9. Myth-of-Mental-Illness Model: Interest Groups and Human Rights Imperatives

Interest Groups

A discussion on the interest groups that support the myth-of-mental-illness (M-M-I) model is made problematic by the confusion of demarcation that generally exists between the mystical and M-M-I models. The type of analysis undertaken by this thesis has not been carried out before and, although analysis reveals these two models to be very different, most interest group activity in relation to schizophrenia is simply polarised between positions that are for and against the medical model. This means that the interest groups that are opposed to the medical model usually contain a confused mixture of positions.[1] Sometimes when the medical model is narrowly confined to biological theories these non-medical positions even include environmental theories of pathology, like problems in the family. But mostly the interest groups opposed to the medical model will simply mix the M-M-I and mystical models together[2] so that it is largely only the preferences of individual members that differentiates between them.

In this situation the public campaigning of interest groups opposing the medical model is more likely to be coloured by the M-M-I model than by the mystical model. Most of the activists who campaign for interest groups opposing the medical model are themselves former involuntary mental patients.[3] A frequently found common denominator amongst these former patients is that they have reached a point of maturity, or self-understanding, which largely removes them from the risk of further involuntary treatment. Rather than call themselves ex-patients they often prefer to be called 'psychiatric survivors'.[4] They tend to display a certain amount of pride in having survived a past ordeal and, when they are closely observed, it is apparent that the common ordeal they prefer to see themselves as having survived is abuse at the hands of the psychiatric profession, rather than a psychiatric illness.[5]

With these attitudes the logic of the M-M-I model is usually more accessible than that of the mystical model. Activists who oppose the medical model find that many medical beliefs and psychiatric treatments are easy targets on which to focus public scepticism and disapproval. When

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[1] See for example, National Mental Health Consumers' Self-Help Clearinghouse, Available URL, http://www.libertynet.org/~mha/cl_house.html

[2] See for example, Duncan Double, Antipsychiatry, 1999, Available URL, http://ourworld.compuserve.com/homepages/Duncan_Double/

[3] See for example, Act-Mad Mental Activism Discussion List, 1999, Available URL, http://www.rainier-web.com/actmad/index.html

[4] See for example, Psychiatric Survivor's Guide, 1999, Available URL, http://www.harborside.com/home/e/equinox/

[5] See for example, Victorian Advocates for Survivors of Therapists (VAST), 1999, Available URL, http://www.cs.utk.edu/~bartley/other/vast.html

the opportunity arises for publicity therefore it is usually not wise for an activist to risk an attempt at explaining schizophrenia in mystical terms. An M-M-I focussed attack on psychiatry can usually serve the anti-medical model cause more effectively, with far less attendant risk to the activist of appearing delusional or mentally disordered.

A further reason for the dominance of the M-M-I model amongst activist groups is that these groups are usually comprised of people with a mixture of psychiatric labels and therefore the groups are not structured for campaigning exclusively on the subject of schizophrenia.[6] Whereas other diagnostic categories, like depression and obsessive-compulsive disorder, do not lend themselves very well to a mystical interpretation, all opponents of the medical model can usually adapt to the M-M-I model. On top of this many activists claim not to have experienced any unusual psychological phenomenal prior to their forced treatment and can therefore only relate to the M-M-I model.

The interest groups associated with the M-M-I model are best described as solidarity groups and fall in the middle of Pross' "funnel of mobilisation",[7] between latent interests and formal interests, which were discussed in Chapter 2. These solidarity groups can be ranged along a spectrum of 'respectability' from a sub-grouping of the Church of Scientology, called the Citizens Commission on Human Rights (CCHR),[8] at one end of the spectrum; through Support Coalition,[9] an international network of psychiatric survivor groups; to research groups of dissident mental heath professionals, like the Peter Breggin led Center for the Study of Psychiatry and Psychology;[10] through to groups of civil liberties and human rights oriented legal professionals, like the US based National Association of Protection and Advocacy Systems,[11] at the other end of the spectrum.

Support Coalition is perhaps the most diverse and ambitious of these groups and warrants a detailed description. Support Coalition is a co-ordinated network of 60 psychiatric survivor groups, called sponsoring groups, ranging through eight different countries; Australia, Canada, France, Israel, New Zealand, Pakistan, the United Kingdom and the United States.[12] The majority are located in the United States. The head office of Support Coalition is in Eugene, Oregon (US) and some of the 60 affiliated groups are branches of Support Coalition while others are independent organisations which take advantage of the international reach of Support Coalition to amplify their voices.

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[6] See for example, Psychiatric Survivors Advocacy/Liberation Movement, 1999, Available URL, http://www.az.com/~bipolar/PSALMS.html

[7] P. A. Pross, Group Politics and Public Policy, Oxford Uni. Press, Toronto, 1986, p. 16.

[8] Citizens Commission on Human Rights, 1999, Available URL, http://www.cchr.org/cchrhome.htm

[9] Support Coalition, 1999, Available URL, http://www.efn.org/~dendron/

[10] Center for the Study of Psychiatry and Psychology, 1999, Available URL, http://www.breggin.com/

[11] National Association for Rights Protection and Advocacy, 1999, Available URL, http://www.connix.com/~narpa/

[12] Support Coalition International, 'List of S.C.I. Sponsor Groups and Spokes', Dendron, Nos. 39 and 40, Winter 1997- 98, pp. 46-47.

Support Coalition primarily relies on two separate methods to build solidarity amongst the groups and to focus campaigns on specific issues. The first is a journal called Dendron which is published several times a year and which carries articles written by members of the network about campaign issues.

The second method is more innovative and utilises the internet. There is a website[13] with extensive material about current campaigns focussed on issues like involuntary treatment, outpatients commitment and ECT. There are also four email lists run from the website.

The first of these email lists is not a discussion list but is used for human rights alerts when cases of particularly blatant human rights abuse come to the attention of the co-ordinator.[14] When this happens a 'Dendrite' is dispatched by email to over 1000 activists in various countries with instructions on how and where to lodge a protest by post or email. There are a number of instances where Support Coalition claims to have had resounding successes using this method by forcing mental health authorities to release individuals from involuntary hospitalisation or to cease forced treatment. The campaign technique seems to be most effective when it targets small-town mental health authorities who are easily embarrassed by international attention.[15]

The second email list which has about 150 international subscribers is called SCI — Support Coalition International. SCI is for members of Support Coalition's international network to exchange campaign news and to plan strategies. Most of the subscribers to SCI have past diagnoses of serious mental illnesses which do not appear to interfere in any way with their ability to articulate complex legal, scientific and political issues in clear simple prose. This, combined with the apparent technical mastery of internet methods of communication, provides significant evidence supporting aspects of the M-M-I model. The Support Coalition lists, in fact, are fairly remarkable for their total absence of the irrational outbursts that are characteristic of many email discussion lists. There is very little in the way Support Coalition members conduct their dialogues that gives any confirmation to the medical assumptions of mental incompetence inherent in the psychiatric labels they have received.

The other two Support Coalition lists are NOFORCE "for discussion about fighting forced psychiatry". And ZAPBACK "which is a fairly new email list for SCI members to discuss fighting electroshock human rights violations".[16]

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[13] Support Coalition, Available URL, op.cit.

[14] David Oaks, Co-Coordinator, Support Coalition International, P.O. Box 11284, Eugene, Oregon, 97440-3484, USA., email: dendron@efn.org

[15] Drug Free!, Dendron, Nos. 39 and 40, Winter 1997- 98, p. 5.

[16] David Oaks, SCI List (sci@efn.org), Support Coalition, 30 September, 1998.

Human Rights Imperatives

From the perspective of the myth-of-mental-illness (M-M-I) model the medical treatment for schizophrenia, particularly when it is given involuntarily, is quite unreasonable.[17] The neuroleptic drugs used as frontline treatment have powerful effects on the minds and bodies of the patients who are treated with them.[18] Some side effects of neuroleptic medication, like tardive dyskinesia, are probably the result of permanent brain damage.[19] If the symptoms of schizophrenia are in fact incorrectly classified as a medical problem then, even when recipients of treatment are volunteers, it is apparent that the medical practitioner offering the treatment has gained the patient's consent by supplying false information. This is bad enough. But when the treatment is given involuntarily, without consent, some very serious violations of basic human rights take place.

A person who is not committed to the M-M-I model might find this proposition thoroughly implausible. It is one thing, as an intellectual exercise perhaps, to assimilate and even acquiesce to the simple logic of the arguments given in the foregoing chapter. But it is altogether another proposition to acknowledge the corollary of these arguments: i.e. that the medical model for schizophrenia is causing human rights violations on a massive scale. In order to make the human rights arguments attached to the M-M-I model at least plausible it might be useful to lay some groundwork by offering a reasonable explanation for why this systematic injustice has developed.

