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THE MAD MRS ROCHESTER[1] REVISITED: THE INVOLUNTARY CONFINEMENT OF THE MENTALLY ILL IN SOUTH AFRICA

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INTRODUCTION.

The involuntary confinement of the mentally ill describes the legal process by which a person is imprisoned for an indeterminate period not because they have committed any criminal act but because they are allegedly ill. The consequences of such imprisonment may be extreme on the person so detained. They lose not only the capacities and liberties of a free citizen, but may also lose the right to refuse "medical" treatment including electro-convulsive therapy.[2] The mere committal to a psychiatric institution is stigmatising and potentially degrading. Although the allegedly ill person opposes or denies the need for incarceration and treatment, the initial decision ordering their committal takes place without their knowledge and is subsequently confirmed in their absence. The committal process, we argue, despite a legal veneer, is essentially an administrative procedure relying on the diagnosis and opinion of medical practitioners. The consequences of a faulty diagnosis are severe, and there is much evidence to suggest that psychiatry has not reached a stage where faulty diagnosis is unlikely.

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1 Mrs Rochester, the deranged wife of Jane Eyre's employer, in Emily Bronte's *Jane Eyre*, is an enduring literary archetype of the mentally ill. Her demonic presence is underlined by her confinement in the attic. A literary attempt to rehabilitate the mad Mrs Rochester is contained in Jean Rhys' celebrated novel *The Wide Sargasso Sea* (1968).

2 The rights of mentally ill patients and the process of committal is discussed fully below.

Transposing this procedure to the criminal justice system or even to the hospitalization of the physically ill is inconceivable.

The confinement of the mentally ill relies on two related justifications: the mentally ill may be dangerous to themselves or to others; and that the confinement of the mentally ill will lead to their recuperation or convalescence. There has been sharp debate in the western world concerning the assumption that psychiatric diagnosis has the same scientific certainty as the medical diagnosis of the physically ill. In regard to the compulsory confinement of the mentally ill the debate has concerned the failure of psychiatry to predict or detect dangerousness, the scientific worth of psychiatric labels, and the value of psychiatric treatment. Until recently, for example, homosexuality was a listed mental disorder.[3]

It is notable that in South Africa the Mental Health Act[4] and its operation has received little critical comment and evaluation.[5] Part of the blame lies with s66A of the Act which has inhibited or stifled public debate and commentary on the conditions in mental institutions.[6] It is appropriate now, during a renaissance of a human rights discourse, to revisit the Mental Health Act and evaluate whether it provides sufficient protection against deprivation of the rights of persons alleged to be mentally ill, and to examine the claim that confinement is justified by its therapeutic value. We argue that the "medicalization" of the committal process has undermined the capacity of patients to assert their rights, while simultaneously introducing an unwarranted complacency by a collaborative legal establishment that confinement is synonymous with hospitalization. The shift in emphasis in the

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3 See below notes 77, 78 and accompanying text.

4 The Mental Health Act 18 of 1973, (The Act).

5 The exception to this general proposition is the position of the psychopath. See for example D M Davis `The Psychopath and Criminal Justice - A Critical Review' (1983) *SACC 259*; J P Roux `Are Psychopaths for Real' in 1981 (5) *SACC* 49 - 55. Even here the debate has been more concerned with criminal justice considerations. D M Davis `Are Psychopaths for Real - or just another Ideological Obfuscation?' (1982) 6 *SACC* 143; J Goldberg and N Morris `The Psychopath in Criminal and Mental Health Law' (1976) 9 *CILSA* 30. J H van Rooyen `The Psychopath in Criminal and Mental Health Law' (1976) 9 *CILSA* 7.

6 See s 66A of Act 18 of 1973 which prohibits the publication of false information concerning the operation of mental institution and casts the onus on the publisher to establish that steps were taken to ensure the accuracy of the allegations. An analogous and similarly worded provision in the Prisons Act of 1959 s 44(1)f has imposed a harsh standard which the publisher must meet to discharge that onus, and in consequence has effectively prevented debate on prison conditions for the last two decades. See K Stuart *The Newspaperman's Guide to the Law* (1986) 156; Ken Owen `Once Again the Poor Lunatic Looks like Being Last in Line' *Business Day* March 1990.

statutory authorization for the confinement of the mentally ill, both in South Africa and elsewhere, from mere confinement to treatment, is welcome if it entails greater attention to care and rehabilitation. However, it is also a dangerous one from the perspective of the potential patient if it broadens the justification for her/his indeterminate confinement and denies the relevance of legal "rights" on the grounds that confinement is necessarily beneficial.

The authors are acutely aware that there are persons in our society who need to be confined and that the major problem facing the mentally ill is gaining access to appropriate mental health care rather than the readiness of institutions to accept them. However, the proper allocation of resources to mental health care will not be improved by the administrative incarceration of the mentally ill in unsupervised institutions.

THE MENTAL HEALTH ACT OF 1973.

The two most important influences on the context in which the Mental Health Act of 1973 was drafted was the assassination of Dr Hendrik French Verwoerd and a resurgence of confidence in the scientific capabilities of psychiatry.

The genesis of the Mental Health Act lies in the public panic which followed the assassinations of Dr HF Verwoerd, and to a lesser extent that of John and Robert Kennedy. The commission of inquiry into the assassination of Dr Verwoerd by Demitrio Tsafendas reported that:

"It is probable that a large number of assassinations, if not the majority, are committed by mentally disordered persons. They are pre-eminently the ones who could be used to commit a murder."[7]

In accordance with this commission's recommendations, a second commission of inquiry was appointed to investigate the efficacy of the law regarding the prevention of dangerous acts by mentally disordered persons. This commission, the Rumpff Commission,[8] duly recommended the appointment of yet a third commission of inquiry into the Mental Disorders Act of 1916. It was this third commission of inquiry, the Van Wyk

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7 Report of the Commission of Inquiry into the Circumstances of the Death of the late Hon Dr H F Verwoerd under Mr Justice J J van Wyk, RP 16/1967 (The Verwoerd Commission).

8 Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters under Mr Justice F L H Rumpff, RP 69/1967 (The Rumpff Commission).

Commission,[9] which proposed the amendments to mental health legislation which eventually found expression in the Mental Health Act of 1973.

