The Mental Health Care Act 2002
Training Guidelines for the South African Police Services

Prepared by the National Department of Health.
Directorate Mental Health and Substance Abuse.

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Introduction:

These guidelines have been drawn up in order to assist police officers in handling situations where they are called to assist or deal with a person with a mental disorder.

Mental disorders are common and cause a great deal of suffering and disability. Sometimes, people with mental disorders behave in a way that brings them to the attention of the police service. As in other countries, members of the South African Police Services (SAPS) are called on to deal with people with mental illness in the line of their duties. In some cases this causes the members a great deal of anxiety, as many of them feel that they have very little knowledge of these conditions and how they should be managed. It is hoped that these guidelines will assist in improving the necessary knowledge and skills of SAPS members.

In most countries, there is legislation around the management of people with mental disorders. In South Africa, the Mental Health Care Act of 2002 outlines procedures for the management of people with mental disorders. This Act outlines the duties and responsibilities of all citizens, health workers and police officials in particular with regard to people with mental disorders. The new legislation promotes a strong human rights approach to people with mental disorders in order to provide the best care available, without discrimination or abuse. It also aims to protect members of the public when people with mental disorders are out of control and behave in a dangerous or harmful manner. It is hoped that the information in this document will be useful to the men and women who protect us, often in very difficult and dangerous situations. It is important to bear in mind that the SAPS has a duty in terms of the Police Services Act of 1995 to maintain law and order. The Mental Health Care Act provides an outline of how this should be done in the case of someone who is believed to be mentally ill.

It must be emphasized that although knowledge, understanding and application of the legislation is essential, this may not be sufficient to ensure that people with mental illness get good or even adequate treatment. What will be much more likely to succeed is the development of good working relationships between Health Departments and SAPS. Both health workers and police officials can do this, and all should be encouraged to develop these relationships at a local level. This has been shown to increase the appropriate utilization of both mental health and criminal justice systems in other countries.¹

In particular, we suggest that district mental health co-ordinators and area commissioners liaise together in order to provide a co-ordinated service to people with mental illnesses and their families. Contact details can be obtained from the provincial mental health co-ordinators listed on page 39.

How to use this manual:

These guidelines should be used as the basis for training members of the SAPS in their duties in terms of the Mental Health Care Act, as well as in the management of emergencies that arise when dealing with a mentally ill person. In particular, training in calming and restraint techniques will be very useful. Provincial SAPS trainers can arrange this through the provincial mental health co-ordinator (see list on page 39) or area/field trainers can contact the district mental health service. Certain sections can be kept in Police Stations as a resource for practical situations. The SAPS Legal Services intend to prepare standing orders in conjunction/in line with this training document, which should be available at every Police Station. In addition, certain information regarding mental health services must also be made available to the SAPS by provincial health authorities.
# Learning Objectives and Outcomes

**Objectives:**

1. To inform police officers of their duties with respect to Section 40 of the Mental Health Care Act of 2002.
2. To provide basic information regarding certain mental disorders that police officers may come across in the course of their duties.
3. To provide general information regarding health services available for people with mental disorders.

**After completion of this training module, the police officer will be able to:**

1. Describe his/her duties in terms of Section 40 of the Mental Health Care Act with respect to people with mental illness or severe/profound intellectual disability who are considered likely to inflict serious harm on themselves or others.
2. Describe his/her duties in terms of Section 40 of the Mental Health Care Act with respect to people with mental illness or severe/profound intellectual disability who have absconded from a health establishment and who need to be returned to that health establishment.
3. Describe the likely behaviour of a person with a mental disorder or severe/profound intellectual disability.
4. Obtain information regarding mental health services in his/her area from the relevant health department personnel/resource lists.
Part 1: The role of police officers in the management of people with mental disorders.

Where do SAPS officials come across people with mental disorders?
Members of the SAPS come across people showing a variety of behaviours in the course of their duties. In particular, the SAPS member will encounter people who are causing a disturbance, threatening or displaying violence and/or aggression. When should a SAPS member suspect that such an individual is mentally ill?

- A family member/friend/health worker reports that the individual has a past history of mental illness
- A family member/friend/health worker reports that the individual is displaying signs and symptoms of a mental illness
- The individual is wandering in the streets and appears to be unable of taking care of him/herself
- The individual is not able to give a coherent account of him/herself, or is talking irrationally and displaying strange beliefs that are out of touch with reality
- The individual appears to be unable to care for her/himself, is dressed strangely and/or is displaying abnormal behaviour
- The individual is threatening to commit suicide

Most individuals with mental illness are not violent or potentially violent; they recognise that they are ill and need treatment and accept such treatment VOLUNTARILY. They will not need the intervention of the SAPS. However, a significant number of mentally ill individuals do come to the attention of the SAPS, and these are likely to be those people who are displaying abnormal behaviour. Members of the SAPS have a significant role to play in the management of such individuals, in particular, in the case of mentally ill individuals displaying violence or aggression. These people often need INVOLUNTARY admission to hospital for treatment of their mental illness (i.e. against their will). It is important that all involved in this process do so in terms of the law, and with respect for the rights of everyone involved.
Symptoms and signs of mental illness

A person with a mental illness may complain of certain symptoms. These are subjective feelings/sensations that the person is aware of. The person may also show signs of mental illness. These are objective observable behaviours that the person demonstrates.

For example: a person may say: 'I feel low, sad and depressed'. These are symptoms of depression. When you look at this person, they may look very sad, move and speak very slowly. These are signs of depression.

Many people with mental illness do not display any abnormal behaviour. However, some people with mental illness do display abnormal behaviour, and these people are often the ones that come to the attention of the SAPS. The following are some common signs of mental illness that are likely to be noticeable. Usually a mentally ill person will complain of and/or display a number of symptoms and signs, and not just one symptom or sign. The more symptoms and signs a person has, the more likely it is that they are mentally ill. It is important to obtain as much information as possible, both from the person who may be mentally ill, and from other people (family members, community members, bystanders etc.)

Confusion: This is a general term and could mean that the person is disoriented or that he is incoherent (unable to conduct an understandable conversation).

Level of consciousness: If a person is not fully awake, appears to be drowsy or in a stupor, s/he is either intoxicated or has a medical condition, which needs urgent attention. If there is no evidence that the person is under the influence of alcohol, then s/he should be taken to hospital immediately.

Disorientation: the person does not know what day of the week it is, what the date is, what month it is or even what year it is (depending on how severely ill s/he is). S/he may also not know where s/he is or even who s/he is (again, depending on how severely affected s/he is).

Abnormal mood: The person may display signs of being depressed: looking sad, crying, not moving very much, or even not moving at all. A person who is severely depressed may eat and sleep very little, and may even stop eating or drinking. The person may threaten or actively attempt to commit suicide. On the other hand, mental illness can also cause a person to have an abnormally elevated mood. S/he may appear to be very happy, even euphoric, may laugh excessively, sing, be very active and talk a lot. This is not appropriate to the person's situation, and is out of proportion to his/her circumstances. In addition, sometimes a person with this kind of illness dresses strangely, with very bright clothes and make-up, or an odd assortment of clothes. Sometimes the person's mood is "infectious"; that is, you may also find him/her amusing or want to laugh along with them (or even at them). This is not a good idea: in the first place, it is not respectful of the
person, who is actually ill, and secondly, this may upset or anger the person concerned and s/he could react negatively, resulting in aggression or even injury. Because the person is ill, his/her mood may change very rapidly to become irritable or aggressive.

**Aggression or violent behaviour:** Although most people with mental illness do not become aggressive, some may do so, and such a person can display any type of aggression (verbal, physical) or violent behaviour.

**Incoherent speech:** A person with a mental illness may not be able to conduct a coherent conversation. The person may not be able construct sensible sentences; his/her speech may ramble from one unrelated topic to another; s/he may not be able to answer questions put to them; the person may talk about things that are strange or unrealistic (see below). Sometimes a mentally ill person may not speak at all (i.e. they may be mute)

**Strange beliefs:** A person with a mental illness may have strange beliefs and ideas, such as that someone is trying to electrocute him/her with brain waves from a power station, or that s/he is someone very special or important, or that s/he has special powers, or that s/he is being persecuted or threatened in some way (e.g. being poisoned, being followed, under threat of assassination). Sometimes it is not possible to know whether these beliefs are true, unless one has additional information from family members. However, if the belief is bizarre and appears to be unrealistic, and/or if there are other signs of mental illness, and/or if the person appears to be likely to act dangerously as a result of these beliefs, then the situation should be taken seriously and the person should be apprehended and taken for an assessment.

