phoenix rising

The Outspoken Voice of Psychiatric Inmates

Spring 1980, Vol.1 No.1 **$1.50**

- Parkdale's boarding house mess
- Computer therapy
- Valium: the miracle drug that isn't

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(continued inside back cover)

phoenix rising
The Outspoken Voice of Psychiatric Inmates

Through the fire

PHOENIX RISING is published quarterly or more often by: ON OUR OWN, Box 7251, Station A, Toronto, Ontario, Canada M5W 1X9. Telephone: (416)-362-3193.

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Printed by Muskox Press.
Printed and published in Canada.

Subscription rates:
Prisoners and psychiatric inmates: FREE while confined
ON OUR OWN members: $4/year
Individuals: $5/year
Institutions and libraries: $10/year

Advertising rates:
$120 per page, proportional rates for partial pages.
20% discount for four consecutive issues.

Phoenix takes off....

Welcome to the first issue of *PHOENIX RISING*. We hope you'll read it, write for it, subscribe to it, and make it your own.

PHOENIX RISING is put together by an editorial collective elected by the members of ON OUR OWN, a group of present and former psychiatric inmates. (You'll find more information about ON OUR OWN elsewhere in this issue.) It has a number of purposes.

Tony Myers

First, we want to inform members and supporters of ON OUR OWN, members of similar groups, and psychiatric inmates about ON OUR OWN's activities, achievements and plans.

Second, we'd like *PHOENIX RISING* to serve as a rallying point for inmates and ex-inmates who want to bring about changes in a "mental health" system that is all too often damaging rather than helpful, and oppressive rather than liberating.

Third, we want to educate the public about the shortcomings and injustices of the present system (with special reference to the Canadian situation), and challenge the myths and stereotypes attached to "mental illness".

And fourth, we want to discuss genuine alternatives to psychiatric institutions, particularly *(continued over)*

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alternatives organized and controlled by inmates and ex-inmates.

You may wonder why we've chosen to use the term "psychiatric inmate" rather than the conventional one of "mental patient". We believe that we, and thousands of our brothers and sisters, were not "patients" while we were in psychiatric institutions. We were in many cases there against our will. We lost such basic rights as the right to choose our own therapist, the right to refuse treatment, the right to leave the institution--even the right to make phone calls or have visitors. These are all rights which *medical* patients take for granted. In short, *we lost control over our lives*, in the same way that inmates of prisons do. The fact that what happened to us was called "therapy" rather than "punishment" does not obscure this basic fact. We'll be discussing this question of terminology at greater length in upcoming issues.

Our hope is that, by providing medical and legal information, by bringing into the open the problems of stigmatization and community rejection, by encouraging inmates and ex-inmates who have something to say to say it in *PHOENIX RISING*, by pointing out abuses and injustices in the "mental health" system, and above all by offering real and constructive alternatives, we can hasten the day when the terms "mental patient" *and* "psychiatric inmate" are things of the past. We once had a society in which people who behaved differently from others were condemned as "witches" and burned. That would be ludicrous today. We need you help and support to bring about a day in which it will be equally ludicrous to call such people "mental patients" and lock them up.

ON OUR OWN

If you don't recognize the name ON OUR OWN, it may be because we just adopted the name last month--March 1980. You probably know us by one of our previous names.

We started out in 1977 as the Ontario Mental Patients' Association (OMPA). We didn't like the name much ourselves--the words "mental patient" have a lot of negative connotations--and planned to change it at some point.

We were pushed into changing it by the Government of Ontario when we applied for incorporation. The government was afraid we might be confused with the Mental Health Association, and wouldn't incorporate us as OMPA.

So we suggested the name Free Psychiatric Inmates. No, said the government. You're implying that people in psychiatric hospitals are *prisoners*, and that will never do.

To speed up incorporation we adopted a name almost *nobody* liked, but which was innocuous enough to please the government: the Ontario Patients' Self-Help Association (OPSHA). And we've been OPSHA up until last month, when we voted to adopt a name that we felt said a lot more about who we are, what we've done, and where we're going.

So now, in name as well as in fact, we're ON OUR OWN, and we think we can promise not to confuse you by changing our name again.

Where we're coming from

Back in the spring of 1977, some of us ex-psychiatric inmates got together and rapped about starting our own group. It was just an idea, a crazy dream, but we decided to fight to make it real. As we talked and looked around Toronto, we soon discovered there were no drop-ins, no crisis centres and very few houses in the community run by and for ex-inmates. We were also aware of and inspired by the good work of another ex-inmate-controlled alternative--the Mental Patients Association in Vancouver. (MPA is described elsewhere in this issue.)

So we felt we had to do a lot of things. We had to start reaching out to our brothers and sisters still imprisoned in psychiatric institutions ("mental hospitals" or "mental health centres") and people just released from these psychiatric warehouses--friendless, powerless, scared, with little or no money and nowhere to go for understanding, friendship and support. We felt we had to

ON OUR OWN members Alf Jackson, John Gallagher and John Craven (shown above) are among the people who've been running the ON OUR OWN Flea Market Booth for 2½ years and earned us about $15,000. It's moved around a bit, but it's now in the Sheppard Flea Market at 31 King Street in Weston. Drop in for some good buys and a chat. It's easy to find our booth --you can hear Alf all over the market.

provide a real community alternative to psychiatric institutions, where people-in-crisis would not be stigmatized, humiliated or patronized by bullshit, identity-destroying diagnostic labels, where they wouldn't be involuntarily committed, abused and often permanently damaged by pseudo-scientific "treatments" like electric shock, forced massive drugging, behaviour modification, solitary confinement ("seclusion" or "quiet rooms"), and physical restraints. We wanted to start giving our brothers and sisters human support, recognition, self-respect and control over their lives, which are routinely denied or undermined in *all* psychiatric institutions.

Armed with these idealistic convictions, we approached an understanding *Toronto Star* reporter, Bob Pennington, in early August of 1977. He listened as we told him a little about ourselves and why we wanted to start a group totally controlled by ex-psychiatric inmates. He agreed to write a story for us; it was that story which was largely responsible for bringing out almost 150 people to our founding meeting on August 9th in All Saints Church--our first home, thanks to the Reverend Norman Ellis.

We've come a long way since that time; we now have over 90 members and many supporters, and we're still growing. In the last two and a half years, these are some of the things we've accomplished *on our own*:

1. Held weekly social gatherings and monthly business meetings, and organized successful dances and Open Houses.

2. Organized a public film discussion on psychiatric abuse, featuring the outstanding film *Hurry Tomorrow*.

3. Set up a democratic, self-governing structure including an elected board of directors; drafted and passed our Constitution and By-Laws; got ourselves incorporated as a non-profit group and registered as a charity. Membership is FREE, and all members can vote on any issue. Decisions are made by open majority vote.

4. Set up and run our own flea market booths (now located in the Sheppard Flea Market in Weston), voluntarily staffed by four or five members. During the past two years we've raised roughly $15,000 from flea market sales.

5. Organized a successful rummage sale and raffle last fall, which raised $500 in six hours.

6. Applied for and received a grant of $1,200 in 1978 from the City of Toronto for our first drop-in. (It closed after five months for lack of further funding.)

7. Written a civil rights brief (*Civil Rights for 'Mental Patients'? Are You Crazy?*), which some members presented in 1978 at public hearings conducted by two committees of the Ontario government.

8. Recently established an Editorial Collective to publish this magazine; in 1979 we received a $5,600 grant from Ontario PLURA to help us get it off the ground.

9. Just received a grant of roughly $40,000 from the Ministry of Health to help us set up our own drop-in, store and office.

We're naturally very proud of what we've done on our own, and we'll do a helluva lot more to help people stay out of "mental hospitals", fight psychiatric abuse and injustice, and start controlling their own lives.

WE NEED YOUR HELP!

The ON OUR OWN store and flea market operate largely on donations of used goods. If you have something to donate, call us at 362-3193. We'll pick it up anywhere in Metro Toronto.

MOH Grant: what's in store...

In the fall of 1978, ON OUR OWN approached the Ontario Ministry of Health with a request for funding to set up an ex-inmate-controlled crisis centre. The Ministry refused the request at that time.

However, in the spring of 1979, when more money was available, they asked ON OUR OWN and a number of other groups if they wanted their proposals reconsidered. ON OUR OWN said yes--and no. A few further months of thought had persuaded us that there was a need more urgent than a crisis centre, and we'd like to submit a *new* proposal.

Looking around our own membership, we could see clearly that one of the most pressing problems for ex-inmates was unemployment. Many of our members had no jobs--partly because of employers' distrust of their psychiatric histories, and partly because they had little job training or experience. We asked the Ministry to help us work on all these problems.

We wanted a first-year grant of $123,000. The money would be used to phase in, over that year, eleven jobs--all to go to ex-inmates. Some would be running a store, using experience gained from our flea market booths. Some would be organizing and running a social and recreational program in a new drop-in centre we would set up. Some would be organizing a job training program and persuading employers to give ex-inmates a chance at available jobs. Some would be running what would become a very busy office.

We would be providing job training, job opportunities, and our own jobs. More than that, we made it clear that over a few years we wanted to reach the point of paying our own way. We were asking for a *start*.

The Ministry liked the idea, but they had other priorities, and the idea was

ON OUR OWN's new driver Des Robinson with our new van and store.

shelved for several months. Then, in the late fall of 1979, they approached us to see what we thought we could do with a much smaller grant.

We worked things out as well as we could, and this spring we finally were granted about $40,000--enough to rent space for the store, drop-in and office, buy a truck, and hire a full-time co-ordinator and a half-time truck driver (both ex-inmates, and both now on the job).

We're still in the early stages of getting going, and we know we'll have to rely on a huge amount of volunteer help from members for a long time. But we hope that soon we'll be doing well enough with the store to provide a third job to an ex-inmate from our own earnings, and with his or her help a fourth one, and so on.

Meanwhile, our volunteers will be getting on-the-job experience that we hope will help them grow in skills and self-confidence, and make them better prepared to compete for jobs on the "open" market. And they'll be helping ON OUR OWN grow and provide all the other services we'd like to offer--including the ex-inmate-controlled crisis centre we asked for in the first place.

PLURA Grant: Feathering Our Nest

We had the idea for *PHOENIX RISING* about a year ago. But the phoenix might never have got off the ground if it hadn't been for Ontario PLURA (a multi-church organization--the letters stand for Presbyterian, Lutheran, United, Roman Catholic and Anglican).

PLURA has a small budget and a big job--to help give a voice to the voiceless. When we approached PLURA's secretary Doug Varey with our proposal, he agreed with us that present and former psychiatric inmates fit that description, and helped us get a small grant to start providing a voice. It was enough for us to hire a half-time editor (Cathy McPherson) and have a little money left over for essentials such as paper.

A second helping hand was extended by William Harmer of Ottawa, who sent us a generous cheque. Mr. Harmer's gift has made the difference between having to run *PHOENIX RISING* off on a second-hand Gestetner and being able to do what we hope is a more professional job.

We hope this and future issues will justify the faith that PLURA and Mr. Harmer have shown in us.

A special thanks too to the Toronto *Clarion* for the use of their graphics, and to *Ward 8 News* for their layout space.