According to Kruger, the Act marked a distinct shift in the approach to the confinement of the mentally ill.[10] The discernable concern to facilitate the identification, capture and incarceration of the mentally ill found its ideological justification in the notion that confinement constituted "treatment". The notion that involuntary detention constitutes a form of hospitalization casts the Mental Health Act as an enlightened and humane Act whose emphasis is on rehabilitation and treatment. The concern to protect society from the mentally ill informed in the late sixties by re-awakened primal fear of the deranged lunatic[11] has been represented by the apparent concern to cure the mentally ill.

The clear sentiment in the van Wyk Commission that the objective of the Mental Health Act should be to equate the position of the mentally and physically ill[12] indicated a greater confidence in psychiatry than that expressed by Judge van den Heever in *R v von Zell*[13] that psychiatry is "a speculative science with rather elastic notation and terminology, which is usually wise after the event".

INVOLUNTARY CONFINEMENT IN SOUTH AFRICAN LAW.

This article is concerned with the procedure for the enforced confinement and committal of persons deemed to be mentally ill. The article does not directly

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9 Commission of Inquiry into the Mental Disorders Act 38 of 1916 and Related Matters under Mr Justice J J van Wyk, RP 80/1972 (The Van Wyk Commission).

10 A Kruger *Mental Health Law in South Africa* (1980) 26-8. In the first place the Act, following the Van Wyk Commission report, places greater emphasis on consent and voluntary patients. Secondly, the Act expressly refers to the necessary `treatment' of patients, and not merely their control and confinement. See also Van Wyk Commission, note 9, 3.8.2.

11 The Verwoerd Commission, for example, recommended that all medical practitioners be compelled to submit the names of all their dangerous mentally ill patients to a Commissioner of Mental Health RP 16/1967 para 10.20. This sentiment found statutory form in s 13 of the Act which requires that practitioners report such persons to a magistrate. See also s 14(2) of the Act which allows for the police detention of persons suspected of being dangerous and mentally ill. Section 13, understandably, provoked a controversy at the time of its enactment on the grounds that it constituted an invasion of the privacy of the doctor - patient relationship and that persons might not seek medical assistance out of a misapprehension that they would be reported. See S A S Strauss *Doctor Patient and the Law* (1984) 87.

12 Report of the Commission into the Mental Disorders Act 38 of 1916 RP 80/1972 para 3.8.2.

13 *R v Von Zell* 1953 (3) SA 303 (A) at 311.

concern itself with the position of voluntary patients,[14] nor those deemed incapable of consent,[15] nor with those held as State President's patients after a determination to this effect in the criminal courts.[16] Before critically evaluating the provisions of the Mental Health Act relating to involuntary committal it is necessary to outline the three phase committal procedure set out in the Act.

The first phase provides for the initial committal of a person alleged to be mentally ill to a mental institution for observation. Any person over the age of 18 years who believes that another person is suffering from mental illness "to such a degree that he should be committed to an institution" may apply to a magistrate for an order that the person be detained at a mental institution.[17] This application, setting out the grounds for the application, may be accompanied by a medical certificate and must be handed to the magistrate within seven days after the date it is signed by the applicant.[18] The magistrate in turn calls to her/his assistance two medical practitioners who provide him with a written record of an examination of the allegedly mentally ill person: provided that if only one medical practitioner is available the magistrate may rely only upon this single practitioner's certificate:[19] provided further that s/he need not call for any further certificates if the accompanying certificate has been compiled within 14 days of the application.[20] The magistrate need not personally examine the allegedly mentally ill person although s/he may, if s/he so wishes, conduct further inquiries and examine the patient. The proceedings are conducted in private. After due inquiry the magistrate may order the committal of the person if s/he is "satisfied that such person is mentally ill to such a degree that he or she should be detained as a patient".[21]

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14 Dealt with in Chapter 2 of the Act.

15 Section 4 of the Act contemplates admission by the superintendent of persons who do not understand the meaning and effect of institutionalisation but who do not `oppose' such treatment.

16 Dealt with in Chapter 4 of the Act. A State President's patient is one who is committed to a mental institution on the order of a criminal court when the accused is found not guilty by virtue of insanity or is found to be incapable of understanding the legal proceedings. Sections 77 and 78 of Act 51 of 1977.

17 Section 8 (1).

18 Section 8 (3).

19 Section 9(1).

20 Section 9 (7).

21 Section 9 (3).

A notable feature of the decision to commit or order the reception of a person is the broad definitions of "patient" and of "mental illness". A patient is a person who is mentally ill:[22]

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

Mental illness is defined in equally broad terms as:[23] "any disorder or disability of the mind and includes any mental disease, any arrested or incomplete development of the mind and any psychopathic disorder".

The restrictive qualification that the person be so mentally ill that it is "necessary that he be detained, supervised, controlled and treated" (author's emphasis) is rendered nugatory by the inclusion of persons "suspected" or "alleged" to be so mentally ill. It should be mentioned that this first phase may be short circuited by a special urgent procedure in terms of which the allegedly mentally ill person is committed directly to an institution upon application to the superintendent.[24] After reception the committal process is brought into operation.

The second phase of the committal procedure commences after the issue of the reception order. The reception order authorizes the detention of a patient for a period not exceeding 42 days. During this period the patient is examined by a medical practitioner or the superintendent of a medical institution. This report is then transmitted to the Attorney-General who is referred to in the Act as the "official *curator ad litem*".[25] The Attorney-General may require further reports on the mental condition of the patient but usually simply remits the certificates and reports to a judge in chambers.[26]

The third phase involves the final determination on the fate of the patient by a judge in chambers after considering the reports and certificates submitted to

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22 Section (1).

23 Ibid.

24 Section 12 provides for the superintendent of a mental institution to receive a patient in need of care or control urgently, upon application directly to him. The superintendent thereafter notifies the magistrate of the admission.

25 Section 18.

26 Section 19.

him or her. The judge may inter alia make an order for the further detention of the patient, generally indefinite detention,[27] or direct that the patient be discharged immediately or that a further inquiry be held. This procedure is also conducted in private,[28] even if the patient is not present. If the detention is confirmed the patient is confined in the institution until discharged by either the Director General, the hospital board, the superintendent or a medical practitioner at the institution.[29]

SAFEGUARDS AGAINST INAPPROPRIATE CONFINEMENT.

