7. Mystical Model: Interest Groups and Human Rights Imperatives

Interest Groups

The interest groups which identify with the mystical model are best described as 'latent interests' (see Chapter 2). Latent interests related to the mystical model are mostly comprised of a very small fraction of the psychiatric/psychological professions, a significant proportion of people who have recovered from schizophrenia, but who have no discernible organisation, and a few individual authors who have published books on the subject. As things stand there is no collective voice promoting the mystical model.

The few psychiatric therapists who recognise the mystical model are largely marginalised and although they keep up a running commentary on the inappropriateness of the medical model[1] they rarely become involved in human rights advocacy on behalf of the mystical model.

However, since "schizophrenia is the condition most associated with religious delusion and disturbance"[2] it is worth considering whether there are any religious/mystical influences on psychiatric attitudes towards the mystical model. It is evident in the discussion provided in Chapter 6 that the most significant psychiatric advocates of the mystical model, Laing and Perry, were themselves both involved in personal quests for mystical experience. This observation suggests that some kind of religious/mystical affiliation might play a role in prompting psychiatric practitioners to adopt the mystical model for schizophrenia.[3] However, the effect of religious beliefs on the practice of psychiatry is not easy to determine and there are a number of theories to choose between.

On the one hand there is evidence that psychiatrists are influenced in their professional choices by the religious instruction they have received in childhood[4] (see later in this chapter). This means that it might be possible to tell what kind of religious affiliation is likely to influence psychiatrists to accept or reject the mystical model. On the other hand there is a theory that certain kinds of psychiatrists are vulnerable to adopting the religious 'delusions' of their schizophrenic patients.

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[1] See for example, Selene Vega, Spiritual Emergence or Psychosis?, accessed July, 1997, Available URL, http://www.well.com/user/selene/SENarticles/SpiritPsychosis.html

[2] Mark Sutherland, 'Mental illness or life crisis? A Christian pastoral counselling contribution', in Dinesh Bhugra, ed., Psychiatry and Religion: Context, Consensus and Controversies, Routledge, London, 1996, p. 218.

[3] See for example, Catherine Racine, 'Mystical experience of a counsellor: an autobiographical journey', Women & Therapy, Vol. 20, No. 1, 1997, pp. 61-69.

[4] Gillian Fulcher and Gary D. Bouma, 'Appendix A: The Religious Factor and Modes of Psychiatric Treatment', in Gary D. Bouma, The Research Process, Oxford University Press, Oxford, 1996, pp. 221-231.

This theory suggests that some psychiatrists might only adopt the mystical model after they have been in contact with schizophrenics and therefore any mystical affiliation might be derived indirectly from schizophrenia itself. This theory will be discussed first.

In an essay first published in 1962 a psychoanalyst named Leslie H. Farber wrote about the special hazards that he thought attend therapeutic work with schizophrenics. Farber's insights might help to cast some light on Laing's retreat from psychiatric practice into Buddhist meditation. Farber divided therapists who work with schizophrenics into three groups: "the young, the old and the vagabonds".[5]

The vagabonds are a special class of therapist who have charismatic qualities, very little theory, and who don't last very long. Farber did not find the vagabonds very interesting and instead concentrated his attention on the other two groups — the young and the old. What interested him about these two groups was that he found they both shared the same common denominator of despair at the futility of their efforts to return schizophrenic patients to normal. He argued that there is a special danger that arises for both young and old therapists when this despair goes unacknowledged. When it is unacknowledged subtle changes are wrought on the personality of the therapist.

For the young therapist the despair-induced changes are likely to take the form of a kind of burnout in which the therapist moves on into private practice and arranges his or her professional life so as to avoid further contact with schizophrenics. For the older therapist a more subtle danger lurks when the therapist tries to deal with his or her despair by turning the patient into a kind of oracle. When this happens the patient/therapist roles may subtly reverse.

> Should the therapist forget the degree to which he has supplied meaning to a patient unable to provide any for himself, he may come to regard the schizophrenic as a sort of oracle with whom he sits each day — a truly ragged oracle, untutored, unverbal and naturally unappreciated, who has the rare power to cut through the usual hypocrisies and pretensions of ordinary life, thereby arriving at some purely human meaning. His illness now appears as an appropriate response to the impurities in the therapist's heart, even to the deceits and contradictions of the world in which he lives.[6]

Farber was not in sympathy with the mystical model for schizophrenia, nor was he writing with Laing in mind, since he first wrote about the problem of therapist-despair almost a decade before Laing retired from psychiatry. Nevertheless, he provides a convenient explanation for the process of

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[5] Leslie H. Farber, 'Schizophrenia and the mad psychotherapist', in Robert Boyers and Robert Orrill, eds., Laing and Anti-Psychiatry, Penguin, Harmondsworth, 1972, p. 79.

[6] Ibid., p. 92.

transformation which overtook Laing. Putting aside for this discussion the possibility that Laing may have been best suited to the category of "vagabond", using Farber's description of the at-risk older therapist, it is possible to speculate that Laing's earlier research into family stress as the cause of schizophrenia led to him despairing over finding therapies that would lead to a cure. The despair went unacknowledged and, in order to deal with it, he began to view the schizophrenic experience in a positive light, as being a mystical journey. This in turn caused Laing to convert his patients into oracles, which reversed the patient/therapist roles. At this point Laing became a mystical novice and, after a suitable period of instruction, he embarked upon his own mystical journey into Buddhism.

However, the mystical experience of the patient is not the only religious element that can influence the relationship between the patient and the therapist. There is also scope for considering the religious upbringing of the therapist and whether it influences the explanatory model and treatment a psychiatrist chooses to apply to schizophrenia. A connection between religious affiliation and choice of treatment was apparent amongst psychiatric practitioners as far back as the early 19th century. The 'moral treatment' devised by

> the Englishman Tuke's orientation to psychiatry was very much shaped by his Quaker origins. His asylum would be a religious community: The Retreat would serve as .... a moral and religious segregation which sought to reconstruct around madness a milieu as much as possible like that of the Community of Quakers.[7]

Fulcher and Bouma argue that even in the late 20th century religion, still plays a significant role in the attitudes psychiatrists have towards their patients. A survey they conducted amongst Melbourne psychiatrists provides strong confirmation of this position. Their survey covered 74% of all the psychiatrists who practised in the city. They hypothesised beforehand that the differing theological perspectives of the Catholic, Protestant and Jewish faiths would differently condition the psychiatrists who were raised in these religions and that this would be reflected in their choice of treatments.

The essential differences they were looking for in psychiatric practice were concerned with somatic versus talking forms of therapy. All of the somatic therapies, and most of the talking therapies, used for schizophrenia fall within the medical model. Any psychiatrist who handles schizophrenia from within the mystical model will, of necessity, be found amongst the talking therapists.

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[7] M. Foucault, Madness and Civilisation: A History of Insanity in the Age of Reason, Tavistock Publications, London, 1971, p. 243, quoted in Fulcher and Bouma, op.cit., p. 221.

Fulcher and Bouma's hypothesis argued that when psychiatrists were conditioned by religious upbringing to believe in a locus of control for human experience which is external to the individuals concerned then these psychiatrists would be disinclined to encourage patients to take personal responsibility for their mental state by using talking therapy. These psychiatrists would be religiously conditioned to use somatic therapies instead. The opposite was hypothesised for psychiatrists who had been conditioned to believe in an internal locus of control relying on personal responsibility.