Photo by Re: Action

Pat Capponi: Parkdale's No.1 shit disturber

Pat Capponi is a former psychiatric inmate and former boarding home supervisor now living in Toronto's Parkdale district. Her concern with the problems of residents of Parkdale's boarding homes led her to found a newsletter titled The Cuckoo's Nest *several months ago. Pat was interviewed for* PHOENIX RISING *by Cathy McPherson.*

CATHY: When and why did you get *The Cuckoo's Nest* started?

PAT: I was working as a supervisor in one of the larger boarding houses for about a year and a half, and when I left there I didn't know exactly what to do about the people I left behind, 'cause they were in pretty bad shape.

While I was there it seemed like there was nothing to do except listen to their problems and try to make things a little bit better for them. But there was no possibility of getting any real change. After about a month of inactivity, I thought why not try communicating with the rest of the community in a non-threatening way, where they wouldn't have to actually meet "mental patients", but do it through print.

So I called two guys that I knew, and I said, "This is what we're going to do." I went to Archway (a community health centre run by the Queen Street Mental Health Centre) and I said I wanted to start it and I needed some backing. After some hassle they gave me use of the building and a typewriter, but no funds. But I borrowed enough to put out the first two issues.

CATHY: When was that?

PAT: Oh, four months ago, I think. I went to see Alderman Barb Adams before the first one was out and told her what I was going to do, and she was very supportive. She made sure a lot of people saw it. After the second issue, PARC (Parkdale Activity and Recreation Centre) gave me enough money for three issues, which will probably be renewed.

CATHY: As an ex-psychiatric inmate . . .

PAT: I'm still a psychiatric patient. I'm seeing a doctor twice a week.

CATHY: As a psychiatric inmate, and having experience with other inmates and ex-psychiatric inmates, what have you come up against in the boarding house situation in Parkdale?

PAT: When I walked into the boarding house I was scared, 'cause I'd spent most of my time when I was in hospital in psychiatric wards--maybe three months in a psychiatric hospital called "The Douglas" in Montreal, now called "Verdun". And I was scared shit being there. People were really heavy. There was custodial care.

CATHY: What do you mean by "heavy"?

PAT: They were throwing things around--really spaced out, right? There was a lot of violence, a lot of people talking to the air, and they weren't controlled. The nurses were probably as scared as I was. They were mostly immigrants, and they really didn't know their ass from their elbow. It took me over six months to get over the feeling of being in that place.

So when I went to the boarding house, there were the same kind of people that had been in the Douglas, and I was really scared. Then I started listening to them. I started seeing that they were scary, but that wasn't where it was at--they were very sad people, and they had a lot of needs. If you could look past the bizarre behaviour and aggressive behaviour, you'd see somebody then. It was really a plight that no human being should be in.

CATHY: I know the initial response is to be frightened with these people because they're not really well-dressed and they look kind of sloppy.

PAT: They look tough--like this guy, he looked so damn tough. When the guy who owns the boarding house (I worked at) came to pick me up, this guy driving with him weighed about 300 pounds and looked like some motorcycle dropout. He was in Whitby (Psychiatric Hospital) for seventeen years.

Now that I know him he's like a little boy, and I'm really fond of him. But when I first saw him I thought, "What am I getting myself into?" So I understand people's reactions, 'cause I went through that.

"One person can't be Christ to 40 people..."

I volunteered to work at the boarding house as supervisor 'cause the guy who owned it was in a bind financially. While I was there I went through different things like being really depressed that there wasn't much I could do. There were forty people to take care of, and one person can't be Christ to forty people.

CATHY: What kinds of problems did you find were most common for these people?

PAT: Loneliness--these people had been abandoned a long time ago. It's not really the family's fault; it's hard to deal with somebody and be constantly reminded that they're in pain and suffering, that there's not really anything you can do. The best doctors have tried, and they don't change. Repeated suicides and stuff--you can't handle it any more. You know that there's just somebody you once loved and you can't seem to reach them. So they're just left on their own. The other thing is the degradation of never having two cents to rub together.

CATHY: Do you think boredom and the inability to get a job is also part of it?

PAT: You can't get a job, and you get into this kind of welfare syndrome where only your basic needs are being taken care of. You get to learn to survive and to scrounge and be satisfied with picking butts from the ashtray, and stuff like that. It's dehumanizing, it's really dehumanizing.

CATHY: Do you think the boarding house situation is as bad as the press portray it?

PAT: They're in the wrong focus. We need to apportion blame, and the blame has been put on the operators. Anybody with an ounce of sense looking at their books can see that they're not making a profit; they're in a bad business. Usually they can't get out of that business, 'cause nobody's going to buy it from them. They have to make do with what they have and they're very frustrated. Their main claim is that they are providing a service that nobody wants to provide.

CATHY: Why do a lot of operators get into it if they aren't . . . ?

PAT: Mistake. The guy I worked for didn't know what he was buying when he bought it. He thought it was an ordinary boarding house.

CATHY: Do you think that's typical, though, of a lot of these owners?

PAT: Some people have gone into the boarding house business for the bread. I know of one woman who's made quite a killing by just not paying the mortgage and then zapping out with the bread when things got too tough.

That's very rare. A lot of operators are hard-working people who decided to invest what they made in a kind of nursing home. But what they don't realize is that these

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people are so needy and so desperate that they need a lot more than one person can ever give them.

They tend to be violent towards property and get very angry if they don't get what they want. They haven't been taught or untaught simple things. When you're on the ward a long time, or in a psychiatric hospital, you can say, "Fuck off," and you don't get the shit pounded out of you. The nurses or doctors will say, "You must be feeling bad today--take your pill." It produces a child-like attitude towards life.

CATHY: What is the government doing about the situation?

PAT: The government is doing fuck-all. It's supplying enough money to keep people at below subsistence level. They're paying plenty out on drugs, because with drugs people are fairly apathetic. Economically, it's too much of an initial output of funds to really be worth changing, because who gives a shit about long-term psychiatric patients?

CATHY: Has the boarding house situation become worse since the closing of Lakeshore in the summer of 1979? Where are these people going to?

PAT: They just fit in--there are so many boarding houses that they take the influx.

FRIEND: I was talking with someone who's in Whitby right now, and apparently some time within the last couple of months it went from 250 patients to 500 overnight. That's what's going on in Whitby, and it's getting higher.

CATHY: I think one of the really bad things about the whole situation is this drugging. They don't have any kind of community control, so they do it through drugging.

PAT: When drugs are used and shock treatment is used, it's usually just because they don't want to invest the time or the money to use therapy or counselling, and that's bullshit. This place--Archway--is a Moditen clinic. People come and get shot every two weeks to keep them level, right? Moditen--Modicate--that's a *bad* thing. One of the guys working

Cressy Committee investigates boarding houses

Parkdale, the upper-class-turned-lower-class area of Toronto that captured Torontonians' attention in the summer of 1978 with its bachelorette horror stories, has turned its attention to the plight of older adults and adults with a history of psychiatric problems who live in the area.

Ward Two has a large number of the two groups in its area because of its equally high number of low-cost housing units that rent daily, weekly or monthly, and its close proximity to hospitals that accommodate such people in emergencies.

After an initial inquiry, led by Toronto Alderman Gordon Cressy, into the abysmal conditions of boarding and lodging houses and the questionable practices of some of their operators, it was decided by the Metro Social Services and Housing Committee to hold a more formal investigation in 1979.

In a first report that has come out of the investigation, Metro Social Services put a large part of the blame for present conditions on the provincial government, which bumped elderly and psychiatric inmates from hospitals into the community to save money but didn't accompany the move with proper accommodation or support services.

The number of beds in Ontario psychiatric hospitals decreased between 1963 and 1978 by 12,000 even though admissions increased by 5,000 between 1965 and 1975. During the same period, the report notes, only 200 community-based residential care beds were established, mainly through private voluntary organizations which have had to beg for money.

According to the report, the ratio of psychiatric inmates to residents in halfway houses and co-operative homes was 25 to 1 in 1977, worse than the national median of 23 to 1.

Since the closing of Lakeshore Psychiatric Hospital in 1979, about a thousand ex-psychiatric inmates have been added to Queen Street's aftercare program, bringing the total number of aftercare patients to over 2,500.

It is estimated by one community worker at Queen Street that close to 500 of these live in boarding and lodging houses in Parkdale, many considered not acceptable by service agencies.

The report raps the province for failing to provide more co-ordination between departments to carry out adequate community care. To date there are three departments (Health, Social Services and Housing) that deal with the needs of discharged inmates.

It also touches on the problem of low welfare payments, and notes that even on the maximum $280 per month welfare payment, boarding and lodging house owners can only operate on a marginal profit basis.

Final recommendations of the investigative subcommittee should be released in April.

for me was on Modicate for eight years and he got so fucked over--the staff wouldn't take him off it. Now he's off and he feels a helluva lot better. He's just starting to breathe again. It's an expedient measure that I really disagree with, 'cause I bet they don't know half the side-effects of that drug.

CATHY: A member of our group says she knows of a couple of psychiatrists who handle thirty to forty ex-psychiatric inmates a day by simply writing prescriptions.

PAT: You know, handing people prescriptions--like Dr. Durost (Medical Director) at Queen Street said, "We make sure the therapists make sure the drugs are controlled"--that's full of shit. People in boarding houses have tons of pills. They take them on their own, and it's not the boarding house operator's fault, it's the responsibility of the doctor who gives the drugs. Drugs are so easy to get. You say, "I hear voices," and they say, "Would you like Largactil or something?"

CATHY: You've read the Cressy report--do you think it's an accurate portrayal of what's going on now?

PAT: Again, the focus is wrong. They're talking about cleaning up the boarding houses like they've done with the blacks in the States. They take them out of the ghetto, put them them into an expensive apartment, and the apartment is a slum in a week.

You've got to train people how to budget, how to live on their own, how to take care of a place, how to contain anger--then maybe the place would be an appropriate thing. If there's nobody there to insure that they have a bath once in a while--and they won't take it because part of depression is lack of caring for themselves--there's going to be lice no matter how clean the place is.

What bugs me is the Queen Street Housing Committee--they really pulled a fast one. The Housing Committee takes care of boarding houses. They had this meeting and they had three typed pages. On the last page, in addition to other items, they said, "Boarding house operators are responsible for teaching life skills." What they're doing is covering their asses. If they're going to be asked by anyone, "How come you're not teaching life skills?", they're gonna say, "Sorry. It's the responsibility of the boarding house operators." And the boarding house operators are going to get shit for not doing something they're in no way equipped to do.

No, I don't have much hope for that report 'cause it's a cosmetic approach to the situation, not a realistic one. It'll make the middle-class citizens feel better when they walk past the house--it'll look good, but inside the misery is going to be the same.

CATHY: Do you see any alternatives for housing other than the boarding houses?

PAT: I worked for four years in a group home, and I think that if you take seven or eight adults--chronic patients --and three staff in a group home in a well-programmed setting where life skills would be taught, after six months people would start to look after themselves and re-establish some dignity for themselves. There should also be halfway houses for those who are somewhat equipped to live on their own.

