14

WEAPONIZING ABSENT KNOWLEDGES

Countering the violence of mental health law

Fleur Beaufort and Liz Brosnan

Introduction

*Woman on the Edge of Time* by Marge Piercy tells the story of Connie Ramos, a woman who is detained in a psychiatric hospital after she defends her niece against a violent assault (Piercy, 2016a). The assaulter, her niece’s boyfriend, has her detained by claiming she attacked him and her niece, knowing that her history with mental health services will lead the doctors to believe him and not her. A passage describing how she is physically restrained shortly after the admission interview captures the essence of the multifaceted violence that is wielded by mental health law. This violence is physical or material, on the one hand, and epistemic or symbolic, on the other (Roper, 2018):

Connie writhed on the bed, pinned down with just enough play to let her wriggle. They had pushed her into restraint, shot her up immediately. She had been screaming—okay! Did they think you had to be crazy to protest being locked up? Yes, they did. They said reluctance to be hospitalized was a sign of sickness, assuming you were sick, in one of these no-win circles (Piercy, 2016a: 12).

Mental health law is primarily devoted to establishing mechanisms for forcing mental health interventions on people, by detaining them in mental health facilities or placing them on outpatient orders – or ‘community treatment orders’ – mandating their compliance. These two categories of involuntary status pave the way for specific drugs and procedures to be administered to an individual against their will. Voluntary support and service use tends to receive scant attention in this body of law.

Statutory objectives suggest that mental health law is concerned with providing ‘care’ and ‘treatment’. The experiences of mental health service users and psychiatric survivors, however, indicate that the interventions are often physically violent and harmful, in both the short and long term (Lee, 2013: 110–113; Ashe, 2017). Involuntary measures revolve around incarceration, whether in one’s own body through the action of mind-altering and incapacitating psychotropic medication (Fabris, 2011: 115; Fabris and Aubrecht, 2014), or in the traditional sense of confinement in a physical institution.
Mental health services coerce people into acceptance of mental health or psychosocial norms and treatments in both explicit and implicit ways. Informal coercion occurs in the way mental health services use many forms of containment and an environment of surveillance to create a culture of compliance; Sjöström discusses how staff in inpatient wards use threats and locked doors to control voluntary patients (Sjöström, 2006). Invisible power can be said to be most effective when the oppressed believe oppressive regimes operate in their best interests, or that alternative possibilities do not exist (Gaventa, 2006; Brosnan, 2012). However, for many this power is not invisible but takes the overt form of threats to control access to finances, subsidized housing and even to their children, or which force compliance to avoid imprisonment, outpatient commitment or involuntary hospital admissions (Canvin et al, 2013). Mental health law is a central enabler of the coercive practices permeating mental health services because the threat of an involuntary order is an unspoken constant.

The coercive functions of mental health law are intertwined with acts of epistemic violence and symbolic violence which suppress users’ and survivors’ individual and collective ways of knowing and making meaning. Epistemic violence in this context involves psychiatric institutions and practices operating to invalidate psychiatrized people’s ‘knowledge, and ways of knowing and, consequently, efface their ways of being’ (Liegghio, 2013: 122). The symbolic violence of psychiatry refers to the way in which the dominant biomedical paradigm monopolizes society’s understandings of, and responses to, madness and distress and associated discrimination and social injustice, while marginalising other ways of making meaning about these phenomena (LeBlanc and Kinsella, 2016; Lee, 2013). Mental health law facilitates and compounds this process of symbolic violence, embedding it deeply within socio-political structures and individual lives (Beaupert, 2018a).

When Connie Ramos speaks of ‘reluctance to be hospitalized’ being read as a ‘sign of sickness’, Woman on the Edge of Time gives voice to the way in which the symbolic violence of mental health (law) may merge into ‘ontological violence’. Ontology deals with the nature of being; ontological violence occurs when a dominant ideology imposes an interpretation that ‘determines the very being and social existence of the interpreted subjects’ (Žižek, 2008: 62).

