THE MORAL PERMISSIBILITY OF COERCIVE TREATMENT IN PSYCHIATRY

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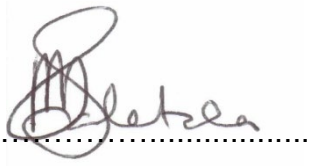
Declaration

I, Dr Mvuyiso Talatala, declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master of Arts in Applied Ethics for Professionals at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.

Signature of Student  ..... Date: 15 May 2024…….

Dedication

Presentations / publications arising from this research

None

Abstract

The advent of psychopharmacological interventions in the middle of the 20th century accompanied by the improvements in psychotherapy has improved the outcomes of treatment of mental illness from the dark days of chronic institutionalisation in mental asylums to the ushering in of an era of deinstitutionalisation. Today it is established that psychiatric treatment is beneficial to people with mental illness and untreated mental illness has negative biopsychosocial consequences. However, some people with severe mental illness such as those with schizophrenia and bipolar disorder or other disorders such as anorexia nervosa, refuse psychiatric treatment despite its established benefits. In these cases, coercive treatment, which is involuntary psychiatric treatment without the patient's consent, may be a consideration even if these people are not infringing on the rights of others. If coercive treatment is considered in these people with mental illness, there could be concerns about respect for autonomy and the infringement of coercive treatment on their rights. In this research report the autonomy of people with mental illness and the respect for their rights is weighed against the benefits of psychiatric treatment. It is argued that in some cases of mental illness the objection to psychiatric treatment may be non-autonomous as the person with mental illness may lack decisional capacity. It is further argued that psychiatric treatment has benefits that far outweigh the temporary infringement on rights by coercive treatment. The overall argument of this research report is therefore that coercive treatment in psychiatry is morally permissible, and that society has a moral obligation to treat people with mental illness even if that treatment includes coercive treatment in selected cases.

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Abbreviations

APA	American Psychiatric Association
BMI	Body mass index
CPA	Criminal Procedure Act 51 of 1977
DUI	Duration of untreated mental illness
DUP	Duration of untreated psychosis
HCW	Health care worker
HCWs	Health care workers
LMICs	Low- and middle-income countries
MHCA	Mental Health Care Act 17 of 2002
SMI	Severe mental illness
WPA	World Psychiatric Association

Chapter One – Introduction

Medical interventions, ordinarily, should be readily acceptable to those who are ill as they relieve the pain and suffering that is associated with sickness unless the medical intervention is more burdensome to the person needing it than the illness it is intended to treat (Matthews 2000). Contrary to this assumption, psychiatric disorders such as schizophrenia and bipolar disorder, often referred to as severe mental illness (SMI), do at times result in people with these disorders being unable to consent to or even refusing psychiatric treatment. In addition to SMI, people with anorexia nervosa, by the very nature of this illness, do at times object to psychiatric treatment. This poses a moral dilemma for health care workers (HCWs) who may be legally obliged and arguably ethically required to subject people with SMI and those with anorexia nervosa to treatment without consent. In South Africa the Mental Health Care Act 17 of 2002 (MHCA) refers to this practice of subjecting people with mental illness to medical treatment they are objecting to as involuntary mental health care. Involuntary mental health care has been termed coercive treatment in philosophical literature (Chieze et al 202:2).

Defining coercive treatment is essential in a discussion that is exploring its moral permissibility, but a universally accepted definition of coercive treatment does not exist (Ewuoso (2016:2). Coercive treatment involves “the coerced [being] made to act, by the coercer, in an involuntary manner” (Ewuoso (2016:2). In mental health care coercive treatment entails psychiatric treatment of people with mental illness against their will because of a judgement that has been made that they lack

decisional capacity. There are disagreements in philosophical literature whether persuasion is a form of coercion or the two should be differentiated. Ewuoso (2016), Shah and Basu (2010) and Beauchamp and Childress (2019) have argued that coercion must be differentiated from persuasion. In persuasion, HCWs are able to convince a person with mental illness to undergo psychiatric treatment by relying on the person's cognitive abilities to comprehend information, reason and agree to psychiatric treatment without the use of any force (Beauchamp and Childress 2019). While philosophers such as Ewuoso (2016), Shah and Basu (2010), Beauchamp and Childress (2019) have argued for the differentiation of coercion from persuasion, Chieze et al (2021:2) views persuasion as a form of coercion which is referred to as an "informal coercion". Persuasion and other forms of "informal coercion" that are "interpersonal leverage, inducements" and ultimately "threats to compulsory treatment" are in continuum with "formal coercion" (Chieze et al 2021:2). Persuasion, an "informal" form of coercion is therefore just a milder or an alternative form of "formal coercion" (Chieze et al 2021:2).

The author of this research report disagrees with the argument put by Chieze et al (2021:2) that persuasion is a form of coercion though "informal". Quite to the contrary to the argument that persuasion is a form of coercion, persuasion is not coercion, but it is an alternative tool to coercion that can be used by HCWs to get informed consent and deliver psychiatric treatment as part of voluntary mental health care. With persuasion HCWs use the therapeutic relationship and rapport they establish with the person with mental illness to tap into his or her cognitive abilities in order to get him or her to process the need for psychiatric treatment and ultimately accept it. At the point of accepting the treatment, the person with mental illness who has been

persuaded (not forced) to take psychiatric treatment is no longer objecting to the treatment. Persuasion is therefore a tool that can be used to minimise coercion and, in this research report, persuasion is therefore not being included in the discussions about coercive treatment.

It is essential that HCWs attempt to persuade a person with mental illness who is objecting to treatment because mental illness is complex and difficult to understand. In addition, the impact of mental illness in the brain is such that it may interfere with cognitive abilities that are used to comprehend and understand information including information about mental illness itself. Further, persuasion is utilised even in people with other medical conditions who refuse medical or surgical treatment to help them process the information about the medical condition and the required treatment and ultimately accept treatment. Instead of HCWs being impatient and just forcing treatment, time should be taken to develop a good rapport with the person with mental illness and persuade them to agree to psychiatric treatment. That way HCWs are assisting the patient to exercise some of the shared elements of decisional capacity that will be discussed later in this research report.

Unlike persuasion, interpersonal leverage and other forms of informal coercion are the true forms of coercion because the acceptance of treatment by the person with mental illness is not based on him or her having processed the information about the illness and accepted the treatment. The person with mental illness cooperates with treatment that he or she does not necessarily agree with because he or she is threatened or enticed by some kind of inducement by the HCWs. In these other

forms of informal coercion, the treatment is therefore without informed consent, the patient is cooperating because of inducements or threats. These other forms of coercion are therefore included in the discussion of coercive treatment in this research report.

The objection to psychiatric treatment by the person with mental illness that usually leads to coercive treatment may seem absurd or even appear as self-harming when it is viewed by most people and especially in the view of the significant people of the person with mental illness such as family members or concerned neighbours and friends. The reasons provided for the objection to psychiatric treatment by the person with mental illness may appear irrational to others and he or she may be viewed as lacking insight. “Poor insight is a core attribute of schizophrenia” and its definition “incorporates the following conceptual elements: awareness of having an illness, recognizing the signs and symptoms of the illness, attributing consequences and deficits to the illness, and understanding the need for treatment of the illness” (Lehrer and Lorenz 2014:11). With this lack of insight, the person with mental illness may object to psychiatric treatment because they do not believe that they have a mental illness or that mental illness even exists. The person with mental illness may be unable to view his thoughts as unreal even though they are delusions and far from truth and reality. In some cases of schizophrenia, the illness seems to affect the core of who we are by destroying our capability to have insight. “In mental illness the problem seems to be, not that the patient is afflicted by something which she [or he] does not want, but that the patient herself [or himself] is somehow not as she [or

he] should be: as it has been put, mental illness (of the sort we are speaking of now) is not something we have, it is something which affects the way we are" (Matthews 2000).

The society may be subjected to a moral conflict when there is a person with mental illness who is refusing treatment if the society views the mental illness as harmful. The members of the society are obligated to make a moral judgement on whether to force a person with mental illness to take psychiatric treatment or leave a person diseased by mental illness alone to suffer the consequences of untreated mental illness. Even outside the context of Western Medicine the members of the society may describe the person with mental illness as "mad" or possessed by evil spirits or demons and seek help on his or her behalf. In South Africa this may involve the person being persuaded to see a traditional healer and at times being forced to consult a traditional healer for healing or for managing an issue that is thought to be related to ancestral calling (Crawford and Lipsedge 2004). Coercive treatment, therefore, begins in the community when those around the person with mental illness decide to seek some kind of health intervention despite the objection of the person with mental illness. If the route of traditional healing is chosen, there could be coercion in the process of diagnosis of mental illness by the traditional healer and the subsequent treatment. If the person with mental illness is taken to a healthcare facility, coercive treatment as prescribed by Western Medicine as well as the statutes will come into effect.

Several coercive measures are used to treat people with mental illness in psychiatry and these include forced hospitalisation, admission to seclusion rooms in hospitals, use of physical and chemical restraints, and the prescription of depot preparations of antipsychotics, as well as the prescription of rapidly dissolving oral antipsychotic medications. The use of physical restraints may cause physical injuries to the person with mental illness leaving physical scars in the forearms and legs that remain testament to the brutality of coercive treatment years later. Physical restraints have also been found to increase the risk of occurrence of other medical conditions such as aspiration pneumonia and deep vein thrombosis (Funayama and Takata 2020). Aspiration pneumonia can lead to death and one of the complications of deep vein thrombosis is pulmonary embolism which can result in sudden death. In addition to the risks of physical restraints, the people with mental illness may suffer harms of poor care and neglect in resource constrained hospitals. In accident and emergency departments of busy hospitals, where there are human resources constraints, there may be limited observation of the persons on physical restraints resulting in the persons soiling themselves or even lying on their excrements for prolonged periods. The inhumane care of people with mental illness in places of care has been described by Drew et al (2011) in lower- and middle-income countries (LMICs), but it is present even in high income countries. The poor treatment of people with mental illness as described above is unethical because it is dangerous, it is degrading to one's dignity, a basic human right and it can be equated to torture, which is a crime.

