

REGIONAL DEVELOPMENTS

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF MENTAL HEALTH IN SELECTED AFRICAN COUNTRIES: A COMMENTARY ON HOW SELECTED MENTAL HEALTH LAWS FARE AGAINST ARTICLE 25 OF THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

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1 Introduction

Persons with disabilities have an equal right to access health services, including general health services and disability-related health services. In accessing health care, persons with disabilities encounter many barriers. These include stereotypes about disability on the part of health care providers; a lack of appropriately-trained health care staff; imbalanced power relationships between persons with health needs and medical professionals; inaccessible health care facilities; inaccessible health-related information; and a lack of individualised accommodations.¹ These barriers are heightened in the circumstances of persons with psychosocial disabilities who face additional challenges, including legally-sanctioned involuntary commitment; forced treatment; and the use of restraints and solitary confinement in mental health care institutions. In addition, certain categories of persons with psychosocial disabilities require particular attention in health care settings. In this regard, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment in his 2013 report notes that 'women living with disabilities, with psychiatric labels in particular, are at risk of multiple forms of discrimination and abuse in health-care settings'.²

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1 Equal Rights Centre *Ill-prepared: Health care's barriers for people with disabilities* (2011) 3.

2 JE Méndez Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment A/HRC/22/53 (2013) para 80.

In recognition of the fact that persons with disabilities continue to experience rights violations, including with regard to the right to the highest attainable standard of health, the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) was adopted on 13 December 2006.³ Forty-seven African states have signed and ratified the CRPD as at 23 April 2017;⁴ 17 states have submitted state reports to the Committee on the Rights of Persons with Disabilities (CRPD Committee) and six states have already received Concluding Observations from the CRPD Committee.⁵

Article 25 of the CRPD provides for the right to the highest attainable standard of health without discrimination on the basis of disability. The right to the highest attainable standard of health falls under the category of economic, social and cultural rights, comprehensively addressed under the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁶ The obligations imposed by economic, social and cultural rights work in a number of different ways, including providing freedoms; imposing obligations on a state regarding third parties; and imposing obligations on the state to adopt measures or to achieve a particular result.⁷

The right to the highest attainable standard of health care is also recognised in African regional human rights instruments, including the African Charter on Human and Peoples' Rights (African Charter),⁸ the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)⁹ and the African Charter on the Rights and Welfare of the Child (African Children's Charter).¹⁰ The African Commission on Human and Peoples' Rights (African Commission) has adopted a Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (African Disability Protocol). Article 13 of the Protocol deals

3 United Nations Division for Social Policy and Development Disability 'Convention on the Rights of Persons with Disabilities' <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> (accessed 26 April 2017).

4 Disabled World 'CRPD List of Countries: Convention, Optional Protocol Signatures, Ratifications' <https://www.disabled-world.com/disability/discrimination/crpd-milestone.php> (accessed 26 April 2017).

5 United Nations Office of the High Commissioner for Human Rights http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=5 (accessed 8 May 2017).

6 Art 12 of the ICESCR addresses health.

7 International Commission of Jurists 'Courts and the legal enforcement of economic, social and cultural rights: Comparative experiences of justiciability' http://www.humanrights.ch/upload/pdf/080819_justiziabilit_esc.pdf (accessed 26 April 2017).

8 Art 16 provides for the right to enjoy the best attainable state of physical and mental health. The following articles of the African Charter also have a bearing on the right to the highest attainable standard of health: art 2 (prohibition of discrimination); art 5 (right to dignity, prohibition of torture and slavery); and art 24 (right to a satisfactory environment).

9 Art 14 African Women's Protocol.

10 Art 14 African Children's Charter.

with the rights of persons with disabilities to the highest attainable standard of health.¹¹ In addition, the African Commission has considered a case that touched on mental health care in The Gambia in *Purohit & Another v The Gambia*.¹² In this communication, the Commission, among other issues, addressed the right to health and the treatment of persons with mental illnesses. The communication was brought on behalf of patients detained at the psychiatric unit of the Royal Victoria Hospital in The Gambia. The communication alleged that the Lunatics Detention Act was inadequate in that it did not prescribe requirements to guarantee the safeguarding of rights during diagnosis and detention of patients.

In its decision, the African Commission emphasised that human dignity was an inherent right, which must be respected at all times irrespective of the mental capability of a person. According to the Commission, persons with mental disabilities must not be denied their right to health care, which is necessary for their survival in society, and they should be accorded special treatment to enable them to attain the highest level of health.¹³ The Commission stated that the right to health was vital for the enjoyment of all other rights and included the right to access health care facilities and health services without discrimination. The Commission found that the government was in violation of the African Charter and urged it to repeal the Lunatics Detention Act and to provide adequate medical as well as material care for mental health patients.¹⁴

Despite the widespread ratification of the CRPD and African regional human rights instruments, persons with disabilities in Africa continue to experience violations of their rights to health, pointing to an inadequate implementation of existing human rights treaties. This commentary examines the extent to which domestic mental health legislation in three African countries (South Africa, Ghana and Tanzania) complies with the standards set in article 25 of the CRPD. All three countries have ratified the CRPD,¹⁵ and legislated on mental health after 2000.¹⁶ South Africa follows a dualistic approach to international law other than for international instruments that are 'self-executing'.¹⁷ Hence, any international agreement becomes law in South Africa once it is enacted

11 Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, adopted at the 19th extraordinary session of the African Commission on Human and Peoples' Rights, held 16-25 February 2016 in The Gambia, http://www.achpr.org/files/news/2016/04/d216/disability_protocol.pdf (accessed 26 April 2017).

12 (2003) AHRLR 96 (ACHPR 2003).

13 *Purohit* (n 12 above) para 81.

14 Sec 3 below further discusses the *Purohit* case.

15 United Nations Treaty Collection 'Convention on the Rights of Persons with Disabilities' https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-15&chapter=4&lang=en (accessed 26 April 2017).

16 South Africa's Mental Health Care Act was enacted in 2002; Tanzania's Mental Health Act was enacted in 2008; and Ghana's Mental Health Act was enacted in 2012.

17 I Grobbelaar-Du Plessis 'South Africa' (2013) 1 *African Disability Rights Yearbook* 313.

into law by national legislation.¹⁸ Ghana¹⁹ and Tanzania,²⁰ similarly, follow a dualist approach to international law.

The commentary is divided into five parts including the introduction and conclusion. The second part briefly explores the meaning of the right to the highest attainable standard of health care in the context of persons with disabilities. The third part examines the legislation governing mental health care in South Africa, Ghana and Tanzania, with a view to assessing the extent to which the legislation complies with the standard set in article 25 of the CRPD. The fourth part is a summarised reflection on the three mental health laws using the CRPD as the standard. In scope, the commentary focuses only on the legislative framework and does not address the relevant policy framework in mental health care in the three countries. The commentary also does not address issues of persons with psychosocial disabilities who are in contact with the criminal justice system, such as prisoners.

2 Meaning of the right to the highest attainable standard of health care in the context of persons with disabilities

According to article 1 of the CRPD, 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’.²¹ This definition encapsulates the social model of disability according to which disability is not an intrinsic aspect of an individual; rather the emphasis is laid on the various barriers that hinder the full and equal participation of persons with disabilities in society.²²

Since the coming into force of the CRPD, persons with mental disabilities, their allies and, indeed, the CRPD Committee,²³ to a large extent, have adapted the terminology ‘persons with psychosocial

18 Sec 231(4) Constitution of the Republic of South Africa, 1996.

19 Constitution of the Republic of Ghana (1992) sec 75(2): ‘A treaty, agreement or convention executed by or under the authority of the President shall be subject to ratification by an Act of Parliament.’