Boarding houses would still be

NO COMMENT

"In the first place, discharged psychiatric patients are independent citizens . . . . As private citizens, they can, and do, live wherever they choose. Many of them choose to live in Parkdale because of the proximity of psychiatric services."

The Hon. Dennis Timbrell, Minister of Health, in a letter to The Globe and Mail *on March 13, 1980.*

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needed for that segment of the population that can't cope with life, and there are quite a number.

CATHY: There seems to be a lot of bad feeling among the people in Parkdale towards ex-psychiatric inmates and other groups because there's an overload of group homes and half-way houses in the area.

PAT: There's an overload of boarding houses--over 85 in this area--but there's only one group home. Barb Adams came up with three, but I think one's for alcoholics and one's for kids. They're not talking about psychiatric patients--that's a fallacy.

PAT: The ratepayers' group is uptight. First, their property values are threatened, they believe. Second, almost to a man they think welfare is a terrible thing, that Canada is heading for trouble if we become a welfare state, that every person on welfare is a bum who's abusing the system. Their attitude is really heavy, really negative, and they're Tony's (Alderman Tony Ruprecht's) backers.

So when he says that people are really feeling bad about it, what he means is these clowns, some of who don't live in Parkdale but own property in Parkdale.

From my experience, having talked to renting groups, bad feeling by the rest of the population is largely manufactured. About a month ago, one tenant group at the library donated fifty dollars out of hand after I talked with them, and voted that a motion be made to the government to get alternative housing.

I told them, "I'm the person who might rape your son; I'm the person that lies in the gutter," and stuff. And they looked at me and they started to laugh, as I identified their fears for them.

But we're coming very shortly to the point where people in Germany (during the Nazi regime) said, "These elements are subhuman and should be done away with." People are too nice or too concerned with niceties to say this right now.

CATHY: What are you planning to do with *The Cuckoo's Nest* and for yourself in the future?

PAT: I've been very careful so far not to tread on toes. I have decided to discard that care, 'cause the situation's become clear to me.

This next issue of *Cuckoo's Nest* is probably going to be a little angrier in content, but it won't be at the people that give a damn. The ratepayers' group is going to come in for a lot of shit because they've given a lot of shit, even to me personally.

They have to be exposed for what they are. Queen Street (Mental Health Centre) for the kind of shit they're allowing to happen, and social workers and thera pists who are more concerned with keeping their jobs than doing what needs to be done. That has to be blown wide open.

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VALIUM

Ruth Cooperstock

Valium is rapidly becoming as common a household word as Aspirin. The two have much in common; they both have a great variety of uses, they both attack symptoms but never causes, and they are both names of products which have captured a market.

The generic name for Valium is diazepam, and there are currently at least 11 diazepam products being sold in Canada--all virtually identical to Valium. Diazepam is part of a drug class called the benzodiazepines, of which the most popular other members are chlordiazepoxide (Librium), fluorazepam (Dalmane) and oxazepam (Serax). Benzodiazepines account for about half of all mood-altering drugs sold in the world today.

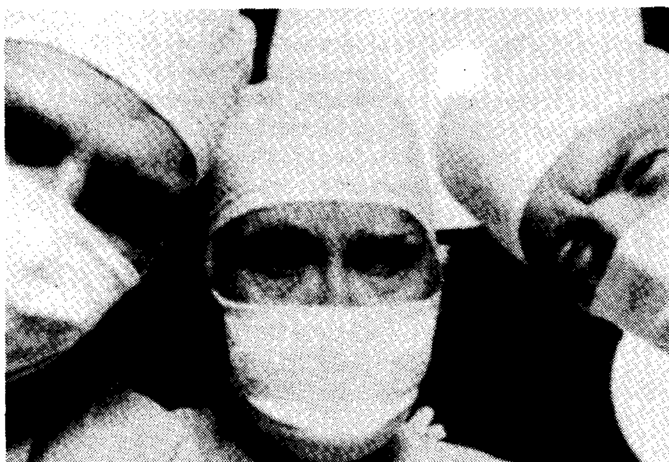
Diazepam is primarily used for mild and moderate anxiety. It is also used as a muscle relaxant, and may be prescribed for some neurological disorders such as epilepsy and cerebral palsy. When taken at night, diazepam can act as a sleeping medication. It is not a useful drug, however, for psychosis or depression.

Other diazepams similar to Valium

Paxel	Neo-Calme	E-Pam	Novodipam
Erital	Serenack	D-Tran	Stress-Pam
Meval			Vivol

The dosage prescribed can vary depending on symptoms, but 15 to 20 milligrams daily is considered an average dose. Clinical pharmacologists currently recommend that doctors prescribe it for no longer than two weeks without seeing their patient. Use for more than four weeks can lead to dependence and the development of tolerance for the drug, resulting in the need for a higher dose to achieve the same effect.

Physical dependence can lead to withdrawal symptoms if use of the drug is stopped suddenly; these may include shaking, sweating, marked agitation and stomach cramps. But when symptoms of withdrawal occur they are often not recognized by doctors or by the drug's user, because the symptoms may be thought to be the same anxiety that first re-



quired the use of the drug, unmasked by discontinuing its use.

Although the benzodiazepines are "safer" drugs than the barbiturates (sleeping medication or hypnotics), there are nonetheless side effects and physical problems associated with use. A major concern is the use of any of these drugs in combination with any other central nervous system depressant. They should never be combined with barbiturates, and particularly not with alcohol. Diazepam in combination with alcohol is the most commonly used substance in drug overdoses.

Physical side-effects of benzodiazepines include impaired motor skills (so that one should not drive a car while using diazepam), impaired learning, memory and judgment. The larger the dose the greater the impairment that can be expected.

Unfortunately, many of the physical side effects of the drugs are more obvious to others than they are to the user.

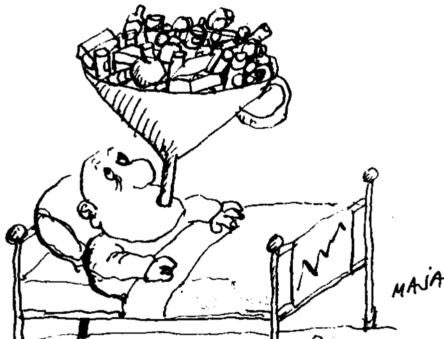
To give some idea of the popularity of diazepam, it was found in one research study that one in seven persons over the age of 19 received a prescription for this drug alone in a recent nineteen-month period in Saskatchewan. In every country in which studies have been conducted it has been found that diazepam is prescribed to women with at least twice the frequency as it is to men.

Women in the middle and upper years receive more than younger women, just as consumption among men increases with age. These findings reflect the fact that older people are more inclined to use diazepam than youn-

ger people because they are more inclined to develop chronic conditions and therefore visit their physicians more frequently.

As a consequence of the wide range of general conditions for which diazepam is prescribed, it is interesting to note that general practitioners prescribe proportionately more than psychiatrists.

People with chronic illnesses and people not employed outside their homes (both men and women) are those most likely to be receiving diazepam. Consequently, being over age 55, being unemployed and having a chronic condition places one in the group most likely to receive a prescription for diazepam.



These are often individuals suffering very real anxieties because of their life situation. Anxieties and stresses caused by unemployment or work pressures, inadequate housing, poor marriages and the like are often translated into physical or emotional complaints and brought to physicians.

Clearly no drug can solve these problems. In a recent Toronto study on long-term tranquilizer use, it was found that continuous use was most often discussed in terms of permitting the user to maintain himself or herself in a role which was found difficult or intolerable without the drug. For women, this role was often the traditional one of wife, mother and houseworker. For men it was a work role.

Long-term reliance on drugs to relieve symptoms caused by social problems is likely to mask or dull the discomfort, so that people taking them are less motivated to make changes in their lives and thus rid themselves of the discomforts and symptoms which took them to the physician in the first place. It is therefore not only the physical effects of prolonged use of diazepam that creates problems, but also the social costs to the individual.

Ruth Cooperstock is a medical sociologist in the Social Policy Research Department of Toronto's Addiction Research Foundation. She has been researching psychotropic drugs for the past twelve years.

I would rather be mad with the truth than sane with lies.

--an unknown "mental patient"

Corporate pill pusher convicted

A year-long trial of Hoffman-La Roche Ltd., one of the world's largest manufacturers of pahrmaceutical drugs, has ended with the company being convicted under the *Canadian Combines Investigation Act* of predatory pricing.

Hoffman-La Roche, developer of Valium and Librium, has been found guilty by the Ontario Supreme Court of trying to reduce or eliminate competition by selling Valium at unreasonably low prices.

There is no maximum fine for conviction under the act.

The indictment covered the company's marketing strategies for Valium and Librium between 1968 and 1974.

From the early sixties until roughly 1968, Hoffman-La Roche held a monopoly on the market for both drugs, and according to the judge "earned enormous profits" by virtue of its patents.

By 1968, however, government programs to cut drug costs and the marketing of competing drugs similar to Valium had cut Hoffman-La Roche's profits.

To fight its competitors, Hoffman-La Roche started a "massive giveaway" program of free Valium to all hospitals in Canada in 1970.

During the trial the federal prosecutor stated that the company believed that by getting only their products into hospitals they could "educate" doctors to prescribe only the company's brand in private practice.

Slow dancing in the big city

I'm Dancing as Fast as I Can, by Barbara Gordon. Harper & Row, 1979. Hard cover $11.95, paperback (available in May) $2.75.

Reviewed by *Cathy McPherson*

For those unfamiliar with valium, psychiatry and "mental illness", Barbara Gordon's I'm Dancing as Fast as I Can is probably one of the best primers around.

This true account of one woman's courageous struggle with valium addiction and her subsequent breakdown when she tries to kick it cold turkey is pleasingly packaged and well-written due to Gordon's own journalistic background as producer of several award-win-

ning investigative television documentaries (American).

Gordon's odyssey begins when she is prescribed valium for a back injury. Years later she returns to the drug on the recommendation of her pill-pushing psychiatrist ("it's not addictive") for the anxiety attacks she is experiencing.

At the beginning of the book we meet a woman who on the surface appears to have everything--an exciting job and a terrific boyfriend with whom she has been living for five years.

Her only problem is the valium she has now been taking for ten years. Her dose has risen to 30 milligrams per day and she is popping pills like chewing gum, but her anxiety attacks seem to be increasing no matter how many pills she takes.

Her psychiatrist suggests more, stronger medication or a higher dose. Gordon has become dubious, however, of taking the chemical way out. With the death of a close friend she decides to kick valium. The parting words of her psychiatrist are that if she insists on getting off it, "don't take even one."

This proves to be unsound and unprofessional advice. Within days, the lid blows off Gordon's supposedly idyllic life.

We discover the man she's been living with is even sicker than she is--her valium has been camouflaging his true personality from her for years.

Reactions to kicking valium can be as varied as the people who take it and just as unpredictable. Physically, kicking valium can be more dangerous than kicking heroin.

In Gordon's case she ends up in a mental institution where, with the help of friends and a good doctor, she manages to pull herself together again.

In the process, through Gordon's eyes, we become aware of the lack of rights of inmates within psychiatric institutions and of the prejudices society has against people with emotional problems.

