phoenix rising

The Outspoken Voice of Psychiatric Inmates

Fall 1980, Vol.1 No.3 $1.50

The Death of Aldo Alviani

PRESS RELEASE October 3, 1980

Prepared by members of ON OUR OWN: ONTARIO PATIENTS' SELF-HELP ASSOCIATION

THE DEATH OF ALDO ALVIANI

Aldo Alviani should be alive today. Instead, he died a tragic and unnecessary death when he was only 19. On June 23, 1980, while a "patient" in Toronto's Queen Street Mental Health Centre, Aldo died after a massive dose of Haldol--one of the most dangerous and powerful of all "anti-psychotic" drugs.

A growing number of people believe Aldo Alviani was killed by the Queen Street staff's excessive reliance on psychiatric drugs.

Aldo was an easy target for psychiatric drug control. He was big (over 6 feet and around 240 pounds), Italian, and poor, with a record of psychiatric incarcerations. He was in trouble with the law; on the night of June 21st he was arrested twice, but the police laid no charges. It is also clear from the events that followed that psychiatric staff, both at Humber Memorial Hospital and at Queen Street Mental Health Centre had already labelled Aldo as "difficult".

Here is a brief summary of what happened to Aldo:

--June 21, 9:30 p.m.: After having arrested Aldo twice, police take him to Humber Memorial Hospital, where some staff judge him to be "agitated" and give him a tranquilizer.
--June 22, 5 a.m.: Humber staff transfer Aldo to Queen Street after a six to seven hour delay. According to Humber staff, he is calm as a result of the tranquilizer.
--June 22, 6:30 a.m.: Shortly after admission, Queen Street staff start drugging Aldo with Haldol, despite the fact that he is already tranquilized. Despite their suspicions that Aldo has been using street drugs, they do no blood or urine tests before or during the drugging.
--June 22, 6:30 a.m. to 7:30 p.m.: Queen Street staff forcibly administer 260 milligrams of Haldol to Aldo. The maximum safe dosage for this drug is 30 to 40 milligrams a day, and then only for "severe" cases, according to a standard reference work for doctors and pharmacists, the Compendium of Pharmaceuticals and Specialties.
--June 23, 8:00 a.m. to 4:00 p.m.: Queen Street staff continue to overdrug Aldo with more Haldol (80 milligrams) in addition to 200 milligrams of methotrimeprazine (Nozinan, another powerful "anti-psychotic" drug) and 50 milligrams of diazepam (Valium). More drugs may have been administered; a page from Aldo's medical records is missing.
--June 23, 5:00 p.m.: Aldo dies, 36 hours after admission to Queen Street Mental Health Centre.

Here is what happened after Aldo's death:

--During the third week of September, a courageous Queen Street staff person leaks part of Aldo's medical record to Mike Breaugh, NDP Health Critic. The medical chart for the morning of June 23, the day Aldo died, is missing.
--The Coroner's Office finally informs Aldo's parents on September 18, three months after his death, that the cause of death is unknown.
--Queen Street's Medical Director, Dr. Henry Durost, admits to a reporter that doctors "don't know how these drugs work". Both Dr. Durost and Dr. Joel Jeffries of the Clarke Institute of Psychiatry claim that an average of 40 to 80 milligrams of Haldol are used on "aggressive" patients, and that some patients at the Clarke receive as much as 500 milligrams a day.
--Last week, the Coroner's Office announces that an inquest into Aldo Alviani's death will be held on November 3rd.

(continued inside back cover)

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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.

EDITOR

Cathy McPherson

EDITORIAL COLLECTIVE

Cathy McPherson
Carla McKague
Don Weitz
Jo-anne Yale
Mike Yale

The opinions of the editorial collective are expressed in the editorials and unsigned articles. Other articles, columns and letters to the editor express the views of the writer.

Printed by Muskox Press.
Printed and published in Canada.

