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Shrinking the Freedom of Thought:

How Involuntary Psychiatric Treatment Violates Basic Human Rights

By Richard Gosden

Introduction

When the international system for the protection of human rights was developed after the second world war, it was largely in response to Nazi atrocities. The Nazis had held a collective belief that the German nation was a living organism and that its well-being was threatened by "useless eaters" and "life unworthy of life."[1] The German medical profession, 45% of whom belonged to the Nazi Party in the early 1930s, was empowered to tend to the health of the national organism. The psychiatric branch of the profession led the way by "medically killing" some 80,000 -- 100,000 hospitalised mental patients. The expertise the Nazi psychiatrists acquired in killing off their mental patients was later applied to Jewish people.[2]

Even under the legislative frameworks that are typical of most modern democratic societies, psychiatry still treads a particularly fine line between benefiting and harming the exercise of human rights. This is largely because the cultural objectives of psychiatry and human rights are, to some extent, opposed to one another. While the basic principle of human rights is to set limits on the degree of social authority which is allowed to be imposed on individuals, the speciality of psychiatry is to fit 'difficult' individuals into the social fabric. These fundamental differences sometimes threaten to turn psychiatry and human rights into antitheses, even in the most benign political conditions.

Psychiatry has little trouble in establishing its potential benefit to the exercise of human rights when 'difficult' individuals acknowledge that they have a mental disease and seek treatment for it. A specific article of human rights law that psychiatry can enhance in this way is Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 concerns "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[3]

The second part of this article specifies "The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: .... (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."[4] The human rights sentiments expressed in Article 12 are the basis for the 'right to treatment' which is often promoted by members of the psychiatric profession as being the most important human right in regard to psychiatry.[5]

But the 'right to treatment' can have a hollow ring to it when psychiatry is practised on people against their will. Many 'difficult' people deny they have a mental illness or, if they are willing to acknowledge it, prefer not to have it treated. The human rights problems for psychiatry largely arise from the tendency of most modern industrial societies to have mental health laws which empower psychiatrists to make clinical judgements about the mental health of the people they encounter in their work and to impose treatment on them, without their consent, if it is thought necessary. (See Support Coalition http://www.efn.org/~dendron/).

Involuntary mental patients often find themselves in a situation in which they are incarcerated for an indefinite period without being charged with a criminal offence, interrogated, coerced into changing their thoughts and beliefs, subjected to painful and uncomfortable treatments if they cannot or will not

make the required mental changes, and denied freedom until their identity has been sufficiently modified. (See Psychiatric Survivor's Guide http://www.harborside.com/home/e/equinox/). It is in this context that questions arise about whether certain psychiatric practices might routinely violate fundamental human rights.

Soviet Psychiatry

Perhaps the most blatant example of psychiatric human rights abuse in recent times occurred in the Soviet Union. In the last couple of decades of the Soviet regime, the communist authorities viewed a growing epidemic of political dissidence as a malign social force, and Soviet psychiatrists were empowered to assist in dealing with it.

As early as 1974, psychiatrists in the West had become curious about reports of the high prevalence of schizophrenia in the Soviet Union -- 5-7 per 1,000 population compared to 3-4 per 1,000 in the UK.[6] In due course it was revealed that Soviet psychiatrists had discovered a unique form of mental disease to fit the profile of political dissidents. They called the condition "sluggish schizophrenia, a form of schizophrenia where the symptoms are subtle, latent or only apparent to the skilled eye of the psychiatrist."[7] Soviet dissidents who "wanted to reform the system and claimed that they had the personal vision to do it . . . . were exhibiting the text-book symptoms of sluggish schizophrenia."[8] Soviet psychiatrists became so deeply involved in the control of political dissidents that a whole system of special mental hospitals was established that were run in co-operation with the KGB.[9]

When the extent of this political abuse of psychiatry became apparent to the international psychiatric community, there was widespread condemnation of the Soviet practice. In order to pre-empt inevitable expulsion from the World Psychiatric Association (WPA), the Soviet professional organisation, the All-Union Society of Neuropathologists and Psychiatrists, resigned from the WPA in 1983.[10] The WPA responded to the resignation by announcing that the Soviets would be welcome to return if they provided "evidence beforehand of amelioration of the political abuse of psychiatry in the Soviet Union."[11] It is worth noting that the WPA considered 'amelioration' as the only criteria necessary to bring the Soviets back into line with international standards. Perhaps what prompted this conciliatory approach was the general recognition that despite the abuses "the concept of disease employed in the former USSR .... was similar to its counterpart in the UK and USA in being strongly scientific in nature."[12]