Mental health law sanctions processes of ontological violence, whereby psychiatry tells a person that they are ‘sick’ and reads any resistance to this interpretation as more profound evidence of ‘sickness’ (Hamilton and Roper, 2006: 420; Beaupert, 2018b: 769–771). It demands capitulation to these interpretations, including through the forced administration of drugs and procedures that alter the person’s psyche, body and social relations (Minkowitz, 2007: 421). In so doing, mental health law cultivates the ontological nullification of its subjects (Beaupert, 2018a: 19). This is a denial of humanness – designation to a nonentity category unworthy of being treated with dignity and having one’s experiences respected and acted on (Roper, 2018: 92–93).

In the first part of this chapter we reflect on the politics and ideologies underpinning mental health law and its violent practices. We approach this topic with a sense of alarm, since the coercive aspects of mental health law are expanding in many respects, while simultaneously becoming less overt and more insidious in others. For example, community treatment orders which extend formal coercion beyond the walls of mental health facilities, are well-embedded and increasingly over-used in jurisdictions such as the UK, Australia and New Zealand, and gradually being introduced in new jurisdictions around the world. There has been a recent push too by prominent psychiatrists to introduce community treatment orders in Ireland (Brosnan, 2018).

The policy justification for introducing outpatient commitment is that this is a ‘less restrictive alternative’ to detention. In fact, these orders may ‘roll over’ for many years, compared to
shorter periods of detention. They can constrain a person’s ability to live where they choose, travel and negotiate the workplace successfully. They facilitate the prolonged forced administration of psychotropic drugs which ‘restrain the body and create dependency … which results in an indefinite form of detention’ (Fabris and Aubrecht, 2014: 186). In some jurisdictions, residency conditions in orders can result in people being placed in secure ‘community’ residential facilities which operate much like institutions.

The socio-political forces that impel the introduction of more coercive mental health laws are often a fortuitous coalition of media induced moral panic whipped up by sensationalist journalism after some tragedy associated with failed mental health supports. The psychiatric professional lobby weigh in promising reduced risk of further tragedy if only politicians place their trust in the profession and give them more legal power to forcefully treat people who pose potential, assumed risks to themselves or others (Fabris, 2011: 97–98). Yet there is no reliable science behind risk assessment; literature on risk modelling in mental health demonstrates a consistent inability of professionals to accurately predict risk in individual cases, as distinct from statistical modelling (Large et al, 2016).

We also offer our reflections with a sense of hope, born out of the knowledge that Mad people and communities resist and persist in the face of violent and discriminatory practices (Costa et al, 2012). In the second part of the chapter, we sketch some developments which may illuminate and assist the Mad Studies ‘project of inquiry, knowledge production, and political action’ (Menzies et al, 2013: 13), and of probing interactions with other systems of oppression affecting differently positioned Mad and marginalized subjects. Liz explores possibilities opened up by Boaventura de Sousa Santos’ analyses of power relations, anti-colonialism and the ‘sociology of absences’. Fleur turns attention to the international human rights landscape and the emancipatory potential (and limitations) of instruments including the Convention on the Rights of Persons with Disabilities.

Both of us have been subjected to mental health laws and services, and while our experiences differed we share a commitment to resist the oppressions of mental health norms and institutional practices, consistent with Mad movements and theories. These oppressions work with, within and upon racist, heteropatriarchal, colonial and capitalist logics through collusions, which are integral to the Mad Studies project of inquiry (Gorman et al, 2013; Gorman & LeFrançois, 2018), and in relation to which we have different privileged and marginalized social positions. We write from privileged positions including as academics who have worked as part of the coercive apparatus of mental health law. It is this final orientation as former agents of mental health law that informs our first section reflecting on how the law is complicit in the dehumanising violence of psychiatry.

Legal capture and complicity: Sanctioning violence

Liz: My involvement with mental health law spans the past three decades. My initial encounters were involuntary, until I realized that accepting the status of voluntary patient was preferable to detention and forced treatment. Many years later, having extracted myself from services and following active involvement in the user/survivor movement, I was privileged to act as a lay member on Irish mental health tribunals over seven years, and witness the procedures surrounding reviews of involuntary detention orders.