20 P Josiah Shughuru ‘Tanzania’ (2013) 1 *African Disability Rights Yearbook* 344.

21 Art 1 CRPD.

22 C Ngwena ‘*Western Cape Forum for Intellectual Disability v Government of the Republic of South Africa: A case study of contradictions in inclusive education*’ (2013) 1 *African Disability Rights Yearbook* 145.

23 See, eg, CRPD Committee General Comment 1: Article 12: Equal recognition before the law (2014) CRPD/C/GC/1.

disabilities'.²⁴ Persons with psychosocial disabilities are those 'who experience mental health issues, and/or who identify as "mental health consumers", "psychiatric survivors", or "mad"'.²⁵ In addition, the World Network of Users and Survivors of Psychiatry includes as users of mental health services people who experience mood swings, fear, voices or visions and people experiencing mental health problems or crises as persons with psychosocial disabilities.²⁶ The term 'psychosocial disability' is meant to express 'a social rather than medical model of conditions and experiences labelled as "mental illness"'.²⁷ This commentary uses the terminology 'persons with psychosocial disabilities' or 'mental health care users'.

Article 25 of the CRPD provides for the right to the highest attainable standard of health without discrimination on the basis of disability. Three elements of article 25 that are pertinent to access to health care services by persons with disabilities are equality and non-discrimination; the provision of health services as close as possible to peoples' own communities; and the provision of health care on the basis of free and informed consent.²⁸ The CRPD Committee is yet to develop a General Comment on article 25 of the CRPD. However, the Committee has issued a number of important Concluding Observations on article 25 that touch on mental health. The Committee has also developed a General Comment on article 12 on equal recognition before the law, which has significant implications for mental health care.²⁹ Hence, it is possible to deduce the core of the right to the highest attainable standard of health care in the context of persons with disabilities.

The CRPD Committee has examined the state reports of various countries, including the following African countries: Ethiopia, Gabon, Kenya, Mauritius, Tunisia and Uganda.³⁰ The Committee has issued Concluding Observations on the right to health to five of the six African

24 It is important to note that legislation in the three countries (South Africa, Ghana and Tanzania) uses different terminology. Eg, Tanzania's Mental Health Act uses 'person with mental disorder' and 'patient'. Sec 2 of the Act defines 'mental disorder' to mean 'a significant occurrence of a mental or behavioural disorder classified in the International Classification of Diseases published by the World Health Organisation'. Sec 2 of Tanzania's Mental Health Act defines 'patient' as 'a person suffering or deemed to be suffering from mental disorder'. Sec 1 of the South African Mental Health Care Act defines 'mental health care user' to mean 'a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user'. Ghana's Mental Health Act uses 'patient' and 'person with mental disorder'. According to sec 97, 'patient' means a person with mental disorder receiving mental health care.

25 Mental Disability Advocacy Centre *Guidelines on article 33 of the CRPD* (2011) 55.

26 World Network of Users and Survivors of Psychiatry 'Psychosocial disability' <https://www.google.com/search?q=persons+with+psychosocial+disabilities&ie=utf-8&oe=utf-8&client=firefox-b-ab#> (accessed 7 March 2017).

27 As above.

28 Arts 25(1)(a)(c)(d) & (f) CRPD.

29 General Comment 1 (n 23 above) paras 7, 13, 31, 41 & 42.

30 United Nations Office of the High Commissioner 'State reports' http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29 (accessed 26 April 2017).

countries whose state reports the Committee has examined so far.³¹ This section summarises the content of Concluding Observations made to African countries on the right to health that relate specifically to mental health.³² Examining these Concluding Observations is important to understand the meaning of the right to the highest attainable standard of mental health.

The CRPD Committee has made several recommendations on article 25 to African states examined so far. These include urging³³

the development of a wide range of community-based services that respond to the needs of persons with disabilities and respect the person's autonomy, choices, dignity and privacy, including peer support and other alternatives to the medical model of mental health.

The Committee also recommended that state parties take the necessary steps to repeal legislation restricting the rights of persons with disabilities to free and informed consent,³⁴ as well as enact laws which explicitly recognise the right of the individual to free and informed consent and prohibits the substitution of consent by a third party.³⁵ The CRPD Committee further recommended the adoption of measures to ensure that all persons with disabilities have access to the highest attainable standard of health on an equal basis with others.³⁶ In addition, the Committee recommended that state parties conduct regular training of hospital and health care personnel on the rights of persons with disabilities, including their right to free and informed consent and reasonable accommodation in all health care settings.³⁷ The Committee also recommended that state parties ensure the availability of essential drugs for persons with mental health conditions in all health centres, especially in rural areas.³⁸

As noted, the General Comment on article 12 on equal recognition before the law has important implications for mental health care. The General Comment states that 'forced treatment by psychiatric and other

31 Concluding Observations on art 25 of the CRPD on the right to health have been issued to Ethiopia, Kenya, Gabon, Uganda and Mauritius. Only Tunisia did not receive Concluding Observations on this article.

32 Kenya, Gabon, Uganda and Ethiopia all received Concluding Observations impacting on mental health care.

33 CRPD 'Concluding Observations on the initial report of Kenya' CRPD/C/KEN/CO/1 para 46(c).

34 CRPD 'Concluding Observations on the initial report of Gabon' CRPD/C/GAB/CO/1 para 57.

35 As above.

36 As above.

37 As above; United Nations Office of the High Commissioner for Human Rights 'Concluding Observations on the initial state report of Uganda' CRPD/C/UGA/CO/1 para 51(a); CRPD 'Concluding Observations on the initial report of Ethiopia' CRPD/C/ETH/CO/1 para 56.

38 Uganda (n 37 above) para 51(c).

health and medical professionals is a violation of the right to equal recognition before the law',³⁹ among other rights.⁴⁰ The General Comment asserts that state parties are obliged to provide access to support for decisions regarding psychiatric treatment, and 'recommends that states parties ensure that decisions relating to a person's mental integrity can only be taken with the free and informed consent of the person concerned'.⁴¹

The General Comment emphasises that 'perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity'.⁴² According to the General Comment, 'persons with cognitive or psychosocial disabilities have been, and still are, disproportionately affected by substitute decision-making regimes and denial of legal capacity'.⁴³ Under a substituted decision-making regime, legal capacity is removed from a person and placed in the hands of another person (a substitute decision maker) by someone other than the person concerned. Substitute decision makers base their decisions on a 'best interests' standard rather than on the will and preferences of the person concerned.⁴⁴

Mental health laws that permit forced treatment are identified as falling under substitute decision-making regimes. As such, the CRPD Committee urges state parties to replace substitute decision-making regimes by supported decision making.⁴⁵ According to the General Comment, a supported decision-making regime 'comprises various support options which give primacy to a person's will and preferences and respect human rights norms'.⁴⁶

3 Evaluation of the mental health laws in selected African countries

In the African context, it is important to acknowledge upfront that poverty impacts the exercise of the right to the highest attainable standard of health by all persons, including persons with disabilities. In *Purohit*,⁴⁷ the African Commission acknowledged that

39 General Comment 1 (n 23 above) para 42.

40 In addition to being a violation of the right to equal recognition before the law, the CRPD Committee identifies that forced treatment by psychiatric and other health and medical professionals is an infringement of the rights to personal integrity (art 7); freedom from torture (art 15); freedom from violence, exploitation and abuse (art 16); and health care based on free and informed consent (art 25).