In view of these potentially harmful effects of coercive treatment, it is argued that its use should be minimised and properly justified in each case where it is used. Lie´geois and Eneman (2008:75) provide "three criteria which are considered

essential prerequisites in the justification of coercive procedures [and these are] incapacity, harm and proportionality". These three criteria must all be simultaneously fulfilled in a person with mental illness for coercive treatment to be considered. Coercive treatment is applicable if the person with mental illness "lacks capacity" and the mental health care will result in the "restoration of capacity" and affirmation of "autonomy" (Lie´geois and Eneman 2008:75). In addition to the criteria of lack of capacity there must be a risk of harm to the persons "physical health, mental health or integrity" or the risk of harm to others (Lie´geois and Eneman 2008:75). The third criterion is "proportionality" which requires that the coercive measures applied to the person with mental illness must be proportional to the harm the mental illness would cause to the person or others (Lie´geois and Eneman 2008:75). This third criterion will therefore disqualify a poorly resourced hospital that is unable to provide coercive treatment in a manner that is humane and that ensures dignity of the person with mental illness. The use of physical restraints should also therefore be minimised as they may cause a disproportionate harm to the person with mental illness when compared to the harm caused by mental illness itself.

With this background, this research report is going to explore the moral permissibility of coercive psychiatric treatment in people with SMI as well as people with anorexia nervosa. The clinical presentation of people with SMI and the moral dilemmas they pose when coercive treatment is being considered is broad. To keep the discussion more focused this research report is going to explore the moral permissibility of coercive treatment in people with mental illness who lack insight and whose choice to refuse treatment is deemed by others (not themselves) as self-destructive, but who do not pose risk of physical harm to others or property. Arguments about the

protection of others from the person with mental illness as a justification for coercive treatment will therefore not be considered.

The position that is being defended in this research report is that coercive treatment is morally permissible in some cases of SMI and anorexia nervosa because psychiatric treatment has significant benefits for the person with mental illness that far outweigh the objections to coercive treatment that are based on respect for autonomy and the respect for the rights of people with mental illness. In chapter two I am going to explore the effect of mental illness on one's brain and the benefits of psychiatric treatment and the recovery from mental illness. However, there are arguments that while psychiatric treatment may be beneficial, it infringes on one's autonomy if it is forcefully given. In chapter three I am going to counter this argument by arguing that the people who are the subject of this case report may lack decisional capacity and make non-autonomous choices. We therefore have a duty as humanity to look out for each other at times when some of us are unable to make autonomous choices. It can still be argued that we have a duty to respect the rights of people with mental illness even if they are unable to make autonomous choices. For instance, people with mental illness have a right to life even if we accept that they at times lack autonomy and psychiatric treatment is beneficial. In chapter four I am going to argue that the arguments from the rights perspective are also outweighed by the benefits of coercive treatment for the person with mental illness. I am also going to argue that these benefits include enhancement of the ability of the person with mental illness to enjoy more rights.

The motivation for exploring the moral permissibility of coercive treatment in people with SMI that this research report is focussing on, as well as the people with anorexia nervosa, is threefold. Firstly, this group of people is the one in which the issue of moral permissibility of coercive treatment is most challenging, as it cannot be argued that coercive treatment on them is intended to protect others who are at risk from the person with mental illness. This selected group of people with mental illness in this research report is morally challenging because if they refuse psychiatric treatment and coercive treatment is not considered, the society has no other way of intervening except to leave them alone to suffer the devastating effects of untreated mental illness. In this category of people with mental illness the society and the healthcare system must deal with a difficult moral choice of leaving a person to suffer from mental illness while they think psychiatric interventions could help.

Secondly, it is essential that the profession of psychiatry should engage with the ethics of coercive treatment in mental health care, especially in the context of LMICs where there is a scarcity of resources and communities have also relied on alternative medicine such as traditional and faith healing. The ethics of coercive treatment and objections to it only apply to the use of coercive treatment in the field of Western Medicine and in the profession of psychiatry. In the process of ethical debates on coercive treatment it must be kept in mind that communities are still at liberty to apply coercive treatment as they seek any other alternative medical intervention and the alternative medicine practitioners can apply coercive treatment too. So, if our hospitals in LMICs, abandon coercive treatment, coercion may still continue in the community as the community seeks alternative care. The debates on coercion will then move away from the hospitals to traditional healers, faith-based

healers and eventually to the courts if people who are subjected to coercion are aggrieved.

Within the context of Western medical care in LMICs, coercive treatment will remain a consideration despite the argument that has been advanced that it is feasible to end coercive treatment as quality of medical care improves. The arguments that are optimistic about us ending coercive treatment in LMICs are anchored on the hope that as we scale up community based mental health care in LMICs there will be improved access to mental health care and that will allow for early intervention in mental illness. Early intervention in mental illness will achieve better outcomes thus reducing the need for hospitalisation and the associated coercion (Wickremsinhe 2021:2 citing Cohen et al 2016). This envisaged end of coercive treatment that is dependent on improved health care systems seems improbable because access to adequate mental health care will take decades to be achieved in Africa because of financial constraints, stigmatisation of mental illness and the lack of political will, amongst many reasons. The improvement of access to care, even if it is achieved, will not necessarily persuade all people with SMI to voluntarily subject themselves to mental health care. It can also be argued that coercive treatment should be replaced with “shared decision making” (Simmons et al 2010). However shared decision making, while it could help reduce the need for coercive treatment, is not accessible to most people in LMICs, in part due to limited resources and it still needs to be further studied in people with SMI living LMICs.

Thirdly, coercive treatment has been objected to by some philosophers, ethicists, mental health advocacy groups and by the people with lived experiences of mental illness. These objections have been brought to the fore by the Article 12 of the 2006 United Nations Convention on Rights of Persons with Disabilities which argues for the respect of legal capacity of persons with disabilities including psychosocial disabilities (United Nations 2006, Freeman 2015). The objections that have been articulated put a duty on the profession of psychiatry to provide moral reasons for the continued use of coercive treatment.

Chapter Two - The outlook of untreated mental illness

2.1 Introduction

The fundamental goal of medical interventions including psychiatric treatment is to heal. Human experience and understanding indicate that without healing there is harm and suffering that is caused by illnesses to persons. Coercive treatment in psychiatry is part of that healing process of medicine. However, this form of treatment by the profession of psychiatry has faced considerable controversy and several objections. Before the ethics of coercive treatment in psychiatry can be explored it is therefore important that I first take a step back to reflect on what would happen if we do not treat mental illness. We do have an advantage in exploring this question because psychiatric treatment that is scientific with proven efficacy is a recent invention that is less than a century old. We can look back at the history of psychiatric treatment and also explore current scientific view on the outlook of untreated mental illness to get insights on the outlook of untreated mental illness. In this chapter therefore I intend to give a brief overview of the damage caused by mental illness to the brain and discuss the biopsychosocial consequences of untreated mental illness. I want to argue that mental illness has bad biopsychosocial consequences for a person with mental illness and psychiatric treatment, even if coercive treatment is part of that treatment, is beneficial for that person. The argument that psychiatric treatment is beneficial is the basis of the argument of this research report which is in support of coercive treatment.

2.2 The impact of untreated mental illness

Mental illness, just like all human ailments, did not always have scientifically proven effective medical treatment. Consequently, people with mental illness used to live with mental illness undiagnosed and even if diagnosed the mental illness would not be treated effectively. Psychiatric treatment, especially the discovery of psychopharmacological agents that have proven efficacy in treating mental illness, is a recent discovery in human history. The first psychopharmacological agents that have efficacy in treating mental illness were discovered in the 1950s (Domino 1999 cited by Pereira and Hiroaki-Sato 2018:308-309). For centuries prior to this discovery there were no biological interventions or psychotherapeutic interventions that had shown efficacy in treating mental illness. In addition, mental illness as a medical diagnosis was not well-defined. The relationship between mental illness and other medical conditions was not clarified. As a result, people with primary mental illness and those with mental illness due to other medical conditions were not properly diagnosed and were not adequately treated. The consequence of untreated mental illness prior to the discovery of psychiatric medications is that in South Africa, just like in many other countries in the world, people with SMI as well as those with mental illness due to other medical conditions were institutionalised in inhumane conditions (Makepeace 1969). As the psychiatric diagnosis at that stage was not yet well-defined it can be concluded that amongst the institutionalised people with SMI were people with other medical illnesses who presented with psychiatric symptoms. It is evident in the history of psychiatry that untreated mental illness resulted in mental asylums. With the discovery of pharmacological interventions to treat mental illness in the middle of the last century and the improvement in the diagnostic

capabilities, better outcomes were achieved in people with mental illness resulting in the welcome deinstitutionalisation of people with mental illness all over the world (Accordino et al 2001). Deinstitutionalisation is a process that is in the right direction towards the reduction of coercive treatment in psychiatry. While deinstitutionalisation has been implemented throughout the world, people with mental illness still get hospitalised and institutionalised involuntarily for prolonged periods. The psychopharmacological interventions have formed part of this coercive treatment in those people who remain institutionalised or who are deemed to need some kind of hospitalisation. Despite the good outcomes of psychopharmacological interventions and the deinstitutionalisation that followed, it is still recommended that some hospital beds be made available “for hard-to-manage patients and adequate quality of care” (Lazarus 2005:65). It is these beds that even today are at times used for coercive treatment in psychiatry.

