Assessing The Accused

"What a fantastic creature is man, a novelty, a monstrosity, chaotic, contradictory, judge of all things, feeble earthworm, bearer of truth, mine of uncertainty and error, glory and refuse of the universe! Who can undo this tangle?"
– Blaise Pascal in "Pensées"

Sean Kaliski

Participants in our adversarial legal system are required to be competent during proceedings and to have been competent in the past when they allegedly performed the disputed deed. In the criminal justice system this usually applies to an accused, and sometimes to witnesses. Unfortunately, there are no mechanisms to assess those officiating.

Sections 77, 78 and 79 of the Criminal Procedure Act 51 of 1977 (CPA) lay down the general requirements for triability and criminal responsibility, as well as the process that must accordingly be followed to assess an accused. From the outset two important aspects should be emphasised:

- Entry into the forensic mental health service almost always occurs when a crime has been committed[1]. This is unlike in other countries, such as the United Kingdom, where aggressive and difficult patients in the general psychiatric service can be assessed and transferred into forensic psychiatric units for risk management (Dunn et al., 2014).

- The CPA does not provide a definition of terms, such as "mental illness" and "intellectual disability" nor details about how an accused should be assessed. Another stumbling block is that the Law and Psychiatry sometimes use words and terms that superficially suggest a common understanding but which obscure mutual confusion. For example, the use of the term "mental illness" by the courts is somewhat more particular compared to its promiscuous use by psychiatrists and psychologists[2]. Consequently, there is not a standardised procedure that is used throughout the country, and thresholds for deciding whether an accused is not fit to stand trial and/or could not appreciate wrongfulness (or act in accordance with such an appreciation) can differ markedly.

What is a crime?

The substantive criminal law of South Africa is not codified, which is a modern rarity (Snyman and Hoctor, 2021). Almost all its general principles are derived from common law and are not contained in legislation, and therefore, in place of a criminal code, depend on a large collection of authoritative

[1] In exceptional circumstances, section 39 of the Mental Health Care Act 17 of 2002 provides for the transfer of involuntary or assisted mental health care users (i.e. an inpatient), to a maximum secure unit if the patients abscond or are at risk of inflicting harm on others. The application for transfer must be submitted to the Mental Health Review Board, who can refuse the transfer if it is to punish the patient or is deemed to be inappropriate. This has never been used (in my experience) probably because of ethical concerns.

[2] Any of the many disorders described in DSM 5 can be considered a "mental illness". Clearly this would be unworkable in a legal system where excuses and justifications must be reasonably rare.

court decisions (i.e. precedents). Consequently, it is difficult for the lay person, which includes almost every mental health practitioner, to ascertain the definitions of crimes and rules of criminal liability[3].

Although mental health practitioners (MHP) commonly are exasperated by the courts refusal to accept their diagnoses and pronouncements, they in turn usually lack an understanding of what elements of criminal liability must be fulfilled before an accused can be referred for their assessment. In summary these requirements conform to the following principles (Snyman and Hoctor, 2021):

a. **The Principle of Legality** ***nullum crimen sine lege ("no crime without a law")***	The index conduct must be recognised in our law as a crime *(ius acceptum* principle*).* This is an important basis of the rule of law and prevents the arbitrary punishment of people[4]. The criminal conduct must be described in clear terms. The courts cannot broaden the meaning of concepts and words to bring an accused's act within the ambit of "a crime". An accused can only be guilty of a crime if that type of act was already recognised as a crime at the time of its commission (*ius praevium* principle). In other words, an accused cannot be found guilty if at the time of his conduct the law did not recognise it as a crime.
b. **There must have been conduct by the accused**	This includes positive acts as well as omissions (the failure to act when obliged to). The act must have been voluntary, in that bodily movements were under conscious control, even if the act was not intentional. Accordingly, automatisms cannot be regarded as voluntary acts.
c. **The conduct conforms with the definitional elements of a crime**	In Addition to the above, the act must conform to the specific conduct and circumstances, including causal links, that are used to define a particular crime.
d. **The conduct must be unlawful**	Although an act may satisfy the above criteria it may not be unlawful because there may be grounds of justification that allows the act. These grounds include self-defence[5], necessity, consent[6] and official capacity[7]. Sometimes an act that satisfies all of the above criteria will be dismissed if the act was of a "trifling nature", such as breaking a twig on someone's tree.
e. **Culpability**	Assuming the above criteria have been fulfilled there must be grounds for blaming the accused personally for his/her unlawful act (or omission). This component is usually referred to as "*mens rea"*, which means "a guilty mind". A better conceptualisation is to regard the accused as possessing the capacity to be blameworthy even if she did not know that the act/omission was unlawful. Culpability encompasses both intention (*dolus)* and negligence *(culpa)*.

[3] Already a conceptual impasse suggests itself. Appreciating wrongfulness of an alleged offence is a bedrock requirement when assessing both triability and criminal responsibility. But how is this possible if the accused genuinely could not access and understand these mostly arcane (and relatively inaccessible) definitions?

[4] Section 35(3) of the SA Constitution (Bill of Rights) provides that the right to a fair trial includes "the right not to be convicted for an act or omission that was not an offence under either national or international law at the time it was committed or omitted".

[5] Also known as private defence.

[6] Consent is not a general ground of justification. In rape, where the absence of consent is part of its definitional elements, consent is commonly used as a defence, whereas in murder cases consent can never be a ground of justification.

[7] For example, when a soldier kills an enemy, his actions will not be regarded as murder, despite satisfying criteria a, b, & c, because he was acting in an official capacity. Necessity is related to a private defence in that the person had to act to safeguard important interests etc.

The criteria "b" to "d" are sometimes called the *actus reus*. MHPs are only concerned with assessing the *mens rea* of the accused (see below under Criminal Responsibility). Therefore, when an accused is referred for an assessment the MHP can assume that there was a valid *actus reus.*

The Start of the Forensic Journey: The Referral

As with all great fortunes entry into the forensic mental health system begins with the commission of a crime[8]. At any stage of legal proceedings, until the accused is sentenced, anyone, such as his family, lawyer, prosecutor, magistrate/judge or others who know the accused, can raise the possibility that he suffers from a mental illness or intellectual disability such that his capacity to stand trial and/or criminal responsibility requires a separate enquiry, as set out in section 79 of the CPA (see Appendix A), that essentially is a trial-within-a-trial, in which the burden of proof is on a "balance of probabilities" rather than the stricter test used in criminal trials of "beyond reasonable doubt" (Louw, 2006).

The implementation of the assessment process requires a coordination of responsibilities of the Departments of Justice, Health, Correctional Services, South African Police Service, National Prosecuting Authority, Legal Aid service, Registrars and Clerks of the court and the courts (see Appendix B).

Psychiatric hospitals are designated, usually by the provinces' health departments, to conduct these assessments, although there is not (yet) a requirement that their MHPs should be trained or registered as forensic psychiatrists or psychologists. The Mental Health Observation Protocol (see Appendix B) does stipulate that the psychiatrist appointed on behalf of the accused should have forensic experience, whatever that means.

Section 79(1) of the CPA differentiates between those charged with murder, homicide, rape or any offence that involved serious violence and those charged with less serious offences.

- The former are assessed by a panel consisting of a psychiatrist representing the head of health establishment, a psychiatrist appointed by the court (who can be employed by the health establishment), a third psychiatrist following an application by the accused and a clinical psychologist. It is not clear what exceptional causes could persuade a court to appoint a third psychiatrist and clinical psychologist. In practice, high profile cases, especially where prominent psychological factors are important, seem to require these added measures.

- Those charged with offences in which serious violence did not occur are typically referred only to the head of a designated health establishment who delegates the assessment to a psychiatrist. Should such an accused fail the tests of triability or criminal capacity he is referred as an involuntary mental health care user to a general psychiatric hospital. If deemed "necessary in the public interest" the court can appoint a panel, as above. Presumably non-violent recidivists, for whom certification as state patients is envisaged, fall into this vaguely described category.

[8] Section 40 of the Mental Health Care Act confers authority on police officers to take a person who appears to be mentally ill for admission to the nearest health facility for a 72-hour observation. Technically this diversion procedure can also be used where such a person has also committed a petty offence, such as malicious damage to property. Unfortunately, there is little evidence that police use this latter discretion, which has resulted in many mentally ill people, charged with minor offences, languishing in remand for unacceptable periods, sometimes longer than a year. The prosecutor or DPP can also decline to prosecute an accused and then direct that he/she be referred to a psychiatric facility.

- The accused can be committed to a psychiatric hospital (or any other facility designated by the court) for up to 30 days, which can be renewed. During this period the accused remains in custody and cannot be allowed the privileges of movement afforded to patients.

Although the referral is implemented by court order, by means of the J138 form, the prosecutor must ensure that the assessing MHPs are informed whether the referral is under section 77 and/or 78, the nature of the charge, who requested it with motivations concerning the accused's mental state, at what stage the proceedings led to the referral, information about the accused's social background (with contact information, if possible), or any other information that may be relevant, such as medical reports, test results, criminal record etc. The assessing MHP is usually provided with the docket, with statements by the accused, complainants, witnesses, police and family.

For discussion:

Almost all cases are referred under both sections 77 and 78, and consequently, the assessing MHPs (as well as the courts) commonly do not differentiate between the requirements for each section. It can occur that the accused's mental state at the time of the alleged offence may differ from that during the assessment. Not uncommonly the assessment can occur years after the alleged offence.

Consequently, it is often difficult to explain to the court why an accused who was mentally ill at the time of the offence is now well, or conversely, was well but has become mentally ill. What are the implications?

- If an accused is mentally ill during the assessment, he may not be capable of providing an account of his actions during the offence. Even if collateral sources of information corroborate that he was ill at the time it may remain moot whether his mental state did influence his actions at all. It seems that procedural justice should ensure that an accused be able to provide a good account.

- The solution would seem to be that the assessment of fitness to stand trial and criminal responsibility should be separate inquiries. Fitness to stand trial should be the initial procedure, and criminal responsibility should only be assessed if the accused is fit to stand trial but during proceedings seems to have lacked criminal responsibility at the time.