After examining theological perspectives the researchers argued, in relation to the external/internal dichotomy, "that both Protestantism and Judaism are paradoxical here, whereas Roman Catholicism much more clearly places the locus of responsibility as external to the individual".[8] This observation led to a prediction that Catholic psychiatrists would favour somatic forms of treatment while Jewish and Protestant psychiatrists would prove to be statistically ambivalent in their choices of treatment. The result of the survey was that 100% of Catholic psychiatrists, 53.3% of Jewish psychiatrists and 55.5% of Protestant psychiatrists practised somatic forms of treatment.

The researchers concluded that their "study of Melbourne psychiatrists has demonstrated the influence of religious upbringing on practitioners' choice of work style".[9] Since the application of somatic treatments, like drug therapies, are anathema to the mystical model of schizophrenia the results of this survey indicate that certain types of religious upbringing, most especially Catholicism, are likely to predispose psychiatrists against using therapies that might be conducive with the mystical model.

Apart from the few professional therapists and authors who identify with the mystical model the main body of support is from people who have recovered from psychosis.[10] These psychiatric survivors, however, are confronted with a number of disadvantages when they try to become proponents of the mystical model. The most important of these obstacles is that, as diagnosed schizophrenics, individual survivors have very little credibility in public forums as interpreters of abnormal mental phenomena.[11] This is particularly true when the interpretation involves something as culturally marginalised as mystical experience. Advocacy of the mystical model by a person who bears the stigma of a mental illness label is easily dismissed as delusions and may simply provide further evidence of the person's madness.[12]

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[8] Fulcher and Bouma, op.cit., p. 226.
[9] Ibid., p. 229.
[10] See for example, Seth Farber, Madness, Heresy, and the Rumor of Angels, Open Court, Chicago, 1993.
[11] Louis A. Sass, 'Heidegger, Schizophrenia and the Ontological Difference', Philosophical Psychology, 1992, Vol. 5, No. 2, 1992, pp. 109-133.
[12] Michael A. Thalbourne and Peter S. Delin, 'A common thread underlying belief in the paranormal, creative personality, mystical experience and psychopathology', The Journal of Parapsychology, Vol. 58, No. 1, March, 1994, pp. 3-39.

In Perry's description of Diabasis, the centre in San Francisco where he applied the mystical model to treatment, he emphasised the importance for a person experiencing schizophrenic symptoms not to emerge from the altered state of consciousness before the psychosis had run its natural course.[13] He claimed a near perfect success rate for his method and said that when people had their schizophrenia handled as a mystical experience their lives afterwards became richer and more meaningful than they had been before. Considering that the drug treatment used in response to the medical model is intended to abort the psychotic experience as quickly as possible it is little wonder that a frequent complaint of psychiatric survivors, who have received involuntary treatment, is that a mystical experience of great importance to them, which they believed they could have handled if they had been left alone, was rudely interrupted.[14]

Strangely, given the widespread acceptance of the idea of mysticism as a legitimate practice,[15] together with the equally widespread intolerance of schizophrenia,[16] there are still no articulated guidelines, whether in psychiatric, religious or lay terms, for distinguishing one from the other.[17] This lack of definition is particularly pertinent when psychiatric survivors claim to be mystics.

There are a number of simple responses to this situation. One response is to assume that mysticism is the theory, and schizophrenia the practice, of the same experience. And that although the idea of mysticism might have legitimacy, the experience does not.[18] Another response is to assume that mystics are so different they are never mistaken for schizophrenics and that when psychiatric survivors claim to be mystics they are demonstrating a lack of insight into their madness.[19]

More extreme responses can be hypothesised from the perspectives of mysticism and authoritative 'scientism'[20]. A mystic who has successfully negotiated the inner journey might argue that psychiatric practice is an obstacle course positioned to test the nimbleness of mystical aspirants and to catch incompetents. Those people who get caught in the mental health net, and who are labelled

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[13] John Weir Perry, interview with Michael O'Callaghan, Global Vision, 1992-1995, Available URL, http://www.ige.apc.org/glencree/dreamch2.html

[14] Seth Farber, op.cit., pp. 99-109.

[15] Sharon M. Van Sluijs, 'Arching Backwards: The Mystical Initiation of a Contemporary Woman', Parabola, Vol. 21, No. 1, 1996, pp. 119-122.

[16] Garland E. Allen, 'Science misapplied: the eugenics age revisited' Technology Review, Vol. 99, No. 6, August-September, 1996, pp. 22-32.

[17] Sandra Stahlman, Defining Mysticism — Commentary on David Lukoff's "The Diagnosis of Mystical Experience With Psychotic Features", 1992, Available URL, http://www.well.com/user/elliotts/smse_lukoff.html

[18] B. A. Fallon and E. Horwath, 'Asceticism: Creative Spiritual Practice or Pathological Pursuit?', Psychiatry, Vol. 56, No. 3, 1993, pp. 310-316.

[19] X. F. Amador, D. H. Strauss, S. A. Yale and J. M. Gorman, 'Awareness of Illness in Schizophrenia', Schizophrenia Bulletin, Vol. 17, No. 1, 1991, pp. 113-132.

[20] Barry Barnes, About Science, Blackwell, Oxford and New York, 1985, pp. 90-98.

as schizophrenics, are simply failed mystics. A converse, scientific/psychiatric approach might argue that mysticism is just a euphemism for mental illness and therefore so-called mystics are simply untreated schizophrenics.[21]

Human Rights Imperatives[22]

Only a very small fraction of practising psychiatrists are supporters of the mystical model. This means that most of the people who encounter psychiatry, after experiencing what they believe is a mystical or religious experience, will be diagnosed and treated by psychiatrists who are guided by the medical model. One of the few psychiatrists in private practice who works from the perspective of the mystical model has written despairingly of such encounters with his medical model colleagues:

> I am quite convinced that a most certain way for a person to acquire a label of schizophrenia is to come before a clinician and talk about certain kinds of topics, these include the occult, ESP, religion, God, and the general range of metaphysical phenomena. I do not really think that *how* one talks about these things has much to do with whether or not he is given the diagnosis. He can be quite coherent and ordered in his speech, follow the rules of grammar and logic, and yet if he expresses serious concern with, or some kind of excitement in, these topics, he is on his way to winning the label.[23]

Even though many people diagnosed in this way might have entered into what they perceive to be mystical experience unintentionally, and suffered considerably from confusion and anxiety as a consequence, a large fraction of them still prefer not to be treated with medications. This preference raises the question of whether their human rights are violated when drug treatments are forced on them involuntarily.

The specific intention of medical treatment for a person diagnosed with schizophrenia is to modify certain supposed malfunctions of the mind which have been psychiatrically identified as delusions, hallucinations and disordered thoughts. However, if the experiencer of these unusual psychological phenomena interprets the flow of thoughts and ideas as valid personal experience then from the

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[21] Lucy H. Labson, 'Zeroing in on schizophrenia', Patient Care, Vol. 18, January 15, 1984, pp. 66-84.