I sought to become a lay member because some of us in the user movement believed that legal review of the practice of detaining people based on a definition of ‘mental disorder’ would not stand up to legal scrutiny. Such scrutiny, we hoped, would change the landscape of mental health services, because legal focus on the lack of scientific validity underpinning the diagnostic
labels used to justify involuntary detention and treatment would herald a new dawn of freedom. What we failed to consider was how the legal profession would become captured by psychiatric hegemony, and align, for the most part, with the mental health system. The legal profession, with a few exceptions, accepted unquestioningly the status quo, the medico-legal paradigm of the Mental Health Commission (‘MHC’) and the mental health establishment. What promised for a brief period of time in 2006 to be an opportunity for reform, was quickly absorbed into a mental health system fundamentally resistant to change.

What is obvious looking back is the lack of dissenting perspectives provided to the incoming panel members. Mainstream psychiatric knowledge pervaded the training provided by the MHC to incoming tribunal members. A module was delivered by a peer advocacy organization, the Irish Advocacy Network. This aimed to humanize the ‘patient’, to sensitize tribunal members to the human experience of distress. The feedback from tribunal panel participants taking this session was that it was helpful preparation for their roles. Yet, at best this may have provided some insight and empathy for people experiencing distress, but failed to unsettle the medico-legal apparatus assembled to adjudicate on involuntary detention and treatment of people against their will with psychotropic medications.

The Irish Mental Health Act 2001 did not incorporate many provisions to facilitate the meaningful participation of the person at a tribunal. There was provision for consulting with the person, and for their attendance at the hearing but not of offering them any choices as to who might support them. The MHC appointed a legal representative unknown to the individual, who they might meet with briefly before the tribunal convened. This is the only advocate mentioned in the legislation: no mention of peer advocates or other possibilities for supported decision-making.

Under Irish legislation mental health tribunals are tasked with determining if the detention is legal or not. The tribunal cannot offer opinions on what other options for treatment might be beneficial, or less restrictive. The tribunal solely determines if the person ‘suffers from a mental disorder’ and would benefit from treatment, which de facto is provided in an institutional setting. Clinical assessments that a person ‘suffers from a mental disorder’ are impossible to counteract, because the twin constructs of ‘lack of insight’ and ‘lacking capacity to consent’ are deployed once a ‘patient’ disagrees with their diagnosis, fails to accept they are mentally disordered, and/or displays non-compliance with their treating psychiatrist’s treatment directives (Brosnan and Flynn 2017; Hamilton and Roper, 2006: 420–421). The weight of medical authority renders the patient an unreliable witness, thus ontologically nullified.

Fleur: My first encounters with mental health services, unlike Liz, were voluntary and culminated in a hospitalization which I did not experience as traumatizing. These experiences led me to develop an interest in mental health law while studying law and to embark on socio-legal research exploring Australian mental health tribunals. A few years after completing my law degree I worked for a year as a solicitor with New South Wales (NSW) Legal Aid’s Mental Health Advocacy Service, a specialist legal service providing representation in mental health law matters. In most cases I represented clients at the first legal review following their detention in a facility to decide whether to approve further involuntary treatment. At that time, initial hearings were conducted by magistrates in NSW, and subsequent reviews by the Mental Health Review Tribunal. During the magistrates proceedings the person was often referred to as ‘the patient’ by the presiding magistrate. In fact, some people would introduce themselves with: ‘I’m the patient’.

While the patient role in general healthcare is infused with the promise of informed consent, the character of this role is effectively inverted in mental health services. The implicit promise is of coercion extending to the use of physical force, rather than respect, as a first response to
decisions that others perceive as risky or unwise. Mental health law plays a pivotal role in producing and sustaining this informal coercion, fostering a culture of compliance – regardless of whether the ‘patient’ has voluntary or involuntary status (Beaupert, 2018a: 17). It was some years after my mental health lawyering experience, and following an involuntary hospitalisation, that I came to understand my ongoing ‘voluntary’ interactions with mental health services as being fundamentally coercive. This was based on not being given adequate information about the effects of drugs my body would become dependent on, not being offered support (other than drugs) to navigate altered states of consciousness and realising that deferral to medical norms and interventions was preferable to an involuntary order.

