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INTERNATIONAL HUMAN RIGHTS PROTECTION AGAINST PSYCHIATRIC POLITICAL ABUSES

George J. Alexander*

I. INTRODUCTION

While some instances of alleged psychiatric abuse have been litigated, much more remains untested in international tribunals. It is even fair to say that issues of human rights violations through psychiatric interventions only elicited sparse domestic jurisprudence until quite recently.[1] That is not to say that there are not announced principles which appear to protect against abuse. Such rules exist both nationally and internationally. They are, however, undermined by exceptions designed to permit medical treatment for those deemed to require it. Unfortunately, those who invoke the mental health system, however cynically, usually begin by claiming therapeutic aims. Secondly, madness, however described, can be used as a claim for relief from legal responsibility, as in the insanity defense, or in claims of legal incompetence. This facet of mental health law is customarily invoked by persons claiming that it dulls the impact of the law on some of the weak. Ironically, it is equally useful to

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1. *See* Heller v. Doe, 113 S. Ct. 2637 (1993); Zinormon v. Burch, 494 U.S. 113 (1990); Washington v. Harper, 494 U.S. 210 (1990); Allen v. Illinois, 478 U.S. 364 (1986); Ake v. Oklahoma, 470 U.S. 68 (1985); Jones v. United States, 463 U.S. 354 (1983); Youngberg v. Romeo, 457 U.S. 307 (1982); Estelle v. Smith, 451 U.S. 454 (1981); Vitek v. Jones, 445 U.S. 480 (1981); Parnham v. J.R., 442 U.S. 584 (1979); Addington v. Texas, 441 U.S. 418 (1979); O'Connor v. Donaldson, 422 U.S. 563 (1975); Jackson v. Indiana, 406 U.S. 715 (1972); Dusky v. United States, 362 U.S. 402 (1960).

others who punish or disadvantage people by labeling them mentally ill.

The dearth of effective opposition to abusive psychiatry is not, in my view, the product of its lack of impropriety. Rather, it mirrors the fact that psychiatric treatment appears to be viewed as part of an admirable scheme to assist patients in need of help. At a minimum, it is caught up in the society's general admiration for things scientific. Consequently, those most active in promoting civil rights in other contexts can often be reduced to ambivalence between what they perceive as the virtues of human freedom and humanitarian welfare.[2] Mental health law remains unique in leaving advocates in doubt as to whether to adopt an adversary position on behalf of those they represent or, instead, to join with those seeking to force what is described as help on unwilling patients. While advocates are in doubt, what can one expect of tribunals and standards writers? This article will discuss the United Nations' Principles governing this area and cases brought in international tribunals as contrasted to well established principles from analogous invasions of personal freedoms in quest of a determination of their legality under international human rights law.

II. THE POLITICAL EXPEDIENCY OF PSYCHIATRIC ABUSE

There are instances of psychiatric intervention which, it may be assumed, almost everyone would repudiate. They provide a useful platform because there are aspects of commonality which emerge best when there is no dispute concerning benefit to the "patient." In 1931, psychiatrists meeting in Bavaria, Germany decried the traditional expressed compassion of the nineteenth century and proposed a more severe response to chronic mental illness. They proposed sterilization and euthanasia.[3] By 1936 the eradication of the unfit was well enough accepted to merit incidental mention in an official German Medical Journal.[4] When Hitler institutionalized the idea, he required all state institutions to report

2. *See, e.g.*, David B. Wexler, et al., *The Trauma of a Due Process Hearing in the Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 69 (1971).

3. Alexander, *Medical Science under Dictatorship*, 2 NEW ENG. J. MED. 241 (1949).

4. *See id.*

patients who had been ill for five or more years and who were unable to work. They were required to fill out questionnaires giving the name, race, marital status, nationality, next of kin, whether regularly visited and by whom, who bore the financial responsibility and so forth. The decision regarding which patients should be killed was made entirely by expert consultants, most of whom were professors of psychiatry in key universities. These consultants never saw the patients themselves. The thoroughness of their scrutiny can be appraised by the work of one expert, who between November 14 and December 1, 1940, evaluated 2109 questionnaires.[5]

These questionnaires were collected by a "Realm's Work Committee of Institutions for Cure and Care."[6] A parallel organization devoted exclusively to the killing of children was known by the similarly euphemistic name "Realm's Committee for Scientific Approach to Severe Illness Due to Heredity and Constitution." The "Charitable Transport Company for the Sick" transported patients to the killing centers and the "Charitable Foundation for Institutional Care" was in charge of collecting the costs of the killings from the relatives without, however, informing them of how the charges were to be used; in the death certificates, the cause of death was falsified.[7]

Fortunately, psychiatric genocide seems to have been defeated with its military proponents. It is raised here principally to demonstrate the utility of medical coloration to achieve political ends. In the beginning, it was useful to the Nazis to describe incarceration as cure and care and killing as charity. Only later was broader genocide possible more openly. That utility has not escaped some governments which also use coercive psychiatry to achieve political ends.

The World Psychiatric Association has recognized the possibility of psychiatric political abuse. At its 1977 Congress in Honolulu, it created a standing committee entitled Com-

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5. *Id.*

6. *Id.*

7. *Id.* In describing the group murdered by this process, the authorities claimed that only the most severely regressed mental patients were slaughtered. *Id.* The authorities developed a ruse to get victims into the gas chambers. *Id.* They were given bars of soap and told to stand under "showers" which then released poisoned gas. *Id.* Despite the claimed disorientation of the mental patient group, they marched into the showers, deposited their towels and took their soap for their supposed showers. *Id.*

mittee to Investigate Abuses of Psychiatry. In 1983 the Soviet Union withdrew from the World Psychiatric Association because of its complaint that it was being discredited by Western influences.[8] While it has never openly confessed to the practices which are described herein, it is interesting to note that several changes in law have recently been reported which seem to validate the concerns. In early 1988, the Presidium of the Supreme Soviet adopted a rule which permits relatives of persons improperly committed to mental institutions to appeal the "medical" decisions made in their cases in court.[9] It also makes it criminal to commit a mentally healthy person.[10] It was also reported in early 1988 that control of special psychiatric hospitals was shifted from the police to the Health Ministry.[11]

Prior to *glasnost* it was difficult to verify reports concerning the Soviet Union. Block and Reddaway[12] have written a horrifying account of prior Russian practice which is supported by other evidence.[13] They describe the imprisonment

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8. Current Digest of the Soviet Press, Vol. XXXV, No. 13, at 1-3.

9. *What's News*, WALL ST. J., Jan. 5, 1988, at A1.

10. *Id.*

11. *What's News*, WALL ST. J., Feb. 12, 1988, at A1.

12. S. BLOCH & P. REDDAWAY, SOVIET PSYCHIATRIC ABUSE: THE SHADOW OVER WORLD PSYCHIATRY (1984).

13. *See, e.g., Political Abuse of Psychiatry in the U.S.S.R.*, Amnesty International AI Index, EUR 46/01/83 (1983) (an Amnesty International Briefing). The anecdotes are numerous. One concerns an Amnesty International prisoner of conscience, Nizametdin Akhmetov. He was imprisoned in 1960 for anti-Soviet propaganda and agitation. He later was convicted for writing on his cell wall to protest conditions in the labor camp to which he was sentenced. In 1982, while he was still serving the sentences for his prior convictions, he was convicted of circulating "anti-Soviet slander" in a letter he wrote and sent to a psychiatric institution for an indefinite period. While in the psychiatric institution he wrote to a friend:

> I am in a very bad way my friend. I fear that you may read my letter like a letter from a madhouse (from where else you will shrug). . . . I am in a very bad way my friend. Never have I suffered so much, never was my situation so hopeless. I have dropped out of society, from the scope of its laws, I am absolutely without rights, depersonalized, indeed dehumanized . . . . There is only one way to escape all this torment (except the torments of conscience), only one way of crawling out of here - that is to betray myself and get out, but no longer as Nizametdin Akhmetov. This way is prohibited for me, but that means that they will grind Nizametdin Akhmetov to nothingness on the millstone of 'state security.'
>
> Of course, I am not ill. Yet I am in an institution which has all the means of *making* me ill. This is no exaggeration: Psychiatry has now reached the limits reached by physics when it split the uranium nu-

of dissidents in mental institutions as confinement of choice. It is said to provide three major advantages. First, it avoids the procedural safeguards associated with criminal prosecution. Second, and more importantly, while a political prisoner may aid his cause by being a martyr; a mental patient and his cause are discredited by his perceived lunacy. Finally, there is no finite period for such confinement as opposed to criminal sentences which have a definite maximum term.[14]

The conditions described in many Soviet institutions were savage. In the Soviet Union, for example, psychotherapy was not available but patients were treated with insulin shock and electroconvulsive therapy as well as tranquilizers. Punishment was administered by the injection of painful sulfur compounds.[15] Romania is said to have used similar practices.[16] It apparently mixed psychiatric confinement with physical torture and drugging. For example, it is said to have used injections of boiled milk and iodine which, in addition to intense pain also caused acute anxiety.[17]

The claim that the use of psychiatry to imprison people for political reasons is a cardinal violation of international human rights will surprise no one.[18] That subject will not be addressed in detail here because the cynical use of psychiat-

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cleus. It is not just the one man with the white coat over his MVD uniform whom I have to face - he has the entire State behind him. There is no doubt I am being ground to pieces. It is horrible - the unbearable continuous torment, this so called 'treatment' . . . .