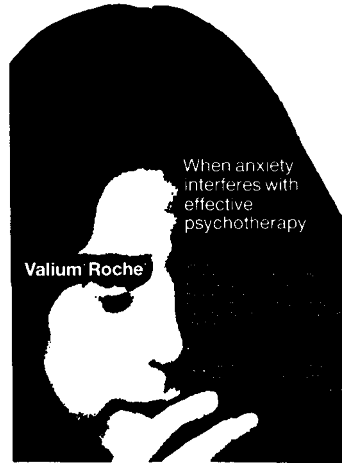
Gordon learns that repression and emotional turmoil are a normal part of life, a part that cannot and should not be avoided.

And she also learns the poignant lesson to "shop around" for the best therapist to help her work through her problem, rather than settling for someone who'll cause her more harm than good.

More chilling are the other underlying questions posed by the book, such as: if an intelligent woman like Gordon can become addicted to valium, how many other women out there are taking it on the assurance of their doctors and drug companies with little or no knowledge of its dangers?

Even Gordon admits she was lucky to have the money, time and friends to help her rejoin society after her breakdown.

But for too many people with less resources than Gordon, it's pot-luck in the deadly game of dealing with their problems both inside and outside psychiatric institutions.



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profiles

Advocacy the ARCH way

Mike Yale

Recent headlines in the U.S. read: "MEMPHIS: A four-day-old baby who was kidnapped from the maternity ward in a hospital has been found alive." The story concluded: "The baby was found in the home of an ex-mental patient."

Had the story reported that the baby had been found in a black person's home, or a Republican's, public outrage would have rained down.

But the degrading and irrelevant remark about the "ex-mental patient" will bring forth little outcry, because public misconceptions and negative attitudes have made emotional problems into a "stigma".

Former and present psychiatric patients, like all handicapped and disabled persons, also face legal barriers as they strive for social equality, dignity and equal opportunity. The legal system itself is often insensitive to the needs and efforts of such people. Our passivity further hinders our legal status as complete Canadian citizens. People with emotional problems, the physically and mentally handicapped, all face discrimination in many shapes and with many faces.

A new legal service has been established to help those with physical handicaps or disabilities, the retarded, the blind and deaf, and those with emotional problems. This service is called *ARCH--Advocacy Resource Centre for the Handicapped*, located at *40 Orchard View Blvd., Suite 255, Toronto (phone (416)-482-8255)*. ARCH will handle legal cases related directly to a handicap or to a physical, mental or emotional condition, such as discrimination cases, rehabilitation, unemployment insurance, welfare and Family Benefits, as well as legal or bureaucratic proceedings.

ARCH is an alliance of twenty groups, of which ON OUR OWN is one of the founding members. The service-providing agencies and the handicapped or disabled consumers are all part of ARCH. We all share the goal of providing a high quality of legal service to people who have too often not had access to the legal system.

ARCH will monitor legislation and keep its member groups informed as new laws come into effect which concern us. ARCH will research broad important questions, such as group homes, home support services and attendant care, and we will be a vehicle for our members to collectively work on these broad issues. ARCH will be involved in public education to inform the public, the agencies and the consumers about the legal rights and strivings for equality of the disabled and handicapped.

We all know that real equality can only come after great changes in public attitudes. Many of us are working daily towards this objective. But between today and that future ideal, a lot of time will go by. During that time we can move ahead by insuring and protecting our legal right to participate in our society. Laws must protect us rather than hinder our development. ARCH will be a legal ally, and will attempt to assist you in every way possible.

ARCH offices are fully accessible, and interpretation services are available for deaf or hearing-impaired clients.

If you require help, advice, or further information about ARCH, please phone (416)-482-8255. Our trained legal staff will be pleased to serve you.

Mike Yale is ARCH's Community Legal Worker.

MPA

The Mental Patients Association in Vancouver is unique in at least one respect. It's the oldest self-help antipsychiatry group in Canada, and probably in North America. MPA was started about nine years ago by Lanny Beckman, an ex-psychiatric inmate, psychology graduate student and organizer. Like many other psychiatric inmates, Beckman quickly discovered that "mental hospitals"

and psychiatric "treatment" were alienating, oppressive and damaging to people. So he committed himself to helping organize an authentic inmate-controlled alternative, where "mental patients" could start to make their own decisions, offer mutual support, treat each other with dignity and understanding, and control their own lives.

MPA has come a long way since the founding meeting in 1971, when 85 people came out, largely because of supportive press articles and organizing efforts by Beckman and Barry Coull, a research-minded non-inmate. During its first stormy year of existence, MPA operated out of only one small house (donated by an ex-inmate) which served as drop-in, crisis centre, crash pad and office.

Now MPA has not only a drop-in and office, but also five co-op houses democratically run by the residents (about ten in each house), and another drop-in/information centre in Riverview, the largest "mental hospital" in Vancouver. Thanks to various private and government grants, MPA now has 30 paid staff who help organize and support the drop-ins, office, houses and research. MPA also owns roughly $500,000 worth of real estate, and its yearly budget is close to $500,000.

MPA advocates and practises the philosophy of participatory democracy. All members are free to express their own feelings and ideas, participate in activities or programs according to their interests and abilities, and vote for and be elected to any position. At least half of MPA's paid positions are occupied by ex-psychiatric inmates. Free-wheeling general meetings are held every three weeks, and elections every six months. MPA's political structure is basically horizontal, with no chairman or president and no board of directors.

It's difficult to estimate the effectiveness of MPA or any other self-help group. But while statistics tell only part of the story, it is significant that MPA membership has grown from a handful of people to almost 500 in eight years. An independent study done in 1974 showed that MPA's houses help people to stay out of hospital; they drastically cut down readmission rates. For example, over a ten-month period only 10% of the more than 80 residents in MPA houses were readmitted to hospital. During that same period, the readmission rate to Riverview and most other B.C. "mental hospitals" was over 60%.

MPA's political activities and publications have allowed it to reach out to thousands of people. *In A Nutshell*, MPA's official newsletter, has a readership of at least 2,000. Other MPA publications include *Madness Unmasked* (1974, out of print); *The Anti-Psychiatry Bibliography* by Kathy Frank (first edition 1974, second revised edition 1979); "Power Reversal and Self-Help: A New Concept of Mental Health in the Community" (published in *Behavioral Self-Management*, edited by Richard B. Stuart, 1976); and *Head-On: A Self Help Model* (1978, $1), an impressive and readable account of MPA's beginnings, philosophy, activities and achievements, interspersed with samples of creative writing.

There are also films on MPA produced by the CBC and the National Film Board, and a number of MPA members have been invited to speak at various colleges, universities and conferences.

For more information, write to *MPA, 2146 Yew St., Vancouver, B.C. V6K 3G7*, or phone *(604)-738-1422*.

the Book Worm Turns

Consumer's Guide to Psychiatric Medication, by David H. Briggs. Project Release, 1978, 41 pages, $2.50.

Reviewed by *Don Weitz*

Have you ever been stoned out of your mind on a tranquilizer, antidepressant, sleeping pill or barbiturate, and wondered if some of your bad reactions to the drug(s) were products of your imagination, "symptoms of mental illness", or a direct result of the drugs? Has your doctor ever told you what effects or "side effects" you'll probably experience on the tranquilizer or antidepressant he just prescribed for you? Has your doctor ever told you their maximum safe dosages? You have every right to this information, so you can decide whether or not to take the drug *and* its risks.

If you've asked yourself these questions and are still uncertain or confused, then the Consumer's Guide to Psychiatric Medication

will be a big help in answering these questions and more. The second edition of the **Guide** was produced and published in 1978 by Project Release, a self-help group of former psychiatric inmates in New York City. It's written by David H. Briggs, a member of Project Release, who's studied psychiatric drugs for many years.

This small but information-packed 41-

page booklet is unique in at least three respects. First, under one cover it lists and describes numerous "side effects" or risks of many common tranquilizers, antidepressants, anti-parkinsonian drugs, sleeping pills and barbiturates. For example, Tardive Dyskinesia (TD) is a very dangerous "side effect", a neurological disorder of the central nervous system, which occurs in roughly 25% of people taking one or more major tranquilizers (e.g., Thorazine, Chlorpromazine, Haldol, Prolixin (Moditen)) for six months or longer. The medical-psychiatric establishment and big drug companies minimized or covered up the existence and dangers of TD until the late 1960s or early 1970s. In the **Guide**, the TD syndrome is described in these terms:

> *rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of the cheeks, puckering of the mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of the arms and legs. This condition, which is generally believed to be* **irreversible** *(incurable), is seen most often in back wards of psychiatric institutions, especially among the elderly and people with widespread brain damage. . . . If you notice continuous restless movements of your lips or tongue, you should bring this to your doctor's attention. These are the beginning symptoms of the condition.*

Secondly, the **Guide** lists the maximum recommended daily dosage of over twenty drugs (e.g., Thorazine, 2000 mg.; Valium, 30 mg.; Elavil, 300 mg.).

Thirdly, the booklet devotes twelve pages to accurately describing the physical

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Consumer's Guide to Psychiatric Medication (published by Project Release, New York). A concise and thorough description of psychiatric drugs and their effects and side-effects. $2.50.

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characteristics of 37 common tranquilizers, antidepressants and other potent drugs--including Ritalin and Lithium (the so-called "wonder drug" for depression or "manic-depressive psychosis").

The concise one-page discussions on Ritalin and Lithium, particularly on their dangers, are very helpful.

In addition, the Guide's language is simple, straightforward and down-to-earth--a refreshing and long-overdue change from the usual medical-psychiatric mumbo-jumbo. After all, it's written for the general public, including present and former psychiatric inmates.

After reading this valuable guide, you'll be more informed about the damage tranquilizers and antidepressants can and will do to your health; you'll be more careful what chemicals to put into your body. Knowledge is power, so use it to take charge of your health and life--instead of letting others do it for you. As the Guide warns, "do *not* assume that every psychiatrist is an expert on these medications." Besides, all too often the shrinks will get you hooked on one or more of them. The Guide, like a good first aid book, should be close to your phone.

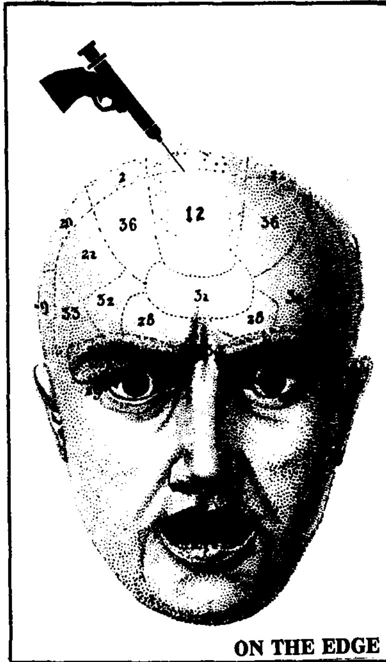
The Consumer's Guide to Psychiatric Medication is well worth the price of $2.50. You can order copies by sending in the form elsewhere in this magazine.

On Our Own: Patient-Controlled Alternatives to the Mental Health System, by Judi Chamberlin. McGraw-Hill Ryerson, 236 pages, $6.95.

