health
Department:
Health
REPUBLIC OF SOUTH AFRICA

TEMPLATE FOR SUBMISSION OF PROPOSED MENTAL HEALTH CARE ACT, 2003 (ACT NO 17 OF 2003) AMENDMENTS

SECTION	PEOPOSED AMENDMENT (additions, deletions, substitutions or text edits)	RATIONALE/MOTIVATION/REASON FOR THE PROPOSED AMENDMENT
Preamble		The act may want to explicitly recognize the UN Convention on the Rights if Persons with Disabilities (UN CRPD) thereby highlighting a human rights perspective for the Mental Health Care Act (MHCA/'the Act'), especially as it governs health services for people with intellectual disability (ID) and more broadly, people with physical, intellectual and psychosocial disabilities.
Definitions and interpretation (Sections 1 and 2)	• Distinguish clearly when 'mental health' and or 'mental illness' refers to persons with SPID or psychosocial disorders and/or disabilities, or both. • Consider using 'psychosocial disorder' when distinguishing from SPID as per the Convention on the Rights of persons with Disabilities. Apply recommendations to the rest of the Act.	• The current act seems to conflate the two at times and is ambiguous. The DSM5 uses the umbrella term 'mental disorders'. THE CRPD distinguishes between SPID and **psychosocial disorders**. (WCFID accepts that medical professionals and annexures to the DSM5 use 'mental illness' but the Act applies to medical professionals and non-

		medical professionals at community-based rehabilitation and care centres.) • The Act implies that persons with mild and moderate intellectual disability (MMID) are excluded from the Act.
Definitions and interpretation (Sections 1 and 2)	• Provide a definition for: - Health establishment - Care and rehabilitation centres that clearly distinguish between state-owned establishments and NGO/independent community-based centres that exist as an element of the CRPD deinstitutionalization principle.	Ambiguous.
		(v) this definition of "care and rehabilitation centres" may need to be clearer so that it includes care and rehabilitation centres in hospitals as well as centres/facilities in the community (funded by health or jointly by DSD and DOH). Due to the de-institutionalisation imperative, hospitals are less inclined to admit people (with ID) for permanent care, and this rather becomes a default when the person cannot be accommodated anywhere else in the community. Ideally and as per the CRPD, mental health care facilities for people with ID should be community-based.
	The term 'habilitation' should be added throughout the document.	(xii) may want to mention habilitation as well, thereby including those with disabilities more inclusively.

		In South African mental health and disability policy, services are often designed around rehabilitation, which can unintentionally exclude people with intellectual disability who primarily need habilitation. DOH is also responsible for mental health (MH) services for people with ID thus the need for specific inclusion of this service term. This distinction is why authors like Abrahams (2025) argue for more rights-based, disability-informed service models.
(xix) mental health care user	Elucidate.	Meaning is unclear. Is it referring to involuntary users? If this clause notes who a mental health care user (MHCU) user is and can extend to others e.g. person's next of kin, then this can be limiting because in CAMHS for example, users can include school and centre stakeholders.
(xxx)	Clarify and elucidate.	Suggests that psychiatric hospitals only render care and rehabilitation to those with mental illness, not accounting for those in care in these settings with disabilities (and not mental illness per se). This may exclude people with ID if it is interpreted to mean that only that mental illness can be treated at psychiatric hospitals. As with SPID and MMID in the MHCA debate, some may interpret this to mean all people with MI or those with only MI.
(xxxiii)	Add definition of 'habilitation'.	Article 26 (UNCRPD): Habilitation and Rehabilitation, defines 'habilitation as part of a state's obligation to:

		"enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life." (UN, 2006) The World Health Organization and disability scholars commonly define habilitation as: interventions designed to help individuals "acquire skills and functioning that were not previously developed, particularly in the context of developmental and intellectual disabilities." Reference: World Health Organization. (2011). *World Report on Disability*. WHO & World Bank.
	Distinguish between ID and mental illness. Clarify and define the place of persons with ID in the Act.	The Act defines a *mental healthcare user* as a person receiving care for a mental illness. While *severe or profound intellectual disability* may fall under mental health services in practice, the Act does not clearly recognise intellectual disability as a developmental condition and does not frame service needs in terms of lifelong skill acquisition. Consequently, people with mild–moderate intellectual disability, who primarily require habilitation, often fall outside the intended scope of services structured under the Act. Services authorised under the MHCA are therefore rehabilitative by design, even when used by people with ID.