Unfortunately, I shall not see the day when my Motherland herself judges me . . . .

The worst thing that can happen to a person may happen to me. In any case, whether I die or whether they drive me mad - that will be the end. The end of a human being. Even if it does not happen in a human way, as with human beings, it will happen to a human being - that's what I wanted to stress. And I would like to be spoken of, and to be remembered, as a human being.

Appeal from a Prisoner of Conscience in a Soviet Psychiatric Hospital, Amnesty International AI Index, EUR 46/50/86 (1986) at 2-4 [hereinafter *Prisoner of Conscience*].

14. *Prisoner of Conscience, supra* note 13 at 2-4.

15. *Id.*

16. *Romania: Psychiatric Repression of Dissent*, Amnesty International AI Index, EUR 39/07/78 (1978).

17. *Id.*

18. *International Declaration of Human Rights*, G.A. Res. 217A[III], U.N. GAOR, 3rd Sess., U.N. Doc. A/810 (1948) [hereinafter *Declaration of Human Rights*].

ric institutions to imprison dissidents has so much in common with other forms of improper imprisonment. Torturing psychiatric patients with painful chemical or electrical "treatments" also overlaps other forms of torture[19] and so its discussion can be truncated as well.

However, it is important to recognize that the unique role of psychiatry in discrediting opinion and dehumanizing those with whom one disagrees is not limited to totalitarian regimes. Indeed, it may be more dangerous in countries in which individual rights are generally protected. If people can transform their opponents from heroes or even martyrs to lunatics in the public's view, they have accomplished a great deal. In that sense, psychiatric incarceration may occasion a greater intrusion of the rights of the politically unpopular than mere jailing. The disagreement among physicians as to diagnosis, prognosis and even common terminology[20] as well

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19. *Id.* at art. 5.

20. In one of the few systematic studies of diagnostic reliability, Ash compared diagnoses made by three psychiatrists on the same patients at a government clinic. The patients were examined by psychiatrists jointly, but the diagnoses were recorded independently. The three agreed on the specific diagnostic category in only 20% of the cases. When only a general diagnostic category was considered, agreement was higher. All three psychiatrists agreed in 46% of the cases; two psychiatrists agreed in another 51% of the cases; in only 3% of the cases did all three disagree. Ash made another rather sobering finding: In fully one-third of the cases, one psychiatrist found serious pathology, while the other two found the patient to be, with some qualifications, a normal individual. Moreover, the joint examinations may have inflated the levels of agreement by allowing tacit communication among psychiatrists.

The findings of later researchers have generally been consistent with Ash's findings. In general, researchers have found that the level of reliability, as measured by inter-psychiatrist agreement on specific diagnostic categories, is quite low, typically in the neighborhood of 32%.

See Ralph Reisner & Herbert Semmel, *Abolishing the Insanity Defense: A Look at the Proposed Federal Criminal Code Reform Act in Light of the Swedish Experience*, 62 CAL. L. REV. 773, 776 (1974).

Traditionally, psychiatrists have developed descriptive diagnostic labels which they use in categorizing and dealing with patients. Although most psychiatrists use these designations, they do not agree on their nature, significance or utility. Some psychiatrists maintain that the labels denote different disease conditions; others maintain that they apply to reaction patterns having manifest similarities and in no way describe disease conditions. The opinions of most psychiatrists probably fall somewhere between the two; they accept some of the diagnostic categories as disease categories, and they view others as convenient ways of grouping reaction patterns. DAVID MECHANIC, MENTAL HEALTH AND SOCIAL POLICY 13 (1969).

as pressures to over-predict mental illness[21] makes assertion of mental illness relatively easy, especially for those who also control the mental institutions. In addition, since psychiatric intervention is described as medical treatment, it is not in the class of activities for which strict procedural impediments are routinely established. Were criminal punishment proposed instead, one would expect barriers to guard against the inadvertent identification of the innocent. Treatment suggests benevolent conduct and the absence of need to guard against its imposition. When procedures exist, they tend to be considerably more lax than their criminal counterpart. This is true in domestic cases and all the more true when the issue is raised in an international complaint.

The conjunction of the effect of stigmatization, disagreement as to what, if anything, constitutes mental illness and the laxness of procedural protections make the use of psychiatry effective as a tool of political oppression. In the West, some problems relating to the use of psychiatry by those who intentionally pervert the process for their national political purposes exist. An infinitely larger group is affected by psychiatric manipulation in the interest of individual aggrandizement.

Several United States cases will be used to illustrate the point for the following reasons: First, the cases arise in the legal system with which the author is personally most familiar; secondly, the United States is generally recognized as a country with a passion for the protection of individual autonomy (it is also correctly seen as a country in which private litigation in aid of law is very highly developed); third, there appears little indication that the country has a national policy respecting the perversion of psychiatric institutions for political ends. Mental institutions are creatures of state and local governments and they, as well, seem not to have an organized arrangement for the use of hospitals to silence dissent. The use of domestic cases is not intended to assert that problems in the United States are worse than in other countries. Instead, America serves simply as an example of the problems that exist everywhere.

21. Bernard L. Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1974).

One of the most famous cases was that of Ezra Pound.[22] Ezra Pound was indicted for treason against the United States for his activities in Rome during the Second World War. He made radio broadcasts in which he denounced the British and the Jews and expressed hope for an Axis victory.[23] After the Japanese bombing of Pearl Harbor, Pound and his wife attempted to return to the United States but permission to enter was denied. Since he could not re-enter the United States, he stayed in Rome and continued his treasonous radio broadcasts for the Italian government. When the Allies invaded Italy, Pound was arrested for treason and returned to Washington.[24]

Pound never admitted that the broadcasts were treasonous; he claimed that they were patriotic because they called for an end to the war. Rather than actually try Pound for treason, the United States government and Pound's defense attorney decided that it would be better to declare Pound unfit to stand trial and commit him to a mental institution. Consequently, psychiatric evidence was introduced by the Government to show his unfitness for trial. The Government's witnesses found that Pound suffered from paranoia. However,

> [n]o evidence was introduced to prove that, in spite of his peculiarities, Pound could not be treated as a responsible defendant. Instead, unproved allegations were insinuated, such as his being 'less and less able to order his life.' This psychiatric accusation was simply untrue. Before the American troops landed in Italy, Pound was able to order his life well enough to stay out of the hands of psychiatrists. Whereas, since the end of the European War he had been a prisoner, his life having been 'ordered' for him.[25]

After the introduction of the psychiatric testimony, the trial judge instructed the jury in a manner that allowed them to find Pound unfit to stand trial in only three minutes.[26] He was committed to St. Elizabeth Hospital where he remained for thirteen years, from 1945 to 1958. In 1958, a motion was

22. JONAS B. ROBITSCHER, THE POWERS OF PSYCHIATRY 105-06 (1980).
23. *Id.* at 106.
24. *Id.*
25. THOMAS S. SZASZ, LAW, LIBERTY AND PSYCHIATRY 202 (1963) [hereinafter SZASZ, LAW AND LIBERTY].
26. *Id.* at 202-03.

filed in the District of Colombia Circuit asking that the indictment for treason be dismissed. The original psychiatrist testified saying that although Pound was incurably insane, he was not dangerous and it would be safe to release him into his wife's care. The petition was also supported by many of Pound's friends who were famous poets and writers including Robert Frost, Ernest Hemingway, and T.S. Eliot. On April 18, 1958, with the consent of the government, the indictment against Pound was dismissed by Judge Laws.[27] Pound, in effect, had the last word.[28]

Although the efforts were more informal, the Nixon administration also made use of psychiatric labeling to discredit its enemies. After Daniel Ellsberg released the Pentagon Papers, the White House authorized a break-in at the office of his psychiatrist in an unsuccessful effort to find incriminating psychiatric evidence to use against him.[29] During the same period, Martha Mitchell, the wife of the soon to be convicted Attorney General, was kept from revealing information about the Watergate break-in by a combination of physical restraint and informing the press that she was mentally unbalanced.[30]

There was also the case of General Walker.[31] During the federal attempt to integrate the University of Mississippi by physically supporting the enrollment of James Meredith, an African American student, former Major General Edwin A. Walker was arrested, charged with crimes, and then held for psychiatric examination.[32] As Dr. Szasz has noted, "[w]ithout a doubt, this is the most widely publicized case ever reported in the American press of an attempt to deny an accused person the right to trial by branding him insane and hence incompetent to stand trial."[33]

To support the government's claim that Walker was too sick to stand trial, the government furnished an affidavit

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27. *Id.* at 203. Judge Laws was the judge who had originally presided at the competency hearing.

28. "It has been your habit for long to do away with good writers, You either drive them mad, or else you blink at their suicides, Or else you condone their drugs, and talk of insanity and genius, But I will not go mad to please you." [sic] *Id.* at 199 (quoting Pound).

29. ROBITSCHER, *supra* note 22, at 340.

30. *Id.* at 341-43.