**Other strange behaviour:** The person may be wandering in the streets, appear to be homeless, rummaging in dustbins, etc. The person may do other strange things such walk in traffic, direct traffic, talk to strangers, shout in the street, and become verbally abusive or aggressive to bystanders. These are examples of a whole range of strange behaviours that a mentally ill person may exhibit.

**Appearance:** A mentally ill person may look neglected, dirty, unwashed or may not have changed his/her clothes for sometime, or may be dressed strangely.

**“Hearing voices”** Sometimes a person with a mental illness hears or sees (tastes, smells or feels) things that other people cannot see. Sometimes the person can tell you about this, but often other people observe that the person appears to be distracted (listening to “voices”) or talking to unseen people. This is a sign of serious mental illness.

**Agitation:** Because the symptoms of mental illness can be very distressing, a person may become very agitated, upset and restless.
Anxiety: Anxiety is a very common symptom and sign of many serious mental illnesses, including depression and psychotic illnesses. The person may show signs of excessive fear, sweating, breathing very fast, and being agitated.

Changes in eating and sleeping patterns: A person with a mental illness or a family member may volunteer that the person is eating much more or less than usual, or that the person is not sleeping at night or is sleeping all day. Any marked change may indicate an illness.

For more information on mental illness, see page 25.
Approach to a situation where a person may be mentally ill:

You may be called to investigate a situation, where someone is causing a nuisance or a disturbance, or may be threatening violence or acting in a dangerous manner. In all cases it is most important to try to be as calm as possible, so that you can help to contain the situation. At the same time it is most important to ensure that nobody gets hurt, so your first priority must be to secure the situation if there is immediate danger to anyone.

Once the situation is secured and people have calmed down, it is important to obtain as much information as possible about what the problem is. Try to talk to the individual concerned, as well as bystanders and other people who may be involved or who may know the individual. In particular, it is important to find out why people around believe that the person involved may be mentally ill. Try to obtain contact details of all witnesses, family members or responsible community members.

While you are doing this, it is also important to observe the individual. The information you obtain from him/her, as well as his/her behaviour may also indicate that s/he is mentally ill.

If you have reason to believe that the person involved is likely to be mentally ill, and is also a serious danger to him/herself or to others around him/her, then you must take the person to the nearest hospital for an assessment of their mental health status.

The management of a mentally ill individual who is threatening violence or who is violent:

This is a difficult situation to be in, and often creates anxiety in SAPS members, in family members, health workers and the individual him/herself. However, there are techniques that can be learnt which will assist all involved in handling such situations.

It is very important that health workers and members of SAPS in a particular area communicate with each other, so that they can assist each other in the case of an emergency. The SAPS, Emergency Medical Services and Mental Health Services should work together in order to develop an approach to the management of such emergencies. This can be done on a provincial basis, but should preferably be done at a local/district/area level.

For example, there are community mental health nurses in all districts in most provinces, who can be called on (during normal working hours) by police officers to accompany them to an individual's home. In turn, the community mental health nurse may call on police officers to assist when s/he learns of a mentally ill patient who requires treatment, but cannot/will not come to the clinic/hospital.
It is important for SAPS members to know where a mental health care practitioner (see page 16) is available to examine patients and complete the necessary forms. The relevant provincial department of health is obliged to provide this information to the SAPS (See regulation 12 on page 21 below).

In addition, it will be very useful to all concerned, if police officers and mental health staff meet on occasions or more regularly if necessary. Joint training in the techniques of calming and restraint would be very helpful when it comes to handling an emergency.

Each Police Station should have the following information:
1. A list of health facilities that provide assessments for assisted and involuntary mental health care users (in terms of Regulation 12).
2. Names and contact details of community mental health services in their area.
3. Names and contact details of the local Emergency Medical Service.

**An approach to calming and restraint:**
(Not necessarily in this order, as circumstances may dictate a slightly different approach): However, the principle should be to calm the situation as far as possible, by talking first, and by using minimum force when necessary.

1. Secure the situation - keep calm, keep everyone else calm. If you cannot calm the person, make sure they are disarmed/held firmly (if necessary).

2. If you suspect that a person has a mental illness, it is important to **talk to the person** and ask how you can help. Because the person is mentally ill, s/he may calm down, and be able to be co-operative if s/he is treated with respect and is given an opportunity to express his/her concerns.

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**Introduce yourself courteously. Respect the person's body space - do not get too close or touch the person unnecessarily. Ensure that there are sufficient people around to restrain the person if s/he fails to respond to talking. Encourage the person to talk, treat him/her with dignity but also with firmness. Threatening the person very often escalates the situation. You can say things like: "We are here to help you. Your behaviour is not allowing us to give you help. We cannot allow you to hurt yourself or other people. Can you tell us more calmly what the problem is?" or Why don't you tell me how angry you feel rather than hitting me?" "I am listening to you"**

**Indicators of potential violence/aggression: look at the person's posture; if s/he appear to be tense and angry, s/he is more likely to be violent. If s/he talks loudly, paces, startles easily, is reluctant to talk, clenching fists, pounding, slamming doors, uses threatening language or shows a weapon.**
Firearms: If possible, remove your firearm before dealing with the person (obviously you must make sure that the person is also disarmed). Having a firearm available may increase the likelihood of its being used, either by the mentally ill person or by the SAPS member.

If a person who appears to be mentally ill has a gun or other weapon: This is a very frightening situation and can end in tragedy. Much may depend on how you handle the situation. In this situation, try to encourage other people/family members/the public to leave the area. Things you can do include: look the person in the eye. Move slowly and deliberately. Speak in a natural tone of voice. Assure the person that s/he is in control. Keep talking in a reassuring voice. Ask the person why they feel it is necessary for them to have a gun/weapon and try and talk the person into putting the weapon down. You can say things like: “I am listening to you. Why don’t you put the gun down so we can talk better?” “You are scaring me so that it is difficult for me to help you. Why don’t you put the gun down so I can listen better and help you more?” The gun might go off accidentally. Why don’t you put it down to prevent an accident?” “You are in control now. Why don’t you put the gun down so you will remain in control?”

2. Get as much information as possible from the person involved, bystanders, family members etc

3. Try to get the person to go with someone to the nearest treatment point (clinic or hospital).

4. If the person appears to be mentally disturbed, is likely to be dangerous to themselves (i.e. is threatening suicide) or to others, and is refusing treatment, then you have a responsibility to contain the person and take them to the nearest health facility.

5. Take the person to the nearest health facility for sedation as soon as possible.

6. Sedation: This must be done by a health professional (a nurse or a doctor). If the person refuses, then usually s/he will need to be restrained in order for the sedation to be given by injection. (Ideally five people are needed in order to restrain someone safely for sedation, one for each limb and one for the head. One can also use a mattress, if available, to restrain someone who is out of control, until enough people can hold him/her.)

7. It is most likely that sedation will be done at the assessment facility. It is important to ensure that the person is properly restrained and sedated before your handover of the person is completed.
8. If a person is sedated before transfer to the assessment facility, then they should be transported in an ambulance by health professionals who can monitor them. However, sometimes this is not possible, and the person must be transported in a police vehicle. If the person has been sedated, s/he must be accompanied by a health professional. Any person who has been sedated must NOT be kept in a prison cell, but must be taken to the nearest health facility immediately.

The only mechanical restraints usually available to police officers are handcuffs (and occasionally leg-irons). There are SAPS standing orders defining when and how handcuffs may be used and procedures that need to be followed when handcuffs are used (including for someone with a mental illness). Handcuffs can cause injuries, especially if the person struggles against them. They should only be used in an emergency until the person has been sedated and/or other means of mechanical restraint are available at a health establishment. If handcuffs are used, it should be for the minimum period of time necessary.