	Add definition of MMID or specifically state that the MHCA applies to all persons with ID regardless of level of severity	In practice and policy, people with MMID are often excluded because some interpretations of the MHCA view that the explicit mention of those with SPID excludes those with MMID. This then results in some in DOH and DSD arbitrarily splitting service responsibility and thus funding, for those with SPID and MMID, where in reality, there may be those with MMID who require intensive psychiatric and habilitative supports.
Xxxvi SPID	Rather use a rights-based definition e.g. Intellectual disability is a developmental condition characterised by differences in intellectual functioning and adaptive behaviour which, in interaction with environmental, attitudinal, and systemic barriers, may hinder a person's full and effective participation in society on an equal basis with others (CRPD). In this definition, all severity levels are accounted for, making it less likely for clauses which are particularly applicable to those with SPID to be used as justification to exclude those with MMID. Current evidence and practice (based on DSM) also notes the importance of referring to support needs, not so much intellectual capacities. Yes, intellectual and adaptive functioning are assessed, however severity of ID is determined by level of support needs. See ICD 11 IDD section and DSM ID criteria.	This definition impresses as limiting in the way it speaks about areas of functioning and need for supervision and care.
	In order to be inclusive of persons with ID the Act should encompass provisions for them in the areas of: • Funding models, • Licensing of facilities, and • Service expectations	Because the Act is rehabilitation-oriented: • Funding models, • Licensing of facilities, and • Service expectations

		are aligned with recovery and restoration, not development and skill-building which is often required for people with ID.
	Align the Act with rights-based habilitation processes for persons with ID.	The Act promotes care in the least restrictive environment, which is positive and rights-based. However, this principle is operationalised through: • discharge planning, • step-down services, and • community placement linked to functional recovery. This works well for rehabilitation trajectories (e.g. moving from acute illness to recovery to discharge), but fits poorly with habilitation, which: • is ongoing, • does not aim at "return" to a previous level, and • often requires long-term structured support rather than time-limited intervention.
Objects of the Act (Section 3)	*Fundamental provisions of this Act 3 (a) I* The Act should clearly state provisions for funding for 'establishments' such as non-governmental organisations (NGOs) and/or community-based organisations (CBOs)) that provide care and rehabilitation/habilitation services to enable equitable, safe and dignified services that are the mandate/obligation of government.	The principle of equitable services is laudable. De-institutionalization, as per the CRPD, at community-based care and rehabilitation establishments (NGOs, CBOs) requires equitable access to funding, resources and support to avoid the 'Life Esidimeni' violations. The White Paper on the Rifghts of persons with Disabilities (WPRPD) Implementation Matrix calls for funding commensurate with the 'actual costs' for NGOs/CBOs fulfilling state service provisioning.