31. The facts about this case are taken from THOMAS SZASZ, SZASZ, PSYCHIATRIC JUSTICE 178 (1965) [hereinafter SZASZ, PSYCHIATRIC JUSTICE].

32. *Id.*

33. *Id.*

from a psychiatrist who had never met Walker but who had been given government collected descriptions of Walker's behavior.[34] The doctor's affidavit concluded: "Some of his [Gen. Walker's] reported behavior reflects sensitivity and essentially unpredictable and seemingly bizarre outbursts of the type often observed in individuals suffering with paranoid mental disorder. There are also indications in his medical history of functional and psychosomatic disorders which could be precursors of the more serious disorder which his present behavior suggests."[35] Another psychiatrist then reviewed the first affidavit and the government's evidence and concurred without seeing Walker. Walker was committed.[36]

Walker's attorney characterized the commitment order as "simply fantastic" in light of the fact that he had just talked to him over a two-day period and found him "in complete possession of all mental faculties."[37] Three days after Walker's arrest, his attorney filed a writ of *habeas corpus*. The district judge issued an order to show cause to the government. Rather than produce evidence of the reasonableness of Walker's confinement, the government released him on $50,000 bond. However, he was ordered to undergo a psychiatric evaluation. In the subsequent examination, Walker was found competent to stand trial. At the hearing the government produced still another psychiatrist who had never seen Walker to testify to his incompetence.[38]

During this period, the media had already started reporting that Walker was crazy. Walker sued for libel and won a judgment against the media defendants. After he was found competent to stand trial, it had yet to be determined whether there was sufficient evidence to indict him on riot charges. On January 21, 1963, the Grand Jury failed to indict him.[39]

The government's plan to convert the matter from the apparently weak criminal case to a psychiatric one failed but the illustration is a useful demonstration of how even democratic governments can use psychiatry to achieve their ends.

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34. *Id.*
35. *Id.*
36. *Id.* at 181.
37. SZASZ, PSYCHIATRIC JUSTICE, *supra* note 31, at 182.
38. *Id.*
39. *Id.*

The major intrusion of psychiatry on human values is yet another troubling facet of its uses. As one author has put it:

> For three hundred years, psychiatry has had a role in controlling deviant behavior. Eccentrics, "originals," vagrants, and homeless wanderers who caused little harm but were irritating to the society they lived in were, and sometimes still are, hospitalized or deprived of legal rights. Some critics of psychiatry see this as a political use of psychiatry and see psychiatry as promoting conformity.[40]

Another author described the danger of psychiatric abuse as follows:

> Lacking the integrity of a scientific definition, the concept of mental health—and its antonym, mental illness—has succumbed to what Bertrand Russell (1953) called the cult of common usage. In contemporary America it has come to mean conformity to the demands of society. According to the common- sense definition, mental health is the ability to play the game of social living, and to play it well. Conversely, mental illness is the refusal to play, or the inability to play well.[41]

The cases that demonstrate the broader concern just expressed are numerous.[42] More frightening is the knowledge that very few instances of psychiatric abuse lead to reported appellate cases. The following cases will illustrate this point, both of which depict how the changing role of women generated a good deal of psychiatric intervention.

Elizabeth Packard (1816-1890)[43] was a strong believer in Christianity. She believed that people are born good and taught others this philosophy. Her husband, a minister, did not care for her philosophy because it was contrary to his. He forbade her from expressing her contrary opinions. She refused to obey him.

"In 1860 Elizabeth Packard's husband psychiatrically imprisoned her because she dared to engage in 'free religious

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40. ROBITSCHER, *supra* note 22, at 326-27.

41. SZASZ, LAW AND LIBERTY, *supra* note 25, at 205.

42. *See generally* SZASZ, PSYCHIATRIC JUSTICE, *supra* note 31; THOMAS S. SZASZ, INSANITY: THE IDEA AND ITS CONSEQUENCES (1987); GEORGE J. ALEXANDER, WRITING A LIVING WILL: USING A DURABLE POWER OF ATTORNEY, Ch. 1 (1988) [hereinafter LIVING WILL].

43. This case study is based on the information found in PHYLLIS CHESLER, WOMEN AND MADNESS (1972).

inquiry'".[44] He kidnapped her and committed her to an asylum in Jacksonville, Illinois. He refused to allow their children to see her and deprived her of her personal belongings. Mrs. Packard kept a diary during her time in the asylum, which she published following her escape after three years of confinement. Subsequent to her release, she fought for the legal rights of mental patients.[45]

Zelda Fitzgerald (1900-1948) was the wife of renowned writer F. Scott Fitzgerald.[46] Fitzgerald disapproved of his wife's devotion to the arts, and felt that she was too self-absorbed. Fitzgerald was also apparently threatened by his wife's aspiration to write. He was very upset when she published her own autobiography before Scott had published a story about Zelda's life and psychiatric confinement. He forbade her to continue writing because her role was to be wife and mother. To this, Zelda rebelled.

> She wants to be a "creative artist": she wants "work." Only if she does "good work" can she defend herself against Scott's slighting comments. She . . . is tired of being forced into accepting Scott's opinions and decisions about everything. In fact, she would not do so, she would rather be hospitalized. She feels that their marriage has been nothing but a struggle from the beginning.[47]

Zelda's psychiatrists tried to re-educate her into her role as wife and mother.[48] She said she would rather be a writer than have a life with Scott. Zelda was diagnosed with an inferiority complex and released after fifteen months' confinement, only to be re-admitted later. "The psychiatrists declared her ambitions to be forms of self-deceptions, which had deeply troubled their marriage. Over the years, despite Zelda's pitiful requests for freedom, her obedient confessions of self-blame, and her promises of 'good behavior,' the men decided if and when she could spend 'vacations' outside the asylum."[49] Zelda died in a mental asylum fire before ever regaining her freedom.

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44. *Id.* at 9.

45. *Id.*

46. *See id.* at 7-9 (providing information from which this case study is based).

47. CHESLER, *supra* note 43, at 9.

48. *See id.* at 8-9.

49. *Id.* at 13.

Fortunately, the feminist movement has encouraged law revision against discriminations based on gender and the revisions have, at least on occasion, applied to psychiatric abuse. In *Lenihan v. City of New York*,[50] a federal district court reviewed a discrimination claim filed by a female police officer. Plaintiff, after being laid off, had participated in a class action claim of sexual discrimination against her police department. The action regained plaintiff her job and gained female police officers substantial seniority and related benefits. In retaliation, plaintiff claimed, she was subjected to a psychological evaluation in which she was found "below standard" principally because of her lack of self confidence. The matter escalated and she was later sent to an internal Psychiatric Board which concluded that she was unfit, for psychiatric reasons, to serve in the Department.

A number of discrepancies, too numerous to recount here, convinced the judge that the result was the product of sex discrimination. He noted that there was a climate of hostility to women in the Department, that no one could recall any other police officer ever having been referred for psychiatric review solely because of perceived deficiency of self confidence. While unprepared to reject psychiatric diagnoses, he concluded that a substantial amount of it was "unhesitatingly" based on the accounts of a police captain whose views he [found] to be affected in some significant measure by her sex, and that they rendered their opinions to accommodate their belief that she was unwelcome on the force.[51] Still hesitant to substitute his own views as to her mental condition, he at least restrained the Department from discharging her on the basis of the record they had compiled.

If *Lenihan* marks progress, it should be noted it does so sparingly. In the end, doctors, whose motivations the judge derided, had the last word. The possibility raised by their findings prevented an order fully reinstating her and left it open to the Department to make a record with fewer errors on the basis of which they could, presumably, still discharge her for behaving in a manner they did not approve.

50. 636 F. Supp. 998 (S.D.N.Y. 1985).
51. *See id.* at 1014-15.

The debate continues over the legitimacy of characterizing as illness conduct perceived to be inappropriate.[52] In 1988, a divided United States Supreme Court was confronted with the issue in a veterans' benefits case which turned significantly on whether alcoholism was willful misconduct as opposed to a protected disability. Although the Court did not have to decide whether or not alcoholism was a disease, the majority opinion could not repress commenting approvingly on the Court of Appeals' finding that there is "a substantial body of medical literature that even contests . . . that alcoholism is a disease."[53]

While all decisions which transform conduct into disease raise prospects of political abuse, paranoia and its permutations are among those most likely to achieve suppression of dissent, as Ezra Pound's case illustrates. When the act of harboring complaints is the "illness" and when its severity varies directly with the intensity of the complaints, one can see that it is a perfect tool for political abuse. There is no reliable data on how many people are involuntarily institutionalized because they stubbornly insist on what they consider the truth.[54] The author has represented several such clients. One, Roy Schuster, had been incarcerated for twenty-five years in a mental institution when the author and another civil rights attorney undertook his case. His diagnosis was paranoia. When questioned about the basis of the diagnosis, the attending psychiatrist testified that Mr. Schuster had told the warden of his prison that there was corruption in the prison and had refused to date to recant.[55] Another client was held to be paranoid when he wrote his Congressman complaining about the military assignment he had received.[56]

Not only are people placed involuntarily in mental institutions, many others are deprived of control over their wealth

52. The debate was popularly initiated by THOMAS S. SZASZ, THE MYTH OF MENTAL ILLNESS (1961).

53. Traynor v. Turnage, 485 U.S. 535, 550 (1988).

54. *See Prisoner of Conscience*, *supra* note 13 (sketching a Soviet case that fits this description).

