health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

PROPOSED REVISIONS OF THE CRIMINAL PROCEDURE ACT, 1977 (ACT NO. 51 OF 1977)

PURPOSE OF THIS DOCUMENT

TO PROVIDE SPECIFIC PROPOSALS BY THE DEPARTMENT OF HEALTH (TASK TEAM) TO AMEND THE PROVISIONS OF SECTIONS 77,78 & 79 OF THE CRIMINAL PROCEDURE ACT, AIMED AT UNBLOCKING BOTTLENECKS IN THE SYSTEM THAT CONTRIBUTES TO THE BACKLOGS FOR FORENSIC MENTAL OBSERVATIONS AND TO FURTHER UPHOLD THE HUMAN RIGHTS OF THE ACCUSED REFERRED BY COURTS.

TO FURTHER PROPOSE ALIGNMENT AND REVIEW OF CHAPTER 6 OF THE MENTAL HEALTH CARE ACT, 2002 IN ORDER TO IMPROVE EFFICIENCY IN CARE, TREATMENT AND REHABILITATION OF STATE PATIENTS AND PROTECTION OF THEIR HUMAN RIGHTS.

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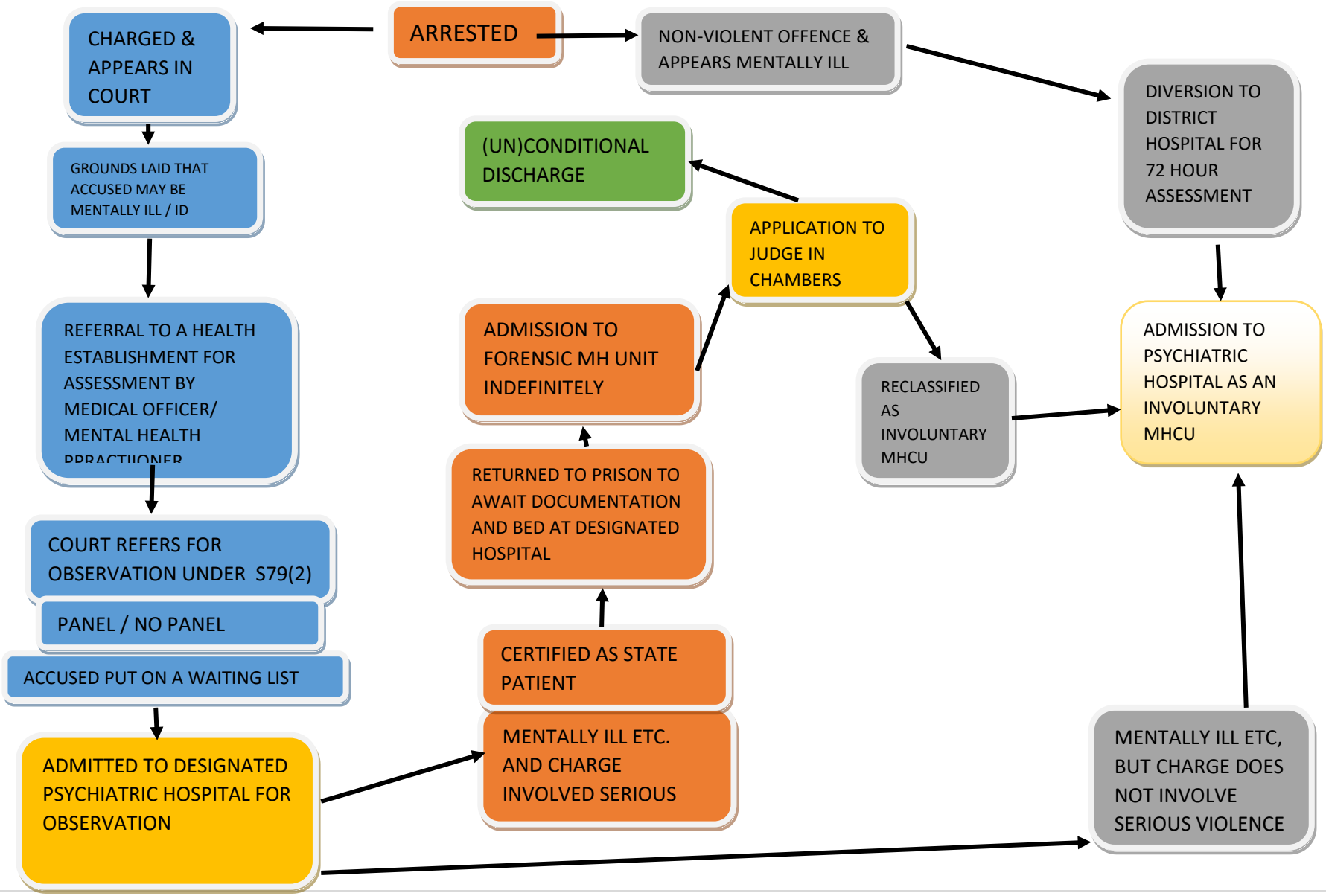
CURRENT PATHWAYS THROUGH THE FORENSIC MENTAL HEALTH SYSTEM