		De-institutionalization should never be a cost-saving measure that violates the best interest of the health care service user.
	(Section 3) (b) regulate access to and provide mental health care, treatment and rehabilitation services to- (i) voluntary, assisted and involuntary mental health care users; (ii) State patients; (iii) mentally ill prisoners; and (iv) people with intellectual disability Explicate the *reasons* for the provision, rather than listing a blanket "severe and profound intellectual disability" as reason for the provision in the various chapters of the Act, where intellectual disability is specifically considered. Instances include the following for example, but the entire Act and its regulations should be reviewed to correct this point. **Chapter ll Section 3d**: regulate the manner in which the property of persons with mental illness and persons with severe and profound intellectual disability…… **Replace with**: regulate the manner in which the property of persons with mental illness and/or persons with intellectual disability who are not able to manage their properties without support ….	If the Act is intended to address services for people with ID specifically, then perhaps this clause should also mention this group explicitly Ideally, an Act should not specify a healthcare user based on their diagnosis or disability. Where it is reasoned that there may be instances where it is helpful to specify this marginalised and vulnerable group to ensure that the provisions of the MHCA protects mental health care user with ID, it would be more fitting to rather state the reasons why these mental health care users might require supports (targeting).
	3(c) Add 'and the Department of Health' (in support and resourcing of CBOs and NGOs)	The Act is silent about the resources and support NGOs/CBOs require to provide government

		services to persons with ID to avoid a recurrence of Life Esidimeni.
Implementation of policies and measures by the State (Section 4)	This clause may need to state the requirement for effective collaboration from other departments.	Given that intersectoral collaboration is a real challenge for MH services, especially for the population with ID, this clause may need to state the requirement for effective collaboration from other departments. Abrahams (2025) notes that custodial departments end up shouldering much responsibility for implementation of acts. This is especially important since the act promotes MH services in the community and thus requires particularly close collaboration with DSD and DOE.
Designation of Health establishments administered under the auspices of the State as psychiatric hospitals or as care and rehabilitation centers (Section 5)	5. Distinguish between CBOs and public health establishments.	The Act conflates public health establishments and community-based rehabilitation and care centres (RCCs). RCCs are not health establishments. This would conflict with the core principles of de-institutionalization and undermine a human rights-based approach to equitable health services. By their very nature they should not aspire to be mini-hospitals or residential hospitals, nor should they be expected to operate as such.
Provision of mental health care, treatment and rehabilitation at health care establishments (Section 6)	Insert clauses that relate the provision of these services and levels of service to an obligation on the relevant department to fund, resource and support RCCs to enable the equitable provision of services to health care users.	Under-resourcing of RCCs contributed to the Life Esidimeni deaths and abuse. 6(8) reflects the core of de-institutionalization in that it recognizes the nature of 'services in a manner that facilitate community-based care',

		This care should not replicate a mini-hospital based in the community. WCFID acknowledges that certain processes and services demand medical practices but this medical model should not undermine positive de-institutionalisation.
Application of the Chapter and Respect, human dignity and privacy (Sections 7 and 8)	Insert clauses that reconcile resourcing of CBO/NGO RCCs with a human-rights imperative.	The Act does not reconcile the matter of under-resourcing of RCCs with the best interests and dignity of 'mental health care users'.
Provision of mental health care, treatment and rehabilitation at health care establishments (Section 6) 7 (b)	Amend this clause to acknowledge the very high needs of some PWID, in terms of equitable resources (human and financial).	This clause can be used to exclude those with MMID from accessing care, treatment, habilitation and rehabilitation services in care and rehab centres. This is particularly important for those with ID and behaviours that challenge who cannot be accommodated in the community and pose a risk to themselves or others due to entrenched and serious behaviours that challenge. Often, their family and community placements breakdown due to their presentations. This cohort requires specialist psychiatric treatment as well as specialist multi-disciplinary team (MDT) care which can provide for their very high and complex support needs. Currently, there are an inadequate number of community centres to accommodate this cohort. This compromises the rights those in this cohort when they are accommodated in community spaces that are not adequately resourced to provide for their support needs. The act should address this potential gap but also note