    - Therefore, if the accused is mentally ill she should be admitted under certification for treatment such that, when well, she can return for continuation of the trial, in accordance with section 77(7) of the CPA. Findings under section 77 do not find the accused "not guilty by reason of insanity" but merely postpone the continuation of the trial when the state patient regains competence. But what if the accused never recovers?

    - Consequently, most state patients should be certified initially under section 77 to ensure that a potential future return to trial can occur. Treating clinicians are frequently berated by state patients that they were not found guilty, are being held unfairly and indefinitely. Commonly they demand a trial to prove their lack of guilt or to get the certainty of a sentence, which usually is much less than the indefinite hospitalization they must endure.

A paradox

An accused has the right to remain silent, even while undergoing a psychiatric assessment. Sometimes his muteness is due to a mental or medical illness, such as catatonia, delirium etc., but occasionally his refusal to engage is purposeful, which complicates the assessment. Usually, the burden of proof

rests with the accused (or whoever raised the defence), which presumes he will cooperate with the assessment. Therefore, although the court accepts his right to remain silent it can take note of his lack of cooperation[9].

Section 79(7) attempts to resolve this by insisting that any statement made by the accused during the psychiatric assessment ("the observation") is not admissible as evidence in the trial. But such a statement can be admissible to verify his mental status. Two potential situations can occur:

- The court can demand that the accused's account be provided when the assessment findings are disputed. Sometimes the accused's account given during the observation period may differ significantly from that he gives the court. This may call into question the validity of the observation findings.

- Although the court accepts that any account or statement obtained during the observation is inadmissible in the actual trial it is probable that it would, nevertheless, influence the proceedings in some way, especially if the account appears to be a plausible confession.

The report

The outcome of all forensic assessments should be a report. Section 79 (3) & (4) of the CPA stipulates that the report should be in triplicate and submitted to the registrar or clerk of the court for the prosecutor. Sometimes the report is submitted to the Director of Public Prosecutions for convenience of distribution. The report must state the following:

- A description of the nature of the enquiry

- The diagnosis of the accused's mental condition, or lack thereof

- Findings under sections 77 and 78 of the CPA.

If the report is not unanimous then dissenting reports must be included. The court may require testimony from the MHPs to clarify the findings, especially if these are disputed.

The following should be considered:

- Although most reports contain summaries of the accused's background, circumstances, psychiatric and medical histories, and mental state this is not a legislative requirement. Consequently, every jurisdiction has historically developed its own accepted format and content. Most reports conclude with recommendations concerning the. disposal of the accused, even though this does not seem to be a requirement.

- The findings on sections 77 and 78 of the CPA should be regarded as recommendations. The ultimate issue, namely whether these are accepted or rejected, is the court's discretion. Too often MHPs are aggrieved when their findings and recommendations are not accepted.

[9] *In Ntshongwana v The State (1304/2021) [2023] ZASCA 156(21November2023)* the Court of Appeal noted that the accused had the right not to testify in his trial, but that the court was entitled to draw a negative inference from his refusal.

Fitness to stand trial.

Every accused has the right to a fair trial (in accordance with section 35 of the Constitution), which demands that set rules of procedure must be followed (Khan, 2017). A crucial aspect is that an accused must be present in court to hear testimony and be able to assist with the evaluation of evidence[10]. Not only must the accused be present physically but also mentally or psychologically. This latter requirement encompasses the requirement of "fitness to stand trial"[11]. Section 77(1) of the CPA states

"If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or intellectual disability not capable of understanding the proceedings so as to make a proper defence, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79."

Superficially this seems to be quite straightforward. An accused can only be found not fit to stand trial if he has been diagnosed with a psychiatric disorder which significantly impairs his capacity to understand proceedings. Implicitly, the accused must be able to instruct counsel, evaluate information before the court and make decisions. Several difficulties suggest themselves:

1. *The importance of the diagnosis.* An inquiry into to fitness to stand trial cannot proceed unless a convincing psychiatric diagnosis is offered. But the presence of a diagnosis does not automatically render the accused incompetent. The terms "mental illness" and "intellectual disability" imply that the psychiatric disorder must produce impairment in relation to the complexity of the case. Many psychotic individuals could be competent for petty offences, such as shoplifting, but lack competence in complicated cases such as murder and fraud.

2. *Therefore the threshold of competence depends on the examiner's judgement.* Pienaar (2019) asserts that the threshold for declaring mentally ill defendants fit to stand trial is too low. Consequently, she claims, many defendants who are mentally ill are being returned to court and thereby denied appropriate interventions. Unfortunately, she does not provide evidence for this. Almost all who are referred under section 77 are also referred under section 78. It is very rare for a defendant to be referred only under section 77, and most examiners, incorrectly, seem to regard these sections as interchangeable (see above).

3. *Fitness to stand trial and criminal responsibility may have different thresholds for any particular accused.* The more obvious reason is that adjudicative capacity refers to the here and now, whereas criminal responsibility is assessed retrospectively, which can be years before. But an underappreciated reason is that the mental demands of participating in the trial can be much less than that required to be responsible for one's actions, or vice versa.

4. *The period of validity of the assessment.* The course of psychiatric disorders can vary over any period. Sometimes an accused's mental state at the time of the trial can differ markedly from that observed during the assessment, especially in cases that reach the court years afterwards. As adjudicative capacity can only indicate the accused's mental state at the time of the assessment it is possible that, given convincing information, a follow up assessment may be necessary.

The two elements on which this assessment is based are firstly, the ability to follow proceedings, and secondly, the ability to conduct a proper defence. The former can be difficult to assess because most are ignorant of the workings of the court, whether mentally ill or not (Kaliski et al., 1997). It is easy to

[10] This basic right is enshrined in section 158 of the CPA as well as section 35(3)(e) of the South African Constitution.
[11] In the USA this is also sometimes called "adjudicative competence" to cover all legal processes that can occur outside the court, such as plea bargaining.

conflate ignorance and competence, and therefore the focus ought to be on an accused's capacity to learn. The latter usually implies an accused's ability to consult with counsel to assist in his defence. What if the accused insists on conducting his own defence? Should the threshold be raised because greater understanding of the proceedings is then required? Most authorities believe that this issue remains moot, because there is no general accepted level of capacity anyway (Mossman et al., 2007).

The wording of the section, nonetheless, is vague. Therefore, it is suggested that these assessments should follow the requirements laid down in the USA's *Dusky*[12] case, even though it is not a formal requirement in our law (Mossman et al., 2007). The *Dusky* standard demands that an accused should

- "..have sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, which includes an ability to make decisions, and
- ..have a rational as well as factual understanding of the proceedings against him".

Although the precise meanings of "rational" and "reasonable" are elusive this does allow the examiner to use "common-sense" to evaluate the accused's responses on the following questions (Mossman et al., 2007, Kaliski, 2006, Pienaar, 2019):

- *Does he know what the charge against him is, and what is alleged he did? Is he aware of the information contained in the docket?*
- *Is committing such an offence wrong, and why?*
- *Why has he been referred? What are the possible consequences of this assessment?*
- *Who are the important role players in court, and can he explain what their functions are? Can he explain why he needs a lawyer (or why he refuses to be represented)?*
- *Can the accused provide an adequate account concerning the charges against him?* This obviously requires that the examiner applies "common sense" to determining what is adequate.

The accused's inability to answer the above may be due to ignorance and not incapacity. Therefore, he should be evaluated after an explanation has been given to him. For example, when told the difference between "guilty" and "not guilty" he can be asked to choose which applies to him, and why.

While interviewing the accused the following should be evaluated:

- Can the accused retain and process new information, such as the evidence presented and witness testimony? This includes having an adequate memory and attention span.
- Consequently, can he discuss this information with his lawyer such that he can also make reasonable decisions related to his defence?
- The accused should be able to provide a "rational, consistent, and coherent account of the offence"(Mossman et al., 2007). He should be able to describe events that led up to the offence, and what happened during and afterwards.

[12] Dusky v U.S. 362 U.S 402 `(1960)

- Collateral information from those familiar with him, or from documents. This can be added to an appraisal of his activities of daily living (ADL).

- Neuropsychological assessments, which can be invaluable when the accused's impairment is ambiguous or subtle.

Consequences of the findings under section 77

If the accused is found fit to stand trial, he is returned to court to continue with the trial.

If the accused is found to be unfit to stand trial the court holds an inquiry to establish on a *balance of probabilities* whether the accused committed the *actus reus*. This is not to establish the accused's guilt but to guide the court in deciding on an appropriate order (Pienaar, 2018). A finding on section 77 alone is based on a determination of the treatability of the accused's disorder, which could result in his return to court for continuation of the trial or discharge, and the seriousness of the offence.

If the offence involved serious violence, such as murder, culpable homicide, or rape, and the accused is unfit to stand trial, he will be certified as a state patient under the *Mental Health Care Act no. 17 of 2002* (MHCA). He will be detained in a designated psychiatric hospital (in a specialised forensic unit, if possible) or in any other appropriate facility. Discharge can only occur following a submission to a judge in chambers.

If the accused committed an offence that did not involve serious violence, he can be referred to the general psychiatric service as an involuntary mental health care user in accordance with the provisions of the Mental Health Care Act. Presumably these can be discharged as other general patients, providing the court is informed.

Following the Constitutional Court decision in *De Vos NOS v Ministers of Justice and Constitutional Development 2015 (2) SACR 217 (CC)* the Criminal Procedure Amendment Act 4 of 2017 was passed and enabled that:

- The assumption that the accused is dangerous because of is his mental illness is not an acceptable reason to deprive him of his right to freedom, and security of the person, equality, and dignity (as envisaged in the SA constitution and in the United Nations Convention on the Rights of Persons with Disabilities).

- Detention in a prison is unconstitutional because the aim is treatment and not punishment but is permissible temporarily if the accused is awaiting a bed in an appropriate psychiatric hospital.

- Many disorders are not treatable, such as intellectual disabilities and neurocognitive disorders, and therefore institutionalising such individuals is not fair (especially if young) because they are not expected to recover. The courts can now exercise some discretion, based on expert opinion, in deciding on more appropriate disposals, such as unconditional release, a conditional discharge and referral to an outpatient facility, or release subject to any conditions the court considers appropriate. The aim is to ensure that the least restrictive care ensues (Pienaar, 2018).