It is clear from this procedure that the courts must rely on the opinions of the medical practitioners for the determination not only as to the existence of any mental disorder, but also in regard to the second requirement that it is necessary to control, supervise and treat the patient. These may be general practitioners and are not required to be psychiatrists and may not be psychologists.[30] The principle safeguards in the Act against a *mala fide* committal, unjustified detention, or continued confinement after confinement is necessary, exist in three forms. First, the position of the Attorney-General as an official *curator ad litem*. Secondly, the Act allows the person concerned or any relative or guardian to apply directly by petition to the court for an inquiry into the mental condition of the person detained.[31] Thirdly, s23 prohibits a variety of persons who may have an interest in the committal of a person from giving a medical certificate required for the committal of an allegedly mentally ill person.[32] The disqualified persons include relatives or partners, or officials of the institutions or households or dwellings to which a patient is to be admitted.

The Act should attempt to balance and protect the interests of society, persons accused of being mentally ill, and persons confined on account of a finding that they are mentally ill. The adequacy of the Act's attempt to do so is best assessed by reviewing the relative provisions cumulatively. Our

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27 Ibid. See, too, Kruger note 10 at 68.

28 Ibid.

29 Section 25 (4), s53 (3).

30 Section 8 (3), 9(1). See note 44 below.

31 Section 21.

32 Section 23 prohibits medical certificates given inter alia buy the applicant's close relatives, certain members of the institutions which will receive the patients, or persons closely related to the medical practitioner furnishing the certificate.

submission that the Act fails to find a proper balance does not hinge on the failure of any single provision, but on the general assumptions underlying the process.

First, the definition of "mental illness", and of "patient", is so broad, even circular,[33] that it can never have been intended that it would guide the judicial officer responsible for committing or confining the patient. This broad definition places the magistrate entirely in the hands of the medical practitioners on whose report he or she relies. The magistrate and the judge respectively can only rubber stamp the opinion of the medical expert. In effect the medical practitioner will be required to make two findings: that the patient is mentally ill; and that the patient requires control, confinement, supervision and treatment. In regard to both findings the medical doctor will have to rely on her/his own experience and diagnostic manuals.

The broad definition of a mental illness reflects, as Professor S A Strauss comments, that:[34] "Today, the isolation of the mentally ill is a medical and administrative rather than a judicial activity." South Africa is not alone in opting for a wide definition of mental illness. South Africa has followed the United Kingdom in deciding that it is "unnecessary for the purposes of law to attempt to define the concept of `insanity'" and also that it is undesirable.[35] The Rumpff Commission cited, in support of this option, the remarks of Lord Blackburn:[36]

"I have read every definition of insanity which I could meet with, and never was satisfied with one of them, and I have endeavoured in vain to make one satisfactory to myself. I verily believe that it is not in human power to do it."

The Van Wyk Commission similarly recommended that the expression "mentally ill" should be wide enough to include "all possible classes of mentally disordered or defective persons".[37] The failure to provide a specific

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33 `In circular fashion the law defines mental illness as a psychiatric or other disease which substantially impairs mental health.' R Slovenko *Psychiatry and the Law* (1973) 208 cited in Kruger op cit note 10 at 49.

34 S A Strauss *Doctor, Patient and the Law* (1984) 78.

35 Rumpff Commission para 9.79.

36 Ibid para 9.77.

37 Kruger op cit note 10 at 49.

definition of mental illness touches on the heart of the matter. Brenda Hoggett comments:[38]

"defining mental disorder is not a simple matter, either for doctors or for lawyers. With a physical disease or disability, the doctor can presuppose a state of perfect or "normal" bodily health and point to the ways in which the patient's condition falls short of that. A state of perfect mental health is probably unattainable and certainly cannot be defined. The doctor has, instead, to presuppose some average standard for normal intellectual, social or emotional functions, and it is not enough that the patient deviates from this, for some deviations will be in the better than average direction. Even if it is clear that the patients capacities are below the supposed average the problem still arises of how far below is sufficiently abnormal, among the vast range of possible variations, to be labelled a `disorder'."

As we shall argue, it is not our contention that the medical diagnosis of a patient should be the task of the judicial officer. Rather, it is submitted that the law should establish a framework within which expert opinion is properly based and tested. A review of the British Mental Health Act of 1959, published by the United Kingdom Department of Health and Social Security, reported in 1976 that the interpretation of mental illness is a matter of "individual medical opinion".[39] The wider definition in the South African Act broadens the powers of compulsory admission even beyond that contained in s4(1) of the British Mental Health Act of 1959.[40] For our purposes it is necessary only to note the difficulties faced both by medicine and the law in offering a definition of mental illness, and the consequent reliance on individual medical diagnosis that this has caused. The challenge to the law is to provide a framework whereby any individual medical diagnosis is properly assessed and tested, recognising the fallibility and even subjective nature of such diagnosis. Does the Mental Health Act meet this challenge?

One means of meeting the challenge to test medical opinions would be to allow the resisting patient an opportunity to contest the certification of her/his mental health at either of the judicial stages. However the Act makes no provision for notice to be given to the patient, nor is he or she made aware of

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38 B Hogget *Mental Health* (1976) 59 cited in Kruger op cit note 10 at 49.

39 *A Review of the Mental Health Act 1959* Department of Health and Social Security (1976) para 1.9 (the Review).

40 Ibid. The British Act lists several sub-categories of mental illness. A general definition as in South Africa broadens the powers of the committals according to the Review.

the contents of the reports furnished to the judicial officer. The patient is not present at the enquiries, and the Act makes no provision for the judicial officers to allow him or her/his psychiatrist to contest the reports furnished. That it was possible to introduce some elements of an adversarial approach to the determination of mental illness is clear from the provisions relating to the committal of psychopaths. Here the regulations allow a psychopath to be present at the inquiry into his or her committal and to be legally represented.[41] The law also requires additional certificates, in regard to the committal of psychopaths, from a social worker, a clinical psychologist and a psychiatrist.

A second means of meeting the challenge to test the diagnosis would be to ensure that any medical reports are subject to independent corroboration. In this regard the Act implicitly recognises a possible divergence of opinion by allowing for three medical certificates prior to the order to commit a patient. However this process is undermined by the proviso which provides that one certificate will be sufficient. The problem of relying on a single report, or, in the case of a committal order, two reports, is compounded by the fact that the Act only requires that such certificates be filled out by a medical practitioner. Black patients are interviewed by white doctors or psychiatrists through an interpreter, thus compounding the errors in perception which may occur not only where there are vastly differing patient populations but very different behavioral norms between diagnostician and patient. This is of particular importance where diagnosis must rely on the assessment of the patient's behaviour as a symptom of a hidden disease which has no other outward manifestations.[42] There is no requirement that the medical practitioner need have experience in psychological or psychiatric care. Indeed the Van Wyk Commission deemed it advisable that a clinical psychologist be used, at least for the reception order:[43] "Registered clinical psychologists are frequently better qualified than the general practitioner to report on the mental state of the patient."

