

# Transforming Communities for Inclusion

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## Critiquing Global mental health Movement's advocacy around SDGs

F E B R U A R Y A I M S A N D R E S O U R C E S

The World Network of Users and Survivors of Psychiatry, in collaboration with the Bapu Trust, had responded to a Journal article by leaders of the Global Mental Health Movement. The details of the key article, find below

Thornicroft, G. and Patel, V. (2014) "Including mental health among the new sustainable development goals: The case is compelling". *British Medical Journal*, 2014; 349:g5189

Our critique, find below:

WNUSP response to Global Mental health Movement's recommendation on Inclusion of mental health in the post 2015 sustainable development goals by setting of 'treatment targets'

WNUSP is an international organization of persons with psychosocial disabilities, and users and survivors of psychiatry. The WNUSP advocates for a CRPD compliant human rights based approach to Inclusive Development.

The leaders of what is called in some parts of the world as the 'Global Mental Health Movement' [1] (GMHM), Prof. Thornicroft and Prof. Patel, have argued for inclusion of persons with psychosocial disabilities in the post-2015 Development agendas. The authors have suggested throughout this signpost Editorial of GMHM addressing the United Nations, that it is lack of treatment of 'mental disorder' that leads to exclusion, and they highlight the UNCRPD in the context of Right to Health care. 'Scaling up mental health treatment' and setting target of coverage is one of the key recommendations made by Global Mental Health Movement [2].

WNUSP expresses serious concerns about the GMHM advocacy for several reasons. In the OECD countries, including those in Asia, mental health law provides the framework for 'treatment of the mentally ill'. WNUSP considers such law as the most indomitable barrier to the inclusion of persons with psychosocial disabilities [3]. As a necessary first step towards inclusion, WNUSP has called for a repeal of mental health legislations where they exist; and where they don't, as is the case in most LMICs, not to create new mental health laws.

Since long, users and survivors of psychiatry have advocated on the freedom from inhuman, degrading, cruel and torturous treatments within the context of health care, such as solitary confinement, cage beds, forced treatment, forced institutionalization, etc. [4,5]. Specifically, WNUSP has called for the repeal of any legal provisions that authorize detention or compulsory treatment in mental health settings. It is of great concern to us that, both old laws, and new 'reforms' of mental health laws that putatively serve communities, use coercion; and once brought within this system, people's access to justice is seriously compromised [6].

The Right to Liberty and security of persons with disabilities (Article 14) is more pronounced within the UN CRPD Monitoring system, with progressive Concluding Observations coming out since the Committee began its work [7]. The country presentations before the UNCRPD committee so far have shown that, while Article 25 (Right to Health) and provisions therein are ignored, the focus of the mental health treatment system has been Article 14 and deprivation of Liberty. In country after country, the CRPD Monitoring Committee has expressed deep concern about laws that allow a person to be confined against his or her will in psychiatric institutions. Importantly, the COs have recommended ending deprivation of liberty on the basis of disability; repeal of legislations that authorise coercive medical intervention; de-institutionalization policies; and practices that will ensure that

appropriate supports and accommodation are provided within the criminal justice system.

Thornicroft and Patel (2014) claim that “poorer mental health is a barrier to ... providing access to justice for all.” Within Mental health law, where they exist, ‘access to justice’, like ‘access to health care’, has only meant using extant legal provisions on limiting the right to Liberty (Article 14). Incapacity laws found in tandem with mental health legislation curtail independent access to legal remedies for persons with psychosocial disabilities’. For example, the authors mention mental health as ‘relevant’ to the goal of ‘promoting sustainable agriculture’, a Development goal. However, incapacity provisions in many countries, especially the post colonial nations designated as the ‘Commonwealth’, deny the right to acquire, possess or inherit land and property for persons who have or may have received a psychiatric diagnosis. It is the medico-legal framework of coercive treatment and incapacity presumption in law that are formidable barriers to access to justice.

In this paper by Thornicroft and Patel (2014), involuntary detention and forced treatment is the “Elephant in the Room”, not mentioned and therefore not addressed in the way it should be. In the context of the World Health Organization (WHO) and the homogenization of psychiatry worldwide, WNUSP and IDA (2010) had observed an “extraordinary oversight” when this issue is missed, referring to this as a subject that is “ever present but never mentioned” [8]. While in this paper, the subject of Liberty deprivation is the elephant in the room, GMHM leaders in their own national context (exemplified in Patel, 2012) [9] have endorsed the use of coercive mental health legislation and involuntary treatment procedures. When Thornicroft and Patel (2014) [10] argue that “poorer mental health is a precursor to reduced resilience to conflict” and repeatedly bring up the matter of “safe and resilient” cities, they reinforce the prejudicial claim of a “Dangerous and Violent” mentally ill person, who, left untreated, will cause conflict to happen in cities, and therefore, worthy of involuntary detention and treatment. The connection GMHM makes between poor mental health and being vulnerable to being in conflict is an unacceptable and morally wrong presumption; It is also a significant that the authors fail to mention the growing body of evidence which suggests that, psychiatric medication, especially when given to children and young adults, causes violence. Considering the black box warnings on some psychotropics, especially the SSRIs, we contend that taking psychiatric medication is inversely proportional to outcome of peace.