It is perhaps unsurprising that legal professionals working in this field may become captured by the mental health hegemony. Commenting on civil commitment proceedings in the US thirty years ago, Decker suggested that key difficulties providing effective legal representation in these matters were due to the almost impenetrable barrier ‘psychiatrists’ organizationally-situated knowledge’ presented to asserting alternative perspectives (1987: 169). This surfaced unmistakably on one occasion when my arguments against clinical views about the allegedly high risk of violence posed by one of my clients prompted the tribunal’s legal member to ask, ‘Are you questioning the expert opinion?’ – as if this was an unthinkable course of action. Rigorously challenging the other party’s evidence is expected of lawyers working in most other fields. Even rigorous legal advocacy in mental health law matters is only sometimes accompanied by a determination at odds with the recommendation of the consultant psychiatrist.

Legal professionals are often complicit, albeit sometimes reluctantly, in the symbolic violence of psychiatry and the operation of sanist practices through mental health law. Research has consistently shown that ‘relaxed’ legal adjudication styles, characterized by reliance on clinically oriented proxies for legal tests (Peay, 1989; Perkins, 2003) and uncritical deference to clinical opinion (Parry et al, 1992; Hiday, 1981; Carney et al, 2011: 209–217), become normalized in mental health law matters. Lawyers who take an adversarial approach may find themselves cut short because of the way in which ‘therapeutic jurisprudence’ is applied by some Australian mental health tribunals.

Therapeutic jurisprudence seeks to maximize the ‘therapeutic’ effects of the law while upholding principles of justice, applying insights from the social sciences and psychology (Winick, 2005: 6). The following quote in the leading NSW textbook on mental health law demonstrates one influential interpretation of this approach:

> while some hearings may require robust questioning and advocacy, strident advocacy is rarely appropriate, and lawyers should ensure that they maintain an appropriate demeanour and tone that does not undermine a positive therapeutic relationship between the patient and their treating team.  

*(Howard & Westmore, 2018: 55)*

Such interpretations jar with the concern of therapeutic jurisprudence to protect individual self-determination because of beneficial impacts on psychological wellbeing (Winick, 1992). Nonetheless, a focus on relaxing adversarial processes within therapeutic jurisprudence can reinforce ‘existing distributions of power in the relationship between the treated and the treater’, while ostensibly promoting autonomy (Arstein–Kerslake and Black, 2020).

Mental health law is arguably intrinsically ‘anti-therapeutic’. It assumes that deprivation of liberty and violence are legitimate means of ensuring that people deemed dangerous and disordered due to ‘mental illness’ receive ‘needed treatment’. Yet little may be offered in the way
of real help and support and the force applied is a one-way street: the State cannot be ordered to provide the spectrum of social supports a person may seek.

Housing was an issue for one of my clients, another assessed as being particularly dangerous. During the hearing I put forward arguments that the legal criteria for his continued detention were not met. The arguments I presented on his behalf included his explanation for tipping a cup of coffee on his case worker. This incident was being used as evidence that he posed a risk of serious harm to others. He said that the case worker not only failed to help him with housing but also laughed at him when he asked about securing accommodation. I ultimately regretted drawing attention to this backstory. The magistrate responded: ‘But was it reasonable to throw coffee on your case worker?’

This example is emblematic of injustices which may be inextricably linked to experiences that come to be labelled as mental illness (Kinouani, 2018), and which therefore underly the legal encounter. Attempts to articulate the struggles that a person may be encountering in their daily lives are generally disavowed if explicitly raised, including concerns about harmful effects of drugs or a desire for more holistic support services. Although some Australian tribunal members or panels may be sympathetic and make non-binding recommendations in response (which may never be followed through), the legal ‘brief’ is highly circumscribed as Liz has discussed.