		the need to adequately resource community centres to allow community living and care.
(8)	Make provisions for PWID with very high support needs and/or, behaviour that challenges.	The above applies here too. Yes, the ideal and right is to community living, however funding is inadequate to support the development of community centres who can accommodate this particular cohort, ie. those with ID and serious behaviours that challenge.
Application of the Chapter and Respect, human dignity and privacy (Sections 7 and 8)		
Consent to care, treatment and rehabilitation services and admission to health care establishment (Section 9) 9 (1)	Insert 'and intellectual disability'.	Can this clause be interpreted to mean that only if someone with ID consents, can they be admitted? 9 (1) may need to be adjusted to include "due to mental illness **and intellectual disability"**
Unfair discrimination and Exploitation and abuse (Sections 10 and 11)	Use the term 'accessibility', so that it aligns clearly with the CRPD and imminent disabilty act	10 (3) is this clause meant to address accessibility for MH users with disabilities? If so, it may be better to use the term accessibility, so it aligns clearly with the CRPD and upcoming disabilty act. E.g. Policies and programmes aimed at promoting mental health status of a person must be implemented regarding the mental capacity of the person concerned to ensure accessibility of care, treatment, rehabilitation and habilitation.
11(2)	In the light of existing and draft acts, insert ' … in the prescribed manner as per applicable acts'.	Is the prescribed manner for reporting set out somewhere? The Children's Act details who should act and how to report abuse. The Older Persons Act notes the duty to report. The draft

		Disabilty Act is in progress and should note this too in terms of safeguarding. Perhaps this clause should state …in the prescribed manner **as per applicable acts**".
Determinations concerning mental health status and Disclosure of information (Sections 12 and 13)	Include that determinations of mental health status may also not be made on disability status.	12(1) this clause may want to include that determinations of mental health status may also not be made on disability status. Due to diagnostic overshadowing (Diagnostic overshadowing occurs when a clinician attributes a person's physical or mental health symptoms to their intellectual disability, resulting in missed, delayed, or inadequate diagnosis and treatment of other conditions.) In clinical practice, this often results in people with ID being excluded from mental health services and especially health services. In effect, their ID diagnoses are used to discriminate and exclude them from service access.
Limitation on intimate adult relationships (Section 14)	The clause should note that intimate relationships of adult mental health care users may only be limited if due to mental illness or disability, the ability of the user to consent is diminished.	This is a progressive clause since people with ID residing in psychiatric hospital residential ID units have their rights to sexuality curtailed by the current MHCA. In community centres, this also occurs through unfair restrictions to reduce risk but inadvertently infringes on the right to sexual expression and relationships amongst adults with ID who have the capacity to consent. It also drives sexual relationships *underground* and may be a factor in sexual abuse in such institutions. The clause could be improved by noting that intimate relationships of adult mental health care

		users may only be limited if due to mental illness or disability, the ability of the user to consent is diminished.
Right to representation (Section 15)		
Discharge reports (Section 16)		
Knowledge of rights (17)	Use the term accessible. For example, “every health care provider must, before administering any care, treatment, **habilitation** and rehabilitation services, inform a MH care user in an appropriate **and accessible** manner of his or her rights, unless the user has been admitted under circumstances referred to in section 9(1)(c)	As indicated in the comment above, it may be important to use the term accessible. For example, “every health care provider must, before administering any care, treatment, **habilitation** and rehabilitation services, inform a MH care user in an appropriate **and accessible** manner of his or her rights, unless the user has been admitted under circumstances referred to in section 9(1)©
Establishment (of Mental Health Review Boards) (Section 18)		
Powers and functions of Review Boards (Section 19)		
Composition of a Review Board (Section 20)		
Removal and Vacancies (Sections 21 and 22)		
Remunerations (Section 23)		
Procedures of Review Boards (Section 24)		
Voluntary care, treatment and rehabilitation services (Section 25)		

