Organizing Collective Resistance Through Children's Rights Legislation and Children's Agency

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PsychOut: A Conference for Organizing Resistance Against Psychiatry, OISE, Toronto, 2010

Introduction

This paper, presented at the PsychOut conference in Toronto in May 2010, outlines lessons learned from a study conducted within an adolescent psychiatric inpatient unit. The oppressive nature of child psychiatry is discussed, along with an analysis of children's agency within mental health services. The combination of children's agency and children's rights is considered in relation to individual and collective resistance to the exercise of practitioner and institutional power.

Setting

This paper is based on an ethnographic research study that was conducted within Child and Adolescent Mental Health Services (CAMHS) in the UK. I lived in an adolescent inpatient unit for four months. During this time there were 12 children included in the study, aged between 11 to 18 years. The children were labeled with a range of diagnoses from depression, obsessive compulsive disorder, eating disorders and queried psychosis, to name a few. This was a 4th tier service (HAS, 1995), which implies that all other services on an outpatient basis were inadequate to support these children from a professional point of view. However, this was not a locked ward, and the inpatient unit was staffed by a psychiatrist, nurses and support workers. The day-patient unit, where the children received their education and some of their treatment, was staffed by psychiatrists, social workers, psychologists, counselors and teachers. All of the children in the study were prescribed psychotropic medications, including one child who was given a neuroleptic drug against his wishes, despite not having been given a diagnosis of a psychotic disorder.

Coercion

Coercive means were used in a variety of forms, both subtle and overt, in order to ensure compliance with rules and treatment plans. One such form included the enforcement of treatment by threatening to or taking away privileges. That is, denying weekend leave or forcing weekend leave – depending on which was most unappealing to the individual children – was regularly threatened and executed as a punishment for noncompliance with treatment or for breaking rules. Another form of coercion included the 'blame and shame' technique. This technique involved attempts to instill guilt and blame the children for their mental health problems. In particular, the children were told that if they wanted to get better they would comply with treatment. By not complying, they were accused of not wanting to get better. Within the inpatient unit, the discourse of 'getting better' became equated with compliance. Any alternative notions the children may have held regarding other forms of treatment – such as peer support - were silenced, considered harmful and/or out-rightly banned. As such, the use of coercion was legitimized through the production of a discourse on compliance.

Another form of coercion for noncompliance included increasing observations levels of individual children, which resulted in intense emotional distress for some children, particularly when put on level 4 observation (LeFrancois, 2007a). Threatening and/or executing suspension or discharge from the hospital were also used as a means to coerce children to comply with treatment and hospital rules. At times, children were even put at significant risk by being sent home, which showed a complete disregard for the 'best interest of the child'. Overtly illegal means of coercion were also applied by threatening to formally detain the children under the mental health legislation for refusing such things as neuroleptic medication or meal portions. These forms of coercion, as well as several others documented in the study and detailed elsewhere (LeFrancois, 2007a), point to an enormous abuse of power on the part of the

practitioners and the institution that condoned these methods.

Power Relations

I analyzed the relations of power in the inpatient unit, which were very complex and are examined in detail elsewhere (LeFrancois, 2007a). One of the very interesting aspects of the relations of power in this setting that I want to discuss here is the realization that the children are not merely passive vulnerable victims within this dynamic. They too were actively involved in exercising power over the practitioners and each other in both positive and negative ways. Some examples of their doing so included: refusing to cooperate with practitioners; engaging in reasoned arguments with the practitioners in an attempt to get them to change their minds; absconding from the inpatient unit; recruiting allies from the staff team and obtaining the collusion of practitioners; and many successful covert forms of pleasure seeking that were contrary to hospital rules. They did not have equal access to the exercise of power, and they were rarely the beneficiaries with the relations of power (Keating, 1997), however their active engagement points to their own agency (James and Prout, 1997; Shotter, 1974; Ingelby, 1974). Their active engagement points to their own abilities to resist the exercise of power exerted by the practitioners and by the institution as a whole.

Children's Rights

Although the experiences of oppression in the inpatient unit in some ways relate directly to the experience of discrimination and oppression in the greater society due to belonging to the minority groups of 'children' and 'psychiatric patients', the experiences are not additive in relation to these aspects of their identities. Instead, an intersectionality approach highlights the often complex role that not only social inequalities but that multiple subjectivities may play within the dynamics of power relations. For example, issues of oppression and privilege that interweave within hierarchies of race, gender, sexuality, class (Cole, 2009; Daley et al, 2007; McBride, 2007) mental health status and age (LeFrancois, submitted) are important categories of analysis in this regard. In particular, the denigration of children through normative conceptualisations of sanism and adultism are problematic within society as well as within inpatient child psychiatry (LeFrancois, submitted; 2007a). However, the category 'child' may actually position the young people in a place of resistance, given the national and international legislative backing of children's participation rights in mental health services.