Khan (2017), nevertheless, objects to the remaining requirement that certification as a state patient should be reserved for those who are charged with offences that involved serious violence, on the

grounds that seriousness of the crime and prediction of future violence may differ. Firstly, the charge of violence is not tested properly in these cases (as "balance of probabilities" is not as stringent as "beyond reasonable doubt") and if the index offence was singular or exceptional it may not be possible to determine whether the accused continues to be a danger to others. The courts do not seem to appreciate that indefinite hospitalisation as a state patient usually results in much longer detentions than the sentence the accused may have received. This is inherently unfair, especially considering the threshold used to certify them.

Restoration of competence

An accused found not fit to stand trial is not acquitted (as with a finding on section 78 of CPA) but remains in a legal limbo, so that he can be returned to court should he regain competence. Many studies have demonstrated that most defendants, if psychotic during their trials, eventually become fit to stand trial with treatment (Mossman et al., 2007). Unfortunately, it is not possible to predict who will not regain competence[13]. But 3 possible scenarios may confront the assessor:

- The accused has a history of psychiatric disorder but has defaulted with treatment.
- The accused is not known to have a psychiatric disorder but is psychotic during the assessment (30-day observation).
- The courts request an opinion as to the likelihood the accused will regain competence, and what modalities of treatment would be required.

This can be a complicated situation. If the accused is well known to mental health services, it is standard practice to prescribe his medication during the assessment period. Often the referral is the accused's first contact with the service, and the assessor should feel ethically obligated to treat him. However, several ethical issues arise:

- During the assessment the examiner does not have a fiduciary relationship with the accused. This changes when treatment is prescribed, with the immediate effect of introducing dual agency issues. The accused becomes both someone to be assessed dispassionately as well as a patient whose care must be a priority.
- An accused who is mentally ill likely is not competent to consent to treatment. There is no legislative procedure whereby treatment can be imposed without consent in this situation, such as is provided for in the MHCA. The accused was referred, sometimes against his will, for an assessment and not for treatment.
- Treatment mostly likely will be with medication that has side effects, which may interfere with the accused's ability to attend and concentrate in court.

The latter 2 points were raised in the USA in the *Sell* case, where a dentist who had been charged with fraud was found to be psychotic during his assessment. Treatment rendered him competent which he contested. His appeal to the Supreme Court was successful on the two latter issues. This has not been raised as a problem in South Africa but does have important ethical considerations.

[13] Generally, if the accused presents with cognitive impairment due to a degenerative disorder, he is unlikely to respond to treatment.

Criminal responsibility: The Insanity Defence.

Where there are rules there are excuses. In the criminal justice system valid excuses to a charge can be used either as a defence or for diminished responsibility. Superficially this seems to refer to an accused's inability to act with intent, *mens rea,* or to have acted in legitimately, especially in self-defence. But there are many contexts in which an inability to form intent is prominent, such as states of intoxication and intense emotional turmoil, which are not allowed as a complete defence. What is left is an added, but unspoken, requirement that a person lacking *mens rea* also lacks moral blameworthiness. Consequently, it is assumed to be unfair to blame a young child or a mentally ill person for their bad deeds.

Section 78 of the CPA has codified the tests of criminal responsibility as follows:

(1) A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or intellectual disability which makes him or her incapable-

(a) of appreciating the wrongfulness of his or her act or omission; or

(b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission,

shall not be criminally responsible for such act or omission.

(2) If it is alleged at criminal proceedings that the accused is by reason of mental illness or intellectual disability or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court shall in the case of an allegation or appearance of mental illness or intellectual disability, and may, in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.

The basis of criminal capacity rests on a cognitive test (*appreciation of wrongfulness)* and a test of impulse control (*incapable of acting in accordance with the aforementioned "appreciation")*. Lawyers refer to the latter as a conative test (Rumpff et al., 1967). Consequently, legal scholars have clung to the assumption that cognition and conation are distinct, and therefore can be assessed separately. This may have been a view that psychiatry held in the 1967 when the Rumpff Commission published its report, but after more than 5 decades of advances in neuropsychiatry no psychiatrist could truthfully separate these functions, as if there are parts of the brain that control one's thinking independent of one's intentions. In fact, most of our decisions and actions are performed automatically, outside of conscious awareness (Aharoni et al., 2008, Waldbauer and Gazzaniga, 2001) This is an example where the law lags behind science, and, in the pursuit of clarity, these 2 functions should be subsumed into one test, namely whether an accused's actions during the alleged offence were influenced by mental illness or intellectual disability.

A religious extremist kills someone because of his beliefs. Courts have no difficulty in holding him responsible for his actions. Another man kills because of religious delusions, and the courts readily accept his lack capacity because of mental illness. But the qualitative differences between them is negligible. Both acted in accordance with aberrant thinking and did not inhibit their actions from an appreciation of wrongfulness. Psychiatrists routinely grapple with the differences between so-called overvalued ideas and delusions. Not only is it absurd to differentiate between cognition and conation but there is no objective test to separate the mentally ill from the misguided. Morse (1994) has encapsulated this as follows:

> *"Crazy actors may act on the basis of delusional reasons, for example, but these actions are usually no more compelled than the behaviors of normal actors who act for intelligible, rational reasons. Acting in accord with one's beliefs - beliefs that are themselves caused - is not*

psychological compulsion unless one delusionally believes that he or she is in a hard choice situation" (p.163)

Morse (1994), in his seminal paper, argues that whether one uses an empirical or moral theory to distinguish between rationality (i.e. cognition) from compulsion (i.e. inability to act in accordance with an appreciation of wrongfulness) there remains almost insurmountable difficulties to determine why the accused's dysphoria just before the offence caused him to lose control in the face of intact cognition. In fact, he asserts that most cases of "loss of control" are failures of rationality and not poor impulse control[14]. Several important features should also be considered:

- A diagnosis of a serious psychiatric disorder is necessary but not sufficient to establish a lack of criminal capacity. There must be a credible likelihood (i.e. on a balance of probabilities) that the disorder was responsible for the accused's actions. Despite the possibility that an accused who was seriously mentally ill at the time of the alleged offence still possessed criminal capacity could occur it may be very difficult to convince a court of this.

- The language used in section 78 is seemingly clear and unambiguous but is problematic.

    - The degree to which the mental illness or intellectual disability can be accepted as having led to the commission of the offence depends on judgements that can vary between experts. Not surprisingly high-profile cases, such as that for John Hinkley who attempted to assassinate President Reagan in 1981, often descend into organized chaos as experts from both sides contest each other's opinions. Such cases enhance the public view that psychiatrists and psychologists obfuscate to help an accused escape justice. A public relations disaster for MHPs (Stone, 1985).

    - The use of "appreciate" can mean either the accused just "realises" or has an "understanding" of wrongfulness. And if the latter, how deep must that understanding be? Even ordinary people may not quite realise why certain crimes are wrong. For example, how many know why Ponzi schemes are illegal?

    - Similarly, there is no objective test to determine whether an accused lacked control of his actions, regardless of whether he could or not appreciate wrongfulness[15]. In *Ntshongwana v The State (1304/2021) [2023] ZASCA 156(21November2023)* the accused had gruesomely murdered and assaulted several people, as well as having kidnapped and raped a woman. He had been admitted to many psychiatric hospitals with the diagnosis of schizoaffective disorder, and consequently insisted that he could not act in appreciation of wrongfulness. The Court of Appeal ruled that even though he suffered from a serious mental illness his actions were the result of premeditation, planning and had occurred over extended periods when his behaviour was goal directed and rational. This approach is consistent with the opinion expressed by Morse (1994).

  Paragraphs 1 & 2 contain seemingly conflicting requirements. In section 78(1) the requirement for lack of criminal capacity depends on "mental illness" and "intellectual

[14] In one of many pithy points he states "..the delusional mistaken belief of a persecuted paranoid that she is about to be attacked and must use self-defensive force is no more "compelling" than the accurate belief of a police officer that she must use deadly force in justifiable self-defence." (p.173)

[15] Forensic MHPs can attest that even seriously mentally ill defendants usually appreciate or understand wrongfulness but were possibly disinhibited by their illness. A good example is an accused who has a delusion that his neighbour tried to kill him via a satellite, and consequently kills his neighbour. He would readily admit that murder is wrong but that he was merely defending himself.

disability", whereas paragraph 2 introduces "or for any other reason", which, in its vagueness, surely flings open the floodgates of defences from the ludicrous and incredulous to plausible.

The insertion of the phrase "or for any other reason" was an attempt to formalise a distinction that had been gathering momentum in case law (since *S v Chretien* in 1982) between inherent mental illness, a cause of pathological incapacity, and psychological factors that apparently originated externally, which can cause non-pathological incapacity.

Pathological and Non-pathological incapacity

Historically the so-called insanity defence rested on the M'Naghten rules[16] that postulated the existence of a "disease of the mind". Clearly the mind, which is an abstraction, cannot be diseased. Consequent legislation therefore required a diagnosis of mental illness that was assumed to be caused by an inherent brain disorder. Hence the term "pathological incapacity" has been used. In tandem the defence came to include *irresistible impulse*, which was assumed to flow from the mental illness. Unfortunately, there was no objective means of determining whether an impulse (or urge) could not be resisted or merely acceded to. Therefore the defence had psychiatric and psychological legs (Van Oosten, 1990). The Rumpff Commission recognised this difficulty and recommended the now used cognitive/conative requirements that do not explicitly refer to urges or impulses[17].