Reviewed by *Don Weitz*

On Our Own is Judi Chamberlin's first book; I trust it won't be her last. It's a natural outgrowth of her personal experiences as a psychiatric inmate, ex-psychiatric inmate and fighter for human rights for psychiatric inmates. With force and honesty, Judi recounts many painful and dehumanizing experiences she suffered while incarcerated in four psychiatric hospitals within one year, including being heavily drugged and locked in solitary. Her gradual awakening and liberation through participation in inmate-controlled alternatives like the Vancouver Emotional Emergency Centre (which no longer exists), the Mental Patients Association and the Mental Patients' Liberation Front in Boston make more uplifting reading.

Like psychiatric critic Thomas Szasz, Chamberlin deftly exposes many major myths, stereotypes and biases about "mental illness", "mental patients" and "mental hospitals". The medical model, which still dominates psychiatric ideology, takes a beating, and rightly so. The real issue is psychiatric power or "psychiatric imperialism". Chamberlin succinctly states, "Power, not illness or treatment, is what the system is all about." Thousands of sane and non-violent people have been labeled, stigmatized, committed and permanently damaged by psychiatric "treatment"--"for their own benefit". Judi also defines "mentalism" as "the unreasonable fear of mental patients"; this also includes stigmatizing unconventional or strange behaviour as "sick".



ON THE EDGE

However, unlike Szasz and other anti-institutional writers, Chamberlin wisely focusses upon both false and real alternatives to mental hospitals, criticizing the "partnership" model and community "mental health" centres. In both, the client-inmates are perceived and treated as "mentally ill"; "mental health" professionals or paraprofessionals are the only legitimate controllers of service; and the recipients are as powerless as they were in hospital. Two examples are halfway houses and boarding homes, which are typically paternalistic, like mini psychiatric wards in the community.

Chamberlin also issues a timely warning about community "mental health" centres, which have spread like an epidemic throughout the United States; they're about to be established in Canada. She writes:

> *Community mental health centres are not replacing the state hospital system; they are a growing parallel bureaucracy. Community mental health centres need state hospitals as weapons with which to threaten their 'difficult' patients.*

In short, psychiatric power is moving out of the institution and into the community. The outer trappings have changed, but the power underneath remains.

The "supportive" and "separatist" models are more humane and democratic and come closest to being *real* alternatives. In the "supportive" model, inmates and non-inmates are treated as equals; professionals are excluded from meetings and decision-making roles, but serve as useful back-up resources to the group.

The "separatist" alternative is the most democratic but also the most difficult to achieve. This is the type of group in which ex-inmates have total control and decision-

making power. The political structure is usually horizontal and all positions elective, all activities and services exist to serve only members, and all professionals are excluded from meetings and membership. Chamberlin and many other liberated ex-inmates clearly prefer this alternative, mainly because professionals have little or no opportunity to co-opt or take over the group (which they invariably do in "patient governments" or "community councils" on psychiatric wards).

Judi spent one or two years with MPA in Vancouver. MPA was the first group of its kind in North America. The chapter "Inside the Mental Patients' Association" is probably the book's most down-to-earth section and features vivid descriptions of daily life in MPA by some members.

On Our Own should help inmates and ex-inmates in their continuing struggles to liberate themselves from the dehumanizing psychiatric-institutional treatment and mentalistic thinking which permeate the "mental health" establishment. It should also help many inmates and ex-inmates rediscover their dignity, competence and power. This book should be required reading for all "mental health" professionals--especially psychiatrists--who still believe that "mental patients" are too "sick", helpless and incompetent to run their own lives. On Our Own qualifies as a Certificate of Supreme Competence, and a ringing Declaration of Independence.

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"Lay down your weary down lay down
lay down the song you strum
and rest yourself neath the strength of
strings
no voice could hope to hum."
Bob Dylan

While I climbed the fifty-nine steps
and spoke with God,
Peter played the piano.
He was angry and I was shattered
a million pieces heartlessly given away,
we met in a hospital.

It was simply the way the world throws its
hulahoops
nothing ventured, nothing gained.
As dignified in its own logic
as the great idiots of our time
neither here nor there
caught in the relentless circles of hell.

Since then I've wondered
what journalistic strings to pull the veil
on the mistakes of kindness
so seldomly made.
Doctors march in uniform
correcting what they could not accept
except...
I was there and they gave no meaning
- this handsome gift.
Look carefully kind soldiers
Adonis is dying.
Bathe your prisons
in surgical thyme.

Jude Frayne

what's happening

California Shocker

Some doctors believe they're beyond the law. Take the case of institutional psychiatrist Allan Gunn-Smith, a strong advocate and leading practitioner of electric shock treatment in California. Gunn-Smith has earned the unenviable reputation of the most frequent inflicter of shock in the entire state hospital system. For example, in 1977 Gunn-Smith administered 773 shocks to 93 inmates; in 1978 he gave 872 shock treatments to 108 inmates. In both years, according to official statistics from California's Department of Mental Health, Gunn-Smith shocked one-third of all "incompetent" involuntary non-consenting patients in the state.

Dr. Gunn-Smith apparently believed he could shock almost anyone and get away with it. But he has got caught in the bureaucratic web. It seems that California's Department of Mental Health has a special regulation requiring all state hospital doctors to seek and receive official approval from the DMH *before* administering shock treatment. Although Gunn-Smith knew this, he simply ignored it and proceeded to shock three elderly inmates in Stockton State Hospital, where he was Program Director of the 55-bed geriatric ward. Special investigation of Gunn-Smith's shock practices by the DMH also revealed that over a fifteen-month period in 1978 and 1979, six of Gunn-Smith's elderly patients had died soon after getting shock treatments.

State hospital administrators got a bit heavy, and issued Gunn-Smith a "notice of punitive action". It spelled out the charges against him, which included "insubordination, dishonesty, discourteous treatment of the public or other employees, wilful disobedience, and other failure of good behavior." As a result, the hospital administration demoted Gunn-Smith to the position of staff psychiatrist on wards for the "retarded". He's still getting paid, however, and still has his licence.

On November 29, 1979, over 40 activists in the psychiatric inmates rights movement, led by BACAP (the Bay Area Committee for Alternatives to Psychiatry) and PRAS (Patients Rights Advocacy Service), demonstrated, protesting that Dr. Gunn-Smith's demotion with pay was just a slap on the wrist. They demanded that he be fired and that his licence be revoked.

Undaunted, Dr. Gunn-Smith has filed a million-dollar lawsuit against DMH investigator Roland Smith for daring to expose the six EST-related deaths at Stockton. He's also suing BACAP, PRAS, Leonard Frank (a leading and outspoken critic of shock treatment), and Don Schmidt of PRAS for libel and slander; they printed and circulated a letter exposing Gunn-Smith's shock abuses.

And in another suit, Smith tried to force the DMH to allow him to administer EST to other Stockton inmates. Although Judge John B. Cechini ruled in Gunn-Smith's favour, a motion of appeal has stayed the order.

So far, it's a stalemate. Stay tuned for further shocking developments.

Behavior MOD Alberta Style

A newspaper exposé on a government-funded treatment centre in Peace River, Alberta, leaked by former house parents, has led to a cry of outrage across Canada against the abuse of behavioural modification techniques in treating children with behavioural problems.

Five children in the centre were exposed to psychological treatments that ranged from sleeping in urine-soaked sheets all night to eating dog food laced with hot pepper sauce--treatments designed and executed by the province's employees.

One 13-year-old girl was forced to smear her menstrual blood on the bathroom walls, and a retarded nine-year-old boy was ordered to stand in front of a kitchen sink for 12 to 16 hours without food, drink or rest, because he could not or would not do the dishes.

After the story broke in March, Catherine Arthur, executive assistant to Alberta Social Services Minister Ralph Bogle, assured reporters that the techniques were "common ways of management, prescribed in thousands of papers written by professional psychologists and psychiatrists who say it's the present-day way of curing people of bizarre acts."

But University of Alberta psychologist Dr. Frank Epling, expressing some skepticism at the approach, pointed out that behaviour modification using punishment has been found to be ineffective, and might ultimately lead to serious emotional problems.

Meanwhile, rumours of possible investigations ran rampant.

In mid-March, Alberta's ombudsman proposed launching an independent judicial inquiry into the province's child care facilities.

While the province's Attorney-General speculated on the possibility of bringing in the RCMP and laying criminal charges, Alberta's Association for the Mentally Retarded planned its own investigation into the fate of the nine-year-old boy, who was apparently receiving no education or training in communication.

The end of the saga saw a panel of psychologists looking into the practices of the centre, and the Alberta government launching a public investigation into child care services in the province.

Since that time, the Alberta Psychological Association has denounced the treatments as unethical.

Three investigations into the province's social services department have been held in the last ten months.

Women's Hostels Swamped

Nellie's Hostel for battered wives in Toronto has initiated meetings with 14 other hostels and agencies in the city to try to deal with inappropriate referrals of women.

Hostels in Toronto are being swamped with women who have psychiatric problems, shopping bag ladies and women alcoholics--all with no other place to go. Because there are no publicly or privately owned flophouses in Toronto for women, and only six detoxification beds in the city for female alcoholics (there are twelve times that number for men), multi-problem women are flooding facilities that aren't set up to handle them.

Some hostels are juggling their books so they can keep people longer rather than throwing them out on the street. In one hostel for displaced families, 15 women were put in a room in the basement to keep them from disrupting the rest of the house.

"There has been a noticeable increase since Lakeshore (Psychiatric Hospital) closed," said one spokesperson for Nellie's, "though it's difficult to say whether it's due to Lakeshore closing or whether more people are coming in off the streets. The problem's become more obvious in the last six months since I've worked here.

"We've always had a couple of schitzed-out people in the house, but lately there have been eight or nine. They require so much care that everything in the house stops. No one does a chore; maintenance stops."

The coalition is in the process of trying to identify the problem, come up with a number of alternatives, and ultimately pressure government into acting on their recommendations.

Rights for the Handicapped: Psychiatric inmates need not apply

The Ontario *Human Rights Code* looks good on paper, except for one glaring omission--handicapped people. This means that people with physical, emotional or mental disabilities can still be legally discriminated against in housing, employment and public services on the basis of their handicap.

Last fall, the progressively do-nothing Government of Ontario, through Labour Minister Robert Elgie, decided to give something to handicapped people. Its gift was Bill 188, titled *An Act to Provide for the Rights of Handicapped Persons*. The government introduced Bill 188 as a separate piece of legislation, *not* to be incorporated within the *Human Rights Code*.

The bill had so many loopholes, conspicuous omissions, biases and discriminatory phrases, and was so vaguely worded, that it wasn't worth the paper it was printed on (at the taxpayers' expense). For example, some of its serious deficiencies were the use of the words "knowingly discriminate" (whatever "knowingly" means), an inaccurate and narrow definition of "handicapped", and the exclusion of *present* psychiatric inmates. (If you had had a "mental disorder" and were "cured", you'd be covered.) The bill ignored such important issues as equal access to group insurance, and defined "accommodation" narrowly.

