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Navigating the complexities of the mentally ill and mentally incapacitated in the criminal justice system in South Africa

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ABSTRACT

Those with mental illness, learning disabilities, and speech and language difficulties continue to be over represented in the global criminal justice system, create immense difficulties for these individuals in navigating the system itself, and the prison environment, and contribute to the revolving door of incarceration. Very little is known with regard to the situation of the mentally ill and mentally incapacitated in African criminal justice systems. In this *Commentary* we discuss how the Criminal Procedure Act in South Africa still does not fully comply with the or the Protocol to the African Charter on the Rights of Person with Disabilities in criminal proceedings. An urgent review of due process is warranted where the existence of capacity based defense needs are to be considered. It is vital to distinguish between intellectual and psycho-social disability, regarding assessment and issuance of appropriate court orders to the specific needs of the person, the identified disability and the interest of justice. Consistency in mental capacity or illness assessment using validated screening tools and specialist expert reports provided to the court should comply with the general requirements of expert evidence.

1. Background

On any given day, almost 11 million people globally are detained in prisons or other closed settings (Penal Reform International, 2020). The prison population is heterogenous and contains specific vulnerable prisoner groups, including those who are mentally ill and mentally incapacitated (United Nations Office on Drugs and Crime, 2009; United Nations Office on Drugs and Crime, 2016). Those with mental illness, learning disabilities, and speech and language difficulties continue to be over represented in the global criminal justice system, create immense difficulties for these individuals in navigating the system itself, and the prison environment, and contribute to the revolving door of incarceration (Barnett et al., 2014; Houston & Butler, 2019; Mallett, 2014; Mundt & Baranyi, 2020; Ogloff et al., 2015; Wetterborg et al., 2015; Zhang et al., 2011). There is a growing literature base on the concept of judiciarisation of the mentally ill (MacDonald & Dumais-Michaud, 2015; Sugie & Turney, 2017) and critique of the judicial-psychiatric interface (Paradis-Gagné & Jacob, 2021). The principle of imprisonment as the last resort for all offenders, cognisant of the offence itself, risk to society and social rehabilitation needs is fundamental when dealing with the mentally ill and mentally incapacitated. Detention potentially constitutes a disproportionately severe punishment and with their unique special needs are better addressed in the context of non-custodial measures (United Nations Office on Drugs and Crime, 2009).

A host of ethical, clinical and political issues are associated with judiciarisation of people with mental illness and mental incapacity further exacerbating existing marginalisation and stigma (Chaimowitz, 2012; Paradis-Gagné & Holmes, 2020; Paradis-Gagné & Jacob, 2021; Rogers & Pilgrim, 2014). (*Article 1*) (United Nations, 2007) (are most applicable with regard to the rights of persons with disabilities in the criminal justice system. The Protocol provides for the right to access to justice in *Article 13* in that State Parties need to take measures to ensure that persons with disabilities are dealt with equally, including through the provision of procedural, age and gender-appropriate accommodations, in order to facilitate their effective roles as participants in legal proceedings, as well as legal assistance including legal aid to persons with disabilities. *Article 17,* dealing with the protection of the integrity of the person, states that *"[E]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others"* (United Nations, 2007).

Recent developments in international human rights law have however questioned the legitimacy of the link between mental and legal

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capacity (Craigie, 2015) with the Committee on the Rights of Persons with Disabilities stating in their General Comment on *Article* 12 of the CRPD that; *"Legal capacity is the ability to hold rights and duties (legal standing) and to exercise these rights and duties (legal agency)"*(United Nations, 2014). There are implications of the CRPD on criminal defences based on mental incapacity (Bach, 2009; Loughnan, 2011, 2012; Peay, 2015), underpinned by *Article 12* which requires "*that legal capacity should not be limited on the basis of mental disability: persons with mental disabilities, including mental disorders, must be recognized as persons before the law on an equal basis to others and must be* supported in the *exercise of their legal capacity"*(United Nations, 2014). It also generally mandates States to recognise the legal capacity of those with mental disabilities more broadly than is currently the case, and leaves very little room for the restriction of legal capacity on the basis of mental incapacity. The Committee further state in their General Comment on *Article* 12 that; *"The Convention affirms that all persons with disabilities have full legal capacity"* and that *"perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity"*(United Nations, 2014).