According to the M-M-I perspective the explanation for why the medical model for schizophrenia is dominant, and so blatantly used for social control, in the face of common sense to the contrary, is a matter of long-standing legal necessity. This legal necessity concerns the availability of an insanity plea which can be used to escape criminal responsibility for breaches of the law.[20] The insanity plea has been deeply entrenched in legal custom from ancient times[21] and, so long as it continues to be available — and so long as the symptoms of schizophrenia are thought to be indications of madness — people who manifest these symptoms cannot be held criminally responsible for their actions. The underlying logic of the M-M-I model is that in this situation it is necessary to have an alternative to the criminal justice system to control people who manifest the signs of madness/insanity in order to protect the public from their actions.

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[17] Peter Breggin, Toxic Psychiatry, Fontana, London, 1983, pp. 57-83.

[18] Alan I. Green and Jayendra K. Patel, 'The new pharmacology of schizophrenia', Harvard Mental Health Letter, Vol. 13, No. 6, Dec 1996, pp. 5-8.

[19] B. Bower, 'Rat model of tardive dyskinesia gets boost', Science News, Vol. 136, No. 20, 11 Nov, 1989, p. 308.

[20] Thomas Szasz, Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices, Routledge and Kegan Paul, London, 1974, pp. 126-127.

[21] Chester R. Burns, 'American Medico-Legal Traditions and Concepts of Mental Health: The Nineteenth Century', in H. Tristram Engelhardt, Jr., ed., Mental Health: Philosophical Perspectives, D. Reidel, Dordrecht, Holland, 1976, pp. 3-14.

It should be noted that this explanation of the situation implies that even in the absence of a medical system for identifying, treating and controlling people who manifest the symptoms of schizophrenia there would still need to be another system of socially alienating mad people. And in their alienation these people would still most likely be labelled in non-medical terms as child-like, mad and insane. They would also still have a chance of escaping criminal responsibility for their actions. This indeed was the case before the development of the medical model.[22] Acceptance of the M-M-I model does not necessarily preclude a belief in a lay understanding of madness/insanity, but only that the medical interpretation of this understanding is inappropriate.

Background to the Insanity Plea

There is a long-standing tradition in most legal systems that allows two kinds of excuses as a justification for breaking the law.[23] The first is the argument that the illegal act was committed in ignorance.[24] Here one person might shoot another. But the shooter can try to claim it was an accident because he or she did not know the gun was loaded. Or, one person might admit to poisoning another after cooking a meal. But the poisoner might claim that he or she did not know that rat poison was kept in the jar marked 'food colouring'. The excusing of children from legal culpability is derived from this area and when a child is found to have committed a serious offence it is assumed that he or she did not know any better.

The second kind of excuse occurs when the perpetrator can claim that he or she was compelled to act in a particular way. Self-defence and extreme provocation are included in this area. Acts committed under duress of threats, as well as behaviour that is motivated by extremes of emotion, might also be excused on the grounds of compulsion.[25]

There is a long history of excusing people who are deemed to be insane at the time of committing a crime, on one or the other, or both, of these grounds. Roman law of the latter Empire period excused insane people because an analogy was drawn between them and children.[26] Ancient Hebraic law "recognised that deaf-mutes, idiots and minors were not responsible for their actions"[27] and "[a]ncient Mohammedan law applied punishment only to individuals who have attained their majority, and who are in full possession of their faculties".[28]

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[22] Michael S. Moore, 'Legal Conceptions of Mental Illness', in Baruch A. Brody and H. Tristram Engelhardt, Jr., eds., Mental Illness: Law and Public Policy, D. Reidel Publishing, Dordrecht/Boston, 1980, p. 27.
[23] Ibid., p. 27-33.
[24] Jerome Neu, 'Minds on Trial', in B. A. Brody and H. T. Engelhardt, Jr., eds., Mental Illness: Law and Public Policy, D. Reidel Publishing, Dordrecht/Boston, 1980, p. 82.
[25] Ibid., pp. 90-100.
[26] Moore, op.cit., p. 27.
[27] Ibid.
[28] Ibid.

In modern times countries with legal systems derived from English law have developed a test for insanity which excuses legal culpability when the person, at the time of committing the crime, is believed to be unaware of the difference between good and evil. The legal precedent which establishes this test is known as the M'Naghten case.[29]

In England in 1843 Daniel M'Naghten assassinated Edward Drummond, who at the time was the private secretary of the Prime Minister. M'Naghten claimed to believe that a number of people, including the Prime Minister, were persecuting him in various ways. At his trial M'Naghten successfully defended his actions on the grounds of insanity but after the trial many people still believed he might only have been feigning his madness. As a result the judges in the case were asked to appear before the House of Lords and explain the test of insanity they had applied to M'Naghten. The answer supplied by the judges has since become the basis for a test of criminal insanity:

> To establish a defence on the grounds of insanity, it must be conclusively proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from the disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know what he was doing was wrong. (*Regina v. M'Naghten*, 10 Clark and F. 200, 8 Eng. Rep. 718 (1843)).[30]

The so-called M'Naghten test soon became established in English-speaking countries as the principle test of legal insanity but it also came under persistent criticism because it was thought to be too narrow in its definition. This was because it only covered the traditional defence of ignorance and did not provide a defence for a person who was aware of the nature of the act, and aware that it is wrong, but all the same was compelled by mad impulses to act contrary to the law.

In the United States this controversy finally produced a definition by the American Law Institute which incorporated both defences:

> (1) a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law.
> (2) the terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.[31]

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[29] Neu, op.cit., pp. 81-82.
[30] Moore, op.cit., p. 28.
[31] Ibid., p. 30.

The clarification of the meaning of mental disease by excluding "abnormality manifested only by repeated criminal or otherwise antisocial conduct" points to a simmering demarcation dispute over the boundaries of professional territory which has been going on between the legal and the medical professions ever since the medical profession secured its tenure over the madness industry. Some elements of the medical profession would be only too happy to medicalise all transgressions of the law[32] and the above exclusion is to ensure that the bulk of criminal offenders remain accountable to the legal process.

More recently, under the New South Wales Mental Health (Criminal Procedure) Act 1990,[33] the related problems of 'ignorance', 'compulsion' and 'professional demarcation', as they relate to the insanity plea, have been handled differently. The trend now is to define 'mental illness' in the legislation so that the interpretation of the condition is a legal matter as well as a medical matter. Then, the terminology of criminal insanity is omitted and replaced with 'mental illness'. This creates conditions whereby a person, who at the time an offence was committed is deemed to have been mentally ill, according to the legal definition of mental illness, is not to be held responsible for criminal acts.

The definition of mental illness given in the NSW Mental Health Act 1990 is a very simple one involving five symptoms.[34] The presence of any single symptom indicates that a person is mentally ill. In respect to legal action, normally only medical practitioners are authorised to identify the symptoms. As has been discussed in an earlier chapter four of the five symptoms are also listed as DSM-IV Criterion A positive symptoms for schizophrenia.

This means that a contemporary medical practitioner in NSW, who encounters a person manifesting positive symptoms for schizophrenia, and who thinks the person might also be at risk of causing serious harm, is legally authorised to have the person incarcerated, involuntarily if necessary, in a mental hospital.[35] Now this is where the existence of the insanity plea is important as a background motivator for the medical impositions that are placed on the person.

Ostensibly the doctor is free to choose, or not to choose, to have the person incarcerated, according to the best interests of the patient. But in reality, from the M-M-I perspective, a doctor involved in psychiatric matters is simply an agent of social control. As such the doctor is required to consider the consequences of allowing the person with schizophrenic symptoms to remain free. Having

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[32] Jane Ellen Stevens, 'The biology of violence', BioScience, Vol. 44, No. 5, May, 1994, pp. 291-295.
[33] Mental Health (Criminal Procedure) Act 1990, NSW Government Information Service, Reprinted as in force at 17 October, 1994.
[34] Mental Health Act 1990, Schedule 1, NSW Government Information Service, Reprinted as in force at 17 October, 1994, pp. 115-116.
[35] Mental Health Legislation Amendment Bill 1997, Section 9, Assented to by the NSW Parliament 26th June, 1997, p. 3.

diagnosed the person as schizophrenic, and therefore as being mentally ill in a legal sense, the doctor has in effect provided the person with a legal excuse to get away with murder, or any other crime, in the future.

From the criminal justice perspective, therefore, a diagnosis of serious mental illness, without a subsequent imposition of control, has to be seen as a sign of professional irresponsibility. The precautionary control of people who could possibly invoke an insanity plea is a necessary task that goes with the job of doctor.