While deinstitutionalisation has been a major benefit of psychiatric treatment, there are several other benefits that can be accrued out of treating mental illness. People with mental illness such as schizophrenia and bipolar disorder may present with psychotic features, mood symptoms and cognitive decline (Stahl 2021). The onset of mental illness tends to be in adolescence and young adulthood, a stage in human development that is associated with the development of one’s identity, the establishment of one’s career and the beginning of one’s family life choices (Jones 2013). Schizophrenia, characterised by this onset in adolescence and young adulthood, is associated with cognitive decline which occurs early in the course of the illness. Most of the decline in people with schizophrenia occurs in the first two to three years after the onset of schizophrenia (Murrua and Carpiniello 2018: 60). The

cognitive decline in schizophrenia and other forms of mental illness is directly correlated with what has been termed “duration of untreated mental illness” (DUI) which is the period from the onset of mental illness to the first pharmacological intervention (Dell’Osso and Altamura 2010:238). In schizophrenia there is a focus on the psychotic features and the period from the onset of psychotic features to the first pharmacological intervention is called the “duration of untreated psychosis (DUP)” (Dell’Osso and Altamura 2010:238; Cotter et al 2017:1; Murrua and Carpiniello 2018: 60). Theories such as the neurodegenerative theories have been provided to explain this cognitive decline in mental illness. It has been hypothesised that there is a process of “neurodegeneration” in the brains of people with schizophrenia which begins before the onset of psychotic features and continues after the onset of psychotic features if there is no treatment taken or if the treatment provided is inadequate (Stahl 2021:154-156). It has been theorised that active psychosis is toxic to the brain cells in what is called “neurotoxicity hypothesis” (Murrua and Carpiniello 2018: 61). “Th[e] neurotoxicity [is thought to] occur via several mechanisms, including glutamatergic excitotoxicity, elevated dopamine levels, and persistent catecholaminergic activity” (Murrua and Carpiniello 2018: 61). It is also thought that further “neuronal damage” is exacerbated by increased “glucocorticoid secretion” which is a consequence of the “activat[ion] of the hypothalamic-pituitary-adrenal axis” by “prolonged stress” (Murrua and Carpiniello 2018: 61).

There remains inconclusive scientific evidence in studies to support the neurotoxicity hypothesis (Bora et al 2018). However, this lack of conclusive evidence in support of neurotoxicity hypothesis is not proof that it does not exist. Clinical observations have shown a notably decline in brain functions of people with schizophrenia.

Neuroimaging studies have also revealed brain atrophy in chronic schizophrenia which is indicative of brain damage and accounts for the cognitive decline (Lynn et al 2006). The lack of scientific evidence of the neurotoxicity hypothesis may be the result of the shortcomings of the available scientific methods to prove its existence rather than its absence. In future and with the advances in science, we are likely to show with evidence the damage caused by the neurochemistry of schizophrenia to the brain which is a consequence of untreated mental illness. The brain just like any other organ in the body does get ill and its biological structure and functions get damaged by mental illness with consequent cognitive decline and loss of mental functions as has been described in this chapter (Cotter et al 2017:1). As it has already been mentioned, the neurodegeneration in the brain results in "[m]any patients with schizophrenia hav[ing] a progressive, downhill course, especially when available treatments are not used consistently and there are long durations of untreated psychosis" (Stahl 2021:154). This downhill course of schizophrenia is associated with psychotic episodes that are much more severe and difficult to treat. The declining course of mental illness due to prolonged DUI is not limited to schizophrenia and other psychotic disorders. In depressive disorders too, neuroanatomical damage associated with the prolonged DUI has been found (Dell'Osso and Altamura 2010:243).

Mental illness with its neurodegeneration has biopsychosocial consequences for the affected person and his or her community and these get worse the longer the person does not receive effective treatment. Untreated mental illness affects the quality of life and results in human suffering. To illustrate this human suffering let us look at the economic decline and the resultant homelessness in people with untreated or

inadequately treated schizophrenia. The negative economic consequence of untreated mental illness affects the person with mental illness, his or her family and the society. The economic consequences and financial benefits of treating mental illness for countries has been described (Docrat, Beseda and Lund 2019; Insel 2008). With economic decline the person with schizophrenia may be dependent on family members for financial support and shelter which some families may not cope with. Untreated mental illness may result in behavioural changes in the person with mental illness that could make it difficult for families to cope with the person with mental illness. This inability to cope by family members may be exacerbated if the person with mental illness is objecting to psychiatric treatment which should include psychosocial support for the family. The person with mental illness may then find himself or herself homeless due to the family's inability to cope with him or her or because of his or her own choice. Homelessness is a kind of suffering on its own, impairs human dignity and is associated with increased mortality (Sones et al 2022).

Psychotherapeutic interventions such as cognitive behaviour therapy and specific pharmacological agents have been shown to have efficacy in treating mental illness and reducing the decline in cognition. Specific pharmacological agents, such as antipsychotics, do reduce psychotic features of mental illness such as delusions, hallucinations and disorganized behaviour which could assist the person with mental illness and his family to live better with each other. With some antipsychotics there could be reduction of mood symptoms, cognitive decline, suicidality, and anxiety symptoms which are features of SMI. The improvement in these symptoms results in better quality of life for the person with mental illness as well as the reduction in suffering.

2.3 Conclusion

In this chapter it has been stated that untreated mental illness results in human suffering. The onset of mental illness tends to be early in one's life resulting in many years of poor quality of life and suffering. The early onset of schizophrenia and the cognitive decline which occurs in the first two years of the course of schizophrenia necessitate early intervention in schizophrenia to prevent long term poor outcomes. To reduce the impact of mental illness on one's quality of life we need to therefore halt the neurodegeneration that occurs in the period of untreated mental illness by reducing the DUI and in the case of schizophrenia, the DUP.

It appears therefore that the consequences of untreated mental illness are dire and there are substantial potential benefits to psychiatric treatment even if that may entail coercive treatment. However, substantial questions concerning consent, capacity, autonomy, and rights still need to be addressed before reaching a conclusion about the moral justification of coercive treatment and these will be addressed in the next chapters.

Chapter Three – Decisional capacity in people with mental illness

3.1 Introduction

It has been argued in chapter two that early intervention in the treatment of mental illness has many benefits including reduction or even prevention of further human suffering. However, the biomedical principle of respect for autonomy requires that informed consent be obtained from the person with mental illness for the intended psychiatric treatment to be initiated. Informed consent refers to an exercise by a competent person of a choice to freely accept or refuse treatment after adequate information has been received for a specific treatment (Beauchamp and Childress 2019; Eyal 2019:3). Eyal (2019:2) succinctly defines "[i]nformed consent" as a "shorthand for informed, voluntary, and decisionally capacitated consent". Informed consent has become mandatory in medicine as a requirement that ensures that patients make autonomous decisions. This is a step forward from the era where the doctor-patient relationship was based on the trust that the doctor will always act in the best interest of the patient (Eyal 2019).

Respect for autonomy is one of the four principles of biomedical ethics, the other principles being beneficence, non-maleficence, and justice (Beauchamp and Childress 2019). Christman (2020:1) describes "[i]ndividual autonomy [as] an idea that is generally understood to refer to the capacity to be one's own person, to live one's life according to reasons and motives that are taken as one's own and not the product of manipulative or distorting external forces". In biomedical ethics respect for

autonomy means that all patients have a “right to make their own self-regarding choices in [medical] situations where more than one option is available” (Gylling 2004:41). Such “medical situations” include acceptance or refusal of psychiatric treatment by people with mental illness.

In mental health care, a difficult ethical situation does arise in which the person with mental illness objects to treatment and coercive treatment has to be considered in order for the significant benefits of psychiatric treatment to be gained by the person with mental illness. However, such coercive treatment seems to violate the autonomy of the person with mental illness if they choose to refuse treatment. The question must be posed whether in certain cases of SMI and anorexia nervosa such coercive treatment does indeed violate autonomy or not. In this chapter it will be argued that coercive treatment in certain cases of SMI and anorexia nervosa does not violate autonomy, because people with these mental illnesses may at times lack decisional capacity.

3.2 Decisional capacity

Decisional capacity refers to mental competence or capacity. Competence in biomedical ethics is the “capacity to understand material information, to make a judgement about this information in light of [one’s] values, to intend a certain outcome, and to communicate freely [one’s] wishes to caregivers or investigators” (Beauchamp and Childress 2019:114). The use of the terms “competence” and “capacity” can have two different meanings, with competence being said to be determined by the courts and incapacity determined by the HCWs. This distinction

between competence and capacity is not necessary in this research report as we are only dealing with decisional capacity as determined by HCWs. The two terms will therefore be used interchangeably. This approach is in keeping with Hawkins and Charland's (2020:6-7) recommendation that competence and capacity may be used interchangeably with authors providing a "pre-emptive minor proviso or caveat at the beginning of a discussion to that effect".

3.2.1 The shared elements of decisional capacity

Lack of competence or capacity in a person refers to reduced or no decisional capacity. Decisional capacity is an essential component of the valid informed consent that has been described in the introduction of this chapter (Hawkins and Charland 2020:10). In addition to decisional capacity, for informed consent to be valid the patient must be provided with "[a]ll relevant information" (Hawkins and Charland 2020:10). The patient "must [then] understand [the information that] has been conveyed" and "make a voluntary choice either accepting or refusing [medical treatment]" (Hawkins and Charland 2020:10).

Decisional capacity, a component of informed consent as described above, has many "shared elements" which Hawkins and Charland (2020:12) also refer to as "sub-capacities". There are four main shared elements of decisional capacity that are universally accepted by most philosophers as essential for decisional capacity to be valid (Hawkins and Charland 2020). These four shared elements which will be discussed below are "choice", "understanding", "appreciation", and "reasoning"

(Hawkins and Charland 2020:12-16). In addition to these four shared elements, some philosophers include “values and authenticity” as additional shared elements of decisional capacity (Hawkins and Charland 2020). Values and authenticity, though not universally accepted by philosophers as important shared elements of decisional capacity, will also be discussed in this research report, because they are relevant to decisional capacity in people with mental illness (Hawkins and Charland 2020). In the discussion of values and authenticity below, it is going to be shown that inauthenticity is the moral justification of coercive treatment in mental illness.