55. Trial Transcript, Herold v. Schuster, 396 U.S. 847 (1969) (No. 248) (on file with author).

56. *In re LCDR "C"*, unreported military "fitness" hearing (official summary in author's files).

by guardianship,[57] still others are "voluntarily" placed in institutions by their guardians who have not obtained their consent, having accused them of mental imbalance.[58] Many who are not institutionalized are dehumanized by being labeled mentally ill.

The generic feature of an accusation of mental illness or insanity is that it diverts attention from the accuser to the accused. A dissenter's political message is drowned in his or her alleged lunacy. The accused politician who charges his attacker with being mentally ill, for example, escapes legal notice while concern shifts to the ward's mental health. Failure to conform to common conduct is condemned as illness.

Some of the abuses result simply from the stigma attached to an accusation of lunacy. For them, defamation law is the only legal remedy. The great bulk of abuses, however, require the active participation of the state. For that reason, they fall within the state's obligation to conform to agreed upon human rights standards. When the state cynically uses psychiatric institutions to stifle dissent, its violation is obvious. It is, however, also the state that inters mental patients and uses its force to keep them in institutions at the behest of security personnel or litigants, and so must be charged with the impropriety of the parties if it exists.[59] It is the state which divests allegedly incompetent persons of their control of property, and so it must guard against enforcing private schemes which use mental illness as an excuse for achieving private ends. The state ultimately legitimates the definition of normality and, so, is responsible when it adopts standards which discriminate against the legitimate aspirations of women or persons with homosexual proclivities or otherwise enshrined conformity.

In short, the state must guard against using or endorsing the use of the concept of mental illness as a means of achieving improper ends. It must do so whether the impropriety is

57. *See generally* LIVING WILL, *supra* note 42, at chs. 1-3.

58. Von Luce v. Rankin, 588 S.W.2d 445 (Ark. 1979); AMERICAN BAR FOUND., THE MENTALLY DISABLED AND THE LAW 260 (Samuel J. Brakel & Ronald S. Rock eds., rev. ed. 1971).

59. *Cf.* Shelley v Kraemer, 334 U.S. 1 (1948) (developing this point with respect to privately made racial covenants which it declared unconstitutional). Since only the state is governed by the relevant constitutional principle, it found "state action" in the necessary enforcement which courts provided for the private contracts and without which they would have no effect. *Id.*

its own or that of a private party, if the state's authority is invoked. In that regard, there is no country of which the author is aware that has met its minimal obligations to international human rights.

III. Review of Existing International Guarantees

To what extent do international guarantees of human rights deal with such problems? As a beginning, one might look to basic guarantees of human rights from the United Nations Universal Declaration of Human Rights.[60] This document sets forth the fundamental rights of all people which are to be established and protected by the Member States. The list is quite formidable. Pertinent to the problem of the abuse of psychiatry and commitment to mental institutions are the following Articles:

1. Article 3 provides that everyone has the right to life, liberty and security of person.

2. Article 5 provides that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

3. Article 8 requires that there be a "right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law."

4. Article 9 proscribes "arbitrary arrest, detention or exile."

5. Article 10 provides that "[e]veryone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him."

6. Article 12 protects a person's family, reputation and honor from interference or attacks.

7. Article 18 ensures that "[e]veryone has the right to freedom of thought, conscience and religion . . . ."

8. Article 19 states that "[e]veryone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers."

60. *Declaration of Human Rights*, *supra* note 18, at 71.

All of these rights have been sacrificed for coercive psychiatric intervention in certain cases.

Since the Universal Declaration, the United Nations in 1975 adopted a Declaration of Rights of Disabled Persons which includes the mentally ill.[61] It also adopted without vote Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care on December 17,1991. The Principles are far better than other UN work on the subject but it remains unclear what their effect will be. In brief summary they provide:

Principle 1 adopts fundamental freedoms and basic rights principally: best available medical care, protection from exploitation and degradation as well as discrimination; retention of political and civil rights and, most importantly, legal representation to contest alleged incapacity, a fair hearing and the right to appeal and for periodic review of incapacity if it is found.

Principle 2 provides for special protection of minors, expressly recognizing the need to have a representative other than a family member if necessary.

Principle 3 provides a mentally ill person the right to live and work in the community to the extent possible.

Principle 4 provides that mental illness shall not be determined on the basis of status nor shall societal non-conformity be used as a factor; prior treatment or hospitalization shall not justify present or future determination that a person is mentally ill; present classification of mental illness is limited to purposes directly relating to mental illness. Unfortunately, it also uncritically adopts "internationally accepted medical standards" suggesting that such standards exist and can be found.

Principle 5 limits the right to force medical examination to determine mental health.

Principle 6 requires confidentiality concerning those to whom the principles apply.

Principle 7 states a preference for community based treatment.

Principle 8 requires the same standard of social and medical care as is appropriate to other illnesses.

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61. *Declaration on the Rights of Disabled Persons*, G.A. Res. 3447, U.N. GAOR, 30th Sess. (adopted Dec. 9,1975).

Principle 9 requires that all treatment aim at preserving personal autonomy, be individuated and least restrictive.

Principle 10 limits medication to that which is medicinally required.

Principle 11 provides elaborate informed consent requirements.

Principle 12 provides for notice of rights.

Principle 13 provides for specific rights in mental health facilities.

Principle 14 mandates a level of resources for mental health facilities modeled on general health facilities.

Principle 15 provides that admissions procedures make every effort to avoid involuntary admission and that voluntary patients be allowed to leave at will.

Principle 16 provides the conditions for involuntary admission and limits them to danger to self and others and grave disability and requires that periods of such confinement be short.

Principle 17 provides for a review body and its procedures.

Principle 18 provides for procedural due process safeguards.

Principle 19 gives patients access to his or her records.

Principle 20 allows confinement of criminal offenders who are mentally ill but requires the same level of treatment as for others.

Principle 21 provides for a right to complain.

Principle 22 requires a state to monitor compliance.

Principle 23 says states should implement the Principles and make them widely known.

Principle 24 applies the Principles to all who are admitted to mental institutions.

Principle 25 saves other rights not mentioned in the Principles.

It is important to note that this document recognizes mental health treatment and confinement as potentially quite harmful and attempts to limit it unlike the case law which generally treats both as presumptively beneficial and socially acceptable.

Also instructive is the important European Convention on Human Rights which prohibits torture and inhuman or

degrading treatment or punishment.[62] It also ensures liberty and security of person. In addition Article 10 provides a right to free expression; Article 9 prescribes the right to freedom of thought, conscience and religion; and Article 8 ensures the right to respect for an individual's privacy and that of his family. There have been many cases brought before the European Commission on Human Rights and the European Court of Human Rights for the enforcement of the rights guaranteed in the Convention. Whatever may be true of their impact on persons not accused of mental illness, they do not offer much hope to involuntary mental patients.

Begin by considering a case of confinement in a mental institution as an alternative to prison—in itself quite common. In *Y. v. United Kingdom*, Y had been convicted by a criminal court of numerous counts of fraud.[63] Under the applicable domestic law, a court may order a defendant to be confined to a mental institution in lieu of prison if the circumstances warrant it. Y was examined by four psychiatrists (two chosen by his solicitors) who agreed that Y was suffering from paranoid schizophrenia. They disagreed, however, as to the treatment required. The psychiatrists appointed by Y's solicitors found that he should be confined to either a minimum security hospital or treated on an out-patient basis. The Crown's psychiatrists found that he should be confined at Broadmoor, a maximum security institution housing the insane. The domestic court ordered his incarceration in Broadmoor.[64]

Before the Commission, Y attempted to obtain an order transferring him to a lower security mental institution. He alleged that Broadmoor was overcrowded, lacked privacy, and had inadequate sanitary facilities. He further claimed that he was not given treatment or even an explanation of what treatment was necessary, and lacked fresh air and exercise. He also indicated that there were inadequate fire precautions and that he lived in constant fear, all in violation of Article 3 of the Convention. He further complained of his compulsory, indefinite detention in a mental hospital without

62. *Collection of Decisions of the European Commission of Human Rights*, Eur. Comm'n H.R. Dec. & Rep. 1-20 (1981).

63. Y. v. United Kingdom, App. No. 6870/75, 10 Eur. Comm'n H.R. Dec. & Rep. 37, 37 (1979).

64. *Id.* at 38.

periodic judicial review of the substantive justification for the detention, citing Article 5 of the Convention.[65]

In evaluating his first claim; that the conditions at Broadmoor were inhumane or degrading in violation of Article 3's protection of life, liberty and personal security, the Commission concluded:

> The ill treatment must attain a certain level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the cases such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim.[66]

The conditions at Broadmoor were thought to result primarily from overcrowding. The Commission acknowledged that the Broadmoor facility was grossly overcrowded, but concluded that the applicant had a "tendency to exaggerate the inadequacy of conditions in Broadmoor Hospital partly because of his uncooperative and negative attitude towards the institution where he considered he should never have been detained."[67] The Commission concluded on a vote of 8-5 that there was no violation of Article 3.[68]

Note how comfortably the Commission indicated that his claims could be disregarded because he was crazy. For a person not crazy, being negative about being institutionalized would, presumably, be normal. The Commission also found that there was a lack of sanitary facilities in all the dormitories, but again stated that "[i]t appears that the applicant unduly and obsessively magnified his complaint concerning the absence of toilet paper."[69] Since he was crazy, he apparently improperly missed toilet paper. As to his feeling that he should never have been detained at Broadmoor, two of the four psychiatrists agreed. Indeed, the question of whether his mental state required involuntary confinement in such a place was at issue but the Commission apparently thought

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65. *Id.* at 39.