Occasionally it is necessary to give the medical profession an oblique reminder of their social control duties in this area. A recent case in the United States is a good illustration. The October 10, 1998 edition of the New York Times reported a front page story with a headline that tells it all — "Killer Sues His Therapist and Wins $500,000".[36]

Wendell Williamson was a law student at the University of North Carolina when he was first directed to attend a consultation with Myron B. Liptzin, the head of student psychiatric services, after he disrupted a class by claiming he had telepathic powers. Liptzin diagnosed Williamson with delusional disorder grandiose and prescribed neuroleptic medication. After eight consultations Liptzin informed Williamson that since he was soon to retire Williamson should find another psychiatrist. Williamson did not follow Liptzin's advice and instead of finding another psychiatrist he simply stopped taking the medication.

Eight months after the last contact with Liptzin, Williamson shot two men in the street without provocation. He was diagnosed with paranoid schizophrenia and at his trial was found innocent on the grounds of insanity. At a subsequent trial he was awarded $500,000 in damages against Liptzin, his former psychiatrist. The damages were awarded because a jury believed that Liptzin had not correctly perceived the seriousness of Williamson's disorder and had not imposed the necessary control measures. A newspaper report said Williamson claimed that,

> the verdict in the civil case showed that he and the people he killed were all victims of Dr. Liptzin's failure. "The murders would not have happened if Dr. Liptzin had done his job properly." Williamson testified at trial of his suit last month, telling the jurors that Dr. Liptzin "had more control over the situation than I did."[37]

Williamson's success with this unlikely argument is an unequivocal message to psychiatrists that the justice system expects them to impose precautionary control measures on anyone they encounter

[36] William Glaberson, 'Killer Sues His Therapist and Wins $500,000', New York Times, 10 October, 1998, p. 1.
[37] Ibid., p. 1.

who might be violent, and who is likely to escape criminal liability with an insanity plea. This type of message is particularly disturbing to those who subscribe to the M-M-I perspective because it tends to reinforce the expectation of an authoritarian imposition of the medical model. Thomas Szasz and Jeffrey Schaler are leading advocates of the M-M-I model and they both responded within a few days of the Williamson story with letters to the editor.

> To the Editor:
> That killers can successfully blame their therapists for their actions (front page, Oct. 10) is the consequence of the fiction of mental illness and the junk science of psychiatry that it supports. Although lawyers, psychiatrists and society conspire in the twin charades of civil commitment and the insanity defence, the main culprits are the mental health professionals. If they believed in personal responsibility rather than in mental illness — and rejected the practices of depriving innocent people of liberty and excusing guilty people of crimes — we would be spared the spectacle of criminals' being acquitted of crimes and collecting damages as if they were the victims of untreated diseases.
> THOMAS SZASZ, M.D., Syracuse, Oct. 10, 1998
> The writer is professor emeritus of psychiatry at SUNY Health Science Center.[38]

> To the Editor:
> Why did a jury hold a psychiatrist, Myron B. Liptzin, accountable for Wendell Williamson's murderous acts (front page, Oct. 10)? Because psychiatrists invented and perpetuate the myth of mental illness. As long as people believe in mental illness as a cause for behaviour, those who receive such a "diagnosis" will be exculpated — and someone else will be culpable.
> Since psychiatrists removed the blame, it is only fitting that they should be saddled with it.
> JEFFREY A. SCHALER, Silver Spring, Md., Oct. 10, 1998
> The writer is an adjunct professor of justice, law and society at American University.[39]

Despite these M-M-I arguments, and numerous doubtful applications of the insanity plea like Williamson's, it is still apparent that most people agree that an insanity plea should be available. Without it, undoubtedly, some people would be unjustly punished for crimes they were incapable of understanding. If an insanity plea is an inevitable component of a modern criminal justice system then for it to exist it is apparent that the definition of insanity must be couched in some kind of socially comprehensible framework. The range of possibilities in this respect seem to be limited to

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[38] Thomas Szasz, Letter to the Editor, New York Times, 14 October, 1998.
[39] Jeffrey A. Schaler, Letter to the Editor, New York Times, 14 October, 1998.

analysing mental and/or moral incompetence in terms of either a religious, philosophical or medical framework.

Szasz's solution is for all accused people to be tried and a verdict reached. A court would then consider pleas of mitigating circumstances as part of the sentencing procedure. In the meantime the essential problem from the M-M-I perspective is that any positive effect on human rights gained by the application of a medically-defined insanity plea is disproportionately counter-balanced by a negative effect.[40] The negative effect is caused by the large number of innocent people who become victims of precautionary control measures.

Some comparative figures might be useful to illustrate this point. In NSW in 1996, for instance, there were 10 people who were tried for criminal offences and who were found not guilty by reason of mental illness.[41] A further 3 people were found mentally unfit for trial.[42] These 13 people who escaped criminal liability in that year can be compared to 7,601 involuntary admissions to mental hospitals,[43] 2,095 Community Treatment Orders[44] and 167 Community Counselling Orders,[45] totalling 9,863 involuntary impositions, in the same legal jurisdiction in the same year.

All of these involuntary impositions required a medical opinion that the people involved were at risk of causing serious physical harm to themselves or other people. But what was the real risk? For every case where a person did successfully evade criminal liability on the grounds of mental illness there were some 760 occasions on which innocent people had their human rights violated as a precautionary measure.

Relevant Human Rights

When viewed from the M-M-I angle it can be argued that people who are involuntarily hospitalised as a precautionary measure routinely have their human rights violated by the deprivation of liberty and the imposition of forced treatment. Article 9 of the International Covenant on Civil and Political Rights (ICCPR) guarantees:

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[40] Thomas Szasz, Law, Liberty, and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices, op.cit., pp. 228-230.
[41] Mental Health Review Tribunal, Annual Report , NSW Government, 1996, p. 50.
[42] Ibid., p. 50.
[43] Ibid., p. 57.
[44] Ibid., p. 39.
[45] Ibid., p. 37.

> Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with procedure as are established by law.[46]

The key word here is 'arbitrary'. If correct procedures are followed and there is good reason to arrest a person, because he or she has broken a law, then the person no longer has a right to liberty. But on most occasions when schizophrenics are involuntarily hospitalised it is not in response to a breach of the law but is only a precautionary measure. Is this arbitrary? If, as the M-M-I model asserts, there is no disease underlying the symptoms, the answer to this question revolves around whether the psychiatric diagnostic processes, even though they arbitrarily attribute the symptoms to a non-existent disease, can still accurately select people who are in need of control because they are dangerous to themselves or other people.

A great deal of research has been undertaken to determine whether people with the symptoms of schizophrenia, and other mental disorders, are more dangerous than other people.[47] The results of this research vary from marginally more dangerous[48] to being no more violent than the general population.[49] In the context of this research it is frequently observed that there are some other classes of people, like young men between the ages of 15-25, and men consuming alcohol, who are statistically far more dangerous to other people than schizophrenics.[50] Since it would be considered a blatant transgression of human rights to incarcerate all young men, and/or all alcohol drinkers, the rhetorical question is sometimes posed as to why it is thought just to incarcerate a statistically less dangerous group on the grounds of their supposed dangerousness.

Nor is there scope for the simple retort that schizophrenics are also incarcerated in order to protect them from themselves because of their supposedly high suicide rate.[51] A far higher suicide rate prevails amongst people who have already attempted to kill themselves, particularly when there is a background of childhood sexual abuse.[52] This is a group on whom no precautionary incarceration is

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[46] United Nations, 'International Covenant on Civil and Political Rights', Article 9, reproduced in Satish Chandra, ed., International Documents on Human Rights, Mittal Publications, New Delhi, 1990, p. 29.

[47] See for example, Dan Hurley, 'Imminent danger', Psychology Today, Vol. 27, No. 4, July-August 1994, p. 54-63.

[48] G. D. Glancy, C. Regehr, 'The Forensic Psychiatric Aspects of Schizophrenia', Psychiatric Clinics of North America, Vol. 15, No. 3, 1992, pp. 575-589.

[49] David Shore, Schizophrenia: Questions And Answers, Schizophrenia Research Branch, National Institute of Mental Health, 1995.

[50] Bruce Bower, 'Law and Disorders: Studies explore legally sensitive judgments in treating mental illness', Science News, Vol. 147, No. 1, 7 January, 1995, pp. 8-11.

[51] E. Nieto, E. Vieta, C. Gasto, J. Vallejo, and E. Cirera, 'Suicide Attempts of High Medical Seriousness in Schizophrenic Patients', Comprehensive Psychiatry, Vol. 33, No. 6, 1992, pp. 384-387.