UN Principles on Mental Illness

The Soviet use of psychiatry for political purposes was the catalyst for a more general investigation into international psychiatric practices by the UN Commission on Human Rights. In 1977 the Commission appointed a "Sub-Commission to study, with a view to formulating guidelines, if possible, the question of the protection of those detained on the grounds of mental ill-health against treatment that might adversely affect the human personality and its physical and intellectual integrity."[13] The primary task given to the two Special Rapporteurs the Sub-Commission subsequently appointed was to "determine whether adequate grounds existed for detaining persons on the grounds of mental ill-health."[14]

The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care[15] did not emerge until more than a decade later. Unfortunately, despite the brave start, the final document has been so repeatedly rewritten and massaged by numerous committees that the original focus -- on the problems of involuntary detention and the risks of treatment -- has been lost. The primary tasks of attending to involuntary detention and the risks of treatment have been largely buried by cross-referencing and other priorities.

The final version of the 'Principles' adopted by the United Nations General Assembly in 1991 is primarily designed to protect the rights of voluntary patients, not involuntary patients. Principle 1 begins with an assertion of the 'right to treatment.' This right thereafter becomes the basis for most of the other voluntary patients' concerns, like confidentiality and protection against discrimination, addressed by the document.

Where the problems of involuntary patients are addressed, the 'Principles' tend to undermine their rights rather than protect them. Principle 11, for instance, deals with "Consent to Treatment" and specifies that "No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13, and 15." Paragraph 6, however, denies the right of informed consent to involuntary patients: ".... treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied: (a) The patient is, at the relevant time, held as an involuntary patient...."[16]

Involuntary admission is not only permitted under the 'Principles,' but the civil liberties protections concerning this issue are considerably weaker than those already found in some existing mental health legislation. In the state of New South Wales (Australia), for instance, the Mental Health Act (MHA) requires that a person be dangerous to themselves or other people, as well as mentally ill, before involuntary committment is permitted.[17] The 'Principles', however, allow the requirement of 'dangerousness' to be bypassed and the effect of this discrepancy has been to provide grounds for an argument that the NSW legislation should be weakened to bring it into line with UN standards.[18]

The weakness of the UN Principles in relation to involuntary patients invites a speculation: had the Principles been in existence in the 1970s and 1980s would they have deterred the Soviets from using psychiatry for political purposes? The answer to this question is by no means certain. Although Principle 4 requires that diagnosis "shall be made in accordance with internationally accepted standards" and "A determination of mental illness shall never be made on the basis of political, economic or social status,"[19] these requirements might merely have served to guide Soviet psychiatrists to be more circumspect in their definitions.

The Burdekin Inquiry

The UN Commission on Human Rights was not the only official human rights body to be galvanised into action by the Soviet example -- only to end up burying psychiatry's darker side beneath a restatement of the 'right to treatment.' In Australia the Human Rights and Equal Opportunity Commission undertook a national inquiry (The Burdekin Inquiry) into mental health practice only a few years ago. The Australian Human Rights Commissioner, Brian Burdekin, in his opening address to the Sydney hearings in 1991, referred to Soviet psychiatry and said that Soviet human rights abuses in this area had been the catalyst for his own Inquiry.[20]

Burdekin explained that human rights circles in the Western democracies had formed the view that the mental health systems of democratic countries should be reviewed, to ensure that they were beyond reproach, before a full human rights assault was launched on the Soviet psychiatric system. He said that his own Inquiry had been conceived as part of this project, but while preparations had been under way to commence his Inquiry, the issue had gone off the boil because the Soviet Union had collapsed.[21] This change of affairs probably explains the confusion that subsequently developed in the Commission's priorities over mental health.