The stereotyping of “mentally ill” people occurs throughout this paper, for example, when the authors write that “people with untreated mental disorders have a negative effect on global wealth because they increase school and work absenteeism and dropout rates, healthcare spending, and unemployment rates”. Contrarily, for global wealth to increase, and for children to continue in schools, we need to treat mental disorder. This portrays that “mental disorder” is in the individual, who, if not treated, can cause the stock markets to crash and for the school system to crumble. The authors write that, ‘educational stressors are risk factors for suicidality among school and college students’ not mentioning a significant contributor to suicidality among children and young people, viz. psychiatric medication for developmental disorders (or societal causes?) Such prejudicial claims victimize and diminish the stature of people with psychosocial disabilities and reduce their chances at inclusion.

As decades of western cultural practice of psychiatric treatment has shown, a significant factor impeding the -inclusion of all peoples is indeed the ‘Treatment of mental disorder’ [11]. For example, in the context of employment, for many people trying to keep their jobs, and live lives, psychiatric diagnosis and medication comes in the way [12]. Reactive to the psychiatrization of the western world, many authors including ex-psychiatrists have written critically about the ‘new colonization’ of the non-western world by psychiatry [13]. Healers around the world are struggling with helping people come off psychiatric drugs [14]. The UNCRPD is not about the sustainability of global wealth, but rather, the accumulation of insight and practice concerning disability identity, interdependence, autonomy and choice indeed, the sustainability of lives lived with disability. If some people choose, whether disabled or not, not to contribute to global wealth, would they be treated for ‘mental illness’? As WNUSP and the Bapu Trust have argued before [15], the CRPD takes the Development paradigm beyond an economy driven ‘Development’, emphasizing full inclusion and effective participation of persons with disabilities. The CRPD places a mandate on states parties to think beyond ‘growth’, an economic concept central to ‘sustainable development’; and to think and practice inclusion, a social concept. Even in the context of medical treatment, the authors fail to acknowledge the failure of public health systems globally to address health crises affecting populations around the world, compounding their mental health status.

We note further that peaceful cities are not wrought by “treatment of mental disorder” but rather by addressing the super fast pace of urbanization, migration, societal breakdown, growing inequity and impoverishment, deprivation, marginalization, and in

investing in humane strategies of building social capital, empowerment and inclusion in local contexts. Inclusion, in the CRPD, is in fact all of the CRPD, and not just the right to health care. Respecting the CRPD means realizing all the rights, including the right to liberty, legal capacity, political participation, integrity, choice and autonomy, living independently and being included in the community, etc. Inclusion, from a psychosocial perspective, and under Article 19 of the CRPD, means the provision of a range of supportive services nearby the location of the person, including peer support, trauma informed counselling, and a variety of healing alternatives, so that the person with psychosocial disability has choice in their own well being and recovery.

Thornicroft and Patel have reduced Development to global wealth and Inclusion to mere treatment of mental disorders. The authors recommend a target of "service coverage for severe mental disorders will have increased by 20% by 2020 and the rate of suicide will be reduced by 10% by 2020". True to a medical perspective, they even refer throughout to a "mentally ill person" resisting the use of the terminology of "person with psychosocial disability". And significantly, they have not addressed the key provision of Article 25 on informed consent.

In conclusion, the article by GMHM leaders works within the frame of extant medico-legal deprivation of human rights; and does nothing to reassure the world community of users and survivors, that in the new world of inclusion that they envision, there will exist vibrant support systems and practices of reasonable accommodation within families, neighbourhoods and communities and, that no medico-legal barriers will exist to exercise the full range of rights provided for in the CRPD. Over the years, and especially in post colonial states, psychiatric professionals have established a gate keeping role and function for themselves using law that makes it impossible for persons with psychosocial disabilities to enter into the Development arena or exercise choice and autonomy. Nowhere have the authors acknowledged the heavy medico-legal odds against which people with psychosocial disabilities have to strive, to even enter the Development arena, whether relating to wealth or to education or indeed, every other sphere of life.

WNUSP is committed to a vision about the holistic nature of all human rights – civil and political together with economic/social/cultural, vide the Vienna Declaration and programme of action on human rights: Human rights are "universal, indivisible, interdependent and inter-related" [16]. We strongly reiterate that psychiatry as practiced in the west, and now transported to LMICs through the GMH, must divest itself of its practice of over medicalization and coercion. We refute the targets set by GMH based on exaggerated claims of the 'burden of mental disorder' [17].

Inspired by the CRPD, which is stellar reinforcement of the Vienna Declaration, and in light of the above considerations, the WNUSP has recommended the following towards the post 2015 Development agenda:

(1) World communities must address our exclusion from society, and consider especially the exclusion wrought by the 'treatment of mental disorder' by medical professionals. International communities must note the practice of gate keeping by psychiatric professionals worldwide, and creating barriers for us from making choices with respect to our own well being, especially in accessing alternatives to psychiatry and ensuring our human rights.