[22] Research for this section was initially undertaken for, Richard Gosden, Psychiatry and Human Rights, Honours Thesis, Department of Science and Technology Studies, University of Wollongong, 1996. Parts have also been subsequently published as, Richard Gosden, 'Neuroleptics and the Freedom of Thought: How Involuntary Psychiatric Treatment Violates Basic Human Rights', Monitors: Journal of Human Rights and Technology, Vol. 1, No. 1, University of Texas, 26 February, 1997, Available URL, http://www.cwrl.utexas.edu/~monitors1.1index.html

[23] Kenneth E. Lux, 'A Mystical-Occult Approach to Psychosis', in Peter A. Magaro, The Construction of Madness, Pergamon Press, Oxford, 1976, p. 95.

mystical perspective the unwanted interference of a psychiatrist is a very serious violation of human rights. The right of individuals to have their own thoughts, and to hold whatever beliefs they choose, is protected under international law. Article 18 of the International Covenant on Civil and Political Rights (ICCPR) states:

> 1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.
>
> 2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.
>
> 3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.[24]

The Article 18 rights most relevant to people who have undergone a mystical experience and who are consequentially alleged to have schizophrenia are the freedoms of thought, conscience and belief; the freedom to manifest belief; and the protection against coercion which would impair freedom of belief. The only limitations that are allowed to be placed on these rights are in respect to the manifestation of beliefs. The protection of thoughts and beliefs is particularly relevant to people who have undergone mystical experience because it is unusual varieties of thought and belief that characterise the residual phenomena of mystical experience.

Article 2 of the ICCPR specifies that the Covenant protects the rights of all individuals "without distinction of any kind".[25] This means there is no scope for making exceptions for supposedly 'mentally ill' people. This point is pivotal for an Article 18 defence of the mystical model because such a defence only becomes necessary after a person has been labelled mentally ill by the medical model.

Further confirmation of this point can be found in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care: "Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and

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[24] United Nations, 'International Covenant on Civil and Political Rights', Article 18, reproduced in Satish Chandra, ed., International Documents on Human Rights, Mittal Publications, New Delhi, 1990, pp. 32-33.

[25] Article 2, Ibid., p. 25.

Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments ....”[26]

The rights protected in Article 18 of the ICCPR are so fundamental to the human experience that they have been restated as Article 1 of the more recently formulated UN Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief.[27] Article 18 of the ICCPR and Article 1 of the Declaration are almost identical.

The Spirit of Article 18

The ideas behind the freedoms of thought, conscience and belief, and the right to express beliefs, are as old as human society. Social organisation is inevitable for people who live in groups and this organisation generally requires group members to conform to prescribed behavioural patterns and subscribe to commonly held beliefs. But these same people also have to face life as mortal individuals and in this respect the knowledge of personal mortality imposes on individuals a consciousness that the self is unique and separate from the rest of the social group and that it is often necessary to ignore the collective good in order to pursue personal needs.

John Stuart Mill sought to resolve the conflict between the good of the society and the good of the individual with a simple formula:

> The principle is that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.[28]

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[26] United Nations Commission on Human Rights, ‘Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care’, Principle 1.5, in Australian Human Rights and Equal Opportunity Commission (eds), Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, Australian Government Publishing Service, Canberra, 1993, pp. 990-991.

[27] United Nations, ‘Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief’, UN Resolution 36/55, 25 November, 1981, reproduced in Human Rights and Equal Opportunity Commission, Free to Believe? The Right to Freedom of Religion and Belief in Australia, Human Rights and Equal Opportunity Commission, Sydney, 1997, pp. 35-36.

[28] John S. Mill, ‘On Liberty’, in Mary Warnock, ed., Mill: Utilitarianism and Other Writings, World Publishing, New York, 1962, p. 135.

Mill's utilitarian approach is based on the underlying moral principle that a person's action should be judged by evaluating the consequences of the action for all those who will be affected by it.[29] Starting with the assumption that a fundamental benefit will accrue to the individual as a result of him or her exercising the individual right to act, the only justification for stopping that action is if a greater concentration of harm can be expected to accrue to other people. The question of whether or not the performer of the action actually makes a net gain should be no concern of the society.

The right of individuals to think freely and discover their own beliefs is an area which the European cultural tradition has defended against imposed conformity with particular ferocity since the Reformation. The words 'freethinking' and 'freethinker' did not begin to appear in English literature until the end of the 17th century but there were movements of people who described themselves as freethinkers as far back as the 13th century in Italy.[30] In the European Christian tradition heretics have usually been severely punished[31] but at the same time there has also been a retrospective tendency to applaud heretics as "heroes who were badgered by ignorant and vicious men"[32] and who often overcame great obstacles to bring new 'light' into the world.

One advocate of freedom in thought has argued that it is superstition that inhibits freethinking and that "the mission of freethought is to relieve spiritual misery".[33] The conquest of superstition is a widespread ideal in modern society and the recognition of the role played by freethinking individuals in this quest is undoubtedly one of the reasons why the freedoms of thought, conscience and belief have been enshrined in Article 18 as inviolable human rights.

The Technical Requirements of Article 18

The UN Centre for Human Rights compiles an annual report on action the UN has taken in regard to human rights. In a section that discusses resolutions formulated by the Commission on Human Rights there is a cumulative record of how the Commission has interpreted various human rights articles since its inception. Under the heading of "Freedom of thought, conscience and religion or belief",[34] there is a record of the occasions when the Commission has been called upon to interpret Article 18 and what it has resolved.

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[29] Rolf E. Sartorius, 'Paternalistic Grounds For Involuntary Civil Commitment: A Utilitarian Perspective', in Baruch A. Brody and H. Tristram Englehardt Jr., eds., Mental Illness: Law and Public Policy, D. Reidel Publishing Company, Dorecht, Holland, 1980, p. 140.

[30] J. M. Robertson, A History of Freethought, Watts and Co., London, 1936, p. 2.

[31] See for instance, R. I. Moore, The Origins of European Dissent, Basil Blackwell, Oxford, 1985, pp. 23-45.

[32] Barrows Dunham, The Heretics, Eyre and Spottiswoode, London, 1963, p. 2.

[33] Karl Pearson, The Ethic of Freethought, T. Fisher Unwin, London, 1888, p. 21.

[34] United Nations Centre for Human Rights, United Nations Action in the Field of Human Rights, United Nations, Geneva, 1994, p. 110.

The discussions and resolutions recorded to date only concern matters of conscience and religion. There is a record of repeated discussions on the subject of conscientious objection to military service, particularly when the military service involves enforcement of apartheid, and also on the religious rights of minorities. But there has been no discussion regarding specific infringements of the freedoms of thought or belief. Nor has the Commission been called upon to make a ruling under Article 18 in regard to either mental health or psychiatric practice.

The key terms in Article 18 are fairly straightforward and unequivocal. The meaning of words like 'thought', 'conscience' and 'belief' are not dependent on specific circumstances for interpretation as are value-laden words like 'cruel', 'inhuman' or 'degrading' which can be found in other articles of the ICCPR. The specification is simply that individuals should be free to think their own thoughts and to hold whatever beliefs they choose without interference. One human rights analyst has argued that this right is inviolable because "[t]here are some aspects of person's lives that are so deeply personal and intrinsic, such as the right to freedom of thought .... that they are not subject to explicit balancing because there is no cumulative or collective interest that can justify an intrusion."[35]

One interpretation by the Human Rights Committee of the United Nations seems particularly relevant for use in defence of the mystical model:

> Article 18 protects theistic, non-theistic and atheistic beliefs, as well as the right not to profess any religion or beliefs. The terms belief and religion are to be broadly construed. Article 18 is not limited in its application to traditional religions or to religions and beliefs with institutional characteristics or practices analogous to those of traditional religions.[36]

A generalised UN interpretation of Article 18 emphasises the implied dichotomy of inner and outer and says that "no restriction of any kind may be imposed upon man's inner thoughts or moral conscience" but goes on to point out that external manifestations "may be subject to legitimate limitations."[37]

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[35] Margaret G. Wachenfeld, The Human Rights of the Mentally Ill in Europe Under the European Convention on Human Rights, Nordic Journal of International Law and The Danish Center For Human Rights, Copenhagen, 1992, p. 277.