Mental health law sanctions forced interventions revolving around drugging individual bodies against a backdrop of inadequate systems for the provision of ‘care’ (Shimrat, 2013) and a culture of silence around the severe harms caused by psychiatric interventions (Whitaker, 2002). In this way the law is complicit in the physical and symbolic violence that is unleashed through the mental health paradigm, while simultaneously constructing the official ‘truth’ that effective ‘treatment’ is being provided via involuntary orders.

**Recovering and weaponizing absent knowledges**

Liz: In seeking new ways to understand and resist the operation of symbolic violence in medico-legal discourse it is enlightening to find writings from other fields of emancipatory scholarship, offering new lenses to dissect and dismantle the crushing hegemony. Anti-colonialism is one such promising perspective for Mad scholars and students, because it looks at how a small elite in a particular time and place in Europe developed so much power that their worldview dominated the world. They did this as much, if not completely, through how they thought of themselves and regarded the rest of humanity. Santos is one writer whose work offers us a way of understanding the power relations that determine what, and whose knowledge matters. What follows is a very brief truncated account of his work on how Eurocentric thinking and science dominate the global structures of power and resource extractions.

Epistemologies are philosophies about how we know what we know, or think we know, and Santos (2018) uses the term ‘Epistemologies of the North’ to refer to the most taken for granted ones that influence us all in many ways most are not aware of. The ‘North’ is the term used because geographically all colonial systems arose in Europe, and spread outwards to conquer and settle the rest of the world, usually referred to as the ‘South’. However, both ‘North’ and ‘South’ are much more than geographical designations. The North refers to an overarching structure of power from which all other more familiar oppressive structures, such as racism, sexism and classism, get their power to designate one group and worldview as superior over others. So the term ‘North’ designates structures of power located within the centre (the metropolis), as distinct from the local, rural and remote, colonized and Indigenous peoples and others at the bottom of oppressive hierarchies, including predominantly racialized people incarcerated in
Weaponizing absent knowledges

the modern psy/prison industrial complex (White, 2018). These latter constitute the majority of humanity who populate the ‘South’: a designated space that renders those occupying it as sub-human, non-knowers and objects to be ignored or exploited to enrich those enjoying the privileges of the North. Indeed, in the geographical South, there are elites in all societies who may have more in common with elites in the North, than with the marginalized, dispossessed in their own societies.

What is most useful for Mad activists to take from decolonial scholars such as Santos is the explanations of how the dominant ways of knowing are rooted in western enlightenment traditions which privilege whiteness, reason and rationality, order, strength, individualism, science, and the heteropatriarchal worldview. Epistemologies of the North underpin the oppressions of capitalism, colonialism and patriarchy and are promulgated by political systems, the academy and the rule of law – structures which regulate and reproduce systems of belief which shore up the dominant structures of power. Building on these understandings, Mad activists may seek to explore how the symbolic violence of psychiatry informs, operates through or otherwise interacts with a range of oppressions.

Santos (2018) theorizes a dividing line between those radically excluded by these epistemologies, which he calls the abyssal line. Many of the justice and equality struggles of oppressed peoples situated within the apparently positive side of the North/South abyssal line use the tools and thinking of the very structures that subject them to oppression to seek advantages in their struggles for recognition and fairer access to resources. These oppressed peoples are deemed inferior but still human by the controlling structures of those on the privileged side of the line. So, feminists, unionized workers and anti-racist activists are somewhat less human with less access to power, privilege and resources within this hierarchy, but believe in (and are technically afforded) their birthright to be full citizens in many countries. These struggles occur on the ‘Northern’ side of the line. And conversely some positioned geographically in the so called Global South, as distinct from the theorized South, partake of the privileges of the North, in that their status and power is upheld by their relationship to Eurocentric thinking and the Academy, and indeed white privilege.