Not long after the CPA was promulgated courts began to question whether non-psychiatric states could be advanced as absolute defences. In an obitur dictum the court in *S v Chretien 1981 (1) SA 1097 (A)* mused that it may be possible that a person who was intoxicated and provoked may not be responsible for his actions. In *S v Arnold 1985 (3) SA 256 (C)* the accused had married a much younger woman who was a stripper. One of her conditions for marrying him was that he institutionalize his son who had an intellectual disability. After visiting his son, which provoked deep guilt, he found his wife packing her bag to leave him. When he asked her how she intended to support herself she bent down, flashed her breasts at him and indicated she would have no such difficulty. The accused happened to be holding a pistol. His first shot hit the ceiling, and the second her head. The defence produced a psychiatrist who testified that

> *"..(His) conscious mind was so "flooded" by emotions that it interfered with his capacity to appreciate what was right or wrong, and because of his emotional state, he may have lost the capacity to exercise control over his actions."*

The state could not produce an expert to rebut this opinion and the accused was acquitted. So began the defence that became known as "temporary non-pathological incapacity". Several important considerations arose:

1. This was not a defence based solely on poor impulse control, but also included cognitive impairment. Expert testimony in these cases would refer to "his ego shattered" or something cognitively caused the accused "to snap" and act involuntarily[18]. This appeared logical in that the accused would have had to process the meaning of the provocation and subsequently act. In almost all cases the accused would claim amnesia for the period of the offence, which again is a sign of cognitive impairment.

[16] Daniel M'Naghten was a Scottish woodturner who assassinated the secretary of then British prime minister, Sir Robert Peel. He suffered from delusions and was acquitted (but admitted to Broadmoor) on grounds of insanity. The ensuing public outcry resulted in a commission that produced these rules. South Africa incorporated these rules during the mid-19th century.
[17] The Rumpff Commission also proposed that affective state should also be added, which was not adopted.
[18] For example, see S v Potgieter 1990 (1) SACR 401 (T)

2. Despite the requirement in section 78 of the CPA that a diagnosis of a mental illness or intellectual disability be determined before assessing the accused's actions non-pathological incapacity relies on external factors as the cause, as if the accused's personality and other mental characteristics are unimportant. In other words, the reasonable man exposed to similar provocation would be expected to act similarly.

3. The court should decide on the merits of a non-pathological incapacity after hearing evidence from an expert (*S v Campher 1987 (1) SA 940 (A)*). Who would qualify as an expert if a diagnosis is not required?

4. The usual narrative was that the accused had had a history of difficulties with the deceased, with whom he, or she, had been in an intimate relationship. These difficulties could include abuse, violence, rejection or humiliation, which culminated in a provocation (the trigger), such that he, or she, lost control.

5. But the problem encountered with the defence of irresistible impulse remains. How is the court to determine whether an accused lost control or chose not to control his actions? In almost all cases the accused professed to have amnesia for the alleged offence and therefore could not provide an account of their experience of losing control[19]. As the court stated in *S v Eadie 2002 (3) ZSCA 919 (SCA):*

> *"When an accused acts in an aggressive goal-directed and focused manner, spurred on by anger or some other emotion, whilst still able to appreciate the difference between right and wrong and while still able to direct and control his actions, it stretches credulity when he then claims, after assaulting or killing someone, that at some stage during the directed and planned manoeuvre he lost his ability to control his actions. … The accused is claiming that his uncontrolled act just happens to coincide with the demise of the person who prior to that act was the object of his anger, jealousy or hatred".*

The Court of Appeal in *S v Eadie* concluded that the defence had to be that of sane automatism[20]. There must be evidence that the accused acted in an apparently purposeful (or purposeless) manner in that his behaviour could not have been premeditated, planned or goal-directed. Some legal scholars objected to this formulation because in an automatism the accused's cognition is *ab initio* severely impaired and therefore makes consideration of his volition (or his control over impulses) meaningless (Snyman and Hoctor, 2021). But the essential point is that qualitatively there is no distinction between cognition, volition and affective states. Neuroscience has demonstrated that these functions occur simultaneously and are not compartmentalised brain functions. In other words, non-pathological incapacity can only be due to impairments in both cognition and volition in which affective arousal is prominent.

Effectively the defence has excluded instances where rage, fear and intense emotions disinhibited the accused, unless an automatism occurred. As it stands the defence depends on the following sequence:

a) A preceding history of stressful interpersonal conflict with the deceased.

b) A trigger, such as a provocation or rejection, that principates

[19] It is worth repeating that the presence of amnesia, a sine qua non for the defence, implies that the defence must include cognitive impairment.
[20] Automatism will be discussed in a separate section.

c) An automatism. During this state there cannot be evidence of premeditation or planning, and the accused's actions cannot be purposeful, especially if he had never engaged in those actions beforehand[21].

d) When he comes to his senses he should be bewildered and not realise, for a while, what he had done. He should be horrified at his actions, and hopefully summoned help instead of fleeing.

e) He should have amnesia, a cognitive phenomenon, for the event. One could argue that as it is a dissociative (psychogenic) amnesia it should resolve in time. Most insist that the amnesia is permanent, possibly in order not to have to provide an account.

Joubert (2014) has pertinently challenged the validity of this entity, which he calls Emotionally Triggered Involuntary Behaviour (ETIVB), on the grounds that there are no universally accepted definitions of "automatism" and "involuntariness". Nor do involuntary actions occur solely in states of impaired consciousness. He proposes that although it is almost impossible to distinguish convincingly between voluntary and involuntary behaviour there must surely be cases where a person in a moment (which he defines as occurring no longer than 10 seconds after a trigger and should last for longer than 10 seconds) acts involuntarily. Unfortunately these instances of "psychological blow automatisms" accepted by the courts have not been subjected to much scientific study. It is trite law that an essential component of *mens rea* is cognitive appreciation with voluntary action, but the methods of assessment with interpretation of these concepts in those who are not mentally ill remain questionable (Joubert and van Staden, 2016).

Note should be taken that according to section 78(7) of the CPA the accused's mental state, whether conforming to some criteria of pathological or non-pathological incapacity, can also be used to support a plea of diminished responsibility (or for mitigation), which could be used for purposes of sentencing. It is useful to compare the two defences as in the table below:

PATHOLOGICAL INCAPACITY	**NON-PATHOLOGICAL INCAPACITY**	**COMMENTS**
Caused by inherent brain disorder	Caused by external factors, such as provocation	*This assumes that a response to provocation does not involve brain function or dysfunction. Many are prone to poor impulse control without being (legally) mentally ill, for example people with borderline personality disorder.*
Actions are influenced, directly or indirectly, by symptoms	Sane automatism ensues following provocation.	*It can be argued that symptoms influence behaviour in both defences. In non-pathological incapacity it is common for the accused to describe longstanding symptoms of depression, anxiety, or even PTSD.*

[21] For example: if the accused used a gun that he seldom used and which required complex actions to fire – such as releasing the safety catch, cocking it, aiming etc – he cannot insist that he was in an automatism. Conversely if he practised shooting daily in response to a threat (as a soldier or policeman might) he may satisfy the criteria. Consider the soldier who has spent months in a battle zone is awoken by thunder. He grabs his rifle crawls outside and fires his rifle at no one in particular but does kill.

Without treatment the behaviour will recur. Therefore, treatment is imperative/	The behaviour was a singular event and therefore unlikely to recur. Treatment is not required	*In both cases violence can be recurrent or singular. Someone who is acquitted on grounds of non-pathological incapacity is arguably at risk for recidivism because his underlying personality or psychological characteristics have not been treated or may feel emboldened by having escaped censure.*
The burden of proof generally rests on the accused, which is determined on a "balance of probabilities".	In most cases the burden of proof has rested with the prosecution, and it is not quite clear whether the same test of balance of probabilities also applies, or whether the more stringent "beyond reasonable doubt" test.	*Generally the courts should assume that whoever raises the defence should bear the burden of proof.*
Found not guilty by reason of insanity and committed as a state patient to a designated hospital indefinitely.	Found not guilty and acquitted.	*Mentally ill offenders usually face the prospect of a lifetime as a state patient even if they do not commit another violent offence. Acquittal based on provocation surely contains a moral hazard, especially as all citizens are required to control their impulses.*

Conclusion

Psychiatry and Law are like a long-married couple who still struggle to understand each other. Consequently, they bicker often knowing that a divorce is impossible. This is especially problematic when they meet in the criminal justice arena. The solution is for both to learn the language and concepts the other uses, which is important for the extended family in the community.

APPENDIX A

CRIMINAL PROCEDURE ACT 51 OF 1977
CHAPTER 13
ACCUSED: CAPACITY TO UNDERSTAND PROCEEDINGS: MENTAL ILLNESS AND CRIMINAL RESPONSIBILITY (ss 77-79)

77 Capacity of accused to understand proceedings

(1) If it appears to the court at any stage of criminal proceedings that the accused is by reason of mental illness or intellectual disability not capable of understanding the proceedings so as to make a proper defence, the court shall direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.

(1A) At proceedings in terms of sections 77 (1) and 78 (2) the court may, if it is of the opinion that substantial injustice would otherwise result, order that the accused be provided with the services of a legal practitioner in terms of section 22 of the Legal Aid South Africa Act, 2014.

(2) If the finding contained in the relevant report is the unanimous finding of the persons who under section 79 enquired into the mental condition of the accused and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence.

(3) If the said finding is not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under section 79 enquired into the mental condition of the accused.

(4) Where the said finding is disputed, the party disputing the finding may subpoena and cross-examine any person who under section 79 has enquired into the mental condition of the accused.

(5) If the court finds that the accused is capable of understanding the proceedings so as to make a proper defence, the proceedings shall be continued in the ordinary way.

