Brief Overview of Mental Health Law, Ethics, and Suicidology

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A broad concept of health

- The right to health recognizes that both health care and social conditions are important parts of health.
- These include factors such as gender, age differences and resource distribution, poor sanitary conditions as well as events that may damage health such as violence and armed conflict.
- The right to health is related to other human rights such as the right to food, housing, education, and safe working conditions.

WHAT IS THE RIGHT TO HEALTH?

- Not a 'right to be healthy'
- The right to health is not a right to be *healthy*. The state cannot provide people with protection against every possible cause of ill health or disability such as the adverse consequences of genetic diseases, individual susceptibility or the adoption of unhealthy lifestyles.
- Nor is it a limitless right to receive medical care for any and every illness or disability.
- It is a right to the enjoyment of a variety of facilities and conditions that are necessary for good health.
- These can be divided into two basic components:
- Those related to *health care* and
- Those related to *general living conditions affecting health*, such as safe water, food, sanitation and shelter.
- More specifically, the right to health can be understood as a right to an effective and integrated health system, encompassing health care and other determinants of health.

The Right to Health v Mental Health

- The right to health does not differentiate between mental and physical health. They are both central to human wellbeing. In reality, this is not often recognized.
- Despite the significant social and economic burden of mental illness, provision for mental health often comes a very poor second to physical illness.
- Mentally disordered individuals are often subject to multiple inequities, and to significant burdens of stigmatization and marginalization.
- In many parts of the world, there are disproportionate restrictions on the freedom of the mentally disordered.
- In the absence of resources, harsh restraint is used. Realizing the right to health means refusing to discriminate against the mentally ill patients

Mental Health

- Most countries have legal mechanisms that are designed specifically for people with mental disorders
- In England this is the Mental Health Act 1983 and The Mental Health Reform Act 2005
- In South Africa it is called the Mental Health Care Act 2002
- These Acts have two main functions:
- 1. They enable the State to enforce hospital admission for the assessment and treatment of patients with mental disorder that go beyond the common law
- 2. They provide mechanisms for the protection of mental health patients, including appeal mechanisms, designed to ensure that those powers are not abused

Why do we need powers that go beyond the Common law in Mental Health Cases

- Under Common law a competent adult or person can refuse treatment- this should protect the individual by exercising his right to autonomy
- If the patient is incompetent he can be treated in his own best interests- right?!
- So why do we need anything more for people with mental disorders?
- The problem is that the common law anticipates that sooner rather than later, the temporarily incompetent adult will regain competence and exercise their freedom of choice
- However a patient with mental disorder may remain incompetent for prolonged periods of time-without regaining insight, and therefore would be unable to exercise his/her right to autonomy
- Such patients are therefore deserving of further protection by special laws?!

Adults without Capacity

- *" The imposition of medical treatment, without consent of a mentally competent adult patient, would interfere with a persons physical integrity in a manner capable of engaging the rights protected ….under Art 8 (1) of the Convention. (ECHR)"*

Fluctuating Capacity

- **A patients capacity may fluctuate and if so, this may mean that he or she effectively lacks capacity where there is a need to submit to regular treatment**
- **in *Re D* where D suffered from long standing psychiatric illness and was found to lack capacity to take decisions and exercise judgment with regard to his medical treatment**
- **Independent psychiatric evidence concluded:**

"On consideration I find the patient lacks capacity, Although I believe he can at times understand the purpose and nature of his proposed treatment at considerable extent at others, I consider his appreciation and his understanding is critically defective and he is unable to retain information and weigh it in the balance. In circumstances where he needs to to submit regularly and reliably to treatment, such fluctuating capability effectively means he lacks capacity"

Clinical Trials in Mental Health- A Case Study

- DR Dee, PhD, is a psychiatric researcher at a university hospital. His main area of research is the quality of life of patients diagnosed with severe mental disorders. Over the years, he has heard many stories from patients who have participated in clinical trials at his hospital.
- Two scenarios have come up more than once and caused him great discomfort.
- First, some patients reported relapsing or severely declining during a trial. They failed to go to their scheduled follow up visits, effectively dropping out of the study. Because of this, they received no monitoring or follow up treatment.
- One patient said his friend actually tried to kill himself when he was “off everyone’s radar screen.”

Case Study continued

- Second, some patients who relapsed reported that they suffered severe consequences. Some lost their jobs and subsequently their housing. One patient in particular reported how he lost his job as an accountant and ended up living on the streets for 3 months until his ex-wife found him and brought him into treatment.