The Commission's confusion of priorities is apparent in a number of respects. A good example is the lack of significance given by the Inquiry to the rights of involuntary patients when they conflict with the needs of their frustrated relatives. Under the heading of "Involuntary Detention," the Burdekin Report observed:

> Involuntary detention -- for any reason and under any circumstances -- is an extremely serious matter invoolving curtailment of several fundamental rights the most important of which is the right to liberty. The Inquiry received extensive evidence on this subject, particularly from consumers.[22]

Even so, after only one more brief sentence on the subject, the report moves on to a lengthy discussion in support of denying the very same "fundamental rights" the Inquiry had just recognised:

> Difficulty in Gaining Involuntary Admission -- Families and other carers are faced with a dilemma when the person for whom they are responsible has lost touch with reality and has insufficient insight[23] into his or her condition to accept the need for treatment.[24]

The Commission's confused priorities become further evident when the Terms of Reference are carefully analysed in the light of the subsequent course of the Inquiry. The first Term of Reference clearly listed the classes of people the Inquiry had initially intended to deal with: "To inquire into the human rights and fundamental freedoms afforded to persons who are or have been or are alleged to be affected by mental illness, having due regard for the rights of their families and members of the general community."[25] [my emphasis]

What is meant by alleged to be affected by mental illness is not immediately apparent. An early usage of the term 'alleged mental illness' can be found in a published dialogue between US patient rights activist Leonard Roy Frank and American Civil Liberties Union attorney and mental patient advocate, Bruce Ennis. Ennis explains in the interview that he uses 'alleged mental illness' because "I personally have seen no evidence at all that there is such a thing as mental illness."[26]

The Terms of Reference made no attempt to define what it meant by alleged , but it is unlikely that it was used to question the existence of all mental illnesses in the way that Ennis used the term. What is more likely is that in the planning stage of the Inquiry it was thought necessary to distinguish between certainty in the accuracy of diagnoses of mental illness when applied to some people and uncertainty when the diagnoses are applied to others.

There are at least two ways the Inquiry might have originally intended to utilise this distinction. The first possibility may have been an intention to examine the problem of false positive diagnosis. This is a perennial problem for psychiatry and arises from the subjective nature of psychiatric diagnostic techniques. The second possibility may have been an intention to determine whether any patients had been diagnosed with certain varieties of mental illness which some psychiatrists may allege to exist although they are not generally recognised by international standards. Sluggish schizophrenia would fit into this category as would Fanatic Personality Disorder, which is indicated by traits like strict vegetarianism. Perhaps the Inquiry had originally planned to investigate both problems. There are well-established concerns about Western psychiatric practice regarding both the problem of false positive diagnosis[27] and the proliferation of new varieties of mental disease.[28]

Regardless of what the Inquiry's original interpretation of alleged mental illness might have been, it certainly seems appropriate that an Inquiry into Human Rights and Mental Illness should give hearing to any person who might have suffered the discomfort and humiliation of a psychiatric diagnosis and, more seriously, incarceration and imposed treatment on the basis of a mere allegation. But despite the nomination of this category in the Terms of Reference, as it transpired, the Inquiry completely ignored these people. Outside of the Terms of Reference, those with an alleged mental illness were not mentioned at all in the Inquiry's Report.

In fact, the definitions that were eventually adopted by the Inquiry made it impossible to recognise people who are alleged to be mentally ill. The Inquiry chose to use the term "consumer"[29] to describe

all of the people who are deemed to have a mental illness thereby implying that they are all willing participants in a mental health service industry. This does not necessarily pose a problem for the recognition of people who are or have been mentally ill, but the description of "consumer" was totally inappropriate for those who are alleged to be mentally ill. Neither false positives nor people diagnosed with non-existent diseases are satisfactorily described as consumers.

It seems apparent therefore that somewhere between the time when the Terms of Reference were drafted and the time when the hearings of witnesses began a mechanism was deliberately or inadvertently put into place which blocked the people who are alleged to be mentally ill from influencing the outcome of the Inquiry. This diversion of purpose is similar to the UN Commission on Human Rights' diversion from its original investigation of the human rights risks involved in coercive psychiatry and its subsequent drafting of 'Principles' that endorse coercion. Perhaps it is time that a definitive human rights test was applied to try to determine whether or not coercive psychiatry actually violates human rights.

Requirements of a Human Rights Test

One obvious requirement of a human rights test is that it should involve people who are alleged to be mentally ill. But in order to use this description it will be necessary to define what is meant by alleged. Further, the test should be designed in such a way as to facilitate a fairly definitive conclusion. There is little point in applying a test that relies on matters of opinion which could be easily discounted.