(6)*(a)* If the court which has jurisdiction in terms of section 75 to try the case, finds that the accused is not capable of understanding the proceedings so as to make a proper defence, the court may, if it is of the opinion that it is in the interests of the accused, taking into account the nature of the accused's incapacity contemplated in subsection (1), and unless it can be proved on a balance of probabilities that, on the limited evidence available the accused committed the act in question, order that such information or evidence be placed before the court as it deems fit so as to determine whether the accused has committed the act in question and the court may direct that the accused-

(i) in the case of a charge of murder or culpable homicide or rape or compelled rape as contemplated in section 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, respectively, or a charge involving serious violence or if the court considers it to be necessary in the public interest, where the court finds that the accused has committed the act in question, or any other offence involving serious violence, be-

(aa) detained in a psychiatric hospital;

(bb) temporarily detained in a correctional health facility of a prison where a bed is not immediately available in a psychiatric hospital and be transferred where a bed becomes available, if the court is of the opinion that it is necessary to do so on the grounds that the accused poses a serious danger or threat to himself or herself or to members of the public, pending the decision of a judge in chambers in terms of section 47 of the Mental Health Care Act, 2002;

(cc) admitted to and detained in a designated health establishment stated in the order as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act, 2002;

(dd) released subject to such conditions as the court considers appropriate; or

(ee) referred to a Children's Court as contemplated in section 64 of the Child Justice Act, 2008 (Act 75 of 2008), and pending such referral be placed in the care of a parent, guardian or other appropriate adult or, failing that, placed in temporary safe care as defined in section 1 of the Children's Act, 2005 (Act 38 of 2005); or

(ii) in the case where the court finds that the accused has committed an offence other than one contemplated in subparagraph (i) or that he or she has not committed any offence be-

(aa) admitted to and detained in a designated health establishment stated in the order as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act, 2002;
(bb) released subject to such conditions as the court considers appropriate;
(cc) released unconditionally; or
(dd) referred to a Children's Court as contemplated in section 64 of the Child Justice Act, 2008, and pending such referral be placed in the care of a parent, guardian or other appropriate adult or, failing that, placed in temporary safe care as defined in section 1 of the Children's Act, 2005,

and if the court so directs after the accused has pleaded to the charge, the accused shall not be entitled under section 106 (4) to be acquitted or to be convicted in respect of the charge in question.

(b) If the court makes a finding in terms of paragraph *(a)* after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside, and if the accused has pleaded guilty it shall be deemed that he or she has pleaded not guilty.

(7) Where a direction is issued in terms of subsection (6) or (9), the accused may at any time thereafter, when he or she is capable of understanding the proceedings so as to make a proper defence, be prosecuted and tried for the offence in question.

(8) *(a)* An accused against whom a finding is made-
(i) under subsection (5) and who is convicted;
(ii) under subsection (6) and against whom the finding is not made in consequence of an allegation by the accused under subsection (1),

may appeal against such finding.

(b) Such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence.

(9) Where an appeal against a finding in terms of subsection (5) is allowed, the court of appeal shall set aside the conviction and sentence and remit the case to the court which made the finding, whereupon that court must deal with the person concerned in accordance with the provisions of subsection (6).

(10) Where an appeal against a finding under subsection (6) is allowed, the court of appeal shall set aside the direction issued under that subsection and remit the case to the court which made the finding, whereupon the relevant proceedings shall be continued in the ordinary way.

78 Mental illness or intellectual disability and criminal responsibility

(1) A person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or intellectual disability which makes him or her incapable-
(a) of appreciating the wrongfulness of his or her act or omission; or
(b) of acting in accordance with an appreciation of the wrongfulness of his or her act or omission,

shall not be criminally responsible for such act or omission.

(1A) Every person is presumed not to suffer from a mental illness or intellectual disability so as not to be criminally responsible in terms of section 78 (1), until the contrary is proved on a balance of probabilities.

(1B) Whenever the criminal responsibility of an accused with reference to the commission of an act or an omission which constitutes an offence is in issue, the burden of proof with reference to the criminal responsibility of the accused shall be on the party who raises the issue.

(2) If it is alleged at criminal proceedings that the accused is by reason of mental illness or intellectual disability or for any other reason not criminally responsible for the offence charged, or if it appears to the court at criminal proceedings that the accused might for such a reason not be so responsible, the court shall in the case of an allegation or appearance of mental illness or intellectual disability, and may, in any other case, direct that the matter be enquired into and be reported on in accordance with the provisions of section 79.

(3) If the finding contained in the relevant report is the unanimous finding of the persons who under section 79 enquired into the relevant mental condition of the accused, and the finding is not disputed by the prosecutor or the accused, the court may determine the matter on such report without hearing further evidence.

(4) If the said finding is not unanimous or, if unanimous, is disputed by the prosecutor or the accused, the court shall determine the matter after hearing evidence, and the prosecutor and the accused may to that end present evidence to the court, including the evidence of any person who under section 79 enquired into the mental condition of the accused.

(5) Where the said finding is disputed, the party disputing the finding may subpoena and cross-examine any person who under section 79 enquired into the mental condition of the accused.

(6) If the court finds that the accused committed the act in question and that he or she at the time of such commission was by reason of mental illness or intellectual disability not criminally responsible for such act-

(a) the court shall find the accused not guilty; or

(b) if the court so finds after the accused has been convicted of the offence charged but before sentence is passed, the court shall set the conviction aside and find the accused not guilty,

by reason of mental illness or intellectual disability, as the case may be, and direct-

(i) in a case where the accused is charged with murder or culpable homicide or rape or compelled rape as contemplated in section 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, respectively, or another charge involving serious violence, or if the court considers it to be necessary in the public interest that the accused be-

(aa) detained in a psychiatric hospital;

(bb) temporarily detained in a correctional health facility of a prison where a bed is not immediately available in a psychiatric hospital and be transferred where a bed becomes available, if the court is of the opinion that it is necessary to do so on the grounds that the accused poses a serious danger or threat to himself or herself or to members of the public,

pending the decision of a judge in chambers in terms of section 47 of the Mental Health Care Act, 2002;

(cc) admitted to and detained in a designated health establishment stated in the order and treated as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act, 2002;

(dd) released subject to such conditions as the court considers appropriate;

(ee) released unconditionally; or

(ff) referred to a Children's Court as contemplated in section 64 of the Child Justice Act, 2008, and pending such referral be placed in the care of a parent, guardian or other appropriate adult or, failing that, placed in temporary safe care as defined in section 1 of the Children's Act, 2005; or

(ii) in any other case than a case contemplated in subparagraph (i), that the accused be-

(aa) admitted to and detained in a designated health establishment stated in the order and treated as if he or she were an involuntary mental health care user contemplated in section 37 of the Mental Health Care Act, 2002

(cc) released subject to such conditions as the court considers appropriate;
(dd) released unconditionally; or
(ee) referred to a Children's Court as contemplated in section 64 of the Child Justice Act, 2008, and pending such referral be placed in the care of a parent, guardian or other appropriate adult or, failing that, placed in temporary safe care as defined in section 1 of the Children's Act, 2005.

(7) If the court finds that the accused at the time of the commission of the act in question was criminally responsible for the act but that his capacity to appreciate the wrongfulness of the act or to act in accordance with an appreciation of the wrongfulness of the act was diminished by reason of mental illness or intellectual disability, the court may take the fact of such diminished responsibility into account when sentencing the accused.

(8) *(a)* An accused against whom a finding is made under subsection (6) may appeal against such finding if the finding is not made in consequence of an allegation by the accused under subsection (2).

(b) Such an appeal shall be made in the same manner and subject to the same conditions as an appeal against a conviction by the court for an offence.

(9) Where an appeal against a finding under subsection (6) is allowed, the court of appeal shall set aside the finding and the direction under that subsection and remit the case to the court which made the finding, whereupon the relevant proceedings shall be continued in the ordinary course.

79 Panel for purposes of enquiry and report under sections 77 and 78

(1) Where a court issues a direction under section 77 (1) or 78 (2), the relevant enquiry shall be conducted and be reported on-

(a) where the accused is charged with an offence other than one referred to in paragraph *(b)*, by the head of the designated health establishment designated by the court, or by another psychiatrist delegated by the head concerned; or
(b) where the accused is charged with murder or culpable homicide or rape or compelled rape as provided for in section 3 or 4 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, respectively, or another charge involving serious violence, or if the court considers it to be necessary in the public interest, or where the court in any particular case so directs-
  (i) by the head of the designated health establishment, or by another psychiatrist delegated by the head concerned;
  (ii) by a psychiatrist appointed by the court;
  (iii) by a psychiatrist appointed by the court, upon application and on good cause shown by the accused for such appointment; and
  (iv) by a clinical psychologist where the court so directs.

[(1A) The prosecutor undertaking the prosecution of the accused or any other prosecutor attached to the same court shall provide the persons who, in terms of subsection (1), have to conduct the enquiry and report on the accused's mental condition or mental capacity with a report in which the following are stated, namely-

(a) whether the referral is taking place in terms of section 77 or 78;
(b) at whose request or on whose initiative the referral is taking place;
(c) the nature of the charge against the accused;
(d) the stage of the proceedings at which the referral took place;

(e) the purport of any statement made by the accused before or during the court proceedings that is relevant with regard to his or her mental condition or mental capacity;
(f) the purport of evidence that has been given that is relevant to the accused's mental condition or mental capacity;
(g) in so far as it is within the knowledge of the prosecutor, the accused's social background and family composition and the names and addresses of his or her near relatives; and
(h) any other fact that may in the opinion of the prosecutor be relevant in the evaluation of the accused's mental condition or mental capacity.

(2) *(a)* The court may for the purposes of the relevant enquiry commit the accused to a psychiatric hospital or to any other place designated by the court, for such periods, not exceeding thirty days at a time, as the court may from time to time determine, and where an accused is in custody when he is so committed, he shall, while he is so committed, be deemed to be in the lawful custody of the person or the authority in whose custody he was at the time of such committal.

(b) When the period of committal is for the first time extended under paragraph *(a)*, such extension may be granted in the absence of the accused unless the accused or his legal representative requests otherwise.

(c) The court may make the following orders after the enquiry referred to in subsection (1) has been conducted-

(i) postpone the case for such periods referred to in paragraph *(a)*, as the court may from time to time determine;
(ii) refer the accused at the request of the prosecutor to the court referred to in section 77 (6) which has jurisdiction to try the case;
(iii) make any other order it deems fit regarding the custody of the accused; or
(iv) any other order.

(3) The relevant report shall be in writing and shall be submitted in triplicate to the registrar or, as the case may be, the clerk of the court in question, who shall make a copy thereof available to the prosecutor and the accused.

(4) The report shall-
(a) include a description of the nature of the enquiry; and
(b) include a diagnosis of the mental condition of the accused; and
(c) if the enquiry is under section 77 (1), include a finding as to whether the accused is capable of understanding the proceedings in question so as to make a proper defence; or
(d) if the enquiry is in terms of section 78 (2), include a finding as to the extent to which the capacity of the accused to appreciate the wrongfulness of the act in question or to act in accordance with an appreciation of the wrongfulness of that act was, at the time of the commission thereof, affected by mental illness or intellectual disability or by any other cause.