- Dr. Dee is a member of his hospital's Research Ethics Committee (REC). At one meeting when the REC was reviewing a placebo-controlled trial of a new anti-psychotic medication, he recommended that the REC adopt two new protections for patients with severe mental disorders who enter into any clinical trial that includes a risk of relapse (thus any trial that involves washout, placebo controls, or switching medications).

Case Study- New Proposals

1. The informed consent form and discussion should disclose not only the risks of relapse, but also the possible consequences of relapse including: loss of employment and housing, stigma, and difficulty becoming re-stabilized.
2. All outpatient enrollment should require the consent of the participant to contact a third party (friend, family member, or other who provides social support) in case the participant misses two consecutive follow up visits or leaves the study.

- The purpose would be to facilitate follow up care for individuals, who will no longer be monitored by the researchers and may need treatment. The third party would be required to sign an agreement stating that he or she is willing to be contacted by the researchers and is willing to try to locate the participant and assist the participant in finding treatment if necessary.

Case study- Discussion

- Most of his colleagues in psychiatry are upset by this proposal because they think it exaggerates risks and will unnecessarily and unfairly exclude patients from participating if they lack the same support system that others have. They note that people might be reluctant to be a contact person if they are asked to sign something, which could put them at legal risk.
- *If you were a member of the REC, would you vote to support the routine use of either or both of these additional protections? Why or why not?*

Case study- “The universe will grant you a miracle cure”

- Twenty years ago, Roger was diagnosed with schizophrenia, paranoid type. Over the years he has undergone many types of treatment with varying degrees of success.
- Roger found that although the treatments reduced his symptoms, often the side effects were more than he could bear. So he would take himself off medication and his schizophrenic episodes would return.
- At times Roger is so worn out by frightening all-night psychotic episodes that he considers suicide; but he still resists going back on medication.

‘The universe’

- Lately Roger has been feeling a lot better. He hasn’t had an episode in a month and his mind feels “clear”.
- He has even been able to work on the next chapters of his mystery novel, which he had abandoned months ago when his episodes were particularly intense.
- Rogers mother, whom he visits regularly, notices his improvement and is delighted. However, they both know that it is only a matter of time before the symptoms return and the disorder consumes his life again.
- Willing to try anything to avoid another episode, Roger decides to visit a psychic to get “advice from the heavens.” His mother is not particularly bothered by Rogers visits to psychics. She’s glad he’s trying to find some source of hope. Upon visiting an astrologer he is advised to seek out an experimental drug and is assured that the “universe will grant him a miracle cure” through this new medicine.

‘The universe’ continues

- Roger leaves the astrologer and heads to the local diner to read the newspaper. On the back page he reads about a Phase II clinical trial of an antipsychotic agent that is enrolling adult patients with schizophrenia.
- Roger immediately contacts the research director at the university-affiliated hospital.
- The researcher explains that this experimental drug is being tested for its efficacy and safety and might not improve his symptoms. The drug has shown modest success in previous trials, but has potentially severe side effects. Roger expresses extreme interest in participating.
- The research protocol involves administering a short assessment of decision-making capacity to all potential participants who are interested in the project.

‘The universe’- Discussion

- Those who are deemed incompetent are either not allowed to participate, or need the permission of a legally authorized surrogate decision-maker in addition to providing their own assent.
- Among other things, the assessment explores understanding of the protocol, appreciation of risks and benefits, and the reasoning processes used to decide whether to enroll.
- The evaluator finds that Roger is not in a psychotic episode and that he understands the risks and benefits extremely well.
- But he is concerned when Roger explains that he is certain he will receive benefits from the study, and that he decided to enroll because an astrologer instructed him to seek out this study.
- *Should Roger be enrolled in the study, and if so, what procedure should be used?*

Mental Capacity/Competence

- In the legal and ethical analysis of treating people against their will a great deal depends on whether the patient is competent or has legal capacity
- Presumption of Capacity- any adult is presumed to have capacity until proven otherwise by acceptable evidence- the onus lies with showing that someone does not have capacity- even if they have a mental illness
- In Re C- A schizophrenic patient refused amputation of his gangrenous leg- The UK Court of Appeal found him mentally competent to refuse amputation- despite his mental illness!! (incompetence in one area does not mean incompetence in all areas- one can only talk of competence to do a particular thing)