It is very important that you receive some practical skills training in calming and restraint techniques.
Call received re a disturbance/situation

Secure situation/disarm and restrain if necessary

Investigate situation

Information received re mental status of person

Probably mentally ill
Willing\(^2\) to go for treatment?

Yes  No

Has a crime been committed?

Yes  No

Normal procedures  Release the person

Likely serious harm?  Later evidence of mental illness

Voluntary/assisted treatment  Refer for Psychiatric Observation

Yes  No

Take to nearest assessment centre  Inform mental health care practitioner

\(^2\) Not competent to decide, but not actively refusing treatment = assisted admission and treatment.
Part 2: The SA Police Service, the law and people with mental disorders.

In this section, relevant sections of the Mental Health Care Act of 2002 are dealt with in some detail.

The Mental Health Care Act of 2002.

There are a number of new terms in this Act. The following definitions are important:

**Mental Health Care User:** This is a new term in the legislation for a patient with a mental illness. By definition in the act:

“A mental health care user is a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, State patient and mentally ill prisoner and where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include— (i) prospective user (i.e. someone who is not yet at a health establishment); (ii) the person's next of kin; (iii) a person authorised by any other law or court order to act on that person's behalf; (iv) an administrator appointed in terms of this Act; and (v) an executor of that deceased person's estate and "user" has a corresponding meaning.”

**Assisted mental health care user:** this is a person with a mental illness who is in need of treatment and who is not capable of consenting to treatment, but does not refuse or resist such treatment.

**Involuntary mental health care user:** this is a person with a mental illness who is in need of treatment, who is not capable of consenting to treatment, who refuses or resists treatment and who is a danger to themselves or others or runs the risk of damaging their finances or reputation as a result of their illness.

**A Mental Health Care Practitioner** is a psychiatrist or registered medical practitioner, or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services. Mental Health Care Practitioners may examine mental health care users, complete certificates for assisted and involuntary admissions and serve on Mental Health Review Boards.

**Health establishment:** is an institution, facility, building or place 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.
**Mental Health Review Boards:** consist of a minimum of three and a maximum of five people, one of whom must be a mental health care practitioner (see above), one of whom must be a legal practitioner (magistrate, lawyer, advocate, judge etc.) and one of whom must be a community member. The review boards oversee procedures in terms of the admission, care, treatment and rehabilitation of assisted and involuntary mental health care users, mentally ill prisoners, and certain aspects of the management of State patients.

**NB:** Whereas, under the old legislation, SAPS members would take a mentally ill person who required involuntary admission to a magistrate (for a Reception Order), this is no longer done. Instead, any mentally ill person that is apprehended by a SAPS member must be taken to a health establishment that provides assessment facilities (by mental health care practitioners). Heads of health establishments now play a major role in assisted and involuntary admission procedures.

SAPS members do not deal directly with the Mental Health Review Boards. However, a SAPS member could have dealings with a Review Board if s/he reported abuse of a mental health care user to a Review Board (in terms of Section 11; see below). It is also possible that a review board could call a SAPS member to give evidence regarding a particular patient that s/he has apprehended. This is unlikely to occur routinely or very often. However, it is important for SAPS members to bear this in mind and to ensure that they document the circumstances of such situations very clearly.

**RELEVANT SECTIONS OF THE MENTAL HEALTH CARE ACT OF 2002 FOR THE SAPS:**

**Section 11**

11. (1) Every person, body, organisation or health establishment providing care, treatment and rehabilitation services to a mental health care user must take steps to ensure that—

(a) users are protected from exploitation, abuse and any degrading treatment;

(b) users are not subjected to forced labour; and

(c) care, treatment and rehabilitation services are not used as punishment or for the convenience of other people.

(2) A person witnessing any form of abuse set out in subsection (1) against a mental health care user must report this fact in the prescribed manner.
(1) A person witnessing any form of abuse set out in section 11(1) of the Act against a mental health care user:

(a) Must report this fact to the Review Board concerned in the form of MHCA 02 (see attached); or
(b) May lay a charge with the South African Police Service.

(2) A report referred to in subregulation (1) received by the Review Board must be investigated by such Review Board and if necessary a charge by laid by such Review Board with the South African Police Service.

In terms of Section 11(2), any SAPS official has a duty (as a member of the public) to protect mental health care users from exploitation, abuse or degrading treatment, and to report any form of abuse to the relevant Mental Health Review Board. SAPS officials are likely to be in a position where they may witness such abuse, and should take this responsibility seriously. In addition, the SAPS has a responsibility to investigate any charge related to Section 11(1) laid with them by a member of the public or by a Review Board.

Section 25

SAPS are unlikely to have to deal with voluntary mental health care users, and do not have any obligations to users in this section. However, it is important to bear in mind that police officials can inform any person with a mental illness of their right to receive treatment (voluntarily), can encourage them to go for such treatment and can refer them to the appropriate resources.

Section 27

A person with a mental illness who is not capable of consenting to voluntary treatment, as a result of their illness, (but who does not resist such treatment) may obtain treatment as an “assisted mental health care user”. In this case, a relative applies for admission and treatment on behalf of the user. The procedures involved all take place at a health facility, and the SAPS are not obliged to play any role in the application of this Section of the Act. However, in certain circumstances, the head of a health establishment may request the assistance of the SAPS in the transfer of an assisted mental health care user from one facility to another.

There may be occasions when the SAPS become aware of someone with a mental illness in the community who is not capable of consenting to treatment, but who could benefit from treatment. From time to time, people with mental illness wander from their homes, or may even be homeless. They may not be a danger to themselves or to others (and thus there is no legal obligation on the part of SAPS to apprehend them and take them for assessment and treatment). However, members of the public may complain about the person and their behaviour, and situations can become tense if the person is handled inappropriately or aggressively by members of the public (or the police). If possible, in such situations, it is advisable to try and locate a family member of
the person concerned, and to explain to them the need for treatment. It is then up to the family to apply to the nearest appropriate health facility for assessment and/or admission and treatment as an **assisted mental health care user**. If no family member can be traced, then the SAPS can encourage the person to go to a hospital, but they cannot force the person or apprehend them. In such a case a health care provider may apply for admission on behalf of the patient. The SAPS could inform the nearest health or social service of the situation, and if resources allow, a mental health service provider could visit the person and also encourage them to obtain treatment. Bear in mind that a person with a serious mental illness who does not get treatment may eventually become a danger to themselves or others. If you are unsure whether this is likely to happen, it is better to take the person to a health facility for treatment, than to leave them unattended.

**Section 33**

*Application to obtain involuntary care, treatment and rehabilitation*

This section applies to:
- a person with a mental illness,
- who is not capable of consenting to treatment,
- who REFUSES TREATMENT,
  - and who is a DANGER to themselves or to others, or who
  - needs treatment in order to protect the person’s financial or personal reputation.

A person must meet all these criteria in order to be admitted to hospital for treatment as an **“involuntary mental health care user”**. As with an assisted mental health care user, a relative must apply for the admission as far as possible. Only if a relative/next of kin is not available or unwilling to make the application, can a health care provider do so. The procedures involved all take place at health facilities, and no longer involve a magistrate, as was the case with the equivalent section in the Mental Health Act of 1973 (Section 9).

The SAPS may be called upon to assist in the apprehension and/or transport of people covered by this section of the Act (as well as other sections mentioned below). Their duties and responsibilities in this regard are outlined in Section 40 of the Act (see below).

**Section 40**

*Intervention by members of South African Police Service*

40. (1) If a member of the South African Police Service 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, the member must apprehend the person and cause that person to be—

(a) taken to an appropriate health establishment administered under the auspices of the State for assessment of the mental health status of that person; and

(b) handed over into custody of the head of the health establishment or any other person designated by the head of the health establishment to receive such persons.

(2) If a mental health care practitioner, after the assessment referred to in subsection (1), is of the view that the person apprehended is—

(a) due to mental illness or severe or profound intellectual disability, likely to inflict serious harm to himself or herself or others, must admit the person to the health establishment for a period not exceeding 24 hours for an application to be made in terms of section 33; or

(b) unlikely to cause harm, he or she must release the person immediately.