(5) If the persons conducting the relevant enquiry are not unanimous in their finding under paragraph *(c)* or *(d)* of subsection (4), such fact shall be mentioned in the report and each of such persons shall give his finding on the matter in question.

(6) Subject to the provisions of subsection (7), the contents of the report shall be admissible in evidence at criminal proceedings.

(7) A statement made by an accused at the relevant enquiry shall not be admissible in evidence against the accused at criminal proceedings, except to the extent to which it may be relevant to the determination of the mental condition of the accused, in which event such statement shall be admissible notwithstanding that it may otherwise be inadmissible.

(8) A psychiatrist and a clinical psychologist appointed under subsection (1), other than a psychiatrist and a clinical psychologist appointed for the accused, shall, subject to the provisions of subsection (10), be appointed from the list of psychiatrists and clinical psychologists referred to in subsection (9) *(a)*.

(9) The Director-General: Health shall compile and keep a list of-

(a) psychiatrists and clinical psychologists who are prepared to conduct any enquiry under this section; and

(b) psychiatrists who are prepared to conduct any enquiry under section 286A (3), and shall provide the registrars of the High Courts and all clerks of magistrate's courts with a copy thereof.

(10) Where the list compiled and kept under subsection (9) *(a)* does not include a sufficient number of psychiatrists and clinical psychologists who may conveniently be appointed for any enquiry under this section, a psychiatrist and clinical psychologist may be appointed for the purposes of such enquiry notwithstanding that his or her name does not appear on such list.

(11) *(a)* A psychiatrist or clinical psychologist designated or appointed under subsection (1) by or at the request of the court to enquire into the mental condition of an accused and who is not in the full-time service of the State, shall be compensated for his or her services in connection with the enquiry from public funds in accordance with a tariff determined by the Minister in consultation with the Minister of Finance.

(b) A psychiatrist appointed under subsection (1) *(b)* (iii) for the accused to enquire into the mental condition of the accused and who is not in the full-time service of the State, shall be compensated for his or her services from public funds in the circumstances and in accordance with a tariff determined by the Minister in consultation with the Minister of Finance.

(12) For the purposes of this section a psychiatrist or a clinical psychologist means a person registered as a psychiatrist or a clinical psychologist under the Health Professions Act, 1974 (Act 56 of 1974).

APPENDIX B

PROTOCOL ON PROCEDURE TO BE FOLLOWED IN THE CASE OF CONDUCTING FORENSIC PSYCHIATRIC OBSERVATIONS IN RESPECT OF ACCUSED PERSONS (MENTAL HEALTH OBSERVATION AND RELATED MATTERS PROTOCOL)

MENTAL HEALTH OBSERVATION AND RELATED MATTERS PROTOCOL

This Mental Health Observation and Related Matters Protocol deals with the procedures and practices in respect of enquiries into the mental health of accused persons in terms of sections 77, 78 and 79 of the of the *Criminal Procedure Act, 51 of 1977*, and following court procedures. It does not deal with the procedures in respect of other persons who may require mental health care such as State patients, sentenced offenders or members of the public. Furthermore, it does not address the procedures and practices in the case of children.

THE DEPARTMENT OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT
AND
THE SOUTH AFRICAN POLICE SERVICE
AND
THE NATIONAL PROSECUTING AUTHORITY
AND
LEGAL AID SOUTH AFRICA
AND
THE NATIONAL AND PROVINCIAL DEPARTMENTS OF HEALTH
AND
THE DEPARTMENT OF CORRECTIONAL SERVICES

WHEREAS Cabinet, on 7 November 2007, approved a package of seven fundamental and far-reaching transformative changes ("the CJS Seven-Point-Plan") that must be adopted and implemented in an integrated and holistic manner to achieve a new dynamic and coordinated Criminal Justice System;
AND WHEREAS one of the seven transformative changes adopted by Cabinet provides that practical short- and medium-term proposals to improve the performance of the courts should be developed;
AND WHEREAS the agreement to and adoption of this Protocol was one of the initiatives flowing from the CJS Seven-Point-Plan;
ACKNOWLEDGING that the present processes in dealing with accused persons referred for an enquiry into and report on their mental condition in terms of the *Criminal Procedure Act, 1977*, is inefficient;
ACKNOWLEDGING that there are currently backlogs with regard to the observation of accused persons which impacts on the finalisation of cases;
WHEREAS Departments are committed toward solving problems facing the Criminal Justice System in an integrated way;
AND WHEREAS Departments have previously adopted a protocol which has been revised and is hereby replaced;
THE PARTIES HEREBY AGREE AS FOLLOWS:

ARTICLE 1
INTERPRETATION

(1) In this Protocol, unless the context otherwise requires –

(i) **"court"** includes all district, regional and High courts;

(ii) **"*CPA*"** means the *Criminal Procedure Act, 51 of 1977*;

(iii) **"correctional centre"** includes a prison;

(iv) **"DCS"** means the Department of Correctional Services;

(v) **"DCS facility"** means a correctional centre or remand detention facility or any other place where persons remanded in detention may be held;

(vi) **"DOH"** includes the National Department of Health and Provincial Departments of Health;

(vii) **"DoJ&CD"** means the Department of Justice and Constitutional Development;

(viii) **"DPP"** means a Director of Public Prosecutions;

(ix) **"head"** means a person who manages the establishment or facility concerned;

(x) **"health establishment"** means institutions, facilities, buildings or places where persons receive care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals;

(xi) **"High Court"** means the High Court of South Africa;

(xii) **"Legal Aid SA"** means Legal Aid South Africa;

(xiii) ***"head of a designated health establishment"*** means a head of a psychiatric hospital[22];

(xiv) **"*MHCA*"** means the *Mental Health Care Act, 17 of 2002*;

(xv) **"NPA"** means the National Prosecuting Authority;

(xvi) **"prosecutor"** includes all members of the prosecuting authority as set out in section 4 of the *National Prosecuting Authority Act, 32 of 1998*;

(xvii) **"psychiatric hospital"** means a health establishment that provides care, treatment and rehabilitation services only for users with mental illness[23];

(xviii) **"psychiatrist"** means a person registered as such in terms of the *Health Professions Act, 56 of 1974*, and for purposes of observation preferably a forensic psychiatrist registered under the subspecialty of forensic psychiatry or one with forensic experience.

[22]CPA was amended with reference to superintendent now Head of Health Establishment

[23]. The *CPA* has been amended and now refers to Head of Health Establishment.

(xix) **"clinical psychologist"** means a person registered as such in terms of the *Health Professions Act, 56 of 1974*;

(xx) **"SAPS"** means the South African Police Service; and

(xxi) **"*Sexual Offences Act*"** means the *Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007*.

(2) This Protocol will be known as the Mental Health Observation and Related Matters Protocol.

ARTICLE 2
OBJECTIVES

The objectives of this Protocol are to—

(a) promote, facilitate and regulate cooperation between the Departments in relation to mental observation of accused persons;

(b) ensure that the most effective mechanisms are utilised to deal speedily with accused persons who may be affected by mental illness or intellectual disability, in relation to the charges against them or in relation to court proceedings; and to reduce case cycle times and the postponement of cases;

(c) reduce delays, unnecessary detention and the impact on accused persons who require mental health observation.

ARTICLE 3
RESPONSIBILITIES OF THE COURT

(1) If at any stage of criminal proceedings it appears that an accused person is not capable of understanding the proceedings so as to make a proper defence due to mental illness or intellectual disability, the court is obliged to direct that an enquiry be made into the mental health condition of the accused person and that a report be submitted to the court.

(2) If it appears at any stage of criminal proceedings, that an accused person, by reason of mental illness or intellectual disability or for any other reason, who is alleged to have committed an offence, was at the time of the commission of the offence not criminally responsible, due to a mental illness or intellectual disability which made him or her incapable of appreciating the wrongfulness of his or her act or omission, or acting in accordance with an appreciation of such wrongfulness, the court is obliged to direct that an enquiry be made into the mental health condition of the accused person and that a report be submitted to the court.

(3) Where such accused person is unrepresented, the court may, in accordance with section 77(1A) of the *CPA*, order that the accused person be provided with a legal practitioner in terms of section 3B of the *Legal Aid Act, 22 of 1969* at the proceedings, if it is of the view that substantial injustice would otherwise result.

(4) **I**n the absence of a medical or factual basis, the court will not direct that the mental health of the accused person be enquired into. Presiding officers may refer accused persons to a medical practitioner for preliminary screening for mental illness or intellectual disability.

(5) Where the court directs that an enquiry be conducted into the mental health of an accused person, the court shall direct that:

(a) Where the accused is charged with—
(i) murder;
(ii) culpable homicide;
(iii) rape or compelled rape contemplated in sections 3 or 4 of the *Sexual Offences Act*;
(iv) charges involving serious violence;
(v) where the court considers it necessary in the public interest; or
(vi) where the court in a particular case so directs,
the enquiry to be conducted and reported on by a panel.

(b) Where the accused person is charged with any other offence, the enquiry shall be conducted, and the report be compiled by a single psychiatrist.

(6) A panel normally consists of *two* psychiatrists and where relevant, a clinical psychologist and will be made up of:

(a) The *head of the health establishment* designated by the court, if such head is a psychiatrist, or a psychiatrist appointed by such *head of the designated health establishment* at the request of the court.

(b) A psychiatrist appointed by the court.

(c) A psychiatrist appointed for the accused person by the court *upon application and on good cause shown by the accused person for such appointment. The court must ensure that the required psychiatrist has a forensic background.*

(d) A clinical psychologist, where the court so directs.

(7) Where a panel observation is to be conducted, a court must identify every panel member that is not the head of the designated health establishment, or a psychiatrist appointed by such head of the *designated health establishment*.

(8) For purposes of the enquiry the court shall commit the accused person to a *designated health establishment,* or any other place designated by the court for such periods as it may from time to time determine. The period may not exceed thirty (30) days at a time.

(9) When the period of committal is extended for the first time, such extension may be granted in the absence of the accused person, unless requested otherwise by the accused person or his or her legal representative.

(10) Should the accused person not be in custody, the court shall specify the date or dates that the accused person must present himself or herself at the *designated health establishment* or other designated place.

