

## Open Letter to WPA

This letter is in reaction to the latest issue of *World Psychiatry* (Volume 18, Issue 1, February 2019), an official journal of the WPA.<sup>1</sup> We would like to express our concerns in regard to both its content, as well as the perspectives excluded when putting this issue together.

In terms of content, we would particularly like to draw attention to the Editorial: while discussing the challenges of implementation of the CRPD, the author presents ‘ignoring, re-interpreting or amending the CRPD’ as ways forward, and concludes that governments should “ignore the Convention when it would interfere with a commonsense approach” (Appelbaum, 2019:2). This is nothing less than an official call by the WPA to ignore international law and the hard-won rights of persons with disabilities, including those with psychosocial disabilities as enshrined in the CRPD. Coming from the representative international organisation of psychiatric professionals, this call could damage national efforts to build a legal framework in compliance with the CRPD, which is an immediate obligation of states parties. The “common sense” approach and the lack of scrutiny of psychiatry that has prevailed up until now has had a devastating impact on persons with psychosocial disabilities. This approach to the rights of a marginalized population tends to naturalize discrimination; thus the need for human rights treaties.

In terms of the process behind and the methodological approach of the issue of this journal, we see that the debate on central issues of our lives such as *our* capacity, *our* best interests and *our* will and preferences is taking place without us: none of the eight invited commentaries to the Forum that discusses the above issues in relation to the CRPD (Szmukler, 2019:34-41) is authored by people who know psychiatric forced treatment first-hand *and* oppose it.

Users and survivors of psychiatry from every region of the world and other persons with disabilities involved directly in the negotiation and drafting of this landmark Convention achieved a rare consensus, together with States parties, on the need for a new paradigm with a human rights based, non-discrimination and social approach to all disabilities. This was not “due to a drafting process that was captured by some of the most radical elements of the

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<sup>1</sup>Freely available at [https://www.wpanet.org/uploads/Publications/WPA\\_Journals/World\\_Psychiatry/Past\\_Issues/English/World\\_Psychiatry\\_Feb\\_2019.pdf](https://www.wpanet.org/uploads/Publications/WPA_Journals/World_Psychiatry/Past_Issues/English/World_Psychiatry_Feb_2019.pdf)

patients' rights movement, which are willing to sacrifice the well-being of persons with disabilities" (Appelbaum, 2019:1), but rather, was a milestone achievement in our shared humanity and belief in freedom.

This new paradigm need not be based on "psychiatric expertise", the concept of "mental illness" and "clinician input" which the WPA believes is lacking, but on the continued efforts of persons with disabilities themselves to meaningfully contribute to the many changes needed to implement the CRPD. The majority of contributors to this issue from the psychiatric sector paint a very polarised picture of implementation versus non-implementation of the Convention. Issues such as the interpretation of will and preferences, advance directives, how to provide "effective" support, protection from undue influence and exploitation, or the required changes to criminal law allowing persons with disabilities proper accommodation and support do not by definition require depriving persons with disabilities of their freedom and decision-making capacity. Fundamental rights do not inevitably contradict each other as Szmukler and several other psychiatrists in this issue claim. This is what persons with disabilities, civil society, professionals and State authorities need to work on together.

The overall approach of this whole issue therefore not only promotes the maintenance of the status quo but also exemplifies the very practice of excluding and substituting our voices. We write this open letter from the perspectives of those who have been denied legal capacity, whose will and preferences have been ignored and their "best interests" defined by experts; we write from the perspectives of those who have been abused by forced psychiatric treatment and are traditionally and purposefully being excluded from spaces such as this journal, where *our* lives are being debated. Indeed, the CRPD is precisely there to ensure that what we have to say is not silenced and marginalised any longer.

In this brief statement, we will not engage in detail with the argumentation presented by Szmukler. We have read it with great interest together with all the commentaries and found ourselves in agreement with several counter-arguments presented (Bartlett, Funk and Drew, Flynn, Puras and Gooding). Rather than repeating what has already been said - we will point to some additional aspects that we feel have not been sufficiently addressed:

## **1. Coercion is not care - even as an “exception”**

All the argumentation in favour of occasionally depriving people with psychiatric diagnoses of their fundamental rights and their physical and mental integrity in order to protect them - rests on presumptions about the helpfulness and effectiveness of psychiatric treatment. Little attention is paid to the nature of this treatment and the existing evidence of its ability to help, protect and support. Moreover, there is no evidence in support of the biological nature of what is being treated (Kupfer, 2013) or the success of such treatment (Bola and Mosher, 2003). On the contrary, there is a considerable amount of evidence that contests such treatment and also points to poor health outcomes and drastically shorter life-expectancy of those psychiatrically treated (Moncrieff, 2016, Gøtzsche et al., 2015, Moncrieff, 2013, Whitaker, 2010). The conflicts of interest of policy makers, prescribers and institutions in dealings with the pharmaceutical industry and a lack of transparency regarding trials and the effectiveness of treatments should also be taken into much greater consideration (Mental Health Europe, 2019).