This recommendation was rejected by the Minister of Health who stated:[44]

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41 Section 2 of the general remarks to the Regulations to the Mental Health Act 1973 GN R565 Reg Gaz 2127 *GG* 4627 of 27 March 1975.

42 J E Wild `"Mad or Bad": The Psychiatrists Discretion' in M C J Olmesdahl and N C Steytler (eds) *Criminal Justice in South Africa* (1983) 224 at 231.

43 Van Wyk Commission para 3.8.6.1.

44 Cited in Kruger op cit note 10 at 64.

"The medical practitioner on the other hand receives a comprehensive training and is best equipped to make a correct diagnosis... It could well happen that a person could be certified as mentally ill while his illness could have been cured by means of surgical or other medical procedure."

While a certificate from a general practitioner is preferable to an examination and diagnosis performed by the magistrate himself it is not an adequate to basis for a decision overruling the will of a patient to undergo treatment. The Minister's remark reveals an astonishing faith in the psychodiagnostic capabilities of general practitioners.

Where the Act does seek to introduce a restrictive provision on the furnishing of certificates it is directed not so much at verifying the diagnosis, as at establishing the *bona fides* of the doctor. Thus, s 23, in inhibiting or restricting the classes of persons who may furnish a certificate, places the emphasis on the prevention of the improper committal of persons to secure personal gain. This constitutes some recognition that wrongful committal is perfectly possible within the framework of the Act once a doctor is prepared to furnish a report supporting certification. In a similar vein the court's supervision of the operation of the Act has focused on strict formal compliance with the provisions.[45]

The Act does provide for access to the courts. How effective are the channels provided? First, the reference to the Attorney-General as a *curator ad litem* is a misnomer. Kruger, commenting on his own experience in the Attorney-General's office is of the view that, in regard to this function, the attorney-general in reality plays the function of a registrar,[46] and does not look after the interests of a patient in any adversarial sense. Letters to the attorney-general by the alleged lunatic are simply referred to the judge.[47] This does not amount to an application to court. The person or her/his relative or guardian may however apply directly to court which would ensure that the application is formally considered. It would seem however that for most persons committed, particularly black patients, adequate access to the court is barred by a lack of means and possibly by lack of knowledge of any remedy.

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45 *Rutland v Engelbrecht* 1952 (2) SA 338 (A); *Day v Minister of Justice* 1913 TPD 853.

46 A Kruger `Die Amptelike Curator ad litem van Geestesongestelde Persone' in 1977 (40) *THRHR* 260. `Registrar', here, is a reference to a legal, not medical, registrar.

47 Ibid. The letters are simply and informally given to the judge who decides whether `he thinks any action should be taken'. *Ex parte Trimble* 1958 (4) SA 22 (N) at 23.

For the first three years and thereafter in the fifth year, the eighth year, and every three years thereafter, the superintendent of the mental institution in which a patient is being held submits a report to the Director General of Health and Population Development as to the mental condition of the patient.[48] A patient may be released as a result of one of these reports, or by the hospital board after proper inquiry but there is little onus on an institution to justify the continued detention of a patient. Indeed the general shortage of space at such institutions and the lack of adequate psychiatrists to serve at these institutions means that, in all probability, it is the pressure to accommodate patients in need of hospitalization that is likely to secure the release of an inmate.[49]

Finally, regarding the treatment of patients and conditions at institutions, it should be noted that mental institutions are treated in the same way as a prison in regard to reporting on conditions in such institutions. Section 66A of the Act casts the onus on any person who publishes incorrect information on a mental institution to establish that s/he has taken reasonable steps to verify the truth thereof. The analogous provision in the Prisons Act[50] has been interpreted in a way that has stifled and restricted reporting on prison conditions. It is clear from the absence of public awareness on conditions in mental institutions that the same is true for mental institutions. One of the justifications for a provision in the Prisons Act which limits legal supervision of prison conditions is that judges have access to prisons for the purposes of inspecting conditions therein and receiving complaints from prisoners.[51] There is no provision for judges or magistrates to visit mental institutions. Hospital boards, however, are required to visit the institution in respect of which they have been appointed at least every two months.[52] The board reports on the outcome of its visits to the Minister of Health and Population Development. The authors remain sceptical as to whether a member of a board would have the same authority and stature as a judicial officer. The monitoring of the treatment of the mentally ill is all the more important in that

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48 Section 25.

49 E P Nkhabele *The Attitude of Mental Health Professionals Towards Primary Mental Health Care* (unpublished BA Hons dissertation 1989) 38. A psychiatrist interviewed by the author referred to overcrowding and the `revolving door' syndrome as this institution was compelled to release 200 patients a month.

50 Section 44(1)f of Act 8 of 1959. See note 6.

51 In *Goldberg v Minister of Prisons* 1979 (1) SA 14 A this safeguard is cited to justify the limitations on access to the courts. See also G Marcus `Prisons: A Judicial Obligation' 1984 (3) *Bulletin of the Lawyers for Human Rights* 67 -78.

52 Section 49.

the South African law, unlike in the United States, has not recognized a clear right of a medical patient to refuse treatment.[53] If, as Ken Owen suggests, patients are, "drugged until their condition stabilizes, and then discharged onto the streets"[54] and potential abuses in mental institutions escape public exposure, those who are responsible for the decision to commit the mentally ill should at least be aware of the conditions in mental institutions.

In short the Mental Health Act has, by medicalising the committal process, undercut the potential for patients to resist confinement and treatment. This has been accomplished by establishing a correspondence between the diagnosis and treatment of the physically ill and the diagnosis and treatment of the mentally ill. It is not suggested that the judiciary should be involved in taking medical decisions, but that due process elements could and should be incorporated into the process in order to ensure that compulsory confinement and treatment is administered only when it is necessary to disregard the opinion of the patient himself. It can and has been argued that a due process, or "regstaatlike", approach to the committal of the mentally ill is entirely inappropriate.[55] To this extent we can talk of a due process -social control debate in the area of mental health care and psychiatric confinement.

THE DUE PROCESS - SOCIAL CONTROL DEBATE.