41 General Comment 1 (n 23 above) para 42.

42 General Comment 1 para 13.

43 General Comment 1 para 9.

44 General Comment 1 para 27.

45 General Comment 1 paras 3 & 28.

46 General Comment 1 para 29.

47 *Purohit* (n 12 above).

millions of people in Africa are not enjoying the right to health maximally because African countries are generally faced with the problem of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full enjoyment of this right.⁴⁸

However, the African Commission emphasised the need for state parties to the African Charter 'to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind'.⁴⁹

This section evaluates the extent to which mental health laws in South Africa, Ghana and Tanzania protect and promote the right to the highest attainable standard of mental health for persons with psychosocial disabilities.

3.1 South Africa

Globally, there are many misconceptions on mental health that lead to persons with psychosocial disabilities not being valued as equal members of society. These misconceptions also exist in Africa, and include beliefs that persons with psychosocial disabilities are cursed,⁵⁰ violent, dangerous,⁵¹ and incapable of making their own decisions.⁵² As a result of stigma and discrimination engendered by these misconceptions, persons with psychosocial disabilities all over the world, including in South Africa, find it difficult to enjoy their human rights on an equal basis with others.⁵³

This section examines South African domestic legislation, gauging the extent to which the legislation complies with the key elements of article 25 of the CRPD, namely, equality and non-discrimination; the provision of health services as close as possible to peoples' own communities; and the provision of health care on the basis of free and informed consent.⁵⁴

48 *Purohit* para 81.

49 *Purohit* para 84.

50 H Combrinck 'Everybody counts: The right to vote of persons with psychosocial disabilities in South Africa' (2014) 2 *African Disability Rights Yearbook* 99.

51 M Dako-Gyeke & E Sowah Asumang 'Stigmatisation and discrimination experiences of persons with mental illness: Insights from a qualitative study in Southern Ghana' (2013) 11 *Social Work and Society International Online Journal*.

52 Mental Health America 'Position statement 22: Involuntary mental health treatment' <http://www.mentalhealthamerica.net/positions/involuntary-treatment> (accessed 7 March 2017); S Kleintjes et al 'Barriers to the participation of people with psychosocial disability in mental health policy development in South Africa: A qualitative study of perspectives of policy makers, professionals, religious leaders and academics' (2013) 13 *BioMed Central International Health and Human Rights*.

53 M Swanepoel 'Human rights that influence the mentally-ill patient in South African medical law: A discussion of sections 9; 27; 30 and 31 of the Constitution' (2011) 14 *Potchefstroom Electronic Law Journal*; CO Egbe et al 'Psychiatric stigma and discrimination in South Africa: Perspectives from key stakeholders' (2014) 14 *Bio Med Central Psychiatry*.

54 Arts 25(1)(a)(c)(d) & (f) CRPD.

3.1.1 *Obligation to prohibit discrimination against persons with disabilities in the provision of health services*

Constitution of South Africa

Section 9 of the Constitution of the Republic of South Africa, 1996 comprises a robust equality and non-discrimination clause that operates both vertically⁵⁵ and horizontally.^{56,57} Disability is one of the prohibited grounds of unfair discrimination. Hence, persons with disabilities are protected from unfair discrimination across all spheres of life, including access to health care. However, as South Africa's state report to the CRPD Committee notes, protection in law does not always translate into protection in practice:

So while persons with disabilities are, in principle, able to harness the law to protect and pursue interests on an equal basis with others, a number of obstacles, including persistent harmful traditional beliefs, ingrained stigmatisation and consequent discrimination on the one hand, and the interrelatedness of disability and poverty on the other ... detract from the equality provided for in law.⁵⁸

Section 27(1)(a) of the South African Constitution provides that everyone has the right to have access to health care services, including reproductive health care. It has been argued that 'the South African Constitution provides for universal access to health care services and not the right to attain the highest standard of physical and mental health'.⁵⁹ However, section 27(1)(a) is phrased broadly enough to be interpreted generously as including 'claims to all services, goods and facilities aimed at securing the greatest attainable standard of physical and mental well-being'.⁶⁰ In addition, the manner in which the right to health is understood in international law must influence the understanding of this right in the context of the South African Constitution. This is particularly pertinent given that South Africa has ratified the ICESCR.

Other sections of the South African Constitution that touch on health care include sections 24 and 184. Section 24 of the Constitution provides

55 Sec 9(3) provides for a vertically-applicable right by prohibiting the state from unfairly discriminating against any person based on any ground.

56 Sec 9(4) provides for a horizontally-applicable right to non-discrimination by prohibiting any person from unfairly discriminating directly or indirectly against any person based on any ground.

57 Grobbelaar-Du Plessis (n 17 above) 314-315.

58 Office of the High Commissioner for Human Rights 'Initial report of South Africa submitted in accordance to Article 35 of the Convention' para 51 http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29 (accessed 7 March 2017).

59 South African Human Rights Commission *Public inquiry: Access to health care services* (2009) 23.

60 M Pieterse *Can rights cure? The impact of human rights litigation on South Africa's health system* (2014) 20.

that everyone has the right to an environment that is not harmful to their health or wellbeing. According to section 184(3), each year the South African Human Rights Commission must require relevant organs of the state to provide the Commission with information on measures they have taken towards the realisation of the rights in the Bill of Rights concerning a variety of issues, including health care. In practice, the responsiveness of relevant organs of the state to the Commission's request for information varies. For example, in its 2012-2013 report, the Commission states:

All of the departments submitted their responses [to questionnaires sent by the Commission] after the initial deadline and some departments, including Social Development and Agriculture; Forestry and Fisheries had to be threatened with legal action before a response was received. The Commission aims to build stronger relationships with these departments to ensure smoother collaboration and compliance in the future.⁶¹

South Africa does not have a specific Act to address issues of persons with disabilities; rather, disability issues are mainstreamed throughout various Acts as necessary.⁶²

Mental Health Care Act

A key overarching principle under South Africa's Mental Health Care Act 17 of 2002 is the integration of mental health care into the general health services.⁶³ It is important to note, however, that mere integration is not enough; persons with disabilities may require support in exercising their health rights. The Special Rapporteur on the Rights of Persons with Disabilities in her 2016 report notes that support is a human rights obligation arising from various rights, including the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.⁶⁴ In the absence of adequate support, persons with disabilities may not exercise their health rights on an equal basis with others.

With regard to equality and non-discrimination, section 10(1) of the Mental Health Care Act prohibits discrimination against a 'mental health care user' on the grounds of his or her mental health status. Section 1 of the

61 South African Human Rights Commission 'Report on economic and social rights sec 184(3) report' (2012-2013) 10.

62 Acts that mainstream disability issues include the Broad-Based Black Economic Empowerment Act 53 of 2003; the Child Justice Act 75 of 2008; the Children's Act 53 of 2003; the Co-Operatives Act 14 of 2005; the Employment Equity Act 55 of 1998; the National Building Regulations and Building Standards Act 103 of 1977; the National Health Act 61 of 2003; the Sterilisation Act 44 of 1998; the National Land and Transport Act 5 of 2009; the Preferential Procurement Policy Framework Act 5 of 2000; the Social Assistance Act 13 of 2004; and the South African Library for the Blind Act 91 of 1998. See Grobbelaar-Du Plessis (n 17 above) 315.

63 Integrating mental health into general health care services is one of the objects of the Mental Health Care Act under sec 3(a)(iii).