STAGE	CURRENT DIFFICULTIES/BACKGROUND AND MOTIVATIONS	PROPOSALS
ARREST **DIVERSION TO A DESIGNATED INPATIENT PSYCHIATRIC UNIT IIN TERMS OF THE MENTAL HEALTH CARE ACT**	• Many mentally ill people that are aggressive/violent are admitted as involuntary mental health care users without being charged • But there are many mentally ill people who commit non-violent offences that are not diverted to the general psychiatric system and instead are charged and then referred for 30-day observations. These offenders can wait for up to a year in remand for an assessment. • Not only is this inhumane but during this extended period most are not treated adequately, which complicates their subsequent treatment and recovery	According to section 40 of the Mental Health Act a policeman who "has reason to believe, from personal observation or from information obtained from a mental health care practitioner that a person due to his or her mental illness or severe or profound intellectual disability is likely to inflict serious harm to himself or herself or others" should be taken to an appropriate health establishment. *This should be modified so that it also applies to individuals who are arrested for non-violent / petty offences who should rather be treated timeously than charged and placed in remand. In other words, a formal diversion programme should be created to a hospital nearest to them (and not a forensic hospital)* *It is envisaged that a list of offences that would qualify for diversion be developed and used, and that training of SAPS on basic assessment of mental illness be offered.*
CHARGED IN COURT Grounds laid that accused may be mentally ill	• Usually a family member or the accused informs the court of a possible mental illness or ID, or it appears from the accused's behaviour in court that he/she suffers from such.	
REFERRAL TO A HEALTH ESTABLISHMENT FOR ASSESSMENT TO DETERMINE WHETHER ACCUSED SHOULD UNDEGO FORMAL FORENSIC MENTAL OBSERVATION .	• The above occasions a referral to a health facility for a preliminary screening assessment that can motivate for a formal observation or allow the court to continue with its findings. • Where practised most of these assessments are being conducted by medical officers. • Sometimes the medical officer finds no evidence of a mental illness and recommends that the trial continue,	*Section 79 could include a requirement that an accused should be screened by mental health care practitioner i.e appropriately trained medical officer, psychologist or psychiatric nurse. If the screening is not conducted by a medical practitioner then the accused must be examined by one in addition.* *See Appendix for an example of a screening form that could be standardised for all of these assessments*

	yet the accused still gets referred forensic mental observation	
COURT ISSUES COURT ORDER (FORM J138) FOR A FORMAL FORENSIC MENTAL OBSERVATION IN A DESIGNATED PSYCHIATRIC FACILITY	APPOINTMENT OF PANELS Despite the recent changes in legislation there is some confusion about the appointment of panels • Some provinces do not have enough psychiatrists to set up panels • Forensic psychiatry is now a recognised sub-specialty registered by the HPCSA. This begs the question whether general psychiatrists should now be appointed to panels. • Forensic psychology is also recognised as a sub-specialty registered by the HPCSA • It is not clear what the actual grounds for appointing a private psychiatrist or clinical psychologist to a panel are. • Some courts are insisting that each panel member submits a separate report even if there is consensus amongst the members	There should be provision that a clinical psychologist also be appointed to panels (instead of a second psychiatrist, for example) for issues that will have to be specified, such as when intellectual disability is an issue, and especially when there are few available psychiatrists. Ideally forensic psychology should be recognised as a sub-specialty for this purpose The grounds for appointing additional psychiatrists or psychologists to panels should be specified. Only clinical psychologist with forensic experience would be considered.
DISTINCTIONS BETWEEN SECTIONS 77 & 78 OF THE CPA	• There are instances where an accused was not mentally ill at the time of the offence but subsequently did become mentally ill or cognitively impaired. Under the current legislation these are certified as state patients, even though they often recover in a relatively brief period following treatment and could be returned to court for continuation of the trial • The converse also occurs, when an accused was mentally ill at the time of the offence but has since recovered and should not be hospitalized but does need to be followed up. Currently it seems that the courts always certify these cases for admission as state patients.	Section 77 could be amended such that when an accused can be expected to recover from his mental illness he/she will be referred under a temporary order for involuntary treatment (at a health establishment) until he/she is fit to stand trial, then returned for trial without first having to be discharged. When an accused has recovered since committal of an offence the court could have an added option of directing that he/she be treated as an outpatient State patient or involuntary mental health care user.