However, those positioned on the Southern side of the abyssal line are differently positioned, regarded as non-human, with sub-human status, mere objects. Abyssal thinking renders ‘nonexistent, irrelevant or unintelligible all that exists on the other side of the line’ (Santos, 2018: 84). Such lives have no value to the elites and their knowledges are therefore absent or silent because they are not regarded as having any of the features that make knowledge valuable: reason and rationality, systematic, scientific, and masculinist. Oppressed people located on the Northern side of the abyssal line may be rendered sub-human in some respects and contexts. For example, Santos (2018) observes that an African American student studying at a prestigious university may hope to succeed despite institutional racism but will encounter a radically and lethally different level of assigned non-humanity if he is stopped by racist police officers on his way home.

Applying these ideas to mental health activism we can see that those of us labelled with mental ill-health, and active in knowledge creation about the first-hand experience of coercive responses to distress, can obtain some trickle-down benefits. In our struggles to reform intolerable systems of sanist oppression (LeBlanc and Kinsella, 2016), and the total dominance of brain malfunction explanations (i.e. Santos’ ‘Epistemologies of the North’) above embodied, social and relational explanations (i.e. ways of knowing of those far from the centre of power), we can believe in (and achieve) some precarious success on the advantageous side of the divide. However, if we become ‘unwell’, display symptoms of distress or confusion and are deemed ‘incompetent’, ‘irrational’ or otherwise ‘mad’ – particularly when formal or informal coercion
is applied in response – we may fall over the other side of the divide (Santos’ abyssal line), with epistemic and legal agency removed. We therefore walk a tightrope each time we take up some of the many new roles opening up in the psy-industrial complex as the embodied mad.

There are connections between our struggles against the dehumanizing ideologies and structures of psychiatry and the struggles of other marginalized groups confronting differing oppressions. Indeed many of us face the impact of being oppressed in other ways as well as, prior to, or interlocking with psychiatry, of struggling in capitalist, colonial or heteropatriarchal worlds. In fact, for many of us our earlier experiences of oppression and trauma led us into the world of the psychiatric industrial complex (Kinouani, 2018; White, 2018). In *Woman on the Edge of Time*, for example, Connie Ramos’ experiences and socio-political positions as a Chicana single mother on welfare are integral to her capture by this complex.

Santos speaks of the ‘sociology of absences’ – turning absent subjects into present subjects – as the foremost condition for identifying and validating new and different knowledges, which can reinvent social emancipation and liberation (2018: 2). The ‘absent’ is produced through very unequal relations of power, so that recovering the absent is an eminently political gesture. Giving space to these absent knowledges is part of the emerging Epistemologies of the South which challenge the dominance of the de-humanizing processes of the North’s worldview. This process of recovering the absent is evident in the mental health field through the emergence of both survivor-controlled research and Mad Studies. By bringing the knowledges of those subjected to mental health services to the fore, by focusing on the deliberately absented knowledge of those subjected to mental health law, we can reinvent social emancipation and liberation from the symbolic violence of mental health law.

Fleur: Human rights are one set of tools that may be wielded to further the project of recovering the absent, including the knowledges of those subjected to mental health services and laws. Recent evolutions in the international human rights landscape hold potential for asserting rights claims, and developing approaches, which may shift the oppressive epistemological structures of mental health law and help to bring about their disruption. The fact that human rights discourse can shore up dominant systems of power does not prevent the strategic use of human rights mechanisms by Mad individuals and constituencies to expose discriminatory institutional arrangements and work towards genuinely inclusive societies.

The overt positioning of psychiatrized people as rights holders within the international disability human rights law framework with the advent of the Convention on the Rights of Persons with Disabilities (‘CRPD’) is one development providing valuable new lines of resistance. The relationship between madness and disability is contested; not all users and survivors identify as disabled (Russo and Shulkes, 2015). However for others, including some communities in the Asian region (Davar, 2015; Davar, 2018), the CRPD offers an inspiring paradigm, free from the constraints of laws (and activism) oriented around the coercive medical model. The social model of disability is a foundational tenet of the CRPD deriving from disability studies, whose relevance for madness and distress is an area of ongoing exploration (Beresford et al, 2010). With its emphasis on the ideological construction of disability and the social and environmental conditions that oppress disabled people (Erevelles, 2011: 151), this model is arguably equally – if differently – relevant to ‘mental health’.

