Scattered throughout a recently published Annual Report of the NSW [New South Wales, Australia] Mental Health Review Tribunal are repeated references to a perception by members of the Tribunal that involuntary commitment to mental hospitals is being erroneously restricted. The Mental Health Review Tribunal is a quasi-judicial body constituted under the NSW Mental Health Act with some 29 designated responsibilities for hearing appeals and reviewing the cases of detained mental patients. As the Act currently stands people who are judged to be mentally ill or mentally disordered by a medical practitioner can only be ‘scheduled’ into a mental hospital against their will if there is a risk they might cause serious physical harm to themselves or other people. This requirement of dangerousness can only be downgraded when the symptoms of mental illness concern disorders of mood in which case serious risk to the person’s finances or reputation can also be considered.

The Mental Health Review Tribunal appears to be of the opinion that the current interpretations of these requirements are too strict and that a much wider net should be cast for coercive psychiatric practice. One of the Tribunal’s statements even goes so far as to appeal for involuntary commitment to be expanded to include people with personality disorders "who would benefit from behavioural modification, rehabilitation, or drug and alcohol programmes".

Yet, despite these repeated appeals to widen the criteria for involuntary commitment, the Tribunal, in the same report, has ironically also drawn attention to the way the numbers of involuntary patients are steadily increasing under the existing criteria. The total number of involuntary admissions in NSW has risen from 5499 in 1992, to 6403 in 1993, to 7190 in 1994.

This has been accompanied by an even more accelerated rise in the numbers of Community Counselling Orders (CCOs) and Community Treatment Orders (CTOs). CCOs and CTOs are legal devices in NSW which facilitate the involuntary medication of a person for psychiatric reasons outside of an institution. A CCO achieves this by restriction; a CTO provides for arrest and it is usually seen as a last resort. A CTO provides for arrest and it is usually the last resort. One NSW community psychiatrist comments, "they offer too many avenues for appeal."

The NSW Minister for Health, however, has recently introduced amendments to the Mental Health Act so that the maximum period for which a person can be held under CTOs for 1992 was 510; for 1993 it was 1020, and for 1994 it was 1830 days.

Apart from drawing attention to involuntary patients, the Tribunal highlights voluntary patients. According to the Tribunal, voluntary patients are developing "trend towards coercive use of the Act." But the Tribunal does not indicate that it is difficult to avoid the conclusion that voluntary patients are being treated by arguing for a relaxation of the law.

Expanding the Diagnosis of Mental Illness

The significance of a trend towards increased use of mental health legislation was brought into focus by reference in the New South Australian study found that the prevalence of mental illnesses. 11% were found as compared to a similar study undertaken in 20.8% of the general population in the United States which found rates of 20.8%.

The South Australian study found that 8% of mental illnesses had seen a psychiatric diagnosis and it agreed with U.S. research that treated for their psychiatric problems. GPs: "the ability of GPs to identify and treat mental health problems and who sought specialist help. In the group of 11 people (4.2% of 26.4%) who were diagnosed as receiving treatment.

From the medical point of view, the importance of psychiatric diagnosis and if they are unwilling..."
institution. A CCO achieves this under threat of arrest for non-compliance. A CTO provides for arrest and incarceration for non-compliance. There has been a lot of opposition to the concept of CCOs and CTOs, particularly in the United States where variants are currently being introduced state by state. One NSW community mental health nurse has criticised them because "they offer too many avenues for abuse by punitive and anxious staff." The NSW Minister for Health, however, is currently proposing to amend the Mental Health Act so that the maximum period for CTOs can be extended from three months to six months. The combined total in NSW of CCOs and CTOs for 1992 was 510; for 1993 it was 782; and for 1994 it was 1233.

Apart from drawing attention to the increase in the numbers of involuntary patients, the Tribunal has also reported declining numbers of voluntary patients. According to the Tribunal, the combination indicates a developing "trend towards coercive, as opposed to consensual, treatment." But the Tribunal does not indicate any disapproval of this trend and it is difficult to avoid the conclusion that it is deliberately encouraging the trend by arguing for a relaxation of the criteria for involuntary commitment.

Expanding the Diagnostic Net

The significance of a trend towards coercive psychiatry can perhaps be brought into focus by reference to a recent survey published in The Medical Journal of Australia. Using the standard DSM diagnostic system the South Australian study found that 26.4% of 1009 ordinary rural adults had mental illnesses. 11% were found to have two or more disorders. This compared to a similar study undertaken in Christchurch NZ which found that 20.6% of the general population had mental illnesses and two studies in the United States which found rates of 20% and 29%.

