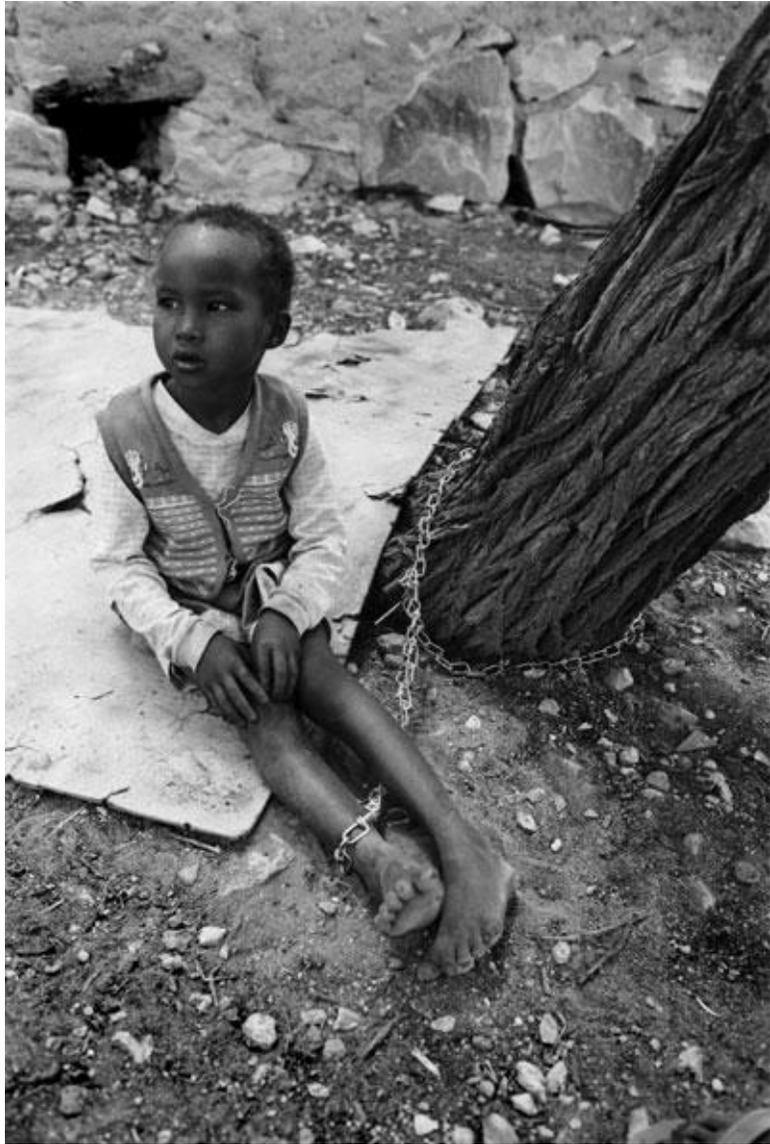


Psychotropic Kids: navigating children's right to (mental) health and right to refuse treatment in contexts of poverty
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‘Improving treatment for children with mental illness...is an urgent priority’ (Collins and others, 2011:27)

‘it is ironic that, although substantial investment has been made in mental health promotion and interventions for young people in many developed countries, no equivalent acknowledgement of mental health needs of young people exists in developing countries. The priorities for young people seem to be different in rich and poor countries. We disagree with this dualism. Young people in every society have mental health needs’. (Patel and others, 2007:1309–10)

Patel and others (2006:1312) call for a move beyond the ‘scientific evidence base’ of particular treatments (which is taken as well established), and push the ‘moral case’; ‘that it is unethical to deny effective, acceptable and affordable treatment to millions of persons suffering from treatable disorders’.

A strange irony

In countries of the global North, many people who identify as users and survivors of psychiatry are drawing attention to how some psychiatric treatments, particularly those administered against people's will, are in violation of a number of human rights – including the right to self-determination and bodily integrity – and thus the right to refuse treatment (a right often denied to people who are labelled as mentally ill and seen as incompetent and irrational).