(11) Where accused persons are committed to DCS facilities for purposes of observation, it is preferable that DCS facilities which have a health facility and are in near proximity to the designated health establishment are utilised.

(12) Pending the committal of the person for the enquiry, the case shall be postponed. Where an accused person is in custody, the accused person may continue to be detained, but the J7 warrant for detention should be endorsed to reflect that the accused person is being detained pending observation.

(13) Where an accused person who is detained is committed for the enquiry, a J138 warrant shall be issued. The place where the observation is to be conducted and the type of observation required, i.e., single psychiatrist or panel observation, must be clearly indicated on the J138.

(14) Where the finding contained in the relevant report is unanimous, and not disputed by the prosecutor or accused person, the court may determine the matter based on the report without the hearing of further evidence.

(15) Should the finding not be unanimous, or be disputed by the prosecutor or accused person, the court shall hear further evidence and provide an opportunity for the prosecutor and the accused person to present such evidence as they deem relevant.

(16) Should the court find that the accused person is capable of understanding the proceedings so as to make a proper defence, the proceedings shall be continued in the ordinary way, including any possible proceedings in terms of section 78 of the *CPA*.

(17) Should the court find that the accused person is not capable of understanding the proceedings so as to make a proper defence, the court may consider such information or evidence as it deems fit to determine whether the accused person committed the act in question or any other offence and whether the offence involved serious violence.

(18) If an accused person is found not capable of understanding the proceedings so as to make a proper defence by reason of mental illness or *intellectual disability,* the court may:

(a) In terms of the section 77(6)(*a*)(i)(*aa*) or (*bb*) of the *CPA* direct that the accused person be detained in a psychiatric hospital or temporarily in a correctional centre; in terms of section 77(6)(*a*)(i)(*cc*) of the *CPA* direct that the accused person be admitted to and detained as if the accused person were an involuntary mental health care user in terms of section 37 of the *MHCA*; in terms of section 77(6)(*a*)(i)(*dd*) of the *CPA* release the accused person conditionally; in terms of section 77(6)(*a*)(i)(*dd*) of the *CPA* refer the accused person to a Children's Court in all cases of—

(i) murder;
(ii) culpable homicide;
(iii) rape or compelled rape contemplated in sections 3 or 4 of the *Sexual Offences Act*;
(iv) charges involving serious violence; or
(v) where the court considers it necessary in the public interest.

(b) In terms of section 77(6)(*a*)(ii)(*aa*) of the *CPA*, where the accused person has committed any other offence than the above or has committed no offence, have the accused person admitted to and detained in a designated health establishment stated in the order as if the accused person were an involuntary mental health care user, after which the procedure contemplated in section 37 of the *MHCA*

applies; or in terms of section 77(6)(*a*)(ii)(*bb*) of the *CPA*, to direct that the accused be released conditionally; or in terms of 77(6)(*a*)(ii)(*cc*) of the *CPA* be released unconditionally; or in terms of 77(6)(*a*)(ii)(*dd*) of the *CPA*, refer the accused person to a Children's Court.

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(19) If the court finds that an accused person is able to conduct his or her defence and committed the act in question and was, at the time of the commission of the act, not criminally responsible due to mental illness or intellectual disability, the court after finding the accused not guilty by reason of mental illness or *intellectual disability* has a discretion to:

(a) In terms of section 78(6)(*b*)(i)(*aa*), (*bb*), (*dd*) or (*ee*) of the *CPA* to declare the accused person a state patient and direct that he or she be detained in a psychiatric hospital or temporarily in a correctional centre; or direct that the accused person be admitted to a mental health facility as if the accused person were an involuntary mental health care user; or release the accused person conditionally; or release the accused person unconditionally; or *refer the accused person to a Children's Court* in all cases of—

(i) murder;
(ii) culpable homicide;
(iii) rape or compelled rape contemplated in sections 3 or 4 of the *Sexual Offences Act*;
(iv) charges involving serious violence; or
(v) where the court considers it necessary in the public interest.

(b) In any other cases than the above the court has a discretion to direct in terms of section 78(6)(*b*)(ii)(*aa*), (*cc*); (*dd*) or (*ee*) of the *CPA* that the accused person be admitted to a designated health establishment stated in the order as if the accused person were an involuntary mental health care user, or that the accused person be released conditionally or unconditionally, or to refer the accused person to a Children's Court.

(20) Where the court makes a finding and gives a direction in terms of section 77(6) or 78(6) of the *CPA,* that the accused person is by reason of mental illness or *intellectual* disability not capable of understanding the proceedings so as to make a proper defence or was, by reason of mental illness or intellectual disability, not criminally responsible for the act which constituted murder, attempted murder, rape, indecent assault, or assault with the intent to do grievous bodily harm, with regard to a child, the accused person shall be found unsuitable to work with children in terms of section 120(4)(*b*) of the *Children's Act, 38 of 2005*.

(21) Where the court has made a finding and given a direction in terms of section 77(6) or 78(6) of the *CPA,* that the accused person is by reason of mental illness or intellectual disability not capable of understanding the proceedings so as to make a proper defence or was, by reason of mental illness or intellectual disability, not criminally responsible for the act which constituted a sexual offence against a child or a person who is mentally disabled, the court shall make an order that the particulars of the accused person be included in the National Register for Sexual Offences in terms of section 50(2)(*a*)(ii) of the *Sexual Offences Act*.

ARTICLE 4
RESPONSIBILITIES OF THE SOUTH AFRICAN POLICE SERVICE

(1) Where it is suspected or alleged that a person detained or arrested for the alleged commission of an offence, is suffering from a mental illness or intellectual disability, the police shall investigate whether there are grounds for believing that the person may be suffering from a mental illness or *intellectual disability.*

(2) In the case of minor offences, the investigating officer shall take the docket to the relevant prosecutor for a decision whether or not to institute a prosecution.

(3) If the prosecutor declines to prosecute, such accused person must be taken to a hospital or clinic for an application in terms of section 32 of the *MHCA*. A form *MHCA* 04 needs to be completed.

(4) Where the court directs that an accused person be committed to a designated health establishment or other place for purposes of enquiry into the mental health condition of the accused person, the SAPS are responsible for the transport of the accused person who is in custody between the court, DCS facility, hospital and mental health facility.

(5) The SAPS shall, as soon as they have been informed that a bed is available for observation of the person, provide transport to take the accused to court in order for the J138 warrant to be issued.

(6) Where the accused person is detained in custody, the SAPS shall transport the person to the relevant designated health establishment or other designated place as soon as possible, upon receipt of the relevant order.

(7) Whilst the accused person is undergoing investigation at the designated health establishment, the SAPS remain responsible for the safe custody and 24 hour guarding of that person.

(8) Where the SAPS have been informed that the observation has been concluded and the accused person is to be discharged, they shall immediately arrange for collection of the accused person from the designated health establishment and transportation to the place where the accused person is to be detained or alternative place that may have been arranged arising from the investigation.

(9) SAPS shall assist in the execution of an order by a magistrate for the detention, apprehension or removal of a mentally ill person.

ARTICLE 5
RESPONSIBILITIES OF THE NATIONAL PROSECUTING AUTHORITY

(1) Where a prosecutor becomes aware or it is alleged that an accused person may be suffering from a mental illness or intellectual disability the prosecutor shall request the investigating officer to obtain the evidence in respect of this issue, which may include taking the accused to a mental health practitioner to conduct a preliminary examination into the mental condition of the accused.

(2) A prosecutor may decide not to institute a prosecution in a particular case and may request the investigating officer to take the person to an appropriate health establishment.

(3) Where it is alleged or appears that an accused person before court may be suffering from a mental illness or *intellectual disability*, the prosecutor shall request the court to consider the issue of referral of the person for enquiry into the mental condition of the accused person.

(4) Where an accused person is not legally represented at such proceedings, the prosecutor should first request the court to consider the appointment of a legal representative for the accused person in terms of section 77(1A) of the *CPA*.

(5) The prosecutor should ensure that a proper basis, whether factual or medical, is placed before the court to enable the presiding officer to determine whether the mental health condition of the accused must be enquired into.

(6) Prosecutors must oppose requests for referral by or on behalf of the accused person where the available evidence indicates a contrary position or where, upon application for the appointment of a third psychiatrist by the accused person, no good cause is shown for such appointment.

(7) Prosecutors should ensure that when the court directs that an enquiry be conducted, the court specifies whether the enquiry is in terms of section 77 or 78 of the *CPA* or both and that the panel members other than the head of the health establishment or a psychiatrist identified by the said head, are identified.

(8) Prosecutors should request the court, in cases where the accused person applies for the appointment of a third psychiatrist as a panel member, to establish whether such psychiatrist has a forensic background to be able to assist the court.

(9) Before the referral of an accused person to a designated health establishment for observation, the prosecutor shall ensure that the relevant institution has been contacted and a reference number obtained, or arrangements are made in connection with reserving bed-space for the accused person.

(10) Where the case is withdrawn and the bed-space is no longer required, prosecutors should ensure that the designated health establishment has been advised that the reservation can be cancelled.

(11) Where the observation is to take place at a Correctional Centre the prosecutor shall be informed and shall confirm that the relevant institution has been contacted or purposes of observation.

(12) Where an accused person is held in a police cell or DCS facility pending referral, prosecutors should ensure that the situation is continually monitored with a view to having the accused person admitted to the hospital or institution as soon as possible.

(13) As soon as it is known that a bed is available for an observation, the prosecutor must arrange to have the accused person appear in court in order for the person to be referred for observation and inform the representative of the arrangements made.

(14) Prosecutors may assist in relation to the reservation of bed-space where necessary.

(15) Prosecutors must forward a report, as set out below, to the head of the designated health establishment and, where applicable, to each psychiatrist, as well as the relevant DPP.