One revolutionary aspect of the CRPD is how it rejects the dichotomy between mental capacity and incapacity in the disability law context (Minkowitz, 2007: 408), which has traditionally been validated by international human rights law (Steele, 2016: 1014). This dichotomy aligns with Santos’ abyssal line. Historically, disabled and Mad people were often placed automatically on the sub-human side of this divide through legal determinations or societal practices effectively casting these oppressed peoples as ‘incompetent’ (United Nations, 2014: 2), including
Weaponizing absent knowledges

institutionalization under lunacy laws. These practices took away a person’s ability to make a range of decisions about their life and body based solely on their deemed status as disabled or, in the case of madness, attributions of ‘disorder’ and ‘dangerousness’. Of course, mental health laws continue to have the same effect. However, today’s laws incorporate legal standards which assume a mantle of objectivity – such as ‘mental illness’, ‘harm to self or other’ and ‘in/capacity’ – buttressed by clinical concepts and opinions of their applicability in a particular case (Dhanda, 2007: 431–432).

According to Article 12 of the CRPD, enshrining the right to equal recognition before the law, such practices involve the denial of ‘legal capacity’, which encompasses the ability to hold and exercise legal rights and duties (Minkowitz, 2007: 408–410; United Nations, 2014). Article 12 prohibits the discriminatory denial of legal capacity, where the legal personhood of people with disabilities is singled out for arbitrary removal in purpose or effect (United Nations, 2014: 6). The Committee on the Rights of Persons with Disabilities (‘CRPD Committee’), the United Nations body responsible for monitoring the CRPD, has determined that forced mental health interventions contravene Article 12 and that only voluntary support measures are acceptable (2014: 11). In fact numerous CRPD provisions operate in tandem to prohibit forced interventions, including Article 15 (freedom from torture), Article 16 (freedom from exploitation, violence and abuse), Article 17 (protecting the integrity of the person) (United Nations, 2014: 11), Article 14 (liberty and security of the person) (United Nations, 2015) and Article 25 (right to health) (United Nations, 2017: 14–15).

The CRPD Committee’s interpretation of Article 12 has meant that numerous governments have been considering for the first time whether forced mental health interventions are intrinsically discriminatory and incompatible with human rights standards. This interpretation has generally been resisted by parties to the Convention, through interpretive declarations stating their understanding that involuntary orders are permissible as a last resort subject to safeguards. Even so, the debates around the CRPD and connected developments signal a dislocation of dominant discourses surrounding mental health law which can be capitalized on to fuel the demand for change.

The CRPD’s rearticulation of human rights standards has also contributed to renewed understandings of the measures needed to protect rights contained in other core international treaties. For example, the Special Rapporteur on torture has increasingly drawn attention to mistreatment in disability and health service settings, including situations in which forced psychiatric interventions amount to torture (United Nations, 2008; 2013). This extended to a recommendation for an ‘absolute ban’ on non-consensual psychiatric interventions in 2013 (United Nations, 2013: 23). A ground-breaking 2017 report of the Special Rapporteur on the right to health pointed to: failures of research to confirm concepts supporting the biomedical model; harms caused by power imbalances in psychiatry; and the imperative to research and develop ‘psychosocial, recovery-oriented service and support and non-coercive alternatives to existing services’ (United Nations, 2017: 5–8).

To date, much scholarship and thinking about the CRPD in the Global North has considered Article 12 and provisions prescribing how the State should not intervene. Yet the spectrum of CRPD rights envisions numerous actions that should be taken to support and empower people with disabilities, including Article 9 (accessibility) and Article 19 (living independently and being included in the community) (Davar, 2018), in addition to Article 12 itself which enshrines a ‘support model’ in the requirement that people be provided with ‘the support they may require in exercising their legal capacity’ (Minkowitz, 2010: 157–166). For Davar and Transforming Communities for Inclusion Asia, ‘legal capacity’ and ‘voluntary and informed consent’ are limited in their capacity to effect positive change, whereas the wider
Situating Mad Studies

CRPD framework revolving around Article 19 is one of ‘mutual respect, interdependence and support’, calling for investments in ‘community based inclusion practices for their heuristic value’ (Davar, 2018).