Refusal of treatment: Capacity

- Prima facie- every adult has the capacity to decide whether he will accept or refuse any treatment…
- Furthermore it matters not whether he reasons are rational or irrational, unknown or even nonexistent-
- This is so not-withstanding the very strong public interest in preserving life and health of all citizens i.e. constitutional right to life… however this presumption is rebuttable
- an adult may be deprived of this capacity by mental disorder

Determining capacity

- Capacity is ultimately a legal not a medical decision
- **…it is for the court to decide the question of capacity- although the court must pay attention to the evidence of experts in the medical profession who can indicate the meaning of symptoms and give some idea of the mental deterioration which takes place in cases of this kind' (Richmond v Richmond 1914)**
- in practice, courts usually take considerable notice of the doctors assessment of capacity

Children: Assent and Dissent-A case study

- Ryan is a 10-year old boy who was diagnosed with ADHD at age 7. Put on Ritalin at age 8, it was quickly discovered that he did not respond to this medication (about 20-30% of children do not respond). Ryan's physician also prescribed two other medications, Adderall, and dextroamphetamine, to which he also did not respond.
- Ryan has been having many problems in school. Although originally supportive of integrating Ryan into a "normal" 3rd grade classroom (Ryan is repeating 3rd grade), both Ryan's teacher and school principal have recently expressed concern that not only is Ryan not learning, but he is also disrupting other students as well. There have been several complaints from parents of other children.

Assent & Dissent- Continued

- You have been asked to evaluate Ryan.
- You find that Ryan is aware that his inability to pay attention and follow directions creates problems for himself, his family, and his class, but he doesn't want to try another medication. In addition to not helping his hyperactivity and impulsivity,
- Ritalin made Ryan very nauseous, depressed, tired yet unable to sleep, and blurred his vision.
- He also doesn't like taking medicine in general because it makes him feel "different" from the other kids in his class and from his older brother and younger sister. He already is very angry at the fact that he has to repeat 3rd grade.

Children: assent & dissent- Discussion

- You are also the principal investigator (PI) of a randomized controlled trial on Settler, a potential ADHD drug that shows promising results for those children who have not responded to other drugs used to treat ADHD.
- When you discuss enrolling Ryan in the study, Ryan's parents immediately sign the consent form and have very few questions or reservations.
- However, when Ryan is told that he is going to be trying out a new medicine that might work better than the others, he says, "It doesn't matter if it's a new medicine. Medicine makes me sick, and my brother and sister don't have to take it, so I shouldn't have to either." Ryan refuses to sign an assent form.
- Ryan appears to understand the potential benefits and risks of participation, despite his somewhat aggressive manner.
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- *Do you enroll Ryan in the study?*
- *Examine your decision in the Context of current South African law*

SA Laws and Children

- **The Child's welfare is paramount**
- **The child should be treated as a person, not an object of concern- children of sufficient maturity should be listened to (not necessarily be given full power**
- **e.g 14 year old may consent to treatment but may not necessarily be allowed to refuse treatment**
- **Children should be brought up/ protected by parents, without interference by state, except when at risk e.g. (child abuse)**
- **One should avoid delays when legal or urgent medical processes are required**
- **The National Health Act 2003 provides that even if the person does not have the legal capacity to consent, he or she must still be consulted- The Child's assent must be obtained**

Under what circumstances can minors make medical decisions for themselves?

- Minors have the ethical and legal authority to make medical decisions for themselves when they have reached the legal age of majority or become "emancipated."
- Most countries recognize an emancipated minor as a person who meets one of the following criteria:
- self-supporting and not living at home
- married
- a parent
- in the military
- In addition, most states/ countries may allow treatment without parental consent for sexually transmitted diseases, pregnancy, and drug or alcohol abuse.

Children's Assent and Surrogate Decision-Making- A case study

- A researcher is planning to conduct interviews to learn about the relationship between heroin use and high-risk sexual behaviors among street youth ages 12-18.
- He proposes to ask subjects about their knowledge, attitudes, and beliefs about heroin, where they get the drug, how they use it, their sexual practices, and their knowledge and practice of safer sex.
- Access to this population will be gained through locations where the teens hang out, including a youth drop-in center, a coffee shop, a park where they meet to shoot heroin, and a local needle exchange clinic.

