or any other mental health care practitioner".

[208] Section 33(9)(b) of the Act.

[209] See [33] to [34] above.

[210] See [35] above.

[211] According to the statistics, there were 154 389 involuntary applications in 2019, 2020 and 2021. Of these applications, 61 027 served before Review Boards and 35 583 before Judges. In *P.S. v Ontario* 2014 ONCA 900 (CanLII); 379 DLR (4th) 191 at para 26, the Court noted that provincial statistics for Ontario in the period 2009-

typically contain enough information to allow the Judge to second-guess the assessment of the MHC practitioners. This is, again, reflected in the statistics furnished by the Minister: in the years 2019-2021, Judges rejected involuntary applications in only 0.1% of cases, and in seven of the nine provinces there were no rejections at all.[212]

The value of judicial involvement

[144] Despite the minimal level of judicial interference, judicial involvement serves important purposes. First, the fact that a Judge will eventually see the papers plays a part in ensuring that the persons involved at the earlier stages do their jobs properly. Second, the Judge provides a safety net for those rare cases where, despite the earlier safeguards, involuntary treatment turns out not to have been justified.[213]

[145] It is unclear whether Makana contends that a judicial officer (or other independent body) should be involved at both the initial and the final stages. Judicial involvement at both stages would substantially increase Judges' work load. According to the Minister's statistics, Judges have to deal with about 11 900 involuntary applications annually. If they also had to deal upfront with all the applications made to health establishments, this would add more than 51 000 cases to the annual workload. At the early stage, information would be incomplete and thus inadequate to enable the Judge to make an informed decision. Since many involuntary users are discharged or reclassified within the first couple of weeks of admission, there seems little justification

2010 indicated that 34% of patients involuntarily committed were in hospital for less than a week, 80% for less than a month and 98% for less than six months. A recent review of involuntary commitment in the United States noted that "[i]n practice, most people are discharged at early stages without reaching judicial review or after a relatively short period of hospitalization" – see the report by Dailey et al "Grading the States: An analysis of U.S. psychiatric laws" *Treatment Advocacy Centre* (September 2020), available at https://www.treatmentadvocacycenter.org/grading-the-states, at 10.

[212] Of the 35 583 cases which served before Judges over the three years in question, only 40 were "rejected". All the "rejections" occurred in KwaZulu-Natal (14) and the Western Cape (24). The statistics do not indicate whether the applications were rejected on substantive or procedural grounds. The 40 "rejected" applications represent only 0.02% of the 154 389 applications made to health establishments.

[213] I should emphasise that the statistics do not allow us to conclude that the 40 "rejected" applications were all cases where the users should not have been subjected to involuntary treatment. Applications may have been rejected on procedural grounds; or the user's condition might have improved by the time the Judge made his or her investigations; or the Judge's rejection may perhaps not have been justified.

for early judicial involvement and little reason to believe that it would have any material effect on the number of involuntary admissions.

[146] In terms of the 1973 Act, the equivalent of involuntary admission on application to the head was a reception order made on application to a Magistrate. The Magistrate had the power to examine the user and was in any event required to call upon the assistance of two medical practitioners, one of whom if practicable was to be the district surgeon. The Magistrate could dispense with the assistance of the two medical practitioners if the application was accompanied by a sufficiently recent medical certificate, in which case the Magistrate had to call upon the assistance of the certifying doctor. The reception order could authorise the detention of the user for up to 42 days. Counsel for Makana submitted that the Minister has not shown that this is not still feasible.

[147] The question, however, is not whether upfront judicial oversight is feasible but whether the procedure in the Act meets the test of a fair process. More importantly, the premise of Makana's argument is that early judicial involvement is a more effective, and thus a fairer, process than the one in the current Act. For the reasons I have given, that proposition is dubious. When the current Act was introduced into Parliament, the explanatory memorandum said that Review Boards were an innovation which would protect patients from arbitrary or unnecessary committal and retention. This was said to be a shift from certification by a Magistrate "which in practice has become a magisterial ratification".[214]

[148] This statement echoes what the House of Lords said in *MH v Secretary of State*.[215] Lady Hale remarked that before MHRTs were established in England, compulsory detentions were authorised by a judicial officer "who was

[214] Memorandum on the Objects of the Mental Health Care Bill, 2001 *GG* 22598, 21 August 2001, clause 4(d). See also Haysom, Strous and Vogelman "The Mad Mrs Rochester Revisited: The involuntary confinement of the mentally ill in South Africa" (1990) 6 *The South African Journal of Human Rights* 341 at 346.

[215] Above n 187.

widely regarded as a 'rubberstamp' of little practical value in challenging the decision to detain". The MHRTs were composed of a lawyer, a medical member and a third member with other suitable experience, for example in the social services. The MHRTs' procedures were "designed to be user-friendly and to enable the patient and her relative to communicate directly with the tribunal".[216]

[149] In August 2017, Judge Mark Hinchliffe, who heads the relevant Chamber of the First-tier Tribunal to which the MHRTs' functions in England were later transferred, said the following about the English regime:

> "[T]he England and Wales regime for 'sectioning' does not involve the tribunal or a District Judge at the admission stage. Instead, an Approved Mental Health Professional (AMHP) takes the lead. I very much commend this approach. Judges should stand apart and let practitioners on the ground, some of whom should know the patient, make the initial decisions, even if they involve removing or curtailing liberty. Tribunal judges are an independent backstop and a safeguard, providing a speedy review and remedy. But, in my view, judges should not routinely commence the medical or administrative process."[217]

The independence of Review Boards

[150] The Act envisages the Review Boards as being independent. This flows from their function of assessing whether decisions made by persons engaged at health establishments are justified. The composition of Review Boards points to an intended separation between functionaries at health establishments and functionaries who serve as Review Board members. The Review Board members who are lawyers and community members would, in the nature of things, not be employed at health establishments. In the case of Review Board members who are MHC practitioners, the intended statutory separation finds expression in the injunction that such a practitioner may not participate in Review Board decisions emanating from the establishment at which that practitioner is employed.