This second requirement is not easy to satisfy because much of the terminology describing human rights is heavily dependent on either value judgements or fine points of law for definitive interpretations. The human rights prohibition on "cruel, inhuman or degrading treatment,"[30] for instance, might allow for arguments to be made against certain psychiatric treatments like electro convulsive therapy (ECT). But the success of such arguments would largely depend on the specific circumstances in which the ECT was used and the receptivity of the audience to whom one was presenting the argument. Similarly, although involuntary hospitalisation appears to deny the spirit of a person's "right to liberty,"[31] so long as it is done "in accordance with such procedures as are established by law,"[32] which is normally the case, it does not technically violate human rights.

The simplest way to get around this problem of imprecision in the specification of human rights would be to narrow the test to a single article of human rights law. An article should be selected which protects certain individual liberties in terms that do not require specific events to measure degrees of malice nor the argumentation of fine points of law in order to prove a violation. These rights should also be closely associated with the focus of psychiatric endeavour so that it is easy to see they might be routinely violated by normal psychiatric practice.

A further requirement of the test is that its parameters should be narrowed to examine psychiatry as it is practiced within a specific legislative jurisdiction. Many human rights articles allow for limitations to be placed on rights, so long as the limitations are specified in law. This means that a definitive conclusion can only be reached if the test is applied to the practice of psychiatry as it is sanctioned by specific legislation.

A final parameter of the test is to confine it to people who are alleged to share the same specific mental illness. This is because the methods of psychiatric diagnosis and treatment, which are the most likely areas to affect a person's human rights, vary considerably according to the nature of the perceived mental illness.

After combining these elements the following test has emerged: An examination of psychiatric practice under the New South Wales (Australia) Mental Health Act 1990 in order to determine whether the

rights, specified in Article 18 of the International Covenant on Civil and Political Rights (ICCPR), of involuntary patients who are alleged[33] to have schizophrenia, are violated.

Article 18

Article 18 of the International Covenant on Civil and Political Rights (ICCPR) reads,

> 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. [34]

The Article 18 rights most relevant to involuntary mental patients 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 allowed to be placed on these rights are in respect to the manifestation of beliefs. Thoughts and beliefs are particularly relevant to the mental disease of schizophrenia because it is pathological varieties of these mental forms that are the main symptoms.

Article 2 of the ICCPR specifies that the Covenant protects the rights of all individuals "without distinction of any kind."[35] This means there is no scope for making exceptions for mentally ill people. This point is further confirmed 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 Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments ...."[36]

The Spirit of Article 18

Social organisation is inevitable for people who live in groups, and this organisation generally requires group members to conform to prescribed behavioural patterns and to subscribe to commonly held beliefs. But these same people also have to face life as mortal individuals. 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.[37]

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.[38] 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 to 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.[39] In the European Christian tradition the imperative to conform to orthodoxies in religious thought has often led to freethinking individuals being branded as heretics. Although there is a long record of severe punishment for heresy,[40] at the same time there has also been a retrospective tendency to applaud heretics as "heroes who were badgered by ignorant and vicious men"[41] 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."[42] 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,"[43] there is a record of the occasions when the Commission has been called upon to interpret Article 18 and what it has resolved.

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 on 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 so dependent on specific circumstances for interpretation as are value-laden words like 'cruel,' 'inhuman' or 'degrading.' 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: "There are some aspects of person's lives [sic] 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."[44] 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."[45]

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[46] which severely restrict the manner 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."[47] 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"[48] 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 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."[49] Similarly, limitations are permitted to protect other peoples rights. 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.[50] 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"[51] to the person who is actually manifesting the belief.

Involuntary Treatment Provisions in New South Wales (NSW)

Australian mental health legislation will be used in this test of Article 18 rights because a test can not be applied without using a specific piece of legislation. But this analysis of the NSW law is only meant to be a demonstration, and any other modern mental health law could probably be adapted for use in the test just as easily.

The NSW Mental Health Act 1990 (MHA) is the most recent State mental health legislation in Australia.[52] The framing of the 1990 Act was the second major overhaul of mental health law in NSW since 1958,[53] 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.[54]

To facilitate the least restrictive environment, the MHA provides for Community Counselling Orders (CCOs) and Community Treatment Orders (CTOs) whereby people can 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."[55] If the psychiatry practised under the sanctions of the NSW MHA cannot pass the Article 18 test, 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. . . ."[56] The contrary legislative impulses -- to control people while simultaneously protecting their civil liberties -- illustrate the difficulties in providing a legal framework for psychiatry to operate within.

