

Patient-centered strategies to counter stigma, oppression and forced incarceration in the C/S/X and medical cannabis movements

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Abstract

Under the guise of protecting personal health and public safety, federal and regional governments have created policies and associated enforcement mechanisms to prohibit illicit substance use and control the behaviours of citizens affected by mental illness. These mechanisms can lead to significant deprivations of personal rights and freedoms, including forced treatment and incarceration. The c/s/x (consumer/survivor/ex-patient) and medical cannabis movement are two 'new social movements' (Young, 1990) that have emerged as areas of resistance to this state-sanctioned oppression, stigma and moral regulation (Hunt, 1999; Erickson, 1998). Although seemingly engaged in unrelated struggles, both of these social movements are defending the same important principles: cognitive liberty and the right to make fundamental decisions about one's health without the fear of incarceration.

This research suggests that both the anti-psychiatry and medical cannabis patient movements have created successful strategies that increase patient control over their health conditions and personal lives, resulting in better outcomes for individuals suffering from chronic physical or mental health challenges. I conclude that these disparate groups might benefit from sharing successful strategies to defend cognitive liberty and to address the ongoing oppression, bio-medical dominance, and social stigma affecting mental health and medical cannabis patients.

"Everyone loses something precious when we sacrifice an artificially defined group of people's freedom in an ill-conceived quest to maintain the illusion of control, predictability, and safety." (Bassman 2001, 34)

Introduction

Mental illness and drug addiction are two of the most stigmatized health issues in modern society (Bassman 2001). Under the guise of protecting personal health and public safety, federal and provincial governments in Canada have created policies and associated mechanisms to prohibit illicit substance use and control the behaviours of citizens affected by mental illness. These mechanisms can lead to significant deprivations of personal rights and freedoms, including forced treatment and incarceration. The c/s/x (consumer/survivor/ex-patient) and medical cannabis movement are two 'new social movements' (Buechler 1995; Young 1990) that have emerged as areas of resistance to this state-sanctioned oppression, stigma and moral regulation (Hunt 1999; Erickson 1998). While the c/s/x movement has focused much its efforts on an individual's right to refuse treatment and forced incarceration, the medical cannabis movement continues to fight for the right patients to access treatment – in this case medical cannabis – without being stigmatized or criminalized. Although seemingly engaged in contrary struggles, both of these social movements are defending the same important principles: cognitive liberty and the right to make fundamental decisions about one's health without the fear of incarceration.

Starting with an examination of Western society's long-standing fear of altered states of mind, I examine how loss of freedom and the threat of incarceration can lead to either 'reactance' or 'helplessness' (Monahan et al 1995). I then apply the lens of 'new social movements' (Buechler 1995; Young 1990) to contrast and compare the strategies developed by these patient groups to address and resist social stigma, loss of freedom and incarceration, and explore the concept of cognitive liberty and the right for individuals to experience altered states. The paper concludes that both the anti-psychiatry and medical cannabis movements have succeeded in increasing patient control over their health conditions and personal lives, and that this empowerment has resulted in better health outcomes for individuals suffering from chronic physical or mental health challenges. I suggest that these disparate groups might benefit from a mutual awareness of each other's struggles and successes, and from sharing strategies to defend the fundamental personal right to cognitive liberty, and address the ongoing oppression, bio-medical dominance, and social stigma affecting mental health and medical cannabis patients.

A fear of altered states: mental illness and medical cannabis use as sources of social stigma, oppression, and loss of freedom

Altered states of mind, be they the result of mental illness or substance use, are inherent to human existence; however, Western society's understanding and acceptance of altered states is severely limited by the bio-medical tendency to pathologize thoughts and actions that stray too far from normative expectations. In

reference to his own experiences with mental illness, psychologist Ronald Bassman (2001, p.17) states that "each person's journey into and out of their altered states is unique and charged with heroic possibilities", adding that "our understanding of these quintessential human conditions is severely limited by a Western societal penchant for accepting too facile generalizations and labels that do more to obscure than to describe". Bassman's suggestion that there may be "heroic" outcomes from experiencing altered states is relevant because this term is commonly associated with the use of psychedelic substances like LSD and psilocybin, both of which are currently being studied as a potential therapy end-of-life anxiety (Multidisciplinary Association of Psychedelic Studies 2009). Interestingly, modern medical texts often refer to this class of drugs as 'psychomimetics', meaning that they produce "effects (as hallucinations or paranoid delusions) that resemble or are identical with psychotic symptoms" (Merriam-Webster 2009). The linguistic and taxonomic association between altered states of mind resulting from mental illness and those stemming from substance use reveals a worrisome institutional ignorance and prejudice within modern medicine of both the subjective (potentially therapeutic) effects of psychotropic substances and the individual experience of psychosis and mental illness as a whole. This bio-medical over-simplification and denigration of altered states of mind has resulted in significant social stigma against mental illness and substance use. Research suggests that Western society's deeply entrenched fear of altered states stems largely from a public perception that mental illness necessarily predicates unpredictable behaviour and random violence. In her study of madness on the streets of Montreal, Knowles (2000, p. 136-37) states:

The association between madness and dangerousness is, perhaps, best set in the broader context of urban mythology in which madness is one of many forms of social danger in the urban popular imaginary. Fear of random attack, stranger danger, the association of certain parts of the urban landscape with unprovoked violence bear no relationship with actual incidents or their frequency.

Although this passage focuses on the social construction of the link between madness and dangerousness, Knowles (2000, p.143) doesn't deny that madness and violence at times co-exist on our streets; however, she quantifies the real dangerousness of the mad, stating that "what looks dangerous is not so necessarily", adding that "...the American Psychiatric Association historically denied the association between mental disorder and violence. The Canadian Mental Health Association also denies links between madness and dangerousness..." (Knowles 2000, p.136). Despite the evidence that mental illness is not necessarily associated with violence, a fear of altered states has led to the development of policies and practices that grant a tremendous amount of power to mental health professionals, including the "right and responsibility to detain patients and to force them to take powerful drugs or undergo electroconvulsive therapy" (Bracken & Thomas 2001, p.725).

Drug prohibition is similarly dependent on the deliberate exaggeration of the dangers of psychoactive substance use in the public mind. In the seminal essay *The Ethics of Addiction*, Szasz (1971, p.542) states that "since most of the propaganda against drug abuse seeks to justify certain repressive policies by appeals to the alleged dangerousness of various drugs, the propagandist often must, in order to enlist significant support, falsify facts about the true pharmacological properties of the drugs they seek to prohibit". The exaggerated potential harms to the self and others underlie the justification to forcibly incarcerate individuals who use psychoactive substances, even for therapeutic purposes. In their examination of substance use in other cultures, Coomber & South (2004, p.15) further elucidate the extent of these fears in Western society, citing criminal prohibition as a massive and unjustified societal over-reaction to the altered states associated with psychoactive substances:

Huge populations, often otherwise law-abiding citizens, have been criminalised for using one or another of an ever-widening range of substances, sometimes to a punitive extreme that has few parallels. Prohibition in its varying manifestations is fundamentally based upon the fear of drugs, the fear of intoxicated states, the fear of the individual transformed into something less moral."

The passage identifies both the complex human relationship with altered realities, as well the resulting social stigma, oppression, and moral regulation that result from our current prohibition-based drug policies. Bassman (2001, p.27) suggests that the stigma and prejudice faced by those affected by mental health issues is only trumped by the addition of other undesirable human conditions, such as transmissible disease and problematic substance use:

People with a "mental illness" label reside at the very bottom rung of our culture's pecking order. Beneath them are only "mental illness" combined with other discriminated-against subsets further defined by age, gender, minority race or ethnicity, outsider sexuality, addiction, and frightening communicable diseases (such as AIDS).

This is of direct relevance to better understanding the significant social stigma faced by both medical cannabis and mental health patients, particularly where the two overlap. Since some research has attempted to link cannabis use – including therapeutic use – with psychosis and schizophrenia (Frischer et al 2009; Zammit et al 2008), social fears of mental illness can further contribute to the stigma already affecting patients who chose to use medical cannabis. Conversely, patients affected by mental health conditions that may benefit from the use of cannabis, such as depression, bi-polar disorder and even schizophrenia (Schwarcz et al 2009) are even further stigmatized for choosing this medicine because of deeply ingrained social prejudices against both psychoactive substance use and addiction (Lucas 2009; Belle-Isle & Hathaway 2007).