The United Nations High Commissioner reported in 2009 that the CRPD requires replacing criminal defences based on "*mental or intellectual disability*" with "*disability-neutral*" doctrines (*para 47*), and meaning that defences based on diminished responsibility and insanity could be in violation of the Convention (Bartlett, 2012; Flynn & Arstein-Kerslake, 2014; Peay, 2015; Slobogin, 2015). The criminal defences based on *"mental or intellectual disability"* refers to the capacity to stand trial and criminal responsibility. Legal capacity is a requirement for criminal responsibility and all persons are presumed to have legal capacity. A defence based on the inability of person to appreciate the wrongfulness of their actions or to act in accordance with such appreciation due to mental illness or intellectual disability, is regarded as a substantive law defence, with the burden of proof on the person raising the defence (Schwikkard & Van Der Merwe, 2016, p. 604). The inability to understand court proceedings "*concerns mental fitness to stand trial and raises the fundamental procedural issue of "triability". It is not a substantive law defence and does not give rise to issues pertaining to criminal responsibility …"* (Schwikkard & Van Der Merwe, 2016, p. 606) and the burden of proof is on the prosecution.

Furthermore, the human and health rights assurances of vulnerable prisoners form the basis of prison management, with minimum standards of care applying to all without discrimination. The principle of non-discrimination recognises the special needs of some prisoners and provides for them to ensure they are dealt with in a manner that does not discriminate against their human rights entitlements (United Nations, 1948, 1966a, 1966b, 1988, 2016). For many, however incarceration is characterised by unjust deprivation of liberty and indicative of a range of neglect and human rights abuses (Fazel et al., 2016). *Article 14* of the CRPD states clearly that; *"States Parties shall ensure that persons with disabilities, on an equal basis with others enjoy the right to liberty and security of person; are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation."* (United Nations, 2007).

The incarceration of the mentally ill and mentally incapacitated however continues globally, with their situation in prison neglected, and efforts to divert them from the penal system underpinned by resource and systemic challenges (Okasha, 2004). The criminalisation and incarceration of the mentally ill and mentally incapacitated often occurs where lack of suitable facilities exist in the community or are still detained in prisons despite acquittal on the basis of their mental disability at the time of the criminal offence (Boyd-Caine & Chappell, 2005). This incurs significant pressure on the correctional system, often lacking in requisite healthcare capacity to meet their care mandate (Lamb et al., 2004). This is in violation of the United Nations Standard Minimum Rules for the Treatment of Prisoners (United Nations, 2016) (*Rules* 2(2), 27) which recommends specialized treatment rather than imprisonment in such cases.

2. Human rights in the African penal context

Recent global commentaries in *Lancet* have called for operationalisation of a harm reduction model with enhanced governance, development of robust clear national policies awarding greater responsibility to health services; and context-specific clinical tools and interventions in low-income and middle-income countries (LMICs) (Jack et al., 2018). Data on the extent of mental illness and mentally incapacity in the criminal justice system in prisons in LMICs is not well established but speculated to be greater than in high income countries due to the lack of psychiatric care (Fazel et al., 2016; Fazel & Seewald, 2012). Forensic health monitoring and clinical intervention for many at the intersection of the criminal justice and mental health care systems in LMICs also remains under developed, with few interventions adapted or evaluated in LMIC prison settings (Jack et al., 2018). The window of opportunity to intervene and support within the penal system is under-utilised in such low resource settings, and warrant continuous care modalities spanning community and prison (Mundt & Baranyi, 2020).