[52] A. L. Beautrais, Peter R. Joyce and Roger T. Mulder, 'Risk factors for serious suicide attempts among youths aged 13 through 24 years', Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 35, No. 9, Sept, 1996, pp. 1174-1183.

imposed. Nor is there any institutionalised intervention in the lives of people who pursue life-threatening dangerous sports, like mountain climbing and car racing. On the contrary, such people are encouraged because they inspire normal people with their willingness to take risks.

In the context of this debate about the need to take schizophrenics into custody in order to protect them from themselves there is an interesting statistic. It seems that schizophrenics undergo a particularly high risk of suicide shortly after they are released from hospital.[53] This can be interpreted in a number of different ways. On the one hand it could be argued that hospitalisation protects a person from suicidal impulses and those who suicide after release should have been kept in longer. But on the other hand it can also be argued that it is the treatment, or the humiliation of the incarceration experience itself, that causes people to suicide as soon they get a chance.

The possibility that neuroleptic treatment might induce suicidal or violent reactions is very disturbing. Neuroleptic-induced akathisia is a side-effect of standard drug treatment for schizophrenia: "The individual is virtually tortured from inside his or her own body as feelings of irritability and anxiety compel the person into constant motion, sometimes to the point of continuous suffering".[54] DSM IV is unequivocal about the risks of suicide and violence associated with neuroleptic medication:

> Akathisia may be associated with dysphoria, irritability, aggression, or suicide attempts. Worsening of psychotic symptoms or behavioural dysfunction may lead to an increase in neuroleptic medication dose, which may exacerbate the problem. Akathisia can develop very rapidly after initiating or increasing neuroleptic medication. The development of akathisia appears to be dose dependent and to be more frequently associated with particular neuroleptic medications. Acute akathisia tends to persist for as long as neuroleptic medications are continued, although the intensity may fluctuate over time. The reported prevalence of akathisia among individuals receiving neuroleptic medication has varied widely (20%-75%).[55]

If mainstream psychiatric manuals observe that up to 75% of the people who are treated for schizophrenia are put at increased risk of suicide as a result of a side effect, then it would seem somewhat paradoxical to argue that the same schizophrenics need to be locked up to ensure they are given treatment to *protect* them from suicide.

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[53] B. J. Carone, M. Harrow, and J. F. Westermeyer, Posthospital Course and Outcome in Schizophrenia, Archives of General Psychiatry, Vol. 48, No. 3, 1991, pp. 247-253.

[54] Peter Breggin and David Cohen, Your Drug May Be Your Problem, Perseus Books Reading Massachusetts, 1999, p. 78.

[55] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM IV), Fourth Edition, American Psychiatric Association, Washington, 1994, p. 745.

Torture and Cruel Treatment

Another article of human rights law that is of particular interest to proponents of the M-M-I model is Article 7 of the ICCPR:

> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.[56]

The linkage in Article 7 between torture and unreasonable forms of punishment, on the one hand, and medical experimentation on the other, is noteworthy. From the M-M-I angle all medical treatment for mental illnesses is, and can only be, experimental.[57] And further, since there is thought to be no illness underlying the supposed symptoms of schizophrenia the rationale for applying medical treatment can only be explained in terms of punishment. That is, punishment for having allowed thoughts, beliefs and behaviour to have crossed a threshold of social tolerance.

Concerns about torture and unreasonable forms of punishment are so fundamental to human rights that a special United Nations convention is dedicated to their elimination, which is supplementary to Article 7. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment conveniently supplies a definition of torture as:

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[58]

The exclusion described in the last sentence is concerned with the application of prescribed punishments for specific breaches of the law. In some countries, for instance, whipping is still used as a punishment for certain criminal offences and the intention of the Convention is to exclude such "lawful sanctions" from the definition of torture. However, if medical treatment for schizophrenia

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[56] United Nations, 'International Covenant on Civil and Political Rights', Article 7, op.cit., p. 29.

[57] Scott O. Lilienfeld, 'Pseudoscience in Biological Psychiatry: Blaming the Body', Skeptical Inquirer, Vol. 19, No. 6, Nov-Dec 1995, pp. 45-48.

[58] United Nations, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G. A. res. 39/46, annex, 39 U. N. GAOR Supp. (No. 51) at 197, U. N. Doc. A/39/51 (1984), entered into force June 26, 1987, Available URL, http://www.umn.edu/humanarts/instree/h2catoc.htm

can be shown to fit the former part of the definition of torture then it is unlikely that it would be excluded merely because it has lawful sanction under mental health legislation. It can be assumed that the lawful sanction for the application of medical treatment for schizophrenia is only given on the assumption that it will benefit the patient, not that it will deliberately cause pain and suffering.

An M-M-I argument can be made that medical treatment for schizophrenia fits the above definition of torture because it causes: *severe physical and mental suffering; it is intentionally inflicted on a person for the purpose of obtaining a confession in the form of a demonstration of 'insight'; it intimidates and coerces the person to change his or her pattern of thinking and belief; and, in the case of involuntary treatment, the mental suffering is inflicted by a government employed psychiatrist acting in an official capacity.*

The assertion that schizophrenia treatment causes physical and mental suffering in those who receive it is not difficult to establish. Medical treatments for madness, from the 15th century onwards, have almost always done so. Some noteworthy examples are "stone operations — that is, pretending to remove stones from incisions made in the heads of patients thought to be mad".[59] This European practice, which flourished between the 15th and 17th centuries, is thought to be the origin of the description of a mad people as having 'rocks in their heads'.[60]

A 17th century English medical text-book on madness relates "that the observations that sword wounds penetrating the skull sometimes produced a cure for insanity led to operations to let out the 'fuliginous humours' by boring the skull".[61] The 19th century saw the widespread use of treatments such as prolonged exposure in cold water, shock therapy by the sudden dunking in cold water on the opening of a trap-door, and a rotating swing device in which the patient's head was strapped into a position in which the centrifugal force pushed more blood into the brain.[62]

There have also been various kinds of infection therapies whereby pustules and running sores have been deliberately induced on the scalp so that they could be incised to let "the black vapours escape".[63] Early in the 20th century fever therapies were used by infecting psychiatric patients with tuberculin, typhoid and malaria.[64] The exponents of all these improbable treatments claimed success at the time they were applying them and, if it is true that such applications can indeed eliminate the symptoms of schizophrenia then, from the M-M-I perspective, it is simply a demonstration that torture and punishment can persuade people to change their minds.

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[59] Elliot S. Valenstein, 'Historical Perspective', in Elliot S. Valenstein, ed., The Psychosurgery Debate, W. H. Freeman, San Francisco, 1980, p. 15.
[60] Ibid.
[61] Ibid.
[62] Ibid., p. 22.
[63] Ibid., p. 17.
[64] Ibid.

It was not until well into the 20th century, with the advent of more sophisticated medical treatments like insulin coma treatment in the late 1920s,[65] and in the 1930s metrazol convulsive treatment,[66] psychosurgery[67] and electro convulsive treatment (ECT),[68] that schizophrenic patients were properly introduced to modern medical practices. Insulin and metrazol have long ago been phased out as schizophrenia treatments but the record of their usage is quite relevant to the current discussion on torture. Early psychiatric pioneers of these treatments were often candid in their opinions about the usefulness of insulin and metrazol in 'fear therapy':

> No reasonable explanation of the action of hypoglycaemic (insulin) shock or of epileptic fits in the cure of schizophrenia is forthcoming, and I would suggest as a possibility that as with the surprise bath and the swinging bed, the 'modus operandi' may be the bringing of the patient into touch with reality through the strong stimulation of the emotion of fear, (and) that the intense apprehension felt by the patient after an injection of cardiazol (metrazol), and so feared by the patient, may be akin to the apprehension of the patient threatened with the swinging bed. The exponents of the latter pointed out that fear of repetition was an important element in success.[69]

During insulin treatment a person experienced a range of symptoms beginning with clouding of consciousness and progressing to wild excitement, involuntary gasping and sucking, protrusion of the tongue, snarling, grimacing, twitching, convulsions, spasms and deep coma.[70] It is reported to be a very unpleasant experience.[71] One line from the quotation above worth repeating concerns the "bringing of the patient into touch with reality through the strong stimulation of the emotion of fear". The reality presumably presented to the patient was that if he or she was not prepared to cease manifesting schizophrenic symptoms, and make the required adjustments of thinking and belief, then the patient would be made to suffer more insulin or metrazol treatments. This is a fairly concise description of torture, and the objective of torture — i.e. compliance.

> The patient is mentally sick, his behaviour is irrational; this "displeases" the physician and, therefore, the patient is treated with injections of insulin which make him quite sick. In this extremely miserable condition he seeks help from anyone who can give it.