Children's Assent and Surrogacy

- While the primary purpose of the research is to gather information, he plans to use the data to design a public health intervention for the same group. He also has made provisions to provide those who are poorly informed about safe sex practices with an informational brochure, and to give every participant referral cards to drop-in addiction treatment centers. While he promises to maintain strict confidentiality, he also plans on informing participants that if they express suicidal intentions he will both refer them to a crisis counseling center and will give their names to a state social worker who will try to get them some help.
- The researcher knows from experience and the literature that many of these teens are homeless, and those who are not often come from abusive or neglectful homes.

Children's assent and Surrogacy- Discussion

- Obtaining parental permission might prove impossible in the case of those teens who are estranged from their parents and difficult or dangerous for those living with their parents.
- The researcher therefore believes that obtaining parental consent is neither feasible nor in the best interests of the adolescents, and he asks the REC for a waiver of parental permission.
- Although the study will ask about private information and illegal activities that could put subjects at risk with the law, he thinks risks associated with the research interview are not greater in and of themselves than those that these teens would ordinarily encounter during the performance of routine physical exams or psychological tests.
- *Should the REC require parental permission? If not, how should permission be obtained? Explore this in the context of SA*

Enforcing Hospital treatment on mentally disordered persons

- There are two main reasons for enforcing hospital treatment on mentally ill patient:
- **1. The first is for the protection of the person himself**
- **2. The second is for the protection of others in society from harm**
- The justification for this is that the mentally disordered person may pose a risk to both himself and others
- Consider that the main mechanism by which society protects itself from those who are dangerous to others is by criminal law!
- However it would be inappropriate to apply this same law to mentally ill patients because, as a result of their mental illness they are generally not responsible for their actions

Grounds for Compulsory detention in Hospital

- Generally there are 3 necessary conditions for compulsory detention in hospital:
- 1. The patient is suffering from mental disorder
- 2. The nature and degree of mental disorder make it necessary for the patient to receive treatment in hospital
- 3. It is necessary either for the health or safety of the patient or for the protection of others, that he or she should be detained in hospital

Who may make application for involuntary care

- An application for involuntary care, treatment, and rehabilitation services may only be made by:
- the spouse, next of kin, partner, associate, parent or guardian of a mental health care user
- Where the user is below the age of 18 years on the date of the application, the application must be made by the parent or guardian of the user
- Where any of the above nominated persons is unwilling, incapable or unavailable to make such application, the application may be made by a health care provider.
- The application may be withdrawn at anytime
- The Mental Healthcare Act also provides that if the head of a medical establishment finds or observes that a detained individual has regained capacity to consent, then he must obtain the persons consent for to continued treatment under inpatient or outpatient care

The Objectives of the SA Mental Health Care Act

- **A. To regulate Mental health Care in a manner that:**
- **1. Makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources**
- **2. Co-ordinates access to mental health care, treatment and rehabilitation services to various categories of mental health care users**
- **3. Integrates the provisions of mental health care services into the general health services environment**
- **B. Regulate access to and provide mental health care, treatment and rehabilitation services to:**
- **voluntary , assisted and involuntary mental health care users**
- **State patients and mentally ill prisoners**

The Objectives of the SA Mental Health Care Act-2

- **C.** Clarify the rights and obligations of mental health care users and the obligations of mental health care providers
- **D.** regulate the manner in which the property of persons with mental illness and persons with severe or profound intellectual disability maybe dealt with by a court of law

The MHCA 2002

- The MHCA 2002 is based on a number of important principles:

1. People with mental health problems are regarded as 'users', since any individual is a potential user of mental health care services.
2. Services should offer care, treatment and rehabilitation to users.
3. The human rights of the mental health care user (MHCU) are not inferior to the welfare of general society.
4. All health care practitioners are also regarded as mental health care practitioners (MHCPs) and should take some responsibility for mental health needs.
5. Mental health care should be fully integrated with primary health care.
6. Users have a right to be treated near to their homes and within their communities, as far as possible.
7. Users have a right to be provided with care, treatment and rehabilitation, with the least possible restriction of their freedom.
8. Users have a right to representation, knowledge of their rights, and the right of appeal against decisions made by MHCPs.
9. Mental health review boards should be created to act as independent 'ombudsmen' concerned with the rights of the user, to review decisions made in terms of the Act, and to respond to and investigate appeals.