The UN Convention on the Rights of the Child (CRC), international legislation ratified by every country in the world other than Somalia and the USA, provides children with rights in relation to their protection, the provision of services and their participation (Archard, 2004; Teeple, 2004; Franklin, 2002; Fortin, 1998). Recognition of children's participation rights with regards to mental health services are directly and indirectly embedded within articles 12, 13, 37 and 42 of the CRC. These articles provide children with the right: to be consulted on all matters in their lives; to have their views be given due weight in decision making; to have access to information and to provide information regarding their lives; to a safe environment, free from "torture, cruel, inhumane and degrading treatment or punishment"; to be placed in detention only as a last resort and to be treated with "respect for the inherent dignity of the human person" if they are detained.

Adult service users do not have similar legislation in terms of having direct rights to user involvement in their treatment, care and service development. However, as this study demonstrated (LeFrancois, 2006; 2007a; 2007b; 2008), the extent to which these rights are accorded in practice for children are minimal to non-existent. Instead, children's participation

rights are reinterpreted to suit the professional agenda relating to the bio-medical model of treatment and the adult agenda of social control. This reinterpretation leads to widespread rights abuses within the inpatient unit. These rights abuses took a variety of forms, some of which included: lack of consent sought for admission to hospital; limited access to information; curtailing of the voicing of opinions; lack of informed consent to treatment; coercion to comply with treatment by threatening detainment under the mental health legislation; coercion to comply with medication by a punishment system; and forced participation, amongst others.

Collective Resistance

Although it appears as though children's rights are not always being accorded within mental health services, there is still room to demand – with international legislative backing - that they be accorded. This research demonstrates the capacity of children to resist psychiatric oppression at the individual level. That capacity, coupled with children's rights instruments, point to the ability – and necessity - of children to *collectively* resist psychiatric oppression. However, for the most part, children with psychiatric labels have been excluded from the children's rights movement as well as from the psychiatric survivor movement. The children's rights movement literature is sparse with regards to mentioning or acknowledging the importance of children's rights within mental health services. Also, there is little evidence of children's organizations actively taking up the issue of the rights of children who are labeled with mental health problems. In addition, there has been, for the most part, a lack of accessible involvement of children and young people at conferences put on by the psychiatric survivor movement, and there is a dearth of writing in this area from children's perspectives. These are all unacceptable exclusions.

Discussion

Rather than take up the cause ourselves as adults, rather than seeing children with psychiatric labels as weak and vulnerable, we need to acknowledge their agency and support their full participation in collective action. This leaves us with the following questions to ponder and to actively find answers:

- How do we make the psychiatric survivor movement more accessible to children?
- How do we create space for young voices to be heard along with adult survivors?
- Rather than take up the cause on their behalf as adults, how do we build on children's own agency to actively participate in collectively contesting child psychiatry (and its affiliates) whilst working toward dismantling the system?

Although I make no attempt to answer these questions fully here, which I believe should involve a collective effort by adult and child survivors, I offer some insights from the general children's rights and children's participation literature. Hart's (2002) reworking of Einstein's ladder of participation remains instructive in its elaboration of engaging in real participation with children, whilst avoiding the common adult pitfalls of minority tokenism and manipulation of children for an adult agenda. This work provides a map for engaging in true collaboration between children and adults and may be the best starting point for adult survivors who are interested in not only engaging but learning from children who have been psychiatrized and are struggling to survive the mental health system. It is crucial for the adult survivor movement to commence any collaboration ensuring that they are not doing so merely to benefit the adult survivor agenda but to enable children's participation in such as way that they can realize their own collective

agenda within the larger movement. Like adults working with children within the system, adult survivors should also consult the practice principles of children's participation (Holland and O'Neill,2006; Connolly and McKenzie, 1999; Sketchely and Walker, 2001; CROA, 1998; Michel and Hart, 2002) in order to facilitate children's full involvement in a meaningful and informed manner. If this is not done with care and respect, the adult survivor movement runs the risk of emulating the actions of the very oppressors they are trying to overthrow.

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