Let us first then explore the four shared elements of decisional capacity and later deal with values and authenticity. The element of **choice** refers to “the ability to express or communicate one’s choice” (Hawkins and Charland 2020:13). When the element of choice is being evaluated in a patient, what is actually being evaluated is not the ability to make a choice but the ability to express or communicate a choice. The determination of the ability to make a choice still requires the remainder of the shared elements of decisional capacity that are discussed below. At this stage of the discussion, I am still exploring what choice as a shared element contributes to decisional capacity.

The ability to express a choice may be lost even if the other three elements of decisional capacity are intact. This may occur in some neurological disorders such as “locked in syndrome” and psychiatric states such as catatonia and mutism (Hawkins and Charland 2020:13). People with these disorders may not be able to freely express their choice. Indeed, treatment is given to people with locked in syndrome and mutism without their expressed choice to accept or reject treatment.

In psychiatry people do receive treatment without expressing a choice if, due to their mental illness, they are deemed to lack capacity to express a choice on whether to accept or refuse treatment. This treatment is however not coercive treatment but treatment without an informed consent. In coercive treatment the person does express a choice which is to object to psychiatric treatment. He or she is then given treatment forcefully and against his or her objection which he or she has expressed because he or she is deemed to lack capacity. The inability to express a choice is therefore not the reason for coercive treatment in psychiatry but rather the objection to psychiatric treatment by a person with mental illness who is deemed to lack capacity. In the South African context, a person with mental illness who is unable to express a choice of acceptance or refusal of psychiatric treatment is categorised as an “assisted mental health care user” by the MHCA. Consent to administer psychiatric treatment in an assisted mental health care user is obtained from the next of kin and the MHCA prescribes a legal process that must be followed when such treatment is being given. The MHCA reserves coercive treatment which it refers to as “involuntary mental health care” for people with mental illness who express a choice of refusing psychiatric treatment while they lack the other shared elements of decisional capacity.

The element of **understanding** is complex to comprehend. It can be understood as the ability of a person to take in the facts, process the facts and understand the information that is provided. The information that has been processed and understood by the person will influence the choice that is to be made about the medical treatment (Hawkins and Charland 2020:13). Part of the process of understanding the information by the person is the “appreciation of the nature and

significance of the decision that they are faced with" (Charland 2020:14 citing Grisso and Appelbaum 1998: 42–52). The person needs to appreciate the depth of his or her problem. For a medical illness they need to appreciate and weigh the risk of the medical intervention against the risk of no treatment. The long-term prognosis of the illness needs to be considered as does the quality of life with treatment or without treatment. **Appreciation** is therefore a significant shared element of decisional capacity on its own and it also enhances understanding. Good cognitive abilities and rationality are required for a person to have the element of appreciation. **Reasoning** is "the mental ability to engage in reasoning and manipulate information rationally" (Hawkins and Charland 2020:16). When the person is doing risk-benefit analysis of the medical intervention they need to have good reasoning abilities. They need to think about and reason through the advice that is being given by the HCW and weigh this advice against their own needs and interests.

The inability to understand, appreciate and reason about medical information may result in the person with mental illness expressing a choice to object to psychiatric treatment. This objection by the person with mental illness may result in him or her being deemed to be lacking decisional capacity and coercive treatment could then ensue. HCWs should tread carefully before they declare a person to be lacking the shared elements of understanding, appreciation, and reasoning because even without mental illness human beings do not have the same ability to comprehend information and the same level of reasoning capability. This ability to understand and reason about information may be further impacted by the mental illness. Naturally we may find it easier to navigate and reason through a situation that is familiar to us or within our frame of reference than a foreign concept such as psychiatry is to most

people. It is difficult for any of us to understand how a brain functions as it is a complicated organ that has not been fully understood even by science. Factors such as the asymmetry of knowledge between the HCW and the patient, the level of education of the patient, familiarity with biomedical science, socioeconomic status and cultural background may all influence the comprehension of medical information. Before a person with mental illness is deemed to lack decisional capacity, HCWs must take time to explain the biomedical jargon so that it is processed thoroughly by the patient and a fully informed consent is obtained. In the South African context, the HCWs must take note of the socioeconomic status, race and cultural background, as psychiatry may be viewed by some communities as a Western concept or the HCWs may be seen as being from a higher social status and these could affect how information is received by the person with mental illness.

Before moving on, it would be important to sum up the key conclusion at this point. This conclusion, I think, would be that HCWs need to be very careful in concluding that people lack capacity but, nonetheless, some of the relevant mentally ill people do lack capacity. So, in these cases coercive treatment would not violate autonomy.

3.2.2 The significance of authenticity in the decisional capacity of people with mental illness

In each assessment of decisional capacity patients must simultaneously possess all the four shared elements of decisional capacity that have been discussed above. This means that the patient should be deemed to lack decisional capacity if any of these four elements is missing. The other way of stating this is that a person can be

deemed to have decisional capacity if it can be shown objectively that they possess all these four shared elements of decisional capacity. However, this is not always the case in mental illness as in some psychiatric disorders people with mental illness may be deemed not to have decisional capacity even if they have all the cognitive abilities that are required for decisional capacity and their four shared elements of decisional capacity are intact. Hawkins and Charland (2020: 33-40) use the example of anorexia nervosa to illustrate this argument. A person with anorexia nervosa may be deemed to lack decisional capacity while he or she objectively possesses all the four shared elements of decisional capacity.

Anorexia nervosa is an eating disorder characterised by the "[r]estriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health" (APA 2013: 338). In anorexia nervosa, there is a strong desire to lose weight which could result in life threatening low body weight with extremely low body mass index (BMI) of less than 15kg/m^2 (APA 2013: 339). The person with anorexia nervosa could continue with food restriction and intense exercises despite the risk to his or her life, as the concern about weight gain in people with anorexia nervosa far outweighs their fear of medical complications of low BMI and the associated risk of death. The person with anorexia nervosa may object to any form of medical intervention that will make them gain weight to a life sustaining body weight. This choice by a person with anorexia nervosa to starve himself or herself may seem irrational especially because their four elements of decisional capacity remain intact even on objective testing.

Treatment without consent or even coercive treatment may be applied to the person with anorexia nervosa to prevent the adverse consequences of the illness (Elzakkers 2014). Coercive treatment is not unusual in the management of anorexia nervosa. In a systematic review done by Clausen and Jones (2014: 3) that looked at “frequency, duration, type and effect of involuntary treatment for people with anorexia nervosa" it was established that “[t]he frequency of involuntary treatment was reported in six of the studies reviewed and ranged from 13-44% of patients treated for anorexia nervosa”. It is also important to remember that in South Africa involuntary mental health care as prescribed by the MHCA is not applicable to medical treatment of a person with anorexia nervosa in a medical ward even if coercion is applied as the MHCA regulates psychiatric admissions and does not apply to other medical admissions. Therefore, it is likely that coercive treatment is applied in people with anorexia nervosa with more frequency than the legislated involuntary mental health care. Despite this established application of coercive treatment in people with anorexia nervosa, we hold a different moral standard when it comes to people with other medical illnesses such as diabetes mellitus when they object to medical treatment. If a person with diabetes mellitus objects to treatment and continues with a non-diabetic diet, he or she is never treated forcefully against his or her will. What is it then about anorexia nervosa that makes the people affected by it to be deemed to lack decisional capacity and yet they possess all the four shared elements of decisional capacity just like a person with diabetes mellitus? The answer lies in the additional shared elements of decisional capacity which are values and authenticity.

Let us then explore the significance of values and authenticity as shared elements of decisional capacity and how these differentiate people with mental illness from

people with other medical illnesses such as diabetes mellitus when it comes to capacity assessment. People with mental illness may be deemed to have “pathological values” and “inauthenticity” (Hawkins and Charland 2020: 34). As part of the process of unpacking pathological values, an additional concept called “value neutrality” needs to be explained (Hawkins and Charland 2020: 34). Value neutrality means that HCWs ought not to impose their values on the medical choices that patients make when informed consent is being obtained. A patient may make a choice that the HCWs do not like or that HCWs think most people would not make but the HCWs need not impose their judgement and values to the patient on this choice. The patients may, for instance, refuse treatment such as blood transfusion on religious grounds and accept complications of such a choice. The HCWs may not impose blood transfusion in a patient who is objecting to blood transfusion on religious grounds, as such a choice is an autonomous choice and demands the HCWs to maintain value neutrality (Hawkins and Charland 2020).

It can be argued then that such value neutrality that is afforded to people who refuse blood transfusion on religious grounds and people with other medical conditions, such as diabetes mellitus, must be maintained even when HCWs are dealing with people with mental illness. By contrast such value neutrality is not afforded to people with anorexia nervosa and some cases of SMI, because it is thought that the values that they hold that make them to object to food intake (in the case of anorexia nervosa) are pathological (Hawkins and Charland 2020: 33-40). Pathological values are a deviation from what the person previously stood for and values that they previously possessed. Pathological values, as in the case of anorexia nervosa, are influenced or are a product of mental illness and therefore, are not authentic to the

person or part of the real self (Derek Bolton and Natalie Banner in Radoilska 2012: 88-90; Childress 2012: 311). It is argued that the authentic values and the real self are there before the mental illness, making the real self to be the authentic self before the mental illness (Derek Bolton and Natalie Banner in Radoilska 2012:88-90). It is therefore necessary that the assessment of decisional capacity in mental illness include values and authenticity as the additional shared elements of decisional capacity.