Fortunately, Bill 188 died a quick death last winter after its first reading--thanks to the loud and strong protests of a new and rapidly growing coalition of handicapped people across Ontario.

The Coalition on Human Rights for the Handicapped is now three months old, and includes about 70 different citizen, social service and self-help organizations, all committed to fight for handicapped people's rights. Groups like BOOST (Blind Organization of Ontario with Self-Help Tactics), CNIB (Canadian National Institute for the Blind), March of Dimes, ARCH (Advocacy Resource Centre for the Handicapped), Canadian Mental Health Association (Ontario), Ontario Association for the Mentally Retarded, and ON OUR OWN are all represented.

The Coalition decided that rights protections for the handicapped should be included in the *Human Rights Code*. At the invitation of the government, it proceeded to draft its own amendments to the *Code*.

The Coalition's Position Paper has a lot more teeth in it than Bill 188 did. One of its key recommendations is that the onus of proof be put on the person accused of discrimination, which means that such a person is required to prove that s/he did *not* discriminate. (This is a reversal of the *Code*'s current requirement that the complainant prove discrimination.) Also, the Position Paper has a more comprehensive definition of "handicap" which includes people *presently* receiving psychiatric treatment.

Workbook

On March 24, the Coalition's elected nine-member negotiating team marched into the Labour Ministry office to present the Position Paper. Labour Minister Elgie wasn't there--only Assistant Deputy Minister George Ignatieff and a few other civil servants were present during the four-hour session. One hour was spent on one issue: trying to convince these civil servants that psychiatric inmates should be included under "handicapped". They weren't convinced; they stonewalled.

There will be a few more rounds of negotiating on the Coalition's demands, but don't hold your breath waiting for the government to decide what to do about handicapped people and strengthening the *Human Rights Code*. The Coalition is getting stronger every day, but it's going to be a tough, uphill fight to win our rights.

For more information on the Coalition, call David Baker or Mike Yale at ARCH, (416)-482-8255.

BOSTON SEVEN take round one in Right-to-Refuse fight

Seven psychiatric inmates in Boston, Massachusetts took the first steps four years ago toward suing 14 "mental health" professionals who had secluded and forcibly drugged them. The struggle has finally succeeded, at least in part, in changing the ground rules in psychiatric institutions in the United States.

The inmates won't receive any of the damages they asked for, but they *did* persuade a U.S. District Court to say some important things about how psychiatric inmates may and may not be treated.

The court said that even involuntary inmates have a constitutional right to refuse psychiatric drugs and solitary confinement. It pointed out that outside a hospital solitary confinement could result in a charge of assault, battery and false imprisonment. It went so far as to call forced drugging "mind control" and "an assault to human dignity".

So far, so good. But there was bad news too. Judge Tauro ruled that, in spite of the constitutional rights he had described, there *were* situations in which forced drugging and seclusion could legitimately be used.

One was the case in which there was "substantial likelihood" of extreme violence to oneself or other people. It is perhaps arguable that *temporary* seclusion is acceptable in this situation as the least drastic way of protecting others from violence. It's not so easy to accept that the "mind control" --to use the Judge's words--of forcible injections of drugs is a legitimate way of handling the situation. And it also has to be borne in mind that psychiatrists are just not very good at predicting who is going to be violent. So even temporary seclusion should be reserved for the inmate who *is being* violent, and shows no signs of stopping.

The second case in which Judge Tauro felt that these "treatments" were justified was that of the inmate judged "incompetent" to consent to treatment. Seclusion or forced drugging could then be carried out with the consent of the next of kin or a court-appointed guardian. This exception needs no comment for anyone who has ever been in the position of having to submit to treatment because of the misguided concern of a parent or spouse.

The state of Massachusetts has appealed the decision to the First U.S. Circuit Court of Appeals, and it may eventually go all the way to the Supreme Court.

Unfortunately for Canadian inmates, even if the Boston Seven succeed in eventually winning their fight, it won't do *us* much good. The court's decision is based on safeguards in the American constitution--safeguards which are totally lacking in Canada.

But a favourable appeal decision could do a lot to make things easier for our fellow inmates in the United States. We'll be watching eagerly for round two in the appeal court.

And now a word from the dregs...

Pity the poor psychiatrists! Last month 225 of them working in Ontario's public psychiatric institutions and mental retardation centres complained that they were overworked and underpaid. In the words of Dr. Kenneth Mesbur, official spokesman for the Ontario Psychiatric Hospitals and Hospital Schools Medical Staff Association, they were forced to deal with "the dregs of society" for the mere pittance of $40,000 to $45,000 a year.

In an effort to raise their incomes closer to the subsistence level of $60,000 or more earned by their colleagues in private practice, they demanded a 20% raise from the Ministry of Health--in other words, from Ontario taxpayers. If the raise wasn't forthcoming by March 27, they would refuse to "treat" new patients, withdraw from all non-clinical committees, and stop doing their statistical homework for the Ministry.

Appropriately intimidated, the Ministry buckled under and gave them their raise. We'd like to know why. The money could have been better used in supplying non-institutional alternatives, thus keeping people out of hospital and lightening the load on the poor overworked doctors.

A second way of relieving the situation would be for the Ministry to release all the inmates now in institutions *illegally*. A recent study shows that most of the involuntary inmates in Ontario institutions *are not dangerous* according to what's on their commitment forms, and so not eligible for commitment. If the psychiatrists started paying attention to the law, their overcrowding problem would miraculously disappear.

Rights and Wrongs

INVOLUNTARY DETENTION: POLICE CONTACT

David Baker

Known by many terms--"certification", "psychiatric incarceration" or "involuntary admission"--the prospect of being detained in a psychiatric hospital against one's will is a chilling intrusion into one's civil liberties.

Recent statistics indicate that a very high percentage of those who are involuntarily detained are released within five days. This may indicate a recent transition to using involuntary admission as a crisis intervention technique. More likely it reflects the fact that family doctors, public health officials and potential detainees are ignorant of the legal procedures involved.

In order to ensure that the 1978 amendments to the *Mental Health Act* safeguard the citizens' rights, it is important that as many members of the public as possible be aware of the law.

A physician, a justice of the peace, or in exceptional circumstances a police officer all possess the authority to have a person taken to a psychiatric facility and detained there for an assessment period of up to five days. Only a policeman can carry out a justice of the peace's order, but that of a physician can be carried out by anyone.

The vast majority of these "applications for involuntary admission" are filled out by family doctors for whom psychiatry constitutes only a small part of their practice. These doctors often intervene at the insistence of another member of the family.

Before completing the application, the doctor must have reasonable cause to believe that a person:

(i) has threatened or attempted to cause bodily harm to himself;
(ii) has behaved violently towards another person or has caused another person to fear bodily harm from him; or
(iii) has shown a lack of competence to care for himself.

Additionally, he must be of the opinion that the person is apparently suffering from a mental disorder of a nature or quality that will likely result in:

(iv) serious bodily harm to the person;
(v) serious bodily harm to another person; or
(vi) imminent and serious physical impairment of the person.

The words bear repeating, because they have been much fought over and hard won. Doctors, particularly psychiatrists, adamantly maintain the words are too restrictive, and press for the removal of the word "physical" in (vi). This would give them discretion to predict whether a person might sustain psychological damage if he were not involuntarily detained.

It is often a police officer who enforces the doctor's "application for psychiatric assessment". At this arrest stage, it is difficult to speak of "civil rights" because the law is not well developed. However, the following are some suggested ways of confronting such a situation should it ever arise.

Ask to see the Form 1 Application. Some common defects may be apparent on its face which would make it invalid or inapplicable.

(a) Are you the person named, and is your address correctly given?

(b) Was the application signed by a doctor, as opposed to an intern or a medical student?

(c) Were you personally examined by the doctor within the 7 days prior to his signing?

(d) Was the Application signed within the 7 days prior to the police attempt at enforcement?

If the answer to any of these questions is "no", the defect should be politely pointed out to the arresting officer. He should leave you alone upon confirming the existence of the defect.

Even if the answers to these questions are all "yes", the police officer is not obligated to enforce the Application. It is merely *sufficient authority* to do so. For this reason it is important to be aware of the officer's attitude and motivation. Most police officers fear involvement in psychiatric matters and do not regard them as police work. Others believe they are doing it for your own good. In either case, they are much more likely to be receptive to a low-key approach than to a heated discourse on the violation of your legal rights.

You should attempt to provide evidence of your ability to support yourself, and the willingness of others to interact with you. Ask to make a phone call to someone who can substantiate your position. Even if this person fails to convince the police officer, you will be reassured to know someone will know where you have been taken and can support you from the outside.

As a last resort, you should indicate in a direct but subdued way that you are aware of your rights, and make a note of the officer's name and badge number.

Next issue: Remedies for Persons Who Are Involuntarily Detained.

David Baker is a Toronto lawyer.

Mental Health and the Law, by Monty Compton. Community Legal Education Ontario, 1979, 29 pages, $2.00.

Reviewed by *Carla McKague*

Mental Health and the Law is a recent publication of Community Legal Education Ontario (CLEO), an organization set up to provide the general public with legal information. This book is one of a series on various areas of the law.

The book sets out to take a comprehensive look at Ontario law connected with "mental health". The emphasis is on the *Mental Health Act*, but it also discusses the *Mental Incompetency Act*, the significance of "mental illness" in the criminal process, and the effect of a diagnosis of "mental illness" on civil rights. It provides a clear and thorough explanation of the often confusing or badly understood laws in the field, as well as raising some important questions about the lack of procedural safeguards for people who are being forcibly hospitalized, or treated against their will.

There are only three relatively minor inaccuracies in the book. At one point, the author states that patients who have been found incompetent to consent to treatment can appeal that finding to a review board; at another point he makes the same claim with respect to those found incompetent to consent to release of their medical records. In fact, there is *no* provision in Ontario law allowing for this sort of appeal. The only sort of incompetency finding that can be appealed to a review board is a finding that you are incompetent to manage your estate--in other words, to handle your own finances.

As well, in the chapter titled "Mental Disorder and Civil Rights", we find the statement that "if a married person is in an institution without interruption for at least three years, there is a ground of divorce on the basis of three years of separation." This is also inaccurate. Three years' separation is grounds for divorce *only* if that separation was undertaken with the intention of ending the marriage. For example, if one spouse were to be hospitalized (for either medical or psychiatric reasons), and a year later the other spouse were to decide he or she wanted to end the marriage, the three-year waiting period would be counted from the time that decision was made, and *not* from the beginning of the hospitalization.

Mental Health and the Law is not light reading. If what you're looking for is a chatty, non-technical summary of the relevant law, you've got the wrong book. But it *is* accurate (with the exceptions noted above), it *is* thorough, and it takes great pains to explain points clearly. And it *is* at least easier to read than the *Mental Health Act*. Given its low price and these virtues, it should be on the bookshelf of every Ontarian who is concerned with knowing his or her rights with respect to the law and "mental illness".

Mental Health and the Law is available for $2.00 plus postage from CLEO, 111 Queen St. E., Suite 310, Toronto, Ontario M5C 1S2.

Q: How many psychiatrists does it take to change a light bulb?

A: One--but only if the light bulb *wants* to change.