Care, treatment and rehabilitation services for mental health care users incapable of making informed decisions (Section 26)	Refer to intellectual disability in general because the clause in (ii) then stipulates that the MHCU must be incapable of making an informed decision on the need for the care, ...	This clause refers to severe or profound mental disability. Rather refer to intellectual disability in general because the clause in (ii) then stipulates that the MHCU must be incapable of making an informed decision on the need for the care, ...
Application for assisted care, treatment and rehabilitation services (Section 27)		
Initial review of assisted mental health care user by Review Board and Periodic Review and annual reports on assisted **mental** health care users (Sections 28 and 30)		
Appeal against decisions of head of health establishment to approve application for assisted care, treatment and rehabilitation (Section 29)		
Recovery of capacity of assisted mental health care users to make informed Decisions (Section 31)	Rephrase. Use synonym for 'suffering'. Refer to acuity/acuteness of the disability or disorder during the specific period.	The mental disorder or disability, in certain cases, does 'end'. It's acuteness may be more manageable after rehabilitation and other services.
Care, treatment and rehabilitation of mental health care users without consent (Section 32)		

Application to obtain involuntary care, treatment and rehabilitation (Section 33)		
72-Hour assessment and subsequent provision of further involuntary care, treatment and rehabilitation (Section 34)		
Appeal against decision of head of health establishment on involuntary care, treatment and rehabilitation (Section 35)		
Judicial review on need for further involuntary care, treatment and rehabilitation Services (Section 36)		
Periodic review and annual reports on involuntary mental health care users and Recovery of capacity of involuntary mental health care users to make informed Decisions (Sections 37 and 38)	Stipulate monitored intersectoral work to ensure users are not admitted for extended periods, where psychiatric wards become placements for these vulnerable children.	Patients under 18 with ID are often admitted as involuntary users into psychiatric units when acutely ill or showing significant behavioural challenges, but then due to lack of community placements, end up remaining admitted with this status for extended periods. The Act notes that users should and can be discharged but does not account for the gap in DSD's placement options, especially when the child cannot be discharged safely to their family. Discharge of patients relies on intersectoral collaboration with DSD to either ensure safety in the family or access to an

		appropriate facility in the community. This is all too often not forthcoming, resulting in rights infringements. The act may need to stipulate monitored intersectoral work to ensure users are not admitted for extended periods, where psychiatric wards become placements for these vulnerable children.
Periodic review and annual reports on involuntary mental health care users and Recovery of capacity of involuntary mental health care users to make informed Decisions (Sections 37 and 38)	Rephrase. Refer to acuity/acuteness of the disability or disorder during the specific period.	The mental disorder or disability, in certain cases, does 'end'. Its acuteness may be more manageable after rehabilitation and other services.
Transfer of mental health care users to maximum security facilities (Section 39)		
Intervention by members of South African Police Service (Section 40)	Suggest removing "severe of profound intellectual disability" replacing with "intellectual disability" Same applies to (2)(1)(a)	(40) (1) can be interpreted to exclude those with MMID because it specifically references people with SPID. There have been instances where SAPS fails to intervene with people with ID exhibiting high risk behaviours. Families need to know that SAPS can provide support to take a person with ID to a health facility regardless of level of severity.
Intervention by members of South African Police Service (Section 40)	(7) Stipulate the period for police custody.	(7) This section is too vague. Stipulate the period to be kept in police custody. This clause exposes the PWID or a psychosocial disability to abuse of the process.

Designation of health establishments for State patients and Designation of health establishments for prisoners who are mentally ill (Sections 41 and 49)		
Admission of State patients to designated health establishments (Section 42)		
Transfer of State patients between designated health establishments (Section 43)		
State patients who abscond (Section 44)		
State patients leave of absence from designated health establishments (Section 45)		
Periodic review of State patients mental health status (Section 46)		
Application for discharge of State patients (Section 47)		
Conditional discharge of state patients, amendments to conditions or revocation of conditional discharge (Section 48)		
Enquiry into mental health status of prisoner and		