3.2.3 Objections to the concept of authenticity as a shared element of decisional capacity

There are grounds for objections to the concept of authenticity and values as shared elements of decisional capacity. It can be argued that with the insidious onset of mental illness in adolescence it may be difficult to differentiate authentic values from pathological values, because adolescence is the stage in human development in which one's identity is being formed. The values established in adolescence which we think are influenced by mental illness may actually be authentic and be what the person stands for, because the person has never had other values developed before adolescence. Even if a person had developed and held some values, naturally, and as part of human growth, people may develop new values that are different from the values that they previously had a year or two ago. That does not make those values inauthentic. One may convert to be a Jehova's Witness and refuse blood transfusion on religious grounds, while previously he or she had no values that prohibited acceptance of blood transfusion. He or she will not be deemed to be inauthentic and

his or her autonomy will be respected, although refusal of blood transfusion may not be a value he or she previously held.

If that is the moral position that we hold for those who refuse blood transfusion on religious grounds, it can then be argued that similarly to the case of refusal of blood transfusion, the values held by the person with mental illness are his or her own values, though unusual or not reflective of previously held values. People with mental illness are entitled to change their values over time just like everyone else and the conclusion that such a change is due to mental illness should be rejected. As stated above, mental illness tends to have its onset in adolescence and young adulthood, a period which coincides with us developing our own identity and values. The evolution of values as the person goes through adolescence and young adulthood to new values that may be unpopular need not be deemed to be a product of mental illness and pathological even if the person has a mental illness. A person may have new values after the onset of mental illness that are different from the values that were previously held. These new values could include even the rejection of any medical intervention for the mental illness. This change in values after the onset of mental illness, including the rejection of psychiatric treatment, need not be assumed to be pathological as the experience of any illness may make a person change his or her values. People with mental illness must be afforded value neutrality even in this context and be given space to make their autonomous choice regarding psychiatric treatment.

People around the person with mental illness as well as HCWs fail to maintain value neutrality because they are of the view that the choice that is being made by the

person with mental illness is inauthentic, the process followed to make the choice lacks internal rationality and the values held by the person with mental illness are pathological. Such conclusions about the person with mental illness are made because the people around the person with mental illness do not like the choice that is being made by the person with mental illness, the consequences of such a choice and the values held. There is even a possibility that if the said choice did not have bad consequences, it would not be judged as irrational and not autonomous. It can therefore be argued that it is the evaluation of the choice that is being made by the person with mental illness rather than its irrationality that makes it not acceptable to others to an extent that coercion is implemented.

The argument that is being considered in this subsection of the chapter is that coercive treatment should be rejected as it infringes on the autonomy of people with mental illness and the basis for finding their choices nonautonomous is inauthenticity and pathological values both of which are argued to be underlying the medical incapacity concept. It is being argued that we must accept people's unusual choices. The unusual choices being made by people with mental illness should be acceptable to HCWs because "[p]eople vary greatly in their values and so, even when confronted with similar situations, make very different kinds of choices" (Hawkins and Charland 2020: 20). People may make informed decisions about their situations that may not be popular or the most preferred choices by others. Such unpopular choices are not evidence of the lack of decisional capacity and as such they should be respected even in mental illness (Hawkins and Charland 2020: 20). HCWs have a greater knowledge of human bodily functions and illness resulting in knowledge gap between HCWs and their patients. With this knowledge gap it can be tempting for

HCWs to view patients' choices as ill-informed, unwise or even irrational because these patients' choices are not backed up by biomedical evidence. The HCWs may be tempted to declare these patients as lacking decisional capacity because of the choices that they are making that seem ill-informed from a biomedical point of view. Value neutrality should be maintained even in such seemingly unpopular or ill-advised choices being made by patients and coercive treatment be rejected.

It has already been argued in section 3.2.2 that authenticity and values are shared elements of decisional capacity and intact decisional capacity is a requirement that must be fulfilled for a valid informed consent and autonomous choice to be made. However, in view of the objections to authenticity that have been discussed in this section above, it is important that I provide some counterarguments to these objections. These counterarguments are in addition to my acceptance of authenticity and values as shared elements of decisional capacity. The objections to inauthenticity and pathological values in essence are demanding us to afford people whose values have changed with mental illness the same value neutrality that we afford to people whose values have changed or are unpopular but are based on religious beliefs or even political choices. I argue that we must remember that there is an underlying brain pathology in mental illness, and this was briefly discussed in chapter two. The values in mental illness are pathological because they are the product of a brain whose normal physiology has been disrupted resulting in brain dysfunction that produces these values. In Jehova's Witnesses, there is no brain dysfunction and the unpopular choice of refusing blood transfusion is not a product of an ill brain. The important difference in the case of mental illness is that the pathological values are a product of mental illness, while in Jehova's Witnesses the

values are thought to be due to the religion. So, even if it is sometimes hard to make the judgement and there might be tough cases, there is still a principled distinction here that it is the mental illness that renders the person with mental illness to be inauthentic and to be unable to make an autonomous choice.

In view of the counterargument that inauthenticity and pathological values are a product of mental illness, then we must accept that authenticity and values are shared elements of decisional capacity, a component of autonomy. As Hawkins and Charland 2020: 38 put it, “[i]f authenticity is, in turn, thought of as part of autonomy, then it might be thought that inauthentic values undermine [decisional] capacity”. The philosophers who accept that authenticity is a shared element of decisional capacity argue that coercive treatment is therefore morally justified as choices made by people who lack decisional capacity are not autonomous choices. What is morally impermissible is for us to let a person with mental illness suffer while we are aware that they lack decisional capacity. “It is reasonable to believe that most people accept and find comfort in the thought that they will be provided medical care if they become too ill to consent to the care needed, and that this therefore is in line with their autonomous will as healthy individuals” (Sjöstrand and Helgesson 2008: 115). This argument easily applies in medical emergencies where a patient cannot provide consent because they are unconscious. It is easy to see why it would be unethical and morally impermissible for HCWs to refuse to treat an unconscious person because he or she is unable to provide informed consent. We all expect that those around us, including the medical professionals, would help us when we are unable to take care of ourselves. The objection to treatment by a person who lacks decisional capacity is not an adequate ground for HCWs to ethically decline to treat the person

because “the obligation to allow people to choose is only an obligation where the individuals in question can meaningfully be said to choose for themselves” and this cannot be said in the case of inauthenticity (Hawkins and Charland 2020: 9).

An additional argument in support of coercive treatment from the respect for autonomy is that psychiatric treatment has a potential to restore the person’s mental capabilities resulting in the recovery of the person’s autonomy for decisions related to his or her mental health as well as many other autonomous decisions that one has to make in his or her life (Matthews 2000). Psychiatric treatment therefore has a potential to get the person with mental illness to recover his or her autonomy. That way psychiatric treatment has a potential to reinforce one’s autonomy that is lost due to mental illness and this makes coercive treatment not only justified but also a moral, an ethical and even a legal obligation in some jurisdictions. This justification of coercive treatment in people with mental illness who are not dangerous to others, is referred to as the “stone model or thank you theory” (Ewouso 2016:4). Stone (1975) as cited by Ewuoso (2016:4) states that people with mental illness “may need to be admitted involuntarily, for medical treatment, even when they are not dangerous to themselves nor to others; and might then thank those who forcibly committed them for insisting on treatment even against their will”. The coercive treatment as permitted in the stone model is no different to treating people who are unconscious without informed consent.

3.3 Conclusion

The benefits of psychiatric treatment give HCWs a strong ethical reason to provide psychiatric treatment. However, such treatment requires that a valid informed consent be obtained from the person with mental illness. Most people with mental illness are able to provide informed consent. Where people with mental illness are unable to provide informed consent there are cases where coercive treatment is fairly uncontroversial because the person with mental illness lacks decisional capacity because a problem with one or all the four universally accepted shared elements of decisional capacity. However, there are difficult cases where the four shared elements are intact, but people are found to lack decisional capacity because of inauthenticity and pathological values. In such cases of inauthenticity, the person with mental illness cannot be said to be making autonomous choices and coercive treatment may then be morally permissible. However, a remaining concern might be that, even in these cases, considerations about rights would show that coercive treatment is still impermissible. The next chapter will address this concern.

Chapter Four – Rights and Coercive Treatment in Psychiatry

4.1 Introduction

Thus far in this research report it has been argued that coercive treatment comes with significant benefits and does not always violate autonomy, as some people with mental illness lack decisional capacity and as a result make non-autonomous choices. However, there remains a concern that even if coercive treatment has significant benefits and does not violate autonomy, it may involve an unacceptable violation of patients' rights.

The objections to coercive treatment from human rights perspective have been argued even in the context of the strict criteria for application of coercive treatment that are outlined by Lie´geois and Eneman (2008: 75), which were discussed in the introduction of this research report. In this chapter, it is going to be argued that in cases of potential coercive treatment, there is a complex trade-off between rights and potential benefits of coercive treatment. So, considerations of rights do not clearly count against coercive treatment in people who lack decisional capacity.

4.2 Arguments from the rights perspective

It has been argued morally and documented in statutes such as the MHCA that coercive treatment is necessary to protect the rights of others who can be

endangered by the person with mental illness. As it was stated in the introduction of this research report, the group of people with mental illness who put others in obvious physical danger is not the focus of the research question that is being answered in this research report. The focus in this research report is people with SMI or anorexia nervosa who are not a physical danger to themselves, others and property but who are objecting to psychiatric treatment. As the presence of mental illness and its expression in this group of people with mental illness does not infringe on the rights of others, it can be argued therefore that coercive treatment cannot be justified based on the protection of the rights of others or property. To keep this discussion focused, the infringement on the rights of others is kept narrow and does not include, for instance, the rights of a child of a person with mental illness to a healthy parent which could be another argument to justify coercive treatment.