The Rights of Mental Care Users

- The Act details the rights of mental health users stating that every user must be provided with care treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential; an to facilitate his or her integration into community life
- The care, treatment and rehabilitation services administered to a mental health care user must be proportionate to his or her mental health status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation
- It makes provision for the establishment by the MEC for Health in each province of at least one Mental Health Review Board

Functions of the Mental Health Review Board

- The Review Board must: Consider appeals against the decisions of a health establishment
- make decisions with regards to assisted or involuntary mental health care, treatment and rehabilitation services
- consider reviews and make decisions on assisted or involuntary mental health care users
- consider 72-hour assessment made by the head of the health establishment and make decisions to provide further involuntary care, treatment and rehabilitation
- consider applications for transfer of mental health care users to maximum security facilities
- consider periodic reports on the mental health status of mentally ill prisoners

The 72-hour observation

- A major responsibility of district hospitals, in terms of the MHCA 2002, is to provide 72-hour admission and observation for MHCUs. This requirement has given rise to many problems, shared by most district hospitals throughout the country, which are very practical in nature and relate to operational aspects of implementing this legal requirement.
- The problems do not relate to the *idea* or *concept* of an observation period, but to their translation into practice.
- In defense of the principle of a 72-hour observation period, there are several good reasons for this practice:

1. The most important is that, within a general medical environment, it allows for exclusion of medical causes of behavioral or psychiatric disturbance.
2. Many users recover sufficiently to be discharged within the first 72 hours (e.g. in substance intoxication or withdrawal, acute trauma, parasuicide and brief psychotic disorders).
3. Unnecessary admission to a psychiatric institution is unfair on users as it may cause humiliation and shame.
4. Many MHCUs can receive care and treatment close to their homes and communities.

Problems in managing 72-hour MHCUs

- The reality of providing 72-hour observations at district hospitals is that most institutions encounter serious problems leading to suboptimal levels of care and occasional disasters, such as:

1. MHCUs heavily sedated throughout the observation period, preventing adequate review.
2. Highly agitated or psychotic MHCUs inadequately sedated and difficult to contain within general ward settings, leading to unsafe conditions.
3. Inappropriate medications or doses of medications used for behavioural control of MHCUs, sometimes leading to iatrogenic problems.
4. Inadequate screening of medical conditions; having been labelled 'a psych patient', the MHCU is thereafter neglected in terms of routine examination and investigation.
5. Failure, at district hospital level, to comply with the requirements of the MHCA 2002 with regard to completion of MHCA forms.

- These problems are generic to district hospitals throughout the country, they relate to the practical implementation rather than the validity of the Act.

Implementing the MHCA 2002- Current Problems at District Level

1. Inadequate facilities for containing disturbed, aggressive MHCUs.
2. Inadequate skills of health workers in managing psychiatric patients.
3. Poor understanding and knowledge of the MHCA 2002 and its forms.
4. Inadequate medications, treatment protocols and guidelines as well as awareness of referral options.
5. The roles of the South African Police Services (SAPS) and

Emergency Medical Rescue Services (EMRS) in respect of the management of MHCUs are not clear, and their involvement is often unhelpful.

Solutions for improving mental health care at district hospitals

- Translating legislation into reality with regard to the care of MHCUs at district hospitals has been difficult owing to practical deficiencies and lack of preparedness at service level.
- Other nations also struggle with the painful realities of implementing legislation within poorly resourced and inadequately prepared circumstances.
- De-institutionalisation in the USA became a politically expedient and necessary project, commencing during the 1960s. Large numbers of chronically institutionalised patients were discharged from psychiatric institutions with little planning or preparation in terms of community services, and many ended up on the streets as homeless people, or in prison.
- In the UK, de-institutionalisation during the 1980s was also difficult, but it was perhaps better prepared with its policy of 'Care in the community'. These mental health reforms have since been further reformed by the UK Mental Health Reform Act 2005
- South Africa is not alone in the often painful task of transforming and modernising legislation and services in accordance with ethical principles of care. Given the real problems encountered in managing MHCUs, what are some of the 'improvisations' possible at district hospital level in SA?

Infrastructure- suggestions

- At least 2% of beds in general wards at district hospitals should be made available for the care of MHCUs.
- Every district hospital should have at least one seclusion room for the care of aggressive, disruptive MHCUs during 72-hour observation.
- Every district hospital should have a dedicated psychiatric outpatient clinic.