A review by Lovett et al. (2019) has reported on the high pooled prevalence of mental illness in African prisons, consistent with global trends, and with many detained without charge in non-prison settings (forensic hospitals, youth institutions). Whilst the included studies were heterogeneous, their meta-analysis reveals high pooled prevalence of mental disorders and substance use among people detained within the justice system in Africa. Efforts have been made at international and regional levels to enable, encourage and support prison and criminal justice reform in Africa, in order to tackle poor conditions of detention and criminal justice system structural problems. Historically, the Commission adopted several regional instruments to extend the rights and protections of people deprived of their liberty, based on the Standard Minimum Rules (United Nations, 1955), Basic Principles for the Treatment of Prisoners (United Nations, 1991a) and Standard Minimum Rules for Non-custodial Measures ("*Tokyo Rules"*) (United Nations, 1991b). Early regional African instruments included the 1995 Resolution on Prisons in Africa; the 1997 Resolution on the Right to Recourse Procedure and Fair Trial and the 1996 Kampala Declaration on Prison Conditions in Africa. Current protocols are generally based on the 2016 *Mandela Rules* (United Nations, 2016) which outline 122 rules setting out the minimum standards of care, and the adjunct UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders ("*Bangkok Rules"*) (United Nations, 2010) containing 70 rules regarding gender sensitive international standards for the treatment of women in detention. The Commission has appointed two special mechanisms (the Special Rapporteur and the Committee for the Prevention of Torture in Africa) in prisons, and a range of soft law instruments to support criminal justice and penal reform in addition to the Guidelines and Measures for the Prohibition and Prevention of Torture and Cruel, Inhuman or Degrading Treatment or Punishment in Africa ("*Robben Island Guidelines"*) were adopted by the Commission in 2002; *"to complement the provisions of Article 5 of the African Charter on Human and Peoples' Rights, further provide for the absolute prohibition against torture and other cruel, inhuman or degrading treatment or punishment, and declare that: all "options such as "necessity", "national emergency", "public order" … shall not be invoked as a justification of torture or cruel, inhuman or degrading treatment or punishment"* (African Commission on Human and Peoples' Rights, 2008).

The pan-African Conference on Prison and Penal Reform in Africa in 2002 generated the Ouagadougou Declaration and Plan of Action on Accelerating Prisons and Penal Reforms in Africa which contained recommendations to reduce prison populations, make African prisons more

self-sufficient, promote offender reintegration into society, apply rule of law to prison administration, encourage best practice and promote the (draft) African Charter on Prisoner Rights (Muntingh, 2020). Other pan African meetings yielded the 2004 Lilongwe Declaration on Accessing Legal Aid in the Criminal Justice System in Africa which promotes the right to fair trial and access to justice. Subsequently, the African Commission on Human and Peoples' Rights 2014 Luanda Guidelines on the Conditions of Arrest, Police Custody and Pre-Trial Detention in Africa were created to advocate for a rights-based approach to pre-trial detention, and their 2017 Principles on the Decriminalisation of Petty Offences in Africa represent the most recent development within the broader regional effort to articulate standards regarding rule of law and access to justice (Muntingh, 2020). The African Charter on Human and Peoples' Rights *Article* 16(1) affirms *"the individual's right to enjoy the best attainable state of physical and mental health"* with *Article* 16 (2) imposing "*a duty upon State parties to take all necessary steps for the ensuring that the individual's right in Article 19 (1) is realized"*(Organisation of African Unity, 1981). Similar is provided in the African Charter on Human and People's Rights On the Rights of Women in Africa (African Union, 2003) and African Charter on the Rights and Welfare of the Child (Organisation of African Unity, 1990). The Commission notes that the obligation regarding right to health is "*heightened"* when an individual is in State custody, with their integrity and well-being wholly dependent on the State. The 2003 Principles and Guidelines on the Rights to a Fair Trial and Legal Assistance in Africa provides in Article 2(b) for the *"equality of all persons before any judicial body without any distinction whatsoever as regards race, colour, ethnic origin, sex, gender, age, religion, creed, language, political or other convictions, national or social origin, means, disability, birth, status or other circumstances"*.