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 provided. The principal mechanism to achieve this goal requires mental patients to be divided into those who are voluntary, which it calls informal patients,[57] and those who are involuntary. Anyone can seek treatment as a voluntary patient, and people who seek treatment should only be refused admittance to a mental hospital if the medical superintendent "is not satisfied the person is likely to benefit from care or treatment."[58]

Involuntary patients, by definition, do not seek treatment, and so, if treatment is to be given to them, it must be imposed. 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 Object 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).[59]

A person who is diagnosed with mental illness and is unwilling to be treated can only be made an involuntary patient if,

> 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 physical harm; or
>
> (b) for the protection of others from serious physical harm.[60]

Four of the five symptoms of 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 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 that is likely to be dangerous.

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 the human rights test that has been

proposed, it will be necessary to distinguish which of these 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 is dangerous 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). But such an incarceration would only accord with Article 18 if the inner symptom that gave rise to the dangerous behaviour was 'delusions' because it is the only one of the three symptoms that could be described as a form of 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.'

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 their own 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."[61]

By allowing for people to be incarcerated for having 'hallucinations' and 'disordered thoughts,' and by not requiring more positive evidence of dangerousness for deluded people, 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 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 are incarcerated means that it is impossible to resolve this doubt.

About three quarters of all involuntary admissions in NSW take place in response to a doctor's certificate.[62] This certificate needs only an equivocal statement by a doctor who declares:

> I am of the opinion that the person examined/observed by me is a mentally ill person suffering from mental illness .... 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,
>
> (i) for the person's own protection from serious physical harm; or
>
> (ii) for the protection of others from serious physical harm.[63]

No record is required of the particular symptom of mental illness identified by the doctor nor the reason for the doctor's perception that the person might be dangerous. After a person has been involuntarily admitted to a hospital, the MHA requires that the person be further examined by the medical superintendent[64] of the hospital as well as by a second hospital doctor[65] in order to confirm the certifying doctor's diagnosis. Published statistics indicate that confirmation is given in over 99% of cases,[66] 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 is dangerous.

The MHA also requires that the person be brought "before a Magistrate as soon as practicable"[67] for the purpose of making a judicial determination "on the balance of probabilities"[68] as to whether the person is mentally ill. This usually happens within about a week. (It should be noted that during this period the person can be given treatment without informed consent.)[69]

About half of the people admitted involuntarily are either released or have their status changed to voluntary patients before the Magistrate's hearing can be arranged.[70] Of those people who were brought before a Magistrate in 1994 about 64%[71] 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 2120 people.[72]

There is no published information indicating whether any of these 2120 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. Nor is there any readily available assessment of the quality of the evidence used by the Magistrates to determine that these 2120 people were dangerous. But the minimum level of evidence of dangerousness required by the Magistrate under the MHA -- "on the balance of probabilities" -- once again would not satisfy the Siiracusa Principle that "All limitation clauses shall be interpreted strictly in favour of the rights at issue."[73]

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.

So, in order to progress with the test it will be necessary to make further refinements to it. The easiest way to overcome the problem we have so far encountered is to concede the benefit of the doubt to the NSW mental health system. This can be done by assuming 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 'delusions' in ways that are irrefutably dangerous to themselves or other people.

By making this concession we can assume that there are legitimate reasons for limiting the Article 18 rights of these people. The way is then cleared for a close examination of the psychiatric treatment that is subsequently practised on them and whether it violates their rights. The point of refining the test is that, even though it might 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 holds beliefs about life that are not shared by other people, and, on occasions when Kerry has attempted to communicate these beliefs, antagonism has resulted and Kerry has become involved in minor scuffles. This has sometimes led to Kerry making threats of violent retaliation. Kerry's relatives have become anxious about the situation, and the family doctor has been called in to make an examination. The doctor has identified delusions and found reasonable grounds for concluding that Kerry might be dangerous to other people and is therefore in need of care, treatment and control. This has led to Kerry being involuntarily admitted to a mental hospital.