66. Y. v. United Kingdom, App. No. 6870/75, 10 Eur. Comm'n H.R. Dec. & Rep. 37 (1979).

67. *Id.*

68. Dissenting opinions were filed by three members of the Commission. *Id.*

69. *Id.*

that issue foreclosed because his complaints were a product of his mental state.

As to the violations of Article 5 which ensures freedom from inhuman and degrading treatment, the Commission found that since the applicant was committed to Broadmoor by order of a competent court, no violation had occurred.[70] They also concluded that the conditions at Broadmoor were not as inhumane or degrading as Y indicated, based on their determination that Y had a habit of exaggerating. The Commission did not even address Y's complaints that he did not receive proper medical treatment and was not apprised of which treatment was necessary, finding that there were good grounds for concluding that the applicant was mentally ill. They were persuaded of the merit of this diagnosis because four psychiatrists concurred that Y suffered from paranoid schizophrenia and two were appointed by the applicant's solicitors. Thus, they found it was not unreasonable for him to be incarcerated in Broadmoor.

Perhaps the Commission missed the point. The value of the diagnostic concurrence by the four psychiatrists is overshadowed by the fact that they had fundamentally different opinions about Y's mental state, as demonstrated by their disagreement concerning treatment.[71] On that they were evenly divided.

As to the charge that he did not receive psychiatric or medical treatment, the Commission found that Y refused psychiatric treatment because he thought himself sane. Y stated that he refused treatment because the need for it was not explained to him. The facts also reveal a dispute between the applicant and his "Responsible Medical Officer." Due to the dispute, the hospital claimed it was impossible to administer any treatment to the applicant.

As a result, Y, who claimed he was sane, was locked in an overcrowded maximum security facility. The state had abandoned attempting to treat him and excused his continued confinement on the basis of its claim that he was ill, which had now become medically irrelevant. Discounting the allegations made by Y on the grounds of his alleged mental illness reminds one of the folk wisdom related on many a bumper sticker, "Just because you're paranoid don't mean they're not

70. *Id.*

71. *See generally supra* notes 20 and 21.

out to get you." In United States jurisprudence, the Supreme Court has held mental health confinement in such circumstances unconstitutional at least when the "patient" was confined solely for his own welfare.[72] It has also interdicted placing persons in a mental institution without a formal commitment hearing.[73]

One example of a case involving political uses of psychiatry is that of X, a German lawyer charged with fraud.[74] X, in turn, accused his public prosecutor of plotting against him and of intentionally bringing false charges. He sought to have criminal charges brought against the prosecutor. In response, the prosecutor, relying on X's attempt at suicide nine years earlier, obtained a court order to have X examined by a psychiatrist. X refused to be examined, claiming he was not mentally ill. X was then placed in a mental institution and ultimately agreed to the examination as the only means of obtaining his release.[75] The court order and its implementation were before the Commission.

The Commission began by disposing of the applicant's Article 3 claim, finding it manifestly ill-founded. The Commission concluded that it is a common procedure for a court to request a psychiatric evaluation of a criminal defendant and that such examination, of itself, cannot be considered degrading treatment.

The Commission next proceeded to the Article 8[76] contention that the evaluation impinged X's right to privacy. The Commission acknowledged that the order for a psychiatric evaluation does interfere with Article 8's prescriptions. However, Article 8 has broad exceptions if the infringement is necessary in a democratic society. The Commission found the order to be within the exception of Article 8(2) based on the rationale that the Court acted within its rights in asking for the evaluation: It was in the interests of both X and the Court to be apprised of the defendant's mental condition.

The applicant also complained that the Court was not justified in considering a police report unconnected with the

72. O'Connor v. Donaldson, 422 U.S. 563 (1975).

73. Vitek v. Jones, 445 U.S. 480 (1981).

74. X. v. the Federal Republic of Germany, App. No.83334/78, 24 Eur. Comm'n H.R. Dec. & Rep. 103, 103 (1981).

75. He was examined, found fully criminally responsible and convicted of fraud. *Id.*

76. *See supra* note 60 and accompanying text.

present case. The Commission disagreed, citing Article 8(2). It concluded that the Court did not have jurisdiction to examine the lawfulness of how it came to be apprised of the document and, once disclosed, the Court could not simply disregard it unless it were completely irrelevant.

The applicant's next complaint was that police retention of the record of the attempted suicide was unjustified. The Commission found that this was an issue of data protection which is within the scope of Article 8, however, it found that X had failed to exhaust his domestic remedies on this issue. Therefore, X did not prevail on any issue.

It may well be true that X was incorrect in his claims against the public prosecutor. Perhaps he was deluded. The case is raised to demonstrate a potential political tactic which seems immune from Commission review. The prosecutor was able to shift the issue from the questionable legality his own behavior to a question of his accuser's sanity. If the psychiatrist had corruptly or negligently found X insane, that would have ended X's claim and probably resulted in X's incarceration (even if he was not guilty of a crime). A public official—especially a prosecutor—would likely have easy access to a court for such an order. Nothing in the Commission's response indicates that it is ready to assist in such circumstances.

Another case which touches on some of the same issues is *X v. Norway*.[77] In this case, the applicant had served in the Norwegian Foreign Ministry since 1963. Commencing in 1969, he felt that he was subject to surveillance by the intelligence services which exceeded normal security requirements. In 1972, he was admitted to a mental hospital for a brief period. Thereafter, he was promoted to the rank of Division Head with the Foreign Office. In 1973, the applicant filed a complaint against some high ranking officials for persecuting him, but no action was taken. A few weeks later, the applicant was forcibly confined to a mental hospital with the consent of his family. At the beginning of 1979, he was relieved of his duties.

The applicant contended that his criticism of Norwegian officials for subjecting him to surveillance directly resulted in his being relieved of his duties. He claimed that this was in

77. X. v. Norway, App. No. 9401/81, 27 Eur. Comm'n H.R. Dec. & Rep. 103, 103 (1981).

violation of Article 10 of the Convention,[78] which protects the right to free expression.

The Commission found the applicant's petition to be without merit. It determined that there was no evidence to suggest that the applicant was hindered in his right to free expression since he, in fact, publicly denounced the conduct of the high officials. How nice for them that he had been branded a lunatic.

The Commission also gave weight to the Norwegian authorities' denial that applicant was subject to surveillance and their assertion that he imagined it. Additionally, the Commission found that applicant's feelings of persecution detracted from his ability to do his job. Also, the Commission deferred to the judgment of the Norwegian officials that the applicant's behavior diminished the prestige and credibility of his division. Due to these considerations, the Commission found that applicant's transfer to another job at the same salary did not violate domestic law or the Convention. It therefore concluded that the application was ill-founded.

But could he have been rational and telling the truth? Psychiatrists are trained to treat patients based on their account of events to the physician. Nothing in their training makes them able to evaluate the truth of the account as opposed to its reflection on the patient's mental health. They are not supposed to investigate for truth and do not. One of the most curious anomalies concerning forensic use of psychiatry is that it uses people with such training to testify to the truth of their patient's accounts!

Once a person is incarcerated or found incompetent, the possibility of involuntary drugging often follows, making resistance difficult. In *X v. the Federal Republic of Germany*,[79] the Commission considered the application of the Convention to the forced administration of medicine to patients confined in a mental hospital. In 1971, X was convicted of indecent assault and sentenced to two years imprisonment. He was found to be of diminished capacity and ordered confined to a psychiatric hospital under domestic law. In 1973, the Court reviewed the applicant's condition and found him to be dangerous. The Court also appointed a guardian for X,

78. *See supra* note 60 and accompanying text.

79. X v. The Federal Republic of Germany, App. No. 8518/79, 20 Eur. Comm'n H.R. Dec. & Rep. 193, 193 (1980).

charged with the duty to administer his property and to authorize medical treatment for him.

X complained that the drugs Psychopharmaca and Neuroleptica had been administered with the consent of his guardian but against his will. He complained that forced administration of the medication violated both Articles 3[80] and 8.[81] As to Article 3, the Commission concluded that forced medication was not inhumane or degrading treatment. They deferred to the judgment of the physicians and the guardian and found that it was in X's best interests to be medicated by force.

They next considered the Article 8 charge. Article 8 ensures the right to a private life. The Commission found that when a person is placed under guardianship, it interferes with his right to privacy but also found that the appointment of a guardian was authorized by domestic law. It relied on the exception to Article 8 for prevention of disorder or crime, finding that when the applicant failed to take proper medication, he threatened other patients and wardens with murder. It therefore found no violation of Article 8.