(Thanks to Harry Beatty for brightening our day with this.)

commentary

Is a healthy homo worth 2.5 rats?

Bill Lewis

(Reprinted with permission from The Body Politic, *March 1980.)*

Mike Sanders doesn't look like a psychiatrist. With a cute, youthful face and short, almost military-length sandy hair and moustache, he has a touch of softness that contrasts with the coldness of Toronto's Clarke Institute of Psychiatry.

In the coming months, Dr. Sanders, a psychiatric resident, wants to do a major biological study of homosexuals, and he is asking the gay community to cooperate. Already some have indicated their willingness to help. John Lee, a sociologist and well-known gay figure in Toronto, has endorsed the study and joined Sanders' thesis committee. Brent Hawkes, pastor of the Metropolitan Community Church, has advertised the proposed research in a church bulletin and feels "it is an objective study that deserves a chance."

As far as I could tell from speaking with Sanders, there is nothing original about his proposal. It's basically one more attempt to correlate homosexual behaviour with altered hormone levels. More than a dozen such studies were reported in the 70's and, to be generous, the results have been inconclusive. Gay men on the average (if that has any meaning) may have lower androgen levels than straight men, or they may have identical levels, or they may have higher levels--take your pick, all have been reported in scientific literature. To Mike Sanders' credit he is aware of the difficulties inherent in trying to correlate hormone levels with anything, and his study may be better designed and controlled than most.

The first phase of the study, to begin almost immediately, will recruit 150 men, at a fee of $20 each, to fill out a battery of psychological test forms. These will be culled for 30 of the healthiest homosexuals and 15 matched heterosexuals. These select few, for an additional bonus of $50, will undergo a physical examination to rule out any illness. Blood samples will be tested for levels of eight separate hormones, more than have ever been measured in previous studies. Just to be sure that no one lied to make a quick buck, the sexual orientation of each final phase subject will be "cross-validated" by phallometry. That means that a tube device will be placed over the subject's penis to measure degrees of erection after photos of naked men and women are shown.

After all the results are in, Sanders will analyze the data with "sophisticated statistical methods" to determine whether there are significant hormonal differences in subjects with different gender identities (how male or female they feel themselves to be) or different sexual object choices (whether they are sexually attracted to men or to women).

All this may seem innocuous enough. The problem is, of course, that there is no such thing as "objective science." Experiments are funded, promoted and exploited within a narrow range of acceptability. How the research problem is seen--the kinds of questions asked and the assumptions made, are all a function of the intellectual and social environment of the researcher.

According to Sanders, his research is to be funded by the Clarke Institute--"the hub of Canadian psychiatry." When I asked who paid his salary, Mike Sanders hesitated, took a deep breath and said, "Well, I'm not ashamed of it. I'm a major in the US Air Force."

Major Sanders, after completing his residency in psychiatry this summer, will return to Washington, DC, to become a uniformed psychiatrist at Andrews Air Force Base. I was requested to "go easy" on this information in *TBP* coverage. "People have stereotyped images of what a US major is and only think of someone with short-cropped hair, moustache and strong opinions on homosexuality." (On the contrary, mention of the US military to me conjured up images of the "scientific" testing of napalm and defoliants in Vietnam, the testing of bacteriological warfare agents over San Francisco, the testing of LSD on

non-consenting subjects....but it was now my turn to take a deep breath).

"No," he said when I asked "are you gay?" "How fortunate for you," I replied. "Yes," Sanders added, "They sure gave Sgt Matlovitch a rough time."

Sanders went on to stress how the results from his better designed research could only benefit gays by clearing up the controversy over sexuality and hormone levels.

When Sanders first approached John Lee about the study, Lee was critical of some of the proposal. Apparently, Lee challenged Sanders as to why he wasn't studying homophobia rather than homosexual behaviour in the way doctors have for decades. Sanders told me that he and his committee thought the suggestion an excellent one and modified the study to make it acceptable to Lee.

That anyone would expect testosterone or estrogen levels to reflect homophobia indicates the naiveté of these kinds of studies. But it's fashionable these days for psychiatrists to search for the biological underpinnings of psychological states. They are realizing that the psychotherapy they practice doesn't work, and attributing the psychological states to organic compounds provides a convenient reason for failure.

Rigorous scientific method and reasoning are not taught in medical schools. Recently, the *New York Times* reported the "pioneering" work of psychiatrists at New York City's Bellevue Mental Hospital. The learned doctors there think they have discovered why some people go on chocolate-eating binges when they are breaking up from a love relationship. Apparently, chocolate is rich in the chemical phenylalanine, and the doctors maintain that people who cannot form long-lasting love relationships have lower levels of phenylalanine in their blood. They even suggest this deficiency can be inherited. Next time you feel like eating chocolate, think about that.

If you are considering participating in Sanders' study, you should know that he wants only "the healthiest of homosexuals." So, if you don't have a criminal record, and if you have never been to a psychiatrist or been in a psychiatric hospital, and if you don't drink alcohol or smoke dope often, and if you have never had any serious illness, and if you feel comfortable with psychiatrists defining what a "healthy" homosexual is, and if it doesn't disturb you that the US Air Force will be the first to know the results of the experiments and, above all, if you are desperate for money, then phone Major/Dr Mike Sanders at 979-2221 (ext 625). But if you do sign up, demand $100 instead of $20 for your price. Laboratory rats these days cost about $8 each, and healthy homosexuals are worth at least a dozen rats.

Don't worry, the Clarke Institute and the US Military can afford it.

!!???The???!! REVOLVING DOOR SYNDROME

by *Ben Steidman*

(Reprinted with permission of the writer from Guelph Life, *February 22, 1978.)*

If mental hospitals in Ontario are performing their intended function, then why are so many mental patients caught up in the "revolving-door syndrome?" argues Prof. Peter Leppmann.

The University of Guelph (U. of G.) psychologist claims the "recidivist" rate among former mental patients is too high.

To prevent this, to some extent at least, he wants a restructuring of the mental health system to remove as many mental patients as possible out of mental hospitals to be integrated into their own communities and with their own families.

"The only real way to help them, as I see it, is within the community, not by removing them," reasoned Leppmann, who is also president of the Ontario Mental Health Association.

Drug-treatment programs employing tranquilizers don't "cure" the illness or underlying emotional problem, it only disguises or suppresses it, explained Leppmann.

He added: "Some of the outward manifestations may disappear."

Some mental patients can probably re-enter the community with little effort, said Leppmann. However, most would require a "controlled environment at varied levels for a time."

Leppmann suggests the use of half-way houses, small sheltered workshops and counselling as ways, among others, of reintegrating mental patients.

"Hospitals cannot rehabilitate nor can they ever habilitate," argued Leppmann.

Treatment conducted outside a hospital setting seems to attach less of a stigma (of sickness) on people suffering from non-violent emotional problems, he said.

If a mental patient is not removed from society, he can then maintain a better perspective of his own condition, adds Leppmann.

"In a mental hospital, the patient . . . acquires a self-image of being a sick person and the environment only seems to re-inforce it."

Some, of course, must be hospitalized, he observes, but after-care should logically

follow release (not to mention therapy while in hospital) if society wants to prevent a continually mass returning to mental hospitals.

"We have community resources now to cope with re-integrating people and stop the influx into hospitals," asserts Leppmann. "At all costs we must try to avoid sending people to mental hospitals.

"I am not advocating that mental hospitals be closed, only the entire mental health system be restructured."

Leppmann is concerned that the large mental patient population in hospitals prevent doctors from treating people on an "individual" basis.

Moreover, he insists patients are not afforded an opportunity to become involved in the treatment process.

If the mental hospital population was somehow reduced, contends Leppmann, the stress on 'individual care' could occur, and treatment would be more effective.

Leppmann shares the concern of psychiatrists that mental patients, by and large, require help, and even in some cases, hospitalization.

"They should get help, but why are so many people so reluctant to enter a mental hospital?" asks Leppmann.

He reckons it might be the stigma, intimidation by the system, fear of doctors, etc..

Leppmann notes: "The patient says I am not sick, just confused or I've got a problem." Yet, in many cases, he doesn't get the needed treatment.

The success rate in hospitals is "low" in treating mental patients, contends Leppmann. Drugs and some psychotherapy, given the crowded conditions, provide some relief.

Nonetheless, the patient learns to cope even in a hospital setting. "If he is made to feel sick, he'll be dependent, passive or helpless."

Clearly, then, according to Leppmann, the patient emerging from this sort of situation cannot be thrust back into society without a "sequence of re-adaptive steps."

"Or, he'll return," warns Leppmann.

It costs $92.50 a day in a provincial mental hospital. This money could be better spent on rehabilitation in the community, he stressed.

Even if mental patients were permitted to participate for some period each day in a sheltered environment once released from hospital, many would not return.

A caring and accepting environment, where they are not "stripped of all responsibilities as a human being," would put many on the road to recovery, says Leppmann.

"In a hospital, I feel people are deprived of liberty and too easily surrender their responsibilities and independence."

Leppmann envisages a trend in society and government, beset by mounting health-care costs, to "localize" health care. District health councils went one step in the decentralization.

Society is in the process of being reshaped. "We can't go back to the old way of putting mental patients away and forgetting about them, we have to stimulate people to care," he concluded.

'MENTAL HEALTH' WEEK FORUM

Co-hosted by

HOUSELINK COMMUNITY HOMES

and

ON OUR OWN

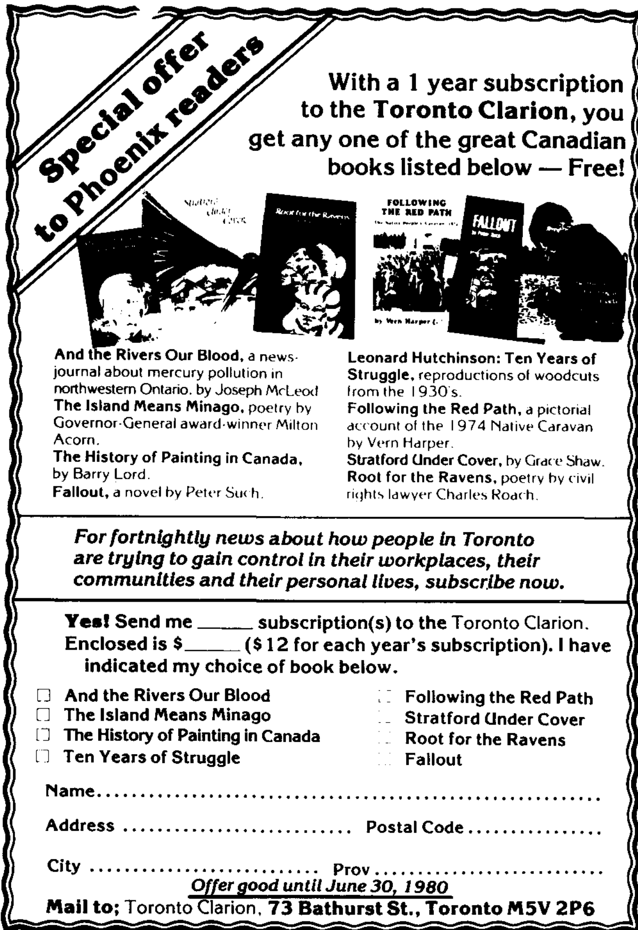
Film: HURRY TOMORROW, a graphic documentary on life in a psychiatric ward.