[216] Id at para 26.

[217] Hinchliffe above n 202 at 6.

[151] Although the Act can be presumed to give effect to the level of independence contemplated by the lawmaker, does that level of independence comply with the Constitution? In relation to involuntary inpatient treatment, there are two potential sources for the required independence. First, section 12(1)(a) of the Constitution requires that deprivations of liberty occur by a fair process. In order for the current statutory regime to be constitutionally compliant, Review Boards may need to have more independence than they do. Second, to the extent that section 34 of the Constitution is implicated by the statutory regime, the question may arise whether a Review Board, although it is not a "court", is "another independent and impartial tribunal or forum" for purposes of section 34 the Constitution.

[152] In relation to section 12(1)(a), the flexible criterion of fairness calls for a consideration of the characteristics of the statutory scheme in question. In the context of involuntary inpatient treatment, international law supports the view that a fair process should include oversight by an independent body. I do not have in mind, in this regard, Article 10 of the UDHR and Article 14 of the ICCPR, which – in the context of involuntary inpatient treatment – arguably only apply to legal proceedings instituted by or against the user. However, the MHC Principles require the involvement of an "independent authority" for involuntary treatment on account of lack of consensual capacity, "independent authority" being defined as "a competent and independent authority prescribed by domestic law". For involuntary detention, the MHC Principles require the involvement of a "review body" that must be a "judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law". Since the MHC Principles are in the form of a UN General Assembly resolution, they are not legally binding[218] but they are

[218] The Charter of the United Nations does not empower the General Assembly to pass resolutions binding on Member States. See also *South-West Africa Cases (Ethiopia v South Africa; Liberia v South Africa); Second Phase* [1966] ICJ Rep 6 at para 98 and Tiwari "Binding Value of the UN General Assembly Resolutions in International Law" (2018) 4 *Commonwealth Law Review Journal* 180.

nonetheless an important expression of world opinion,[219] all the more so since they were adopted unanimously.[220]

[153] Although the MHC Principles are non-binding, it is different with the CRPD.[221] In terms of this Convention, which is binding on South Africa on the international plane, all measures relating to the exercise of legal capacity of persons with disabilities must provide for appropriate and effective safeguards to prevent abuse. The safeguards must ensure that the measures in question "are subject to regular review by a competent, independent and impartial authority or judicial body".[222] Although this provision does not deal explicitly with involuntary inpatient treatment, it is wide enough to include such treatment of a user who is found to be incapable of making an informed choice.

[154] It should thus be accepted that, in terms of section 12(1)(a), Review Boards must be independent when performing the function of overseeing deprivations of liberty. What, then, are the features of Review Boards which might arguably imperil their independence? Most involuntary admissions take place at public health establishments. The Health MEC has political responsibility for the provincial health department which runs these establishments. The department employs the MHC practitioners and heads who work there. It is those practitioners and heads whose decisions the Review Board must evaluate.

[155] The MEC appoints the members of the Review Boards and determines their terms of office. An MHC practitioner or lawyers appointed to a Review Board may

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[219] See United Nations Model UN Programme "General Assembly" in United Nations (ed) *MUN Guide General Assembly* (2020), available at https://www.un.org/en/model-united-nations/general-assembly, where the UN states that "[a]lthough the General Assembly's recommendations on global issues are an important expression of world opinion, the Assembly cannot force a Member State to follow its recommendations on a particular issue".

[220] The resolution was adopted "without vote" (*Index to Proceedings of the General Assembly: Forty-sixth session – 1991 / 1992 Part 1* at 387). See United Nations Model UN Programme id at "How Decisions are Made at the UN", available at https://www.un.org/en/model-united-nations/how-decisions-are-made-un, where the UN states: "When consensus on the text is reached all of the Member States agree to adopt the draft resolution without taking a vote. Adopting a draft without a vote is the most basic definition of what consensus means". South Africa, of course, was not a member of the UN when the resolution was adopted in 1991.

[221] Above n 1.

[222] Id at Article 12(2).

permissibly be a full-time state employee. The Health MEC, with the concurrence of the Finance MEC, determines the remuneration and allowances payable to Review Board members who are not full-time state employees. The department of which the MEC is political head must make human and other resources available to the Review Boards to enable them to perform their administrative functions. Subject to the holding of an enquiry, the Health MEC has the power to remove a Review Board member if a statutorily specified ground of removal exists.

[156] In the context of the statutory scheme for involuntary inpatient treatment, how significant are these alleged impediments to independence? There are several considerations which weaken the force of the argument that they are significant. To the contrary, the supposed lack of independence is a matter of form rather than substance.

[157] First, the MEC, whose powers in relation to Review Boards is said to imperil their independence, is the political head of the relevant department. The MEC is not a functionary within the department. In particular, the MEC is not a manager of the health care practitioners and heads involved in the involuntary treatment regime, nor is the MEC a manager of any members of the Review Board who may be full-time employees of the health department.

[158] Second, a Review Board does not have any oversight over the MEC's actions. It also does not have general oversight of health establishments. It has oversight functions in relation to those individual cases which the Act requires to be referred to it. In relation to each such case, the Review Board is concerned with the decisions made by particular individuals at health establishments. Those individuals have no say in the appointment, terms of office, remuneration or removal of Review Board members.