		<u>Proposed additions in Section 77 (6) (i)</u> *(aa)* detained as a State patient 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*) released and treated on out-patient as a State patient/involuntary mental health care user subject to conditions as the court considers; *(dd)* 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; *(ee)* released subject to such conditions as the court considers appropriate; or *(ff)* referred to a Children's Court as contemplated in section 64 of the Child Justice Act, 2008 (Act No. 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 No. 38 of 2005); or
ACCUSED PLACED ON WAITING LIST	There are very long waiting lists for admission to designated hospitals for formal observation. Many wait for longer than a year to be admitted to a forensic facility for an observation. Some remain thus in remand for periods longer than the sentence they would have been served with. Those who are mentally ill will have had their treatment delayed for a year while in the stressful environment of prisons. Some of the causes are • Too few beds allocated for observation cases • The requirement for panels that results in delays (especially if a panel member is in private practice)	*A possible remedy would be to provide for the referral of an accused who has already been charged with a non-violent/petty offence to be diverted to a general psychiatric facility as an involuntary mental health care user* *While in remand these cases should be held separate from other prisoners*

	• Delays in obtaining collateral information, conducting special investigations • Lack of human resources in many provinces	
ADMISSION TO A DESIGNATED PSYCHIATRIC HOSPITAL FOR FORMAL OBSERVATION	• SAPS often do not bring (for admission) or fetch (for discharge) cases timeously • SAPS often refuse to transport observation cases to other hospitals for special investigations, such as brain scans etc. • There remains some confusion as to whether an accused should be assessed for the full 30 days, or any period up to 30 days. REPORTS Despite requirements as prescribed in 79(4) of the CPA there does not seem to be standardisation of reports. Some produce long narratives about the accused, whilst others provide just the findings (as stipulated in CPA). Legislation requires a "psychiatric report", which possibly precludes input from other mental health practitioners where applicable. Should each member of the panel or assessing MDT submit their own reports (even as an addendum to main report)?	The regulation that the South African Police Service must provide transportation and guarding service for detainees referred for forensic psychiatric evaluation and between health establishments as part of the psychiatric evaluation process should be reinforced *Proposed additions in s79 (2)(a)* The court may for the purposes of the relevant enquiry commit the accused to a designated health establishment **[psychiatric hospital]** or to any other place designated by the court, for such periods, at the discretion of the assessing mental health care practitioner, of thirty (30) days or less 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. *Proposed amendments to Section 79 (4) :* (3) The forensic mental health report written and signed by all mental health care practitioners appointed by court in terms of Section 79(1) 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 mental defect or by any other cause; and *(e) Further make recommendation to the Court specifying proposed conditions on further care treatment and rehabilitation or if accused is to be released conditionally in terms of Section 77 (6) (i) (bb) or (ii) (bb) and 78 (6)(i)(dd) or (ii) (cc). [2]* *The legislation could provide for more recommendations provided by the observation multidisciplinary team*
FOR DISCUSSION: "GUILTY BUT INSANE" FINDING	This is not part of SA jurisprudence, but is surely worthy of debate. Most state patients complain that they have not been found guilty and therefore resent being certified indefinitely when they believe they would have been found "not guilty" if they had not been found to be mentally ill at the time. In related vein, sections 77(6)(a) and 78(6) use the test of "balance of probabilities" to determine whether the accused committed the offence. This is a much lesser test than "beyond reasonable doubt", yet unlike the latter results in indefinite detention rather than a set sentence.	*In some countries, such as Sweden, a guilty verdict results in sentencing options that include detention in a forensic psychiatric hospital.*
CHARGE DID NOT INVOLVE SERIOUS VIOLENCE / NO PANEL WAS APPOINTED	The current Law states that the accused should be "treated as if involuntary"	*The CPA should be more specific that these cases are to be admitted under court order to a general psychiatric hospital, as if the 72 hour observation and forms 4-6 have been filled out and be further handled in terms of the Mental Health*