In none of the cases mentioned was psychiatry obviously used simply to suppress dissent, although psychiatry has been used overtly to accomplish political suppression, as has been noted. It is important to observe that the defenses available are inadequate to guard against more cynical abuses and, of course, to realize that the denial of human rights may occur even when there are no darker motives.

Also, it must be admitted that there has been limited protection in some cases against the most egregious types of governmental conduct. One example is a case involving the recall, without notice, of a former mental patient. In *X. v. United Kingdom*,[82] X had been confined to Broadmoor Hospital after he had been convicted of a violent assault. He was subsequently released by the Secretary of State for the Home Office on a conditional basis. The conditions of his release were that he should live at a specified address with his wife, that he should be under the supervision of a probation officer and that he should attend a psychiatric out-patient clinic.

80. *See supra* note 60 and accompanying text.

81. *Id.*

82. X. v. United Kingdom, App. No. 6998/75, 8 Eur. Comm'n H.R. Dec. & Rep. 106, 106 (1977).

However, the Secretary of State for the Home Office retained the power to recall him to Broadmoor.

X lived with his wife and secured a job. After three years, he was arrested by the police and returned to Broadmoor Hospital but was not informed of the reason for his return. He applied for a writ of *habeas corpus*. At the hearing of the writ, three of X's co-workers testified that there was nothing unusual about his behavior. His general practitioner also testified that there was no cause for concern. However, the Court rejected the writ and deferred to the analysis of a probation officer.

The applicant contended that his detention at Broadmoor violated Article 3,[83] 5(1)(c),[84] 5(2)[85] and 5(3).[86] The Commission held that the charge as to Article 3 was inadmissible. Once the proceeding commenced, the United Kingdom came forward with information as to why X had been recalled to Broadmoor. X's wife stated that her previous assurances that X was making good progress were untrue. She further complained that he was deluded and threatening, and that she was afraid of him.

Article 5(1)(a) prohibits the detention of a person unless his detention is ordered by a competent court. The Government contended that since X was only conditionally released from Broadmoor, his detention had been ordered by a competent court. X maintained that this section did not apply to his case.

Article 5(1)(e) prohibits detention unless the detention is required to prevent the spreading of infectious diseases, or for persons of unsound mind, alcoholics, drug addicts or vagrants. The applicant claimed that no effort had been made to check his state of mind.[87]

Article 5(2) requires that those detained be informed of the charges against them, however, the Government asserted that this section was inapplicable to cases involving section 5(1)(e).[88] The applicant contended that the vague and general reasons for his recall were insufficient under section 5(2).

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83. *See supra* note 60 and accompanying text.
84. *See supra* note 60 and accompanying text.
85. *See supra* note 60 and accompanying text.
86. *See supra* note 60 and accompanying text.
87. X. v. United Kingdom, App. No. 6998/75, 8 Eur. Comm'n H.R. Dec. & Rep. 106, 106 (1977).
88. *Id.*

The Commission found that the application may have merit and found it admissible. In its report of July 16, 1980 it found:

> By 14 votes to 2, that X's recall to Broadmoor Hospital and further detention there had not violated his rights under article 5, paragraph 1;
>
> Unanimously, that there had been a breach of article 5, paragraph 2, in that X [had not been] given prompt and sufficient reasons for his arrest and readmission to Broadmoor;
>
> Unanimously, that article 5, paragraph 4 had been violated, since X had not been entitled to take proceedings by which the lawfulness of his detention consequent upon his recall to hospital could be decided speedily by a court.[89]

The Commission requested that the European Court of Human Rights determine whether the "applicant was a victim of a violation of article 5, paragraphs 1 and 2 of the Convention when he was recalled to Broadmoor Hospital on 5 April 1974 and whether thereafter the applicant was entitled to and received an adequate judicial determination of the lawfulness of this renewed detention in accordance with article 5, paragraph 4 of the Convention."[90]

The Court first disposed of the issue of whether Articles 5(1)(a) and (5)(1)(e) were applicable. It found that X had been convicted by a competent court within the meaning of Article 5. It therefore found that paragraph 1(a) applied. Since he was committed to Broadmoor, the Court indicated, subparagraph (e), in so far as it related to the detention of 'persons of unsound mind', also applied."[91] The Court placed particular reliance on the fact that X was conditionally released from Broadmoor and had enjoyed a lengthy period of liberty. It found no breach of article 5, paragraph 1.

As to Article 5, paragraph 4, the applicant had alleged that there was no opportunity to determine judicially the lawfulness of his detention in Broadmoor. The Court found that

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89. U.N. SUB-COMM'N ON PREVENTION OF DISCRIMINATION AND PROTECTION OF MINORITIES, PRINCIPLES, GUIDELINES AND GUARANTEES FOR THE PROTECTION OF PERSONS DETAINED ON GROUNDS OF MENTAL ILL-HEALTH OR SUFFERING FROM MENTAL DISORDER at 33, U.N. Doc. E/Cn.4/Sub.2/1983/17/Rev.1, U.N. Sales No. E.85.XIV.9 (1986).

90. *Id.* at ¶ 93.

91. *Id.* at ¶ 97.

the recall decision by the Home Secretary was based, at least in part, on considerations different from those pertaining to the original confinement order. Further, though the medical condition of a conditionally released patient might change with the passage of time, no provision had been made for periodic review. Therefore, the Court found a breach of Article 5, paragraph 4.

The Court next addressed whether the United Kingdom violated Article 5, paragraph 2 by failing to inform X of the reasons for his recall to the hospital. The Government asked the Court to look to its new procedure with regard to recalling patients to mental hospitals. They conceded that the old procedure did not comport with Article 5. Changes had been made because of the criticisms made by the European Human Rights Commission.

The Court found that "it was clear from the evidence that lack of information as to the specific reasons for the recall, a matter almost exclusively within the knowledge of the Home Secretary, prevented X's counsel, and thus the Divisional Court, from [deciding the original habeas petition]."[92] Since the Court had already found a violation of Article 5, paragraph 4 and the Government had rectified the problems with its procedure, it did not decide the issue.

In *Van Der Leer v. The Netherlands Nationwide Life Insurance Co.*[93] the Court of Justice determined that the conversion of a voluntary commitment into involuntary status without notice or hearing violated Articles 5(1), 5(2) and 5(4) by confining her without the hearing required by national law to inform her of the reasons for her new status and in failing to resolve the matter speedily. While the case does stand for some due process requirement in involuntary commitment, it should be noted that several procedures under national law which allowed a hearingless detention were not invoked and the court merely noted the absence of the justification they would provide. The court did, however, equate the confinement with criminal arrest holding that the "arrest" provision in Article 5(2) was breached.

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92. *Id.*

93. Van der Leer v. The Netherlands, App. No. 11509/85, 12 Eur. H.R. Rep. 567, 567 (1990).

In *E v. Norway*[94] the Human Rights Court also invoked Article 5(4) to condemn the tardy review of a detention although they held that the Norwegian Courts were free to hold a person in administrative custody for being "someone with an underdeveloped or permanently impaired mental capacity" creating a danger of recidivism.[95] There was also some doubt that review procedures really permitted national courts to release the prisoner should they find the administrative detention improper: Nonetheless, the court gave the state process the benefit of the doubt and denied that aspect of the Article 5(4) claim.

In *App. No. 12535/86 v. Netherlands*[96] the Commission held that it retained jurisdiction in a case which had progressed through its preliminary examination even though the patient who had filed it had since been released.

On the other hand, consider *Keus v. Netherlands.*[97] There a prisoner who, under Dutch law, could be sentenced to two year periods of detention at "the Government's disposal" in a mental institution following a penal sentence escaped on the eve of a hearing to determine whether he should be so detained. The government did not notify him for the good reason that it could not find him. It also did not notify his lawyer whom they could find. The result was that, when shortly thereafter he was returned to custody, he had no authorized court procedure in which to litigate the need for his confinement. By a five to four vote, the Court of Human Rights found no violation of the hearing provision of Article 5(4). They agreed that the absence of a court hearing was a violation of 5(4) but, precisely for that reason, found that he had a remedy. Since the Netherlands was bound by Article 5(4) and "the fundamental adversarial principle" he could have claimed a hearing on the appropriateness of his immediate release without such a hearing being preestablished by law.[98]

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94. E. v. Norway, App. No. 11701/85, 17 Eur. H.R. Rep. 30, 30 (1990).

95. *Id.*

96. App. No. 12535/86 v. Netherlands, App. No. 12535/86, 11 Eur. H.R. Rep. 46, 102 (1986).

97. Keus v. Netherlands, App. No. 12228/86, 13 Eur. H.R. Rep. 700, 700 (1990).

98. *Id.* at ¶ 28.

