The WHO and the Medical Colonisation of Psychosocial Disability

David Webb, December 2010

Introduction

In September 2010, The World Health Organisation (WHO) released *Mental Health and Development: targeting people with mental health conditions as a vulnerable group*[1]. The report is a "call to action to all development stakeholders ... to focus their attention on mental health"[2] and "makes the case that people with mental health conditions are a vulnerable group, and as such, deserve targeted attention in development efforts" (p vii). A central feature of the report is that it is at least partly in response to the UN Convention on the Rights of Persons with Disabilities (CRPD):

> *The human rights-based approach to development recognizes the protection and promotion of human rights as an explicit development objective. This approach, coupled with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), places a duty on countries to ensure that the rights of people with mental health conditions are protected, and that development efforts are inclusive of and accessible to people with disabilities.* (p xxv)

There is much to be commended in this report, including the recognition of people with psychosocial disabilities as particularly vulnerable to human rights violations, the need for them to be included in development programs, and for these programs to be based on the human rights principles of the CRPD.

A closer reading, however, reveals that this report in fact represents another example of the WHO's participation in the medical colonisation of psychosocial disability that is currently occurring around the world. We look first at how the WHO remains locked into the very western, very medical model of psychosocial disability that lies at the foundation of this new colonialism of the 21st century. We then notice that the WHO is remarkably silent on the most critical human rights issue for people with psychosocial disabilities – the elephant in the room of involuntary medical treatment. Finally, we look at what the WHO does say elsewhere about the rights of people with psychosocial disability and find that they still seem to be living in a pre-CRPD world.

The WHO is still locked into the medical model of psychosocial disability.

The WHO is very careful in the language it uses in *Mental Health and Development* but a closer reading reveals that they still see psychosocial disability primarily through a medical lens.

The WHO now avoids the phrase "mental illness", which does not appear in the report at all (except in some quotes by others). Similarly, the use of the term "disorder" is only found in conjunction with specific psychiatric labels, such as bipolar disorder etc (e.g. p 40). Perhaps this language is avoided by the WHO because they know that it is provocative and indeed offensive language to many people with psychosocial disabilities. Rather, the preferred terminology of the WHO these days is to refer to "mental health condition". This follows the

concept of a "health condition" in the ICF[3], which has been criticised by people with disabilities because it puts an ICD-10 medical diagnosis at the centre of the WHO's definition of disability.

The term "psychosocial disability", however, does not appear at all in the report even though this is the preferred terminology of people with psychosocial disabilities themselves and is now generally accepted elsewhere throughout the UN. This preferred terminology reflects one of the key principles of the social model of disability that underpins the CRPD, which is that a medical diagnosis becomes a disability when you experience discrimination because of that diagnosis. The WHO is well aware of this preferred terminology but chooses not to use it.

There is an attempt in this report to de-medicalise psychosocial disability, but it only goes part of the way. Phrases such as "diagnosable mental health condition" (p 30) and the frequent mention of symptoms and treatment, including "treatment gap" (pp 16, 24, 35), indicate the medical bias behind the report. Similarly, statements such as "Children with sub-clinical mental health conditions (mental health problems not meeting criteria for psychiatric diagnoses)" (p 20) establish psychiatric diagnosis as the gold standard for what constitutes a mental health condition, and therefore of psychosocial disability.

Of particular concern are statements like "The treatment of mental health conditions is as cost effective as retroviral treatment for HIV/AIDS, secondary prevention of hypertension, and glycaemia control for diabetes" (Box 4, p 36), which sounds perilously close to the now discredited "chemical imbalance of the brain" hypothesis of mental illness[4]. It is also a concern that the report claims that "Patients must have access to essential psychotropic medications" (Box 5, p 37) without any discussion of the hazards of these medications – especially when they are forced on people without their consent.