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[65] Leonard Roy Frank, The History of Shock Treatment, Leonard Roy Frank, San Francisco, 1978, p. 5.
[66] Ibid.
[67] Valenstein, op.cit., pp. 20-23.
[68] Frank, op.cit., p. 8.
[69] P. K. McCowan, 98th Annual Report for 1937 of the Crichton Royal Institution, Dumfries (Scotland). Quoted in L. C. Cook, 'Has fear any therapeutic significance in convulsion therapy?', Journal of Mental Science, Vol. 86, No. 484, 1940. Quoted in Frank, op.cit., p. 6.
[70] Frank, op.cit., p. 7.
[71] Ibid., pp. 5-7.

> Who can give help to a sick person, if not the physician who is constantly on the ward, near the patient, and watches over him as over a sick child?[72]

Don Weitz is a psychiatric survivor and an antipsychiatry activist based in Toronto, Canada. He produces an antipsychiatry radio programme called Shrinkrap and is the co-founder of a Toronto-based organisation called People Against Coercive Treatment (P.A.C.T.). A perception that the forced insulin treatment he received as a young man was a deliberate form of torture motivates his ongoing campaign against psychiatric coercion.

> I was once tortured for six weeks 46 years ago — it happened in December 1951 and January 1952. I was forcibly subjected to a series of over 50 sub-coma insulin shocks which psychiatrist Douglas Sharpe prescribed as a treatment for "schizophrenia". I never believed I was "schizophrenic" or "mentally ill" — just a very confused college student struggling to find himself, a common identity crisis. I was an involuntary psychiatric patient in McLean Hospital (a teaching-research facility affiliated with Harvard Medical School and Massachusetts General Hospital).
>
> Psychiatrist Douglass Sharpe prescribed a series of insulin shock treatments for me because I was openly angry and defiant. Here's a telling excerpt by Dr. Sharpe in my medical records: "The patient was finally placed on sub-coma insulin and after a month of sub-coma insulin three times a day he showed tremendous improvement...There was no longer the outbursts of anger...He spends most of his time trying to figure out what the effect of insulin has on him..."
>
> The shock treatments terrorised and debilitated me. I once went into a coma and thought I was dying — a "side effect" Dr. Sharpe and other psychiatrists never warned me about. When I frequently complained to Dr. Sharpe about the maddening hunger, profuse sweating and convulsions I was forced to experience everyday on insulin-shock and that it was torture, he dismissed my complaints and calmly replied, "I'm not torturing you. These complaints are just part of your problem." The usual blame-the-victim game. I was finally released in 1953 only after I promised to conform to the psychiatrists' stereotype of a middle-class young student — study and go back to college.
>
> It took me almost 20 years to understand my forced psychiatric incarceration and forced treatment in political terms, 20 years to realise that I was a political prisoner of

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[72] Marcus Schatner, 'Some observations in the treatment of dementia praecox with hypoglycemia: part 2, psychological implication', Psychiatric Quarterly, Vol. 12, No. 1, 1938, pp. 22-26. Quoted in Frank, Ibid., pp. 6-7.

> psychiatry — locked up against my will, tortured, no right to a hearing or trial before losing my freedom, no right to appeal.[73]

Like insulin treatment, ECT has also earned a reputation as a 'fear therapy'.[74] Sylvia Plath described a personal experience of ECT in The Bell Jar.

> "Don't worry," the nurse grinned down at me. "Their first time everybody's scared to death."
> I tried to smile, but my skin had gone stiff, like parchment.
> Doctor Gordon was fitting two metal plates on either side of my head. He buckled them into place with a strap that dented my forehead, and gave me a wire to bite.
> I shut my eyes.
> There was a brief silence, like an indrawn breath. Then something bent down, and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant. I wondered what terrible thing it was that I had done.[75]

Unlike insulin and metrazol, ECT is still widely used as a psychiatric treatment although, unlike Sylvia Plath's experience, patients are now anaesthetised first. Even so, fear of the experience has been well documented. One group of researchers exploring the role of fear in ECT elicited comments from patients who had undergone it:

> Reaction ranged from strong denial of fear, such as "I'm glad to take it," to fear of total mental destruction or death, such as "Shock will destroy my mind," "My heart will stop," "I will die." Many subjects expressed fears of being electrocuted, such as one who said, "It's like being burned to a crisp." Often the subject revealed under questioning a high degree of fear after first denying any fear, such as a depressed subject who admitted "I'm scared to death every time. I never know if I'm going to come out of it or not." A very psychotic subject described ECT as "like crossing a river."[76]

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[73] Don Weitz, 'Cruel and Usual — A Human Rights Violation', unpublished article, posted on, Support Coalition SCI list (internet discussion list), 4 December, 1998.
[74] Evelyn Crumpton, Norman Q. Brill, Samuel Eiduson and Edward Geller, 'The role of fear in electroconvulsive treatment', Journal of Nervous and Mental Disorders, Vol. 136, 1963, pp. 29-33.
[75] Sylvia Plath, The Bell Jar, Bantam, New York, 1972, pp. 117-118.
[76] Crumpton et al, op.cit., pp. 29-33.

In the past ECT was, for a time, the main treatment for schizophrenia.[77] More recently it has been largely reserved for so-called drug resistant cases of severe depression.[78] However, ECT is still recommended in treating acute symptoms of schizophrenia "in certain patients who are in severe states of withdrawal (catatonia) or who present with significant affective symptoms such as uncontrolled mania".[79]

The medical profession often seem to have a blind spot in their collective conscience concerning the difference between treatment and torture when electric shocks are involved. When electric shock is applied to the genitals it is unequivocally torture. This point if illustrated by an article in Australian Doctor which reports on evidence gathered by the London-based Medical Foundation for Victims of Torture. It relates how a Sudanese political prisoner was subjected to "burns with cigarettes and a hot metal bar, electric shock treatment to his genitals and scalding with boiling water".[80] However, when a person is imprisoned in a mental hospital, subjected to toxic chemicals and electric shocks to the head, it is called treatment.

Psychosurgery is another psychiatric treatment that was widely used for schizophrenia in the past, but which contemporary psychiatrists now reserve for other mental illnesses, like depression and obsessive-compulsive disorder.[81] Psychosurgery is a form of psychiatric treatment which ordinary people have little trouble understanding. Its conception is not much more sophisticated than an operation to cut a rotten spot out of an apple. It relies on crudely conceived brain-mapping which purports to locate specific forms of deviant mental activity in certain areas of the brain.[82] The basic principle is that unwanted mental activity can be surgically removed. The effects of psychosurgery are irreversible.

Psychosurgery has been "practiced in most countries with the necessary technical skills"[83] but it particularly boomed in the United States in the late 1940s and early 1950s, shortly before the widespread adoption of antipsychotic drugs. In Britain, between 1942 and 1954, 10,365 people were given leucotomy operations, two-thirds of them being performed on schizophrenics.[84] At this

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[77] Marin Fine and Michael A. Jenike, 'Electroshock: exploding the myths', RN, Vol. 48, Sept 1985, pp. 58-64.

[78] Egon Weck, 'Electro 'shock' therapy; controversy without end?', FDA Consumer, Vol. 20, March 1986, pp. 8-12.

[79] Deborah Dauphinais, Medications for the treatment of schizophrenia: questions and answers, Pamphlet produced by U.S. Department of Health and Human Services, Washington, 1992.

[80] Lynda Griffiths, 'BMA condemns torture cases', Australian Doctor, 25 September 1998, p. 82.

[81] Neuropsychiatric Institute, General Information, Neuropsychiatric Institute (NPI), Prince Henry Hospital, Sydney, Australia, 1999, Available URL, http://acsusun.acsu.unsw.edu.au/~s8700122/npiphh.html/#NPS

[82] Thomas H. Lewis, 'Psychosurgery: Damaging the Brain to Save the Mind', JAMA, The Journal of the American Medical Association, Vol. 269, No. 8, 24 Feb, 1993, p1051-1053.

[83] F. A. Whitlock, 'Psychosurgery', in Erica M. Bates and Paul R. Wilson, eds., Mental Disorder or Madness, University of Queensland Press, St Lucia, 1979, p. 182.

[84] Ibid.

time insulin and metrazol were passing out of favour for schizophrenia treatment and mental hospitals were over-crowded with war veterans from World War II.

