Mental Health and Human Rights: In Search of Context, Consequence and Effective Care

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Introduction

An examination of the treatment of the mentally ill reveals a history marked by both state and personal abuse and neglect. In the Soviet Union, psychiatry has been used as an instrument of repression (Cohen, 1989; Fireside, 1979) and in the West proponents of the anti-psychiatry movement and other social advocates have ubiquitously reported institutional abuses (Belknap, 1956; Dunham & Weinberg, 1960 cited in Scull, 1981; Goffman, 1961; Rosenhan, 1973). These occurrences are not merely isolated to other countries but have been reported in South Africa (APA, 1979 and WHO, 1977 cited in Haysom, Strous & Vogelman, 1990; Saspu, 1982; Weekly Mail, 1991a; 199lb). Although this points to a lack of fundamental human rights for the mentally ill, a comprehensive understanding of rights in this area has not been clearly documented. Rather many polemic conceptualisations have been postulated, each with their own strengths and limitations.

This paper examines the concept of human rights in the area of mental health. This will be achieved through:

- A brief examination of the shift from institutionalisation to community care and the violation of human rights that occurred in the process.
- Defining the concept of human rights in the field of mental health.
- A discussion of the hegemonic medical approach to mental health and the undermining of human rights that followed.

- A brief focus on the role of the socio-political context in the understanding and distribution of human rights.

These areas of discussion are used as a framework for the development of a human rights approach to mental health. It is argued that in order for human rights to be ensured in the field of mental health, the nature of a right needs to be explored. In addition, the interface between medicine and mental health needs to be investigated. Finally, it is forwarded that human rights and mental health are contextual. Human rights are always granted or withheld within a specific socio-political context. Accordingly, the provision of rights relies on dominant ideologies (state- or sector-based) and are restricted by the availability of material resources. It is the appreciation of this context, and the consequences of change within it, that will provide an understanding of substantive mental health rights in South Africa.

Importantly, the paper focuses predominantly on the move from institutionalisation to community-based psychological and psychiatric care. Underlying this paper is the belief that the most effective treatment model for the mentally ill exists in the development of an expansive mental health-care service in the community. As a result, it concentrates on the notion of substantive human rights of the mentally ill rather than procedural rights or the 'due process of the law'. This is not to argue for an artificial split of the various rights pertaining to the mentally ill, but rather for a specific understanding relevant to community psychiatric and psychological mental health care. Although the authors are acutely aware of human rights abuses within institutional care, and mention is made of these, the present paper chooses to focus on community care as one branch of future mental health care services in South Africa.

The Anti-Psychiatry Movement and the Move to Community Care

Over the past few decades there have been fundamental shifts in the major treatment modalities of psychology and psychiatry.[1] In combination with psychotropic medication (Castel, Castel & Lovell, 1982), the realisation of the increasing costs of institutionalisation (Castel *et al.*, 1982; Lamb, 1985; Rehin & Martin, 1968) and the anti-psychiatry campaign there has been a shift towards deinstitutionalisation. This occurred predominantly in the United States and the United Kingdom. The effects of deinstitutionalisation were quite visible and in the United States alone the patient population in state psychiatric hospitals decreased from 558 000 patients to 193 000, between 1955 and 1975 (Castel et al , 1982). This represented an effective decrease of 65,5% over a twenty year period (Castel *et al.*, 1982). State hospital beds were reduced from 339 per 100 000 population to 41 (Lamb, 1993).

At the forefront of the human rights struggle in the 1960s were the proponents of the anti-psychiatry movement (Cooper, 1972; Goffman,1961; Goffman, 1963; Laing, 1967; Scheff, 1966; Szasz, 1960; Szasz,1983) who gave voice to a growing awareness and protest of the abuses and inefficiencies perpetrated in the name of mental health. Based upon a libertarian idea of human rights, aiming at allowing people the right to health and liberty, this perspective has traditionally attracted human rights activists. Therefore, by attempting to give the mentally ill their rights and freedom, mental health professionals took on a role of civil advocacy.

This shift unwittingly planted one of the seeds for the birth of the community psychiatry and psychology movement that was to occur several years later. This movement was founded in the belief that individuals are best understood and treated within their communities.