If you look at some of the other WHO mental health and development programs, such as its Mental Health Gap Action Programme (mhGAP), then it is clear that psychosocial disability is still seen very much in terms of contemporary western psychiatry – i.e. mental illness, psychiatric disorder, diagnosable symptoms, medical treatments, and so on. The mhGAP Intervention Guide, for instance, targets depression, psychosis, schizophrenia and bipolar, which are all contested diagnostic categories in many western societies though this doesn't get mentioned in any of the WHO literature on mental health and development.

This report is a step towards understanding psychosocial disability through the lens of the social model of disability and the CRPD. But it is only a small step and much more is required, especially when you consider that the medical label of "mental illness" is so often the basis for discriminatory legislation against people with psychosocial disability.

Involuntary treatment – the elephant in the room

The *only* mention of involuntary treatment in *Mental Health and Development* is:

> *For example, they can encourage the establishment of mechanisms within the justice system to prevent abuses in relation to involuntary admission and treatment in mental health facilities.* (p 50)

Given that involuntary treatment is the most serious and urgent human rights issue for people with psychosocial disability, it seems an extraordinary oversight that the report fails to address this issue. But those of us familiar with the Department of Mental Health and Substance Abuse at the WHO recognise that this is no accidental oversight. On the contrary, their silence on this critical human rights issue is the elephant in the room that is always present but never mentioned.

The WHO clearly endorses involuntary psychiatric treatment, which can be seen in this report through its endorsement of South Africa's Mental Health Care Act:

> *Development stakeholders can catalyze human rights reform through encouraging the development and implementation of policies and laws that comprehensively address mental health and human rights (see Box 14 for an example from South Africa).* (p 49)

If you look at the South African Act you will see that, like most mental health legislation around the world, it gives legal sanction to the detention and involuntary medical treatment of people with psychosocial disabilities on the basis of "mental illness" when that the person is deemed to be a potential danger to themselves or others (Section 9 of the Act). Such discrimination on the basis of a medical diagnosis violates the CRPD, which becomes apparent when you consider that other people who might be at risk of danger to self or others are not subject to the same infringements of their rights. That is, people with psychosocial disabilities (i.e. labelled as "mentally ill") are not treated in South African law on an equal basis as others, as required under the CRPD.

It is worth noting that the Preamble of the South African Act refers to the South African Constitution that "prohibits against unfair discrimination of people with mental or other disabilities", which suggests that it allows for the curious notion of "fair discrimination" when it comes to people with mental or other disabilities.

The implicit acceptance of involuntary treatment in this report without any discussion, along with its endorsement of South Africa's discriminatory Mental Health Care Act, represents a failure by the WHO to address the most serious and urgent human rights issue for people with psychosocial disability. This is no accidental oversight by the WHO. They are well aware of the global controversy around involuntary psychiatric treatment but choose to remain silent on it – the elephant in the room that is always present but never mentioned.

The WHO Literature on Mental Health and Human Rights

The WHO mental health literature does include various documents on human rights, the major one being its *Resource Book on Mental Health, Human Rights and Legislation*. To read this you need to carefully note its date of publication, 2005, which is prior to the adoption of the CRPD by the UN General Assembly in 2006 but also, significantly, towards the end of the five years of negotiations leading up to the CRPD. The WHO knew that the CRPD was coming when it published its *Resource Book.*

It is not surprising, perhaps, that the *Resource Book* does not mention the CRPD. It is, however, surprising that it remains the WHO's primary reference on mental health and human rights four years after the UN's adoption of the CRPD.

The Resource Book is very much based on an earlier WHO document called the *UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1991), commonly known as the MI Principles. Many countries, including Australia, have adopted the MI Principles as the human rights standard for their mental health legislation, policies and programs.