The South Australian study found that only 4.2% of the people with mental illnesses had seen a psychiatrist or psychologist in the previous 12 months and it agreed with U.S. researchers that "most community residents are not treated for their psychiatric problems." Blame for this was directed towards GPs: "the ability of GPs to identify psychiatric problems and to provide an accurate diagnosis, particularly of depression, has been questioned."

These findings can be expected to encourage the medical profession in the belief that they are underdiagnosing mental illness and that more effort should be put into early diagnosis and treatment. Yet there is an altogether different way of interpreting these findings. Of 1009 people there were 11 people (4.2% of 26.4%) who acknowledged they had mental problems and who sought specialist treatment for them. A further 255 people (26.4% minus 11) were diagnosed with mental illnesses but were not receiving treatment.

From the medical point of view these 255 people should receive treatment and if they are unwilling to volunteer for it then coercion might be
necessary. But at the same time most of these 255 people must be coping with life in their untreated state—otherwise they would have already come into contact with psychiatry as either voluntary or involuntary patients.

What is apparent from this interpretation of the survey is the huge gap that exists between the psychiatric profession's view of the community's state of mental health and the community's own view of itself. This confirms sociological research which has found that 'lay beliefs are often quite distinctive in form and content' to clinical medicine. By finding about a quarter of the population to be mentally ill, when these same people seem to be willing to carry on with life as they are, the psychiatric researchers have raised very interesting questions: Are we living in a society that is quite literally partly mad, where a quarter of the population seem to be unaware that they have already developed mental illnesses, and where the rest of us appear unwilling to acknowledge that soon it might be our turn? Or is there something wrong with the diagnostic techniques used by the researchers? Is there something about the way psychiatry is practised that predisposes psychiatrists to find pathology where ordinary lay people might find foolishness, stupidity, aggression, laziness, drunkenness, boorishness, unhappiness, self-doubt and numerous other character faults that affect most people at some time or another, making them unpleasant company, but which do not really distinguish people as having sick minds?

**The DSM Diagnostic System**

*The Diagnostic and Statistical Manual of Mental Disorders (DSM)* used in the South Australian survey was devised and published by the American Psychiatric Association (APA). The APA is the main professional organisation of psychiatrists in the United States and their diagnostic manual has become a de facto international standard for psychiatric diagnosis. The DSM system is deeply entrenched in Australian medical practice, and codes from the manual are required for lodging medicare claims for psychiatric expenses.

Early versions of the DSM had little pretence of being scientific and were largely heuristic guide books that incorporated much of the psychiatric lore derived from Freudian psychoanalytical techniques. But with the third revision in 1980, a "fateful point in the history of the American psychiatric profession was reached. . . . The decision of the APA first to develop DSM III and then to promulgate its use represents a significant reaffirmation on the part of American psychiatry to its medical identity and its commitment to scientific medicine." Scientific pretensions have been a central feature of the hyperbole surrounding the use of subsequent revisions of the manual.

The recent editions of DSM attempt to classify all deviant personality types in such a way as to provide a universal reference for aspects of human expression and identity. The preparation of the most recent revision involving more than a thousand pages is scheduled for a total of 390 separate meetings.

"Disorders Usually First Diagnosed in Childhood and Adolescence: First Diagnosed in Adult Life"—like the learning disorders—3,353 of 3,364 are in the category of Attention Deficit Disorder—three per cent of the general population, deviantly including substance abuse, relationship personality disorders, and psychological disorders.

There are obvious dangers of over-reliance of medical practitioners in identifying and treating the general population. For example, 25% of people who are regularly employed show signs of alienation of a quarter of the population in terms of their work. . . . When someone is described in self-appraisal (e.g., feel that one is 'a failure') is described as having a diagnostic concern about their current mental state as "too obsessive, opinionated, self-assured, and paranoid."

This type of person may be described as a "sociopath". It is clear that this is a label that has been applied to individuals who have been described as having a personality disorder. Some Australian psychiatrists have been critical of the use of this label, particularly in the context of the courts of law:

"When a sceptical psychiatrist provides a distillate of the prejudices and unscientific obsessions of academics, of no interest to most psychiatrists, . . . some Australasians, this carries little weight."