3. Navigating the complexities of the mentally ill and mentally incapacitated in the South African criminal justice system

The denial of legal capacity of persons with mental disabilities (including mental illness and intellectual disability) occurs disproportionately worldwide, and South Africa is no different. In this *Commentary* we report on the South African justice systems in play, which faces several of the key challenges of many governments in Africa and many LMICs, including the division of responsibility between Ministry of Justice, Social Development and Health. There is a dearth of literature in South Africa on the issue of mental illness and mental incapacity in its justice and penal systems, limited to several small studies indicating a high prevalence of mental disorders among prisoners (Naidoo & Mkize, 2012; Prinsloo, 2014; Sukeri et al., 2016).

South Africa signed and ratified the CRPD and its Optional Protocol in 2007, and is obligated under this convention to fulfil its commitments in terms of implementation and reporting. Further it has ratified the 2018 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa. Currently despite the ratification of the CRPD, it has not yet been formally '*incorporated'* into South African law as required in terms of *Section* 231 of the South African Constitution. *Section* 12 of the Mental Health Care Act 17 of 2002 provides that any determination concerning the mental health status of any person must be based on factors exclusively relevant to that person's mental health status, or to give effect to the Criminal Procedure Act 51 of 1977.

The Criminal Procedure Act differentiates between the capacity of the accused to understand the proceedings in court so as to make a proper defence due to mental illness or intellectual disability (*Section* 77) and where the accused at the time of the commission of the offence suffered from a mental illness or intellectual disability which made the accused either incapable of appreciating the wrongfulness of his or her act or omission or of acting in accordance with an appreciation of the wrongfulness of his or her act or omission (*Section* 78). The relevant sections do not differentiate between mental illness or intellectual disability and the assessment procedure in respect of both sections are ***the same*** in terms of *Section* 79 of the Criminal Procedure Act. There is also no distinction in respect of the determination of criminal responsibility between persons with a mental illness or those with an intellectual disability. The only difference for assessment purposes is that less serious offences only require examination by one psychiatrist, while those accused of serious violent crimes such as murder and rape, must be examined by a panel of either two or three psychiatrists, with the option of including a clinical psychologist as part of the panel. The option to refer to or include a psychologist is not available for less serious offences in terms of *Section* 79(1) (a) so the court must use *Section* 79(1) (b) for a panel assessment in a less serious offence if the court wants a report from a psychologist. The composition of these panels has been questioned and criticised by the courts, which led to amendments to *Section* 79. However, the amendments to *Section* 79 are still regarded as problematic, as it is not clear whether the second psychiatrist to be appointed by the court, should be a state or private psychiatrist (Pienaar, 2017). Also, there are no guidelines for the requirement that the accused has to show good cause for the appointment of a third psychiatrist nor is the appointment of a psychologist mandatory (Pienaar, 2017). Though the Act refers to observation for a period not exceeding 30 days, in most instances persons are taken to the psychiatrist for an assessment session of an hour, while being kept in custody. There is further no consistency between the procedure for evaluation followed by different psychiatrists for evaluation nor is the reporting method consistent, as in some instances it will be a short report with conclusion and recommendation, while others will provide detailed reports. In terms of *Section* 79(3) the report must be in writing and must include in terms of *Section* 79(4) a description of the nature of the enquiry, a diagnosis of the mental condition of the accused and if the enquiry is made under *Section* 77 (1), a finding as to whether the accused is capable of understanding the proceedings in question so as to make a proper defence. In *Chauke v The State* the Supreme Court of Appeal in analysing the report held that the report did not comply with the requirements in terms of *Section* 79(3) and (4), as it was not a holistic assessment of all the relevant facts and circumstances, nor did it include the previous psychiatric reports of the accused. No interviews with any person other the accused were done either. The psychiatrists and psychologist if appointed, have to provide the court with reports and can be called to testify, in which case they will have to testify as expert witnesses. To qualify as an expert witness, the court in general must be satisfied that the witness has specialist knowledge, training, skill or experience and can on account of these attributes or qualities, assist the court in deciding the issues; that the witness is indeed an expert for the purpose for which he is called upon to express an opinion; and that the witness does not express an opinion on hypothetical facts, that is, facts which have no bearing on the case or which cannot be reconciled with all the other evidence in the case. Expert witnesses are in principle required to support their opinions with valid reasons (Schwikkard & Van Der Merwe, 2016).