[159] Third, the setting is one in which institutional bias or incentives in favour of deprivation of liberty are unlikely to be present:

(a) Within a law enforcement hierarchy, there may be an institutional bias or incentive to continue detentions initiated by law enforcement officers within the hierarchy. By contrast, MHC practitioners and heads have no incentive to detain people whose mental health status does not justify it. There is no revenue-earning incentive. With bed space at public health establishments at a premium,[223] those who work there are unlikely to allow beds to be taken up by people whose inpatient treatment is not justified.

(b) The decision to admit a person as an involuntary user involves several MHC practitioners and the head. The practitioners make their assessments individually, not as a collective. They are bound by the ethical codes of their professions. The head, if he or she is not a medical practitioner, nevertheless holds a responsible senior position. One is thus not dealing with a policing power exercised by a single potentially low-ranking official in a hierarchy.

(c) The Review Board members likewise have no institutional bias or incentive in favour of supporting unjustified involuntary inpatient treatment. The members have no institutional relationship with the health establishments or with the individual practitioners and heads. At least two members of the Board will be professionals who are bound to exercise their judgments individually in accordance with the ethical codes of their professions. They have nothing to gain by supporting unjustified inpatient treatment.

(d) The MEC is completely removed from decision-making in relation to individual cases. The MEC has no statutory right to tell anyone that a person should or should not be treated as an involuntary user. The MEC also has no incentive to become involved in such matters.

[223] See Szabo and Kaliski above n 6 at 69: "Acute beds are at a premium, and longer-stay beds even more so. This of course raises a critical qualifier in the Act, namely that everything is dependent on resources (i.e. funding)".

[160] It is thus difficult to see how the MEC's power to appoint and dismiss Review Board members and to determine their terms of office and remuneration could have any influence on how Review Board members do their jobs. This said, the MEC's powers in these respects are not conferred in arbitrary terms.

[161] Appointments must be based on published criteria and must be preceded by a gazetted call for nominations. In *Van Rooyen*,[224] which dealt with the independence of the magistracy, this Court held that the Magistrates' Courts did not have to enjoy all the institutional independence of the Superior Courts in order to meet the constitutional standard of independent courts. In regard to the appointment of Magistrates, Chaskalson CJ pointed out[225] that in the *First Certification* judgment[226] this Court had held that "the appointment of Judges by the executive or a combination of the executive and Parliament was not inconsistent with the requirement that the judiciary be impartial and independent".[227] A total separation of powers was neither feasible nor required by the Constitution.[228] The fact that the Minister was not bound by the recommendations of the Magistrates Commission, with whom he had to consult, was thus not objectionable.[229]

[162] Also unobjectionable, so this Court held, was the fact that the Magistrates Commission was an executive structure and that it included members of Parliament and executive nominees. An important consideration in constitutional adjudication was "that decisions of the Magistrates Commission and the Minister in giving effect to powers vested in them by the legislation are subject to constitutional control".[230] Chaskalson CJ said in that regard:

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[224] Above n 93.

[225] Id at para 59.

[226] *Certification of the Constitution of the Republic of South Africa*, [1996] ZACC 26; 1996 (4) SA 744 (CC); 1996 (10) BCLR 1253 (CC).

[227] Id at para 124.

[228] *Van Rooyen* above n 93 at para 105.

[229] Id at para 109.

[230] Id at para 87.

> "Any power vested in a functionary by the law (or indeed by the Constitution itself) is capable of being abused. That possibility has no bearing on the constitutionality of the law concerned. The exercise of the power is subject to constitutional control and should the power be abused the remedy lies there and not in invalidating the empowering statute.
>
> The findings made by the High Court concerning the Magistrates Commission are premised on the assumption that a body consisting of judicial officers, legal practitioners, members of Parliament and nominees of the executive, charged with the important duty of protecting the independence of magistrates, will either be, or objectively be perceived to be, a sham, concerned more with pleasing the Minister of Justice than with discharging its responsibilities. I should say immediately that there is in my view no basis for such an assumption, nor for the conclusion reached by the High Court to that effect."[231]

[163] The Health MEC cannot determine remuneration and allowances without the concurrence of the Finance Minister.[232] Again, this is not a power that can be exercised arbitrarily. Legislation must be construed consistently with the Constitution.[233] Remuneration and allowances in terms of section 23 of the Act must be set at reasonable levels, commensurate with the qualifications required of members of Review Boards. In *Van Rooyen*, the power of the Minister of Justice to determine the salaries of Magistrates, with the concurrence of the Minister of Finance and after consultation with the Magistrates Commission, was found to pass constitutional muster.[234]

[164] As to the term of office of Review Board members, the MEC's power remains subject to constitutional control. It would be an improper exercise of the power if the term were set so as to make Review Board members in some way dependent on the MEC's goodwill. As I have said, however, the MEC would have no incentive to set terms of office in that way. Flexibility in setting terms of office may serve legitimate

[231] Id at paras 37-8.

[232] See [16] above.

[233] *Van Rooyen* above n 93 at paras 88, 181-2 and 192.

[234] Id at paras 136-49.

purposes. A proposed board member might be unwilling to serve for longer than a certain period, for example one year. In the case of a temporary vacancy, it might be necessary to appoint a substitute for a short period. Reasonable rotation might be healthy. Short terms of office (if that is Makana's concern) is not necessarily incompatible with independence. Acting Judges and Acting Magistrates may be appointed for short periods.