		Care Act. *The court order should refer to section 9(b) instead of section 37 of the MHCA*
CHARGE INVOLVED SERIOUS VIOLENCE & THEREFORE CERTIFIED AS STATE PATIENT	**Indefinite certification of State patient** • State patients are certified for an indefinite period, which mostly exceeds the prison sentence they might have been given, and most are mentally well within one year of certification • None has been found guilty "beyond reasonable doubt" (see above) • The sole reason for the indefinite certification is that they are mentally ill, which is an infringement of their human rights as well as of article 14 of the *UN Convention on People with Disabilities* • See also *Constitution of South Africa:* sections 12 & 34	*State patients should be certified for a minimum period, subject to review. The continued detention of state patients could be subjected to 2-yearly reviews by the Courts, and if adequate motivation not presented the state patient should be discharged or reclassified.* ***Mental Health Care Act, 2002, Section 46*** *Indefinite certification should be replaced by either* • *Specific periods of certification that expires unless motivation for an extension is submitted & accepted by the court, or* • *A system could be compared to the (TBS) in other countries such as the Netherlands where every 2 years certification is reviewed by Psycho Legal tribunals* *Otherwise the NDOH should be granted more authority/power to determine the continued detention of state patients. Proposals include:* • *Establish Mental Health courts/Psycho legal tribunals (like Mental Health Review Boards) that deal with the regular assessment and discharge of state patients* • *As in USA, Canada & Holland these courts deal with a variety of issues, such as frequent offenders and discharges* • *Reviews of periodicals with authority to enforce recommendations* • *Introduce automatic discharge after a certain period if periodicals report positive findings*

RETURNED TO PRISON TO AWAIT DOCUMENTATION AND A BED AT A DESIGNATED HOSPITAL	• The MHCA requires that newly certified state patients return to prison to await transfer orders from NDOH and often also for a bed in a designated facility. • Consequently, there are unacceptable numbers of mentally ill state patients in prisons for indefinite periods. Not only is this an abuse of human rights but it complicates their future recovery • Apparently some magistrates are certifying state patients to be held at a prison indefinitely and not a designated hospital • In some provinces, such as W.Cape & Gauteng courts are sending new state patients directly to forensic hospitals and bypassing the prisons. Consequently these hospitals are responsible for completing the forms etc that have to submitted to the National Dept of Health	*Status quo as provided for in the new CPA amendment remains. Because the DOH is in the process of improving resources including beds* *We need to allow for the necessary admin process for transfer to hospitals*
ADMISSION AS A STATE PATIENT INDEFINATELY	• The point above concerning period of certification refers Other issues: **The protection of state patients' legal rights and affairs are not adequate**: • Curator bonus & administatorships are difficult to organise. State patients' assets and income are not safeguarded (especially from unscrupulous relatives). CEO's of hospitals etc are reluctant to be administrators because they could be held personally liable • Although the DPP is the official *curator ad litem* the actual ambit of this has not been established. In the Western Cape the DPP believes they act as *curator ad litem* only for the purposes of discharge applications and not for other legal issues	*The role and responsibilities of the **curator ad litem** to be clearly spelt out in order to provide guidelines on their responsibility in ensuring protection of State Patients right and application and appointment of **curator bonis** upon certification of the State patient* *CHAPTER VIII of Mental Health Care Act, 2002 to be aligned and make provision for appointment of an administrator i.e curator bonis for certified State patient [1]*