In light of these facts, the promotion of (forced) psychiatric treatment as a ‘right to health’ is particularly ironic. The whole debate exclusively focuses on ‘patient characteristics’ while leaving the characteristics of treatment completely unquestioned. Thinking CRPD and its implementation is inseparable from shedding light on and re-evaluating biomedical responses to people deemed psychiatrically “disordered”. Instead of promoting the necessity of forced pharmacological and electroconvulsive treatment as a solution to complex situations, there should be honesty and transparency about the contested nature of these treatments, their many evidenced damaging effects and their failure to prevent what they claim to be ‘preventing’: see for example Swedish suicide statistic from 2007 which shows that 86% persons who committed suicide in that year were treated with psychiatric medications in the year of their suicide (Larsson, 2009).

## **2. The exception quickly becomes the norm**

As several authors in the WPA journal and other scholars have observed, interventions that are initially introduced as ‘exceptional’ or a ‘last resource’ often end up becoming the norm and turn into the first resource used. This trend can for example be observed in the significant increase in the community treatment order (CTO) rates in the UK since their introduction (Trevithick et al., 2018) as well as in the increase of both involuntary hospitalisation with the introduction of a fast-track “imminent peril procedure” and CTOs in France since the 2011/2013 law reform (Coldefy et al, 2015). For international comparison, see also various European country statistics (Mental Health Europe, 2018).

## **3. Disproportionate use of coercion in treatment of disadvantaged social groups**

If forced interventions are aimed at protection and life-saving – why are some members of the population more often than others on the receiving-end of such interventions? Can it be that psychiatry ‘cares’ more for people of colour or people socially excluded and/or living in poverty? The independent review of the Mental Health Act in the UK for 2017/2018 determined that “there were 289 detentions per 100,000 population for the black or black British group, compared to 72 for the white group” and that “CTO rates for the black or black British group were over eight times greater than for those in the white group” (Legraien, 2018). The institution of psychiatry is part of other systems of oppression that intersect with each other and work in synergy. How can we work towards change if this reality is not even recognised and the debate continues in abstract and universal terms only? The implementation of the CRPD requires development of systems of support capable of addressing and balancing out powers rather than reproducing and enforcing structural inequalities of our lives by virtue of not even seeing them.

## **4. The possibility of forced treatment alone makes any interaction with mental health services potentially coercive**

The journal’s debate approaches involuntary psychiatric treatment as a fully separate issue from voluntary treatment and fails to recognise that it is the coercive *potential* of treatment that determines its overall impact and is in complete opposition to the very notions of support and healing. Involuntary interventions do not affect just those subjected to them:

“That an individual can be compelled to receive psychiatric treatment affects each in-patient regardless of whether his stay is formal or informal. It is hardly possible to be unaware that you are being cared for within a legal framework that allows for treatment against your will.” (Campbell, 1996:59)

The option of forced psychiatric treatment affects each citizen (although not equally) and has implications for anyone who comes into contact with the mental health system. The related debate can therefore not continue based on ‘exceptional’ cases and constructed scenarios only.

## **IN CONCLUSION**

The provisions of the CRPD open up fundamental questions about how we relate to each other in society, including in difficult circumstances, such as for example suicidal crises. There are neither easy answers to such questions, nor can they be resolved by legal documents only. The value and one of the most important contributions of the CRPD is that it opens up new avenues for thinking through questions and reclaiming of tasks that were traditionally delegated to psychiatry. Based on a social model of disability, the UN CRPD and the CRPD Committee’s guidance offer us an important prospect to shift away from the biomedical paradigm when approaching madness and distress and explore not only dignified but also socially responsible and good-quality responses to human crises. This requires the relinquishment of power by the psychiatric profession and a re-definition of psychiatry’s role in society. At times of such a significant historical turn, rather than admit its many failures and join efforts to *collaboratively* develop *different and better* responses, the WPA has chosen to expand its ‘expertise’ into the field of lawmaking in order to ‘save the CRPD from itself’.

If this is not the case for the whole of this profession, and if there are WPA members who do not agree with this call to amend the CRPD and in the meantime to ignore it, if there are psychiatrists in the world willing to “break from the old, controlling paradigm” (Bartlett, 2019:50) and take *new* departures— then it might be about time for them to speak up.

Signatories:

European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP)

Absolute Prohibition Campaign

Red Esfera Latinoamericana de la Diversidad Psicosocial

TCI Asia Pacific

World Network of Users and Survivors of Psychiatry (WNUSP)

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