[165] Removal can only occur on specified grounds and after an enquiry.[235] In *Van Rooyen*, this Court found constitutionally objectionable a power, vested in the appointing or designating authority, to remove a member of the Magistrates Commission "if in his, her or its opinion there are sound reasons for doing so". Chaskalson CJ said that if the power of recall had been subject to "objective criteria consistent with the Constitution" there would have been no objection to the power being vested in the executive; the exercise of the power, subject to constitutional control, would meet the Constitution's requirements. In the provision under consideration, however, the power depended on the subjective opinion of the authority, which was not an objective test. This could be remedied, the Court held, by severing the words "in his, her or its opinion" from the provision.[236] The grounds of removal in section 21(1) of the Mental Health Act are not framed in subjective terms. Although one of them, removal on account of "public interest", may be imprecise, it is no more so than a removal "for sound reasons", which passed muster (subject to severance of the subjective element) in *Van Rooyen*.

[166] In *Van Rooyen*, however, a distinction was drawn between the removal of members of the Magistrates Commission and the removal of Magistrates. The Court said that a member of government should not have the power to exercise discipline over judicial officers and to punish them for misconduct since that would place the

[235] See [17] above.

[236] *Van Rooyen* above n 93 at paras 93-5.

judicial officers concerned "in a subordinate position in relation to the government which is inconsistent with judicial independence".[237]

[167] If Review Boards are required to have the same independence as the judiciary, it would be objectionable for the Health MEC to have the power to impose discipline. The MEC may, of course, not remove a Review Board member except after an enquiry. This can be interpreted to mean that the MEC may only remove a Review Board member if this is the recommendation emanating from the enquiry. The Act does not, however, regulate the appointment of, and procedure to be followed by, the persons conducting an enquiry. The MEC would, I think, be legally bound to establish the enquiry with the object of an impartial and independent investigation. Even so, section 23 would probably be objectionable if the Review Board members had to have the independence of judicial officers.

[168] I do not think, however, that the requirement of independence for Review Boards should be set so high. Although it may not be necessary to go as far as finding that a Review Board is an "independent and impartial tribunal or forum" for purposes of section 34 of the Constitution, I think Review Boards meet that standard. An "independent and impartial tribunal or forum" for purposes of section 34 is something other than a "court". The international instruments to which I have referred likewise draw a distinction between a "judicial body" and an "independent and impartial authority".

[169] Even within the judicial hierarchy, there are degrees of independence. In *De Lange*[238] and again in *Van Rooyen*[239] this Court referred with approval to Canadian jurisprudence on section 11(d) of the Canadian Charter of Rights and Freedoms, which guarantees the right "to be presumed innocent until proven guilty according to law in a

[237] Id at para 179.

[238] Above n 74 at para 69.

[239] Above n 93 at para 20.

fair and public hearing by an independent and impartial tribunal". In *Valente*[240] the Canadian Supreme Court said:

> "It would not be feasible, however, to apply the most rigorous and elaborate conditions of judicial independence to the constitutional requirement of independence in section 11(d) of the Charter, which may have to be applied to a variety of tribunals. The legislative and constitutional provisions in Canada governing matters which bear on the judicial independence of tribunals trying persons charged with an offence exhibit a great range and variety. The essential conditions of judicial independence for purposes of section 11(d) must bear some relationship to that variety."

[170] In *Van Rooyen*, this Court went on to say that, in deciding whether a particular court lacks the institutional protection that it needs to function independently and impartially, it is relevant to have regard "to the core protection given to all courts by our Constitution, to the particular functions that such court performs and to its place in the court hierarchy".[241] In the case of Magistrates' Courts, relevant considerations were: that lower courts are entitled to protection by the higher courts; they are courts of first instance, their judgments being subject to appeal and review; and they do not have jurisdiction to deal with administrative reviews or cases where the validity of legislation or government conduct is disputed. Case of this kind were "the most sensitive areas of tension between the legislature, the executive and the judiciary", so that "[m]easures considered appropriate and necessary to protect the institutional independence of courts dealing with such matters, are not necessarily essential to protect the independence of courts that do not perform such functions".[242]

[171] There are, in turn, significant differences between the functions performed by Review Boards and Magistrates' Courts. Review Boards have a very limited jurisdiction. The state at all levels of government may feature as a litigant in the Magistrates' Courts. By contrast, the state does not, in a substantive sense, feature as a

[240] *Valente v The Queen* 1985 CanLII 25 (SCC); [1985] 2 SCR 673; (1986) 24 DLR (4th) 161 (SCC) at para 25.

[241] *Van Rooyen* above n 93 at 23.

[242] Id at paras 23-5.

party in the matters which serve before Review Boards. What is at issue are assessments made by MHC practitioners and heads. If further involuntary inpatient treatment is approved by a Review Board, the matter must automatically be reviewed by a Judge within 30 days. Apart from this automatic review, the decisions of Review Boards are subject to the general review jurisdiction of the High Court. As I have explained, the incentives for executive interference are virtually non-existent. In relation to their limited jurisdiction, therefore, the Review Boards have sufficient independence to qualify as independent and impartial tribunals for purposes of section 34 of the Constitution.

[172] The cases on independence cited by Makana must be read in their context. There is no one-size-fits-all template. *Glenister II* was about the independence of the DPCI, a statutory corruption-fighting unit located within the South African Police Service. This Court split 5:4 on the question whether the DPCI had adequate independence. Both the majority and minority judgments show that the content of the required independence was gauged with reference to the DPCI's intended function of combating corruption. The majority quoted a report by the Organisation for Economic Co-operation and Development on specialised anti-corruption institutions where it was stated that the "level of independence can vary according to specific needs and conditions".[243] The majority quoted another passage from the report alluding to the effect on independence of hierarchies such as are often encountered in the police and other investigative bodies. The independence of such bodies required careful consideration "in order to limit the possibility of individuals abusing the chain of command and hierarchical structure".[244]

[173] Corruption typically involves people holding public office. The DPCI thus needed to be shielded from undue political interference. According to the majority, our law demanded "a body outside executive control to deal effectively with corruption".[245] The question was "not whether the DPCI has full independence, but whether it has an

[243] *Glenister II* above n 68 at para 119.