The due process approach argues that as long as a patient is competent to understand the nature of psychological treatment, he or she should also be able to refuse treatment. Such an approach holds that, contrary to popular belief, mentally ill patients do not necessarily show the poorest comprehension of consent information and do not reach irrational decisions more often than others.[56] If the goal of psychological intervention is the achievement of a patient's contentment, it is questionable whether a patient who is comfortable with him or herself should be treated. The adherents of

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53 The US federal court recognized at first a qualified and subsequently an absolute right to refuse treatment. *Rennie v Klein* F Supp 1342 (DC Mass, 1979); *Rodgers v Okin* 4 F Supp 478 (DC Mass 1982) cited by Wanck B `Two Decades of Involuntary Hospitalization Legislation' in 1984 (141) *American Journal of Psychiatry* 33. In South Africa consent is required for drastic treatment or for an operation but this is to be provided by a relative. See s 60A. Indeed the certified patient's consent is irrelevant.

54 Ken Owen note 6 above.

55 M Zajc `The Right to Refuse Antipsychotic Medication: Who Decides?'(1987)6 *Medicine and Law* 45; see S A Strauss op cit note 34 at 87; see, also, notes 62 - 66 below.

56 H L Packer `Two Models of the Criminal Process' 1964 (118) *University of Pennsylvania Law Review* 163, though Packer refers to a due process - crime control model.

the due process approach see in the supposition that the "adequate functioning" of a patient should be a criterion for their discharge, the denial of the patient's volitional ability and worth as well as a potential for psychiatric autocracy.[57] Stressing that sane but dangerous criminals are released after serving their sentences, the due process approach stresses the importance of limiting, or supervising the exercise of official power and insists on a formal, adjudicative, adversarial, fact finding elements to the committal process. They argue that current procedures render the due process element vacuous since the judicial decision is pre-determined by the judge's limited knowledge of mental illness, their faith in the medical model, and the assumption that treatment cannot hurt.[58]

Those who favour the social control position stress the danger posed by the "deranged" and lunatics, not only to ordinary members of society but to themselves. It is further argued that immediate internment and treatment may allow patients greater autonomy by re-establishing the ability to think rationally.[59] This position suggests it is more benign to concentrate on developing the patients' general competencies than to focus on their immediate rights.[60] Internship will increase patients' coping skills and will eventually heighten their independence and autonomy in the outside world. They stress the importance of judicial deference to medical evidence and argue that a due process approach will result in a challenge to medical autonomy and an even greater danger that judges will take on the role of psycho-diagnosticians.[61] The underlying assumption behind many of these assertions is the belief in the therapeutic efficiency of psychiatric care, and the inappropriate intervention of legal procedures in the administration of such care.

It is be wrong to view this debate as a professional battle between psychiatrists and lawyers. On the one hand the medicalization of the committal process relies on the happy collaboration between both professions.

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57 M Zajc op cit note 55 at p49 citing Barry R Furrow `Public Psychiatry and the Right to Refuse Treatment' 1984 (19) *Harvard Civil Rights Law Review* 21.

58 Rosenberg and Rosenberg `Psychiatry: the Lost Horizon' in 1981 *Legal Medicine* 82; D Mechanic *Mental Health and Social Policy* (1969) 27.

59 D Mechanic op cit note 58 at 128.

60 M Zajc op cit note 55 at48 citing Appelbaum and Gutheil `Drug Refusal: A Study of Psychiatric Inpatien's' (1980) *American Journal of Psychiatry* 137.

61 Ibid.

On the other hand critiques of the social control protagonists have emanated from within psychiatry itself. It is necessary to deal with only two of these criticisms: first, that psychiatry is frequently incapable of accurately predicting dangerous conduct or of detecting the mentally ill; secondly, that the treatment actually delivered to the mentally ill does not necessarily warrant the faith placed in it by the judges who commit patients, the doctors who treat them, or the public which takes comfort from their committal.

PSYCHIATRIC DIAGNOSIS: SCIENCE OR SPECULATION.

In regard to the first criticism, there have been several research programmes conducted for the explicit purpose of measuring the accuracy of the psychological categorization of a patient as dangerous. Perhaps the best known is the *Baxtrom* case in which a natural experiment occurred as a result of a Supreme Court decision ordering that prisoners detained as psychologically disturbed and dangerous be released. Nine hundred and sixty seven patients were transferred mostly to civil mental hospitals and thereafter released into the community. Follow up research revealed that only two percent were returned to institutions for the criminally insane.[62] Furthermore Kozol's research has indicated that it is necessary for the effective incarceration of the dangerous to detain two false positives (persons who would not commit a dangerous act) for every one positive (a person who would commit a dangerous act).[63] One of the reasons for the inability to accurately predict violence is that violence in itself has a situational quality. It does not necessarily inhere in certain dangerous individuals. It may erupt in crisis situations (although it is accepted that different persons have differing potentials for anti-social conduct).[64]

More fundamentally, various studies have challenged the reliability and meaning of such terms as sanity and schizophrenia. What is viewed as normal in one culture may be seen as quite aberrant in another. Or, put differently, can the sane necessarily be distinguished from the insane, and can degrees of insanity be distinguished from each other? The psychiatric establishment believes the answer to both questions is in the affirmative, as Rosenham commented:[65]

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62 Horowitz `Court Legislated Reform: Viable Approach or Paper Victory' in R Castel, F Castel and A Lovell (eds) *The Psychiatric Society* (1982).

63 F Goldberg and N Morris `Psychopaths in Criminal and Mental Health Law' 1976 (30) *CILSA* 46.

64 H Kozol *Crime and Delinquency* 371.

65 Goldberg and Morris op cit note 63 at 47.

"From Bleuler through Kretchmer, through the formulators of the recently revised diagnostic and statistical manual of the American Psychiatric Association, the belief has been strong that the patients present symptoms, and that those symptoms can be categorised, and, implicitly, that the sane are distinguishable from the insane."

More recently, however this belief has been questioned. Based in part on theoretical and anthropological considerations, but also on philosophical, legal, and therapeutic ones, the view has grown that psychological categorization of mental illness is at best misleading, and at worst perjorative. Rosenham set out to test this thesis by submitting eight pseudo-patients to a mental institution.[66] If their sanity was detected it would be prima facie evidence that a sane individual can be distinguished from the insane context in which he or she was found. The eight sane people gained admission to twelve different hospitals. Despite their display of sanity the pseudo-patients were never detected. Admitted, except in one case, with a diagnosis of schizophrenia, each was discharged with a diagnosis of schizophrenia "in remission". It was however quite common for fellow patients to "detect" a pseudo-patient's sanity. An institution which doubted the results of this research survey was informed that one or more pseudo-patients would attempt to be admitted into that psychiatric hospital and each staff member was asked to rate each patient who presented himself according to the likelihood that the patient was a pseudo-patient. Forty one patients out of 193 were alleged with high confidence to be pseudo-patients by at least one member of the staff. Actually no pseudo-patient presented himself at the institution. Rosenham concludes:[67] "One thing is certain; any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one."