Of further concern is that whilst in custody persons with mental illness or intellectual disability are generally detained with all other awaiting trial detainees where they are particularly vulnerable to abuse, where those with mental illness are generally not provided with the necessary medication, including those who have not previously been diagnosed and treated. At proceedings in terms of Sections 77(1) and 78 (2) the court may, to prevent substantial injustice, order that the accused be provided with the services of a legal practitioner in terms of Section 22 of the Legal Aid South Africa Act 39 of 2014 (see also *Section* 77(1A), inserted by *Section* 3 of Act 68/98 and amended by *Section* 25 of Act 39/2014). Though the legal practitioners in some cases will insist that the psychiatrists present and testify regarding the evaluation and its finding, especially in regard to reports without any details, more often than not such reports will just be accepted by them.

The constitutionality of *Section* 77(6) of the Criminal Procedure Act was challenged by two accused persons who were incapable of understanding trial proceedings as both were found to suffer from permanent intellectual disabilities, which rendered them unfit to stand trial. The

section was found to infringe the right to freedom and security of such an accused person in the Constitutional Court decision of the 2015(a) *De Vos NO v Minister of Justice and Constitutional Development* which resulted in legislative amendments of *Section* 77(6) (Act 4 of 2017). In this case, the Constitutional Court also found that *"[T]he distinction made between the options provided for under* Section 77*(6) (a) (i) of the Criminal Procedure Act on the one hand, and* Section 78*(6) on the other, is not irrational. They deal with different enquiries and different possible outcomes.*" The Constitutional Court observed that accused persons are more readily institutionalised under the Criminal Procedure Act without the ordinary safeguards prescribed by the Mental Health Care Act (*para* 54), and stated; " …..*the objective of treatment cannot alone justify institutionalisation as this fails to appreciate that mental illness is complex. There are varying types and degrees of mental disability such that institutionalisation and treatment are not always required or appropriate. For example, an intellectual disability such as Down syndrome cannot be treated and institutionalisation or treatment will never improve such a cognitive condition.*"

The complexities lie in that *Section* 77 only applies to persons who are thought to have a mental illness or *"mental defect"*. Mental illness as defined in *Section* 1 of the Mental Health Care Act encompasses; *"a positive diagnosis of a mental health related illness in terms of accepted diagnosis criteria made by a mental health care practitioner authorised to make such diagnosis"*. The lack of international and indeed African consensus on what types of psychiatric disorders constitute mental illness (Kaliski, 2012) is evident and are further complicated by the fact that is not clear from the Mental Health Care Act what is meant by persons with a *"mental defect"* as it is undefined. The difference between *"mental defect"* and mental illness is uncertain but psychiatrists seem to be in general agreement that the former refers to a *"disorder characterised by cognitive impairment"* (intellectual disabilities or impairment of general mental abilities in the social, conceptual and/or practical domains), while the latter refers to *"psychotic or severe mood disorders"* (Du Toit, 2019). The term *"mental defect"* was repealed and substituted with *"intellectual disability"* in the subsequent amendments to *Sections* 77 and 78. Du Toit (2019) underscores the impact of the amendment in that "*[I]f the triggering criterion is a disability of the intellectual capacities, then a disability of emotional or conative type would not qualify.*" (Du Toit, 2019, p. 38). *Down Syndrome South Africa* as first *amicus curiae* before the High Court submits that the best option for an accused with an intellectual disability is to be placed in a rehabilitation centre and not in a psychiatric centre (see the 2015b *De Vos NO v Minister of Justice and Constitutional Development*). Hence amendments to *Section* 77(6) of the Criminal Procedure Act now gives the court the discretion to refer the person to a designated health establishment, which includes a rehabilitation centre (*para* 55). For serious offences such as charges of murder, culpable homicide, rape, compelled rape or a charge involving serious violence or if found to be necessary in the public interest, after the court has found that the accused has committed either the offence in question, or any other offence involving serious violence, *Section* 77(6) of the CPA provides that the person be detained in a psychiatric hospital, or temporarily detained in correctional health facility should a bed not be available. *Section* 77 further provides that if this finding is made after the accused has pleaded to the charge, the accused shall not be entitled to be acquitted or to be convicted in respect of the charge in question. If the finding is made after conviction, the conviction will be set aside and the accused may at any time thereafter, when he or she is capable of understanding the proceedings so as to make a proper defence, be prosecuted and tried for the offence in question.