Human resources

- District hospitals should ensure that they have at least one medical officer with expertise in managing MHCUs and who is proficient in the practical application of the MHCA 2002.
- District hospitals should have full-time psychiatric nurses and part-time occupational therapists, psychologists and social workers for psychiatric services.
- District hospitals should insist on outreach and support visits from regional or tertiary MHCPs.

➢ Employ more Social Workers and auxiliaries to help access MHCU within communities

➢ Retraining of unemployed Nurses to 'Mental Health Nurses' to assist with assessment and Rx of MHCUs within communities

Education and training

- District and community health workers require regular training updates on the MHCA 2002 and the use of MHCA forms-as staff change regularly and the complexity of the Act requires refresher training.
- Treatment protocols for managing mental disorders should be developed regionally for distribution to district and community level health workers.
- District hospitals should second medical officers for occasional periods to tertiary psychiatric hospitals for training in the management of mental disorders. ?? The value of achieving such skills and qualifications (e.g. Diploma in Mental Health) cannot be over-estimated.
- Local SAPS and EMRS personnel should receive regular training in their roles in respect of MHCUs and the requirements of the MHCA 2002.
- Copies of the MHCA 2002 and MHCA forms must be available at all district and community health institutions This is the responsibility of institutional managers and the district office.
- A District Mental Health Forum should be established in every district, including health workers, administrators, SAPS and EMRS representatives, community organisations and MHCU representatives.

Crime and Mental illness

- **It has long been established in law that mental disorder can affect criminal responsibility. Mental disorder can affect three main aspects in the courts procedure in dealing with a person accused of crime**
- **1. The question of whether the person is *fit to plead***
- ***2.* The question of whether the person is *fully responsible* for the crime**
- **3. The sentence**

Fitness to Plead

- In order to stand trial for a crime in English law, a person must be in a fit state to defend himself. The test follows to test for *capacity.* If the person is found on a 'trial of facts' to have done the act but is not fit to plead, then the judge would normally require that he receive psychiatric treatment, in the case of violent crime in a secure hospital
- Responsibility for the crime- In English law for the person to be found guilty- it must be proved that the person actually committed the guilty act '*actus reus'* and also that the person had a guilty mind '*mens rea'*
- The specific '*mens rea'* which is required for a person t be found guilty depends on the crime committed. E.g. for conviction of murder the person must have 'specific intent'

Insanity: The McNaughten Rules

- The McNaughten rules provide the main legal guidelines for establishing that someone is 'not guilty by reason of insanity'
- These are essentially criteria for fully absolving the individual of responsibility on the grounds of mental disorder. The rules state:
- "*To establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he id know it, that he did not know that what he was doing was wrong.*"

Diminished responsibility

- In English law diminished responsibility may only be pleaded as a defence in the case of murder
- if the defence is successful but the person is found guilty, then the crime is reduced from murder to manslaughter
- "*Where a person kills or is party to a killing of another, he shall not be convicted of murder if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for the acts or omissions in doing or being party to the killing*"
- The UK Homicide Act 1957

The Sentence

- Even when a person with a mental disorder is found guilty of a crime, the judge in most situations, although not in the case of murder, has considerable discretion with regard to sentencing
- Further the UK Mental Health Act gives powers to the Court to require that a mentally disordered offender found guilty of a crime, be treated in a psychiatric hospital, rather than sent to prison

RECENT FACEBOOK POST

Please do not relent, talk to your neighbors, check on your friends also. As you take your challenges to Pastors for help, also know that they go through their own personal difficult times too, no one is exempted, please do check on them, ask how they are doing too. Together we can make impact.

Let's Talk Sucide is not the option.

- **SUICIDES IN NIGERIA??**

Within 72 hours In Nigeria Alone ...

*** 38 year old UNN lecturer commits suicide**

*** 400 level UNN student commits suicide**

*** Rape victim commits suicide**

*** Fresh YABATECH Graduate Commits Suicide**

*** Student Commits Suicide After Failing JAMB**

*** RCCG minister commits suicide in Abuja,.etc**

***Living Faith Pastor Committed Suicide dropping a note.**

Culture, mental health and suicides

- **According to Geertz (1973), ". . . there is no such thing as a human nature independent of culture . . . We are . . . Incomplete or unfinished animals who complete or finish ourselves through culture . . ."**
- ". . . biological beings become human beings through their engagement with the meanings and practices of their social world . . ." .
- Therefore, the sociocultural context is crucial to peoples' lives, which inevitably means that it also plays a crucial role in suicide.
- "If we want to *understand* suicidal behavior and suicidal people, it is absolutely essential to take the cultural context into consideration in *all* kinds of suicidological research"- Hjelmeland et al 2010
- However, it turns out not to be, and in an endeavour to include a cultural perspective in suicidological research we face a number of challenges – conceptual, theoretical, methodological, ethical, and political challenges (Hjelmeland, 2010).
- One of the most important challenges, and the one to be discussed here, might be the current "biologification" of suicidology.
- **Key takeaway- Recent research suggest 'NO GENES for DEPRESESSION"**