[36] Human Rights Committee, United Nations, CCPR/C/21/Rev.1/Add.4. p.1. quoted in Human Rights and Equal Opportunity Commission, Free to Believe? The Right to Freedom of Religion and Belief in Australia, op.cit., p. 21.

[37] United Nations Centre for Human Rights, op. cit., p. 110.

A conference of international jurists in 1984 made a detailed examination of the limitations allowed for in the ICCPR. The outcome of the conference was the Siracusa Principles[38] which severely restrict the way in which limitations can be imposed. In relation to Article 18, for instance, the provision to limit the manifestation of beliefs could not be extended to limit the holding of beliefs. Nor would it be possible to place any limitations at all on a person's thoughts or conscience.

Article 18 only allows for limitations to be placed on the manifestation of belief when it is "necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others." According to the Siracusa Principles "necessary" means that it has to be "in response to a pressing public need".[39] The definitions of 'public safety' and 'public health' would probably allow them to be used as justifications for limiting the kinds of manifestations of belief likely to be made by a person who was thought to be mentally ill. So would protection of the 'rights and freedoms of others'. But limitations on the grounds of public 'order' and 'morals' would probably not be allowed. For 'public order' to be invoked "the rules which ensure the functioning of society"[40] have to be endangered and 'public morals' are generally recognised as being outside of the province of psychiatric practice.

So, according to the Siracusa Principles, mental health legislation does not violate human rights guaranteed under Article 18 when it empowers psychiatrists to limit a person's manifestations of belief when those manifestations cause "danger to the safety of persons, to their life or physical integrity, or serious damage to their property".[41] Similarly, limitations are permitted to protect the rights of others. But other people's rights only have precedence if they are 'more fundamental' than the right to manifest a belief. Being more fundamental is indicated when a conflicting right is also specified in the ICCPR and has no limitations attached to it.[42] The limitation allowed on the grounds of protecting public health generally overlaps with public safety but public health extends a little further and would probably include "preventing disease or injury"[43] to the person who is actually manifesting the belief.

Despite the severe restrictions on the application of these limitations their existence still generates some uncertainty about the level of protection Article 18 can offer against involuntary psychiatric treatment for schizophrenia. Since Article 18 requires any limitations to be specified in law it is

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[38] International Commission of Jurists, Siracusa Principles on the Limitations and Derogation Provisions in the International Covenant on Civil and Political Rights, American Association for the International Commission of Jurists, Washington, 1985.
[39] Ibid., p. 6
[40] Ibid., p. 7.
[41] Ibid., p. 9
[42] Ibid.
[43] Ibid., p. 8.

proposed to analyse the way in which a typical piece of mental health legislation actually functions in regard to schizophrenics and their Article 18 rights.

Involuntary Treatment Provisions in New South Wales (NSW), Australia

The NSW Mental Health Act 1990 (MHA) will be used for this analysis but the NSW legislation is only meant to be a demonstration and any other modern mental health law could probably be adapted in a similar way.

The framing of the 1990 Act was the second major overhaul of mental health law in NSW since 1958[44] and it has a number of new features. Unlike earlier versions it contains a detailed definition of 'mental illness'. It also reflects recent developments in community attitudes towards mental illness by insisting on the least restrictive environment for treatment.[45]

To facilitate the least restrictive environment the MHA provides for Community Counselling Orders (CCOs) and Community Treatment Orders (CTOs) which allow people to be treated involuntarily outside of an institutional setting. Care and treatment of mentally ill people must be performed so that "any interference with their rights, dignity and self-respect are kept to a minimum necessary in the circumstances".[46] If the psychiatry practised under the sanctions of the NSW MHA cannot satisfy the requirements of Article 18 then it is likely that psychiatric practice in many other modern democratic legal jurisdictions would also fail.

The objects of the MHA are to provide for "the care, treatment and control of persons who are mentally ill or mentally disordered .... while protecting the civil liberties of those persons ...."[47] The contrary legislative impulses — to control people, while simultaneously protecting their civil liberties — illustrates the difficulties in providing a legal framework for psychiatric coercion.

The main thrust of the MHA is to identify the types of people who are thought to require care, treatment and control and to regulate the way in which the services and the restraint are delivered to them. The principal mechanism to achieve this goal is to divide mental patients into those who are voluntary, which it calls informal patients,[48] and those who are involuntary. Anyone can seek treatment as a voluntary patient and people who seek treatment should only be refused admittance

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[44] The Mental Health Act Implementation Monitoring Committee, Report to the Honourable R. A. Phillips MP Minister For Health on the NSW Mental Health Act 1990, August 1992, Preface.
[45] Mental Health Act 1990, Section 4.(2) (a), NSW Government Information Service, Reprinted as in force at 17 October, 1994, p. 3.
[46] Ibid., Section 4.(2) (b), p. 3.
[47] Ibid., Section 4 (1), pp. 2-3.
[48] Ibid., Chapter 4, Part 1.

to a mental hospital if the medical superintendent "is not satisfied the person is likely to benefit from care or treatment".[49]

Involuntary patients, by definition, do not seek treatment and so, if treatment is to be given to them, it must be imposed on them. The imposition of care and treatment can be facilitated by incarceration in a hospital or by placing the person under the direction of a CCO or CTO. Incarceration and imposed care and treatment are the means by which the MHA achieves the objective of 'control'. For a person to be controlled as an involuntary patient a diagnosis must be made of either mental illness or mental disorder. The person must also be manifesting the complaint in a manner that gives rise to alarm.

People who are made involuntary patients because they are alleged to have schizophrenia are usually diagnosed under the MHA's definition of mental illness:

> a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
> (a) delusions;
> (b) hallucinations;
> (c) serious disorder of thought form;
> (d) a severe disturbance of mood;
> (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).[50]

However, people who are diagnosed with mental illness, and who are unwilling to volunteer for treatment, can only be made involuntary patients if they also fit a definition of 'dangerousness':

> owing to that illness, there are reasonable grounds for believing that care, treatment and control of the person is necessary:
> (a) for the person's own protection from serious harm; or
> (b) for the protection of others from serious harm.[51]

This cross-referencing to ensure that a mentally ill person is also 'dangerous' is meant to be a safe-guard to ensure that people are not treated involuntarily unless it is absolutely necessary. But the definition of 'dangerousness' in the MHA has been recently watered down. In its present form there

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[49] Ibid., Section 17, p. 8.
[50] Ibid.,, Schedule 1, pp. 115-116..
[51] Mental Health Legislation Amendment Bill 1997, Section 9, Assented to by the NSW Parliament 26th June, 1997, p. 3.

is only a requirement of "serious harm" whereas in the original legislation 'dangerousness' was defined as a risk of "serious physical harm".