The MI Principles have been criticised by people with psychosocial disabilities ever since they were released because of their low human rights standards and because people with psychosocial disability were not consulted during the drafting of them. Since the adoption of the CRPD, people with psychosocial disabilities have been calling for the MI Principles to be either withdrawn or revised to make them consistent with the CRPD. It is pleasing to see the WHO now finally recognise this for the first time in *Mental Health and Development*:

> *The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991) were developed without significant involvement by people with mental health conditions. As a result, the credibility of the Principles was diminished in the eyes of many, and resulted in a call to have them revoked. In contrast, the UN Convention on the Rights of Persons with Disabilities was drafted with the active participation of disability organizations, including mental health service user representatives. The Convention has been embraced widely by the disability movement as the universal standard for the human rights of all people with disabilities, and has taken precedence over previous instruments, including the UN Principles.* (p 15)

Despite this, the *Resource Book on Mental Health, Human Rights and Legislation* continues to be cited by the WHO as their recommended reference, with no indication yet from the WHO on when it might be revised or replaced. This is a task that needs to commence with some urgency as the CRPD is already four years old and the *Resource Book*, and the MI Principles on which it is based, represent a significantly lower human rights standard than the CRPD. And when this task does finally commence, it is essential that people with psychosocial disabilities and their organisations have a major, leadership role in the project, in line with the CRPD and the principle of Nothing About Us Without Us.

The medical colonisation of psychosocial disability

In many western countries, the excessive medicalisation of psychosocial disability is a major controversy that is hotly debated, especially (but not only) when it occurs in partnership with involuntary psychiatric treatment. The WHO is well aware of this controversy but chooses to remain silent about it in its documents on mental health and development.

This excessive medicalisation is sometimes described as the medical colonisation of psychosocial disability, which is particularly apt terminology when this very medical, very western model of psychosocial disability is being so heavily promoted in developing countries. The WHO is at the forefront of these efforts to spread the influence of modern, western psychiatry, which also includes some major Australian organisations such as Asia Australia Mental Health (a partnership of Melbourne University, St Vincents Mental Health and the Nossal Institute), Mental Health First Aid International (born in Melbourne, now exported to Hong King, Singapore, Japan, Cambodia and Thailand), and the Nossal Institute (again), this time in partnership with Basic Needs UK.

In *Mental Health and Development* a distinct colonialist attitude can be seen, an attitude that western, medical concepts of psychosocial disability are superior to other local, traditional and indigenous ways of understanding extreme psychosocial distress. On page 9, the report gives some examples from Afghanistan, Oman, Thailand and Turkey of stigmatising superstitions and prejudices against psychosocial disabilities. It is difficult to read these examples without thinking they show the ignorance of non-medical (and non-western) ways of understanding madness. The report fails to balance this with any examples of non-medical and non-western ways of understanding psychosocial distress that many people find useful, helpful and healing. One notable example of this is in New Zealand where traditional Maori values and ways of understanding psychosocial distress are respected and integrated into New Zealand's mental health system.

The colonialist attitude can also be seen in the lack of any critical analysis by the WHO of the stigmatising prejudices to be found in the western, medical model that they endorse. Modern (western) psychiatry is under serious attack in many western countries for its flawed diagnostic system, its frequently hazardous treatments, and also its participation in human rights violations. The challenge to modern psychiatry is being led by users and survivors of psychiatry but also includes many other experts from a broad range of disciplines, such as psychology, social workers, mental health practitioners, and also a growing number of dissenting voices within psychiatry itself. Once again, the WHO is well aware of these criticisms but, yet again, chooses to defend the status quo of modern psychiatry by remaining silent.

This is of particular concern in the context of the WHO's mental health and development activities where they claim to be following a human rights approach. People in developing countries that do not currently have mental health legislation are asking whether they need to introduce such laws. Sometimes this is being asked in the context of the CRPD and whether these laws are necessary to help protect the rights of people with psychosocial disabilities. But the reality is that in those countries that do have mental health legislation, these laws are used not to protect the rights of people with psychosocial disabilities but, as in South Africa, to give legal sanction to depriving them of their rights. And as noted above, these laws use the western, medical concept of "mental illness" as the basis for depriving people with psychosocial disabilities of some of their most fundamental human rights.