The global reach of the CRPD as an international instrument is critical considering that mental health agendas are increasingly imposed on countries around the world under the banner of the Global Mental Health Movement (Wildeman, 2013). This trend towards establishing a global hierarchy in which psychiatric classifications are unassailable risks the further erosion of diverse local knowledges about distress, madness and psychiatrization (Mills, 2018), and suppression of Indigenous practices of healing and experiences of colonization (Tam, 2013). However, the limitations of the CRPD are also heightened in countries where there is deep socio-economic inequality and governments may not recognize the status of people with psychosocial disabilities as rights holders – within or separate to (other) constituencies of disabled peoples. The manner in which the oppressions confronting people with disabilities may be inseparable from life-threatening injustices of poverty, inadequate social welfare, capitalism, occupation or war in parts of the world (Erevelles, 2011; Puar, 2017) should be of central concern for the project of Mad Studies.

The CRPD provides for people with psychosocial disabilities to exert influence on certain government processes, a position which may be used to frame and drive local, regional and international advocacy initiatives. According to the CRPD people with disabilities, including children with disabilities, through their representative organisations must be closely consulted and actively engaged in the development and implementation of laws and policies affecting them (Art 4(3)), and shall ‘participate fully’ in the process of monitoring the Convention’s implementation (Art 33(3)). The CRPD Committee has emphasized that Art 4(3) places the ‘effective and meaningful participation of persons with disabilities … at the heart of the Convention’ (United Nations, 2018: 1). Importantly, these provisions are about how meaning is made and how knowledge is built, validated and activated. They mandate the creation of more authoritative roles for the fast-growing knowledges of psychiatrized people within domestic law and policy reform processes.

On the one hand, these CRPD requirements fall short of the goals of ensuring ownership and control (Sweeney, 2016), or even co-production (Roper et al, 2018), in research and policy making initiatives. On the other, this is a moment of unprecedented confluence between the agendas of Mad Studies, survivor research and the CRPD in their privileging of user and survivor perspectives, epistemologies and expertise – vis-à-vis professional medical and psy epistemologies – which offers opportunities for alliance building and collaborative action.

Conclusion

On the future society in which the heroine of Woman on the Edge of Time is able to find some refuge, Marge Piercy writes: ‘[W]hat we imagine we are working toward does a lot to define what we will consider doable action aimed at producing the future we want and preventing the future we fear’ (Piercy, 2016b). We are drawn to Mad Studies because of the exciting possibilities it opens up for imagining and building futures in which we can control and nurture our own minds and bodies within community spaces offering real help and support, and assert our diverse social needs and political demands without fear that they will be redefined as illness and disorder. We have suggested that interrogating and exposing the symbolic violence of mental health law – and how this body of law renders its subjects unworthy of having their ways of being, knowing and making-meaning taken seriously through a process of ontological nullification – is a vital part of this enterprise.
Our comments on the anti-colonial work of Boaventura de Sousa Santos and international human rights trends focused on the Convention on the Rights of Persons with Disabilities have been offered in the spirit of inquiry, seeking to highlight synergies that exist between different fields from which Mad Studies may draw methods and approaches for research and activism. These developments indicate the deep extent to which individual and collective user and survivor knowledges have been absented and subverted, but also offer tools for change aligned with the Mad Studies’ enterprise to recover, foster and produce knowledges that will – ‘transform oppressive languages, practices, ideas, laws and systems, along with their human practitioners, in the realms of mental “health” and the psy sciences, as in the wider culture’ (LeFrançois et al., 2013:13).

References


Situating Mad Studies


Downloaded By: 10.3.97.143 At: 01:45 31 Aug 2023; For: 9780429465444, chapter14, 10.4324/9780429465444-17
Weaponizing absent knowledges