The more radical critique of the diagnostic process relates to the psychiatric labels themselves. The most radical of these critiques emanates from the anti-psychiatry movement. The movements' leading protagonist, Thomas Szasz, stated:[68]

"A disease of the brain, analogous to a disease of the skin and bone, is a neurological defect, not a problem in living. For example, a defect in a

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66 D L Rosenhan `On Being Sane in Insane Places' in (1973) 179 *Science* 251.

67 Ibid.

68 Ibid at 252.

persons visual field may be explained by correlating it with certain lesions in the nervous system. On the other hand, a persons `belief'- whether it be in Christianity, communism or in the idea that his internal organs are rotting and that his body is already dead - cannot be explained by a defect or disease of the nervous system."

Szasz criticized western psychiatric practise on the basis that it controls behaviour which deviates from the psychological norm by labelling it mental illness. Labelling persons as mentally ill serves the function of unifying the rest of society, identifying scape goats and in isolating deviant behaviour.[69] In particular the anti-psychiatry movement viewed the concentration of power in the hands of selected mental health professionals, coupled with the development of new and sophisticated techniques for behavioral control, as a threat to individual human rights. In the hands of Szasz and French philosopher Michel Foucault,[70] the confinement of the mentally ill was part of a more elaborate form of controlling aberrant behaviour and they considered that mental institutions are institutions within a broader social disciplinary framework. Although the claims of the anti-psychiatry movement that mental health is a social construct have been appropriately criticized for their denial of an organic base to some forms of mental illness and for their denial of the real need to care for others who are incapable of caring for themselves, Szasz was the first to draw attention to the cultural and historical relativism in the diagnosis of mental illness. In his view mental illness could be and was used to punish those with merely inappropriate belief systems.

Although Szasz argued against the mainstream psychiatric establishment in the USA, his view that psychiatric labelling was intrinsically susceptible to political manipulation appeared to be corroborated by revelations of the internment of dissidents in the Soviet Union. There are numerous documented cases of the use of psychiatric abuse in which dissent was categorised as a form of schizophrenia or a form of pathological paranoia.[71]

One case which illustrates this viewpoint is that of General Pyotr Grigorenko.[72] Son of a peasant family in the Ukraine, Grigorenko rose to the

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69 T Szasz *Ideology and Insanity* (1974) 13. For Szasz just as societies sought out witches in the 17th century, today it seeks out the mentally ill.

70 M Foucault *Madness and Civilization* (1967).

71 E Stover and E Nightingale *The Breaking of Bodies and Minds* (1985) Part II `Psychiatric Abuse'.

72 W Reich `The Case of General Grigorenko: A Second Opinion' in Stover and Nightingale op cit note 71.

rank of major-general and was the author of more that 60 articles on military science. He was rewarded with numerous decorations including the order of Lenin and 11 other military medals. After he called for the democratization of party rules in 1961 he was stripped of his post at the military academy and in 1963, after he called for a return to Leninist principles, he was arrested and charged. Instead of a formal prosecution he was sent for observation, found to be ill and in need of compulsory hospitalization. In 1969 after testifying in favour of Tartar dissident leaders he was himself charged, and again sent to a psychiatric commission for an examination (which found him sane). He was later moved to the Serbsky Institute in Moscow for a second examination which reported as follows:[73]

"Grigorenko is suffering from a mental illness in the form of a pathological (paranoid) development of the personality, with the presence of reformist ideas that have appeared in his personality, and with psychopathic features of the character and the first signs of cerebral articular sclerosis. Confirmation of this can be seen in the psychotic condition present in 1964 which arose during an unfavourable situation which manifested itself in ideas, with strongly affective colouring, of reformism, and of persecution. Reformist ideas have taken on obstinate character and determine the conduct of the patient: in addition, the intensity of these ideas is increased in connection with various external circumstances which have no direct relation to him, and is accompanied by an un-critical attitude to his own utterances and acts. The abovementioned condition of mental illness excludes the possibility of his being responsible for his actions and controlling them: consequently the patient must be considered of unsound mind."

In support of this general analysis the Serbsky Commission found that Grigorenko exhibited "paranoid interpretation of neutral facts", "over-estimation of his own knowledge and capabilities", and that Grigorenko was "irritable and unable to bear contradiction". As a result the Serbsky Institute found him mentally ill as a result of paranoid delusional development of the personality combined with the first signs of articular sclerosis of the brain.

The documented instances of psychiatric abuse in the Soviet Union was evidence of exactly the phenomenon Szasz and others had warned was capable within mainstream mental health care in the United States.

A related challenge to the assumptions underlying psychiatric care was that which contested the ability of mental institutions to provide any therapeutic

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73 Ibid at 191.

benefits for their patients. Goffman's celebrated work *Asylums*[74] illustrated that mental institutions, and other "total" institutions such as prisons, were capable of shaping or re-shaping inmate behaviour in conformity with the institutional culture. The institutional culture in turn imposes behaviourial patterns on inmates which conform to the custodian's view of how the inmate should perform. The principal effect of Goffman's study was to suggest that mental institutions damage inmates by reducing their sense of self-worth, stripping them of self-autonomy and stigmatising them as mentally incompetent.

From this perspective the Fourth Annual North American Conference on Human Rights and Psychiatric Oppression held in Boston in May 1976 adopted the following resolution:[75]

"We reject compulsory commitments to mental hospitals. We reject the mental health care system, because it is by nature despotic and acts as an extra-legal police force for the suppression of cultural and political dissidents. We reject the concept of mental illness because it is used to justify involuntary commitment, and in particular we reject the imprisonment of people who have committed no crime... We reject the use of psychiatric terminology, because it is intrinsically stigmatising and degrading, non-scientific and magical."