This means that while the MGMH invokes children's rights to access psychiatric treatment in LAMICs, some (including some psychiatrists) call for extreme caution, if not full prohibition, in giving psychiatric drugs to children (Breggin, 2014).



In some countries of the global North, 'mental illness' in children is framed as an 'epidemic', with up to 8 million children in the USA taking one or more psychotropic drugs (Morris and Stone, 2009).

'no convincing evidence that psychiatric disorders or symptoms are caused by a chemical imbalance and no evidence that psychiatric drugs exert their effects by correcting such an imbalance' (Moncrieff, 2009:101).

Psychiatric drugs, like any psychoactive substances, alter brain chemistry through intoxication (Moncrieff, 2009), disrupting normal brain function and constituting, for Breggin (2008), the 'brain-disabling' principles of psychiatric medications.

‘[t]here are no specific cognitive, metabolic or neurological markers and no medical tests for Attention Deficit Hyperactivity Disorder (ADHD)’ — the diagnosis which warrants the most prescriptions of stimulants (Timimi and Taylor, 2004:8).

In the USA, 3.5 million children take stimulants for ADHD (Whitaker, 2010). Sami Timimi (2002) points out that stimulants are highly addictive and have no proven long-term benefit for children, and research into the long-term effects of stimulant use in children has found; suppressed growth, tics, sudden cardiac death, dullness, anxiety, and psychosis; as well as atrophy of the brain, apathy and depression (Breggin, 2002, 2008, also see Breggin, 2014).

Because they are psychoactive substances, ‘the drugs used to treat ADHD are the same [chemically] as speed and cocaine. We react with horror to the idea that our kids would use such drugs, but don’t react about drugs such as Ritalin being given to them, by doctors’. (Healy, cited in Fowler, 2010:21)

‘ADHD is not a valid diagnostic category that meets the criteria for a medical syndrome’ (Breggin, 2014; also see Baughman and Hovey, 2006; Breggin, 2008a; Whitely, 2010)

Despite this, many proponents of GMH argue that a ‘strong body of evidence from high-income countries (HICs) suggests that AD/HD is a neurobiological syndrome’, and thus a ‘crucial aspect of access to effective treatment for AD/HD is access to the psychostimulants and other pharmacological agents’ (Flisher and others, 2010:1&5).

The World Health Report (2001a:xii) states that ‘essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in every country’s essential drugs list...They often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable’.

Children who can't refuse

Devereux notes this 'catch 22 by which patients whose competence is in doubt will be found rational if they accept the doctor's proposal but incompetent if they reject professional advice'. Thus, despite the recognition of children as subjects of rights within statute law, case law, on which much clinical practice is based, gives children fewer and fewer choices regarding their own treatment, meaning that young people under 18 'now have no right to refuse treatment'.

Dickenson points out that 'If people have rights, it is not because they pass a rationality test'.

J.A. Deverux, D.P.H. Jones and D.L. Dickenson, 'Can Children Withhold Consent to Treatment?' (1993) 306 *British Medical Journal* 1459.

D. Dickenson, 'Children's Informed Consent to Treatment: is the Law an Ass?' (1994) 20 *Journal of Medical Ethics* 205.

'Outside' rights

In framing experiences (such as psychosis) as irrational, as outside the realm of 'normal' childhood experiences, and thus outside the parameters of child rights, seems to enable violence against children in the name of 'treatment' to coexist alongside the strong push for children's rights (Spandler and Calton, 2009). Such children are then subjected to 'treatment' that outside of this psychiatric 'state of exception' would be constituted as legal battery and child abuse (Spandler and Calton, 2009).

For, Schrag and Divoky (1981:36), due to psychiatric diagnosis, 'millions of children are no longer regarded as part of the ordinary spectrum... but as people who are qualitatively different from the "normal" population'. Here, then, the location of children's distress within their so-called chemically imbalanced brain, not only denies the potentially personal or social meanings and causes of distress but also denies the potential psychiatric and iatrogenic causes of impairment.