Although this community psychological approach orientated towards utilitarian welfare maximisation and a legalised human rights approach emphasising legal change, the deinstitutionalisation movement floundered (Hirschowitz *et al*, 1976). Ahmed *et al* (1976) indicated that the major issue in deinstitutionalisation was that communities could not absorb the sudden influx of discharged patients. In most cases, particularly in the West, communities did not have the human resources or infrastructure to cater for this overload.

Having been essentially custodial, the responsibility for care has shifted to being primarily community- and family-based, often placing the person back in the very context that has contributed to their breakdown. In South Africa this situation is exacerbated by the disintegration of the nuclear family and by the overwhelming social stressors that impinge upon the family; affecting their capacity to care for a family member who is mentally ill.

Scull (1989) argues that deinstitutionalisation only reflected the hopes of a community-oriented health care system and not the uncomfortable reality of having to invest energy and expense in its development. The result has been that just as human rights abuses have been committed in institutions, so too have the rights of discharged patients been transgressed. Many have been sent into under-resourced communities and been abused, stigmatised and marginalised within their very own communities.

The Concept of a Human Right and Mental Health

For the purpose of this paper the concept of a right is defined as a morally permitted or prohibited social or personal action, the purpose of which is to provide just and fair treatment to which individuals are entitled. Human rights can be divided into substantive and procedural rights. Substantive rights consist of a broad range of rights including political, economic, cultural, personal and social rights (Carpenter, 1987). Procedural rights concern how justice is administered and the processes that should be undertaken to ensure these rights are maintained.

Although the 'process of the law' concerning the mentally ill is not the focus of the paper, it is important to note that it is a crucial area concerning the rights of the mentally ill. This includes issues relating to the confinement of the mentally ill, the right to refuse treatment, and the control, responsibility and accountability of the mentally ill for criminal activity.

Haysom *et al* (1990) provide a useful account of the involuntary confinement of the mentally ill and the legal process by which persons can be imprisoned and institutionalised. They discuss the loss of liberty, the loss of right to refuse medication and the difficulties in definition of mental illness, diagnosis and opinion of medical practitioners in this essentially administrative procedure. In summary, several conclusions can be drawn. Namely, that the present Mental Health Care Act of 1973 medicalises the committal process, undercuts the patients' ability to resist treatment and confinement and that this has been established by linking the diagnosis and treatment of the physically ill with those deemed mentally ill (Haysom *et al*, 1990). In addition, it is suggested, noting the difficulties of diagnosing in psychiatry, that the judiciary should not:

Be involved in taking medical decisions, but the due process elements could and should be incorporated into the process. (Haysom *et al*, 1990, p.351)

In turning our attention to the substantive rights of the mentally ill, particularly concerning rights to liberty, freedom and life, Freidman (l97l) maintains that the idea of a right normally implies two parties. This may be the individual making claim from the state or, more broadly, from any other person or party. In absolute terms this claim is unlimited and those entitled to it can make unequivocal demands to their claim. In reality, however, resources are limited. More specifically, limitations in terms of claiming human rights exist for the psychiatrically ill. The stigma of psychiatric illness, the specific location of the patient (for example, in an institution or marginalised within a society) and the actual nature of the psychiatric condition often result in the patients themselves being offered little space for asserting social power.[2]

The development of a comprehensive Bill of Rights is one crucial step in the move towards a democratic infrastructure in South Africa.[3] However, the notion of rights can often be ethereal and intangible. Typically the delineations of rights assume an abstract form or are not clearly documented in the bill or charter that is supported and enforced by stringent legislation. For example, children have a right not to be abused. Ideally, this right has to be enforced by the state. To this end, severe legislation is passed to deter offenders and reduce the incidence of these abuses.[4] Here, the relationship between a right and the enforcement of that right is primarily legal. In a more philosophical sense, rights, in their absolute form, should have no limits and be part of social conscience. However, in certain

areas the implementation of rights depends on various laws and institutions, be they public or private.