Now that the rights of others have been put aside in this discussion, it can be argued that coercive treatment in people who lack decisional capacity is immoral and should be abolished because it, by itself, infringes on the rights of the person with mental illness. It can be further argued that coercive treatment is even more unethical from human rights perspective if it is applied to the kind of people who are the subject of this research report who lack decisional capacity but whose rights are not being weighed and balanced with the rights of others. It is already known that people with mental illness suffer an array of “human rights violations [that] span basic civil, cultural, economic, political, and social rights” (Drew et al 2011: 1664). The human rights violations that come with coercive treatment are in addition to these standing human rights violations that are suffered by people with mental illness. While coercive treatment results in human rights violations, promotion of human rights in

people with mental illness “improve[s] their mental health outcomes” and “human rights violations can themselves negatively impact mental health” (Mahdanian et al 2023:151). If human rights violations negatively “impact mental health” as Mahdanian et al (2023) argue, it can be inferred that coercive treatment can worsen the mental health of people with mental illness as coercive treatment increases the burden of human rights violations.

Coercive treatment has been claimed to violate several specific human rights of people with mental illness such as “liberty; autonomy; freedom from torture, inhuman or degrading treatment; physical and psychological integrity of the person; non-discrimination; and a home and family life” (WPA Position statement 2020:1). In addition to these human rights violations and the stigma associated with mental illness, coercive treatment itself leads to further stigmatisation of people with mental illness. This stigmatisation of people with mental illness is part of the reason that people with mental illness, through coercive treatment, may be deprived of their “right to live freely in the community, and the[ir] right to make [their own] decisions about treatment or support” (Sugiura 2020). Coercive treatment tends to classify people with mental illness as belonging to a psychiatric hospital and therefore not capable of making decisions about themselves or being part of the decision-making process in a community. Stigma and coercive treatment will not be discussed further in this chapter. At this stage some elaboration will be provided on the proposition about trade-off between rights of people with mental illness and coercive treatment.

4.2.1 Right to equality and fairness

Refusing a medical intervention for an illness is an unpopular choice that is exercised by some people with other medical conditions that are not mental illness. With coercive treatment people with mental illness are prohibited from making such an unpopular choice. It can be argued therefore that coercive treatment deprives people with mental illness of their right to equality with people with other medical conditions who are at liberty to make their choices about acceptance or refusal of medical treatment. Is the acceptance of the objection of treatment by a person with mental illness (the kind of mental illness that is the subject of this research report) out of respect of the right to equality a fair and equitable treatment of person with mental illness? I argue that such acceptance of this objection to treatment is unfair to people with mental illness and results in the worldwide lack of parity between physical health and mental health when it comes to medical care.

We have a moral obligation to provide medical care in a just and equitable manner. We are therefore morally obliged to treat people with mental illness with fairness and equity to people with other medical conditions. To be fair and just to people with mental illness we need to appreciate that the physical organ (the brain) whose function is to make decisions about the need for treatment may be impaired and dysfunction just like any other organ of the body. Mental illness is a clinical presentation of the pathology of the brain just like respiratory symptoms are a manifestation of lung pathology. The brain, just like any other organ, may present with failure to do some of its functions when its normal physiological functioning is disturbed.

The brain is responsible for various functions of the human body such as the motor functions of the body, the regulation of hormones, cognition, emotions, thoughts, and language. When the brain is ill it will then display such illness with disruption in any or all these functions. For instance, the person with a stroke may present with paralysis of muscles and language difficulties due to pathology in the brain regions that are responsible for these functions. Similarly, the person with mental illness may present with the disruption in thought processes, perceptual disturbances, language difficulties, problems with cognition and disturbances in the emotions. Insight and judgement, which are also functions of the brain, are lost to a varying degree when there is brain pathology. This may range from a person who is in a coma who obviously lacks insight and judgment completely to some people with mental illness who may have no insight or partial insight. With lack of insight and judgement, which is part of the decisional capacity that has been discussed in this research report, the person with mental illness may therefore not appreciate the illness he or she has or its consequences if it remains untreated and this may be due to the physical disruption in the brain. For one to have his or her thought processes preserved he or she needs a physically healthy brain. Without the required insight, cognition and intact thought processes the person may choose not to receive treatment and suffer the consequences of untreated mental illness. In this state of affairs, it would be unfair to the person with mental illness if those around him or her were to choose not to provide him or her with assistance including coercive treatment if necessary. When we refrain from coercion, when it is appropriately indicated, we are actually providing inferior care to this person with mental illness when compared with other medical conditions.

The objection to coercive treatment out of respect for the right to equality results in the lack of moral equivalence between mental illness and physical illness which may be grounded on our non-acceptance of the view that symptoms of mental illness are the product of the physical brain. Even with regards to the illnesses of the brain, there is a moral discrepancy in how we deal with psychiatric symptoms that have a proven and accepted link with physical brain pathology compared to psychiatric symptoms with no obvious link to the physical brain. This argument is illustrated by the history of neurosyphilis in human beings over the past few centuries. Neurosyphilis, previously called the general paralysis of the insane, is a disease of the brain caused by syphilis (Braslow 1995). The illness starts with syphilis, an infection caused by bacterium called Treponema Pallidum that is contracted through sexual transmission or vertical transmission from mother to child during pregnancy. Neurosyphilis is the progression of the syphilitic infection, and it usually presents 10 to 20 years after the initial syphilis infection (Braslow 1995). The clinical features of neurosyphilis are mainly psychiatric and neurological symptoms. Prior to the discovery of effective biological therapies for neurosyphilis and the identification of the bacterium that causes syphilis, people with neurosyphilis were treated as mentally ill in keeping with their clinical presentation that is characterised by psychiatric symptoms (Braslow 1995). They were involuntarily admitted to mental asylums (Braslow 1995). Once biological therapies were discovered, doctors had more favourable views of people with neurosyphilis and the patients themselves presented voluntarily to treatment facilities (Braslow 1995). Today patients with neurosyphilis are generally treated in the general hospital wards and not in psychiatric wards or mental institutions and the question of morality of involuntary treatment does not arise even if such treatment is applied. A patient with

neurosyphilis who presents with psychiatric symptoms and refuses treatment does not fall under the prescriptions of the MHCA and does not get classified as an involuntary mental health care user. Instead, he or she gets forced treated in the medical wards in a similar manner in which the person with seizures or delirium is treated even if he or she objects to treatment. If we had not discovered the biological basis of neurosyphilis, we would have continued to treat neurosyphilis as a mental illness and argued about the moral permissibility of coercive treatment when it is applied to them.

The next question that needs to be answered is why there remains a lack of full acceptance of the view that mental illness is an expression of the biological pathology that is located in the brain. The difficulty that we have in accepting the link between mental illness and an underlying physical brain pathology is due to the complexity of the relationship between mind and a healthy brain even before we consider the mental illness as an expression of brain pathology. Stein (2021: 39-58) in his conceptualisation of the relationship between brain and mind proposes a "metaphor" he refers to as "wetware". "Wetware [is] a metaphor used to describe the [brain] cell as a computer comprising both hardware and software attuned to logic gates" (Kulkarni et al 2022). "A living [brain] cell is [therefore] a complex adaptive system that is capable of making decisions" (Kulkarni et al 2022). The functioning of the brain as a wetware is "distinct from the computational processing undertaken by electronic hardware and software" (Stein 2021:51). If the brain-mind is conceptualised as wetware it can be studied scientifically and be conceptualised in a similar way in which the functional unit of any other organ of the body can be studied and conceptualised. With scientific advances we could be able to link the functions of

the brain to the brain's functional unit, the wetware, as we do with gaseous exchange in the lung. Unfortunately, science has not yet been able to link each function of the wetware such as thoughts with exact neuronal activity and this makes psychiatry to be behind other areas of medicine in terms of scientific advances (Kelly et al 2022). This then leads to us not able to show a link between mental illness and underlying brain pathology to the same extent as we do for other medical conditions.

Another complexity that may hinder us giving moral parity between people with mental illness and those with other physical illnesses is that the expression of mental illness, a consequence of brain pathology, affects one's values and reasoning. Unlike lung pathology which may present with cough, shortness of breath and ultimately respiratory failure and death, mental illness presents with features that may impact one's values at the time of presentation resulting in those looking after the person with mental illness having moral dilemmas. Instead of us viewing the change in values due to mental illness in the same way we view shortness of breath in lung diseases we go into a moral debate on whether to respect the new values or not. However, these moral dilemmas and the objections to coercive treatment need not arise if we accept that mental illness is an expression of physical brain pathology. People with mental illness are more likely to object to treatment when compared with people with other physical illnesses because of the impact their illness has on their values, reasoning and insight. We have an obligation out of fairness to treat the people with mental illness whose values make them object to treatment even if our medical interventions include coercive treatment.

Mental illness being a product of the brain has a specific presentation that includes lack of insight. People with mental illness are therefore more likely to end up refusing clearly beneficial treatment much more often than people with other medical conditions. So, if we do not allow coercive treatment for mentally ill patients, our failure to pay attention to the distinctive feature of this sort of illness, will disadvantage mentally ill patients. So, if we are really committed to equality and fairness for people with mental illness, we are morally obligated to allow for coercive treatment.