Section 78 of the Criminal Procedure Act further provides that a person who commits an act or makes an omission which constitutes an offence and who at the time of such commission or omission suffers from a mental illness or intellectual disability which makes him or her incapable (a) of appreciating the wrongfulness of his or her act or the omission; or (b) of acting in accordance with an appreciation of the wrongfulness of his or her act or the omission, will not be regarded criminally responsible for such act or the omission. *Section* 78 further provides that the court must, in a case where the accused is charged with murder, culpable homicide, rape, compelled rape or another charge involving serious violence, or if in the public interest, after hearing evidence and finding that the accused did commit the act in question, bring out a not guilty verdict due to not being criminally responsible and direct that the accused be detained in a psychiatric hospital (or temporarily detained in a correctional health facility of a prison should a bed not be available) under *Section* 47 of the Mental Health Care Act, 2002. The Constitution Court in this regard stated that "[*T]he accused is properly and extensively evaluated in terms of* Section 79 *of the Criminal Procedure Act. Once an accused is found not to understand court proceedings due to a mental illness or an intellectual disability, and a prosecutor requests that the accused be dealt with in terms of* Section 77*(6) (a), and a court so directs, then a trial into the facts is undertaken. Only once the accused person is found to have committed a serious offence is he admitted to a psychiatric hospital* (or para [55] in the case of intellectual disability a rehabilitation centre). [It] further states that; *"This precautionary measure is constitutionally permissible and any admission into a hospital will subsist no longer than is necessary."* This can however amount to ***indefinite*** incarceration. There are also options for admittance and detention in a designated health establishment where the person is treated as if he or she were in involuntary mental health care under *Section* 37 of the Mental Health Care Act, 2002 (subject to unconditional release or release where the court deems it appropriate).

We speculate that the amendments to *Section* 77(6) still do not remedy aspects of non-compliance with the CRDP. *Section* 78(1A) provides that "*every person is presumed not to suffer from a mental illness or intellectual disability so as not to be criminally responsible in terms of* Section 78*(1), until the contrary is proved on a balance of probabilities*". *Section* 79 also does not distinguish between the manner in which persons with mental illness and intellectual disability are dealt with in their assessment. According to Combrinck (2018), "*the assessment of criminal incapacity arising from mental illness under* Section 78 *of the CPA in essence is a functional test (resting on proof of incapacity to appreciate the wrongfulness of an act or to act in accordance with such an appreciation). It also amounts to the conflation between legal capacity and mental capacity cautioned against by the CRPD Committee in that the accused person's legal capacity is 'removed' because of a finding that her decision making was impaired at the time of the offence. These considerations further complicate the insanity defence in its current form.*" Once a person is referred for observation, there are often inordinate delays (Houidi et al., 2018) due to the lack of registered psychiatrists willing to do these observations. It should be noted that there are a limited number of psychiatrists on the notice with the list of psychiatrists to whom the courts can do the referrals for assessment.