(3) If an application is not made within the 24-hour period, the person apprehended must be discharged immediately.

(4) If an assisted or involuntary mental health care user has absconded or is deemed to have absconded or if the user has to be transferred under sections 27(10), 33(9), 34(4)(b), 34(6) and 39, the head of the health establishment may request assistance from the South African Police Service to—

(a) locate, apprehend and return the user to the health establishment concerned; or

(b) transfer the user in the prescribed manner.

(5) The South African Police Service must comply with the request.

(6) When requesting the assistance, the South African Police Service must be informed of the estimated level of dangerousness of the assisted or involuntary mental health care user.

(7) A person apprehended in terms of subsection (4) may be held in custody at a police station for such period as prescribed (current Regulations state: not longer than 24 hours) to effect the return or the transfer in the prescribed manner.

(8) A member of the South African Police Service, may use such constraining measures as may be necessary and proportionate in the circumstances when apprehending a person or performing any function in terms of this section.
Who can be apprehended and taken for treatment?

The decision regarding who can be apprehended and taken to a health facility for treatment by the SAPS hinges largely on the interpretation of what is meant by “likely to inflict serious harm” in Section 40 (1). Clearly, if a person with a mental illness is already behaving in an aggressive manner, has hurt someone else or is threatening to harm him/herself or others, this would be covered by the phrase above. It is not clear that a mentally ill person, behaving in an inappropriate manner, perhaps by undressing or urinating in public, would be covered by this phrase. In between, there may be people with mental illness who behave in a reckless manner, or who may be verbally aggressive or abusive, where a distinction cannot be clearly made. In all cases, it is important to try and talk to the affected person as calmly as possible, and to attempt to elicit their co-operation. Often, through talking, the person calms down, or it becomes clearer what the level of risk of potential serious harm is. Also, if there are others in the vicinity who can give any information about the person, this can also help the police officer to make a decision in this regard.

The most common scenario is that a family member calls a Police Station regarding a mentally ill family member who is out of control and needs to be taken for treatment. A SAPS member should investigate the situation. If at all possible, they should contact a mental health care practitioner for advice. In some cases, it may be possible for a mental health care practitioner to accompany them to the site, but this will depend on local circumstances.

Once a person with a mental illness has been apprehended, they must be handed over to an appropriate person at the nearest health establishment that provides assessments for involuntary mental health care admission and treatment. A list of these facilities must be available at every police station. It is the responsibility of every provincial health department to provide the SAPS in their province with this information.

Regulation 12: Information regarding health establishments that provide assessment

(1) The head of a provincial department shall submit to all health establishments under the auspices of the State (and private health establishments) within the province and to the South African Police Services a list of health establishments in each district in such province that provide assessments referred to in regulations 9 and 10 (of assisted and involuntary mental health care users).

(2) The head of such provincial department shall update such list on an annual basis indicating which health establishment falls in which district and submit such updated list to the health establishments and South African Police Services referred to in subregulation (1)
The provincial department of health will provide a list of all health facilities that have sufficient numbers of mental health care practitioners available on a 24-hour basis in order to do assessments for admission of assisted and involuntary mental health care users. This is likely to apply to general hospitals with a 24-hour casualty/emergency service.

The police official concerned must complete a hand-over form and give it to the appropriate person at the health establishment.

See also Regulation 28:

| Regulation 28: Apprehension and handing over of person to a health establishment by South African Police Service: If a member of the South African Police Services apprehends a person in terms of section 40(1) of the Act, such member must cause that person to be:
| (c) taken to an appropriate health establishment administered under the auspices of the State for assessment of the mental health status of that person; and
| (d) handed over using form MHCA 22 attached hereto into custody of the head of the health establishment or any other person designated by the head of the health establishment to receive such persons. |

What are necessary and proportionate constraining measures?
In the short term, in an emergency situation, a person can be held by (preferably) more than one other person. As mentioned above, handcuffs (and leg irons) are the only forms of mechanical restraint that are available to the SAPS. These should be used in accordance with Standing Order (G) 350: Use of restraining measures. If it is necessary to restrain a mentally ill person, then it is important to get that person to a health establishment for sedation as soon as possible.

Assisted and involuntary mental health care users, and State patients who have absconded from a specialized psychiatric hospital: See Section 40(4) above and Regulation 29 below. (See also similar Sections 44(1) (State patients) and 57(1) (Mentally ill prisoners)).

The SAPS can also be called upon to apprehend the above users/patients. It is the duty of the head of the health establishment concerned to inform the SAPS of the abscondment, the last known address, and the level of dangerousness of the person concerned.

| Regulation 29: Return of an absconded person who has been apprehended and is being held in the custody of the South African Police Service. |
| (1) If a mental health care user has absconded or is deemed to have absconded, the head of the health establishment concerned may in terms of sections 40(4), 44(1), or 57(1) of the Act and in the form of MHCA 25 attached hereto notify and request assistance from the South African Police Services to locate, apprehend and return the user to the health establishment concerned. |
(2) If a mental health care user referred to in subregulation (1) is apprehended by the South African Police Services in terms of sections 40(4), 44(1), or 57(1) of the Act in the vicinity of such health establishment, the South African Police Services shall return the person immediately to such establishment using form MHCA 26 and hand over such person the head of such health establishment.

(3) If a mental health care user who has absconded from the health establishment concerned is apprehended by the South African Police Services in terms of sections 40(4), 44(1), or 57(1) of the Act outside the vicinity of such health establishment, the South African Police Services, shall -

(a) notify the head of such health establishment that such user has been apprehended and is in the custody of the South African Police Services; and

(b) provide such information with regard to the physical and mental condition of such user as notifying member will be able to provide.

(4) The head of the health establishment referred to in subregulation (1) shall, if circumstances so require, take steps to ensure that a mental health care practitioner from the health establishment nearest to the police station where the mental health care user is held in custody or another suitable mental health care practitioner, examines such mental health care user and provides such treatment as may be required at such police station.

(5) After the examination referred to in subregulation (4), it is the responsibility of the member in command of the South African Police Service facility where the mental health care user is being detained, to consult with the head of the health establishment concerned and to make such arrangements in the form of MHCA 26 for the return of such mental health care user as may be feasible in the circumstances, taking into account the physical and mental condition of the user. Provided that if such user is -

(a) Too dangerous to be transferred in a vehicles staffed only by health personnel; or

(b) Likely to abscond during the transfer, unless guarded, such user must be conveyed by the South African Police Services or a member of the South African Police Services must accompany such user while being conveyed.

(6) The mental health care user may be held in custody at a police station for a period of not more than 24 hours to effect the return of such user.

Transfer of mental health care users by SAPS between health establishments:
Applicable Sections: 27(10), 33(9), 34(4)(b), 34(6) and 39,45(1) and (3), 66(1)(j). See also Regulation 27 below.
The SAPS may be called upon to assist in the transfer of the following persons:

1. An assisted mental health care user who is to be admitted to hospital [Section 27(10)]
2. An involuntary mental health care user who is to be admitted to hospital for the initial 72-hour assessment. [Section 33(9)]
3. An involuntary mental health care user who is to be transferred to a specialized psychiatric hospital for further involuntary treatment after the 72-hour assessment period. [Section 34(4)(b)]
4. An involuntary outpatient who has violated the prescribed schedule of conditions attached to his/her status as an involuntary outpatient, and
who is to be returned to the hospital from which s/he was discharged. [Section 34(6)]

5. Any assisted, involuntary, observation or state patient who is to be transferred to a maximum-security facility. [Section 39]

6. Any State patient or assisted or involuntary mental health care user who is on leave of absence, who does not comply with the terms applicable to the leave of absence. [Section 45(1) and (3)]

7. A mentally ill prisoner. [Section 66(1)(j)]

In all the above cases, it is preferable for the user or patient to be transferred between health facilities by Emergency Medical Services vehicles and health personnel. The user or patient should be adequately sedated and monitored by a health professional. However, this is not always possible, and there are times when the SAPS may be called to assist in transporting users/patients in the above situations. According to the regulations of the Mental Health Care Act, assistance must be provided if the user/patient is considered too dangerous to be transferred in a vehicle staffed only by health personnel, or is likely to abscond during transfer unless guarded.