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV), which has become the main diagnostic system used in most English-speaking countries, including Australia, delusions are a primary symptom of schizophrenia.[74] The manual defines delusions as false beliefs that are not "ordinarily accepted by other members of the person's culture or subculture."[75] 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 unacceptable.[76] This might appear to be a fairly dubious provision in human rights terms, but since we are conceding that Kerry has been manifesting his/her beliefs in a manner threatening to public safety, then his/her Article 18 rights have not been violated by the incarceration process.

The delusions identified by Kerry's family doctor should not be thought of as preliminary indicators of an underlying brain disease that can be confirmed by psychiatric specialists using high-tech diagnostic equipment or laboratory tests. There are no biological back-up tests available to either identify or verify the presence of mental illness. In fact, the key controversy over psychiatric practice is the question of whether there is anything more to mental illness than just the symptoms.[77]

For over a hundred years, mainstream psychiatry has responded to this doubt by vigorously asserting that symptoms such as delusions have a yet-to-be-discovered biological cause[78] -- like an imbalance in brain chemistry, a genetic defect, or an abnormality in brain architecture -- and that a break-through in the identification of the exact nature of this cause is imminent.[79] But as things stand, state-of-the-art diagnosis is wholly limited to medical practitioners subjectively forming opinions about what patients choose to say about their private thoughts and beliefs and observing how this inner mental activity is manifested outwardly in behaviour.[80]

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 has been hospitalised in order to receive treatment for a mental illness that was 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 will 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 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 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."[81] The further case I want to make is that the standard neuroleptic drug treatment that is given to people who are alleged to have schizophrenia does not merely select delusions for 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 choice for schizophrenia: "Over 90% of hospitalised patients with a diagnosis of schizophrenia are prescribed neuroleptic drugs."[82] Neuroleptics are alternatively known as major tranquillisers and antipsychotics and are used to moderate the seemingly 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.[83] However, 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. [84]

The first commercially developed neuroleptic, chlorpromazine, was synthesised in 1950 by French scientists while attempting to develop an antihistamine.[85] (For a general introduction to pharmaceuticals see http://www.mentalhealth.com/p30.html.) 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 commercially useless until an experiment was carried out in 1953 on "about 100 psychiatric patients and it was declared to be an effective antipsychotic."[86] Thereafter it proved to be one of the most profitable drugs in pharmaceutical history.

This new drug was found to be highly sedating. One of the early French pioneers of its usage, a physician named Labroit, found it very useful in calming anxious surgery patients. He noted of 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."[87]

Although there are various hypotheses regarding the cause of schizophrenia, and medical scientists have not reached a consensus on the subject yet, psychiatric textbooks tend to promote the belief that the "neurochemical theory affords the best explanation"[88] and that "the symptoms of schizophrenia are due primarily to hyperactivity in the dopamine system".[89] But the widespread promotion of this brain-chemistry-imbalance hypothesis, and its adoption by hospital psychiatrists, owes more to the convenient rationale it provides for neuroleptic drug treatment than to its founding in scientific evidence. Since it is known that neuroleptics block dopamine receptors in the brain, the promoters of the chemical imbalance theory tend to argue that if a dopamine blockade can moderate irrational behaviour then it must follow that an over-supply of dopamine is the original cause of the schizophrenia.

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 dependant 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."[90]

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 has been established, 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, leading some to refer to neuroleptic treatment as a "chemical lobotomy."[91]

In Toxic Psychiatry, Breggin argues that neuroleptic drugs are a thoroughly inappropriate treatment regime because they are only used to make people more docile and easier to control. He says that the long-term changes they make to a patient's thought patterns and behaviour are actually a result of brain damage. He cites the apparent brain damage associated with major side effects like tardive dyskinesia as evidence.[92]

When neuroleptic treatment is directly related 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 this treatment. However, there seems to be considerable divergence of opinion as to whether this disruption of thoughts will be beneficial to patients.

A recent psychiatric text describes the intended outcome of the treatment 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"[93]

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. interpretation is more likely. This 'improved reasoning' should be 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 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."[94] 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"[95] (Haldol).[96]

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.