The deletion of 'physical' in the recent amendments was deliberately intended to widen the net of psychiatric coercion. An explanatory note appended to the amending legislation clarifies the definition by saying that "serious harm" extends beyond "serious physical harm" to include "other kinds of harm, such as financial harm or harm to reputation....".[52] A further new addition also instructs that "the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of such deterioration, are to be taken into account."[53]

Four of the five symptoms specified for mental illness — delusions, hallucinations, disordered thoughts and mood disturbance — are phenomena that occur inside a person's mind. The other one — irrational behaviour — is an outward manifestation indicating the presence of one or more of the inner phenomena. For a person to be made an involuntary patient under the MHA at least one of the inner phenomena must be present together with an outward manifestation, or the possibility of an outward manifestation, that might cause "serious harm".

The people who are alleged to have schizophrenia are a sub-set of the total number of people who are incarcerated under these legal provisions. So, in order to apply a test of Article 18 rights for people who have had their mystically-derived thoughts and beliefs diagnosed as symptoms of schizophrenia, it will be necessary to distinguish which of the MHA symptoms apply to schizophrenia.

Incarceration of Alleged Schizophrenics

The symptoms of mental illness specified in the Mental Health Act (MHA) relate to the two main branches of psychosis — the schizophrenias and the affective disorders of mania and depression. The first three of the four inner symptoms — delusions, hallucinations, disordered thoughts — are generally associated with schizophrenia while the fourth, mood disturbance, is a symptom of the affective disorders.

Under the MHA therefore a person who is incarcerated because of alleged schizophrenia will normally be required to have at least one of the first three inner symptoms, as well as behaviour that might cause harm to self or others. Incarceration on these grounds could possibly accord with the Article 18 provision that allows for the limitation of a manifestation of belief in order to protect public safety (of others) or public health (the patient from injury).

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[52] Ibid.
[53] Ibid.

But such an incarceration would only accord with Article 18 in very specific circumstances. These circumstances are considerably narrower than the scope provided for in the legislation. In the first instance, since Article 18 only allows for limitations to be placed on manifestations of belief, then 'delusions' is the only MHA-specified inner symptom which fits the criteria for possible limitation. This is because a delusion is a form of belief: i.e. a false belief. There is no provision in Article 18 for limitations to be placed on manifestations of 'thoughts' even though they may be in the distorted/deceptive form of 'hallucinations', or 'seriously disordered'. In the second instance, the expansion of the definition of 'harm', to include such considerations as "financial harm and harm to reputation" goes far beyond the circumstances for which Article 18 allows limitations. The Siracusa Principles restrict such limitations to the protection of public safety and public health.

A further related problem with the MHA provisions is that to accord with Article 18 more certainty of the person's threat to public safety or public health would be needed than is required by the MHA. The MHA stipulation of "Reasonable grounds for believing" would not satisfy the Siracusa Principle that "All limitation clauses shall be interpreted strictly in favour of the rights at issue".[54]

By not restricting the criteria for involuntary hospitalisation to delusions (false beliefs), and allowing for people to be incarcerated for having 'hallucinations' and 'disordered thoughts'; and by having a definition of 'harm' that is considerably broader than that of public safety and public health; and also by not requiring more positive evidence for the risk of that 'harm'; the MHA clearly provides a legal framework that does not strictly accord with Article 18. Even so, it is not an easy matter to determine whether, in practice, any of the people who are incarcerated under the provisions of the MHA actually have their Article 18 rights violated. The lack of publicly available details about the exact reasons why people get incarcerated means that it is impossible to resolve this doubt.

About 80% of all involuntary admissions under the MHA take place in response to a doctor's certificate.[55] This certificate only requires the doctor to state in the most equivocal language that:

> I am of the opinion that the person examined/observed by me is a mentally ill person suffering from mental illness/or a mentally disordered person and that there are reasonable grounds for believing the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment, or control of the person is necessary :

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[54] International Commission of Jurists, op. cit., p. 6. It should be noted that although there is provision in both Article 18 and the Siracusa Principles to limit a manifestation of belief to protect the rights and freedoms of other people this can only be done if it is specified by law. Since the MHA doesn't specify this area of limitation it can't be used and it is therefore not relevant to the test.

[55] Mental Health Review Tribunal, Annual Report 1995, NSW Government, p. 58.

(a) in the case of mentally ill person:
(i) for the person's own protection from serious harm, or
(ii) for the protection of others from serious harm.[56]

No record is required of the particular symptom of mental illness identified by the doctor nor the exact nature of the "reasonable grounds" for believing that the person might cause serious harm. After a person has been involuntarily admitted to a hospital the MHA requires that the person be further examined by the medical superintendent[57] of the hospital as well as a second hospital doctor[58] in order to confirm the certifying doctor's diagnosis. Published statistics indicate that confirmation is given in over 99% of cases[59] but there is no public record of the precise symptoms found by the hospital doctors nor is there any indication of the quality of the evidence they use to determine that the person might cause serious harm.

The MHA also requires that the person be brought "before a Magistrate as soon as practicable"[60] for the purpose of making a judicial determination "on the balance of probabilities"[61] as to whether the person is a mentally ill person. This usually happens within about a week. (It should be noted that during this period the person can be given treatment without informed consent.)[62]

In 1996 about 44% of the people admitted involuntarily were either released or had their status changed to voluntary patients before the Magistrate's hearing could be arranged.[63] Of those people who were brought before a Magistrate in 1996 about 59%[64] had their medical diagnosis of mental illness confirmed by a legal determination and temporary patient orders were made on them. This amounted to a total of 1,971 people.[65]

There is no published information indicating whether any of these 1,971 people were found to be mentally ill by Magistrates because they had hallucinations or disordered thoughts. It is not even possible to accurately determine what fraction of them were alleged to have schizophrenia, though anecdotal information indicates about half of all involuntary patients are diagnosed with schizophrenia spectrum disorders. Nor is there any readily available assessment of the quality of the evidence used by the Magistrates to determine that these 1,971 people were dangerous. But the minimum level of evidence of dangerousness required by the Magistrate under the MHA — "on the

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[56] Mental Health Legislation Amendment Bill 1997, Schedule 2, op.cit., p. 5.
[57] Mental Health Act 1990, Section 29.(1), op. cit., p. 12.
[58] Ibid., Section 32.(1), p. 14.
[59] Mental Health Review Tribunal, Annual Report 1996, NSW Government, p. 57.
[60] Mental Health Act 1990, Section 38.(1), op. cit., p. 18.
[61] Ibid., Section 51.(1), p. 23.
[62] Ibid., Section 31.(2), p. 13.
[63] Mental Health Review Tribunal, Annual Report 1996, op. cit., p. 20.
[64] Ibid.
[65] Ibid.

balance of probabilities" — once again would not satisfy the Siracusa Principle that "All limitation clauses shall be interpreted strictly in favour of the rights at issue".[66] Needless to say, no statistics are available on how many of these involuntary patients would claim to be mystics, if the opportunity were available to them.

So far then all that can be said about the Article 18 rights of people who are alleged to have schizophrenia and who are involuntarily committed in NSW, is that the MHA provides a legal framework that allows for their rights to be violated. But it is impossible to determine in a generalised way, without exploring minute details of individual cases, whether the rights of this class of people are actually violated by the incarceration process.