The popularisation of psychosurgery in the United States was largely attributable to Walter Freeman and James Watts, who jointly developed new techniques. Freeman was a neuropsychiatrist, and Watts a neurosurgeon, and in 1946 they performed the first operation using a new all-purpose technique called transorbital lobotomy: "The only instrument needed was a simple penetrating and cutting tool, which was forced through the bony orbit over the eye to enter the region of the frontal lobes".[85]

This instrument, which Freeman referred to as resembling "an ice-pick",[86] was called a leucotome and, being a blunt instrument in both literal and metaphorical senses, was driven into the frontal lobe area with the aid of a mallet. Once in place it was rotated "so that the cutting edge would destroy fibres at the base of the frontal lobes".[87] Estimates for the number of first wave lobotomy operations performed in the United States using this method range up to 50,000.[88] One of the main reasons for this popularisation was that:

> transorbital lobotomies were relatively easy to perform and electroconvulsive shock was frequently used in place of anaesthesia, the surgery was commonly performed by psychiatrists without the involvement of neurosurgeons, anaesthetists, and surgical amphitheatres. In some instances, the operation was performed as an office procedure and the patient was taken home by the family a few hours after the operation.[89]

What the family took home, however, was a very different person to the one they had taken in.

> Typically the patient tends to become more inert, and shows less zest and intensity of emotion. His spontaneous activity tends to be reduced, and he becomes less capable of creative productivity, which is independent of the intelligence level .... With these changes in initiative and control of behaviour, our patients resemble those with frontal lobe lesions.[90]

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[85] Valenstein, op.cit., p. 26.
[86] Ibid.
[87] Elliot S. Valenstein, 'Rationale and Surgical Procedures', Valenstein, ed., op.cit., p. 69.
[88] Valenstein, 'Historical Perspective', op.cit., p. 27.
[89] Ibid., p. 26.
[90] R. Anderson, 'Differences in the course of learning as measured by various memory tasks after amygdalectomy in man', in E. Hitchcock, L. Laitinen and K. Vaernet, eds., Psychosurgery, Charles C. Thomas, Springfield Ill., 1972, pp. 177-183. Quoted in Peter R. Breggin, 'Brain-Disabling Therapies', in Valenstein, ed., op.cit., p. 491.

An extensive study undertaken by P. MacDonald Tow in 1955 of Personality Changes Following Frontal Leucotomy found very significant changes in intellectual functions including "impairment of the powers of abstraction and synthesis; of perception of relations and differences; of the ability to deal with complex situations, planning and thinking out of the next action and its consequences; and appreciation of one's own mistakes. .... There is also impairment of the power of sustained attention and of the capacity for fine discrimination; and a dulled appreciation of the subject's own level of success or failure".[91]

Tow also examined journals written by patients before and after their psychosurgery. The post-surgery journals were particularly good indicators of the effects of the operation and showed that patients had deeply felt concerns about loss of creativity and self awareness and in particular they frequently had "a terrible fear of being harmed and controlled by scientific and psychiatric technology."[92] Breggin describes having made similar observations in post-psychosurgery patients: "I have observed a florid paranoid schizophrenic with terror of being controlled by psychiatric technology following amygdalotomy".[93]

There is little doubt that psychosurgery — when it was performed on involuntary schizophrenic patients, and viewed from the M-M-I perspective as a punishment — could be neatly fitted into the United Nations definition of torture. But the psychiatric profession claims to have discontinued the use of psychosurgery to treat involuntary schizophrenic patients and so to properly examine the M-M-I based human rights imperatives it will be necessary to discuss the treatments that are currently in usage. The reason for discussing past treatment methods is to clearly demonstrate that there is a long tradition in psychiatric practice of applying torturous treatments to people who manifest the symptoms of schizophrenia.

Neuroleptics, the M-M-I Model and Human Rights

As already discussed in previous chapters, a group of drugs called neuroleptics, or antipsychotics, is the contemporary psychiatric treatment of first choice for schizophrenia.[94] To complete the examination of human rights imperatives attached to the M-M-I model it will be necessary to determine whether the practice of involuntarily treating schizophrenics with neuroleptics violates human rights such as the right to liberty and the right to protection from torture.

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[91] P. MacDonald Tow, Personality Changes Following Frontal Leucotomy, Oxford University Press, London, 1955. Quoted in Breggin, in Valenstein, ed., op.cit., p. 489.
[92] Breggin, in Valenstein, ed., op.cit., p. 489.
[93] Ibid.
[94] William Glazer, 'Depot neuroleptics: cost-effective and underutilized', JAMA, The Journal of the American Medical Association, Vol. 272, No. 22, Dec 14, 1994, p. 1722.

The issue of liberty will be dealt with first. When a person is diagnosed with schizophrenia, and subsequently made an involuntary patient, the person usually undergoes a loss of liberty in two different ways. In the first instance there is the incarceration process which physically removes the person from the community.[95] In the second instance there is the forced treatment with neuroleptic drugs which effectively restrict brain activity and thereby restrain the person's ability to be physically and mentally active.[96] Neuroleptic drugging is so efficient in this task that earlier methods of physical restraint once commonly used in institutions, like straitjackets, are now rarely needed. In fact, neuroleptic treatment itself is sometimes referred to as a 'chemical straitjacket'.[97]

So efficient is this chemical straitjacket that incarcerated people, although they may be considered still in need of control, are now often released into the community under, what in NSW is called, a Community Treatment Order. In the United States this process is called outpatients' commitment and states are progressively passing legislation to enable it.[98] This type of legislation subjects people to a legally binding order under which mobile treatment teams have access to peoples' homes in order to inject them with long-acting neuroleptics at the required intervals. There is usually a prescribed maximum period for which an order is effective — in NSW this has recently been extended from three months to six months[99] — but successive orders can be made for an indefinite period.

From the M-M-I perspective neuroleptic treatment applied in this way can not possibly have a therapeutic benefit because there is no underlying illness on which to apply the therapy. The only possible reason for using a system like this is for social control. As such the people who are controlled have their right to liberty violated because the medical assessment process that identifies them for forced drugging is fraudulent and arbitrary. There is a simple way to verify this argument. Neuroleptics, or antipsychotics, are supposedly given to schizophrenics as therapy to rebalance their brain chemistry. However, the same drugs are also used in many different institutional settings purely as restraining devices to control the behaviour of non-psychotic people. When they are used on non-psychotic people there is no pretence of a therapeutic purpose. This suggests that the only effective use of neuroleptics may be as chemical restraints.

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[95] P. Munk-Jorgensen, P. B. Mortensen and R. A. Machon, 'Hospitalisation Patterns in Schizophrenia. A 13-Year Follow-Up', Schizophrenia Research, Vol. 4, No. 1, 1991, pp. 1-9.

[96] Kevin Gopal, 'Battling the mind: An old story', Pharmaceutical Executive, Vol. 16, No. 10, October 1996, pp. 32-35.

[97] Lawrence Stevens, Psychiatric Drugs: Cure or Quackery?, accessed March 1998, Available URL, http://www.cjnetworks.com/~cgrandy/stevens/psychiatric_drugs.html

[98] Shay Totten, 'Legislative Madness', Vermont Times, Vol. 8, No. 10, 4 March, 1998, pp. 16-17.

[99] Mental Health Legislation Amendment Bill 1997, Schedule 1, Assented to by the NSW Parliament 26th June, 1997, p.9.

A review of psychiatric literature reveals widespread neuroleptic use for treating agitation in elderly people. But there are also varying opinions within the psychiatric profession about the correctness of this procedure. While one text protests that "the use of antipsychotic drugs to control disturbed behaviour in elderly patients with dementia is a widespread practice that should be deplored" and that "antipsychotic drugs should not be used in the routine treatment of non-psychotic patients"[100] other texts and professional papers canvass a very different point of view.

The influential Synopsis of Psychiatry recommends that "[i]n addition to treating overt signs of psychosis, such as hallucinations and delusions, antipsychotics have also been used to deal effectively with violent, agitated, and abusive geriatric patients".[101] This view is supported by another text which says that neuroleptics are in "widespread use for the control of behavioural complications" in nursing homes and hostel settings where 20-70 per cent of institutionalised patients with dementia are receiving the drugs.[102] (Dementia is not regarded as a psychosis but is a symptom of brain damage/brain atrophy arising from a variety of causes like stroke, accident and suspected problems like aluminium concentrations).

Studies of neuroleptic use in nursing homes have found that informed consent is often not sought in advance but is usually 'presumed' and that treatment continues unless it becomes apparent that the patient no longer acquiesces.[103] Studies have also found that the neuroleptic drugging also has an unequivocally detrimental effect and hastens the decline of elderly people. One recent study found that the intellectual capabilities of elderly people receiving neuroleptics were only half those of untreated elderly people.[104] Another study implicated neuroleptics in an increased incidence of injurious falls in nursing homes.[105]

In its Federal Budget Submission for 1995, the Council on the Ageing (Australia) recommended that Commonwealth funds be allocated to specifically address a number of matters raised by the Inquiry into Human Rights and Mental Illness. One of these matters is referred to as "the use of

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[100] G. Johnson, 'The Biological Therapies' in Pierre J. V. Beumont, Ed-in-Chief, Textbook of Psychiatry, Blackwell Scientific Publications, Melbourne, Oxford, 1989, p. 330.