	Groups with educational & special needs State patients with learning disabilities, adolescents and children are not adequately dealt with in the criminal justice system	*This is a long-term problem, although in light of the "Stuurman" etc cases the law will have to provide better access to care for those with learning disabilities* *Perhaps the Departments of Education and Social Development should be obligated to establish and implement appropriate educational programs and for the educable State patients detained at designated psychiatric hospitals in terms of Mental Health Care Act,2002 Section 44 (1)*
APPLICATION TO A JUDGE-IN-CHAMBERS FOR DISCHARGE OR RE-CLASSIFICATION	• The application process is complicated and must proceed via the Registrar of the High Court and DPP ultimately for the consideration of a judge in chambers • Criteria for discharge are very difficult to satisfy: most state patients derive from impoverished circumstances and live in areas where there are high rates of crime and substance abuse • Most conditional discharges (and leave of absence) must be under the supervision of families, whose members often were the victims of the index offence. Families also frequently cannot accommodate or supervise the patient.	*If the court orders can provide finite periods of certification for state patients this problem could be solved. Under such a system the current procedures for discharge can remain in place because application for discharge would occur only if it were deemed desirable not to wait for the specified period to expire* *The Judiciary to consider appointment or designation of forensic mental health special courts or judge/s in each region to handle applications for reclassification/discharges etc. This will expedite the processing of applications.* *Time period to be specified for retaining the State patient who has absconded from the Health and social work intervention and SAPS efforts to trace and apprehend are unsuccessful* *Applications for reclassifications of State patients to involuntary, assisted mental health or voluntary care status to be clearly provided for in the Mental Health Care Act,2002* *"Pending the decision of the JUDGE IN Chambers" To be unpacked in the Criminal Procedure Act, to reflect reclassifications)*

REVIEW OF JUDICIAL FORMS	• State patients used to be certified with a J105 form. Nowadays a variety of forms seem to be used (MC21 etc) that often do not clearly state under which section the accused is to be admitted. Sometimes these forms state that the accused should be admitted both as a state patient and as an involuntary mental health care user	*The forms should be revised* *Proposed revision of forms for forensic observation, state patient and involuntary admissions to be finalised. The J138 to be specific on the type of mental observation to be conducted and in-out patient panel observations.* *Process to review forms is currently underway with DOJ&CD* *See examples of form revision as added attachments [1]*
TRADITIONAL HEALTH PRACTITIONERS	Whether traditional healers should form part of the panels that are established in terms of section 79 of the Criminal Procedure Act, 1977, which are tasked to do the evaluations.	The interim Traditional Health Practitioners Council (iTHPCSA) input in this matter is as follows: "The iTHPCSA or the permanent Council will be the relevant institution to compile a list of expert Traditional Health Practitioners (THPs) in the form of Government Gazette which will be used by the Judiciary, should the case so desire". The Council will have to make sure that THPs that will be on the list should meet the following criteria. 1. Registered with the Council (the Regulator) 2. Experienced Diviner in the field of mental Health 3. Trained on the provisions of section 77 – 79 of the Criminal Procedure Act and report writing. 4. The motivation for this should not be remuneration but a service in the interest of the offender and to assist the Court to arrive at the most appropriate determination. They will need to be able to work in a team and in facilities where the law requires such an individual (offender) to be kept for observation

APPENDIX A

FORENSIC MENTAL HEALTH PRELIMINARY SCREENING TOOL

The form can be completed by the mental health care practitioner at the health establishment to conduct preliminary assessment of the physical and mental health status of an accused referred by the Court to ascertain whether there are grounds for a formal referral under s79(2)

IDENTIFYING DATA:

Name:	**Age:**	**Gender:**
Charge(if applicable) :	**Case Number (if applicable):** **Referring Court or authority if applicable [1]**	

Psychiatric History (previous admissions, if known):	
Current Psychiatric medication, if known:	
Substance Abuse (Y/N):	**Specify:**
PHYSICAL EXAMINATION: NAD/specific findings	

**MENTAL STATE EXAMINATION FINDINGS: [1 **

Level of consciousness	(e.g. clear, depressed, fluctuating, etc.)
Grooming	(e.g. good, fair, poor, etc.)
Psychomotor behaviour/activity	(e.g. normal, slowed, restless, agitated, physically aggressive, abnormal movements, etc.)
Speech	(volume, level of talkativeness, speed, tone, other)

Mood	(e.g. euthymic, depressed, elevated, expansive, mixed, labile, etc.)
Affect	(e.g. normal, restricted, blunted, fatuous, inappropriate, etc.)
Thoughts	**Form:** (e.g. normal, circumstantial, tangential, derailment, irrelevant, incoherent, etc.) **Content:** (e.g. normal, delusional, suicidal, etc.)
Perceptual disturbances	(e.g. hallucinations, etc.)

Cognition	(e.g. attention, concentration, orientation, memory, etc. – can do MMSE or MoCA)
Provisional Diagnosis if any:	

Name of the practitioner who conducted the assessment: …….....

Professional category:……..... **HPCSA Registration Number** ……

Signature:…….....

Date:…….....