To by-pass this obstacle let us assume that all of the people who are alleged to have schizophrenia, and who are incarcerated as a result, are only treated in this way after they have manifested beliefs (i.e. delusions/false beliefs) in ways that are irrefutably threatening to public safety or public health. Making this assumption clears the way for a close examination of the psychiatric treatments that are forced on them after incarceration and whether these treatments violate their rights.

Even though it might sometimes be legitimate to lock people up who manifest beliefs in a dangerous manner, once they have been restrained they still retain inviolable rights to the freedoms of thought and conscience, and to hold whatever beliefs they like. If psychiatric practice on involuntary patients interferes with these rights it unequivocally violates Article 18.

Hypothetical Mental Patient

Let us try to get a feeling for the human side of this problem by sketching the profile of a hypothetical mental patient. We'll call the patient Kerry. Kerry is a young person who has always felt a little bit different from other people, perhaps because of a heightened feeling of vulnerability or self-consciousness. Kerry has long held a passion for poetry and eastern religions and recently he/she began to find new meaning in favourite writings. After sitting up all one night reading he/she slipped into an altered state of consciousness involving visions and voices. When Kerry began to express unusual beliefs to the family over the next few days, together with fragmented quotations of poetry referring to "slings and arrows of outrageous fortune" and taking "arms against a sea of troubles", the family doctor was called in to make an examination. The doctor identified delusions and found reasonable grounds for concluding that Kerry might cause serious harm to self or others and was therefore in need of care, treatment and control. This led to Kerry being involuntarily admitted to a mental hospital.

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[66] International Commission of Jurists, op. cit., p. 6.

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV) delusions are a primary symptom of schizophrenia.[67] The manual defines delusions as false beliefs that are not "ordinarily accepted by other members of the person's culture or subculture".[68] This suggests that Kerry's family doctor, by virtue of being a medical practitioner, is presumed under the sanctions of the MHA to be a competent judge of ordinary beliefs, and is legally designated to certify anyone who appears to hold beliefs that he/she thinks are culturally unacceptable.[69] This might appear to be a fairly dubious provision in human rights terms but since we are conceding that Kerry manifested his/her beliefs in a manner threatening to public safety then his/her Article 18 rights have not been violated by the incarceration process.

However, even after Kerry's incarceration in a hospital there are still no laboratory tests available to confirm the delusions identified by Kerry's family doctor. As things stand no biological back-up tests exist which can either identify or verify the presence of schizophrenia. In fact a key to the controversy over the aetiology of schizophrenia is the question of whether there is anything more to the condition than simply the symptoms themselves.[70]

The absence of any laboratory tests allows for a simple deduction to be made in respect to the fate of Kerry's Article 18 rights after incarceration. If Kerry was hospitalised in order to receive treatment for a mental illness indicated by delusions, and if there are no laboratory tests that can trace the subsequent course of Kerry's illness, then it is fair to assume that the hospital psychiatrists would have to rely on monitoring Kerry's thoughts and beliefs, and their outward manifestations, to know whether his/her condition is improving or deteriorating. This means that treatment that is intended to 'improve' Kerry's condition will also be intended to coerce him/her to give up or change the 'false' beliefs that were the original symptoms of the illness. So long as Kerry's delusions remain in an unremitted state it is highly likely that the treatment/coercion will continue.

This simple deduction allows us to establish a *prima facie* case that any involuntary psychiatric treatment given to a person alleged to have schizophrenia would most likely violate Article 18 by subjecting the person "to coercion which would impair his freedom to have or to adopt a religion or belief of his choice".[71] The further case to be made is that the standard neuroleptic drug treatment that is given to people who are alleged to have schizophrenia does not merely select delusions for

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[67] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, American Psychiatric Association, Washington DC, 1994, p. 285.

[68] Ibid., p. 765.

[69] The MHA stipulates that people should not be found mentally ill "merely because" they hold a political, religious or philosophical belief. See Mental Health Act 1990, Section 11.(1), op. cit., p. 6.

[70] Bruce J. Ennis and Richard D. Emery, The Rights of Mental Patients: An American Civil Liberties Union Handbook, Avon Books, New York, 1978, pp. 15-29.

[71] United Nations, 'International Covenant on Civil and Political Rights', Article 18.2, reproduced in Satish Chandra, ed., op. cit., p. 32.

modification but also interferes with the person's freedom of thought by blocking the higher thinking centres of the brain.

Neuroleptic Treatment

Neuroleptic drugs are the treatment of first choice for schizophrenia: "Over 90% of hospitalised patients with a diagnosis of schizophrenia are prescribed neuroleptic drugs".[72] Neuroleptics are alternatively known as major tranquillisers and antipsychotics and are used to moderate the irrational behaviour associated with schizophrenia.

The advent of neuroleptics is often identified as a turning point in mental health. These drugs not only normalised psychiatric practice, so that it clearly fell within the medical model for the first time, but the further claim is frequently made that neuroleptics also emptied out the mental hospitals by making the treatment of schizophrenia possible outside of an institutional setting.[73] This latter claim is often hotly contested by arguments that it was actually the development of welfare structures, most particularly disability pensions, which contributed far more to reducing the number of patients in mental hospitals than the use of neuroleptics. [74]

The first commercially developed neuroleptic, chlorpromazine, was synthesised by French scientists in 1950 while they were attempting to develop an antihistamine.[75] Chlorpromazine was first tried as an anaesthetic potentiator but proved to be ineffectual. It was then used as an antiemetic but once again it was found to be not commercially useful until an experiment was carried out in 1953 on "about 100 psychiatric patients and it was declared to be an effective antipsychotic".[76] Thereafter it proved to be one of the most profitable drugs in pharmaceutical history. (Myth-of-mental-illness advocate Thomas Szasz has observed that this proves treating non-diseases can be even more lucrative than treating real ones.)[77]

This new drug was found to be highly sedating. One of the early French pioneers of its usage, a physician named Laborit, found it was very useful in calming anxious surgery patients. He noted of

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[72] David Cohen and Michael McCubbin, 'The Political Economy of Tardive Dyskinesia: Asymmetries in Power and Responsibility', The Journal of Mind and Behaviour, Vol. 11, Numbers 3 and 4, Summer and Autumn 1990, p. 472.

[73] T. J. Steadman and H. A. Whiteford, "Medication 2: In Adults', in Robert Kosky, Hadi Salimi Eshkevari, and Vaughan Carr, eds., Mental Health and Illness: A Textbook for Students of Health Sciences, Butterworth-Heinemann, Sydney, 1991, p. 395.

[74] Peter Breggin, Toxic Psychiatry, Fontana, London, 1993, p. 80.

[75] Norman L Keltner, Hilyard Lee, and Carol E. Bostrom, Psychiatric Nursing, Mosby, St Louis, 1995, p. 227.

[76] Thomas Szasz, Cruel Compassion: Psychiatric Control of Society's Unwanted, John Wiley and Sons, New York, 1994, p. 167.