The number of people suffering from a mental disorder in South Africa is estimated at five million with 330 000 of these suffering from a seriously incapacitating disorder[5] (Freeman, 1989). These people require a broad spectrum of assessment and intervention procedures. Our view refutes the notion of mental illness as purely a social construct or 'myth' (Szasz, 1960). Mental health-care workers are confronted by people who are experiencing real psychological distress. Freeman (1988) says that one "cannot sit back and wait to see what political and economic changes occur" (p.42). This statement may be broadened to include judicial changes. The health professional must play an active part in implementing these changes. However, responsibility to those in distress should not be overlooked.

The mental health movement needs to learn from the mistakes that were made as a result of the deinstitutionalisation processes overseas. By attempting to facilitate the absolute human rights of the mentally ill, advocates of the anti-psychiatry movement in effect legitimised community treatment not by fully demonstrating its merits but rather by rendering the already existing institutional alternatives unthinkable (Scull, 1989). This one-sided focus on individual liberation as an absolute human right has in fact resulted in the violation of human rights. Although the humanising effects of deinstitutionalisation are acknowledged, simple freedom can result in a "life filled with intense anxiety, depression and deprivation, and a chaotic life on the streets" (Lamb, 1985, p.66). Deinstitutionalisation was spawned to unshackle those chained to a barbaric system of 'care' which isolated them from broader society. In essence, the attempt to liberate individuals (without adequate community services) has resulted in a similar alienation preventing them from obtaining vital social support that enhances a sense of community and improved mental health.

More specifically, in the area of mental health the relationship between a right and its enforcement is primarily economic. Although political pressure by the anti-psychiatry movement with its focus on absolute rights was the philosophical cornerstone of deinstitutionalisation (Lamb, 1985), governments supported the process because of the dramatic cutbacks in budgetary considerations that it allowed. Under the guise of humanitarian reform, these governments facilitated an exodus from institutions into inefficient and cheaper underdeveloped community services. The proponents of the anti-psychiatry movement did not operate in a vacuum but were located in an era where social institutions were being questioned. By attempting to redress social imbalances they entrenched an absolute human rights position. In South Africa with the current political changes and the focus on reform a similar tragic process may be set in motion.

The translation of rights for the mentally ill ultimately entails the provision of human and material resources that require enormous financial expenditure. This corresponds with a view that considers the fact that rights have a social or economic value, and that social constructs used to administer these rights are limited in supply. From a humanitarian

perspective the right to mental health-care should not be limited. However, reality dictates that such care is compromised. In South Africa there exist many areas, such as education, which have been grossly neglected and require urgent attention. A central focus in ensuring the rights of the psychiatrically ill is how health-care can best be provided in a country of limited financial resources.

Regarding mental health policy in a future South Africa, the provision of rights needs to fall within the domain of state responsibility. Many private health-care facilities exist and may continue to exist in the future but it is only the state that can legislate changes in the present health-care system to benefit the whole population. In addition, having located the discussion of human rights for the mentally ill within an economic context, it seems that the private sector has sufficient resources to ensure its own implementation of rights. This is seen in other areas in which the wealthy can purchase adequate health-care on a 'fee-for-service' basis. For most of the population, mental health-care is elusive and the provision of this requires state legislation and a national health-care service.[6] (Broomberg & Price, 1989; De Beer & Broomberg, 1990; Freeman, 1992).

Thus, in summary, deinstitutionalisation held the promise of freeing the mentally ill from institutional abuses. However, it resulted in the neglect of the mentally ill, removing them from the confines of psychiatric facilities and placing them on the streets. In essence, it is argued that an effective community-based psychiatric care system would bolster the substantive human rights of the mentally ill. However, the process towards this community-based system needs to be undertaken from a human rights perspective and not only an economic one. In addition, procedural rights need to be simultaneously ensured because of the inadequacy of present psychiatric institutions, and that such legal processes will be necessary in a future health-care network.

The Medical Perspective

Dominant views of medicine and psychiatry are based on the assumption that mental illness occurs because of breakdowns in physiological functioning. Medicine plays a seminal role in our society. The medical ethic is paramount and doctors assume god-like stature with modern medicine representing the panacea for all ills. The right to medical care, while very important, seems to have overshadowed all other rights.

Phares (1984) argues that the present approach to psychiatry is dominated by the medical model. This emphasises the scientific nature of mental illness focusing on underlying biological causes that operate in the same way as other disease processes. This has led to 'physical treatments' such as psychotropic medication and electro-convulsive therapy (ECT). Although these have replaced previously barbaric forms of psychiatric custodianship, for many they represent even more insidious forms of social control (Heather, 1976).