64 C Devandas 'Report of the Special Rapporteur on the Rights of Persons with Disabilities' A/HRC/34/58 (2016) para 31.

Act defines a mental health care user as ‘a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally-ill prisoner’.⁶⁵ In cases where the person concerned is below 18 years of age or considered ‘incapable of taking decisions’, the term ‘mental health care user’ may include the person’s next of kin as well as an administrator appointed under the Act.

The Act further states that ‘[e]very mental health care user must receive care, treatment and rehabilitation services according to standards equivalent to those applicable to any other health care user’.⁶⁶

In spite of these provisions on equality between mental health care users and other health care users, the Mental Health Care Act discards the principle of free and informed consent with regard to mental health care users, as is discussed in more detail below. To illustrate, general health users are discharged from hospital unconditionally.⁶⁷ However, often, in mental health care, discharge is conditional, as illustrated by section 34(6) of the Mental Health Care Act:

The head of the health establishment may cancel the discharge and request the user to return to the health establishment on an involuntary inpatient basis, if he or she has reason to believe that the user fails to comply with the terms and conditions of such discharge.

3.1.2 Obligation to provide health services as close as possible to people’s own communities

Article 25(c) of the CRPD places an obligation on state parties to provide ‘health services as close as possible to people’s own communities, including in rural areas’. Article 19 of the CRPD is closely related to article 25(c) and provides for the rights of persons with disabilities to live independently in the community and not to be obliged to live in particular living arrangements, as happens in the case of institutionalisation in mental health facilities. In addition, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in his 2013 report recommended that forced treatment and commitment in mental health facilities be replaced by services in the community.⁶⁸ According to the Special Rapporteur:

Such services must meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned,

65 Sec 1.

66 Sec 10(2).

67 General health users may be given a set of health instructions which they are free to choose either to adhere to or to ignore.

68 JE Méndez (n 2 above) para 89(c).

with an emphasis on alternatives to the medical model of mental health, including peer support, awareness-raising and training of mental health-care and law enforcement personnel and others.⁶⁹

According to the Special Rapporteur on the Rights of Persons with Disabilities, in her 2016 report, '[s]tates must establish an immediate moratorium on new admissions to institutions and set up a policy framework to guide deinstitutionalisation processes'.⁷⁰ The Special Rapporteur clarifies that policy frameworks on deinstitutionalisation should

include the adoption of a plan of action with clear timelines and concrete benchmarks, the redistribution of public funds from institutions to community services and the development of adequate community support for persons with disabilities such as housing assistance, home support, peer support and respite services.

According to the Special Rapporteur, there is evidence to the effect that 'when adequately planned and resourced, community services are much more cost-effective than institutional care'.⁷¹

In its state report to the CRPD Committee, South Africa identifies that its main policy to mental health is community-based care.⁷² Recent reports and academic articles have criticised the South African state for embarking on de-institutionalisation measures without first setting up support services for mental health care in the community.⁷³ The 2017 report by the Office of Health Standards Compliance provides information on deinstitutionalisation in Gauteng Province that went tragically wrong, resulting in the deaths of more than 94 persons with psychosocial disabilities.⁷⁴

69 As above.

70 Devandas (n 64 above) para 86.

71 As above.

72 Office of the High Commissioner for Human Rights 'Initial report of South Africa submitted in accordance to Article 35 of the Convention' para 276(3) http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29 (accessed 7 March 2017). See also sec 8(2) of the Mental Health Care Act, which states that mental health care services should 'improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life'.

73 South African Human Rights Commission *Public inquiry: Access to health care services* (2009) 50; UA Botha et al 'Assessing the efficacy of a modified assertive community-based treatment programme in a developing country' (2010) 10 *BMC Psychiatry* 2; Ubuntu Centre South Africa 'Esidimeni campaign 2016' <https://ubuntucentre.wordpress.com/esidimeni-campaign-2016/> (accessed 27 January 2017); Office of Health Standards Compliance 'Final report into the circumstances surrounding the deaths of mentally-ill patients: Gauteng Province' (2017) <http://www.ohsc.org.za/index.php/news/media-releases/129-report-into-deaths-of-mentally-ill-patients-gauteng-province-3> (accessed 15 February 2017).

74 As above.

South Africa's Mental Health Care Act has a mixed approach on the provision of care in the community: For persons with 'serious' mental health conditions, institutional care is prioritised, whilst community-based care is the main approach for those with 'less serious' mental health conditions. Section 1 of the Mental Health Care Act defines 'health establishment'. From this definition, it is clear that mental health care facilities range from community health and rehabilitation centres and clinics to hospitals and psychiatric hospitals. To further illustrate, section 6(6)(g) provides that psychiatric hospitals may admit, care for, treat and rehabilitate 'persons admitted for a long period as part of their care, treatment and rehabilitation'.⁷⁵ The approach under section 6(6)(g) seems to be that there are certain categories of people whose care can only be provided within an institution – this goes against the spirit of articles 19 and 25(c) of the CRPD, which provide for the right of all persons with disabilities to live in the community.

3.1.3 Obligation to provide health care to persons with disabilities on the basis of free and informed consent

Article 25(d) of the CRPD emphasises that persons with disabilities should receive care of the same quality as those without disabilities 'including on the basis of free and informed consent'. Article 25(d) is closely linked with article 12 of the CRPD on equal recognition before the law. Specifically, article 25(d) is closely related to article 12(2), which states that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'. Legal capacity 'includes the capacity to be both a holder of rights and an actor under the law'.⁷⁶ As such, legal capacity protects an individual against unwanted interventions such as medical treatment that the person does not wish to receive.⁷⁷

Under the National Health Act 61 of 2003, health services in South Africa are provided on the basis of free and informed consent.⁷⁸ However, South Africa's Mental Health Care Act mandates medical treatment of persons with psychosocial disabilities without their free and informed consent.⁷⁹ In its state report to the CRPD Committee, South Africa

75 See also secs 34(4) and 37. Sec 34(4) mandates transfer for in-patient care in psychiatric hospitals, while sec 37 illustrates that a person can spend more than 12 months as an 'involuntary mental health care user' in a psychiatric hospital.

76 General Comment 1 (n 23 above) para 12.

77 Council of Europe Commissioner for Human Rights *Issue paper: Who gets to decide? Right to legal capacity for persons with intellectual and psychosocial disabilities* (2012) 11.

78 Secs 6, 7(3) & 8(2)(b) National Health Act 2003.

79 Sec 32 of the Mental Health Care Act.

identifies laws with a problematic notion of ‘informed consent’ in light of the CRPD.⁸⁰ The Mental Health Care Act is not identified as one of these laws, and this may be read as signalling that the state does not intend changing this aspect of the mental health law.

In its General Comment on article 12 on equal recognition before the law, the CRPD Committee has identified mental health laws that permit forced treatment as being a key area in which persons with disabilities are denied their rights to legal capacity. The General Comment states:

States parties have an obligation to provide access to support for decisions regarding psychiatric and other medical treatment. Forced treatment is a particular problem for persons with psychosocial, intellectual and other cognitive disabilities. States must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation of mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The Committee recommends that state parties ensure that decisions relating to a person’s physical or mental integrity can only be taken with the free and informed consent of the person concerned.