**Regulation 27: Transfer of an assisted or involuntary mental health care user, State patient or mentally ill prisoners under sections 27(10), 33(9), 34(4)(b)(b), 34(6) and 39 of the Act with the assistance of the South African Police Services.**

1. The head of the health establishment concerned may only in exceptional circumstances and upon the recommendation of a mental health care practitioner, request assistance of the South African Police Service with the transfer of an assisted or involuntary mental health care user, State patient or mentally ill prisoner.

2. A request referred to in subregulation (1) shall only be made if the head of the health establishment is satisfied that medical care has been provided to such user or that an attempt was made to provide such care, and such head is of the opinion that such mental health care user, State patient or mentally ill prisoner is too dangerous to be transferred in a vehicle staffed only by health personnel is likely to abscond during such transfer unless guarded.

3. A mental health care user referred to in subregulation (1) who has to be transferred, may be held in custody at a police station for period of not more than 24 hours to effect the transfer.

4. A mental health care practitioner shall accompany the mental health care user referred to in subregulation (1), during transfer.

How long can a person with a mental illness be held by the SAPS outside a health facility (i.e. in a cell/at a police station)?

A mentally ill person should not be detained in a prison cell for longer than 24 hours. Once a person has been sedated, s/he should not be held in a prison cell, but should be transferred to a health establishment.
Safe custody vs. detention

People with mental illness are not detained by the SAPS, but are held in safe custody. If at all possible, they should be kept separate from people who have been arrested, and they should be kept under observation to ensure that they do not come to harm.
Part 3: Information on mental disorders

This section is intended for the use of SAPS trainers. Any part of it can be reproduced for trainees. It is recommended that SAPS trainers also make use of mental health professionals in their area in training programmes on the Mental Health Care Act.

Definitions:
It is important to understand the following terms:

**Mental Disorder, Illness and Disability:**
The words “disorder” and “illness” are often used interchangeably. A mental illness is a condition affecting the mental state of a person to such an extent that it causes significant distress to the person, and/or it produces impairment in the person's ability to function socially, occupationally and in terms of their self-care. Mental illnesses can be caused by physical illnesses, biochemical abnormalities in brain function, stress and other environmental factors. Often a combination of these factors contributes to causing a mental illness or disorder.

The definition of a mental illness in the Mental Health Care Act of 2002 is as follows:
"mental illness" means a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis

**Intellectual Disability:**
Intellectual disability (previously known as mental retardation or mental handicap) is a condition where the person's intellectual or cognitive function is impaired. This affects the person's ability to function in many spheres. It affects the person's ability to acquire new information, to think independently, to make judgements and to understand normal social behaviour. There is always a physical cause for intellectual disability (it is not caused by stress, bad parenting etc). Sometimes a person is born with intellectual disability (congenital) or they become intellectually disabled as a result of damage to the brain (e.g. head injury in a motor-vehicle accident, exposure to infection or poison). The extent of intellectual disability may range from mild (through moderate and severe) to profound. People with mild or moderate intellectual disability are usually able to cope in society with support and special education or training, while people with severe or profound intellectual disability usually require additional health interventions, in particular, nursing care. The Mental Health Care Act covers certain aspects of the care of people with severe or profound intellectual disability.

The definition of severe or profound intellectual disability in the Mental Health Care Act of 2002 is as follows:
"severe or profound intellectual disability" means a range of intellectual functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring constant aid and supervision, to severely restricted sensory and motor functioning and requiring nursing care.

People with mild or moderate intellectual disability may come to the attention of the SAPS in cases where they are accused of committing a crime. In such cases, the due process of the law must be followed. If the matter comes to court, the court may refer the person for psychiatric observation in terms of the Criminal Procedures Act.

Mental Disability
Mental illnesses/disorders and intellectual disability both cause mental disability. Mental disability refers to impairment in mental functioning: the ability to think, reason, learn, understand, develop emotional awareness and control, work, have relationships, look after one-self. Generally, we talk about impairment in:

- Social functioning: this concerns a person's ability to relate to other people and to develop and sustain meaningful relationships.
- Occupational functioning: this concerns a person's ability to perform a job of work at a satisfactory level in terms of their education and training.
- Leisure functioning: this concerns a person's ability to relax and enjoy life, to develop hobbies and make good use of leisure time.
- Self-care functioning: this concerns the ability to maintain an acceptable level of personal hygiene and to run one's own daily and financial affairs.

Prevalence of mental disorders:
One in four people will develop a mental illness in their lifetime. The most common mental illness is depression. Most mental illnesses are so-called "Minor Mental Illnesses". About 10% of mental illnesses are the so-called "Major Mental Illnesses" and these affect up to 3% of the population at any time.

Types of mental illness:
Major mental illnesses:
These include schizophrenia, bipolar mood disorder (manic-depressive illness), and severe depression. Many of these conditions are chronic, that is the illness is a long-standing illness, and the person usually needs to take medication over long periods of time (years). Sometimes the person can become acutely ill, and then the person may need to go to hospital. However, for the rest of the time, even though the person may still have the illness, and may still need to take treatment, s/he can live at home or in their community, and may even be able to do some kind of useful work, and/or make a contribution to their family and community.
"Minor" mental illnesses:
These are less serious illnesses that cause disability and require treatment. These include less serious cases of depression and anxiety (often as a result of stress). Many people suffer from these illnesses, and should receive treatment (usually counseling or therapy). In the past, we used to call these conditions "neuroses" or neurotic disorders. Doctors, social workers and psychologists are important mental health professionals that can assist people with these conditions.

Conditions that can be confused with mental illness:

Does the person smell of alcohol, or appear to be under the influence of some other substance?

Intoxication:
The most common substance to cause intoxication is alcohol. Alcohol is a sedative in high doses and causes suppression of normal brain functions. The person's speech is slurred, they are unsteady on their feet, they may be slow in responding, and at higher blood alcohol levels may fall asleep or become comatose and stop breathing. Usually their breath will smell of alcohol. They may vomit and have bloodshot eyes. They may be aggressive or appear confused while intoxicated.

Another important substance that causes intoxication, and that can sometimes also cause mental illness (psychosis) is dagga (cannabis, marijuana). Dagga is classified as a hallucinogen. Intoxication with dagga may also produce red, bloodshot eyes, mood changes, impaired co-ordination, loss of judgement and increased appetite. Dagga is often smoked in combination with Mandrax (Methaqualone), another sedative.

If the person does not smell of alcohol and there is no evidence that they have taken another intoxicating substance, and the person still appears to be confused (disoriented, drowsy, not talking sense), consider that the person may have a medical condition that is causing the confusion.

Ask anyone who knows the person if they have ever suffered from "fits" or epilepsy.

Epilepsy:
Epilepsy is a medical disorder of the brain. Abnormal electrical discharges in the brain cause the person to have "fits" or seizures. Epilepsy can be controlled with medication, so that the person does not experience seizures. However, the medication must be taken daily, as it is a chronic illness. People with epilepsy can sometimes become confused after a fit, and can even become aggressive and violent. They need urgent treatment. It is always important to ask relatives of
someone who is behaving abnormally or is confused and aggressive, whether the person has ever had a fit or epilepsy.

Personality disorders:
Personality describes the predominant characteristics of an individual person. Each person has a distinctive personality that makes him/her unique. Personality develops from the time of conception (in the womb) onwards, and the early childhood years and experiences of parenting are considered to be crucial for normal personality development. Other factors that play a role are biological/inherited characteristics, as well as other environmental events (major stressors/losses/abuse etc). When a person's personality development is significantly hindered, s/he may develop a personality disorder. This implies that the person reacts and behaves in negative or destructive ways. Very often, these people are very rigid in the way they react, as they have not developed flexibility in order to deal with stress. A personality disorder is not a mental illness because there is no definite point of onset, as in a mental illness, but is a more constant way of being as described above. A personality disorder also does not affect the person's capacity to understand what is right and wrong. Some people with personality disorders can benefit from treatment (usually a combination of psychological and social treatments), but the treatment usually takes a long time and requires a great deal of commitment from the affected individual. The most common personality disorder that SAPS officials are likely to come across is “Antisocial personality disorder”. The common features of this type of disorder are a pervasive disregard for the rights of others and recognized social norms. The person with such a personality disorder is often impulsive, irritable and aggressive, reckless in terms of their own safety and the safety of others, abuses alcohol and other drugs, is consistently irresponsible and unable to maintain close personal relationships and lacks remorse for their misdeeds. If a person commits a crime, then s/he must be charged and the due process of the law must be followed.