4.2.2 Right to liberty

Similar to the right to equality discussed above there is a balancing act that needs to be done between infringement of the right to liberty by coercive treatment and the limitations on some liberties imposed by the mental illness itself as well as the benefits of coercive treatment that are accrued by the person with mental illness if treated that include civil liberties. On the negative side, coercive treatment infringes on the rights of people with mental illness to enjoy several civil liberties including the right to vote. Section 8 of the Electoral Act No. 73 of 1998 excludes from voting people who are “detained under the Mental Health Act, 1973 (Act No. 18 of 1973)”. While an outdated Mental Health Act of 1973 is cited in the Electoral Act it is still in practice that people with mental illness who are receiving involuntary mental health care are deprived of the right to vote. As a result, the Independent Electoral Commission of South Africa does not offer any opportunity for voting to people who are hospitalised in psychiatric facilities under the involuntary mental health care provisions of the MHCA. It is important to note that the denial of the right to vote for

people admitted as involuntary mental health care users is the prescription of the Electoral Act No. 73 of 1998 and not necessarily the consequence of coercive treatment. However, the prescription of coercive treatment is legislated in South Africa through the MHCA, and it is the use of this legislation that deprives the people receiving coercive treatment their right to vote. If coercive treatment were to be abolished that would remove a category of people with mental illness, who are categorised as involuntary mental health care users by the MHCA, from falling victim to the deprivation of civil liberties by the Electoral Act No. 73 of 1998.

On the positive side, coercive treatment does give a person with mental illness an opportunity to recover from mental illness and freely exercise his or her civil liberties. Freeman et al (2015:3) argue that “application of an absolute rule of not admitting a person [by coercion] because of mental disability could in some circumstances result in the long-term deprivation of liberty—possibly in a prison—rather than a potentially much short(er)-term “deprivation” in a hospital”. Indeed, people with mental illness are likely to end up in prisons where one is deprived of enjoying many rights including the right to liberty and this must be weighed against the harms caused by coercive treatment. The prison system is even more punitive for people with suspected mental illness as they have to be referred to a psychiatric hospital for assessment and determination of the fitness to stand trial and criminal responsibility in terms of section 77 to 79 of the Criminal Procedure Act of 1977 (CPA). The prescriptions of CPA are a fair process but with shortage of psychiatric beds in most cases people with mental illness spend several months in prisons while awaiting forensic psychiatric beds. This detention without trial is by itself inhumane. While efforts should be made to increase the available psychiatric beds for forensic

psychiatric observation, we need to reduce the source of the problem which is untreated mental illness.

4.2.3 Right to dignity and freedom of association

The inhumane and undignified treatment of people with mental illness when they receive coercive treatment especially in resource limited settings was discussed in Chapter 1. It is this harm to one's dignity that makes coercive treatment objectionable. However, a counterargument to that objection to coercive treatment out of respect to the right to dignity is that with better resources the indignity of coercive treatment can be reduced. In addition, coercive treatment including prolonged hospitalisation may be justified to preserve the dignity of the person with mental illness (Ewuoso 2016: 5). "We have a duty – as friends, family and even as a State – to facilitate appropriate and respectful intervention such as involuntary (and sometimes indefinite hospitalization), when a person we love can no longer care for his/her basic needs due to severe mental illness; even when such hospitalization will not lead to recovery" (Ewuoso 2016: 5). While this research report has focused on the benefits of early pharmacological interventions in mental illness there are benefits to chronic care that are not the result of the biological treatment but the protection of one's dignity when they can no longer care for themselves. The psychosocial interventions in chronic care in people with SMI may include prolonged hospitalisation without the consent or even against ones will.

With coercive treatment there is an associated loss of the right to bodily integrity. When receiving coercive treatment people with mental illness can be injected with

medications against their will and be forcefully restrained. People receiving coercive treatment may be kept in locked wards against their will or even put in seclusion rooms, infringing on their freedom of movement and association. The prolonged forced hospitalisation as it happens in some cases, with the associated limitation of the freedom of association may have an impact on the person's ability to make friendships and even intimate relationships with the people of his or her choice. Despite all these harms to one's rights caused by coercive treatment, recovery leads to better enjoyment of rights and even when there is no recovery, the treatment has protective factors for one's dignity.

4.2.4 Right to life and health

The medical complications of the use of physical restraints such as physical injuries, deep vein thrombosis and others that were discussed in chapter one is evidence of the infringement of coercive treatment on the right to health and the right to life. As previously mentioned, physical restraints are a component of coercive treatment. The use of psychiatric medications such as some antipsychotics can cause side effects that can put one at risk of illnesses such as obesity, dyslipidaemia, hypertension and type 2 diabetes mellitus in what is often referred to as metabolic syndrome (Carli et al 2021). Some antipsychotics with these side effects are used in coercive treatment especially because they tend to have the side effect of sedation which is beneficial in a MHCU who is agitated because of mental illness and may at times be the only antipsychotics able to treat the mental illness. However, there are "pharmacological and non-pharmacological interventions" that can be implemented

to mitigate this risk of metabolic syndrome but the purpose of highlighting these side effects is to show that psychiatric treatment comes with risks that may harm one's right to health and life. If coercive treatment is to be accepted as permissible it must be shown that its harms on the right to health and life are far outweighed by the benefits of coercive treatment to the person with mental illness.

Coercive treatment protects the right to life in people with mental illness and mental health care improves the quality of life. Without mental health care even the nonaggressive people with SMI who are the focus of this research report are at risk of increased mortality, homelessness, and neglect if they are not treated. In a systematic review and meta-analysis conducted by Walker, McGee and Druss (2015: 339) it was found that "[people with mental disorders have a mortality rate that is 2.22 times higher than the general population" and their life expectancy is reduced by 10 years. Mental health care reduces the risk of mortality related to neglect, homelessness, and suicide thereby reinforcing the right to life. Use of medications such as clozapine and lithium, for instance, have been shown to lower the risk of death by suicide although such medications could potentially increase the risk of metabolic syndrome discussed above (Masdrakis and Baldwin 2023; Del Matto et al 2020). Antidepressant medications do lower the risk of suicide in people with depression, but clozapine and lithium are being specifically mentioned because they are likely to be used in people with SMI which is the group of people who are the subject of this research report. With regards to those with anorexia nervosa, the physiological complications of starvation could result in death. Mental health care and stabilisation of physiological abnormalities that are due to the restriction of food intake in anorexia nervosa ensures that the people with anorexia nervosa enjoy their

right to life. Similar arguments can be provided for the right to health as a justification of coercive treatment as untreated mental illness deprives a person with mental illness that right to health. In addition, mental illness itself is a state of ill-heath and "[i]n the example of psychosis [a symptom found in SMI], we might be undermining the right to health to allow a person to stay in a psychotic state" (Freeman et al 2015:3).

On the balance, psychiatric treatment helps to protect the enjoyment of the right to life by people with mental illness. Coercive treatment as a mechanism of psychiatric treatment in certain cases of mental illness helps to protect the right to life and health of people with mental illness. So, it is not true that considerations about the right to life and health generally count against coercive treatment.

4.3 Conclusion

In this chapter the impact of coercive treatment on human rights has been discussed. When the infringements caused by coercive treatment are weighed against the benefits of coercive treatment from a rights perspective it is concluded that coercive treatment is morally permissible. As discussed in this chapter coercive treatment may deprive one of his or her rights but once the person who is receiving psychiatric treatment recovers from mental illness, he or she is able to enjoy many rights including certain rights that mental illness itself (not the treatment) deprives the person with mental illness. Coercive treatment implemented correctly and humanely

as well as the recovery from mental illness can reinforce the rights of some people with mental illness and allows them to enjoy some rights that the mental illness hinders them from enjoying. So, considerations about rights do not in general count against coercive treatment.

Chapter Five - Conclusion

The conclusion of this research report is that, all ethical issues considered, coercive treatment is morally permissible in some cases of people with mental illness. The harm caused by untreated mental illness to the person with mental illness has been shown and this includes the damage to the brain (neurodegeneration) and its adverse biopsychosocial consequences which are reduced quality of life, homelessness, and neglect. It has been argued that psychiatric treatment including coercion in certain cases has significant benefits but there is an ethical debate that forcing treatment to people may go against the established medical principle of respect for autonomy. However, people with mental illness for which coercive treatment is prescribed lack decisional capacity and therefore their choice to refuse treatment is not autonomous. This conclusion that persons with mental illness sometimes lack decisional capacity is based on two arguments. The first argument is that mental illness may affect one or all the four universally accepted shared elements of decisional capacity. The second argument is that even if the four universally accepted shared elements of decisional capacity are not affected by mental illness there are cases where mental illness makes one to have pathological values and be inauthentic.

While it was argued that coercive treatment can be highly beneficial and need not violate autonomy, there was a remaining concern that considerations about rights may make coercive treatment morally impermissible. In response to this concern, it was argued that coercive treatment can play an important part in preserving the rights to equality, health, life, freedom of choice, freedom of movement, liberty and

dignity. Upon weighing the infringements of coercive treatment on these rights and the positive impact of psychiatric treatment in protecting these rights, even if it is after a temporary period of their violation by coercive treatment measures, it has been argued that considerations about rights need not count against coercive treatment. When it comes to the protection of one's dignity and the right to life, even prolonged hospitalisation may be morally permissible.

In summary, this research report has argued that coercive treatment has significant benefits when appropriately prescribed, need not violate autonomy and it is not ruled out by the considerations of rights. So, coercive treatment will sometimes be, all things considered, morally acceptable. This argumentation of this research report has some limitations. The argument about the protection of the right to life in this research report, while compelling, has some risks and controversies as it can be abused in medicine if taken too far as it can also be argued that people with other medical conditions should receive treatment against their will so that they can enjoy the right to life. The limitation of the overall argument of this research report is the reliance on the acceptance of inauthenticity as that is the reason coercive treatment is applied in some cases of people with mental illness and not applied in people with other medical conditions. A question that has not been explored in this research report is whether people with other medical conditions can be said to be authentic despite the impact of their physical illness to their emotions and even their physical brains.

The arguments in support of coercive treatment will be enhanced by the developments in science that could link our thoughts, emotions and behaviour to

specific neural functions as well as by the arguments that can show that other medical conditions do not affect one's values and authenticity. The value of rationality and mental health also needs further exploration.