Doubts about whether a U.S. personality disorder has validity in Australia, and whether diagnosticians can ever determine the forms of deviance within the community, as opposed to the manifestations of maladaptive value judgements that have to be treated.
human expression and identity that the APA thinks require modification. The preparation of the most recent edition, DSM IV, was a "team effort" involving more than a thousand people. Codes and descriptions are supplied for a total of 390 separate mental disorders. They range in scope from "Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence" like the learning disorders—315.00 Reading Disorder and 315.1 Mathematics Disorder—and the disruptive behaviour disorder—313.81 Oppositional Defiant Disorder—through to a whole range of adult forms of deviancy including substance abuse of various kinds, sexual dysfunctions, personality disorders, and psychoses.

There are obvious dangers to human rights arising from the empowerment of medical practitioners to use the DSM system as a template for dividing the general population into a 75% portion of normal people and a 25% portion of people who are unfit in their present condition. Even if the alienation of a quarter of the population were acceptable in human rights terms, why should a conservative American professional organisation be allowed to specify the types of people that are unacceptable to Australian society? Consider some of the features of 301.7.

**Antisocial Personality Disorder for Instance**

"Irresponsible work behaviour may be indicated by significant periods of unemployment . . . or by the abandonment of several jobs without a realistic plan for getting another job. There may be a pattern of repeated absences from work. . . . They may have an inflated and arrogant self-appraisal (e.g. feel that ordinary work is beneath them or lack a realistic concern about their current problems or their future) and may be excessively opinionated, self-assured or cocky."

This type of person may be unattractive to employers in the United States, and indeed to Australian employers as well, but do most Australians really believe that these character traits are manifestations of a sick mind? Some Australian psychiatrists have argued, apparently with little success, against the respect given to the DSM system in Australia, particularly by courts of law:

"When a sceptical psychiatrist points out that the DSM is no more than a distillate of the prejudices and power plays of a group of aging American academics, of no interest to most Europeans and only passing relevance to some Australasians, this carries no weight."

Doubts about whether a U.S.-devised classification system for mental deviance has validity in Australia are further compounded by doubts about whether diagnosticians can even be consistent in their identification of the forms of deviance that the manual describes. The diagnostic system largely deals with manifestations of mind and personality and requires subjective value judgements that have to be made without the assistance of definitive
methods of measurement or laboratory tests. What is "excessively opinionated, self-assured and cocky" to one diagnostician might be "well-informed, confident and amusing" to another.

In extensive surveys of psychiatric diagnosis, where two psychiatrists were required to interview the same patients on admission to psychiatric hospitals, it has been repeatedly found that agreement between the psychiatrists is often little better than mere chance. Using a statistical system called Kappa, which is designed to determine the diagnostic agreement between psychiatrists which is over and above chance, researchers found in six studies conducted in the U.S. and the UK that the diagnostic agreement for schizophrenia, for instance, was "no better than fair." When the Kappa figure for chance is .46, the average of the six tests was found to be .57, with a low range in New York well below chance of .32.

This critical weakness in psychiatric practice was exposed over 20 years ago by the much-cited Rosenhan experiment. In 1973 an American professor of psychology enlisted eight volunteers to act as pseudo-patients. Over a period of time they presented themselves at 12 psychiatric hospitals and complained of hearing voices saying the words "empty," "hollow" and "thud." These words had been chosen because of their existential connotations suggesting the emptiness of life and because they had never appeared in psychiatric literature as being symptoms of mental illness.

On each occasion the pseudo-patients were admitted to the hospitals and on all but one occasion they were diagnosed as having schizophrenia. After the initial interview the volunteers did not mention the voices again and acted their normal sane selves. The agreement they had made with the coordinator of the experiment was that they would each have to gain their own release without any outside assistance. This had to be done by convincing the hospital staff they were sane. The length of hospitalisation ranged from 7 to 52 days with an average of 19 days. All those originally diagnosed as having schizophrenia were released with the diagnosis of "schizophrenia in remission." One conclusion made by the coordinator of the experiment was that "Psychiatric diagnoses . . . are in the minds of the observers and are not valid summaries of the characteristics displayed by the observed." Despite these known shortcomings of psychiatric diagnosis the mental health industry continues to expand with the assistance of the DSM diagnostic system which provides psychiatrists with a 'scientific' justification for "the medicalisation of deviance." In the United States between 1975 and 1990, "the number of psychiatrists increased from 26,000 to 36,000, clinical psychologists 15,000 to 42,000, and clinical social workers from 25,000 to 80,000" while the total cost of mental health care rose between 1980 and 1990 from about $20 billion to about $55 billion.