Children with mental disability:
Mental disorders are also common in children. They also have a right to receive appropriate treatment. However, parents usually decide whether or not to take their children for treatment. If a child under the age of 18 years becomes mentally ill, then the parents must make an application for the child to receive treatment (either as a voluntary, or as an assisted mental health care user), but if the child meets the criteria for involuntary admission, treatment and care, then an application in terms of Section 33 must be made. SAPS members may be involved if there is a dangerous or potentially dangerous situation. The procedures are the same, except that a parent should make the application if at all possible.

If a police officer becomes aware of a situation where a mentally ill or severely or profoundly intellectually disabled child is being neglected or abused, then the provisions of both the Mental Health Care Act (Section 11) and the
Child Care Act must be followed. The Child Care Act stipulates the terms under which a child may be removed and placed in alternative care.

**A note about Substance Abuse:**
Substance abuse is extremely common in our society and is an important factor in unnatural deaths, crime, road accidents, loss of employment, domestic violence, rape and sexual abuse, and generally imposes a huge economic and emotional burden on our country. Common substances of abuse are alcohol, dagga, Mandrax, Cocaine, Ecstasy, Morphine and other opiates and LSD. Very often the person who abuses these substances becomes dependent on, or addicted to them. If these substances are excessively abused, they can also cause mental illness. These illnesses need treatment as for any other mental illness. However, a person who is addicted to a substance also needs treatment of the addiction. Some aspects of substance abuse are governed by different legislation from mental health legislation.

**Interventions in Substance Abuse:**
A South African National Drug Master Plan was developed and finalized in 1999. The NDMP emphasizes the need to address the substance abuse problem holistically and inter-sectorally, and states that: "there should be a balance between actions which bring about a decrease in the availability of drugs (control and law enforcement) and the demand for drugs (prevention, treatment and rehabilitation)."

In terms of making an impact on crime, and preventing damage to health and death, there are a number of laws governing substance abuse in South Africa. These include (among others):

- The Drugs and Drug Trafficking Act, 1992 (Act 140 of 1992)
- The Criminal Procedure Act, 1977 (Act 51 of 1977) and its amendments
- The Medicines and Related Substances Control Act (Act 101 of 1965) and the Medicines and Related Substances Control Amendment Act (Act 90 of 1997).

These Acts cover issues regarding the definition of legal and illegal substances and their control, as well as dealing with some of the individual effects of substances. The National Drug Master Plan emphasizes the importance of proper law enforcement. However, it also emphasizes the need to educate and encourage people to minimize dangerous use of substances and to seek treatment when necessary. It emphasizes too, the need for adequate treatment and rehabilitation services. Such treatment should be voluntary as far as possible. However, it is possible for people with substance abuse disorders to be committed for involuntary treatment in terms of the Prevention and Treatment of Drug Dependency Act. It is important for SAPS members to be aware that the Prevention and Treatment of Drug Dependency Act governs the treatment of substance abuse dependency disorders, and not the Mental Health Care Act.
People with substance abuse problems should be referred to social workers in the Department of Social Services and Development or to organizations that deal with substance abuse, such as SANCA.

Violence, mental illness and the issue of “dangerousness”

- It is important to realize that the majority of people who suffer from a mental illness are not dangerous.
- People with antisocial personality disorders are more liable to commit violent crimes.
- Substance abuse, particularly alcohol abuse, plays a major role in violence and violent crimes.

One of the most useful predictors of future violence is a history of having committed violent acts in the past.
Part 4: Training scenarios

These case scenarios can be used as part of training programmes. It is suggested that they are used for group discussions or role-plays.

**Scenario 1:** A middle-aged man has been caught shoplifting a penknife. The shop manager calls you to arrest him. The man is dressed strangely, with layers of clothes and has a selection of knives under his jacket. When you ask him to explain what he is doing, he says that he has to have the knives to protect himself from people that are trying to kill him. He says these people talk to him and threaten him through the air-conditioning in buildings. They want to kill him because he knows about a conspiracy for world domination. He knows where he is and what day and date it is.

Is this man likely to be mentally ill?
How dangerous is he?
Should he be apprehended and taken for an assessment?

**Discussion:** This person has a very strange belief: that people can talk to him through the air-conditioning in buildings. He probably also is experiencing “hearing voices” or auditory hallucinations. His other beliefs that he knows about a conspiracy for world domination, and that people are trying to kill him as a result are all related to this. He is dressed strangely and has a collection of knives. He is likely to be mentally ill. It is also worrying because he may act on his strange beliefs and he has weapons at his disposal. He is likely to be a danger to others (and also to himself). He should definitely be apprehended and taken for an assessment.

**Scenario 2:** You receive a call at your Police Station from a community member about an old woman who is wandering in the streets and rummaging in dustbins. When approached, she has shouted and sworn at the community member, and threatened to hit her. When you go to the scene, the woman is dirty and disheveled. She thinks you are her son, but cannot tell you where she lives, where she is or what the day or date is. She does not smell of alcohol. She cannot explain why she is looking in dustbins.

Is this woman likely to be mentally ill?
How dangerous is she?
Should she be apprehended and taken for an assessment?

**Discussion:** In the above scenario, it is likely that this woman has a mental illness. It is very likely that there is an underlying medical cause for her mental illness (e.g. diabetes, infection, dementia) because she appears to be confused - she is disoriented for person, time and place. She is unable to give a coherent account of what she is doing and why. She appears to have been neglecting her
self-care. Also she is an elderly person. Unless she has a long history of mental illness, starting when she was young, it is very likely that her illness has a medical cause. It is important to try and obtain information from anyone who might know her. If this is a sudden change in behaviour, it is particularly important that she should receive treatment urgently, as conditions that cause such a sudden change in behaviour can be rapidly fatal. Therefore she is a danger to herself and she should be apprehended and taken for an assessment.

Scenario 3: You receive a call from the local mental health nurse. She says she has had a visit from the mother of one of her regular patients. This patient, a 17-year old young girl suffers from Bipolar Mood Disorder. She has not come to the clinic for the last two months and her mother says she has become ill again. She is not sleeping at all, but spends all night singing hymns and doing exercises. She is not eating, and is very talkative. She cannot get her to come to the clinic. When she tried to persuade her to come to the clinic that morning, her daughter started picking up and throwing and breaking the furniture in the house. The mental health nurse has gone to the house to assess the situation, but the young girl has chased everyone out of the house: she will not let anyone in and is threatening to set the house and herself on fire.

Is this young girl likely to be mentally ill?
Is she dangerous?
Should she be apprehended and taken for an assessment?

Discussion: Here you have definite information from a mental health care practitioner that the young girl suffers from a mental illness. Also, the behaviour that her mother describes is abnormal. This kind of illness is chronic, and is characterized by episodes of acute mental illness. In between, the person can be quite well and normal. At this stage, however, this young girl is acutely mentally ill. She is dangerous to herself and others as she has been aggressive and violent (picking up and throwing and breaking furniture, chasing others out of the house) and is now threatening to set the house and herself on fire. She should be apprehended and taken for an assessment. You could practice in a role-play how you would do this.

Scenario 4: You receive a call that a man is standing on a railway bridge on the outskirts of the town, and is threatening to jump off into the river below.

Is this man likely to be mentally ill?
Is he dangerous?
Should he be apprehended and taken for an assessment?

Discussion: This man may be mentally ill. There is not sufficient information here to make a decision. However, he is certainly a danger to himself. He should definitely be apprehended and stopped from jumping off the bridge. Once he
has been restrained, you can talk to him, and find out what he was doing and what his intentions were and are. Although someone can attempt or commit suicide when not mentally ill, threatening or attempting suicide in such a manner is such a serious symptom/sign of mental illness that it should be taken seriously, and the person should be assessed by a mental health care practitioner.