South Africa’s Mental Health Care Act allows for mental health care, treatment and rehabilitation of persons with psychosocial disabilities without their informed consent.⁸¹ South Africa’s Mental Health Care Act has two categories of care, treatment and rehabilitation without informed consent: ‘assisted care’ and ‘involuntary care’. Assisted care is administered to individuals who are ‘incapable of making informed decisions due to their mental health status and who do not refuse the health interventions’.⁸² Involuntary care is defined as ‘the provision of health interventions 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’.⁸³ Substitute decision makers under the Act include a spouse; next of kin; a partner; an associate; a parent or guardian of the user;⁸⁴ the head of the

80 These include the Choice on Termination of Pregnancy Act, 1996; the Sterilisation Act, 1998; the National Health Act, 2003; and the Children’s Act, 2005. See Office of the High Commissioner for Human Rights ‘Initial report of South Africa submitted in accordance to Article 35 of the Convention’ para 125 http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29 (accessed 7 March 2017).

81 See secs 6(6)(c), 19(1)(b), 26(b) i & ii, 28(3), 31(3)(b), 31(4), 32, 33(1)(a), 33(5)(b), 34(3), 36, 38(1) & 40(1) & (2).

82 Sec 1.

83 As above.

84 See sec 27(1)(a) on application for assisted care, treatment and rehabilitation services; 29(1)(a) on appeal against decision of head of health establishment to approve application for assisted care, treatment and rehabilitation; 33(1)(a) on application to obtain involuntary care, treatment and rehabilitation; and 35 on appeal against decision of head of health establishment on involuntary care, treatment and rehabilitation.

health establishment,⁸⁵ a health care provider,⁸⁶ the Review Board,⁸⁷ and the High Court.⁸⁸

Section 32 of the Mental Health Care Act involves ‘care, treatment and rehabilitation of mental health care users without consent’. Under this section, several reasons warrant the provision of care, treatment and rehabilitation without the individual’s free and informed consent. The first reason is the existence of a reasonable belief that the mental health care user has a mental illness that may cause him or her to inflict serious harm to himself or herself or others. Second, mental health care, treatment and rehabilitation may be administered without the consent of the individual if such care ‘is necessary for the protection of the financial interests or reputation of the user’.⁸⁹ Third, such care may be given in cases where ‘at the time of the application the mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services and is unwilling to receive the care, treatment and rehabilitation required’.⁹⁰

Section 26 involves assisted care. Under this provision, assisted care is provided without the individual’s consent to individuals who are ‘suffering from a mental illness or severe or profound mental disability’ in circumstances where the person requires ‘care, treatment and rehabilitation services for his or her health or safety, or for the health and safety of other people’⁹¹ and to individuals who are ‘incapable of making an informed decision on the need for the care, treatment and rehabilitation services’.⁹²

Before a person can be treated on an ‘involuntary basis’, two mental health care practitioners must examine the person.⁹³ The mental health care practitioners are required to submit written findings on whether the mental health care user must receive involuntary care, treatment and rehabilitation services.⁹⁴ If after seven days of the assessment the head of the health establishment is still of the opinion that the mental health care user requires further involuntary care, the head of the health establishment must submit a written request to the Review Board to approve further

85 These include sec 14 of the Mental Health Care Act on limitation on intimate adult relationships; sec 26(a) on care, treatment and rehabilitation services for mental health care users incapable of making informed decisions; and 27(5) on application for assisted care, treatment and rehabilitation services.

86 Sec 33(1)(a)(ii).

87 These include sec 9(1)(b) on consent to care, treatment and rehabilitation services and admission to health establishments.

88 As above.

89 Sec 32(b)(ii).

90 Sec 32(c).

91 Sec 26(b)(i).

92 Sec 26(b)(ii).

93 Sec 33(4)(a).

94 Sec 33(5)(b).

involuntary care.⁹⁵ Ultimately, under section 36, the High Court has the ultimate decision on the length of involuntary treatment.

A member of the South African Police Service may also initiate involuntary care, treatment and rehabilitation in circumstances where

from personal observation or from information obtained from a mental health care practitioner, that a person due to his or her mental illness or severe or profound intellectual disability is likely to inflict serious harm to himself or herself or others.⁹⁶

The Act also has provisions on voluntary care, where a person with a psychosocial disability is seen as an adult capable of giving informed consent.⁹⁷

3.2 Ghana

Human rights violations do occur in psychiatric hospitals in Ghana, as in many other parts of the world.⁹⁸ In 2012, Human Rights Watch published a report on abuses against persons with mental disabilities in Ghana.⁹⁹ The Human Rights Watch report documents prevalent human rights violations in psychiatric facilities and prayer camps in Ghana as including

involuntary admission and arbitrary detention, prolonged detention, overcrowding and poor hygiene, chaining, forced seclusion, lack of shelter, denial of food, denial of adequate health care, involuntary treatment, stigma and its consequences, physical and verbal abuse, electro-convulsive therapy, and violations against children with disabilities.¹⁰⁰

In this report, one respondent who had spent time in Accra Psychiatric Hospital revealed that she had 'witnessed people being injected with medications against their will, and nurses beating patients who failed to respond to instructions'.¹⁰¹ The respondent highlighted that what she needed 'was a clinical psychologist to talk to and community-based rehabilitation, but these services are not easy to come by'.¹⁰²

95 Sec 34(3)(c)(i).

96 Sec 40(1).

97 Sec 1(xi) defines voluntary care, treatment and rehabilitation as 'the provision of health interventions to a person who gives consent to such interventions'. Other sections on persons with psychosocial disabilities giving consent include secs 9, 26, 29(3), 30(5)(a)(ii), 34(3)(a), 35(3)(b) and 38(2).

98 M Roberts et al 'An overview of Ghana's mental health system: Results from an assessment using the World Health Organisation's assessment instrument for mental health systems (WHO-AIMS)' (2014) 8 *BioMed Central International Health and Human Rights*; A Ofori-Atta et al 'A situation analysis of mental health services and legislation in Ghana: Challenges for transformation' (2010) 13 *Africa Journal of Psychiatry* 99-108.

99 Human Rights Watch 'Like a death sentence: Abuses against persons with mental disabilities in Ghana' (2012).

100 Human Rights Watch (n 99 above) 11.

101 Human Rights Watch 7.

102 As above.

In addition to psychiatric hospitals, persons with psychosocial disabilities in Ghana are often held in faith-based facilities, partly because mental disability is seen as having been caused by witchcraft or spiritual attacks.¹⁰³ There is a lack of policy and regulation concerning the practice of psychiatry by faith-based practitioners,¹⁰⁴ and there have been complaints of human rights violations in these facilities.¹⁰⁵

This section examines Ghana's domestic legislation, gauging the extent to which the legislation complies with the key elements of article 25 of the CRPD.

3.2.1 Obligation to prohibit discrimination against persons with disabilities in the provision of health services

Constitution of Ghana

The Constitution of the Republic of Ghana, 1992 specifically provides for the rights to equality and non-discrimination of persons with disabilities. According to article 29(4) of the Ghanaian Constitution, persons with disabilities 'shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature'.

Several provisions in the Constitution of Ghana address health. Article 34(2) places an obligation on the President to present an annual report to parliament of all the steps taken to ensure the realisation of basic human rights, including the right to good health care. Article 36(10) mandates the state to safeguard the health, safety and welfare of all persons in employment.