The WHO documents correctly highlight stigma as a key issue – though it should be called by its correct name, discrimination, to make clear that it is community attitudes rather than any attribute of the stigmatised individual that is responsible for stigma. It also highlights some examples of the ignorance, prejudices and fears that lie behind this discrimination. It fails, however, to mention that the primary source of stigma in those countries that have mental health legislation is this same legislation that makes second class citizens of people with psychosocial disabilities. It also fails to examine the central role of the contested concept of "mental illness" in these laws. Furthermore, it also fails to mention the now solid research showing that the neurobiological understanding of "mental illness" actually increases rather than decreases the stigma/discrimination against people with psychosocial disability[5]. Again the WHO is aware of all this but chooses to remain silent about it in its mental health and development documents.

Crazy Like Us is a recent book by American journalist, Ethan Watters, with the subtitle of *The Globalisation of the American Psyche*[6]. Watters looks at the emergence in recent years of four different psychiatric disorders in four different countries – anorexia in Hong Kong,

PTSD in Sri Lanka, schizophrenia in Zanzibar, and depression in Japan. In each case he found that these countries had cultural narratives for these "disorders" prior to the arrival of America's psychiatric diagnostic system. And on every occasion he saw the new American cultural narrative of biological psychiatry as not only damaging traditional, indigenous knowledge but was also often doing real harm to the individuals struggling with these difficulties. He was particularly surprised to see that the "importation of Western diagnosis was not only changing the way patients and doctors talked about the disorder – it was changing the disease experience itself".

The medical colonisation of psychosocial disability is virtually complete in countries like Australia and the US. The consequences of this are now surfacing and the news is not good. In *Anatomy of an Epidemic*, Rob Whitaker asks why the number of people in the US with long-term, chronic psychiatric disability has trebled during the period that was supposed to be a new era for the treatment of mental illness? The alarming conclusion from his extensive research is that the US mental health system, with its reliance on long-term use of psychiatric medications, is actually *causing* chronic and long-term disability[7].

Conclusions

The WHO is at the vanguard of exporting a very western, very medical model of mental health to the developing world. It is doing this without presenting the heated debates happening in the west that this model often causes significant harm and seems to be actually causing long-term psychiatric disability. It is also failing to discuss the serious human rights issues that arise when western medical diagnoses are used to justify major infringements of the rights of people with psychosocial disabilities. Furthermore, the WHO's mental health human rights standards in their *Resource Book* are obsolete now that we have the CRPD but there is no sign from the WHO of when these might be revised or replaced.

When it comes to psychosocial disability, the WHO seems to still be living in a pre-CRPD world. It is time they dragged themselves into the 21st century and paid attention to the CRPD and the social model of disability on which it is based. And in its development activities, it needs to come clean and disclose and discuss the many controversies in the model that they are so enthusiastically exporting to the developing world.

Endnotes

[1] Available at: http://www.who.int/mental_health/policy/mhtargeting/en/index.html

[2] Quoted from WHO website – http://www.who.int/mental_health/policy/mhtargeting/en/index.html

[3] ICF stands for the "International Classification of Functioning, Disability and Health", which is the WHO's model and definition of disability – see http://www.who.int/classifications/icf/en/

[4] One of many authoritative references that debunk the "chemical imbalance" myth is *The Myth of the Chemical Cure* by Joanna Moncrieff (Palgrave Macmillan, 2009).

[5] A recent study that confirmed previous similar findings is "'A Disease Like Any Other'? A Decade of Change in Public Relations to Schizophrenia, Depression and Alcohol

Dependence" by Pescosolido et al in the *American Journal of Psychiatry*, September 15, 2010 (doi: 10.1176/appi.ajp.2010.09121743).

[6] *Crazy Like Us – The Globalisation of the American Psyche*, Ethan Watters, Scribe, 2010
[7] *Anatomy of an Epidemic*, Robert Whitaker, Crown, 2010.