This 'medicalisation of deviance' is even becoming apparent in the socialisation of children. Social commentators are beginning to observe a growing tendency amongst parents and schoolteachers to rely on drugs like Ritalin to "suppress the passions of perceived behavioural problems."

Early detection of supposed schizophrenia is also becoming a widely discussed area. Schizophrenia InformationCentres are being set up for parents immediately if any symptoms are noticed. Parents find schizophrenia in their children is a funny shape . . . . It is a noise to the internal 'filter' which is not from what's not."

A recent paper on childhood schizophrenia describes examples of supposedly psychotic children. Its observations, describing multiple voices including a love you sister, sister I'm going, God's voice saying, 'Sorry D., I'm here today' and 'You've been a very bad girl, can hear the devil talk—God's voice—God and the devil are always arguing' and saying 'Stupid F . . . .' and saying 'You're clever today.'

The researcher reports that the children with psychotic symptoms were 6.9 years old, but those diagnosed with schizophrenia were 9.5 years old.

It is worth noting that this paper on 38 children, 17 of whom were black and Asian, all the children had been diagnosed with "strict DSM III criteria for schizophrenia which is normally used to determine whether to give an extraordinary to a prescription for of the U.S. National Institute of Mental Health has adapted the diagnostic criteria for schizophrenia to avoid equivocation. The implications for children should meet the same standards as are expected from adults and the sample can explain why the research was conducted.

Observers of psychiatric treatment report a tendency to fund research into the use of psychiatric drugs which it is hoped will lead to the availability of serotonin in...
Ritalin to "suppress the passion of children" and to assist in the correction of perceived behavioural problems.

Early detection of supposedly serious psychiatric problems in children is also becoming a widely discussed imperative. For instance, in NSW the Schizophrenia Information Centre warns parents to be watchful for early signs of insanity in their children, advising that treatment should be given immediately if any symptoms are observed. One of the signs they advise parents to look for is a child who is observed to "say or do things most people find socially embarrassing—like telling someone they're ugly or their nose is a funny shape. . . . It is as if their brain disorder involves some damage to the internal 'filter' which helps people sort out what's appropriate from what's not."

A recent paper on childhood schizophrenia in the U.S. gives a number of examples of supposedly psychotic symptoms that have been observed in child patients. Its observations include: 'An 8-year-old girl reported hearing multiple voices including the voice of a dead baby brother saying—'I love you sister, sister I'm going to miss you.' An 11-year-old boy heard God's voice saying, 'Sorry D., but I can't come now, I'm helping someone else.' An 8-year-old girl reported an angel saying things like, 'You didn't cry today' and 'You've been a very nice girl today.' An 8-year-old boy stated, 'I can hear the devil talk—God interrupts him and the devil says 'shut up God.' God and the devil are always fighting.' A boy described monsters calling him 'Stupid F. . . .' and say they will hurt him."

The researcher reports that the mean age of the onset of Nonpsychotic Symptoms in these children was 4.6 years; the mean age of the onset of Psychotic Symptoms was 6.9 years; and the mean age at diagnosis of schizophrenia was 9.5 years.

It is worth noting that this particular study was conducted in Los Angeles on 38 children, 17 of whom were black, 16 Hispanic, 4 white and 1 Asian. All the children had been screened to ensure their symptoms met "strict DSM III criteria for schizophrenia." The DSM description of schizophrenia is normally used to determine abnormality in adults and it seems extraordinary to read a paper like this, published in a prestigious journal of the U.S. National Institute of Mental Health, reporting research that has adapted the diagnostic criteria for use on children without any explanation or equivocation. The implication is that the researcher believes that children should meet the same standards of conformity in their thoughts, beliefs and expression as are expected of adults. Perhaps the racial mix of the sample can explain why the researcher might hold such an intolerant view.

Observers of psychiatric trends in the U.S. have become concerned about a tendency to fund research into a perceived link between inner-city street crime and an assumed imbalance of brain chemistry in the perpetrators. A part of this line of research involves the development of new psychiatric drugs which it is hoped will pacify aggressive people by increasing the availability of serotonin in their brains. Young black males are seen as
the prime targets for this type of therapy and the accompanying debate has inspired the headline in at least one black newspaper, "PLOT TO SEDATE BLACK YOUTH."