Person with Disabilities Act

The Persons with Disabilities Act 715 of 2006 makes provision for health care for persons with disabilities. Section 31 stipulates that in formulating health policies, the Ministry of Health 'shall provide for free general and specialist medical care, rehabilitative operation treatment and appropriate assistive devices for persons with total disability'. According to section 32, the study of disability-related issues shall be part of the curricula of training institutions for health professionals. Section 33 also requires the Ministry of Health to include education on disability and disability issues in health care programmes. Incorporating specific education on disability issues in health care programmes could potentially ensure better access to good quality mental health care for persons with disabilities, especially if the

103 Republic of Ghana Ministry of Health *The mental health system in Ghana* (2013) 35.

104 Republic of Ghana (n 103 above) 50.

105 UM Read & VCK Doku 'Mental health research in Ghana: A literature review' (2012) 46 *Ghana Medical Journal*.

curriculum approaches disability from a human rights perspective rather than solely from the medical model of disability.

Mental Health Act

The Mental Health Act 846 of 2012 comprises provisions on equality and non-discrimination of mental health care users.¹⁰⁶ Under section 3(j), the Mental Health Authority is obliged to provide psychiatric in-patient care of an equitable standard to physical in-patient care. The Mental Health Act also provides that '[a] person with mental disorder is entitled to the same standard of care as a person with physical health problems and shall be treated on an equitable basis'¹⁰⁷ on all matters, including access to essential medicines. The Act prohibits discrimination and imposes a fine of not more than five hundred penalty units or a term of imprisonment of not more than two years or both the fine and imprisonment to any person who subjects a person with mental disorder to discrimination.¹⁰⁸ According to section 88(1), mental health care is free.

However, similar to the South African Mental Health Care Act, the Ghanaian Mental Health Act makes it clear that, unlike in physical health care, leaving a psychiatric institution – even for a 'voluntary patient' – is at the discretion of the institution. Section 40(5) of the Ghanaian Mental Health Act provides that at the time of admission, a voluntary patient must be alerted that a request for discharge may not be granted if the patient meets the criteria of involuntary admission at the time the request for discharge is made. In the event that a patient leaves the facility without the consent of the psychiatrist or the head of the facility, a report of this fact shall be made to the police, who are mandated to arrest the patient without warrant and return him or her to the hospital.¹⁰⁹

In addition, section 68(1) states that a person with a mental disorder who is unable to manage his or her personal affairs because of the mental disorder shall be protected in a broad range of matters, including the right to treatment of choice. In terms of protection, if a court finds that a person is lacking in mental capacity, and is not competent to make decisions on a broad range of issues, including treatment, 'the court shall appoint a guardian for the personal protection of that person'.¹¹⁰ In taking treatment decisions on behalf of a person with a mental disorder, the guardian is required to 'consult with the incapacitated person where possible' and to make treatment decisions 'on behalf of the incapacitated person using a high standard of substituted judgment'.¹¹¹ This provision runs contrary to

106 See secs 3(g), 54(2) and 94.

107 Sec 57(2).

108 Sec 94.

109 Sec 50(2).

110 Sec 68(4).

111 Sec 68(6).

the General Comment on article 12 on equal recognition before the law, which proposes a complete shift from substitute decision making in the context of adults with disabilities.

3.2.2 *Obligation to provide health services as close as possible to people's own communities*

Section 3.2 highlights that human rights violations often occur in institutional settings,¹¹² and that the human rights of persons with disabilities are best protected when health services are provided as close as possible to people's own communities. This section examines Ghanaian law on the right of persons with disabilities to live in the community as well as provision of community-based health care services.

Constitution of Ghana

The Constitution of Ghana provides for the right of persons with disabilities to live in the community. Article 29(1) provides that '[d]isabled persons have the right to live with their families or with foster parents and to participate in social, creative or recreational activities'. The same article, however, has a claw-back clause on the right of persons with disabilities to live in the community. Article 29(2) provides that a person with a disability shall not be subjected to different treatment in respect of residence other 'than that required by his condition or by the improvement which he may derive from the treatment'.¹¹³ As a safeguard, the article provides that living in 'specialised establishments' for persons with disabilities shall occur in circumstances where such stay is 'indispensable' and the environment and living conditions 'shall be as close as possible to those of the normal life of a person of his age'.¹¹⁴

Mental Health Act

The Ghanaian Mental Health Act espouses the principle of care, treatment and rehabilitation in the least restrictive environment.¹¹⁵ The Act defines 'least restrictive' as 'a regime of treating a person with mental disorder in a situation or environment where the freedom of movement, association and choice of the person is minimally constrained'.¹¹⁶ In addition, the Act requires the Mental Health Authority to 'provide for educational, vocational and leisure opportunities within mental health facilities'.¹¹⁷

112 E Goffman *Asylums: Essays on the social situation of mental patients and other inmates* (1961).

113 Art 29(2).

114 Art 29(3).

115 Sec 2(c).

116 Sec 97.

117 Sec 3(k).

However, the Act mandates in-patient care for persons with psychosocial disabilities.¹¹⁸ In terms of time frames, a person can be institutionalised for a period of up to 12 months under the Ghanaian Mental Health Act once under a ‘prolonged treatment order’.¹¹⁹ Under section 46 of the Act, prolonged treatment in a psychiatric hospital is ordered if the psychiatrist or head of a facility is of the opinion that the severity of the condition warrants this. Section 47 provides that ‘[t]he period of the prolonged treatment order shall not exceed twelve months at a time’.

3.2.3 Obligation to provide health care to persons with disabilities on the basis of free and informed consent

The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment in his 2013 report details abuses in health care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. The report strongly recommends the abolition of legislation ‘authorising institutionalisation of persons with disabilities for their care and treatment without their free and informed consent’.¹²⁰ The Special Rapporteur’s 2013 report further states that ‘informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision’.¹²¹ According to the Special Rapporteur, ‘guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services’.¹²²

Mental Health Act

The Ghanaian Mental Health Act defines informed consent as ‘an agreement or consent for a procedure given freely without coercion by a person with capacity when the person has been made fully aware of the nature of the procedure, its implications and available alternative’.¹²³ The Act classifies mental health care users into three main categories, namely, voluntary,¹²⁴ involuntary¹²⁵ and emergency.¹²⁶ The Act requires the consent of a voluntary patient to be obtained before treatment is given, and a voluntary patient has the right to refuse treatment under the Act.¹²⁷ In addition, a voluntary patient can request a discharge from a facility.

118 Secs 42(1), 46(1)& and 48(1).

119 Sec 47.

120 Méndez (n 2 above) para 68.

121 Méndez para 28.

122 As above.

123 Sec 97.

124 Secs 39-41.

125 Secs 42-44.

126 Secs 48-49.

127 Secs 40(2) & (3).

However, such a request can only be honoured if the person does not meet the conditions for involuntary admission.¹²⁸

Section 42 of the Ghanaian Mental Health Act addresses involuntary treatment. According to the Act, involuntary admission and treatment is applicable where a person believed to be suffering from a mental disorder is at personal risk or a risk to other people,¹²⁹ and where 'there is a substantial risk that the mental disorder will deteriorate seriously'.¹³⁰ Once the court is satisfied that a person meets these requirements, the court may place a person in a psychiatric hospital for treatment for a period not exceeding one month.¹³¹ An individual would then require the consent of a psychiatrist or head of a facility in order to leave the psychiatric hospital.¹³² The Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment in his 2013 report recommended the repeal of provisions

authorising the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness.¹³³

Emergency treatment is addressed in section 48 of the Act. Under this provision, a police officer, a relative or any other person with or without the assistance of a police officer may take the person to a mental health facility for a certificate of urgency in cases where 'it is expedient either for the welfare of a person suspected to be suffering from mental disorder or for public safety'.¹³⁴

The Ghanaian Mental Health Act mandates several categories of substitute decision makers to make treatment decisions on behalf of a person with a psychosocial disability.¹³⁵ To illustrate, section 29 protects the right to informed consent of the individual seeking mental health care services, in particular with regard to intrusive or irreversible procedures. At the same time, the Act contains a claw-back clause authorising the Mental Health Review Tribunal to approve requests for intrusive or irreversible treatment.¹³⁶ In addition, the Ghanaian Mental Health Act mandates the

128 Sec 41(2).

129 Sec 42(1)(a).

130 Sec 42(1)b.

131 Sec 43(3).

132 Sec 50(1).

133 Méndez (n 2 above). para 68.

134 Sec 48(1).

135 Eg, the court under sec 43(3); the Mental Health Review Tribunal under secs 26(3) & 71(5); the psychiatrist or head of facility under secs 46(1) & 50; a police officer under sec 48(1); a relative under sec 48(1); the personal representative under sec 62(2); and a guardian under sec 68(1).