A study of some of these and other cases was made by Professor Dinah Shelton and Dr. Thomais Douraki.[99] From a review of the cases just discussed as well as from a reading of the Shelton-Douraki paper one is led to the conclusion that mental patients are rapidly receiving basic due process in Europe. Unfortunately, as I have written before, due process works to illuminate identified issues but helps little when the basic issue is itself muddled.[100] The European Court of Human Rights in the *Winterwerp* decision[101] realized that the convention language for mental illness, a person of unsound mind, is not a term which can be given a definite interpretation. With a glimpse of the problem, the court concluded that unsound mind cannot be premised on views or behaviors which deviate from the norms of a particular society. To demonstrate that it did not get the point, the court added that the "true" mental disorder should be of a "kind or degree warranting compulsory confinement."[102] The Shelton-Douraki study similarly concludes conventionally by noting, "[i]t must be considered that often mental patients have disabilities which deprive them of the ability to adequately communicate information necessary or relevant to protect their human rights."[103]

It is a short step from stating that those accused of mental illness are sometimes too disabled to communicate to "protecting" them by the confinement that the court finds the final test of the legitimacy of the diagnosis. To look at the accusation of mental illness as an indication of reasons to disregard the claims of the accused is to fall into the trap that forensic psychiatry has always set. Since forensic psychiatric testimony, as opposed to psychiatric diagnoses for treatment purposes, almost always turns on predictions, postdictions or statusdictions of behavior, they overlap usual judicial functions. When they are allowed to determine the issue, they

99. Dinah Shelton & Thomas Douraki, Human Rights and the Mentally Ill (1992) (unpublished manuscript, on file with the author).

100. George J. Alexander, *Premature Probate: A Different Perspective on Guardianship for the Elderly*, 31 STAN. L. REV. 1003 (1979) [hereinafter Alexander, *Premature Probate*].

101. Winterwerp v. Netherlands, 2 Eur. Ct. H.R. (ser. A no. 33) at 387 (1979).

102. *Id.* at ¶ 39.

103. Shelton & Douraki, *supra* note 99, at 20.

usurp those functions. All the evidence we have suggests that the testimony is as often wrong as it is right.[104]

As an example, consider *Nielsen v. Denmark*.[105] In that case a mother committed her minor child to a psychiatric ward of a state hospital in her role as his custodian. The child complained that he did not require medical treatment but was placed solely to deny custody to his father. He pointed out that he had had no hearing to challenge his confinement. On the facts the Commission had found a violation of Article 5(1) and Article 5(4) but the Court of Human Rights disagreed. It was satisfied that the mother, when taking the decision to commit the child to the hospital, had as her objective the protection of applicant's health. Hospitalization was decided in accordance with expert medical advice, and the child was not treated as being of unsound mind nor put in a ward with psychotic children. His mother's action was viewed as acting in his interests so there was no need of a hearing to consider the child's view. Four judges dissented. The circumstances fit the non-definition of mental illness perfectly. The majority could concern itself with the inability of the child to communicate his needs or note that the diagnosis had led to forced confinement. The Shelton-Douraki paper treats the case as illustrating the need for child protection.[106] I think it illustrates the error of reliance on psychiatric advice and any substitute for adversary hearing when incarcerating people.

IV. A United Nations Proposal for the Prevention of Psychiatric Usurpation of Human Rights Concerns

In 1986, in a commendable recognition of the issues, the United Nations commissioned a study of the problems of persons detained on the basis of mental illness to formulate guidelines for domestic law which would protect the rights of these detainees. The Guidelines are only advisory. They are quite comprehensive in scope, undoubtedly well intentioned and a substantial advance over existing practice. They none-

104. For my latest summary of this problem together with a citation of relevant authorities see George J. Alexander, *Big Mother: The State's Use of Mental Health Experts in Dependency Cases*, 24 Pac. L.J. 1465 (1993).

105. 144 Eur. Ct. H.R. (ser. A) at 6 (1988).

106. Shelton & Douraki, *supra* note 99, at 16.

theless ignore some important problems and take what is arguably a wrongheaded approach to others.[107]

The Guidelines begin by prohibiting discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[108] In addition, they indicate that previous detention in a mental hospital may not justify discrimination against the former patient.

The Guidelines then provide that all other fundamental freedoms guaranteed are to be accorded mentally ill persons. The Guidelines provide the following guarantees in addition to the fundamental freedoms:

> 1. A definite time period for detention.
>
> 2. A diagnosis of mental ill-health must be determined in accordance with internationally accepted medical standards.

This statement assumes a far greater agreement among psychiatrists than exists. The failure to agree, that is the failure of reliability, is one of the problems which has plagued psychiatry.[109]

> 3. Difficulties in adapting to particular moral, social, cultural, or political values may not be a determining factor in finding mental illness.

This is a pious statement worthy of consideration. Unfortunately, mental abnormality requires a base line normality for comparison. Failure to adapt to accepted values will likely be medicalized to mental illness irrespective of this directive. Consider whether Joan of Arc could hope to win a trial of her sanity. Jesus Christ? Mahatma Ghandi?

> 4. Every patient shall be treated in a community-based facility to the extent possible.

This is an excellent requirement. It had a good following in the United States in the prior decade. Unfortunately, it amounted mostly to ending state support: The communities did not respond to help even those wanting help.[110]

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107. PRINCIPLES, GUIDELINES AND GUARANTEES, *supra* note 89.

108. *Id.* at art. 2, ¶ 1.

109. *See supra* note 20.

110. *See* ANDREW T. SCULL, DECARCERATION (1977); HOLLY S. WILSON, DEINSTITUTIONALIZED RESIDENTIAL CARE FOR THE MENTALLY DISORDERED (1982); Matt Clark et. al., *The New Snake Pits*, NEWSWEEK, May 15, 1978, at 93.

> 5. Every patient has the legal right to receive social and medical services to protect him from harm.

This provision must be read together with the twelfth provision which bars unwanted treatment. Great care must be taken to see that the right to receive services is not transmuted to the duty to be "served."

> 6. Mental institutions must be inspected monthly by a higher competent authority.
>
> 7. Mental institutions may only accept qualified patients who a competent court would determine require institutionalization.

This provision represents a substantial advance over practice. Not only does it require a preadmission procedure, it rejects a medical, as opposed to a legal determination.[111]

> 8. Patients have the right to the least restrictive alternative.

This is an extremely useful norm. It has some domestic support in the United States.[112]

> 9. Psychosurgery and electroconvulsive treatment may never be applied without the patient's consent or the consent of his/her legal representative.

This, also, has great merit given the disrepute of both treatment forms. A similar rule has been adopted in some states of the United States.[113]

> 10. Psychiatric knowledge shall be used only for diagnosis, therapy and treatment of the patient and shall never be abused for non-medical purposes.

So long as psychiatric knowledge is used to impose treatment, this provision is confusing. Imposition of confinement and compelling treatment (as opposed to the treatment itself) would seem, after all, to be state police power purposes, not medical purposes.

> 11. Medication shall be given only for therapeutic purpose and shall not be used as punishment.

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111. *Cf.* Doremus v. Farrel, 407 F. Supp. 509 (N.D. Neb. 1975).

112. *See* Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966).

113. Robert Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 NW. U. L. REV. 461 (1978); Note, *Regulation of Electro Convulsive Therapy*, 75 MICH. L. REV. 363 (1976).

Although this provision outlaws chemical torture, it misses the problem of the use of sedation and tranquilization as responses to opposition. Both are usually seen as therapeutic.

> 12. Every patient has the right to refuse treatment.

An excellent point. It does not, however, take care of releasing those who cannot be helped by institutionalization because they refuse treatment.[114] Put another way, institutionalization itself is a form of treatment which every "patient" should be allowed to refuse if it is imposed for his or her alleged benefit. Also, it should be clear that this requirement cannot be overridden by the simple expedient of finding the patient incompetent to refuse treatment. Advance directives have utility for this purpose.[115]

> 13. Every hospital patient has the right to communicate with people outside the institution.
>
> 14. Patients have the unrestricted right to receive and send uncensored communications from and to his/her lawyer, guardian or other legal representative or his/her family or friends.
>
> 15. Hospital patients also have the right to receive visitors regularly.
>
> 16. Hospital patients also have the following rights:
>
> a. to practice his/her religion
>
> b. to privacy
>
> c. to enjoy facilities for education and training
>
> d. to enjoy facilities for reading, recreation and sport
>
> e. to purchase essential items for daily living

It is difficult to believe that these rights will not be eroded by transforming their exercise to manifestations of illness. Suppose, for example, a person whose religious perspective includes direct communication with God. Will psychiatrists be prohibited from attempting to cure that belief?

> 17. Any patient who has not been declared incapable (incompetent?) shall not be treated as such because he/she has been admitted to a mental institution.

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114. *See supra* notes 60-70 and accompanying text.

115. Using advance directives, persons, while they are competent, can appoint an agent to carry out their wishes should they become incompetent. Unlike their contemporaneous demands when they become incompetent, their prior written directions are legally binding. *See generally* LIVING WILL, *supra* note 42.

This is a good provision. United States' experience indicates, however, that a finding of incompetence will follow admission.[116]

> 18. Every patient not declared incapable has the right to exercise his/her civil, political, social or cultural rights, including the right to manage his/her own financial affairs.
>
> 19. Forced labor in mental institutions is prohibited.

Again, one must guard against forced labor being termed therapy.[117]

> 20. Every patient shall have the right to a qualified guardian to protect his/her well-being and interests.

This norm expresses a view of guardianship as beneficial. Too often, unfortunately, guardianship is the principal method of depriving the patient of his rights.[118] The provision should at least include the right to choose the surrogate. Again, advance directives would be helpful to insure that the choice would be accepted.