Scenario 5: A 25-year-old woman has just reported that she has been raped by her ex-boyfriend. She has bruises and cuts on her face, her clothes are disheveled and she is crying hysterically.

Is this woman likely to be mentally ill?
Is she dangerous?
Should she be apprehended and taken for an assessment?

Discussion: Anybody who has just been raped is likely to be distressed. This is not a mental illness. She needs immediate physical attention as well as emotional support. She should be assisted to obtain the necessary treatment. In addition, the alleged crime must be investigated. If there is a one-stop medico-legal service in your area, she should be referred there, in order for all the necessary interventions to take place.

It is important to be aware, however, that someone who has experienced a catastrophic and violent event may later develop Post-Traumatic Stress Disorder (PTSD). In this mental illness the person is extremely anxious and afraid, especially of a similar catastrophic event. S/he is often hyper-vigilant and over-aroused. There may also be symptoms and signs of depression and suicidal thoughts. Usually the person is very distressed and aware that s/he needs treatment. Unless s/he is actively suicidal, s/he is not dangerous and will be able to obtain treatment voluntarily.

Scenario 6: A 30-year-old man has just been arrested for reckless driving. He appears to be confused.

Is this man likely to be mentally ill?
Is he dangerous?
Should he be apprehended and taken for an assessment?

Discussion: There is insufficient information to tell if this man is mentally ill. However, if he appears to be confused, he should be questioned more closely to see if this is indeed so. The most likely situation is that he is intoxicated due to alcohol. His blood alcohol level should be tested as part of the criminal investigation into reckless driving. If this is not elevated or there is any reason to suspect that he is not intoxicated, then he could be suffering from an illness. He should be apprehended and taken for an assessment, as any condition causing
such a scenario could be extremely dangerous. He should not be left unobserved in a prison cell.

**Scenario 7:** A woman comes to the police station to say that her boyfriend has been hitting her and is breaking the furniture in their house. They had an argument, and she managed to escape from the house. When you go to the house, the boyfriend is shouting at an unseen person and appears to be confused.

Is this man likely to be mentally ill?
Is he dangerous?
Should he be apprehended and taken for an assessment?

**Discussion:** It is possible that this man is mentally ill. He appears to be seeing things that other people cannot see, and appears to be confused. He is dangerous because of his violent behaviour. He should be apprehended and taken for an assessment.

**Scenario 8:** A 35-year old man is arrested for possession of large quantities of dagga and Mandrax. He has a past criminal record, and has spent time in jail previously for armed robbery, housebreaking, assault and dealing in illegal substances. He claims that he is mentally ill and that he has been treated for depression in a psychiatric hospital in the past. His family does not want to have anything to do with him, but his mother tells you in a telephone conversation that her son has always been a problem. His father was stabbed to death in a fight in a shebeen, she had numerous boyfriends after that, and they led a very unstable life. Her son started playing truant from school, abusing drugs, and engaging in crime from a very young age.

Is this man likely to be mentally ill?
Is he dangerous?
Should he be apprehended and taken for an assessment?

**Discussion:** From the above information this person does not appear to have a mental illness. He appears to have features of an antisocial personality disorder. If he is dangerous, it is not due to a mental illness, therefore he does not need to be taken for an assessment. However, it is important to bear in mind that a person with an antisocial personality disorder may develop a depressive illness or other mental illnesses (sometimes as a result of substance abuse), and may threaten or attempt to commit suicide. This could also be done as a manipulation, to get into hospital or as a defense. This is a very difficult situation. The arrested person should be closely observed, and if there is any concern, he can be referred to the prison doctor for an assessment or referred for observation by the courts.
You are a police officer working in a large urban township, which has an established district health service, including a community mental health service. One Thursday afternoon, your police station receives a call from a distraught community member who claims that a family member is out of control. He has an axe and is breaking down a shack in the back yard. No one can go near him and he is threatening to kill his mother who he says has been poisoning his food. She says he has been mentally ill in the past, and that he appears to be sick again. What do you do?

What if it is a Saturday afternoon?
What if this happens in a rural area, far from any health facility?

Discussion:

If you have made contact with the local mental health nurse and have had meetings with him/her, you could call him/her to assist you. You and your partner/colleague could collect the nurse from the clinic (or if the nurse is lucky enough to have transport available, s/he could travel in a government vehicle) and go to the home as soon as possible. If the person is still wielding the axe and is an imminent danger to those around him, he must be immediately disarmed. Once he has been disarmed and restrained, it is important to talk calmly to him and to family members to find out what is going on. The mental health nurse can do an assessment and decide on what further treatment is necessary. It is likely that this person will need sedation, which the mental health nurse can give in an emergency. If the person is adequately sedated, an ambulance should preferably be called to transport the person to the nearest 24-hour casualty service. A person who has been sedated needs monitoring and observation of their vital signs (blood pressure, pulse rate, breathing). However, if no ambulance is available (a common problem), or if the person is still disruptive or dangerous despite sedation, then he should be transported in your police vehicle to the nearest hospital with a casualty service. Usually, a police officer will sit with the mentally ill person, while another police officer drives the vehicle. The mental health nurse could accompany the individual and the police officer/s to the hospital. NB: A family member must also accompany the person to hospital in order for the necessary applications to be made. At the hospital, you will need to complete a hand-over form.

If it is a Saturday afternoon, the community mental health nurse is not on duty, as it is after hours. Therefore, you and your colleague/partner must attend to this situation alone. You go to the home as soon as possible. If the person is still wielding the axe and is an imminent danger, then he must be disarmed and restrained. Once this has been done, then you must talk calmly to him and to the others around. Explain what you have done and why, and try to find out as much as possible about the circumstances leading up to this episode. Transport the person to the nearest casualty, with a family member (as above). The person is likely to need sedation as soon as you arrive at the hospital. Do not remove restraints until this has been done. Complete the hand-over form and give the health workers any information that you have obtained.
If this happens in a rural area, far from any health facility, you must go to the home as soon as possible. If the person is still wielding the axe and is an imminent danger, then he must be disarmed and restrained. Once this has been done, then you must talk calmly to him and to the others around. Explain what you have done and why, and try to find out as much as possible about the circumstances leading up to this episode.

Try to contact the local clinic nurse for assistance. It may be possible for him/her to at least examine and/or provide some sedation for the person. If the person is sedated, then he must be transported to the nearest health facility as soon as possible (by ambulance if possible, but if not, in a police vehicle, preferably accompanied by the nurse).

If there is no health professional available, the person will have to be held in safe custody in a cell until transport by police vehicle can be organized to take the person to the nearest health facility. It is important that the person is observed regularly while in the cell. A mentally ill person may only be held in a prison cell for a maximum of 24 hours.

Again, it is important that a family member accompanies the person to hospital in order for the necessary applications to be made, if at all possible. At the health facility, you must complete the hand-over form and give the health workers there any information that you have obtained.
Part 5: An outline of mental health services in South Africa

Mental health services form part of general health services provided by provincial health departments and local authorities. Mental health services are provided in different settings by a range of health service providers.

Outpatient/community mental health services:

Primary health care clinics and service points are the first point of care for most people. Registered professional nurses run most of these clinics. They may have additional training in clinical diagnosis and treatment of common illnesses, including mental illnesses. There are usually medical doctors (general practitioners) at the larger Community Health Centres. Due to the intensive nature of mental health care, primary health care service providers currently mainly provide a screening, emergency management and referral service for people with mental disorders. They also provide follow-up care to people with chronic mental illnesses.

Most provinces in South Africa also have a specialized (ambulatory) community mental health service. These services are staffed and/or visited to varying extents by members of specialized multidisciplinary mental health care teams (specialist mental health nurse, psychiatrist, clinical psychologist, occupational therapist, social worker). These professionals provide support to primary health care services and they also see and manage mental health care users that cannot be managed by primary health care practitioners.