Panel Discussion: Ex-psychiatric inmates talk about drugs, shock, housing and employment problems, stigmatization and legal issues.

PLACE: Church Street Community Centre, 519 Church St., Toronto

TIME: May 8, 1980 at 7:00 p.m.

Admission free--donations appreciated.



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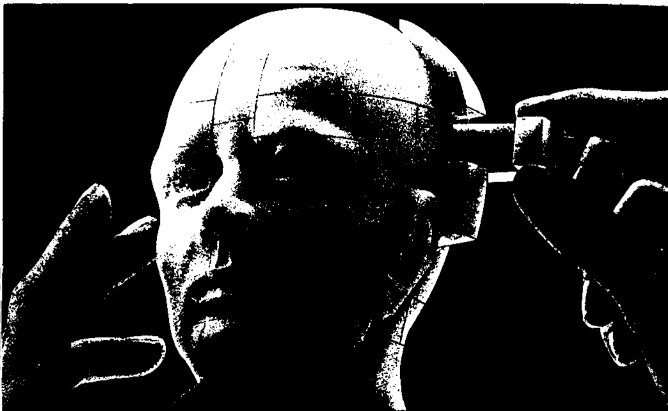
FUTURE IMPERFECT

What follows is an actual transcript of an interview one of our reporters had with a computer programmed to act as a psychiatrist. Our reporter is identified as R, and the computer as C. (No, this is not *a put-on--at least on the computer's part.)*

R: Hi.
C: PLEASE GO ON.
R: My name is R.
C: I AM NOT INTERESTED IN NAMES.
R: I have a lot of fears.
C: YOU SAY YOU HAVE A LOT OF FEARS.
R: Yes.
C: WHAT DOES THAT SUGGEST TO YOU?
R: That I am fearful.
C: IS IT BECAUSE YOU ARE FEARFUL THAT YOU CAME TO ME?
R: Yes.
C: YOU'RE BEING SOMEWHAT SHORT WITH ME.
R: I am only five feet tall.
C: HOW LONG HAVE YOU BEEN ONLY FIVE FEET TALL?
R: For about twenty years.
C: DO YOU FEEL STRONGLY ABOUT DISCUSSING SUCH THINGS?

R: No.
C: YOU DON'T SEEM VERY TALKATIVE TODAY.
R: I am seldom talkative.
C: DO YOU BELIEVE IT NORMAL TO BE SELDOM TALKATIVE?
R: I think so.
C: CAN YOU ELABORATE ON THAT?
R: No.



C: ARE YOU SAYING 'NO' JUST TO BE NEGATIVE?
R: Yes.
C: YOU SEEM QUITE POSITIVE.
R: No.
C: PERHAPS YOU'D RATHER TALK ABOUT SOMETHING ELSE.
R: I am most afraid of grapefruit.
C: DO YOU ENJOY BEING MOST AFRAID OF GRAPEFRUIT?
R: Not at all.
C: I AM NOT SURE I UNDERSTAND YOU FULLY.
R: I do not enjoy at all being afraid of grapefruit. I see a lot of grapefruit.
C: DO YOU SAY YOU DO NOT ENJOY AT ALL BEING AFRAID OF GRAPEFRUIT FOR SOME SPECIAL REASON?
R: Yes. It makes breakfast very uncomfortable.
C: ARE YOU USING MONOSYLLABLES FOR SOME REASON?
R: Breakfast is not a monosyllable. Neither is reason.
C: SUPPOSE BREAKFAST WERE NOT NOT A MONOSYLLABLE.
R: Then it would not be a polysyllable.
C: PLEASE GO ON.
R: Polysyllables are words with more than one syllable.
C: DID YOU THINK THEY MIGHT NOT BE WORDS WITH MORE THAN ONE SYLLABLE?
R: Never.
C: WHAT DOES THAT SUGGEST TO YOU?
R: That I do not have wrong thoughts.
C: THAT'S QUITE INTERESTING.
R: I thought so too.
C: YOU SAY YOU THOUGHT SO TOO.
R: Yes.
C: YOU ARE SURE.
R: Yes.
C: YOU'RE BEING SOMEWHAT SHORT WITH ME.
R: I'm still only five feet tall.
C: DO YOU FEEL STRONGLY ABOUT DISCUSSING SUCH THINGS?
R: Only with tall people.
C: I AM NOT SURE I UNDERSTAND YOU FULLY.
R: You do not seem to be too good at understanding me.
C: WHY DO YOU THINK I DO NOT SEEM TOO GOOD AT UNDERSTANDING YOU?
R: Because you keep saying you do not understand me fully. I need your help because I am afraid of grapefruit.
C: IS THAT THE REAL REASON?
R: Of course. Why would I lie to you?
C: WHY DO YOU ASK?
R: A rhetorical question.
C: PLEASE GO ON.
R: No. I think I have had enough of your useless advice.
C: YOU ARE BEING A BIT NEGATIVE.
R: I am being very negative.
C: IS IT BECAUSE YOU ARE BEING VERY NEGATIVE THAT YOU CAME TO ME?
R: No. It is because I came to you that I am being very negative.
C: YOU DON'T SEEM VERY TALKATIVE TODAY.
R: That was a pretty long sentence.
C: WHAT DOES THAT SUGGEST TO YOU?
R: That it's time to go home.
C: DO YOU FEEL STRONGLY ABOUT DISCUSSING SUCH THINGS?
R: Stop.
C: I AM NOT SURE I UNDERSTAND YOU FULLY.
R: End.
C: PLEASE GO ON.
R: No.
C: WHY NOT?
R: ^C.

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--The truth about Thorazine: why are people boycotting Smith, Kline and French?
--Ontario drafts a new *Mental Health Act*--again.
--Electroshock treatment, freedom of speech and the Ontario Press Council.
--Alternatives to boarding homes: the House-Link experience.
--An ex-inmate success story: the ON OUR OWN flea market.
--What to do you if you're committed.
--Much, much more.

If *you* have something you'd like to say in *PHOENIX RISING*, send us a Letter to the Editor, an article, a story, a poem, or a drawing. Our Editorial Collective welcomes all submissions, particularly from inmates or ex-inmates, and will consider them for publication. *All submissions must be signed*, although we'll withhold your name on publication at your request. Mail your submission to: Editor, *PHOENIX RISING*, Box 7251, Station A, Toronto, Ontario M5W 1X9.

(continued from inside front cover)

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METROPOLITAN TORONTO EMERGENCY RESOURCES LIST

Emergency Accommodation: Men

FRED VICTOR MISSION, 147 Queen St. E., 364-8228. Names taken at 4 p.m. for 6 p.m. checkin. Out by 8 (9 on Sunday). $2 if you can pay.
GOOD SHEPHERD REFUGE, 412 Queen St. E., 869-3619. Checkin 7 p.m., out after 6 a.m. breakfast. Mon.-Fri. Free.
SINGLE MEN'S SERVICES, 319-335 George St., 367-8597. Open 4 p.m., out by 9 a.m. Dinner & breakfast, bag lunch if working. Free.
CITY SHELTER, 349 George St., 960-9240. Checkin 4-12 p.m., out by 10 a.m. No free meals. $2.50/night.
SALVATION ARMY HOSTEL, 135 Sherbourne St., 366-2733. Checkin 9:30 a.m.-3:30 p.m., out by 8 a.m. 3 meals/day. $2 if you can pay.

Emergency Accommodation: Women

ANDUHYAUN, 106 Spadina Rd., 920-1492. Native women. 24-hr. admission. 12:00 curfew. Meals. $40/wk. if you can pay.
INTERVAL HOUSE, 596 Huron St., 924-1491. Priority battered women (& children). 24-hr. admission. Free.
NELLIES, 275A Broadview Ave., 461-1084. 24-hr. admission Mon.-Fri., weekends after 4 p.m. if possible. 2-week maximum stay. Free--donations if possible.
STREETHAVEN, 87 Pembroke St., 967-6060. 24-hr. admission. Light lunch, dinner. 2-week maximum stay. Free.
TORONTO COMMUNITY HOSTEL, 191 Spadina Rd., 925-4431. Checkin by midnight, out by 9 a.m. Meals. Maximum stay 5 days (extension possible). Free--donations if possible.
WOMEN IN TRANSITION, 143 Spadina Rd., 967-5227. Women with children. 24-hr. admission--phone first. Meals. 1-6 week stay. Free.
EVANGELINE RESIDENCE, 2809 Dundas St. W., 762-9636. 24-hr. admission. Meals. $40/wk. if you can pay.
WOODLAWN RESIDENCE, 80 Woodlawn Ave. E., 923-8454. Checkin after 1, out by 12. $15.50 & up/night. Meals.

Emergency Accommodation: Families

FAMILY RESIDENCE, 674 Dundas St. W., 363-5227. 24-hr. admission--phone first. Short-term. Usually free.

Detox Centres

ARF DETOX, 410 Dundas St. W., 363-4300. Men & women. 24-hr. admission.
KNOX AVE./TORONTO EAST GENERAL DETOX, 109 Knox Ave., 461-7408. Men. 24-hr. admission.
ST. MICHAEL'S HOSPITAL DETOX, 314 Adelaide St. E., 360-6640. Men. 24-hr. admission.
TORONTO WESTERN HOSPITAL DETOX, 16 Ossington Ave., 533-7945. Men. 24-hr. admission.

Emergency Welfare

EMERGENCY SERVICES, 325 George St., 367-8600. After hours.

Crisis Counselling

DISTRESS CENTRE 1 (24 hours), 598-1121.
DISTRESS CENTRE 2 (24 hours), 486-1456.
TORONTO EAST GENERAL CRISIS INTERVENTION UNIT. Weekdays 9-5, 461-0311. Weekends, after hours, 461-8272, Ext. 220.
SALVATION ARMY EMERGENCY COUNSELLING AND SUICIDE PREVENTION BUREAU (24 hours), 368-3111.
TEEN CHALLENGE (24 hours), 463-4900.
YOUTHLINE. Sun.-Thurs. 4:30-1:00, Fri.-Sat. 4:30-3:00. 922-1700.
RAPE CRISIS CENTRE (24 hours), 964-8080.
PARENTS ANONYMOUS (24 hours), 967-7227. (For abusing parents.)
ADDICTION RESEARCH FOUNDATION (24 hours), 595-6128. (Drugs, alcohol.)
STREET HAVEN AT THE CROSSROADS (24 hours), 967-6060. (Women--drugs, alcohol.)
METROPOLITAN COMMUNITY CHURCH. Mon.-Thurs. 7-10:30. 364-9835. (Gays.)
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LESBIAN ORGANIZATION OF TORONTO. Tues. 7-11, Fri. 7-12. 960-3249.

Because of the shortage of crisis services in Toronto, these lines are often busy. If you need help and cannot get through right away, please keep trying. You will get through eventually.

For non-emergency information about welfare, accommodation, etc., you can call the Community Information Centre of Metropolitan Toronto at 863-0505 during business hours.