[244] Id at para 188.

[245] Id at para 200.

adequate level of structural and operational autonomy, secured through institutional and legal mechanisms, to prevent undue political interference".[246] Parliament did not have to create an agency with "a measure of independence appropriate to the judiciary".[247] The problem was that the DPCI was "insufficiently insulated from political influence in its structure and functioning".[248] Although one of the concerns in *Glenister II* was the absence of secure tenure, the "gravest disquiet" was caused by express provisions authorising executive involvement.[249] The majority's analysis of the statutory scheme led them to conclude that "senior politicians are given competence to determine the limits, outlines and contents of the new entity's work"[250] and that "the political executive [is afforded] the power directly to manage the decision-making and policy-making of the DPCI".[251]

[174] The mandate of Review Boards does not bring them into potential conflict with political and executive actors generally or with Health MECs particularly. In relation to their comparatively modest functions of overseeing mental health care decisions, there is no statutory scheme for political or executive oversight or interference. The members of Review Boards do not belong to a hierarchy.

[175] *Sonke Gender Justice*[252] concerned the independence of the Judicial Inspectorate of Correctional Services (JICS), established in terms of Chapter IX of the Correctional Services Act.[253] With reference to the Constitution and international instruments, this Court held that there was a positive obligation on the state to provide appropriate protection to inmates through laws and structures designed to afford such protection. Since the lawmaker had chosen to do so through the establishment of the

[246] Id at para 206.

[247] Id at para 207.

[248] Id at para 208.

[249] Id at para 228.

[250] Id at para 234.

[251] Id at para 235.

[252] Above n 84.

[253] 111 of 1998.

JICS, this legislative measure would only be constitutionally compliant if the JICS had sufficient independence to perform this function.[254] The Court reiterated that what was required was an adequate level of independence, not absolute independence.[255]

[176] The Court referred to various "markers of institutional independence" – structural independence, operational independence and perceived independence.[256] The way in which these "markers" were then analysed shows that this Court was concerned with these components of independence in relation to the functions which the JICS was expected to perform. As in *Glenister II*, the Court was testing whether the JICS had adequate independence in relation to those over whom it exercised oversight, namely the Department of Correctional Services. The Court noted that the statutory role of the JICS was to inspect correctional centres and remand detention facilities in order to report on the treatment of inmates, on conditions and on any corrupt or dishonest practices in these centres and facilities.[257] The JICS thus had to be "financially and structurally independent and distinct from any authority charged with the administration of correctional facilities".[258]

[177] The impugned statutory provisions were found to be wanting. The JICS' budget was "determined and controlled by the very Department over which it is meant to exercise oversight". The Department had an unfettered discretion over the JICS' level of funding.[259] The Department was in a position to control how the JICS spent its money.[260] This budgetary control in turn had a negative effect on the JICS' operational independence. It was understaffed and lacked adequate office space, which undoubtedly undermined its independence.[261]

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[254] *Sonke Gender Justice* above n 84 at paras 50-1.

[255] Id at para 110.

[256] Id at para 75.

[257] Id at para 20.

[258] Id at para 68.

[259] Id at para 90.

[260] Id at para 91.

[261] Id at paras 93-108.

[178] Once again, the differences between the role of the JICS and the Review Boards are obvious and striking. A Review Board is not a watchdog over the Health MEC or the provincial health department. The Review Boards have a more modest case-specific mandate. Moreover, the statutory scheme does not pose the same risk of financial dependence. In the case of the JICS, section 91 of the Correctional Services Act bluntly stipulated that "[t]he Department is responsible for all expenses of the Judicial Inspectorate". The JICS had a wide and roving watchdog mandate. The amount of money made available to it by the Department obviously affected the number and extent of inspections the JICS could carry out.

[179] In the case of the Review Boards, by contrast, the Act specifies the matters that have to be referred to it. The Review Board does not choose which cases to deal with. It has to consider all cases that the Act requires to be referred to a Review Board and it does not have a mandate to consider any other cases. The provincial health department is statutorily obliged to make human and other resources available to the Review Board to enable it to perform its administrative functions.[262] In regard to the remuneration and allowances payable to Review Board members who are not in the full-time employ of the state, such remuneration and allowances have to be set at reasonable levels commensurate with the skills required. Although these levels are determined by the Health MEC with the concurrence of the Finance MEC, the resultant expenditure has to be appropriated out of the monies of the relevant provincial legislature.[263] In short, if any Review Boards in South Africa lack resources to carry out their activities, that is not because of a shortcoming in the statutory scheme but because of a failure by the relevant MEC, provincial department or provincial legislature to comply with their statutory duties.

[262] Section 18(3).

[263] Section 23(2).