Hospital/institutional mental health services:

Acute inpatient care:

General hospitals without a specific psychiatric ward can usually manage people with less severe mental disorders, who may need a brief period of admission (a few days). They also provide a detoxification service for people with alcohol abuse and dependence (thereafter, these patients are referred to a rehabilitation service for further treatment). These hospitals are not usually able to manage people with severe mental disorders who are disruptive, restless, aggressive or severely suicidal. Some general hospitals provide an acute psychiatric in-patient service in dedicated psychiatric wards/units. These units are staffed, to varying degrees, by multidisciplinary mental health care teams (as above).

In terms of the Mental Health Care Act, it will be possible for provincial health departments to designate any hospital with adequate facilities to admit involuntary mental health care users for 72-hour assessments. Therefore that part of the hospital will be a "designated psychiatric hospital", although it will not perform all the functions that a psychiatric hospital may perform. This information will be available from provincial mental health co-ordinators (see page 39).

All provinces also have specialized psychiatric hospitals (see page 40). Specialized mental health care professionals/teams also work in these hospitals. Historically, most people with (serious) mental disorders were admitted and
treated in these hospitals. Many people spent very long periods of time (years) in these hospitals. Current trends, government policy and the Mental Health Care Act of 2002 encourage treatment of people with mental illnesses in the least restrictive environment possible. People with mental illnesses/disorders should only be treated in a specialized psychiatric hospital when it is absolutely necessary (need involuntary admission and treatment for more than 72 hours or need longer term and more specialized treatment). The policy is to discharge people back to their families and/or community care as soon as possible, and to try and treat the majority of mental health care users who need inpatient treatment in general hospitals.

Most of the specialized psychiatric hospitals have specialized units, which provide care by mental health professionals who have had additional training and/or experience in a specific field of mental health care (e.g. child and adolescent psychiatry, geriatric psychiatry, eating disorders, forensic psychiatry). This kind of treatment is reserved for people with complex or treatment-resistant mental disorders.

**Chronic inpatient care:**
This is reserved for people with severe mental disorders or severe or profound intellectual disability who cannot be managed or live with their families or in the community. People with severe psychiatric disorders are usually admitted to psychiatric hospitals. People with severe or profound intellectual disability are usually admitted to care and rehabilitation centres. Most of this care is provided by a private organization on a contract basis. It is the policy of the Department of Health to keep the number of people in these facilities to an absolute minimum, and health facilities that provide this type of care are encouraged to try and rehabilitate and re-integrate as many people back into the community as possible. Departments of Health are encouraged to support the development of community-based mental health services. These will largely be provided by non-governmental organizations (NGOs). It is hoped that the majority of people with chronic mental illnesses can live with their families (with support from community mental health services, disability grants, and day care provided by NGOs). Some people may not have families or their families may not be able or suitable to accommodate them, and certain NGOs provide residential as well as day care for such people.
# Provincial mental health co-ordinators

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>TELEPHONE</th>
<th>FAX</th>
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<tbody>
<tr>
<td>EASTERN CAPE</td>
<td>(040) 609 3944</td>
<td>(040) 635 0072</td>
</tr>
<tr>
<td>FREE STATE</td>
<td>(051) 430</td>
<td>(051) 448 3077</td>
</tr>
<tr>
<td></td>
<td>1933/4/5/6</td>
<td></td>
</tr>
<tr>
<td>GAUTENG</td>
<td>(011) 355 3363</td>
<td>(011) 355 3401</td>
</tr>
<tr>
<td>KWAZULU NATAL</td>
<td>(033) 395 2387</td>
<td>(033) 342 1714</td>
</tr>
<tr>
<td>LIMPOPO</td>
<td>(015) 290 9115</td>
<td>(015) 291 3345</td>
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<tr>
<td></td>
<td>(015) 297 0157</td>
<td>(015) 291 3345</td>
</tr>
<tr>
<td>MPUMALANGA</td>
<td>(013) 766 3409</td>
<td>(013) 766 3470</td>
</tr>
<tr>
<td>NORTHERN CAPE</td>
<td>(053) 830 0602</td>
<td>(053) 832 9221</td>
</tr>
<tr>
<td>NORTH WEST</td>
<td>(014) 597 1911</td>
<td>(014) 592 4463</td>
</tr>
<tr>
<td>WESTERN CAPE</td>
<td>(021) 483 4270</td>
<td>(021) 483 4345</td>
</tr>
</tbody>
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Specialised psychiatric hospitals and care and rehabilitation centres
These hospitals should only be used by SAPS as a resource for advice in difficult situations, but for all other matters, please contact your local mental health services via the provincial co-ordinator.

EASTERN CAPE
Elizabeth Donkin Hospital
Private Bag X6024
Port Elizabeth
6000
Telephone: (041) 585 2323
Fax: (041) 585 7143

Fort England Hospital
Private Bag X1002
Grahamstown
6140
Telephone: (046) 622 7003
Fax: (046) 622 7030

Komani Hospital
Private Bag X7074
Queenstown
5320
Telephone: (045) 858 8400
Fax: (045) 858 8802

Tower Hospital
Private Bag X228
Fort Beaufort
5720
Telephone: (046) 645 1122
Fax: (046) 645 2623

Umzimkulu Hospital
Private Bag X514
Umzimkulu
3297
Telephone: (039) 259 0148
Fax: (039) 259 0149
FREE STATE
Psychiatric Complex of the Free State (Oranje Hospital) (includes a care and rehabilitation centre)
Private Bag X20607
Bloemfontein
9300
Telephone: (051) 407 9511
Fax: (051) 407 9260

GAUTENG
Sterkfontein Hospital
Private Bag X2016
Krugersdorp
1740
Telephone: (011) 956 6324
Fax: (011) 956 6380/6307

Tara Hospital
Private Bag X7
Randburg
2125
Telephone: (011) 535 3000
Fax: (011) 884 3066

Weskoppies Hospital
Private Bag X113
Pretoria
0001
Telephone: (012) 319 9500
Fax: (012) 327 7076

Cullinan Care and Rehabilitation Centre
Private Bag X1005
Cullinan
1000
Telephone: (012) 734 1038/9
Fax: (012) 734 1040

KWAZULU NATAL
Midlands Hospital Complex: Fort Napier, Town Hill and Umgeni Hospitals
Fort Napier Hospital
PO Box 370
Pietermaritzburg
3200
Telephone: (033) 345 4221
Fax: (033) 345 5730

Town Hill Hospital
PO Box X400
Pietermaritzburg
3200
Telephone: (033) 342 8741
Fax: (033) 345 5720

Umgeni Hospital Care and Rehabilitation Centre
Private Bag 23
Howick
3290
Telephone: (033) 230 6146
Fax: (033) 230 5564

Madadeni Hospital
Private Bag X6642
Newcastle
2940
Telephone: (034) 374 9221
Fax: (034) 314 1148

LIMPOPO
Thabomoopo Hospital
Private Bag X37
Chuenespoort
0745
Telephone (015) 632 4112
Fax: (015) 632 5201

Hayani Hospital
Private Bag X2272
Sibasa
Telephone: (01596) 31 208/ 31 071/6
Fax: (01596) 32 334

MPUMALANGA

NORTHERN CAPE
West End Hospital
Private Bag X6086
Kimberley
8300
Telephone: (053) 861 3911
Fax: (053) 861 2873

NORTH WEST
Bopheleng Hospital
Private Bag X2031
Mafikeng
2745
Telephone: (018) 383 2005
Fax: (018) 383 2142

Witrand Care and Rehabilitation Centre
Private Bag X253
Potchefstroom
2520
Telephone: (018) 294 5221
Fax: (018) 294 7069

WESTERN CAPE
Lentegeur Hospital (includes a care and rehabilitation centre)
Private Bag X4
Mitchell's Plein
7789
Telephone: (021) 370 1111
Fax: (021) 371 7359

Stikland Hospital
Private Bag X13
Bellville
7530
Telephone: (021) 940 4400
Fax: (021) 919 5066

Valkenberg Hospital
Private Bag X1
Observatory
7935
Telephone: (021) 447 3111
Fax: (021) 447 6041

Alexandra Care and Rehabilitation Centre
Private Bag X1
Maitland
7405
Telephone: (021) 511 2141
Fax: (021) 511 1919