While this research report has argued in support of coercive treatment, this treatment should be prescribed to specially selected cases where other more humane interventions have failed. This view is supported by the fact that the World Psychiatric Association (WPA) has raised concerns about coercive treatment but has not argued that it should be abolished (Herrman et al 2022). WPA has argued for the middle ground by calling for the "implementation of alternatives to coercion" in psychiatry as "an essential element of the broader transition across the mental health sector toward recovery-oriented systems of care" (Herrman et al 2022). The overall argument of this research report supports this position of the WPA as it indicates that coercive treatment is sometimes morally justified, but only after careful consideration of the benefits and harms to the person with mental illness, his or her rights and his or her capacity to make an autonomous decision.

References

Accordino, M. P., Porter, D. F., & Morse, T. (2001). “Deinstitutionalization of persons with severe mental illness: Context and consequences”. *Journal of Rehabilitation* 67(2):16-21.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA: American Psychiatric Association.

Beauchamp TL and Childress JF (2019). *Principles of biomedical ethics, Eighth Edition*. New York: Oxford University Press.

Bolton D and Banner N (2012). “Does mental disorder involve loss of personal autonomy?” In *Autonomy and mental disorder*. Ed. L. Radoilska. New York: Oxford University Press, pp.77-99.

Bora, E., Yalincetin, B., Akdede, B. B., and Alptekin, K. (2018). “Duration of untreated psychosis and neurocognition in first-episode psychosis: A meta-analysis”. *Schizophrenia Research* 193:3-10.

Braslow J.T. (1995). “Effect of Therapeutic Innovation on Perception of Disease and the Doctor-Patient Relationship: A History of General Paralysis of the Insane and Malaria Fever Therapy, 1910-1950”. *Am J Psychiatry* 52(5):660-665.

Carli M., Kolachalam S., Longoni B., Pintaudi A., Baldini M., Aringhieri S., ... & Scarselli M. (2021). “Atypical antipsychotics and metabolic syndrome: from molecular mechanisms to clinical differences”. *Pharmaceuticals* 14(3): 238.

Chieze M, Clavien C, Kaiser S and Hurst S (2021). “Coercive Measures in Psychiatry: A Review of Ethical Arguments”. *Frontiers in Psychiatry* 12:1-16.

Childress JF (2012). “The place of autonomy in bioethics”. In *Arguing About Bioethics*. Ed. S. Holland. New York: Routledge, pp. 308-316.

Christman J (2020). "Autonomy in Moral and Political Philosophy". *The Stanford Encyclopedia of Philosophy*. Ed. E. N. Zalta.

Clausen, L., & Jones, A. (2014). “A systematic review of the frequency, duration, type and effect of involuntary treatment for people with anorexia nervosa, and an analysis of patient characteristics”. *Journal of Eating Disorders* 2(1):1-10.

Cohen A., Chatterjee S., and Minas, H. (2016). “Time for a global commission on mental health institutions”. *World Psychiatry* 15(2):116.

Cotter J, Zabel E, French P, Yung AR (2017). “Prolonged duration of untreated psychosis: a problem that needs addressing”. *Early Interv Psychiatry* 11(3):263-268.

Crawford T. A. and Lipsedge M. (2004). “Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine”. *Mental Health, Religion & Culture* 7(2):131-148.

Dell'osso B. and Altamura A.C. (2010). “Duration of untreated psychosis and duration of untreated illness: new vistas”. *CNS Spectr.*15(4):238-46.

Docrat S., Besada D., Lund, C. (2019). *An evaluation of the health system costs of mental health services and programmes in South Africa*. Cape Town: Alan J Flisher Centre for Public Mental Health, University of Cape Town.

Domino E.F. (1999). “History of modern psychopharmacology: a personal view with an emphasis on antidepressants”. *Psychosom Med*.61:591–598.

Drew N., Funk M., Tang S., Lamichhane J., Chávez E., Katontoka S., et al (2011). “Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis”. *The Lancet* 378(9803):1664-1675.

Elzakkers, I. F., Danner, U. N., Hoek, H. W., Schmidt, U., & van Elburg, A. A. (2014). “Compulsory treatment in anorexia nervosa: A review”. *International Journal of Eating Disorders* 47(8):845-852.

Ewuoso, C. O. (2018). “Beneficial Coercion in Psychiatric Care: Insights from African Ethico-Cultural System”. *Developing World Bioethics* 18(2):91-97.

Eyal N. (2019). "Informed Consent". The Stanford Encyclopedia of Philosophy, Spring 2019 Edition, Ed. Edward N. Zalta.

URL: https://plato.stanford.edu/archives/spr2019/entries/informed-consent/.

Freeman M. C., Kolappa K., de Almeida J. M. C., Kleinman A., Makhashvili N., Phakathi S., et al (2015). “Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities”. *The Lancet Psychiatry* 2(9):844-850.

Grisso T. and Appelbaum P.S. (1998). *The Assessment of Decision-Making Capacity: A Guide for Physicians and Other Health Professionals*. Oxford: Oxford University Press.

Gylling H. A. (2004). “Autonomy revisited”. *Cambridge Quarterly of Healthcare Ethics* 13(1):41-46.

Hawkins J and Charland LC, "Decision-Making Capacity". *The Stanford Encyclopedia of Philosophy (Fall 2020 Edition)*. Ed E. N. Zalta.

Herrman, H., Allan, J., Galderisi, S., Javed, A., & Rodrigues, M. (2022). “WPA Task Force on Implementing Alternatives to Coercion in Mental Health Care. Alternatives to coercion in mental health care: WPA position statement and call to action”. *World Psychiatry* 21:159-60.

Hewitt J. (2010). “Schizophrenia, mental capacity, and rational suicide”. *Theor Med Bioeth* 31:63–77.

Insel T. R. (2008). “Assessing the economic costs of serious mental illness”. *American Journal of Psychiatry* 165(6):663-665.

Jones, P. (2013). “Adult mental health disorders and their age at onset”. *The British Journal of Psychiatry* 202(S54): S5-S10.

Kelly R. E., Ahmed A. O., Hoptman M. J., Alix A. F., and Alexopoulos G. S. (2022). “The Quest for Psychiatric Advancement through Theory, beyond Serendipity”. *Brain Sciences* 12(1):72.

Kulkarni P., Bhattacharya S., Achuthan S., Behal A., Jolly M. K., Kotnala S., et al (2022). “Intrinsically disordered proteins: critical components of the wetware”. *Chemical Reviews* 122(6):6614-6633.

Lazarus R. (2005). “Managing de-institutionalisation in a context of change: The case of Gauteng, South Africa”. *African Journal of Psychiatry* 8(2):65-69.

Lehrer, D. S., & Lorenz, J. (2014). “Anosognosia in schizophrenia: Hidden in plain sight”. *Innovations in clinical neuroscience* 11(5-6): 10-17.

Liégeois A. and Eneman M. (2008). “Ethics of deliberation, consent and coercion in psychiatry”. *Journal of Medical Ethics* 34(2):73-76.

Makepeace R. (1969). “The History of Psychiatry in South Africa”. *Canadian Psychiatric Association Journal* 14(2):221-222.

Matthews E. (2000). “Autonomy and the Psychiatric Patient”. *Journal of Applied Philosophy* 17(1):59-70.

Murru A. and Carpiniello B. (2018). “Duration of untreated illness as a key to early intervention in schizophrenia: a review”. *Neuroscience letters* 669:59-67.

Pereira V. S. and Hiroaki-Sato V. A. (2018). “A brief history of antidepressant drug development: from tricyclics to beyond ketamine”. *Acta neuropsychiatrica* 30(6):307-322.

Radiolska L (2012). “Introduction: personal autonomy, decisional capacity, and mental disorder”. In *Autonomy and mental disorder.* Ed. L. Radoilska. New York: Oxford University Press, pp. ix-xli.

Sjöstrand M., and Helgesson G. (2008). “Coercive treatment and autonomy in psychiatry”. *Bioethics* 22(2):113-120.

Shah R., and Basu D. (2010). “Coercion in psychiatric care: Global and Indian perspective”. *Indian Journal of Psychiatry* 52(3):203-206.

Simmons M., Hetrick S., and Jorm A. (2010). “Shared decision-making: benefits, barriers and current opportunities for application”. *Australasian Psychiatry* 18(5): 394-397.

Sones A. C., Fogelson D. L., Glick I. D., and Shader, R. I. (2022). “Untreated Mental Illness Has Created a National Tragedy: A Pandemic of Homelessness”. *Journal of Clinical Psychopharmacology* 42(2):115-117.

Stahl SM (2021). *Stahl’s Essential Psychopharmacology: Neuroscientific Basis and Practical Applications, Fifth Edition*. New York, NY: Cambridge University Press.

Stein D.J. (2021). *Problems of living, Perspectives from Philosophy, Psychiatry and Cognitive-Affective Science*. San Diego, CA: Academic Press.

Stone A. (1975). “Mental Health and Law: A System in Transition”. Rockville, Maryland: National Institute of Mental Health.; p.37.

South Africa. Criminal Procedure Act No. 51 of 1977.

URL: https://www.justice.gov.za/legislation/acts/1977-051.pdf

(Accessed 12 March 2024)

South Africa. Electoral Act No. 73 of 1998.

URL: https://www.gov.za/sites/default/files/gcis_document/201409/act73of1998.pdf

(Accessed 12 March 2024)

South Africa. Mental Health Care Act No. 17 of 2002.

URL: https://www.gov.za/sites/default/files/gcis_document/201409/a17-02.pdf

(Accessed 19 March 2022)

United Nations (2006). Convention on the Rights of Persons with Disabilities and Optional Protocol.

URL: https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

(Accessed 19 March 2022)

Walker E. R., McGee R. E., & Druss B. G. (2015). "Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis". *JAMA psychiatry* 72(4): 334-341.

Wickremsinhe M. N. (2021). "Global mental health should engage with the ethics of involuntary admission". *International journal of mental health systems* 15(1):20.