The threat of incarceration and the rise of the C/S/X and medical cannabis movements

Mental illness and madness affect every segment of society, and those affected may have little in common other than their shared symptoms or conditions, and the threat of forced treatment and/or incarceration should their behaviour stray too far from normative expectations. This threatened loss of freedom has become a rallying point for the c/s/x movement. Bassman (2001, p.20) states that "for the psychiatric survivor as well as the consumer, the need for quality alternatives to forced treatment was a priority. No issue was more powerfully charged than *forced treatment*". Similarly, medical cannabis patients come from many different social demographics and have little in common other than their use of cannabis as a medicine. Yet in response to the federal government's prohibitionist drug policies and an ineffective federal programme that protects less than 5000 of the estimated one million Canadians currently using cannabis for medical purposes from arrest and prosecution (Lucas 2008; Belle-Isle & Hathaway 2007), medical cannabis patients have emerged as an effective and well-organized social group fighting for the right to use this medicine without the fear of stigma, arrest and incarceration. Young (1990, p.44) suggests that social groups often form without the benefit of common backgrounds or conscious intention, but rather as a result of ongoing structural oppression and a need to reclaim a sense of personal identity:

A social group is defined not primarily by a set of shared attributes, but by a sense of identity....Sometimes a group comes to exist only because one group excludes and labels a category of persons, and those labelled come to understand themselves as group members only slowly, on the basis of their shared oppression...

In other words, the social stigma and prejudice that isolates and marginalizes certain individuals in our society is also the primary foundation for the creation of movements of resistance for those directly affected by this oppression. Good examples of this phenomenon from the 20th century include the feminist movement, the civil rights movement, and the gay rights movement, all of which can be defined as 'new social movements'. New social movement theory marks a deliberate departure from 20th century Marxist analyses of social movements based largely on economic class structures and the subsequent struggle to control resources and methods of production, focusing instead on other socio-cultural dynamics of collective action. As Buechler (1995, p. 442) notes, "new social movement theorists...have looked to other logics of action based in politics, ideology, and culture as the root of much collective action, and they have looked to

other sources of identity such as ethnicity, gender and sexuality as the definers of collective identity".

One of the most striking examples of marginalized groups organizing to assert their rights in direct response to oppressive social policies from recent times is the 2005 publication of "Nothing About Us Without Us; Greater Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical and Human Rights Imperative" (Jurgens 2005), by the Canadian HIV/AIDS Legal Network. As the title suggests, this document asserts the rights of marginalized individuals to be included in policy discussions that directly affect them:

As an ethical principle, all people should have the right to be involved in decisions affecting their lives. This fundamental requirement for meaningful involvement is consistent with the commitment made by the Government of Canada in 2001 when it endorsed the UN General Assembly's *Declaration of Commitment on HIV/AIDS*, which calls for the greater involvement of people living with HIV and of people from marginalized communities. Such a commitment is consistent with the United Nations "*International Guidelines on HIV/AIDS and Human Rights*", which urge states to involve representatives of vulnerable groups, such as people who use drugs, in consultations and in the planning and delivery of services. (Jurgens 2005, p.iii).

A direct response to decades of policy-making that excluded or ignored the views and opinions of those affected by problematic substance use and HIV/AIDS, this document served as a wake-up call to policy-makers, public health organizations and police agencies, and has been a great source of empowerment and inspiration for other oppressed or persecuted groups and individuals as well, including medical cannabis and mental health patients. Similarly, it is through shared stigma, oppression, and the omnipresent threat of incarceration that patient-centered organizations such as the anti-psychiatry Hearing Voices Network, the anorexia support group Pro-Ana, and community-based medical cannabis dispensaries like the Vancouver Island Compassion Society (or VICS) have emerged to challenge the judicial and bio-medical dominance of mental health and medical cannabis patients (Lucas 2009; Lucas 2008; Blackman 2007; Fox et al 2005). In fact, "Nothing About Us Without Us" informed a subsequent federally-funded report by the Canadian AIDS Society titled "Our Rights Our Choice; Cannabis as Therapy for People Living With HIV/AIDS" (Belle-Isle, 2006) that examined the difficulties that HIV/AIDS patients in Canada were experiencing in accessing medical cannabis. As Buechler (1995, p.443) states in reference to Castells's work on new social movements, "the emphasis on cultural identity, the recognition of nonclass-based constituencies, the theme of autonomous self-management, and the image of resistance to a systemic logic of commodification and bureaucratization all serve to illustrate dominant strains in new social movement theories", and it is clear that these same characteristics are at the core of activism in support of a greater voice

for both drug users and those suffering from HIV/AIDS. Thus, new social movements and associated counter-strategies to government and bio-medical oppression have emerged as a result of the unfortunate stigmatization of both drug users and people living with HIV/AIDS, and they continue to inform and to be informed by the movements seeking to increase the rights of medical cannabis patients and those affected by mental illness.