136 Sec 26(3).

appointment of a guardian to protect a ‘person with mental disorder’ in a range of matters including ‘the right to treatment of choice’.¹³⁷

3.3 Tanzania

Tanzania has been said to have ‘an astonishing shortage in mental health care’.¹³⁸ This section examines mental health care in Tanzania, with a focus on equality and non-discrimination; the provision of health services as close as possible to peoples’ own communities; and the provision of health care on the basis of free and informed consent.¹³⁹

3.3.1 *Obligation to prohibit discrimination against persons with disabilities in the provision of health services*

Constitution of Tanzania

The Constitution of Tanzania does not contain a provision on the right to health. Article 12 of the Tanzanian Constitution addresses the right to equality and provides that ‘all human beings are born free, and are all equal’. Article 13(4) of the Constitution concerns non-discrimination and provides that ‘[n]o person shall be discriminated against by any person or any authority acting under any law’.

Persons with Disabilities Act

Section 26 of the Tanzanian Persons with Disabilities Act 9 of 2010 provides that ‘[e]very person with a disability shall have the right to enjoy the attainable standard of health care services without any discrimination’. The Act also requires health facilities to ‘[p]rovide persons with disabilities with the same level and standard of health and rehabilitation services as provided to other citizens’.¹⁴⁰ Further, the Act requires that health and rehabilitation personnel be equipped with knowledge to respect the ‘rights, dignity and needs of persons with disabilities’.¹⁴¹ In addition, the Minister is mandated to ensure that health services provided to persons with disabilities are provided after the person has given his free and informed consent.¹⁴² In line with article 4(3) of the CRPD, the Act requires that persons with disabilities participate in planning, delivering, monitoring and evaluation of health and rehabilitation services.¹⁴³ It is an offence to

137 Sec 68(1).

138 In2mentalhealth ‘Challenges in mental health care Tanzania: What can eLearning add?’ <https://in2mentalhealth.com/2011/06/07/challenges-in-mental-health-care-tanzania-what-can-elearning-add/> (accessed 9 May 2017).

139 Arts 25(1)(a), (c), (d) & (f) CRPD.

140 Sec 26(3)(a).

141 Sec 26(3)(c).

142 Sec 26(4)b.

143 Sec 26(4)(d).

deny or discriminate against any person with a disability in relation to access to health care and rehabilitation.¹⁴⁴

Mental Health Act 2008

Tanzania's Mental Health Act 21 of 2008 does not expressly provide for equality and non-discrimination of persons with psychosocial disabilities. The Act fails to espouse equality between mental health care users and other health care users. To illustrate, the Mental Health Act discards the principle of free and informed consent with regard to mental health care users. According to section 9, a variety of state officials¹⁴⁵ are mandated to cause a 'mentally disordered person' who is not under 'proper care and control' to be brought to a mental health care facility.

Further, according to section 4(3), a mental health care user may only be discharged 'subject to the procedures available to other patients not suffering from mental disorder' if he or she is assessed and found to be capable of taking care of himself or herself and is no longer dangerous to himself or herself, the community or property.

3.3.2 *Obligation to provide health services as close as possible to people's own communities*

Mental Health Act

The Mental Health Act of Tanzania provides for both institutional care and community-based care. To illustrate, according to Tanzania's Mental Health Act, health care interventions include 'institution-based treatment, community-based treatment and social rehabilitation'.¹⁴⁶ Further, a mental health care facility is defined as including 'a forensic psychiatric hospital, rehabilitation centre, boarding houses or community houses providing care for persons with mental disorders'.¹⁴⁷

The Tanzanian Mental Health Act recognises that persons with psychosocial disabilities may require support in living in the community. According to the Act, the district social welfare officer is required to work with available mental health care facilities to improve social support structures for persons with psychosocial disabilities.¹⁴⁸ Further, mental health care facilities are required to ensure family and community involvement in the care of persons with psychosocial disabilities in the

144 Sec 26(7).

145 These include a police officer; a justice of the peace; a social welfare officer; a religious leader; a ward executive officer; and a village executive officer.

146 Sec 2.

147 As above.

148 Sec 9(3).

mental health care facility, and to be involved in establishing strategies for continuity of care.¹⁴⁹ Finally, one of the functions of the National Council for Mental Health is to encourage and facilitate community involvement in the promotion of mental health.¹⁵⁰

3.3.3 Obligation to provide health care to persons with disabilities on the basis of free and informed consent

Mental Health Act

Tanzania's Mental Health Act provides for three different categories of mental health care users, namely, voluntary, involuntary and temporary. Under the Mental Health Act, care, treatment and rehabilitation can be offered to Tanzanians with psychosocial disabilities without their free and informed consent.

To illustrate, upon the discharge of a voluntary mental health care user, the Act mandates the officer in charge of the mental health care facility to ensure continuity of care on an out-patient basis. The Act gives no consideration to whether or not the individual consents to continuing out-patient care.¹⁵¹ In addition, a person who is received as a voluntary patient in a mental health care institution shall be admitted for treatment and care using involuntary admission procedures if found to be incapable of taking care of himself or herself or a danger to himself or herself, the community or property.¹⁵² Additional criteria for involuntary admission and treatment under the Act are where there is a risk of deterioration¹⁵³ and where the individual is being 'cruelly treated or neglected by the person having the care or charge of him'.¹⁵⁴

Tanzania's Mental Health Act provides a category known as 'temporary patient', a status quite similar to 'assisted' mental health care user under South Africa's Mental Health Care Act. A 'temporary patient' is a 'person who is suffering from mental disorder or mental defect and is likely to benefit by temporary treatment in a mental hospital but is for the time being incapable of expressing himself as willing or unwilling to receive treatment'.¹⁵⁵ Under the Tanzanian Act, where an individual is unable to express himself or herself, the individual is simply deemed as a temporary patient as opposed to being provided with support to make his or her own treatment decisions. Further, Tanzania's Mental Health Act

149 Sec 28(3).

150 Sec 31(1)(c).

151 Sec 4(4).

152 Secs 4(6) & 11(7)(b).

153 Second schedule, Form 2 Medical Certificate.

154 Second Schedule, Form 3 Reception Order.

155 Secs 2 & 6.

provides for a guardian, who is defined as ‘any person having charge of a person with mental disorder’.¹⁵⁶

Section 11 provides for involuntary care ordered by the court ‘for a period not exceeding thirty days, or as may be necessary to enable the mental health practitioner to assess the nature of the mental disorder and provide treatment and care’. The Act also charges ‘any person taking care of a mentally disordered person’ to ‘ensure that the person does not abscond from treatment and care in that mental health care facilities’.¹⁵⁷