Magisterial enquiry concerning transfer to designated health establishments (Sections 50 and 52)		
Care, treatment and rehabilitation of prisoners with mental illnesses in prison (Section 51)		How is a vulnerable mental health care user/persona with PS disorder or SPID protected as required by the rest of the Act?
Procedure to transfer mentally ill prisoners to designated health establishments (Section 53)		
Transfer of mentally ill prisoners between designated health establishments (Section 54)		
Periodic reviews of mental health status of mentally ill prisoners (Section 55)		
Recovery of mental health status of mentally ill prisoners (Section 56)		
Mentally ill prisoners who abscond from health establishments (Section 57)		
Procedure on expiry of term of imprisonment of mentally ill prisoner (Section 58)		

Appointment of administrator for care and administration of property of mentally ill person or person with severe or profound intellectual disability (Section 59)	**Chapter Vlll (Title**): CARE AND ADMINISTRATION OF PROPERTY OF MENTALLY ILL PERSON OR PERSON WITH SEVERE OR PROFOUND INTELLECTUAL DISABILITY **Replace with:** CARE AND ADMINISTRATION OF PROPERTY OF MENTALLY ILL PERSONS OR PERSONS WITH INTELLECTUAL DISABILITY This clause should refer to ID not SPID alone, and makes special reference to assessment of capacity, not based on diagnosis alone.	See comments above about singling out SPID rather than referring to ID A person with mild or moderate intellectual disability can administer their property, but it depends on their functional decision-making capacity, not the diagnosis alone. Capacity is decision-specific, not global. While some one with severe to profound ID is unlikely to be able to administer, it is also not presumed. Therefore, it is recommended that this clause refers to ID not SPID alone, and makes special reference to assessment of capacity, not based on diagnosis alone.
Application to Master of High Court for appointment of administrator (Section 60)		
Recommendation to appoint administrator by High Court during enquiry or in course of legal proceeding and Confirmation of appointment of administrator (Sections 61 and 62)		
Powers, functions and duties of administrators and miscellaneous provisions relating to appointment of administrators (Section 63)		

Termination of administrator (Section 64)		
Administration of property of mentally ill person or person with severe or profound intellectual disability (Section 65)		
Regulations (Section 66)	66(1)(h) should include the term "habilitation"	See previous aforementioned concerns.
	Minister 'may' or MUST? (i) 'education programmes' at RCCs? (As is the case at psychiatric hospitals) (k) transport at RCCs (o) regulations for licensing of NGOs	Are community-based RCCs/NGOs considered to be under the auspices of the DOH? What is the education department's mandate in this case?
Content of regulations (Section 67)		
Procedure for making regulations (Section 68)	68 (1) (c) allow at least 60 days …	
Procedure for making regulations (Section 68)		68 (1) Doesn't mention the need for the minister to ensure that regulations and comments on regulations should be accessible thereby allowing inclusive public comment 68(2) the use of the term "may" leaves room for ministers to not consult all stakeholders and ensure participation of important stakeholders in the community 68(4 to 8) seems to note the need for consultation with other departments in specific instances. Should concurrence with DSD not be noted since regulations affect facilities funded by DSD?

Conditions and exemptions contained in regulations (Section 69)		
Offences and penalties (Section 70)		
Establishment of Advisory or Technical Committees (Section 71)	Specify the need for the minister to ensure inclusion/participation of people with psychosocial and intellectual disability on advisory or technical committees.	71 may have to specify the need for the minister to ensure inclusion/participation of people with psychosocial and intellectual disability on advisory or technical committees. This would support better advocacy and self-advocacy to ensure true participation in policy and legislation which affects the lives and rights of this population.
Delegation and assignment of powers and agreements (Section 72)	(6) This section should make provision for funding RRCs.	And funding?
Repeal of Laws (Section 73)		
Transitional arrangements (Section 74)		
Section 75 and Schedule		

Name of Organisation:
Joint submission by

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Signature:

Date: 25 February 2026

NB: The template containing the proposed amendments must be forwarded to the Director-General: Health for attention Adv Kgorohlo Moabelo at Email: Kgorohlo.Moabelo@health.gov.za and copy Dudu.Shiba @health.gov.za, not later than 28 February 2026.