While it is pragmatic to consider greater involvement of psychologists in mental health assessments in forensic cases, their areas of expertise are confined to assessment of intellectual disability and personality disorder. Pienaar (2017) advocates for this, and has motivated that; *"Even though the law has developed to allow for the appointment of clinical psychologists to* Section 79*-assessment panels, such appointment is not mandatory. In view of the enormous shortage of psychiatrists in the South African forensic setting and the delays associated with this shortage, it might be fitting to revisit the role of clinical psychologists in forensic assessments, with a view to intensifying their involvement."* In this instance however, the determination of intellectual disability and whether it impairs legal capacity, for example, can be done by a clinical psychologist, making it unnecessary for them to be evaluated by a psychiatrist due to the fact that the requirement has been limited to intellectual disabilities only. In South Africa there are more clinical psychologists available on the published notice of psychologists competent to undertake such assessments for the court. However, the question should be answered as to whether the court is expecting a "medical expert" in which case only a psychiatrist would suffice.

4. Conclusions

It is therefore argued that despite the amendment to *Section* 77(6) of the Criminal Procedure Act, the current provisions in the Criminal Procedure Act in South Africa still do not comply adequately with the CRPD nor the Protocol to the African Charter on the Rights of Person with Disabilities in criminal proceedings and that an urgent review of due process is warranted. In such a review the existence of the capacity based defense needs to be considered, and it is also necessary to delineate intellectual disability within the broader context of psycho-social disability, especially in respect of the procedure for assessment, as well as ensuring that court orders are appropriate for the specific needs of the person, the identified disability and the interest of justice. Further recommendations applicable to South Africa centre on the imperatives of consistency in mental capacity or illness assessment using validated screening tools and that specialist expert reports provided to the court comply with the general requirements of expert evidence (Schwikkard & Van Der Merwe, 2016). Utilizing skilled and trained clinical psychologists to assess the accused offers a potential avenue for further consideration to address existing backlogs for forensic mental observations, and ultimately to assist in upholding of the human rights of the accused. These individuals are likely vulnerable to a host of abuses during pre-trial detention and when incarcerated. There are also currently no formal diversion or rehabilitative options for adult offenders in the Criminal Procedure Act, nor is it included as an option for adults in terms of *Sections* 77 or 78 of the Criminal Procedure Act. Similarly for juveniles *Section* 64 of the Child Justice Act of 2008 constitutes referral to the Children's Court as a child in need of care. This in essence represents options such as placement in foster care while the various diversion and rehabilitation options otherwise available to children in conflict with the law as provided for in the Child Justice Act not being available as an option in terms of *Sections* 77 and 78.

An inter-departmental government response (Health, Justice and Correctional Services) has been recommended to address the increased criminalisation of the mentally ill, and the lack of comprehensive forensic psychiatric services and a centralised data base on mentally ill prisoners (Sukeri et al., 2016). In 2020 Swanepoel argued that in South Africa; *"institutional care settings for the mentally disabled are often where human rights abuses occur. This is particularly true in segregated services including residential psychiatric institutions and psychiatric wings of prisons. Persons with mental disabilities are often inappropriately institutionalised on a long term basis in psychiatric hospitals and other institutions"*(Swanepoel, 2020). Further multi-stakeholder research is warranted to document the experiences and needs of those incarcerated in South African prisons and psychiatric institutions. Such research plays a significant role in advocacy, and ultimately criminal and penal reforms.

Lastly, our *Commentary* comes during a time where critiques postulate that the CRDP itself potentially requires a reconsideration of existing capacity-based criminal defences such as insanity, diminished responsibility and fitness to plead and that the "[*T]he existence of such capacity-based defences contradicts the very objective of Article 12 and the ethos of Convention to ensure full equality of all persons with disabilities"*(McNamara, 2018). McNamara has argued that *"States Parties may need to consider introducing a disability neutral approach, which does not seek to distinguish between persons based on the existence of a disability. Equally, if a person with a psychosocial disability has been found to have committed the crime (actus reus) and had formed the necessary intention to commit the crime (mens rea), then they can be found culpable on an equal basis with others"* though it must be noted that the debate continues with respect of *Article* 12 of CRPD and its impact on criminal law (Bach, 2009; Bartlett, 2012; Combrinck, 2018; Craigie, 2015; Paradis-Gagné & Jacob, 2021; Pienaar, 2017; Slobogin, 2012).

Case law

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Declaration of competing interest

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