Many writers (Laing, 1967; Szasz, 1960; 1980) have embraced the notion that the psychiatric profession act as society's watchdog. It is easier to conceive of the criminal requiring control and restriction. They break the written laws of society. Although the symptoms of mental illness do not contravene these laws, the mentally ill are often perceived as undermining what it means to most individuals to be human. Those who are mentally ill see visions and hear voices which no-one else can see or hear, they disagree with the emotional context of most events, they are excessively withdrawn from social intercourse, and may experience intense emotion without appropriate stimulation (Cochrane, 1983). According to the medical perspective, this behaviour is located in the person's biochemistry and requires aggressive medical intervention so that 'faulty neurotransmission can be set straight.'

Furthermore, this perspective fails to take account of the subtle dynamics involved in healing. It is one thing doing surgery on a person who remains comatose throughout and whose prognosis depends almost exclusively on the skill of the surgeon. When it comes to mental illness the patient becomes an interactive partner whose own views and beliefs strongly affect the treatment outcome. This introduces a further right of the mentally ill, namely the right of the patient to choose a suitable treatment. A person suffering with cancer who refuses chemotherapy in favour of a macrobiotic diet may be seen, in some quarters, to be exercising the right to maintain a certain quality of life. This is quite different for the mentally ill who are regarded as 'sick in the mind' and thus unable to know what treatment is in their best interests.

This position is leading to the isolation and rationalisation of other healing approaches, such as traditional healing. This is detrimental, given the already meagre distribution of resources in the field of mental health. Collaboration, integration and co-operation between Western doctors and traditional healers is necessary for the provision of an effective mental health-care system.[7] (Allwood, 1986; Edwards, 1986; Freeman and Motsei. 1992; Gillis, 1987; Holdstock, 1989; Robbertze, 1980). Consequently, it is the responsibility of the state to incorporate these approaches into such a system. Unfortunately, the present state of affairs approximates a paternalistic colonial position in which certain statutory and professional bodies have insisted upon the promotion of a scientific ethic. This attempts to 'educate' people seen as clinging to 'less sophisticated' systems of understanding.

Gillon (1986) suggests that these dynamics operate as a result of a hidden agenda in the relations between medicine and society. These are summarised into the following:

- There is a contribution of social factors to the causation of disease, illness, health and well-being.
- There is a contribution of social factors to doctors' attitudes about a wide range of issues.

- There is a struggle for power between the medical profession and other social groups.

Although Gillon (1986) has kept his analysis to the confines of general medicine, it could be argued that similar hidden agendas exist between the fields of psychiatry, psychology and society. In this light, those considered mentally ill have increasingly become part of an individualised medical approach allied to a complex, bureaucratic judicial system incorporating an excessive network of laws. As a result, current treatment strategies have become the slaves to macro socio-economic policy. These policies have traditionally been allied to the apartheid state structures. In addition, treatment has been curative and urban-based (Berger and Lazarus, 1982; Vogelman, 1986; 1987) which have largely served the privileged white minority whose interests have been served by the core of state policy.

Mainstream psychologists often see their approach as different from the medical model's emphasis on symptomology. However, in reality the differences between these approaches may be quite meagre. Generally psychologists have substituted the location of mental illness in a patient's biology with the patient's history (Cochrane, 1983). The desired treatment outcome, however, remains the same – returning the individual to a conventional way of functioning and to a state of personal comfort (Cochrane. 1983). As a result, it has been the 'cure' of a problem that has been emphasised over the prevention of it (Phares, 1984). This model has come under criticism. It is argued that South African psychology cannot assume its traditional role as a 'repair shop' (Anonymous, 1986), but should incorporate social change and context within the urban and rural dichotomies of the Third World.