[77] Ibid.

his patients that "There is not any loss of consciousness, not any change in the patient's mentality, but a slight tendency to sleep and above all a disinterest in what goes on around him."[78]

By targeting the dopamine neurotransmitter system of the brain neuroleptics reduce the circulation of dopamine. Along with this reduction of dopamine certain kinds of brain functions, that depend on dopamine, are also reduced. Some parts of the brain learn to compensate: "Following neuroleptic blockade of A9 neurons, post-synaptic dopamine receptor targets in the striatum undergo a compensatory increase in both numbers of dopamine receptors and their sensitivity. This dopamine supersensitivity or hyper-reactivity in the striatum causes tardive dyskinesia."[79]

Tardive dyskinesia is one of a number of serious side effects characterised by movement disorders which are associated with the use of neuroleptics. Once the dopamine supersensitivity has been established in this part of the brain the movement disorders sometimes continue to get worse, and often remain permanently, even if the dopamine blockade is lifted by discontinuing treatment. But it seems that other centres of the brain, which are also dependent on dopamine for proper functioning, and which regulate many of the higher emotional and mental activities, fail to make a similar compensatory adjustment by becoming supersensitive to dopamine. The result is that these higher mental centres close down and this is why neuroleptic treatment has been referred to as a "chemical lobotomy".

> Neuroleptics have their main impact by blunting the highest functions of the brain in the frontal lobes and the closely connected basal ganglia. They can also impair the reticular activating or 'energising' system of the brain. These impairments result in relative degrees of apathy, indifference, emotional blandness, conformity, and submissiveness, as well as a reduction in all verbalisations, including complaints and protests. It is no exaggeration to call this effect a chemical lobotomy.[80]

In relation to the question of Article 18 rights it is apparent that psychiatrists have prior knowledge that the thoughts and beliefs of their patients might be disrupted by neuroleptic treatment. However, there seems to be considerable divergence of opinion as to whether this disruption of thoughts will be beneficial to patients.

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[78] F. J. Ayds, 'The Early history of modern psychopharmacology', quoted in Keltner, et al., op. cit., p. 227.
[79] Peter Breggin, 'Brain Damage, Dementia and Persistent Cognitive Dysfunction Associated With Neuroleptic Drugs: Evidence, Aetiology, Implications', The Journal of Mind and Behaviour, Vol. 11, Numbers 3 and 4, Summer and Autumn 1990, p. 445.
[80] Peter Breggin and David Cohen, Your Drug May Be Your Problem, Perseus Books Reading Massachusetts, 1999, p. 77.

A recent text describes the psychiatric intention as benefiting the patient through "Alterations in thought. Antipsychotic drugs improve reasoning, decrease ambivalence, and decrease delusions .... Antipsychotic drugs are effective in decreasing confusion and clouding .... hallucinations and illusions are reduced"[81]

Some of these intended effects, like the claim that the drugs "improve reasoning", have to be treated with a certain amount of scepticism. Improvement to reasoning in this context might have at least two different meanings. The first is that a person's ability to solve problems might be improved by the drugs. But if this were true one could expect there would be widespread use of the drugs by non-psychotic people — like students, scientists and competitive chess players — who might have cause to improve their problem-solving abilities. Since there is no indication that neuroleptics are ever used in this way, and are not ever likely to be, the second interpretation is more likely. This is where 'improved reasoning' is understood as a euphemism meaning that the patient's thinking has fallen more into line with the will of the psychiatrist administering the treatment.

But even if submission to the will of psychiatrists can be seen as leading to a beneficial outcome for the patient, neuroleptic treatment does not always go according to plan. The small print in an advertisement for the frequently prescribed neuroleptic Haldol, for instance, warns of possible adverse reactions that are the opposite of those intended. Some of the possible effects are, "insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations and catatonic-like behaviour states which may be responsive to drug withdrawal."[82] In addition to these possible reactions recognised by the manufacturer researchers have also "found in a controlled study that some patients have a marked increase in violence when treated with moderately high-dose haloperidol"[83] (Haldol).[84]

This paradoxical admission by a manufacturer that neuroleptics might actually exacerbate psychotic symptoms, rather than ameliorate them, does not weaken an Article 18 case against the drugs. On the contrary, regardless of whether a treatment diminishes or distorts a person's thinking processes it still interferes with the person's right to freedom in thought and belief.

In a recent book a British psychiatrist related how he had participated in an experiment that required him to take a 5 mg dose of haloperidol. This is about half the normal daily dose prescribed for

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[81] Keltner, et al., op. cit., p. 233.
[82] Haldol Decanoate advertisement, Archives of General Psychiatry, August 1995.
[83] J. N. Herrera, John J. Sramek, Jerome F. Costa, Swati Roy, Chris W. Heh and Bich N. Nguyen, 'High Potency Neuroleptics and Violence in Schizophrenics', Journal of Nervous and Mental Disorders, Vol. 176, Number 9, 1988, pp. 558-561.
[84] Haloperidol is the generic name while Haldol is a brand name for the same drug.

adults with schizophrenia. The experiment was intended to test the affect of the drug on attention and concentration and required him to sit in front of a computer screen and perform simple tasks.

> After an hour I felt terrible. The last thing I wanted to be doing was to be seated in front of that computer. Although I did not feel suicidal, I felt restless inside, as if I could not settle. On several occasions I had to get up and walk around. If I had not done so I don't know what would have happened. On two or three occasions I came close to putting my fist through the screen, because I was so intensely frustrated and bored with what was going on. This sensation was a real physical sensation located somewhere in the pit of my stomach. I felt irritated by everything that was going on at the time. The feeling persisted well into the next day, to the extent that I found it difficult to concentrate at work.[85]

Another psychiatrist who deliberately took a small dose of a commonly prescribed neuroleptic called Thorazine (chlorpromazine), in order to find out what it was like, wrote a description of the experience: "I felt overwhelmed by the blahs. I felt tired and lethargic, motivated to do nothing. My thinking was turned down from 78 to 16 rpms, my mouth got dry and I just didn't care all that much about anything". He went on to describe the effects he had witnessed of neuroleptics on mental patients in hospitals:

> Thinking is slowed down — and at high enough doses "dissolved" — so that so-called "crazy" or "delusional" thinking is prevented (along with other kinds of thinking — including creative thinking). Emotions are blunted, pushed down. The result is some degree of (often total) indifference and apathy. Sterile, zombie-like personalities result when indifference is combined with the drug's sedating effects. The sparkle, vitality and exuberance of an alive human being are cut off by these drugs.[86]

Surveys of patient attitudes towards neuroleptics have found that the drugs are almost universally disliked by the people who take them.[87] Confirmation of this is to be found in the fact that unlike most other mind-altering drugs there is no black market for neuroleptics.[88] One patient described the experience of enforced treatment with neuroleptics as: "They knock you out. They cause aches and pains all through your body. They make you apathetic. They stop the whole spiritual

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[85] Phillip Thomas, The Dialectics of Schizophrenia, Free Association Books, London, 1997, pp. 111-112.
[86] David Richman, 'Pursuing Psychiatric Pill Pushers', Sherry Hirsch, Joe Adams, Leonard Frank, Wade Hudson, and David Richman, eds., Madness Network News Reader, Glide, San Francisco, 1974, p. 113.
[87] Seth Farber, op.cit., pp. 164-165.
[88] Ibid., p. 166.

transformation process. Its like putting molasses in your brain. You can't even concentrate enough to read."[89]

Another patient treated involuntarily with Thorazine said:

> The drugs caused me all kinds of problems. I couldn't see. I couldn't read my music or see across the room. I thought my eyes were going bad. The subjective feeling is actually one of disturbance. Its important for people to know that it's not a tranquillising effect at all. What you feel is a sense of inner turmoil. Viewed from the outside you might look less agitated because you're not going to make much noise or show your spirit. I had difficulty thinking. I remember once trying to make a list of books I needed from class and not being able to finish the list. I had difficulty moving my tongue which I really resent because I still have residual effects today.[90]

Testimonies like those above indicate that people who are alleged to have schizophrenia and who are given involuntary treatment with neuroleptic medication will have their rights to the freedom of thought, conscience and belief violated. When the possibility of permanent brain damage from neuroleptic treatment is also taken into consideration it seems apparent that these violations do far greater harm to Article 18 rights than any benefit that might accrue to the Article 12 (ICESCR) right "to the enjoyment of the highest attainable standard of physical and mental health."[91] (In fact, it could be easily argued that neuroleptic treatment does more harm than good to a person's Article 12 rights as well.)