Haldol is one of the most frequently prescribed neuroleptics and has over 24% of market share in the United States.[97] It was also used in the Soviet Union. The story of 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 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."[98]

A psychiatrist who deliberately took one small dose of another neuroleptic, Thorazine (chlorpromazine), in order to evaluate its effects, 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 "delussional" 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.[99]

Surveys of patient attitudes towards neuroleptics have found that the drugs are almost universally disliked by the people who take them.[100] Confirmation of this is to be found in the fact that unlike most other mind-altering drugs, there is no blackmarket for neuroleptics.[101] One patient described the experience of enforced treatment with neuroleptics: "They knock you out. They cause aches and pains all through your body. They make you apathetic. They stop the whole spiritual transformation process. It's like putting molasses in your brain. You can't even concentrate enough to read."[102]

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 its 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.[103]

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 right "to the enjoyment of the highest attainable standard of physical and mental health."[104] In fact, the situation is so bizarre that an argument could be easily mounted that serious side effects of neuroleptics -- effects like tardive dyskinesia -- are evidence that far more harm thaan benefit is done to these people's Article 12 right as well.

Conclusion

There is little doubt that the conclusions from my Article 18 test level an accusation at psychiatric practice that requires a response. The case study involving alleged schizophrenics in NSW accounts for some thousands of people every year. But there seems to be no valid reason to confine the accusation to this restricted class of people. An accusation of Article 18 violations could just as easily be made on behalf of all the people, under every legal jurisdiction, who are involuntarily administered neuroleptic medication. This would expand the class well beyond people diagnosed with schizophrenia and would include large numbers of elderly people in institutional settings. Worldwide it would probably involve many millions of people every year.

However, even this class of people might be too restricted. Other psychiatric medications and treatments interfere with peoples' thoughts and beliefs in the same way neuroleptics do. Indeed, this kind of interference is precisely the intention of most psychiatric treatments and an argument can therefore be made that all coercisive psychiatry, by definition, violates Article 18.

By enfranchising the medical profession to control people with deviant thoughts and beliefs, modern democratic States avoid being directly implicated in violations of human rights protected under Article 18. This situation has allowed democratic States to gain a loudly-proclaimed moral ascendancy over non-democratic States that take a less sophisticated approach to deviant thinkers and believers by incarcerating citizens for supposed political crimes and making them 'prisoners of conscience'.

But this moral ascendancy is clearly undeserved. States that are parties to the international human rights covenants, apart from agreeing not to violate the rights themselves, also agree to ensure that all their citizens will be free to exercise those rights. This means that the issue does not simply rest on whether particular governments can be directly linked to human rights violations. Ultimately, what is more important is whether the human rights of individuals are violated and, if they are, whether the State, within whose borders the violations occur, takes the necessary steps to ensure that the violations cease.

Footnotes

[1] Robert Jay Lifton, The Nazi Doctors: Medical Killing and the Psychology of Genocide, Basic Books, New York, 1986, p. 46.

[2] Ibid., pp. 34, 134-144.

[3] United Nations, 'International Covenant on Economic, Social and Cultural Rights,' Article 12 (1), reproduced in Satish Chandra, ed., International Documents on Human Rights, Mittal Publications, New Delhi, 1990, p. 16.

[4] Ibid.

[5] See for example, John Grigor, 'The Right To Treatment,' in Human Rights and Equal Opportunity Commission, Schizophrenia: Occasional papers from the Human Rights Commissioner, Number 1, Human Rights and Equal Opportunity Commission, Sydney, December, 1989, pp. 7-14.

[6] J. K. Wing, 'Psychiatry in the Soviet Union,' British Medical Journal, 9 March 1974, p. 435.

[7] David Cohen, Soviet Psychiatry: Politics and Mental Health in the USSR Today, Paladin, London, 1989, p. 24.

[8] Ibid., p. 44.

[9] Ibid., pp. 102-120.

[10] A. L. Halpern, 'Current Dilemmas in the Aftermath of the US Delegation's Inspection of the Soviet Psychiatric Hospitals,' Emerging Issues For The 1990s In Psychiatry, Psychology And Law, Proceedings of the 10th Annual Congress of the Australian and New Zealand Association of Psychiatry, Psychology and Law, Melbourne, 1989, p.11.

[11] C. Shaw, 'The World Psychiatric Association and Soviet Psychiatry' in Robert Van Voren, ed., Soviet Psychiatric Abuse in the Gorbachev Era, International Association on the Political Use of Psychiatry, Amsterdam, 1992, p. 50.