There are various flaws with this radical approach. Far from encouraging the provision of mental health services it ignores the possible benefits of psychiatric care. It provides no alternatives for those individuals who are not capable of caring for themselves and by categorising mental illness as a social construct it ignores the possibility that mental illness may indeed have an organic base. The movement is however important in revealing that the meaning of mental illness is often "rooted deeply and widely in the ethical/legal notions of our culture, rather than a special esoteric or technical notion".[76] Thus, for example, the second edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association* (DSM II), a widely read psychiatric handbook, categorized homosexuality as a mental disorder.[77] The fact that a more socially

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74 E Goffman *Asylums* (1968).

75 Castel et al op cit note 62 at 251.

76 H Fingarette *The Meaning of Criminal Insanity* (1972) at 23.

77 DSM II *The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association* (1968) 2 ed.

permissable attitude has lead to the de-classification of homosexuality as a mental disorder (except in its ego-dystonic form)[78] in the current edition of the manual, DSM III, must surely underline the concern of the anti-psychiatry movement that psychiatric diagnosis and treatment can confuse social with individual problems. It was this perception which informed the deviancy theorists of the 1970s who sought to unmask the claims by positivistic sciences to be value free. The rhetoric of psychiatry they argued was a means of social control which offered "a cloak of scientifism to justify policy decisions".

A related but different criticism of the conventional approach to the psychiatric care of the mentally ill emanates from those psychiatrists and psychologists who locate at least part of the cause for mental illness in the social, political and economic conditions of the patient's community.[79] Such an approach argues that a purely individual approach to the problems of the patient removed from the context in which the aberrant behaviour takes place, is incapable of understanding the causes of the behaviour or of remedying the conditions which gave rise to it. The community social action model and the community health model argue that it is insufficient to institutionalise an individual whose mental health is a function of societal conditions. The community health model argues for the provision of services to the community as an alternative to institutionalization, and the diversion of patients from psychiatric hospitals to such organizations as community mental health centres. For the purposes of this article it is well to note that mental health may be infected by the social conditions in which people live. Any model which relies solely on the incarceration of individual deviants can provide only an illusory sense of security from dangers caused by the social system.

If nothing else, the critics of psychiatric diagnosis have served to warn society of the potential manipulation of diagnostic labels, and of the doubt which should exist in their intrinsic heuristic value. This should not be a novel insight. Our courts regularly witness eminent psychologists doing battle in an attempt to assert the application of one or other psychiatric classification to an accused persons' personality or her/his conduct. The courts are more willing to accept diagnostic classification uncritically in civil committal cases

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78 DSM III *The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association* (1980) 3 ed.

79 For a Community Mental Health Model see B Bloom `Community Mental Health' in O Grusky and M Pollner (eds) *The Sociology of Mental Illness* (1981).

because, we suspect, of an implicit belief in the therapeutic efficiency of institutionalization.[80]

If institutions are incapable of giving patients suitable therapy, proponents of a social control approach may have greater difficulty in validating the need for institutionalization. Furthermore if there is a question mark over the ability of institutions to provide basic and appropriate care, it would seem that the dangers of deviating from procedures of due process are greatly exacerbated.

MENTAL AND PSYCHIATRIC CARE IN SOUTH AFRICA.

Section 66A of the Mental Health Act has greatly inhibited discussion about mental health services in South Africa. In the 1970s both the American Psychiatric Association (APA) and the World Health Organization (WHO) voiced concern that blacks were receiving inferior treatment in South African psychiatric institutions.[81] Both the APA and the WHO reports focused primarily on the inadequate services at the government funded psychiatric facilities at the privately owned Smith-Mitchell and Company institutions.[82] The Smith - Mitchell facilities under contract to the South African government provide racially segregated care on a *per diem* basis for involuntary psychiatric patients transferred from state institutions. The APA report found:[83] disparate amounts being spent on mental health care for white patients and for black patients; the psychiatric care provided at the Smith-Mitchell institutions for black patients to be inadequate; the psychiatrists working at Smith-Mitchell institutions could speak none of the black languages; the facilities for patients were converted mine compounds with insufficient ventilation; toilet facilities were inadequate and dining facilities overcrowded; and that the number of beds provided were insufficient. The Department of Health had informed officials of the APA that there was a shortage of beds because blacks preferred to sleep on the floor. The

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80 In the criminal justice setting Jennifer Wild has shown how the courts defer to the psychiatrist's view on the ability of the accused to appreciate the wrongfulness of his/her actions. Of 20 criminal cases in which the accused's mental health came under consideration, the court accepted official psychiatrists report in every case. In 18 of these cases the psychiatrist was not cross-examined. J Wild op cit note 42 at 231. In civil committal cases there is no adversarial examination of the psychiatrists views, and not one to address the prejudice which the patient may suffer.

81 World Health Organization *Apartheid and Mental Health Care* MNG 77,5 (1977); American Psychiatric Association (APA) `Report of the Committee to visit South Africa in (1979) 136 *American Journal of Psychiatry*

82 Now known as `Life Care' facilities.

83 See note 81.

Department also argued that patients without shoes preferred to go bare foot. Patients interviewed reported having been beaten or assaulted by staff or having witnessed other patients being assaulted. The staff were grossly inadequate to provide decent rehabilitative treatment and nurses were under-trained. There was a high number of needless deaths among patients. Finally, the report concluded, the decision to transfer patients to Smith-Mitchell facilities was predicated on the economic constraints predicated by apartheid.

In this regard reference should be made to the segregation and fragmentation of health services in South Africa. In 1988 the R 2.9 billion public health care budget was split between a bewildering assortment of departments including own affairs ministries, provincial administrations, and separate health departments in the self-governing and "independent" homelands.[84]

The report of the World Health Organization[85] found that whereas the majority of white mental patients in South Africa received care in state hospitals and clinics, the vast majority of black patients received care in inferior private institutions. Moreover, while 17 per cent of the white patients were admitted on a voluntary basis only 2 per cent of black patients were voluntary patients. The report also found that because privately owned facilities for black patients operated on a profit-making basis which was dependent on the number of patients detained, and because patients were admitted under involuntary procedures, the system was technically open to abuse. Particular vehicle for abuse lies in the fact that the very same company who owns the institutions also owns a drug company which may lead to a preponderance of use of drugs as opposed to other forms of therapy.

The Society of Psychiatrists of South Africa, in a statement on 8 March 1989, distanced itself from the principle of treating certifiable patients in private institutions.[86] It claimed that these institutions could not be classified as hospitals. The head of the Department of Psychiatry at the University of the Witwatersrand, Professor George Hart, said that certifiable patients were "voiceless and unable to stand up for themselves".[87] The Society has also noted that although Baragwanath Hospital was one of the southern hemisphere's largest hospitals, it had no in-patient psychiatric ward.