(2) The door to Development is locked for us. We urge that in setting the post-2015 Development agendas, those doors be open through repeal of mental health and incapacity legislations; and our inclusion in other legislations so that we can participate on equal basis with others in accessing all our human rights, social, economic, civil, and political, within communities.

(3) WNUSP objects to setting 'treatment targets' in the post 2015 Development agendas. Post 2015 agendas must have a standalone provision regarding de-institutionalisation, and compliance with Concluding Observations of the UNCRPD committee.

(4) International communities must recognize the value and availability today of a wide range of non medical approaches to recovery and healing, for all persons with disabilities, giving primacy to the lived experiences and choices of persons with psychosocial disabilities.

1. Prince, M., Patel, V., Saxena, S., Maj, Joanna Maselko, Michael R Phillips, Atif Rahman, (2007) 'No health without mental health', Lancet, pp. 1-19 Lancet Online, Published September 4, 2007 DOI:10.1016/S0140-6736(07)61238-0; Patel, V., Collins, P. Y., Copeland, J.,

- Kakuma, R., Katontoka, S. Lamichhane, J., Naik, S. & Skeen, S. (2011). The Movement for Global Mental Health. *British Journal of Psychiatry*, 198, 88-90.
2. (referring to the body of published works inaugurated by the Lancet review of 2007 and including this recent paper).
  3. (2012) WNUSP & Bapu Trust, "Human Rights of persons with psychosocial disabilities in the post 2015 Inclusive Development Agenda: Towards HLMDD, September 2013".
  4. ENUSP, WNUSP, IDA, MDAC (2013). Submission by the European Network of (Ex-)Users and Survivors of Psychiatry, International Disability Alliance, MDAC and the World Network of users and Survivors of Psychiatry to the UN Special Rapporteur on Torture on his upcoming thematic paper on torture in the context of healthcare.
  5. Tina Minkowitz, (2007). 'THE UNITED NATIONS CONVENTION OF THE RIGHTS OF PERSONS WITH DISABILITIES AND THE RIGHT TO BE FREE FROM NONCONSENSUAL PSYCHIATRIC INTERVENTIONS'. *Syracuse Journal of Law*, 34, 405-428.
  6. Tina Minkowitz, 'Why mental health laws contravene the CRPD. An application of Article 14 with implications for the obligations of States Parties'. CHRUSP, New York.
  7. The International Disability Alliance has compiled all the key Concluding Observations in their 2013 document, 'IDA's Compilation of the CRPD Committee's Concluding Observations and List of Issues: Article 14
  8. WNUSP and IDA (2010). 'The Elephant in the Room – Involuntary Psychiatric Treatment and the WHO'.
  9. Patel, V. (2013). 'Legislating the right to care for mental illness', *Economic and Political Weekly*, XLVIII(09), March, p. 49.
  10. Thornicroft, G. and Patel, V. (2014) "Including mental health among the new sustainable development goals: The case is compelling". *BMJ* 2014;349:g5189 doi: 10.1136/bmj.g5189 (Published 20 August 2014)
  11. Minkowitz, T. (2011). Recognizing Forced and Coerced Psychiatric Interventions Against Women, Men and Children as a Harmful Cultural Practice. Submission for Joint CEDAW-CRC General Recommendation/ General Comment on Harmful Practices. New York: WNUSP and CHRUSP.
  12. See Joanna Moncrieff, 2009, *The Myth of the Chemical Cure* Palgrave Macmillan; Robert Whitaker, *Anatomy of an Epidemic*, 2010, Crown; David Ingleby, (2014), 'How evidence based is the movement for global mental health', In China Mills and Suman Fernando, (2014), *Globalising mental health or pathologising the global south: Mapping the ethics, theory and practice of Global mental health. Disability and the global south*, Volume 1, Issue No. 2. Special Issue.
  13. China Mills and Suman Fernando, (Editors) (2014). *Globalising mental health or pathologising the global south: Mapping the ethics, theory and practice of Global mental health. Disability and the global south*, Volume 1, Issue No. 2. Special Issue.
  14. Reviewed comprehensively in Peter Statsny and Peter Lehmann, (2007) *Alternatives Beyond Psychiatry*. Peter Lehmann Publishing: Berlin.
  15. (2012) WNUSP & Bapu Trust, "Human Rights of persons with psychosocial disabilities in the post 2015 Inclusive Development Agenda: Towards HLMDD, September 2013".
  16. UN General Assembly, Vienna Declaration and Programme of Action, 12 July 1993, A/CONF.157/23, available at: <http://www.refworld.org/docid/3ae6b39ec.html> [accessed 2 September 2013]
  17. Ingleby, D. (2014). How 'evidence based' is the movement for Global mental health? *Disability and the Global South*, Volume 1, No. 2, pp. 203-226.

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