[180] The independence of the English MHRTs was not an issue in the litigation of *MH v Secretary of State* and *MH v United Kingdom* discussed earlier.[264] The MHRT is not a court in the conventional sense but an administrative tribunal, though it has been regarded in England as "court" for certain purposes[265] and for purposes of Article 5(4) of the European Convention.[266] Although the MHRTs' procedures are dealt with more elaborately in the English legislation than those of the Review Boards in our legislation, there do not appear to be striking differences insofar as independence is concerned. On the contrary, the English MHRTs may well have been the model for our Review Boards. At the time of the events which were litigated in *MH v Secretary of State* and *MH v United Kingdom*, the members of MHRTs were appointed by the Lord Chancellor, who is a senior member of the Cabinet. Each panel comprised a legal member, a medical practitioner and a person having experience in administration, social services or other qualifications or experience as the Lord Chancellor considered suitable. A member held and vacated office in terms of the instrument by which the Lord Chancellor appointed him or her, which meant that the Lord Chancellor determined a member's term of office. The Secretary of State was to pay MHRT members such remuneration and allowances, and defray such expenses of the MHRT, as he might with the consent of the Treasury determine. The Secretary of State was also empowered to provide each MHRT with such officers, servants and accommodation as the MHRT might require.[267]

[264] See [129] to [132] above.

[265] *Pickering v Liverpool Daily Post and Echo Newspapers plc* [1990] 1 All ER 335 (CA) (*Pickering*) at 341c-j, overruling the contrary conclusion in *A-G v Associated Newspapers Group plc* [1989] 1 All ER 604 at 608h-611e. *Pickering* was upheld on this point by the House of Lords: [1991] 1 All ER 622 (HL) at 630a-b, though perhaps on a narrower basis than in the Court of Appeal.

[266] This was the ECtHR's view in *MH v United Kingdom*.

[267] In 2008 the functions of the MHRTs in England, but not Wales, were transferred to the First-Tier tribunal. The Lord Chancellor still appoints the MHRT members for Wales but their remuneration, allowances and the expenses to be defrayed, and the provision of administrative support are now determined by the Welsh Ministers, that is, the devolved Welsh Cabinet.

The time frames

[181] The procedures in the Act are required to occur within time frames which meet the Constitution's guarantee of a fair process. The initial examination occurs before any decision has been made to admit the person as an involuntary user. Thereafter, and upon admission, the user must immediately undergo the 72-hour assessment. It has not been suggested that 72 hours is too long. The period must be sufficient to enable the practitioners to reach reliable conclusions. It must also allow a reasonable chance for improvement and possible discharge or reclassification.[268]

[182] Following the 72-hour assessment, the Act requires the head to make the findings of the assessment available to the applicant within 24 hours. If the head decides that the user must receive further involuntary inpatient treatment, the head must send the prescribed papers to the Review Board within seven days after expiry of the 72 hours. This is not a licence to delay. However, a reasonable opportunity needs to be allowed for the practitioners to write up their assessment reports, for these to be sent to the head, for the head to consider them and make his or her decision, and for the papers to be prepared for submission to the Review Board.

[183] As to the periods of 30 days allowed to the Review Board and the High Court for making their respective decisions, during oral argument counsel for Makana was invited to say what a reasonable time would be if 30 days is too long. Counsel was not willing to hazard an answer. In each case, the 30-day period is an outer limit. Having regard to the objects of the Act and the rights conferred on users in Chapter III, it is necessarily implied that the Review Board and High Court must make their respective decisions as soon as reasonably possible. This implication would be consistent with the

[268] Freeman above n 143 at 7 says the following on the introduction of the 72-hour assessment in the new Act:

> "The aim of this change is to allow people who fit the criteria for involuntary admission to be treated in the acute phase of their illness in a place as near to their homes as possible. In many instances, with treatment people recover considerably within a 72 hour period and it is unnecessary for them to have to go to a psychiatric hospital as a 'certified patient' and experience the stigma and loss of dignity that this often implies."

MHC Principles, which require that a review of an initial involuntary detention decision should take place as soon as possible after that decision.[269]

[184] Sometimes it will be possible to reach a decision within a day or two. In other cases, investigations may be needed. Account must also be taken of the workload of the Review Boards and Judges. Case numbers may fluctuate significantly from week to week. In the case of the High Court, these matters are dealt with by Judges in chambers. They have to find time for them in between their court and other judicial commitments. The periods of 30 days are not in my view excessive. In *MH v United Kingdom*, the ECtHR did not regard as excessive a 30-day period during which there was no judicial control.

[185] Reviews by the Review Board and High Court take place automatically. Additionally, the user or a relative or associate may appeal to the Review Board at any time within 30 days of the head's initial decision to admit the user involuntarily.[270] This is a prompt and inexpensive appeal to a user-friendly body. The Act requires that users be informed of their rights. The user is entitled to legal representation, and to state-supplied legal aid if indigent. The Act, furthermore, does not bar the user or an interested party on behalf of the user from applying to the High Court for relief.

[269] MHC Principles above n 104 at 17.2. Analogously, in *De Lange* above n 74 Ackermann J said that section 66(3) of the Magistrates' Courts Act did not in express terms prescribe the procedure to be followed before a presiding officer who was a Magistrate committed an examinee to prison. But the section also did not explicitly require the presiding officer to conduct the committal proceedings in a way inconsistent with any norm of procedural fairness required by the Constitution or the common law. The inescapable conclusion, Ackermann J said, was that implicitly the presiding officer had to conduct the proceedings in a way which is not inconsistent with such norms (at para 85).

[270] See [40] above. Some writers have criticised the Act for requiring the head to notify only the applicant and not also the user of the decision to admit the user involuntarily, which is said to diminish the value of the user's right of appeal: see, for example, Bonthuys "Involuntary Civil Commitment and the New Mental Health Bill" 2001 *SALJ* 667 at 676; Kersop and Van den Berg above n 6 at 688; McCrea above n 143. This is not a point raised in the present case. The lawmaker's thinking might have been that users, unlike applicants, know that they are being detained. In terms of section 17, health care providers may not administer treatment without informing users of their rights (this excludes the short emergency regime in section 9(1)(c)). If the Act is properly implemented, users should thus know that a decision has been taken to treat them involuntarily, that they have a right of appeal and that if they are indigent they have a right to legal representation at state expense.