Society and Mental Health

In South Africa it has been extensively reported that there is a direct relationship between South Africa's spiralling mental health problems and the socio-political context (Anonymous, 1986; Bassa et al, 1984; Berger *et al*, 1987; Dawes, 1985; Straker, 1988; Swartz *et al*, 1984; Vogelman, 1986.). Poor living conditions, work alienation, racial and gender discrimination and excessive violence are predisposing and precipitating factors in the development of mental health problems (Vogelman, 1987). Dawes (1985) has shown psychopathology to be higher in areas of social disadvantage. This points to deficits in primary, secondary and tertiary prevention. Brown and Birley (1970 cited in Brown *et al*, 1972) argue that the onset of florid psychotic symptoms is preceded by a significant change in the patient's social environment. In South Africa it has been said that 80% of patients have some precipitating life event before a psychiatric breakdown (Zwi, 1993). Accordingly, mental illness exists and is cultivated and triggered by social conditions.

In this view mental illness does not equal physical illness. Although the medical position assumes that the physical reality is all-encompassing and determining, one need not look further than conditions such as tuberculosis to see that so-called 'physical' illnesses have psychological as well as social sequela. With physical illness the body is ailing and pathology is located within it. In contrast, mental illness typifies behaviour as a "conflict" with societies' view of what it means to be mentally healthy. This view is expressed by Szasz (1983) who claimed that any deviation from the psychological norm in Western society is often labelled mental illness. However, the anti-psychiatry movement took this view of mental illness as a deviation from the norm one step further and argued that mental illness was merely a social construct. These claims, however, have been appropriately criticised for failing to take into account the possibility of an organic base to behaviour (Haysom *et al*, 1990) and for the denial of the real psychological distress experienced by individuals. A purist biological perspective may argue that one's psychological state depends on neurotransmission. However, this state is always negotiated through social relations that greatly affect psychological well-being. The perception of psychological illness, its etiology and treatment are all located within a specific milieu. A focus on human rights in the field of mental health requires scrutiny of the social relations intrinsic to society.

Conclusion

For the psychiatrically ill, absolute human rights can only be guaranteed within an ideal political and social order. The consequences of change in this environment have to be understood from a health perspective and the availability of effective mental health-care needs to be assured. It could be argued that when one is dealing with health-care there is no ground for debates surrounding justice and what is a right. Rather, one is dealing with someone's health and care of the individual and how best to do this. The position held is that the rights of the psychiatrically ill can only be attained or understood if it is acknowledged that the context within which one lives is crucial to the distribution, enforcement and understanding of these rights.

The failures of community programmes and the deinstitutionalisation impetus abroad are clear reminders of the dangers of relying on community services without sufficient structures being available. The resulting backlash has caused certain authors to reconsider the efficacy of institutionalisation as preferable to relocating the mentally ill into insufficient community services (Ahmed *et al*, 1976). In this view, hospitals can serve a function and provide sanctuary from the pressures of the world (Lamb, 1985), which can result in improvement and restoration for the patient (Greenblatt *et al*, 1980).

These arguments, like so much of the history of institutional psychiatry, bring us full circle, parallelling the nineteenth-century reform stressing the need for a "humane institution". In reality, however, it is a false assumption to set up the equation: "Community-based versus hospital-based care" (Ahmed *et al*, 1976, p.42). A holistic service delivery system is

characterised by both modalities in which neither shall fall away and both shall continue to be essential components of psychiatric care.

Ultimately the hospital too can be considered part of the community and can have a rehabilitative function in helping people live in a community (Anthony *et al*, 1990). Anti-psychiatric politics and libertarian human rights perspectives have tended to polarise these sites of care unnecessarily. In a developing country like South Africa, all existing resources need to be utilised, including hospital structures. Psychiatric institutions should be available for certified and forensic patients and for limited chronic and protective care (Freeman, 1992). These, however, require regular monitoring by independent public and professional bodies (Freeman, 1992). Comprehensive service delivery should include the facility for brief hospitalisation, although *effective* community treatment is the cornerstone of future mental health care.

One crucial development of these changes has been the increased reliance on out-patient services. This has further taxed an overloaded mental health-care system. Given the vast discrepancy between the number of health-care workers and the people they treat, this has resulted in the increased reliance on a medically-oriented approach to mental illness. Such an approach facilitates quick patient turnovers who are solely dependent upon medication for a rapid reduction of their symptoms. The limitation of such services precludes a thorough analysis of the individual within their own context.