‘across all cultural contexts...’

‘children with a clinical diagnosis of ADHD are identifiable in developing countries and that they show similar problematic behaviors as in developed countries’ (Wilcox and others, 2007:1608)

When ADHD is described as ‘a neurobiological syndrome’ that ‘affects individuals... across all cultural contexts’, the ‘scale up’ in global access to psychostimulants is seemingly justified (Fisher and others, 2010:1&6).

This allows the WHO (2001b:33) to claim that,

since child mental health symptoms do not differ significantly across cultures, it is feasible to use expertise from child psychiatry services in developed countries to compile training packages for primary care workers in developing countries.

New categories of childhood

The attribution of distress to the individual child's brain chemistry has been criticised from many quarters; as a means of diverting attention from the social conditions and inequalities that may lead to distress (Parker, 1997); as a mechanism for pathologising and medicalising children's behaviour, widening the boundaries of abnormality (Timimi, 2002); as a means to depoliticise children's distress, preventing it from being read as personally and politically meaningful (Johnstone, 1997); and as allowing simple technical solutions to be advanced — 'pills for life's ills' (Moncrieff, 2009:105).

The increasing role that psychotropic drugs play in children's lives brings into being new categories of childhood, new ways to be a child (Timimi, 2005; Timimi and Maitra, 2005).

Arora and Mackay (2004), in their discussion with children with an ADHD diagnosis, found many children associated controlling their behaviour through taking medication. This may work to reduce a child's sense of agency, leading them to internalise 'a potentially lifelong script of disability', which 'exposes children to a plethora of untested, possibly harmful, psychotropic medications' (Timimi and Maitra, 2005:22).

“They did’nae believe things I was saying, they said it was all in my head but I tried to tell them it was real to me, that was what was happening. I tried to tell people but I was never believed about the abuse. And I sort of shut up and I stopped talking about them” (cited in Mills, 2102: 451).

‘From mother to brain’...

The diagnosis of ADHD is often justified as reducing blame for children’s ‘bad’ behaviour on parents (usually mothers) — a ‘transformation of blame, from mother to brain’ (Singh, 2004:1194). Here mothers are encouraged ‘to reconfigure their mothering in line with a bio- logical narrative of behavioral causation’ (Singh, 2004:1202).

However, for Singh (2004:1204), this medicalisation of mothering and of (most often) boys’ behaviour, may actually increase mother-blame as it is ‘built on the back of an oppressive cultural ideology of the good mother’. This is a cultural ideology that may travel with GMH, as alternative ways of knowing children, of child-rearing practices, and of understanding well-being are pushed aside (Breggin, 2002; Timimi, 2002).

Less than human

Various studies have found that to lay members of the public biological explanations may imply that those who experience distress are less human, 'almost another species'; strengthen the stereotype that they are dangerous and unpredictable; lead to desire for social distance; and provoke harsher treatment from others, in comparison to an explanation that emphasizes the psychological or the social, such as distress as a response to trauma (Read et al., 2006:313; Angermeyer and Matschinger, 2005; Fernando, 2010).

classifications and labels provide the conceptual tools with which children understand themselves, how they negotiate local support within communities, and how others relate to children. If these labels focus on pathology and vulnerability this may render children as passive victims, both preventing children from accessing resilience-building resources, and potentially transforming 'the social landscape in which children give meaning to loss and difficult experiences' (Skovdal, 2012: 461). Thus, while the recognition of children's agency seems to enhance that agency, the misrecognition of children as victims may render them powerless (Skovdal, 2012), and, as we have explored, increasingly reliant on professional expertise and psychiatric medications.

Skovdal, M. (2012). Pathologising healthy children? A review of the literature exploring the mental health of HIV-affected children in sub-Saharan Africa. *Transcultural Psychiatry*, 49(3-4): 461-491.