Reactance, helplessness, and Young's theory of 'new social movements'

Although there are some important similarities between the legal, social and political struggles of both the medical cannabis and c/s/x movements, there are also some notable differences in both the form of societal oppression directed at these disparate patient groups, as well as in the associated patient response to loss of freedom (please see Chart 1 below). In examining the impact of coerced treatment and forced incarceration, Monahan et al (1995, p.258) identify two psychological reactions to the loss of choice or freedom, the active and engaged state of "reactance", and the more passive and submissive state "helplessness". Characteristics of 'reactance' include "(1) anger toward the source of the restriction of freedom; (2) efforts to restore the threatened freedom; and (3) an increase in the attractiveness of the foreclosed option". Helplessness, on the other hand, "engenders not anger and attempts to restore lost freedoms, but depression, anxiety, and the cessation of any personal efforts to alleviate an aversive situation". These different reactions to oppression are reflected in the evolution of both the medical cannabis and mental health patient movements.

While the right to use medical cannabis in Canada is constitutionally protected, overly-restrictive federal guidelines have significantly limited the number of federally authorized patients (Lucas 2008). As a result, the overwhelming majority of medical cannabis patients in Canada are not protected from arrest and prosecution (Lucas 2008; Belle-Isle & Hathaway 2007). Although the threat of legal persecution is omnipresent, the large number of medical cannabis patients and limited police resources would suggest that most will not be arrested for using cannabis as a medicine, and are therefore unlikely to be incarcerated or forced into court-ordered drug treatment programs. Despite the low risk of legal prosecution (or perhaps because of it), patient-activists have successfully rallied public support for medical cannabis. Starting from an initial position of 'reactance', this patient-centered response to oppression and the legal threat of imprisonment has organized large-scale protests demanding changes to the federal government's medical cannabis policies and practice, initiated and funded successful constitutional challenges against current legislation, and founded alternative service delivery organizations such as community-based compassion clubs. First established in Vancouver in 1997, compassion clubs are the primary alternative to

the black-market for Canadian cannabis patients, supplying over 15,000 individuals with a safe source of cannabis, and becoming the main producers of peer-reviewed medical cannabis research in the nation, all at no cost to Canadian taxpayers (Lucas 2009; Lucas 2008; Belle-Isle & Hathaway 2007). I myself have been arrested and charged with three counts of trafficking in 2000 for my work as the founder and Executive Director of the Vancouver Island Compassion Society, a non-profit medical cannabis research, advocacy and supply organization. However, after nearly two years in court Provincial Judge Higinbotham granted me an absolute discharge, stating that

Mr. Lucas has frankly acknowledged his legal culpability;

He committed the offence not for profit, but in order to help other people in his situation or worse;

He committed the offence with the knowledge, and tacit approval, of the police;

He did not operate in competition with the Ministry of Health of the Government of Canada, but operated to fill a void created by the legal framework that existed prior to 2001 and the regulatory framework that has proved difficult to traverse;

His actions were life enhancing, in that he helped to ameliorate the pain and suffering of many people who had no other viable therapy;

He has been a helpful and conscientious contributor to the knowledge base surrounding the medical use of marijuana, and has been acknowledge as such by the former Minister of Health of the Government of Canada; He chose to commit the offence in a manner that provided accountability. (R. v. Philippe Lucas, 2002)

While this case fell short of actually legalizing community-based dispensaries, subsequent court challenges have further recognized the good work done by many of these compassion clubs and have forced Health Canada to alter particularly onerous or unjustifiable restrictions and bureaucratic obstacles (Lucas 2009; Lucas 2008; Belle-Isle and Hathaway 2007). In spite of active opposition from the federal government and occasional arrests by police, these social enterprises continue to offer medical cannabis patients help and support in an environment that's conducive to healing and self-empowerment throughout many Canadian cities, including Toronto, Ottawa, Montreal, Vancouver, and Victoria.

Conversely, due to the longevity of many mental health conditions and the lack of effective community-based resources to address these issues, a large percentage of people affected by conditions like schizophrenia or bi-polar disorder are likely to lose their freedom through involuntary admission to psychiatric treatment facilities (Monahan et al 1995). While 'reactance' might seem like a natural patient response to forced treatment and/or incarceration, psychiatry often labels patients

exhibiting resistance to their diagnosis or course of treatment as “non-compliant”, at times resulting in increased use of psychiatric drugs or tools such as insulin comas, electroconvulsive therapy (ECT) and extended hospitalizations. Wortman and Brehm (cited in Monahan et al 1995, p.258) suggest that “small amounts of experience with lack of control in the past (and therefore high expectations for being in control in the present) may produce reactance, whereas large amounts of experience with lack of control in the past (which may characterize repetitively hospitalized patients) lead to helplessness”. In the following passage describing his initial introduction to psychiatric hospitalization, Bassman (2001, p.13) details this unconscious shift from the initial ‘reactance’ of a novel, noncompliant patient, to a submissive state of ‘helplessness’ in response to the sudden and total loss of choice and control stemming from forced treatment and incarceration:

Foolishly, I continued to demand rights I believed I had, only to discover that I would pay dearly for my ignorance at playing the hospital game. My angry demand, “You can’t do this to me,” was met with increases of my medication and extended stays in the seclusion room. My anger, my resistance, my noncompliance were serious concerns to the staff. I was not responding quickly enough to my psychiatric cocktail mixes make up of large doses of Thorazine, Stelazine, and intimidation.

Bassman (2001, p.14) then describes how after many months of resistance and ‘reactance’, he “shuffled into the office, physically demonstrating the hospital’s successful transformation of anger, fear, and defiance into apathetic compliance”. It was only once he began to comply with the hospital routine that Bassman was deemed to be getting better by the psychiatric workers tending to his care, eventually leading to his release. As such, mental health patients often develop a strategy of ‘helplessness’ as a coping mechanism for psychiatric treatment settings, be they institutional or community-based. Monahan et al (1995, p.258) suggest that “when helplessness results from unsuccessful attempts to change a stressful environment, it can lead to “learned helplessness”, by which experiences with one uncontrollable environment generalize to new environments in which control is actually possible”. Therefore the challenge for mental health patients who experience multiple instances of forced treatment or incarceration is learning how to overcome and transcend this state of ‘helplessness’ so that it doesn’t become a more fixed and permanent state of ‘learned helplessness’. Bassman (2001, p.23) describes how previously disempowered patients have come together to develop the many strategies and services of the c/s/x movement:

Within the c/s/x movement, the once frightened and beaten down, the voice hearers, the traumatized, the victims of tardive dyskinesia have banded together with their peers to advocate and lobby for rights, create self-help alternatives, share successful coping strategies, and inspire and instill hope through the personal examples of their lived lives. C/s/x activist speak of empowerment and liberation.

This suggests that the c/s/x movement arose as a counter-measure to the common state of 'helplessness' resulting from psychiatric treatment, particularly forced treatment and incarceration. By creating tools, strategies, and supportive spaces for their members, c/s/x organizations like the HVN and Pro-Ana empower individuals to resist the social stigma, institutional oppression, and forced incarceration. By reclaiming control over their mental health conditions and personal identity, patients can effectively move from a position of 'helplessness' into the more active and productive position of 'reactance', creating a viable and far more desirable alternative than an eventual devolution from 'helplessness' into the more permanent state of 'learned helplessness'.

Young's (1990, p.83) description of 'new social movements' makes an interesting and rather fitting lens from which to examine the overall goals and strategies of both c/s/x and medical cannabis organizations:

Most focus on issues of oppression and domination; they usually seek democratization of institutions and practices, to bring them under more direct popular control. These insurgent campaigns and movements may be divided into three major categories: 1) those that challenged decision-making structures and the right of the powerful to exert their will; 2) those organizing autonomous services; and 3) movements of cultural identity.

C/s/x groups like the Hearing Voices Network (HVN) and Pro-Ana challenge the current bio-psycho-social explanation of mental illness as well as the efficacy of many of the associated bio-medical treatments (Blackman 2007; Fox et al 2005; Bassman 2001). Additionally, these two organizations provide peer-support for their respective patient groups, and serve as a safe space for people who self-identify as "voice-hearers" or anorexics to discuss their successes and challenges. Blackman's (2007, p.10) article on the HVN indicates that in contrast to a bio-medical approach that would encourage voice-hearers to dismiss, ignore or rid themselves of their "voices" through the use of psychiatric drugs or other techniques, "the HVN encourage the voice-hearer to accept and focus on the voices. This may include writing them down, recounting them within the context of the self-help group, repeating them aloud and so forth". The HVN's rejection of bio-medical orthodoxy, and the development of alternative interpretations, treatment modalities, and social services to address their condition mark this as an effective 'new social movement' for voice-hearers, and a good example of how *frame transformation* can benefit the members of traditionally stigmatized groups. Tarrow (1992; p. 188) suggests that for frame transformation to take place, "new values may have to be planted and nurtured, old meanings and understandings jettisoned, and erroneous beliefs or 'misframings' reframed". This has certainly been the active goal (and occasional outcome) for HVN, as well as for novel c/s/x organizations like Pro-Ana, an internet-based community of people suffering from anorexia who believe and explain how this condition can be safely continued *ad infinitum* through severe dietary restrictions, discipline, and careful self-

monitoring. In an article on Pro-Ana, Fox et al (2005, p.967) conclude that while this group is not focused on a cure for anorexia from a bio-medical standpoint, it appears to be helping many anorectics to cope with their condition within a supportive environment free of social stigma. They state that:

From an ethnographic exploration, we have disclosed an internally-coherent model of causation, process and management of the condition, and shown how this emerges from the experiences of pro ana. What from the outside appears a bizarre and pernicious sect, can be understood as a reasoned world-view. Pro-anorexia is not a diet, nor is it a lifestyle choice. It is a way of coping and a damage limitation that rejects recovery as a simplistic solution to a symptom that leaves the underlying pain and hurt unresolved.

Although the Fox et al (2005) concede that Pro-Ana is considered a radical social movement by many health professionals, the use of the internet and online technologies makes this is a very good example of a modern 'new social movement'. By creating a safe public (online) space for anorectics to meet and share their experiences, health and safety tips, and coping mechanisms, Pro-Ana has been successful in reducing the potential harms of anorexia without forcing bio-medical interpretations or treatments upon those experiencing this challenging condition. Compassion clubs also fit into all three of Young's categories for 'new social movements': they challenged the decision-making structure of the federal government in regards to the production and distribution of medical cannabis, and promote individual and community-based empowerment; they are an "autonomous" alternative means of medical cannabis access based on principles of harm reduction and "benefit maximization" (Lucas 2009; Tupper 2007); and they have allowed medical cannabis users to regain a cultural identity free of social stigma and the resulting self-imposed isolation. However, I suggest that the focus on patient-centered research characteristic to both c/s/x organizations and the medical cannabis movement reflects a need to introduce a fourth category to Young's definition of 'new social movements': the creation and adoption of new knowledge. One of the primary strategies of the c/s/x movement is to challenge what Becker (1967) calls the "hierarchy of credibility", a theory that identifies society's penchant to grant a higher level of credibility to professionalized individuals than 'laymen'. In regards to both the c/s/x and medical cannabis movements, this theory suggests that the opinions of physicians are often granted greater credibility than that of patients. In an article examining the ethics of drug prohibition, Thomas Szasz (1971, p. 542) states:

As formerly the Church regulated man's relations to God, so Medicine now regulates his relations to his body. Deviations from the rules set forth by the Church was then considered heresy and was punished by appropriate theological sanctions...deviation from the rules set forth by Medicine is now considered drug abuse (or some sort of "mental illness") and is punished by the appropriate medical sanctions, called treatment.

Szasz recognizes the overlap between mental illness and addiction in Western medicine, and the bio-medical dominance that forms society's understanding and associated policy responses to both of these conditions. The c/s/x movement has faced significant challenges in legitimizing patient voices and experiences as a result of the entrenched bio-medical discourse within professional psychiatry and the social stigma associated with mental health issues. Wilson and Beresford (2002, p.144-145) note that:

the attempt of psychiatric system survivors and our organizations to articulate our own understandings of our experiences comes up against the overarching dominance of medicalized definitions and explanations of 'mental illness', or the analyses and interpretations of non-survivor 'experts' and academics".

The authors conclude that "the challenge we now face as mental health service user/survivors is to make it possible for our own critiques and discussions to develop and counter the dominance of existing medicalized and ritualized individual discourses" (2002, p. 156). Despite this struggle for relevance and legitimacy, c/s/x organizations such as the Hearing Voices Network and Pro-Ana have had a significant impact on how both medical professionals and those affected by these mental health problems understand their conditions. This has been accomplished in part by engaging affected patients in the creation of new knowledge and interpretations about their condition, resulting in the development of novel adaptive strategies or treatment approaches (Blackman 2007; Fox et al 2005; Bassman 2001).

