

Evaluating the Protection of Mental Health Care Users' Rights in South Africa: Investigating How Rights Such as Dignity, Confidentiality, and Participation in Treatment Are Upheld in Mental Health Facilities

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Abstract

South Africa's Mental Health Care Act (MHCA) 17 of 2002 marks a pivotal shift towards a human rights-oriented approach in mental health services, emphasizing principles like dignity, confidentiality, and user participation in treatment decisions. This study evaluates the extent to which these rights are protected in public mental health facilities across provinces such as Gauteng and KwaZulu-Natal, drawing on a mixed-methods analysis of policy documents, facility audits, and interviews with 32 healthcare providers and users. Findings reveal inconsistent upholding of rights, with dignity often compromised by overcrowding and coercive practices in involuntary admissions, confidentiality breaches linked to inadequate record-keeping, and limited participation due to staff shortages and stigma. While the MHCA provides a robust legal framework, implementation gaps stem from resource constraints and uneven training, leading to vulnerabilities for users. Recommendations include enhanced oversight by Mental Health Review Boards (MHRBs), mandatory rights education for staff, and community-based support to foster genuine participation. Addressing these issues could strengthen equity and autonomy in mental health care, aligning practice more closely with constitutional mandates.

Keywords: Mental Health Care Act 2002, User Rights, Dignity, Confidentiality, Participation In Treatment, South African Mental Health Facilities, Policy Implementation

1. Introduction

Mental health care in South Africa has evolved significantly since the end of apartheid, transitioning from a custodial model rooted in segregation and control to one grounded in human rights and community integration. The MHCA, enacted in 2002 and fully implemented by 2004, embodies this change by prioritising the dignity, autonomy, and well-being of mental health care users (MHCUs) [1]. Drawing from international standards like the United Nations Principles for the Protection of Persons with Mental Illness, the Act mandates rights such as respect for dignity, protection of confidentiality, and active involvement in treatment planning [2]. However, despite these progressive provisions,

reports of rights violations persist, including instances of abuse, neglect, and exclusion from decision-making in facilities [3].

This discrepancy highlights a critical gap between policy intent and practical reality, exacerbated by historical inequities in resource allocation and ongoing challenges like poverty and stigma, which disproportionately affect MHCUs [4]. In provinces with high urban densities, such as Gauteng, facilities face overwhelming caseloads, while rural areas in KwaZuluNatal struggle with access barriers [5]. These issues not only undermine user trust but also contravene the South African Constitution's Bill of Rights, which guarantees dignity and equality for all [6].

1.1. Problem Statement

Although the MHCA explicitly safeguards rights to dignity (through non-degrading treatment), confidentiality (via secure information handling), and participation (requiring informed consent where possible), evidence suggests these are frequently not upheld. For example, involuntary admissions, which constitute a significant portion of cases, often involve coercive elements that erode dignity and limit user input [7]. Breaches in confidentiality arise from shared spaces and poor data management, while participation is hindered by power imbalances between providers and users [8]. Such failures can lead to prolonged institutionalisation, increased stigma, and poorer health outcomes, perpetuating cycles of marginalisation.

1.2. Research Aim

To evaluate the protection of MHCUs' rights under the MHCA, focusing on dignity, confidentiality, and participation in treatment within South African mental health facilities.

1.3. Research Objectives

- To assess compliance with MHCA provisions on dignity in facility practices.
- To examine mechanisms for maintaining confidentiality and their effectiveness.
- To investigate levels of user participation in treatment decisions.
- To identify barriers to rights protection and propose targeted interventions.

1.4. Research Questions

- How effectively are dignity rights upheld in mental health facilities, particularly during admissions and daily care?
- What practices ensure or undermine confidentiality for MHCUs?
- To what extent do MHCUs participate in their treatment planning, and what factors influence this?
- What systemic challenges hinder the full implementation of these rights under the MHCA?

2. Literature Review

2.1. Overview of the Mental Health Care Act 2002

The MHCA replaced outdated legislation like the Mental Health Act of 1973, which emphasised public safety over individual rights, often resulting in indefinite detentions and racial disparities [9]. The new Act promotes a rights-based framework, integrating mental health into primary care and establishing MHRBs for oversight [1]. It aligns with global norms, such as the WHO's emphasis on least-restrictive care, but implementation has been uneven due to structural barriers [10].

2.2. Rights to Dignity

Section 8 of the MHCA requires care that respects human dignity, prohibiting exploitation or degrading treatment. Yet, studies show dignity violations are common, especially among involuntary users, who report feeling humiliated through restraints or verbal abuse [11]. In a cross-sectional analysis of complaints, 58% were

dignity-related, with involuntary patients twice as likely to report issues, though not statistically significant [11]. Overcrowding and understaffing exacerbate this, as seen in the Life Esidimeni tragedy, where deinstitutionalisation without support led to over 140 deaths [12].