[101] Harold I. Kaplan and Benjamin J. Sadock, Synopsis of Psychiatry, Sixth Edition, Williams and Wilkins, Baltimore, 1991, p. 816.

[102] S. Tichurst, 'Dementia', 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, pp. 269-270.

[103] B. S. Gurian, E. H. Baker, S. Jacobson, B. Lagerbom and P. Watts, 'Informed Consent for Neuroleptics with Elderly Patients in Two Settings', Journal of the American Geriatric Society, Vol. 38, No. 1, January 1990, pp. 37-44.

[104] Alison Motluk, 'Dementia drugs hasten mental decline', New Scientist, Vol. 153, No. 2067, Feb 1, 1997, p. 9.

[105] James W. Cooper, 'Drugs that cause falls in the nursing home', Nursing Homes, Vol. 42, No. 4, May 1993, pp. 45-47.

chemical restraint in residential care for older people".[106] The Human Rights Inquiry had been told that old people with dementia "get zonked out with medication or tied to their chairs"[107] in some nursing homes as a matter of course. And that "elderly patients are routinely sedated as a management technique — rather than for therapeutic purposes".[108]

But if the psychiatric text-books tend to disagree about the correctness of using neuroleptics to treat agitation and aggression in elderly people there is no such equivocation when it comes to dealing with the mentally retarded: "Treatment of behavioural disturbances in the mentally retarded has tended to rely heavily on medication resulting in up to 50% of retarded people in institutions and community residences being on psychotropic drugs".[109] (Neuroleptics are a sub-set of the psychotropic group). A second text-book confirms the 50% figure as being normal and enthusiastically recommends the neuroleptics Mellaril and Haldol as being "useful in reducing unwanted behaviour, such as self-stimulation, aggression, and motor activity".[110]

Neuroleptics are also routinely used by psychiatrists to treat children and adolescents who have had complaints laid against them for being disruptive. High strength neuroleptics like Haldol, for instance, are routinely prescribed for conduct disorder.[111] Conduct disorder is specific to children and adolescents and is essentially a tendency towards disobedience. Conduct disorder is a non-psychotic condition and so, unlike the dopamine hypothesis for schizophrenia, there is no underlying therapeutic rationale for using neuroleptic medication to control it. This has left drug treatment for conduct disorder open to severe criticism: "neuroleptics are still being prescribed for childhood disorders, such as conduct disorder, for which they have no legitimate medical use."[112] A recent study of children and adolescents receiving neuroleptics in New York found that one third of them had developed symptoms of parkinsonism, and one eighth had developed tardive dyskinesia, as a result.[113]

When neuroleptic drugs are openly used in these ways to control troublesome behavioural patterns, without any pretence of a therapeutic purpose, serious doubt is cast on the claims that these drugs are only administered to people diagnosed with schizophrenia in order to rectify supposed medical

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[106] Council on the Ageing (Australia), Federal Budget Submission For 1995, Melbourne, December 1994, p. 9.
[107] Human Rights and Equal Opportunity Commission, Report of the National Inquiry into the Human Rights of People with Mental Illness, Australian Government Publishing Service, Canberra, 1993, p. 517.
[108] Ibid. p. 245.
[109] H. Molony, 'Mental retardation', in Beumont ed, op. cit., pp. 277-278.
[110] Kaplan and Sadock, op. cit., p. 799.
[111] B. Bowers, 'Antipsychotics Evoke Youthful Concerns', Science News, Vol. 140, No. 18, 2 November, 1991, p. 276.
[112] Ibid.
[113] Ibid.

problems, like an imbalance in brain chemistry. It seems much more likely that the drugs are administered to schizophrenics for the same reason as they are given to disruptive non-psychotic people in institutions — primarily to control their behaviour. From the M-M-I perspective then involuntary dosing with these drugs could be viewed as a restriction of liberty and therefore as a violation of Article 9.

Treatment or Torture

The other major category of human rights imperative associated with the M-M-I model concerns whether forced treatment with neuroleptics is a form of torture or cruel, inhuman or degrading punishment. Modern psychiatry has been implicated on numerous occasions in recent times for assisting police interrogators extract false confessions from political prisoners of repressive regimes.[114] In an attempt to control these activities the World Psychiatric Association (WPA), which is the international umbrella organisation for psychiatric professional bodies, and which claims 140,000 psychiatrist members, has a sub-committee called the Committee to Review of the Abuse of Psychiatry.

When an Australian whistleblower was falsely labelled with a psychiatric disorder in 1997, so as to facilitate dismissal from employment on medical grounds, she complained to the WPA and her complaint was passed on to the Committee. The Committee responded quickly advising the whistleblower that it would investigate her complaint.

The Secretary of the Committee, Marianne Kastrup, wrote under the letter-head of a Danish human rights organisation called the Rehabilitation and Research Centre for Torture Victims/International Rehabilitation Council for Torture Victims (RCT/IRCT).[115] RCT/IRCT is partly funded by the Danish government and is largely dedicated to the investigation of torture and international adherence to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. It is interesting to note that the Secretary of a WPA committee is located in the offices of RCT/IRCT thereby indicating that the highest levels of the international psychiatric community have unequivocally linked certain psychiatric practices with torture.

There are indications that the American Psychiatric Association has made the same kind of linkage. The APA has two standing committees which have been set up to investigate claims that psychiatric diagnosis and treatment are used for punitive purposes. The Committee on International Abuse of Psychiatry and the Committee on Abuse and Misuse of Psychiatry in the U.S. recently advertised a symposium for North American psychiatrists in order to discuss specific instances of abuse.

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[114] Editorial, 'Guilty innocents: the road to false confessions', The Lancet, Vol. 344, No. 8935, Nov 26, 1994, p1447-1451.

[115] Marianne Kastrup, Letter to Louise Roy, 9 January, 1998.

> In the U.S. there are instances of psychiatrists cooperating with big business or government agencies to deny individuals fundamental human rights. One example is of a company which referred to a psychiatrist a nuclear power plant safety inspector who exposed unsafe procedures or conditions and subsequently fired the person on 'health grounds.' Another example is of a forensic psychiatrist who treated a psychotic prisoner to render him fit for execution. Internationally, evidence strongly suggests that the Cuban government is forcing political dissidents to undergo psychiatric treatment, much as that government's former Soviet patrons once did.[116]

Soviet psychiatry is one area where the international psychiatric establishment readily admits psychiatric treatment was used as a form of punishment and torture. This is despite some claims that the approach of Soviet psychiatrists to mental illness was almost identical to that of western psychiatrists. An investigator of Soviet psychiatry in the early 1990s found that:

> The dopamine hypothesis of schizophrenia and amine hypothesis of depression are widely quoted. There is a more intense approach to treatment in the early stages of an illness, and the range of drugs used is similar to that in the West. Interestingly, clozapine [an atypical neuroleptic] was used in the Soviet Union long before it became available in Western countries.[117]

The WPA was very prominent in the early 1980s in a campaign of condemnation of Soviet psychiatric abuse and there was a widespread perception in the West that Soviet psychiatrists were using neuroleptics as a form of torture on dissidents who had been diagnosed with schizophrenia.

Leonid Plyushch, a Russian scientist and political dissident of the 1970s who eventually fled to the United States, was widely reported in the US media after he told how he had been drugged in a Soviet psychoprison on small doses of the neuroleptic Haldol: "I was horrified to see how I deteriorated intellectually, morally and emotionally from day to day. My interest in political problems quickly disappeared, then my interest in scientific problems, and then my interest in my wife and children."[118] Haldol is not a Soviet invention. It is manufactured in the United States by McNeil Pharmaceuticals, a subsidiary of the transnational pharmaceutical giant Johnson and Johnson. In 1995 Haldol had 24% of the neuroleptic market in the United States.[119]

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[116] D. Ray Freebury, 'Abuse of Psychiatry', Psychiatric News, accessed December 1997, Available URL, http://www.appi.org/pnews/march7/freebury.html

[117] Francis I. Dunne, 'Soviet and Western Psychology: A Comprehensive Study', British Medical Journal, Vol. 305, No. 6849, 8 August, 1992, p. 374.

[118] Breggin, Toxic Psychiatry, op. cit., pp. 71-72.

[119] Norman L. Keltner, 'Antipsychotic Drugs', in Norman Keltner, Lee Hilyard Schwecke and Carol E. Bostrom, eds., Psychiatric Nursing, Mosby, St. Louis, 1995, pp. 230-231.