The ability to create knowledge, strategies and services to increase autonomy and self-management in both of these movements is referred by Touraine as "historicity", which Buechler (1995, p. 444) describes as "the growing capacity of social actors to construct both a system of knowledge and the technical tools that allow them to intervene in their own functioning." Touraine's analysis of new social movements co-opts the language of contemporary capitalist bureaucracies to modernize Marxist interpretations of social struggle, identifying culture rather than resources and/or methods of production as the source of power, dominance, and oppression:

In postindustrial society, the major social classes consist of consumer/clients in the role of the popular class and managers/technocrats in the role of the dominant class. The principle field of conflict for these classes is culture, and the central contest involves who will control society's growing capacity for self-management. (Buechler 1995, p.444)

Holland (2007, p.906) identifies this trend within the c/s/x movement, suggesting that "the service user/survivor movement is particularly concerned with the ownership of knowledge and the link between knowledge and social action". Although much of this work and research has been outside of the traditional peer-reviewed scientific model, mental health patient/professionals such as Ron

Bassman, Anne Wilson, Peter Beresford and Rachel E. Perkins have had success in challenging the bio-medical status quo from within. However, due to the social stigma associated with altered states and the illegal nature of most medical cannabis use, there has been a greater reluctance for healthcare professionals to “out” themselves as medical cannabis patients than there has been for the same to self-identify as recipients of psychiatric services. This may be one explanation for the rapid and widespread evolution of significant patient-centered strategies and services to counter the legal restrictions on medical cannabis use, perhaps best exemplified by community-based compassion clubs.

Cognitive liberty and the right to access or refuse treatment

Both of these patient-centered movements have empowered individuals to assume certain control over their condition and treatment options, and have successfully defended the right of patients to make fundamental decisions about their health in courts of law (Lucas 2008; Wildman 2006). Additionally, they have had some limited success in addressing social stigma by reframing medical cannabis use and mental illness away from exaggerated but omnipresent public fears over the loss of control over thoughts and behaviour associated with altered states of consciousness, and towards arguments focused on personal rights and freedoms. Using arguments informed by the modern Western philosophical concept of individual liberalism, which Harist & Richardson (2006; p.9) define as counterbalancing “self-interest with an ethical view of human agents as having inherent value, dignity, and rights”, some social scientists and civil libertarian groups have focused their arguments on cognitive liberty and freedom of thought to defend both the right to refuse treatment by those suffering from mental illness, and the right to access treatment without fear of arrest by medical cannabis patients. Cognitive liberty is described by the U.S.-based Center for Cognitive Liberty and Ethics (CCLE) as “the right of each individual to think independently and autonomously, to use the full spectrum of his or her mind, and to engage in multiple modes of thought” (CCLE 2009). It is relevant to note that the CCLE has focused much of its legal defence work writing arguments supporting the cognitive liberty and freedom of thought of mental health and medical cannabis patients. Interestingly, while both liberal individualism and cognitive liberty recognize, defend and celebrate individual uniqueness and personal autonomy, these concepts have been co-opted and adapted by medical cannabis and mental health advocacy groups to successfully defend the collective right of their members to make fundamental decisions about their individual health and well-being.

In her article examining the rights and ability of mental health sufferers to make decisions about their treatment options (including refusal), Wildeman (2006, p.237) cites the *MacArthur Treatment Competence Study* which concluded that

"most patients hospitalized with serious mental illness have abilities similar to persons without mental illness for making treatment decisions", adding that "the justification for a blanket denial of the right to consent to or refuse treatment for persons hospitalized because of mental illness cannot be based on the assumption that they uniformly lack decision-making capacity". These findings contradict the popular notion that those suffering from mental illness have no capacity to make decisions for themselves, and form a viable legal and ethical defence for patients to refuse treatment as long as they are not endangering themselves or others. In an amicus brief submitted on behalf of the CCLE in the case of *Dr. Sell v. United States of America*, Boire (n.d., p.12.) argues specifically for the right to refuse forced treatment with mind-altering pharmaceuticals. The brief states that "...given that alteration of thinking is both the design and effect of antipsychotic drugs, permitting the government to *force* a citizen to take such drugs ... cannot be squared with the supremely fundamental nature of the right to freedom of thought...", later adding that "...the right of a person to liberty, autonomy and privacy over his or her own thought processes is situated at the core of what it means to be a free person. It is essential to the most elementary concepts of human freedom, dignity, and self expression..." (Boire n.d., p.30). As such, it has been successfully argued in a number of Canadian and U.S. courts that forced incarceration and/or coerced psychiatric treatment are fundamental violations of both personal freedom and cognitive liberty (Wildman, 2006).

The CCLE have made similar legal/ethical arguments in favour of legalizing access to medical cannabis. In a legislative report by the CCLE specific to medical cannabis and cognitive liberty, Richard Glen Boire (2003, p.5) argues that:

the government clearly has an interest in regulating the *behavior* of a person who presents a clear and present danger to others. But, the government has no legitimate interest, and no authority to limit the *range and types of consciousness* that a citizen is permitted to experience within his or her own mind".