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84 `Lady with a Limp' *Financial Mail* 3 June 1988.

85 See note 81.

86 *The Star* 9 March 1989.

87 Ibid.

Sterkfontein Hospital is the only state-run institution of its type for black patients on the Witwatersrand. The others are all privately-owned concerns.[88]

The South African government spends insufficient funds on those in need of psychiatric care. In 1986, the Department of National Health and Population Development reported a shortage of psychiatric nurses, a lack of funds and personnel, and an increased workload on already over-burdened personnel.[89] Because of a lack of adequate facilities, a mentally ill black child may have to wait five years before being admitted to an institution according to Dr Alwood of Baragwanath Hospital.[90] On a research visit made by Vogelman to a Smith-Mitchell institution on the East Rand in the Witwatersrand area in 1986, he found that approximately five hundred patients were being tended to by one fulltime occupational therapist, one fulltime physiotherapist and a few nurses. A medical practitioner and a psychiatrist each consulted at the institution only once a week. In the case of the institution mentioned above if the psychiatrist and psychologist were each to tend to each patient only once a week, this would mean that they would see at least one patient per minute. The Smith-Mitchell institution's huge standing population of both chronically ill and mentally retarded patients does not derive the full benefits of the care because of insufficient and over-extended staff. A heavy workload on staff heightens the potential for a callous attitude towards patients and their pathology. In 1986 there were approximately 9 500 involuntary patients in the custodial care of the Smith-Mitchell institutions.[91] The inadequate monitoring of patients at Smith-Mitchell institutions was recently demonstrated when the body of a patient was found three days after his death.[92]

There are approximately 200 psychiatrists in South Africa to care for a population of approximately 35 million.[93] Of these, only 5 are black, Indian or Coloured. A similar disproportionate representation of the race groups may be found in the psychological profession. Furthermore this figure disguises the fact that most psychiatrists are concentrated in the urban areas

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88 South African Institute of Race Relations *1987 Race Relations Survey* at 810.

89 *Annual Report of the Department of National Health and Population Development* (1986).

90 *The Star* 25 April 1988.

91 *The Star* 9 March 1988.

92 Interview Professor N C Manganyi University of the Witwatersrand 20 July 1988.

93 American Association for the Advancement of Science (AAAS) Mission of Inquiry *Apartheid Medicine* (1990) 52.

and some mental hospitals in the rural areas have no psychiatrists at all.[94] There are only about 10 child psychiatrists in the whole country.[95] In general psychiatrists work in private rather than in public capacities. Because of the fragmented health system psychiatrists may travel up to 200 kms to see 2 patients of one race and the next day yet another psychiatrist must travel the same 200 kms to see a few patients of another race.[96] The most recent report by the American Association for the Advancement of Science (AAAS) Medical Mission of Inquiry to South Africa reviewed the development of Smith-Mitchell (now Life Care) facilities for chronically ill and mentally retarded patients. Their report concluded that the life-care/Smith-Mitchell facilities had improved over the past 10 years but that they suffer from a severe shortage of psychiatrists.[97]

In short, in this setting, institutionalization may well benefit the members of the public who feel endangered or inconvenienced by the mentally ill. There is however little basis for any complacent assumption that such hospitalization benefits the patient.

CONCLUSION.

Recently, the Federal Court of Alabama held that:[98]

"to deprive any person of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process."

In South Africa the ethical implications of confining persons to inadequate institutions ostensibly for their treatment and rehabilitation has not been raised in the courts or in legal journals. This may be attributable to the aura of mysticism surrounding "white-coat expertise" which inhibits criticism of the mental health care professionals. In the short term the authors contend that the following statutory amendments are required.

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94 Ibid.

95 Ibid.

96 Ibid at 53.

97 Ibid.

98 *Wyatt v Stickney* 325 F Supp 781 (1971) at 325.

(1) Judges and possibly magistrates, should inspect mental institutions, to ascertain whether they are providing appropriate services. In this regard similar provisions to those contained in the Prison Regualtions, dealing with the inspection of prisons by judicial officers could serve as a model.[99]

(2) Section 66A should be abolished so as to allow for systematic studies of institutional care in South African mental institutions to be concluded.

(3) The Mental Health Act should be amended to provide that at least two certificates are required prior to the issuing of a reception order by a magistrate. At least one of the reports must be compiled by a clinical psychologist, psychiatrist, or a person with experience in the treatment and diagnosis of the mentally ill.

(4) A person in respect of whom an application is to be brought on the grounds that he or she requires to be confined and treated should be given notice of such an application and afforded an opportunity, if he or she so desires, to appear before the magistrate or to make representations to the magistrate prior to the issuing of a reception order, and,if necessary, to receive legal aid in order to instruct a lawyer to do so on his or her behalf.

(5) A person in respect of whom a reception order has been issued shall be afforded the right to obtain an independent psychiatrist, at state expense, for the purposes of compiling a report which report must be furnished to the judge in chambers together with that of the superintendent of the institution who has received the patient.

(6) The Mental Health Act should be amended to provide for a periodic review procedure whereby confined patients are assessed at regular intervals and may themselves institute, at no costs to themselves, an inquiry into their condition. Such a review board should be comprised of persons other than or in addition to persons connected to the institution in which they are confined.

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99 Regulation 104 (2) (a) of the Regulations promulgated in terms of the Prisons Act in *GG* 1326 of 31 December 1965 provides:

> 'A judge of the Supreme Court of South Africa shall at all times be afforded admission to a prison, as well as access to any section thereof and he may interview any prisoner and may report to the Commissioner in respect of any matter which he considers should be brought to the Commissioner's notice.'

(7) The definition of patient in the Mental Health Act should be amended so as to make it clear that a reception order may be issued only where confinement, control and treatment is necessary in the sense that the failure to so confine the patient will result in harm to him or herself or to others.

In the medium term the more appropriate solution to the state of mental health care and treatment in South Africa can only lie in rational and increased allocation of resources, on a non-racial basis, through a central, single department of health. In the long term it may be argued that a complete overhaul of the existing political system is required for the mental health services to operate optimally in a non-pathological social setting. An increased appreciation of the rights of the mentally ill would, in our view, encourage a more sympathetic treatment of their plight, as well as protect society from the potential abuses which may take place in the name of psychiatric rehabilitation.