This argument, however, might be countered from the perspective of the medical model with the claim that the new generation of 'atypical' neuroleptics appear to cause less of the extrapyramidal side effects, the group to which tardive dyskinesia belongs, than the traditional neuroleptics. However, regardless of whether 'atypicals' cause less brain damage than traditional neuroleptics, they are still used to deliberately interfere with the thoughts and beliefs of patients. This means that an Article 18 case works equally well against both traditional and 'atypical' neuroleptics.

Human Rights Report on Freedom of Religion and Belief

In February 1997 the Australian Human Rights and Equal Opportunities Commission issued a discussion paper[92] on the right to freedom of religion and belief in Australia. The purpose of the

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[89] Ibid., p. 90.
[90] Ibid., p. 105.
[91] United Nations, 'International Covenant on Economic, Social and Cultural Rights', Article 12 (1), reproduced in Satish Chandra, ed., op. cit., p. 16.
[92] Human Rights and Equal Opportunity Commission, Free to Believe? The Right to Freedom of Religion and Belief in Australia, op.cit.

discussion paper was to seek responses from interested parties prior to submitting a report and recommendations to the Commonwealth Government of Australia about the need for specific legal protection in this area. The foregoing Article 18 argument against psychiatric coercion is new and has not been tested so I made a submission to this inquiry to test the Commission's response to it. I have since been informed that my submission was the only one that questioned psychiatric practices in relation to Article 18.

In July 1998 the Commission submitted their report, Article 18: Freedom of religion and belief,[93] to the Commonwealth Attorney General with recommendations for legislative protection. Shortly afterwards the report was released to the public. The issue I had raised concerning routine violations of Article 18 by coercive psychiatric practices had been ignored as a topic of discussion in the report. However, where the report makes specific legislative recommendations a definition of 'belief' is given as a guide for drafting legislation. This definition specifically excludes from protection "beliefs which are caused by mental illness".[94]

In a subsequent telephone conversation with the Director of the Human Rights Unit,[95] who oversaw the writing of the report, I questioned whether this advice accords with Article 2 of the ICCPR which requires protection for all individuals without discrimination. I also pointed out that Principle 1.5 of the Principles for the Protection of Person's with Mental Illness guarantees that every person with mental illness will be able to exercise all the rights specified in the various UN Declarations and Covenants.

The response was that the Human Rights Commission; (a) believed in the existence of mental illness; and (b) believed that mentally ill people have two kinds of belief — those beliefs which are manifestations of mental illness, and which are not protected by Article 18 — and those beliefs which are not manifestations of mental illness, and which are protected by Article 18.

When I asked the Director of the Human Rights Unit the obvious questions about whether she thought medical diagnosticians could be trusted to accurately distinguish between these two kinds of belief, and whether psychiatric treatments only target beliefs that are manifestations of mental illnesses, leaving the others intact, she had no answer. She also had no answer as to why the report was only concerned with making recommendations for legislative protection of religion and belief and completely omitted to address the freedoms of thought and conscience. In fact, at first she

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[93] Human Rights and Equal Opportunity Commission, Article 18: Freedom of religion and belief, Human Rights and Equal Opportunity Commission, Sydney, July 1998.

[94] Ibid., p. 27.

[95] Meredith Wilkie, Director, Human Rights Unit, Human Rights and Equal Opportunity Commission, Sydney, Telephone Conversation, 7 December, 1998.

claimed that thought and conscience were not covered in Article 18. This misconception was quickly corrected by reference to the relevant Article.

Towards the end of the conversation I found I had little confidence in her understanding of the process for which she had been responsible. By way of a test I asked her how many involuntary hospitalisations and community treatment orders are made each year in the state of New South Wales. The reason was to test whether her perception that there was not a human rights problem in this area was based on an informed overview of the situation. She was reluctant to answer at first but under pressure guessed it might be in the hundreds. The actual number for 1997 was almost twelve and a half thousand. This was about 20% more than 1996, and more than double the number in 1992.

Following this telephone conversation I received a letter from the Human Rights Commissioner which sought to clarify some of the issues that had been discussed and to bring the matters to closure. The Commissioner said he agreed "with a great deal of the argument"[96] contained in my submission. However, he went on to say that the Human Rights Commission had already investigated the human rights problems associated with mental illness in a specific inquiry into these matters in the early 1990s. "Having dealt with the issues in such depth in that inquiry I did not consider it necessary or justifiable to deal with them again in our much more limited inquiry into religious freedom. .... Religious freedom in most respects raises other human rights issues".[97]

But according to the mystical model for schizophrenia the Commissioner might be wrong to uncouple the problems of religious freedom from the threat of psychiatric coercion. On top of this the report of the earlier inquiry into human rights and mental illness, which the Commissioner refers to, does not deal with the issues raised by the Article 18 argument. In fact there was a fundamental unsoundness about this inquiry in that it failed to fulfil one of its key Terms of Reference: i.e. to inquire into the human rights and fundamental freedoms of people who are alleged to be mentally ill. This failure has already been discussed in detail in Chapter 2.

It would seem, therefore, that the Article 18 argument against psychiatric coercion still remains untested.

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[96] Chris Sidoti, Human Rights Commissioner, Human Rights and Equal Opportunity Commission, Sydney, Personal Correspondence, 23 December, 1998.

[97] Ibid.

Conclusion

Article 18 evidently provides a powerful human rights defence against forced psychiatric intervention for people who are undergoing a mystical/schizophrenic experience. This defence needs to be adapted to the specific provisions of each legal jurisdiction but the case study based on NSW legislation indicates that proper observance of Article 18 would severely restrict the range of people who could be involuntarily hospitalised.

In addition to the restriction on involuntary hospitalisation, neuroleptic drug treatment, without informed consent, would appear to be a straight-forward violation of Article 18. The unrestricted protection of the freedom of thought and the freedom to hold beliefs provided in Article 18 makes it impossible to apply involuntary treatment, using either conventional or 'atypical' neuroleptics, without violating the person's human rights.

This apparent obstacle to forced drug treatment conflicts with provisions allowing treatment without informed consent in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.[98] However, Article 18, in principle, over-rides the Principles. This is because Article 18 is contained in a UN Covenant and Covenants have higher status in international law than UN Principles.

[98] United Nations, Commission on Human Rights, 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care', Principle 11, op.cit., pp. 990-991.