Soviet psychiatry's professional body resigned from the WPA under pressure in 1983 and in 1989 a Time article warned about the dangers of allowing Soviet psychiatrists to rejoin the WPA. The article canvassed the opinion that psychiatric methods remained essentially unchanged in the Soviet Union and reviewed some of the abuses of the past. At its supposed worst, Soviet psychiatry was dominated by Dr. Andrei Snezhnevsky, the director of the Institute of Psychiatry of the U.S.S.R. Academy of Medical Sciences. Snezhnevsky had died in 1987 but he had been the leading figure in Soviet psychiatry since the early 1950s and his influence was still felt. It was Snezhnevsky who,

> broadened the definition of schizophrenia by adding the category 'sluggish schizophrenia.' He defined the disorder as a slow-developing illness without the hallucinations that are a classic element in the Western definition of many schizophrenias. Instead, the 'symptoms' could be nearly all forms of behaviour — unsociability, mild pessimism, stubbornness — that deviated from the social or political ideal.[120]

But this description of schizophrenia could easily be derived from the current DSM-IV diagnostic criteria where 'hallucinations' are only one of five Criterion A symptoms and are not an essential feature of schizophrenia. 'Unsociability' and 'mild pessimism' that deviate from the social ideal could be interpreted as falling into Criterion A (4) — grossly disorganised behaviour, Criterion A (5) — negative symptoms like affective flattening, and Criterion B — social dysfunction. If a person was troublesome to their family, or a social nuisance, in a Western country there is little doubt that the same criteria could be used for at least a tentative schizophrenia label like schizophreniform disorder (DSM-IV) or simple schizophrenia (ICD-10).

The same article describes the torture/punishment imposed on Soviet dissidents as being "hospitalised for years under prison-like conditions and put on powerful drugs that turned them into zombies".[121] But the powerful drugs that violated human rights by turning Soviet dissidents into zombies are the same neuroleptics used on similar types of people by Western psychiatrists.

Another indignant description of Soviet psychiatry describes sluggish schizophrenia again: "One manifestation of this novel ailment was 'stubbornness and inflexibility of convictions'; the usual treatment consisted of megadoses of powerful tranquillisers like Thorazine for 'prophylactic' purposes".[122] Once again, "inflexibility of convictions" is perhaps just another way of describing

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[120] John Langone, 'A profession under stress; long ostracised by colleagues around the world, Soviet psychiatrists try to show that they are not instruments of oppression', Time, Vol. 133, No. 15, 10 April, 1989, pp. 94-96.

[121] Ibid.

[122] Victoria Pope, 'Mad Russians: Victims of Soviet 'punitive psychiatry' continue to pay a heavy price', U.S. News & World Report, 16 December, 1996, pp. 38-43.

'delusions with lack of insight', which is a common feature of schizophrenia diagnosis in the West. 'Prophylactic purposes' is called 'maintenance treatment' by Western psychiatrists and, as with Haldol in the earlier description, the drug used to supposedly 'punish' Soviet dissidents, Thorazine, is one that is routinely applied to schizophrenics by Western psychiatrists. Thorazine is the brand, and chlorpromazine the generic name,[123] of a commonly used neuroleptic that had 12% of the market for neuroleptics in the United States in 1995.[124] In Britain this drug is known as Largactil.[125]

Thomas Szasz argues that the spectacle of the Western psychiatric profession loudly condemning Soviet psychiatrists for their abuse of professional standards is largely an exercise in hypocrisy. Szasz maintains that it is psychiatric power that is the problem from which psychiatric abuse arises and that psychiatric power is just as prevalent in democratic societies as it was in the Soviet Union: "Psychiatric abuse, such as we usually associate with practices in the former Soviet Union, is related not to the misuse of psychiatric diagnoses, but to the political power intrinsic to the social role of the psychiatrist in totalitarian and democratic societies alike".[126] If one accepts the argument that neuroleptic treatment was a form of torture when it was used by Soviet psychiatrists then there is little reason to have a different opinion about its current usage by Western psychiatrists.

Lawrence Stevens, a lawyer in the United States who represents victims of psychiatric injustice, goes beyond the punishment/torture model for forced treatment with neuroleptics and compares the practice to rape:

> In both cases, the victim's pants are pulled down. In both cases, a tube is inserted into the victim's body against her (or his) will. In the case of sexual rape, the tube is a penis. In the case of what could be called psychiatric rape, the tube is a hypodermic needle. In both cases, a fluid is injected into the victim's body against her or his will.[127]

Descriptions given by patients of the treatment they have received sometimes gives confirmation of Stevens' assertion, despite his apparent hyperbole. One woman patient, who had read a number of books about psychiatric theories of schizophrenia before her incarceration, had the temerity to demand of the hospital staff that they test her dopamine levels before giving her neuroleptic medication, in order to confirm that she did indeed have a chemical imbalance in her brain.

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[123] Breggin, Toxic Psychiatry, op. cit., p. 560.
[124] Keltner, op.cit., pp. 230-231.
[125] Breggin, Toxic Psychiatry, op. cit., p. 560.
[126] Thomas Szasz, 'Psychiatric Diagnosis, Psychiatric Power and Psychiatric Abuse', Journal of Medical Ethics, Vol. 20, No. 3, September, 1994, pp. 135-139.
[127] Lawrence Stevens, op.cit.

> When I was demanding testing at Shellharbour [a psychiatric hospital in NSW, Australia], I refused to lay on the bed for an injection unless they tested my levels first. The hospital brought in the hospital security men who forced me around to the TV room via a back corridor. They held me down and forced the injection on me.[128]

This same former patient goes on to describe how neuroleptics effect patient behaviour by the same 'fear therapy' principle as earlier forms of treatment:

> When the side effects of the drugs started taking effect I told staff that the side effects were totally unacceptable and that the drugs were toxic. Worse, they were forcing untested drugs on untested patients. The psychiatrist 'treating' me was furious. She said in response that I wasn't allowed to leave the ward with the other patients. I was therefore effectively put in isolation on the ward. I had to endure the side effects etc in silence because there is always ECT down the corridor. Staff then naively believed that I had calmed down because of the drugs. One psychiatric nurse said 'Look how much better you are now'. This woman honestly believed that I had calmed down because of biological intervention. I hadn't changed my attitudes or feelings one skerrick. It was just that I was too terrified to say anything because this woman 'treating' me was vicious. She meant business. I gave up the fight out of fear of an increased risk of brain damage from increased doses over a longer period of time.[129]

The fear of "ECT down the corridor" is a particularly noteworthy element in the fear therapy that was applied to this patient. She further clarified the therapeutic principle: "Because biopsychiatrists dehumanise and depersonalise schizophrenics they can't comprehend the fact that we respond rapidly to abuse like anyone else. If someone puts the fear of God into you, you shut up. Because of the silence they think the patient has calmed down and recovered because of biological intervention".[130]

Conclusion

The human rights problems associated with the M-M-I model are mostly concerned with the loss of liberty involved in involuntary hospitalisation and the cruel nature of psychiatric treatment, which the M-M-I model argues is a form of torture/punishment. According to the M-M-I model the underlying reason why a system has been allowed to develop, which treats a non-existent disease with torture, is to be found in the continued existence of the insanity plea as a means of escaping criminal liability. The insanity plea is deeply entrenched in cultural tradition and so long as it

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[128] Heather Nolan, Former psychiatric patient treated involuntarily for schizophrenia, Personal Communication (letter to Richard Gosden), 26 February, 1998.
[129] Ibid.
[130] Ibid.

remains there will be a need for the preventative control of people who manifest indicators that fit its legal criteria.

An analysis of the history of treatment for schizophrenia shows a long tradition of applying torture and cruel punishment as a form of 'fear therapy'. In the past psychiatrists have sometimes been quite candid in their descriptions of the principle of fear therapy as being simply a matter of giving patients a choice of either adopting more acceptable behavioural patterns or suffering more pain and discomfort. Contemporary treatment in the form of neuroleptic medication, while still retaining the same fear therapy principle of earlier forms of treatment, also restricts a person's liberty by acting as a chemical straitjacket.[131] In this way neuroleptic medication appears to have the dual ability to violate human rights which protect against the loss of liberty as well as human rights which protect against torture and cruel punishment.

[131] David Cohen, Testimony to a Vermont Judiciary Committee considering a new bill entitled, An Act Relating to Involuntary Medication of Mental Health Patients, reproduced in, 'In the trenches: Resisting the spread of involuntary psychiatric drugging', Dendron, Nos. 39 and 40, Winter 1997- 98, p. 33.