(16) This report must comply with section 79(1A) of the *CPA* and should contain the following information, namely—

(a) the prosecutor's file reference;
(b) the name of the accused person;
(c) the name of the prosecutor and his or her contact telephone number;
(d) the name of the investigating officer and his or her contact telephone number;
(e) the name of the legal representative of the accused person and his or her contact telephone number;
(f) the case number;
(g) the SAPS CAS or CR reference;
(h) the date to which the case has been postponed;
(i) the social background of the accused person, family composition and the names and addresses of his or her nearest relatives or guardians, insofar as it is within the knowledge of the prosecutor;
(j) the charge(s) against the accused person;
(k) whether the referral was in terms of section 77 and/or 78 of the *CPA*;
(l) the background to the referral including at whose request or on whose initiative the referral took place;
(m) at which stage of the proceedings the referral has taken place;
(n) the purport of the information or evidence relevant to the accused person's mental condition tendered in court;
(o) the facts of the case against the accused person, the relationship between the victim and the accused person, the victim's age and gender and where possible, copies of relevant affidavits from the docket;
(p) a description of any planning before and after the commission of the crime(s) and the relationship between the victim and the accused;
(q) the motive for the crime(s);
(r) any injuries to the complainant or deceased;
(s) the nature and value of damage to property;
(t) the circumstances of the arrest of the accused person;
(u) the essence of any statement made by the accused person before or during the court proceedings and where available, copies of statements made by the accused;
(v) any previous convictions of the accused person;
(w) any report by a social worker, should such be available; and
(x) any other facts that may, in the opinion of the prosecutor, be relevant in the evaluation of the mental capacity of the accused person.

(17) The above report shall, where possible, be electronically transmitted or hand-delivered to the DPP and to the head of the relevant health establishment and psychiatrists as soon as possible after the referral and a copy should accompany the person to the hospital or place of observation. Any annexure to this report (e.g., form J88, *post-mortem* report, photographs; SAP 69's, statements) should be forwarded through the normal channels to all the recipients mentioned above as soon as possible.

(18) Should it be necessary to extend the initial period of committal for the first time, the prosecutor shall generally request that this takes place in the absence of the accused person so that the observation continues uninterrupted.

(19) Where the findings are not unanimous or there is a dispute as to the findings, prosecutors must present evidence and may subpoena and cross-examine any person who enquired into the mental condition of the accused.

(20) Prosecutors should make appropriate submissions (informed by the DPP instruction) to the court in respect of the proper option to be applied to each case where a mental illness or *intellectual disability* is found. In this regard, prosecutors should consult with the authorities at the relevant designated health establishment but must make independent submissions to the court.

ARTICLE 6
RESPONSIBILITIES OF LEGAL AID SOUTH AFRICA

(1) Where it is alleged or appears that an accused person is suffering from a mental illness or mental defect, the legal practitioner must ensure that a basis, whether factual or medical, are placed before the court to enable the presiding officer to determine whether the mental condition of the accused must be enquired into.

(2) Where the court, in terms of section 77(1A) of the *CPA*, has ordered that the accused person be provided with a legal practitioner at state expense in terms of section 3B of the *Legal Aid Act, 22 of 1969*, the services of a suitable practitioner shall be provided as soon as is reasonably possible.

(3) Where the findings are not unanimous or there is a dispute as to the findings, legal practitioners may present evidence and may subpoena and cross-examine any person who enquired into the mental condition of the accused.

(4) The legal representative is entitled to address and make recommendations to the court on any issues arising from the appointment of a panel to enquire into the mental health of an accused person including the number of panellists~~.~~

(5) Where the court finds that the accused is not capable of understanding the proceedings so as to make a proper defence and the court considers information or evidence to determine whether the accused committed the offence in question or any other offence, the legal practitioner is entitled to challenge such evidence or information and has the right to place evidence before the court that is relevant to the court's enquiry. This should be done without delay. The legal representative is also entitled to address the court on any issues raised by the evidence or information before the court makes a finding.

ARTICLE 7
RESPONSIBILITIES OF THE REGISTRAR OR THE CLERK OF THE COURT

(1) Where the court has ordered that the accused be provided with the services of a legal practitioner, the registrar or clerk of the court must notify Legal Aid SA of the order.

(2) Where the designated health establishment does not have a high-security section for dangerous accused persons sent for observation, arrangements shall be made with DCS for detention of such accused persons for observation purposes in the hospital section of the DCS facility closest to the hospital, and the head of the designated health establishment, or the psychiatrist appointed by such head at the request of the court,

and/or the panel, must be advised accordingly and any necessary and relevant arrangements be put in place.

(3) Where an accused person is detained in custody pending the availability of bed-space the J7 warrant for detention must be endorsed to reflect that the accused person is being detained pending observation.

(4) Where an accused person is referred to a designated health establishment the registrar or clerk of the court must ensure that the relevant establishment and officer in charge of the detention centre, where the accused person is or will be detained, is provided with a J138 warrant signed by the Judge or Magistrate.

(5) The registrar or clerk of the court shall ensure that when the written report is submitted following the enquiry into the mental condition of the accused person, that both the prosecutor and the accused receive a copy thereof.

(6) Where the court makes the finding in terms of section 120(4)(b) of the *Children's Act, 38 of 2005*, that the accused person is unsuitable to work with children, the registrar or clerk of the court must notify the Director-General of the Department of Social Development of the finding for entry of the name of the accused person in Part B of the National Child Protection Register.

(7) Where the court has made an order in terms of section 50(2)(a)(ii) of the *Sexual Offences Act* that particulars of the accused person be included in the National Register for Sex Offenders, the registrar or clerk of the court must forward the order to the Registrar of the National Register for Sexual Offenders, together with the particulars of such person, for entry into the Register and, where possible, notify the employer of the accused person of such order.

ARTICLE 8
RESPONSIBILITIES OF THE DEPARTMENTS OF HEALTH

(1) The Director-General: Health must compile and maintain a current list of all psychiatrists and clinical psychologists who are prepared to conduct enquiries and the areas served by them.

(2) The head of the designated health establishment may, in accordance with section 79(1) of the CPA, delegate such person to conduct the enquiry

(3) An updated list must be provided to the Registrars of the High Courts and to all clerks of magistrates' courts, as well as the DPP's, Legal Aid South Africa, DCS and SAPS on an annual basis.

(4) The Departments of Health should also provide a list of facilities where observations can take place on an in/outpatient basis, as well as places where persons can be referred to for admission and detention as involuntary health care users.

(5) The NDOH shall liaise with the DCS with regard to the use of the health facilities in Correctional Centres for enquiries, where applicable.

(6) The NDOH shall charge the DoJ&CD the agreed tariff in respect of awaiting trial detainees observed in terms of the *CPA*.

(7) On an annual basis the NDOH and DoJ&CD shall revise tariffs in accordance with changes to the recommended fees approved by the medical industry and agree to the tariff to be charged.

(8) The NDOH shall allocate beds for forensic observations.

(9) The relevant establishment shall notify the prosecutor who has made a booking as soon as a bed is to become available.

(10) Where an accused person has been referred for observation, the person must be informed that a report will be submitted to the court by a mental health care practitioner and that he or she is under no obligation to divulge information.

(11) Should it become apparent that psychiatric treatment is urgent, such treatment may commence prior to the submission of the report to the court which will detail the treatment initiated. Provision of such psychiatric treatment remains the responsibility of the DOH.

(12) Should the need to extend a period of observation arise, the establishment shall notify the registrar or clerk of the court and the relevant prosecutor five days prior to expiry of the warrant for detention.

(13) Where the date of completion of the observation has been determined, the establishment shall notify the prosecutor and SAPS that the accused person will be ready to be discharged in order for SAPS to make travel arrangements to collect the person.

(14) The written report must be submitted in triplicate to the prosecutor and to the DPP as soon as possible after conclusion of the observation.

(15) The head of the health establishment may, in exceptional circumstances and upon the recommendation of a mental health care practitioner, request the SAPS to assist with the transfer of an assisted or involuntary mental health user to and between health facilities.

ARTICLE 9
RESPONSIBILITIES OF THE DEPARTMENT OF CORRECTIONAL SERVICES

(1) Where it appears to the head of a DCS facility that an accused person remanded in custody pending trial may be mentally ill, the head must make arrangements for a mental health assessment of the person.

(2) If it is found that the accused person is mentally ill, the head of the DCS facility must take the necessary steps to ensure that the required levels of care, treatment and rehabilitation are provided to that person and should also notify the relevant prosecutor or investigating officer of the finding where such person is not already in detention pending forensic observation.

(3) Where accused persons detained in DCS facilities awaiting mental health observation have exhibited high risk behaviour that is suspected to be related to mental illness or intellectual disability, such persons should be accommodated in separate cells from the general population, and a consultation should be made with the correctional facility medical team.

(4) If the evaluation is to be conducted in a DCS facility, the accused person must be transferred to the in-patient section of the DCS facility closest to the designated health establishment for the observation.

(5) Upon receipt of a J138 warrant, the person must be immediately transferred to the DCS facility in-patient section.

(6) Details of any treatment, special investigations, medication prescribed and administered or applied to an accused person detained in the DCS facility whilst waiting for observation, as may be required by the health of the detainee, should be reported to head of the designated health establishment responsible for the enquiry.

(7) The provision of treatment, care and support shall remain the responsibility of DoH and DCS shall ensure medication is administered as prescribed.

(8) The DCS shall provide to the DOH a list of Correctional Centres that have suitable health facilities were mental observation is able to be conducted.

ARTICLE 10
RESPONSIBILITIES OF THE DEPARTMENT OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT

(1) The DoJ&CD is obliged to pay the tariff agreed with the DOH for the observation of awaiting trial detainees.

(2) The DoJ&CD is obliged to pay the fees of psychiatrists and clinical psychologists who conducted enquiries under section 79 of the *CPA* promptly.

(3) On an annual basis the DoJ&CD and DOH shall revise tariffs in accordance with changes to the recommended fees approved by the medical industry and agree to the tariff to be charged.

ARTICLE 11
REVIEW AND AMENDMENT

An amendment to this Protocol must be in writing and adopted by all parties.

ARTICLE 12
COMPLIANCE WITH PROTOCOL

(1) The Protocol is binding on all the employees from those Government Departments and Agencies that are signatories to the Protocol.
(2) The DoJ&CD, SAPS, NPA, Legal Aid SA, DOH and DCS must ensure where relevant that the responsibilities embodied in this protocol are contained in training programmes, norms and standards, standing orders, directives and other instruments with which employees must comply.
(3) Any dispute as to the interpretation of this protocol shall be resolved by negotiation.

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