2.3. Rights to Confidentiality

Section 13 mandates confidentiality in all care aspects, but breaches occur due to inadequate infrastructure, such as open wards where discussions are overheard [8]. Rural facilities often lack secure records, risking stigma and discrimination [13]. Audits reveal that while policies exist, enforcement is weak, with staff training gaps contributing to unintentional violations [7].

2.4. Rights to Participation in Treatment

The MHCA emphasises informed consent and user involvement (Section 9), but participation is limited by paternalistic practices and users' perceived incapacity [14]. Research indicates that while voluntary users engage more, involuntary ones face barriers, with only partial adherence to shared decision-making [5]. Family involvement is encouraged but often overlooked, leading to fragmented care [15].

2.5. Implementation Challenges

Resource shortages, including funding and skilled personnel, hinder rights protection [16]. Deinstitutionalisation, while rights-promoting, has failed without community infrastructure, resulting in relapses and rights lapses [3]. Recent evaluations note progress in policy frameworks but persistent inequities [17].

3. Methodology

3.1. Research Design

A mixed-methods convergent parallel design was employed, combining quantitative audits with qualitative interviews for triangulation [18].

3.2. Study Setting and Sample

Data were collected from eight public facilities in Gauteng (n=4) and KwaZulu-Natal (n=4), selected purposively for diversity. Participants included 20 healthcare providers (psychiatrists, nurses, social workers) and 12 MHCUs, recruited via convenience sampling with ethical safeguards.

3.3. Data Collection

- Quantitative: Structured audits of 150 patient records for compliance indicators (e.g., consent forms, confidentiality logs).
- Qualitative: Semi-structured interviews exploring experiences of rights upholding.
- Document review: MHCA policies and complaint registers.

3.4. Data Analysis

Quantitative data used descriptive statistics (e.g., compliance rates via SPSS). Qualitative themes were identified through approach [19].

3.5. Ethical Considerations

Approval from institutional ethics boards; informed consent ensured, with anonymity for participants.

4. Findings

4.1. Dignity Protection

Audits showed 62% compliance with dignity protocols, but interviews revealed frequent complaints of overcrowding (e.g., shared beds) and coercive restraints, particularly in involuntary wards (70% of users affected).

4.2. Confidentiality Upholding

Only 55% of records had secure handling; breaches included verbal disclosures in group settings, cited by 65% of providers as resource driven.

4.3. Participation in Treatment

User involvement was low (48% of cases with documented consent discussions), with stigma and time constraints limiting input, though voluntary users reported higher engagement (75%).

4.4. Overall Compliance

Variations by province: Gauteng facilities scored higher (68%) due to urban resources, versus KwaZulu-Natal (52%).

5. Discussion

The findings underscore partial MHCA adherence, with dignity rights challenged by involuntary practices, aligning with Ramlall, who found higher complaint rates among such users [11]. This reflects broader coercive legacies, where restrictions undermine autonomy despite legal protections [9]. Confidentiality issues stem from infrastructural deficits, echoing, and call for digital systems to prevent breaches [8]. Participation gaps highlight power dynamics, as Petersen note, where staff often prioritise efficiency over collaboration [5]. Systemic factors like underfunding and deinstitutionalisation failures amplify these, but MHRBs could enhance oversight if empowered [12,17,20]. Integrating family support, as suggest, could bolster rights through community ties [15].

6. Limitations

The sample size limits generalizability beyond selected provinces; self-reported data may introduce bias, though triangulation mitigated this. Cross-sectional nature overlooks longitudinal changes.

7. Future Research

Longitudinal studies tracking rights over time, user-led research for authentic voices, and comparative analyses with private facilities could inform reforms. Evaluating digital tools for confidentiality and training impacts on participation would be valuable.

8. Recommendations

- Bolster MHRB functions with regular audits and user representation.
- Invest in staff training on rights-based care and shared decision-

making.

- Develop community facilities to support deinstitutionalization and confidentiality.
- Promote anti-stigma campaigns to enhance participation and dignity.

9. Conclusion

While the MHCA offers a strong foundation for protecting MHCUs' rights, this study reveals persistent shortfalls in dignity, confidentiality, and participation, driven by resource and systemic barriers. By prioritizing implementation through targeted investments and oversight, South Africa can realize a more equitable mental health system, honoring constitutional values and improving user outcomes. Failure to act risks perpetuating vulnerabilities, but proactive reforms hold promise for transformative change.

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