[12] K. W. M. Fulford, A. Y. U. Smirnov, and E. Snow, 'Concepts of Disease and the Abuse of Psychiatry in the USSR,' British Journal of Psychiatry, Vol. 162, 1993, pp. 801-810.

[13] Yo Kubota, 'The Institutional Response,' in C. G. Weeramantry, ed., Human Rights and Scientific and Technological Development, United Nations University Press, Tokyo, 1990, p. 115.

[14] Ibid.

[15] United Nations, Commission on Human Rights, 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care,' reproduced in Human Rights and Equal Opportunity Commission, 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. 989-1005.

[16] Principle 6, Ibid.

[17] NSW Mental Health Act 1990, Reprinted as in force at 17 October, 1994, NSW Government Information Service, 1994, Section 9, p. 5.

[18] Centre for Mental Health, "Caring for Health: Proposals for Reform - Mental Health Act 1990,' NSW Health,, Sydney, May 1996, p. 11.

[19]United Nations Commission on Human Rights, 'Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care,' Principle 4, reproduced in Human Rights and Equal Opportunity Commission, Human Rights and Mental Illness, op. cit., pp. 989-1005.

[20] Brian Burdekin, Federal Human Rights Commissioner, Opening Address to Sydney hearings, National Inquiry into Human Rights and Mental Illness, June 17, 1991, Personal observation.

[21] Ibid.

[22] Human Rights and Equal Opportunity Commission, Human Rights and Mental Illness, op. cit., p. 230.

[23] 'Insight' is a Catch-22 device used in psychiatric coercion. A person who rejects the label of mental illness is said to lack insight into their condition. Lack of insight means the condition is much worse than would otherwise be the case and it therefore requires more drastic treatment for a longer period. Critics of psychiatric coercion have likened the demand for 'insight' to that of a torturer's demand for 'confession'.

[24] Human Rights and Equal Opportunity Commission, Human Rights and Mental Illness, op. cit., p. 230.

[25] Ibid., p. 5.

[26] Leonard Roy Frank, 'An Interview with Bruce Ennis,' in Sherry Hirsch, Joe Adams, Leonard Frank, Wade Hudson, and David Richman, eds., Madness Network News Reader, Glide, San Francisco, 1974. p. 165.

[27] See for example, David Pilgrim and Anne Rogers, A Sociology of Mental Health and Illness, Open University Press, Buckingham, 1993., p. 55.

[28] See for example, Stuart A. Kirk and Herb Kutchins The Selling of DSM: The Rhetoric of Science in Psychiatry, Aldine De Gruyter, New York, 1992. pp. 1-16.

[29] Human Rights and Equal Opportunity Commission, Human Rights and Mental Illness, op. cit., p. 13.

[30] United Nations, 'International Covenant on Civil and Political Rights,' Article 7, reproduced in Satish Chandra, ed., International Documents on Human Rights, Mittal Publications, New Delhi, 1990, p. 28.

[31] Ibid., Article 9, p. 29.

[32] Ibid.

[33] Alleged in this context should be understood to refer to any involuntary patient who has been diagnosed with schizophrenia. The reasoning for this is as follows: In criminal law a person is alleged to have committed an offence until such time as it is proven beyond reasonable doubt that the allegation is correct. However, this degree of legal certainty is never reached in regard to mental patients. While voluntary patients simply acquiesce to a medical diagnosis, a Magistrate's judgement, which is given under the NSW Mental Health Act to confirm an involuntary patient's diagnosis, only relies on the civil level of evidence, "on the balance of probabilities". When this is considered, together with the subjective way in which the 'disease' of schizophrenia is diagnosed, without the support of any

kind of laboratory tests, it only seems fair that any person who is labelled as schizophrenic, and who disputes the label, should be distinguished from those who accept the label by prefacing the disease with alleged.

[34] United Nations, 'International Covenant on Civil and Political Rights,' Article 18, reproduced in Satish Chandra, ed., op. cit., pp. 32-33.

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

[36] 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, reproduced in Human Rights and Equal Opportunity Commission, Human Rights and Mental Illness, op. cit., pp. 990-991.

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

[38] 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.

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

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

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

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

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

[44] 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.

[45] UN Centre for Human Rights, op. cit., p. 110.

[46] 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.

[47] Ibid., p. 6.

[48] Ibid., p.