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TRANSFORMING MENTAL HEALTH CARE: FROM COERCION TO SUPPORT

As members of the community and healthcare providers, many of us grapple with the complex issue of ensuring the rights of individuals with severe mental conditions. Often, including in South Africa, legislation states that when a person is a risk to themselves or others, and has

lost their mental capacity, they can be involuntary detained. This means a person is treated against their will in an attempt to help restore their ability to make decisions in their and other's best interests.

However, the presupposition that a person with a mental condition can lose their mental capacity and act in dangerous ways is being challenged by the United Nations Convention on Persons with Disabilities General Comment 1 (UNCRPD GC1), a pivotal global guideline for supporting individuals with disabilities. The UNCRPD GC1 argues that accurately measuring a person's mental capacity is inherently flawed and that depriving individuals of their legal autonomy is discriminatory. The GC asserts that assuming individuals with mental health conditions can't make decisions serves interests of social control and the maintenance of the status quo, essentially erasing differences and leading to what some have called the "hygienising" of society. GC1 also argues that the idea that people with mental conditions can become dangerous is unproven, and when such people do apparently become violent, it's probably in reaction to stigma and mistreatment, rather than a result of a mental illness.

Aside from the UNCRPD's global influence, these arguments carry weight in the context of historical injustices where certain social groups have had their autonomy unjustly denied in the past. For example, women being denied the vote, and racial justifications for slavery. Furthermore, the traumatic impact of involuntary care on individuals with mental health conditions cannot be overstated. One participant in our research conducted at Stellenbosch University vividly described the experience as feeling like "the property of the state, feeling "so lost" and experiencing involuntary care as "a nightmare".

In place of involuntary care, the UNCRPD advocates for "supported care". This approach involves providing individuals with the necessary environmental and interpersonal support to make autonomous decisions. It encompasses the importance of destigmatising mental health conditions within communities, fostering an environment where individuals feel understood, and offering empathetic listening without preconceived notions about the decision-making capabilities of a person with a mental condition. According to GC1, with these supports involuntary care will never be necessary, and people with mental conditions will always be able to make their own decisions, and therefore, have their autonomy protected. There is already some evidence that with the proper care, rates of involuntary care can be drastically reduced. Trieste psychiatric hospital in Italy has much lower levels of involuntary care than in most other countries and has become a hallmark of mental health services that are holistic and respect the autonomy rights of people with mental conditions.

In our own research, we found many instances where fear, shame, and panic could often make decision-making harder for people with mental conditions. These experiences could arise due to a person being faced with social stigma, feeling criminalised, losing control or in interaction with the general poor state of care in hospitals. There is often nothing to do in hospitals, and mental health workers are regularly overworked. This can make consenting to treatment an unviable choice for many people with mental conditions, and increase the likelihood that such people will be prevented from expressing themselves or exercising their rights to legal decision-making.

Nevertheless, implementing supported care proves challenging, particularly in a South African context. Limited professional support and heightened risks faced by individuals with mental health conditions in their communities complicate the availability of support. Further, the majority of people with mental conditions interviewed by us and the South African Federation for Mental Health report found that most people with mental conditions in South Africa value involuntary care and still see its use in the country.

While many of us may want to re-evaluate our knee jerk assumption that people with mental conditions are susceptible to being a danger to others, or can lose mental capacity, providing adequate supported care to people with mental conditions in South Africa is a challenge compared to in many more resourced countries. It seems critical to strive towards circumstances where coercion is no longer necessary, and this requires sensitive, holistic engagement with people with mental conditions in order to avoid the denial of their autonomy, however, in the interim careful and considerate involuntary care may have its place; the question is an open and debatable one that doctors, psychiatrists, and the general community must face.

References available on request. MHM