Psychiatrizing Poverty

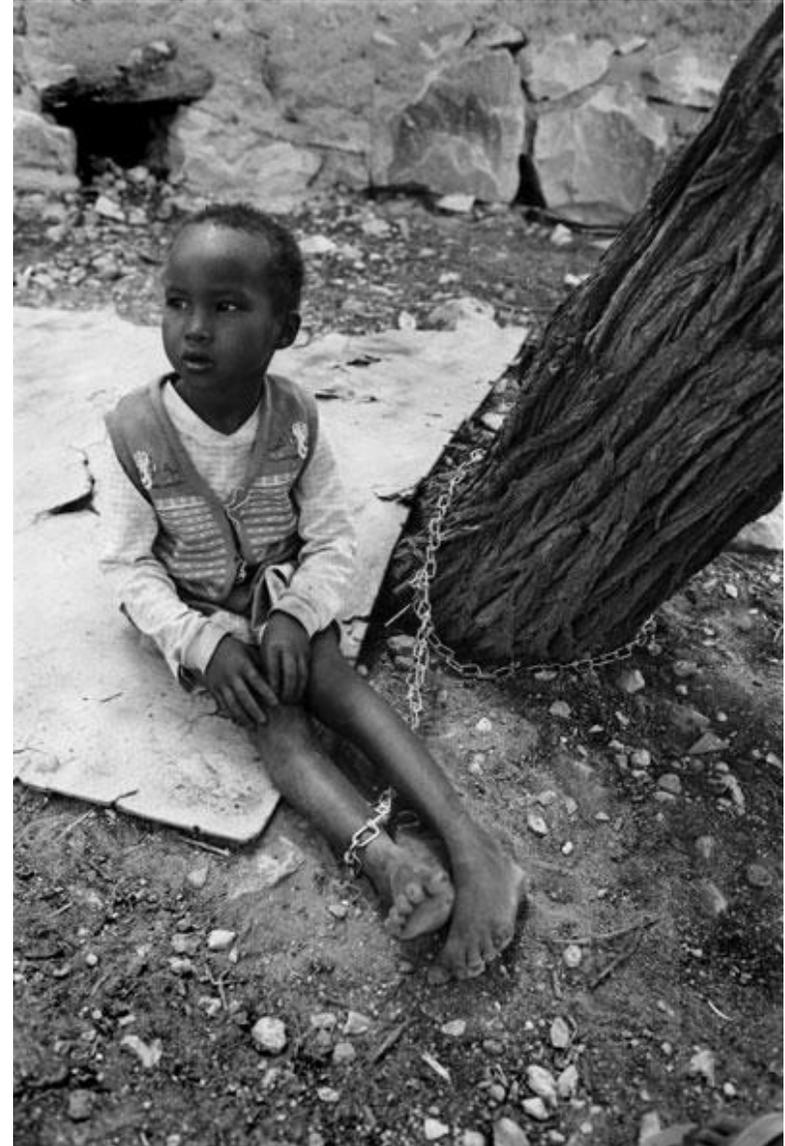
Furedi (2004:27) notes, it seems that 'society is much more comfortable dealing with poverty as a mental health problem rather than a social issue'.

In rural Indian clinics, the local expression of 'uljhan' with its nuanced meanings of unfulfilled economic ambitions, and its increase in the current 'cash-crop environment' leading to family tensions, came to be translated, from Hindi to English, as psychiatric categories of Anxiety and Depression (Jain & Jadhav, 2009:72).

Welfare and poverty are 'being redefined from an economic problem to a medicalized one' (Schram, 2000), where interventions are often reconfigured from resource distribution to individual behaviour modification, increasingly through medications.

However, 'there are real dangers in characterizing the poverty population as primarily a population of people who are psychologically disabled' (Schram, 2000:92)

we are led to wonder about the legitimacy of the call for equity in the global psychiatrisation of children, and to question whether every child should have the right to a psychotropic childhood.



Thanks so much for listening

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