Procedures in other countries

[186] Little purpose would be served by describing in detail the procedures contained in the legislation of other countries I have examined. They vary widely:

(a) Many countries have mental health tribunals similarly composed to our Review Boards. Although periods of assessment differ, a 72-hour period is quite common.

(b) In some countries, initial detention for varying periods occurs on the basis of medical assessments, after which a tribunal has to become involved, either because the patient has not taken the initiative within a specified period or because the legislation requires the authorities to obtain the tribunal's authority for further detention. In England and Wales, automatic review occurs after six months, and the same applies in Ontario and Alberta. In Victoria and Queensland, the tribunals have to become involved after about 30 days.

(c) In some countries, initial detention occurs on the basis of medical assessments, after which a court has to become involved. In New Zealand, a court must be approached within 30-40 days and there is a separate right on the part of the patient to approach a tribunal. In New York State, detention beyond 60 days requires a court order.

(d) In some countries, a court has to be approached before or very soon after a patient is detained (for example, Germany, France, Spain, Texas, Ghana, New South Wales and Florida).[271]

[271] In the case of Germany and France, the requirement of initial judicial involvement flows from express provisions in their Constitutions. Elsewhere, the requirement of initial court involvement may sometimes be attributable to a strong libertarian ethos within the jurisdictions concerned: see Dhanda above n 146 at 441. The author distinguishes between the Therapy Dominant Model (TDM), i.e. a medical model, and the Autonomy Dominating Model (ADM), and observes:

> "Unlike TDM, where legal functionaries had a limited and last resort role, legal functionaries were accorded pride of place in [ADM] . . . . A study of mental health legislations across jurisdictions shows that these instruments have either privileged autonomy or care depending upon whether the prevailing perspective was therapeutic or civil libertarian."

(e) In some countries and states, there is no procedure for automatic review by a tribunal or court (for example, British Columbia, California and Kenya).

[187] The laws summarised above are not necessarily consistent with our Constitution or with our international law obligations. Nevertheless, our Act does not seem to be out of kilter with international standards. Of the above systems, ours is similar to those of Victoria and Queensland in requiring detention beyond 30 days to be authorised by a tribunal. South Africa, however, seems to be unique in having the automatic involvement not only of a tribunal but also, subsequently, of a Judge.

Conclusion on section 12(1)

[188] For all these reasons, the deprivation of liberty for which sections 33 and 34 provide occurs in accordance with a fair process. As part of that process, the Review Boards have sufficient independence to perform their functions. I thus conclude that sections 33 and 34, and relatedly Chapter IV, do not limit section 12(1) of the Constitution. This being so, justification in terms of section 36 of the Bill of Rights does not need to be considered.

Section 34 of the Constitution

[189] Section 34 of the Constitution provides that everyone has the right "to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum". The question whether a user's condition meets the standard for involuntary treatment, as laid down in the Act, is a matter capable of being resolved by the application of law. As I have said, the Act does not prevent the user, or an interested person on the user's behalf, from contesting the lawfulness of involuntary treatment in a court of law. The Act, furthermore, provides for the automatic involvement of a Judge. Although this occurs at a relatively late stage, this is acceptable in the context of the legislative scheme as a whole.

[190] In *C v Department of Health*,[272] the majority (per Yacoob J) held that the provisions of sections 151 and 152 of the Children's Act were unconstitutional because they violated sections 28 and 34 of the Constitution. In regard to section 34, the majority said that where the removal of a child occurred by way of an order of a Children's Court in terms of section 151, the right guaranteed by section 34 of the Constitution was limited because the court order was made in the absence of the child and parents, who would probably only have an opportunity to challenge the removal when the matter again came before the Children's Court in terms of section 155 pursuant to a social worker's report, which had to be compiled within 90 days of the removal. The limitation was perhaps greater in the case of removal in terms of section 152, because the initial removal did not occur pursuant to any court order at all. Both sections were found to be unconstitutional to the extent that they did not provide for a prompt automatic judicial review of the removal in the presence of the child and parents.[273] In a minority concurring judgment, Skweyiya J held that the limitation of section 34 occurred because, although affected families were not denied access to the court, their right of access was undoubtedly delayed.[274]

[191] In my view *C v Department of Health* is distinguishable. In that case the Court was concerned with statutory provisions which permitted a child to be removed without regard to the wishes of the child or the parents. Both the child and the parents stood to be prejudiced by the removal. The grounds of removal concerned objective states of affairs of a kind which a Children's Court was well placed to assess. The decision of a single functionary could result in a removal lasting up to 90 days before the child and parents would be heard in the Children's Court.

[272] Above n 66.

[273] Id at paras 79-83. The Court's remedy was a reading-in which required the automatic judicial review to occur before the expiry of the next court day after the removal (at para 96).

[274] Id at para 28.

[192] In the case of the Mental Health Care Act, by contrast, involuntary treatment occurs on the application of a family member or associate, unless they are unavailable. Where the user is under the age of 18, the application has to be made by the parent or guardian.[275] The involuntary treatment is subject to a sequence of successive assessments and authorisations by a multiplicity of practitioners and responsible persons. If the involuntary treatment endures for any length of time, the Review Board enters the picture much sooner than the 90 days for which the Children's Act provides. And importantly, as soon as involuntary treatment is authorised by the head, the user, relatives and associates have a statutory right to appeal the decision to a Review Board. For reasons I have explained, I consider that a Review Board qualifies as an "independent and impartial tribunal" for purposes of section 34(1) of the Constitution. But even if it does not, it remains an important safeguard. Finally, there is the automatic safety net of a Judge's review if the user is to remain under involuntary treatment after the Review Board's decision.