Culture, mental health and suicides

- It may be considered easier to treat what is often referred to as "a chemical imbalance in the brain" with chemicals instead of spending a lot of resources on unveiling the reason(s) for this "imbalance," which very well may be found in the person's sociocultural environment, so that the patient should therefore rather be treated with alternative therapies.
- Take the current debate about whether the increased use/sales of antidepressants contributed to, or even caused, a reduction in suicide rates (Helgmeland). Even though, according to Jureidini and Raven, the evidence base for such a relationship has proven methodologically weak,
- Isacsson and Rich maintain that "treatment with antidepressants prevents suicide" (Isacsson et al., 2010).
- Governments, for example, perhaps welcome such simple solutions to complex problems, so that researchers have a duty not to contribute to untenable simplification. In fact, the
- relationship between use of antidepressants and risk of suicidality

Culture, mental health and suicides

- Governments, for example, perhaps welcome such simple solutions to complex problems, so that researchers have a duty not to contribute to untenable simplification.
- In fact, the relationship between use of antidepressants and risk of suicidality has proved to be rather complex.
- A meta-analysis of 372 double-blind, randomized, placebo-controlled trials demonstrated that this risk was strongly dependent on age:
- Only among older adults (> 64 years) was the risk of suicidality found to be reduced with use of antidepressants,
- Whereas there was no effect for the age group 25–64 – and even an increased risk for those under 25 years (Stone et al., 2009).

Culture, biological research and Mental Health

- However, there is no reason why biological research should exclude or diminish the focus on cultural influences.
- On the contrary: “Biology is not ‘culture free,’ findings derived from the field of biological psychiatry need to be understood in the context of culture and ethnicity to avoid misleading and mis-interpretation” (Chen et al., 2007,
- Transcultural neuroimaging has shown that cultural background can influence neural activity (Stompe, 2009).
- Thus, the sociocultural context needs to be considered when interpreting brain images (Restak, 2006).
- Henningsen and Kirmayer (2000) argue that “increasing knowedge of neurobiological mechanisms does not indicate the triumph of reductionist models in the sciences of the mind….On the contrary, recent trends in cognitive neuroscience underscore the significance of social context . . .”

Culture, biological research and Mental Health

- In fact, most, if not all, researchers today, at least officially, acknowledge that biological factors (for instance, genes) in themselves do not play a crucial role, particularly not in something as complex as (suicidal) *behavior*.
- It seems commonly accepted that we are not going to find one gene accounting for suicidality, or that even combinations of genes will not, on their own, "cause" suicidal behavior.
- Whether a potential genetic predisposition is expressed as suicidal behavior depends on complex gene-environment interactions (e.g., Mann et al., 2009).
- In other words, the environment *always* plays a crucial role in a
- person's suicidality.
- Therefore we must now recognize the vital significance of the environment (.e.g., gene-environment interactions)……Hegmeland 2010

Summary and conclusions

- MHCU have the same autonomy rights to under the law including the right to accept or refuse any medical treatment except where this impinges on the rights of others
- The current MHCA 2002 is adequate to protect the rights of MHCU's in South Africa-
- The problem appears to be a problem of practical implementation
- There is a need for further training of all stakeholders in the proper application of current regulations especially those contained in the MHCA 2002 in SA

Rights are Rebuttable

- **To paraphrase Lord Donaldson in Re T:**
- ***"… Prima facie every adult has a right and capacity to decide whether or not he will accept medical treatment, even if refusal may risk permanent injury to his health or even lead to premature death…However, the presumption of capacity to decide, which stems from the fact that the patient is an adult is rebuttable…***
- ***An adult may be deprived of his capacity to decide either by long-term mental incapacity, or retarded development, or temporary factors such as unconsciousness or confusion, or the effects of fatigue, pain or drugs.***
- Re T (Adult) (Consent to medical Treatment) [1992] 2 FLR 458

References and further reading

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