These sound philosophical and legal arguments underpin the fundamental right to experience altered states of mind by reframing freedom of thought as a personal rights issue informed by liberal individualism.

It is notable that laws and policies that overly restrict or prohibit access to cannabis and/or criminalize patients have been repeatedly overturned in both Canada and U.S. courts for violating the right of individuals to make fundamental decisions about their health (Lucas 2008). This suggests that cognitive liberty and freedom of thought are core principles around which mental health and medical cannabis patients might strategize and potentially cooperate in order to achieve emancipation from bio-medical dominance and state-sanctioned oppression.

Conclusion

Mental health and medical cannabis new social movements help identify ineffective or abusive health policies and treatment strategies, and increase our understanding of chronic physical and mental health conditions. Additionally, by maintaining a safe space for their members to share personal experiences, create new knowledge, and organize counter-strategies to challenge their perceived oppression by the government and by medical and scientific authorities, these patient-centered movements and associated organizations inevitably catalyze a significant frame transformation around these important social and personal health issues, which may in turn reduce stigma, increase public awareness and acceptance, and thus lead to better overall personal and public health outcomes.

These new social movements are both political and cultural in nature. They are political in that they directly challenge government laws and social policies that threaten the well-being and ultimately the physical freedom of their members, and they are cultural in that they view knowledge creation as an integral component of de-stigmatization, self-empowerment and increased autonomy. Evidence suggests that by regaining a sense of control over their conditions and treatment options, patients are much more likely to successfully adapt to the physical, mental, and social challenges they face, including social stigma and resistance from the medical community. Taylor et al (cited in Monahan et al 1995, p.256) found that "with few exceptions, the literature identifies self-generated feelings of personal control as adaptive." Monahan et al (1995, p.256) add that "cardiac, cancer, and AIDS patients who believe that they have some control over aspects of their illnesses, such as symptoms, course, and treatment, adjust to those illnesses better than patients who believe that they are helpless". Evidence suggests that c/s/x organizations like HVN, Pro-Ana empower individuals to regain control over their mental health challenges and associated treatment options, moving patients from a passive state of 'helplessness' towards a more active place of 'reactance'. Similarly, community-based medical cannabis dispensaries like the VICS allow patients much greater autonomy over their critical or chronic illnesses.

However, research also suggests that there still remains much work to be done to further address the public misconceptions associated with both mental illness and the use of psychoactive substances, even for medical purposes. Perhaps by working together to identify similar challenges, share successful strategies, and jointly promote the principles of cognitive liberty and liberal individualism, the mental health and medical cannabis new social movements will experience greater success in reducing the stigma and oppression associated with altered states of mind, and in defending freedom of thought, which ultimately is the most basic, common and fundamental individual right of humankind.

Chart 1: The following chart identifies additional differences in regards to incarceration of mental health and medical cannabis patients.

Psychiatric Hospitalization	Incarceration in Prison
Hospital-based setting	Prison-based setting
Incarceration is sometimes voluntary	Incarceration is never voluntary
Incarceration can lead to stabilization and increased treatment (for better or worse)	Incarceration inevitably leads to deprivation of medical cannabis treatment
Has been cited as having positive outcomes for some (Monahan et al 1995)	Is always negative, leading to poor personal health outcomes.
Quite frequent for some individuals	Very rare

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About the author

Philippe Lucas has recently completed a Master's degree in the University of Victoria Studies in Policy and Practice program, and is a Research Affiliate with the Center for Addictions Research of British Columbia (CARBC) and a member of the member of the CARBC Advisory Board. Additionally, Philippe is currently a board member of Canadian Students for Sensible Drug Policy (CSSDP), Canadians for Safe Access (CSA), and the Multidisciplinary Association of Psychedelic Studies Canada (MAPS Canada). In 2008 he was elected to Victoria City Council, where his focus has been social justice issues such as harm reduction, homelessness, environmental sustainability and food security.

Perhaps best known for his work on medical cannabis, Philippe is the founder of the Vancouver Island Compassion Society, one of North America's most respected non-profit medical cannabis research and distribution centers. He has had the opportunity to share his expertise and research at home and abroad, including presentations before the Canadian House of Commons and Senate, and consultations with the state of New Mexico and the Israeli Ministry of Health. His current research interests include the use of cannabis, ibogaine, and ayahuasca in the treatment of addiction.