[193] As I have shown, early judicial involvement would not be a useful safeguard. The Act contains other safeguards which are likely to be more effective. When one adds to this that the Act does not take away anyone's right to approach the High Court at any time, sections 33 and 34 cannot be regarded as limiting the right guaranteed by section 34 of the Constitution. Again, therefore, justification in terms of section 36 of the Bill of Rights need not be considered.

Section 10 of the Constitution

[194] In terms of section 10 of the Constitution, "[e]veryone has inherent dignity and the right to have their dignity respected and protected". Counsel for Makana did not press the section 10 in argument. Sections 33 and 34 of the Act do not permit involuntary users to be treated in a way that impairs their dignity. Involuntary inpatient treatment of a user who meets the statutory criteria for such treatment is consistent with respecting the user's dignity. Indeed, to withhold treatment from such persons might

[275] Section 33(1).

impair their dignity, along with their right to health care service in terms of section 27(1)(a) of the Constitution. Without treatment, the users would not be able to look after themselves properly, they might appear in public in a state which would embarrass them if they had command of their faculties, and they might be exposed to ignorant ridicule, exploitation or abuse.

[195] It might be said that an unjustified deprivation of liberty in terms of the Act impairs the person's dignity. But the Act does not authorise unjustified deprivations of liberty. Section 10 does not in that regard add anything to the analysis flowing from section 12(1) of the Constitution. There being no limitation on involuntary users' section 10 rights, there is no need to consider justification in terms of section 36 of the Bill of Rights.

Residual aspects concerning Review Boards' independence

[196] I have said that Review Boards only deal with those cases which the Act requires to be referred to them. Section 19(1) is, when read in the context of the Act as a whole, a summary of the powers and functions expressly dealt with in other sections of the Act.[276] On this approach, independence has to do with case-specific matters. Review Boards do not exercise broad oversight.

[197] In its founding papers, Makana stated, with reference to the Life Esidimeni tragedy,[277] that Review Boards have the power to review and reverse a decision by a health department to transfer users from one facility to another. In the context of Life Esidimeni, this potentially brought the Gauteng Review Board into conflict with the Gauteng Provincial Health Department which, according to the reports cited by Makana, wanted to transfer users as a cost-cutting measure.

[276] See above n 17.

[277] See [44] above.

[198] It is not apparent to me that a Review Board has this function. In respect of transfers, the only power mentioned in section 19(1) is the power to consider applications for transferring users to maximum security facilities. The Act empowers a Review Board to consider such transfers, upon application by the head, in the case of involuntary users and mentally ill prisoners who are at risk of absconding or of inflicting harm on others at the establishment[278] and in the case of State patients if the user is likely to inflict harm on others.[279]

[199] Apart from these cases, the Act requires that if an involuntary user has undergone a 72-hour assessment at an establishment which is not a psychiatric hospital, the user must be transferred to a psychiatric hospital pending the Review Board's decision.[280] The Review Board plays no part in such a transfer.

[200] The Act does not deal with any other types of transfers. Assuming for the moment that assisted and involuntary users can permissibly be transferred from the health establishments where they are being cared for at the time the Review Board authorises further inpatient treatment, this would appear to be an ordinary operational matter. The head does not have to make an application to the Review Board.

[201] However, if Review Boards were thought to have a broader oversight function which included ordinary transfers, it does not undermine my conclusions on independence. In the context of involuntary and perhaps assisted inpatient treatment, the requirement of independence is a component of the fair process necessitated by the fact that users are deprived of freedom. Placing a user in a maximum security facility is a more draconian deprivation of freedom. By contrast, the transfer of a properly admitted user from one ordinary establishment to another is not a decision in respect of which the fair-process requirements of section 12(1) are triggered. If the lawmaker has nevertheless chosen to confer oversight powers on Review Boards in respect of such

[278] Sections 39 and 54 respectively.

[279] Section 43.

[280] Section 34(4)(b).

transfers, one cannot use the section 12(1) analysis to impugn the adequacy of their independence in relation to transfer decisions. The inclusion of an additional layer of decision-making does not in itself import any constitutional standard of independence.

Suspension and costs

[202] Because this Court will not be confirming the High Court's declarations of constitutional invalidity, we need not address questions of retrospectivity or suspension or the WC MEC's submissions concerning *Prince*. For the same reason, the costs orders in favour of Makana should be set aside. Although the declaratory order in paragraph 2 of the High Court's order remains, it was uncontested, and it is not a sufficient basis to justify a costs order against any of the respondents. In terms of *Biowatch*,[281] no order for costs should be made against Makana in the High Court or in this Court. And, finally, because of this outcome, the issue of costs against the WC MEC does not arise.

Order

[203] The following order is made:

1. The declarations of constitutionality invalidity by the High Court are not confirmed.
2. The costs orders made by the High Court are set aside and replaced with an order that the parties are to bear their own costs.
3. As a result of the orders in 1 and 2, the respondents' applications for leave to appeal fall away.
4. The parties are to bear their own costs in this Court.

[281] *Biowatch Trust v Registrar Genetic Resources* [2009] ZACC 14; 2009 (6) SA 232 (CC); 2009 (10) BCLR 1014 (CC).

For the Applicants:	M Tsele and M de Beer instructed by Nandi Bulabula Inc
For the First to Ninth Respondents:	W R Mokhare SC and T C Lithole instructed by the State Attorney, Pretoria
For the Tenth Respondent:	U K Naidoo instructed by the State Attorney, Cape Town