For example, 90% of those patients seen in community clinics in South Africa are treated for psychotic conditions whose symptoms are rapidly decreased by medication. The remaining 10% are treated for anxiety and depressive-related conditions that stem from social factors (Centre for Study of Health Policy, 1990). The contradiction is that in reality 10% of those needing mental health-care interventions have psychotic-related conditions and 90% need intervention in the area of anxiety and depressive conditions.[8] (Centre for Health Policy, 1990). It is this skewed representation that has helped bolster the already hegemonic position of medicine in the treatment of mental illness.

This may have a deleterious influence on treatment outcome as it often places the individual back in the situation that initially contributed to their circumstances. A more effective approach would be to introduce community programmes that may allow for an integration of the individual into their communities. These should pay attention to the "psychological well-being" and empathic care of the individual in their community (Freeman, 1992).

This paper highlights the need for changes in everyday treatment of patients and rejects the 'laissez-faire logic' of the anti-psychiatry movement that implies the less mental health-care services the better. However, the anti-psychiatric movement's stress on the contextual nature of mental illness is considered beneficial. It needs to be acknowledged that the meanings of mental illness are rooted in ethical and legal notions of our culture rather than in specific technical notions (Fingarette, 1972 cited in Haysom *et al*, 1990).

The need to see mental illness as related to a pathological social order and its necessary change are embraced. However, the dismissal of the importance of the individual patient's psychological experience and distress is considered absurd. Ultimately all institutional arrangements are mediated through human action (Inkeles, 1963) and the importance of seeing the individual within a community is considered as important as the need for major socio-economic and political restructuring, which are both crucial in the attainment of the necessary rights of the psychiatric patient.

Notes:

1 Detailed accounts of the history of psychiatry and the birth of the asylum as well as the development of community care may be found in Busfield (1986); Hynum, Porter & Shepherd (1985); Castel, Castel & Lovell (1982); Digby (1985); Lamb (1985); and Scull (1989).

2 This observation was in part confirmed by a study conducted by Hamber (1992). The patients interviewed reported a low level of political affiliation, with 94,9% of the sample unaffiliated to any political organisation. This could be attributed to a lack of social integration resulting from the individuals pathology and/or social stigma attached to psychiatric illness.

3 It is also important to note that bodies of principles aimed at the protection of the mentally-ill are crucial. These can include inclusions in various constitutions, bills of rights, charters and other documents. Specific documents like the Charter of Needs and Demands (1987) tabled at the National Conference of Psychiatric Survivors, The Disability Rights Charter distributed by Lawyers for Human Rights, the Charter of Rights for People with Mental Handicap provide useful examples and guidelines.

4 Severe discrepancies exist between law and justice, and law enforcement does not necessarily translate into the reduction of criminal activities. In addition, the court system is heavily burdened and is unable to cope with matters requiring attention. However, a more in-depth discussion of these factors is beyond the scope of this paper.

5 It is important to note that no formal statistics representing the numbers of mentally ill are available in South Africa. The prevalence of mental disorders is difficult to gauge. Often the dividing line between a disorder and health is blurred, for example is a person who is "healthy but unhappy" someone with a mental disorder (Freeman. 1992). These figures are calculated by taking the World Health Organisation's estimate of 1% of any population being likely to suffer from a serious incapacitating mental disorder at any time, and 10% of the population being likely to suffer from a serious me

ntal disorder in their lives (WHO. 1975 cited in Freeman, 1989).

[6] Debates concerning the formation of a National Health Service, and particularly National Health Insurance. are beyond the scope of this paper, see Broomberg & Price (1989); De Beer et al, (1988); De Beer & Broomberg (19%); Freeman (1989) and Freeman (1992).

[7] It is important to note that the question of the integration of traditional healers is a complex one Issues like the cost would need to be evaluated (Neuman & Lauro, 1982) and various alternatives, advantages and disadvantages of linking modern and traditional health-care systems would need to be considered (cf. Freeman and Motsei, 1992).

[8] Freeman *et al* (1983 cited in Freeman, 1992) noted that South Africa has nearly double the number of psychiatric beds to population rate than is recommended in Europe. Together with minimal community services or care for non-psychotic conditions indicates that services are outmoded and focus on custodial care (Freeman, 1992). In turn it is held that the very notion of custodial care and its focus on psychotic disorders results in the medicalisation of mental health in South Africa.

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