4 Assessing the three mental health laws against the CRPD standard

All three mental health laws considered allow for voluntary care, treatment and rehabilitation. However, under all the Acts, voluntary treatment can be converted into involuntary treatment if certain conditions exist. At the same time, all the Acts provide for care, treatment and rehabilitation without the consent of the individual once certain conditions are met. The common condition for involuntary treatment under all the Acts is where the person with a psychosocial disability is a danger to himself or herself or others. Hence, all three Acts limit the exercise of legal capacity by persons with psychosocial disabilities with regard to mental health treatment decision making. In addition, the Acts do not make a distinction between mental capacity and legal capacity. Under all the Acts, once an individual’s mental capacity is questioned, the individual loses the right to exercise legal capacity with regard to health care decision making among other spheres of decision making. It is clear that the Acts operate under a ‘best interests’ model rather than a model premised on the will and preference of the individual with psychosocial disabilities.¹⁵⁸

One of the key guiding principles under the CRPD is that of the full participation of persons with disabilities, often termed ‘nothing about us without us’.¹⁵⁹ The three Acts differ in the extent to which persons with disabilities are involved in mental health care systems, with the Ghanaian Mental Health Act legislating for the fullest involvement comparatively. For example, under the Ghanaian Act, the composition of the Mental Health Review Tribunal includes a service user.¹⁶⁰ Further, under the

¹⁵⁶ Sec 4(7).

¹⁵⁷ Sec 28(1).

¹⁵⁸ Eg, sec 7(2) of the South African Act explicitly states that ‘[i]n exercising the rights and in performing the duties set out in this Chapter, regard must be had for what is in the best interests of the mental health care user’. For more on ‘best interests’ versus ‘will and preference’, see General Comment 1 (n 23 above) para 21; E Flynn & A Arstein-Kerslake ‘Legislating personhood: Realising the right to support when exercising legal capacity’ (2014) 10 *International Journal of Law in Context* 96.

¹⁵⁹ Art 4(3) CRPD.

¹⁶⁰ Sec 25(2)(d).

Ghanaian Act, the Mental Health Authority should ‘consult persons with experience as service users as well as family members for the formulation, development and implementation of mental health policies’.¹⁶¹

The three Acts make mention of human rights, but differ substantially in the extent of rights protected. To illustrate, the South African and Ghanaian Acts propose specifically regulating intrusive and irreversible treatments and seclusion or restraint, while the Tanzanian Act is silent on this issue.¹⁶² South Africa’s Mental Health Care Act and the Ghanaian Mental Health Act make it mandatory for health care providers to inform mental health care users of their rights prior to treatment.¹⁶³ The Tanzanian Act is silent on this issue. The Ghanaian Mental Health Act has specific provisions for especially vulnerable persons, such as female mental health care users.¹⁶⁴ The South African Act also recognises the special vulnerability of children who use mental health services.¹⁶⁵ The Tanzanian Act is silent on this issue. All three Acts impose a penalty for neglecting or abusing a mental health care user.¹⁶⁶ Only the Ghanaian Mental Health Act provides for a treatment plan.¹⁶⁷ Under this Act, the mental health care user and their caregiver are to be involved in the development of a treatment plan.

The Acts contain a variety of safeguards around care, treatment and rehabilitation without informed consent. These include the right of appeal,¹⁶⁸ limiting the amount of time during which one can be held under involuntary care¹⁶⁹ and limiting the use of intrusive and irreversible treatments during emergency care.¹⁷⁰ An additional safeguard found only in the Ghanaian Act allows a person to lay complaints about management.¹⁷¹

Given the prevalence of human rights violations in alternative places of mental health treatment in the African context, it would be essential for mental health care laws to address this issue. Only the Ghanaian Mental

161 Sec 3(a).

162 Secs 26(5) & 66(1)(d) of the Ghana Mental Health Act; secs 66(1)(a) & (d) of the South African Mental Health Care Act.

163 Sec 17 South African Mental Health Care Act; sec 55(5) Ghana Mental Health Act.

164 Sec 64.

165 Sec 66(1)(h).

166 Sec 70(1)(c) South African Mental Health Care Act; sec 37(c) Tanzanian Mental Health Act; sec 94 Ghana Mental Health Act.

167 Sec 45.

168 Eg, sec 44(2) of the Ghana Mental Health Act; secs 35(1)(a) & 19(1)(a) of the South African Mental Health Care Act.

169 Seventy-two hours under sec 49(1) of the Ghana Mental Health Act; 24 hours under sec 9(2)(b) of the South Africa Mental Health Care Act.

170 Secs 26(5) & 57(5) the Ghana Mental Health Act.

171 Sec 59 Ghana Mental Health Act; the Tanzania Mental Health Act has a similar provision, but the provision is not specific about complaints regarding the *management*. Under the Tanzanian Act, one of the functions of the Patient Welfare Board is to receive complaints from individual patients, their relatives or any concerned third party relating to the affairs of patients.

Health Act addresses human rights violations in alternative places of mental health treatment. The Act requires the Minister to 'make regulations to provide for the welfare of patients and minimal conditions of environmental hygiene in mental health facilities including spiritual mental health facilities'.¹⁷²

Persons with psychosocial disabilities can benefit significantly from community support services. Peer support, for example, is an effective tool to support people experiencing severe emotional distress and to prevent coercion in mental health services.¹⁷³ However, none of the Acts entrenches peer support in legislation.

5 Conclusion and recommendations

The mental health laws of South Africa, Ghana and Tanzania all fall below the standard set in articles 12 and 25 of the CRPD. In legalising the non-consensual psychiatric treatment of persons with psychosocial disabilities, the mental health laws of the three countries also violate the rights of persons with disabilities to equality and non-discrimination. Article 4(b) of the CRPD calls upon state parties 'to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities'. Hence, it is clear that the reform of the mental health laws of the three countries is urgently required, given that the three countries have ratified the CRPD.

There are many challenges in Africa in implementing the right to the highest attainable standard of mental health, namely, limited resources;¹⁷⁴ corruption;¹⁷⁵ weak monitoring systems;¹⁷⁶ and limited expertise on providing health care to persons with disabilities.¹⁷⁷ It is conceded that health budgets in Africa have many demands, including HIV/AIDS, malaria and other diseases. However, mental health should also be considered a priority issue, including in resource allocation. Resource allocation should cover all the important elements of mental health care, including support for decision making; the provision of care in the community; monitoring the quality of health care services; and adequate funding for the various bodies set up under the Mental Health Acts.

172 Sec 96(1)(g).

173 Devandas (n 64 above) para 85.

174 O Nnamuchi & S Ortuanya 'The human right to health in Africa and its challenges: A critical analysis of Millennium Development Goal 8' (2012) 12 *African Human Rights Law Journal* 193.

175 Nnamuchi & Ortuanya (n 174 above) 185-189.

176 World Health Organisation Regional Office for Africa, Brazzaville, Congo 'Leveraging eHealth to improve national health systems in the African region' <https://www.aho.afro.who.int/sites/default/files/ahm/reports/47/ahm-issue-14-leveraging-ehealth.pdf> (accessed 9 May 2017).

177 Centre for Human Rights *Changing the landscape: Core curriculum on disability rights for undergraduate law students in Africa* (2015) 79.

In implementing the right to the highest attainable standard of health care, collaboration and partnerships between public authorities and civil society organisations, including representative organisations of persons with disabilities, is important, especially in the area of provision of support.¹⁷⁸

178 Devandas (n 64 above) para 64.