For a person voluntarily admitting him/herself to a mental institution, the Guidelines provide the following rules:

> 1. Medical standard for admission:
>
> a. two medical practitioners must concur, after a proper personal examination, that the patient is suffering from a mental illness and is likely to benefit from admission.
>
> b. the patient has been informed of the purpose of the admission.
>
> c. the patient requests, consents or does not object to admission.
>
> 2. Every voluntary patient has the right to leave the mental institution at anytime, unless he/she could be admitted as an involuntary patient.

This is the type of provision which makes supposedly voluntary admission truly involuntary. A patient is informed that if he or she does not consent to treatment, an involuntary admission will follow.[119] The rule should be that a voluntary

116. GEORGE J.ALEXANDER & TRAVIS H. D. LEWIN, THE AGED AND THE NEED FOR SURROGATE MANAGEMENT 135, 136 (1971).

117. *See* Weidenfeller v. Kidulis, 380 F. Supp. 445 (E.D. Wisc. 1974).

118. *See*, Alexander, *Premature Probate*, *supra* note 100.

119. RALPH REISNER, LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 270, 271 (1985).

patient may always leave at will. It should be improper to use the threat of involuntary admission to keep a voluntary patient. Only by putting some barriers between the two can the state encourage patients to seek self help without fear of being enmeshed in a more coercive system than they seek.

For a person being committed involuntarily, the Guidelines provide the following rules:

> 1. Medical standard:
>
> a. Two medical practitioners must concur that admission for care and treatment because the patient is suffering from severe mental illness or mental disorder *and* is a danger to himself or others or the community.

This provision adopts the common notion that involuntary hospitalization is justified with which there is sharp disagreement.[120] It attempts to build in some safeguards against excessive confinement but they lack teeth. The insane are usually perceived as dangerous. Some objective evidence of danger should, at least, be required, such as recent dangerous conduct.[121] Advance directives should allow a competent person to reject future "benefit" by incarceration premised on either the person's best interests or because of danger to self[122] if the state insists on disregarding contemporaneous rejection of confinement on competency grounds.

> b. A competent court must order the commitment. The court must afford the patient appropriate preparation and give him/her a proper hearing in the case.

One cannot quarrel with the spirit of this provision. Unfortunately, mental health issues are more difficult to determine than most issues faced by courts.[123]

> 2. A notice must be given in advance of the judicial hearing and must be required by law.
>
> 3. The notice must be in a language which the patient understands and must contain the time and place of the hearing, the name and address of the lawyer who will

120. BRUCE J. Ennis, PRISONERS OF PSYCHIATRY (1972); SZASZ, LAW AND LIBERTY, *supra* note 25; Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54 (1982) [hereinafter Morse].

121. REISNER, *supra* note 119, at 353 n.3.

122. LIVING WILL, *supra* note 42, at 76, 77.

123. *See* Alexander, *Premature Probate, supra* note 100.

represent the patient, the legal and medical standards for committal, the legal rights which the patient has prior to the hearing, the grounds and specific facts that are alleged to justify commitment and the names of the persons who will testify at the hearing.

4. The patient has the following rights in the proceedings before the Court:

a. to be represented by a "trained lawyer and experienced advocate"
b. to be heard personally
c. to attend and participate at the hearing; this right may only be abrogated if the patient's behavior will disrupt the proceedings.

The exception is unwise. It is likely to overwhelm the rule.[124] As in criminal cases, presence is some guarantee of fairness. Cases in which the patient/defendant is removed from court should be truly exceptional.

d. to see all relevant documents submitted to the court
e. to call an independent expert witness
f. to compel the presence of witnesses.

5. The court must make its findings in writing, stating the reasons for its decision.

6. There must be judicial review of the lower court's decision which may be initiated by any interested person.

Does this provide an antagonist a second opportunity to incarcerate? It should not do so, especially if the person seeking review has no psychiatric expertise.

7. The commitment decision must be reviewed at intervals specified by the Court.

In criminal proceedings it is provided that:

1. A suspected, accused, convicted or detained person shall have the right to an independent psychiatric examination and report whenever his/her mental condition is relevant to legal proceedings.

2. Neither criminal charges nor criminal conviction shall be a sufficient reason for varying the procedures and

124. In several studies in the United States rules requiring the presence of the allegedly incompetent person have been mostly disregarded even with stricter language. Lawrence Friedman & Mark Savage, *Taking Care: The Law of Conservatorship in California*, 61 S. CAL. L. REV. 273 (1988); Peter Horstman, *Protective Services for the Elderly: The Limits of Parens Patriae*, 40 MO. L. REV. 215, 235 n.81 (1975).

> standards for determining the presence or absence of mental illness.
>
> 3. If there is a serious reason to suspect that an accused patient is not fit to stand trial because of severe mental illness, the Court shall inquire into the question, if necessary upon its own authority.

While the provision is to be commended for involving the court in the resolution of issues raised by those "unfit to stand trial," the unfitness notion raises the threat of allowing the state to keep an innocent person from exonerating him/herself. Further safeguards are required to prevent abuse.

> 4. A person shall not be held criminally responsible by reason of severe mental illness he/she was unable to control or criminal impulses he/she was unable to restrain or if he/she was unable to appreciate the criminal nature of his/her acts.

There is reason to doubt that the criminal procedure rules are as humanitarian as they seem. The insanity defense appears to be rarely successful in jurisdictions where it is accepted doctrine.[125] It often leads to a period of greater incarceration than conviction.[126] The notion of legal irresponsibility also leads to many of the abuses in the civil system.[127]

> 5. A condition of mental illness which does not fully eliminate criminal responsibility should be considered as diminishing responsibility and should be taken into consideration by the court in determining the sentence. The same concerns expressed about the prior norm apply here.
>
> 6. A patient who is acquitted because of failure to establish a material element of the offense should be admitted to a mental institution only as a voluntary patient, or following a involuntary commitment by order of a competent court.

At a minimum, there would not be a longer period of involuntary treatment following such acquittal, based on the conduct

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125. The insanity defense is raised in fewer than 2% of criminal cases in the United States. It is rarely successful in a contested jury trial. REISNER, *supra* note 119, at 562 n.1.

126. *See* Jones v. United States, 463 U.S. 354 (1983).

127. *See* Thomas Szasz & George J. Alexander, *Mental Illness as an Excuse for Civil Wrongs*, 43 NOTRE DAME L. REV. 24 (1967), *reprinted in* 147 J. NERVOUS AND MENTAL DISORDERS 113 (1968).

which lead to the trial, than the period of incarceration authorized for the crime.[128]

> 7. If a person is acquitted because of lack of criminal responsibility due to severe mental illness, but material facts of the crimes were otherwise proven, if he/she is amenable to care and treatment, the court may order either community-based treatment or, if the commitment standards are met, treatment in a mental institution.

The limitations suggested for the prior provision apply here as well.

> 8. A convicted person confined to a mental institution shall be provided with adequate mental care and treatment.
>
> 9. At the end of his/her sentence, a patient shall be released and shall not be admitted to or retained in a mental institution as an involuntary patient unless the commitment standards are met.

The limitations suggested for the sixth point apply here as well.

As inadequate to the problems as the Guidelines are, they represent commendable recognition that serious problems lurk behind psychiatric "treatment" decisions. Unfortunately, they are not mandatory. Nonetheless, human rights advocates should incorporate their teachings and suggested improvements into their claims to begin the process of establishing them as customary law.

V. CONCLUSION

The coercive use of psychiatry represents a violation of basic human rights in all cultures. Some specific violations are, obviously, more blatant than other. The main concern that must be expressed is that many of the abuses are masked as humanitarian gestures and that society has stereotyped people it calls lunatics in a far more effective way than most racial or ethnic minorities.

It is well beyond the scope of this article to address ways in which one might make substitutions for current practices.

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128. *See* Baxtrom v. Herold, 383 U.S. 107 (1966). This provision should not be limited to the greatest potential criminal sentence but should incorporate opportunities for earlier release, such as by parole, in the same manner as in criminal cases. United States *ex. rel.* Schuster v. Herrold, 410 F.2d 1071 (2nd Cir. 1969), *cert denied*, 396 U.S. 847 (1969).

Evaluating alternatives against present perceived problems is a daunting task. It has, of course, been partially undertaken by some scholars.[129]

At the moment, there is little resistance to even the most Machiavellian use of psychiatry. It is hoped that, by drawing attention to the problem, some support for a more determined attack on this form of rights abuse will be mustered, and that skepticism of the medical aura that surrounds the treatment of persons labeled mentally ill will be stirred. Few groups of psychiatrists these days are likely to join organizations such as the Nazi Realm's Work Committee of Institutions for Cure and Care, and cure and care will usually not be shorthand for administered killing. But will "cure and care" always be benevolent or will it sometimes be dissent opinions that are cured and dissidents taken care of in the sense of American gangster movies? In any event, can there be an effective system of international human rights if it does not guard against such possibilities?

129. *See* ALEXANDER & LEWIN, *supra* note 116; SZASZ, LAW AND LIBERTY, *supra* note 25; Morse, *supra* note 120.