Unfortunately, the Australian Human Rights and Equal Opportunity Commission seems to be unaware of the harm that might be done to human rights by encouraging the early diagnosis and treatment of mental illness. The Burdekin Report, for instance, claimed that:

"Conduct disorder and other disruptive behaviours are a source of considerable morbidity in child and adolescent mental health with problems occurring in 3.2–6.9 percent of young people. . . . Prevention of conduct disorders in childhood and adolescence, or their early and effective treatment, is of special significance given the great personal, social and economic costs produced by antisocial behaviour and other disorders."

Conduct disorder is specifically confined to children and adolescents. According to the DSM IV, "The essential feature of Conduct Disorder is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. . . . Children with this disorder often have a pattern of staying out late at night despite parental prohibitions." The text-book recommendation for treating this kind of waywardness, as well as for treating other social imperfections in children like Tourette's Disorder, characterised by the blurtng out of obscene expletives, is dosing with haloperidol, one of the high-strength neuroleptics.

The Burdekin Report was particularly enthusiastic about the early diagnosis and treatment of schizophrenia:

"Psychiatrists working with general practitioners in an English community have been able to detect the earliest signs of schizophrenia—and with education, supportive interventions and short-termpsychotropic medication—prevent the onset of an episode, . . . Obviously this research must be repeated and tested in different settings, including Australia, but these early findings are encouraging and warrant urgent attention."

The Human Rights Commission apparently had not considered the potential threat which this line of research might pose to basic human rights like those specified in Article 18 of the International Covenant on Civil and Political Rights concerned with the freedom of thought and belief. The implication of the Burdekin Report is that it might be useful to screen the general population for the "earliest signs of schizophrenia." If this screening were to be carried out in Australia, and people with the "earliest signs" were then coerced into preventative psychiatric programmes, the effect would be to lower the community's tolerance level for individual deviancy in thoughts and beliefs.

The current tolerance level is only crossed when a person manifests the symptoms of full-blown psychosis. But if the "earliest signs of schizophrenia" were used to lower the tolerance level this aspect of Western psychiatry might begin to look suspiciously popularised in the Soviet Union.

As early as 1974, psychiatrists reported the high prevalence of 1,000 population compared to . . . was revealed to be fit for the profile of "sluggish schizophrenia," and was later latently described by the psychiatrist. Soviet dissidents have claimed that they had the persistent symptoms of sluggish antisocial movement so deeply involved in the development of mental illness in operation with the KGB.

**Conclusion**

The Mental Health Review Tribunal's report towards coercive psychiatric practice shows that a widening gap seems to be opening up between the profession's perception of the general community's own view of itself. The misdiagnosis with rhetorical catchwords and terms like "deviance" and "antisocial" thinking and behavioural patterns has been taken as a given. In this way the net has been cast wider but strangely this expansion of the human rights inquiry into mental health has revealed that what can be drawn is that psychiatry is in control of society.

Ronald Leifer has argued that industrial societies have given rise to social organisation in which sexuality is centralised in the autonomy and where people can move freely where there is also a large cross-section of attitudes and beliefs, who are also represented in the role of patients.
might begin to look suspiciously like the type of psychiatry that was practised in the Soviet Union.

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. 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.” 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.” Soviet psychiatrists became so deeply involved in the control of political dissidents that a whole system of special mental hospitals was established which they ran in cooperation with the KGB.

**Conclusion**

The Mental Health Review Tribunal in NSW has identified a growing trend towards coercive psychiatric practice and away from consensual treatment. A widening gap seems to be developing between the psychiatric profession’s perception of the general community’s state of mental health and the community’s own view of itself. The medical profession seems to be exacerbating this situation by disguising the essential subjectivity of psychiatric diagnosis with rhetorical claims that the DSM diagnostic system is now a branch of medical science. The DSM system further promotes the “medicalisation of deviance” by continually expanding the number of abnormal thinking and behavioural patterns which it defines as varieties of mental disorder. In this way the net of coercive psychiatry is rapidly expanding, but strangely this expansion appears to have been endorsed by the recent human rights inquiry into mental illness. The only reasonable conclusion that can be drawn is that psychiatry is set to play a growing role in social control.

Ronald Leifer has argued that the prevailing conditions in modern industrial societies have given rise to “the therapeutic state.” This is a form of social organisation in which the law still respects the right to individual autonomy and where people are not criminalised for being different, but where there is also a large class of non-criminal people, with undesirable attitudes and beliefs, who are medically controlled by forcing them into the role of patients.