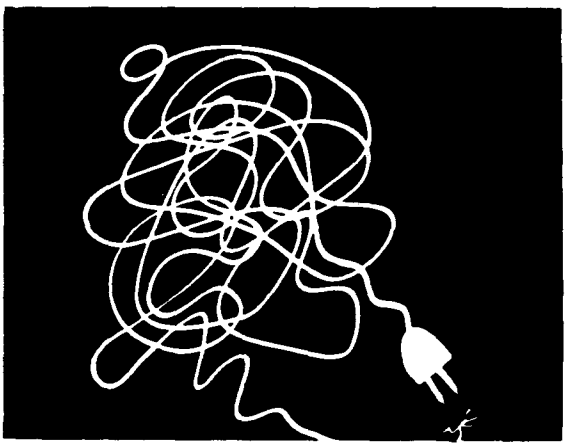
Subscription rates:
Prisoners and psychiatric inmates: FREE while confined
ON OUR OWN members: $4/year
Individuals: $5/year
Institutions and libraries: $10/year

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

Our right to say know

In our last issue, we pointed out some strong similarities between psychiatric inmates and prisoners --specifically, the unjust and massive loss of civil rights, and--more important--the denial of the right to refuse any psychiatric treatment.

Under Ontario's *Mental Health Act*, psychiatric patients have the right to refuse treatment. But the doctors can and will override a refusal and force you to take their treatment, after approval from a review board--which generally rubber-stamps whatever the psychiatrists recommend. So much for your "right" to refuse.



From *The History of Shock Treatment* Chris Pullman

In this issue, we're focussing on one of the most notorious, widespread and damaging psychiatric treatments. It's called electroconvulsive therapy, or more simply electric shock treatment (EST). We have at least four good reasons for this focus:

(1) Shock treatment is known to cause permanent memory and intellectual losses and brain damage.

(2) Informed consent to shock treatment is rarely, if ever, sought. Legally, the shock doctor must inform you of the many risks and dangers of shock, as well as the *(continued over)*

contents

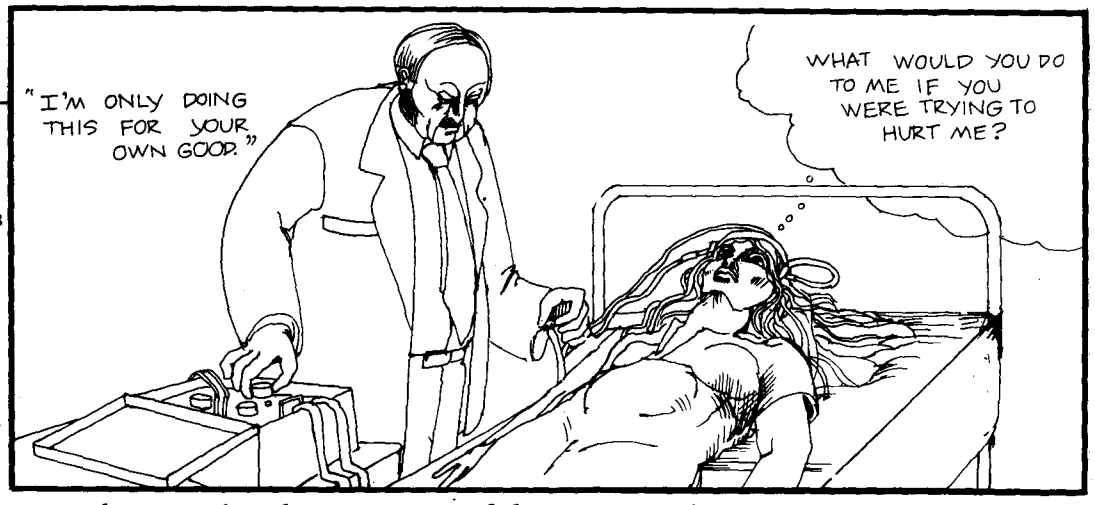
Cover photo from The History of Shock Therapy.

CONTRIBUTORS: *David Baker, June Bassett, Pat Black, Delana Munroe, Tony Myers, Ian Orenstein, Loura Ziolkowska. Special thanks for assistance to Bonnie Armstrong, Bill Lewis and Benjy Wolfe.*

reasons for the treatment and the so-called "benefits"; he must make sure you understand the nature and effects of the treatment before you give or withhold consent. Usually, however, doctors don't bother telling you all this because they automatically assume either that you're too stupid or incompetent to make any decisions for yourself, or that you might refuse.

(3) The medical-psychiatric profession in Canada and the United States have covered up or minimized the many serious risks of shock treatment for years.

(4) Hundreds of thousands of people have been electro-shocked in North America since ECT was first introduced over 40 years ago, despite the fact that shock is still considered an experimental procedure. The damage caused by shock is incalculable and tragic. We believe it's time to abolish shock treatment as harmful and unethical.



From *The History of Shock Treatment*

These are the reasons that convinced us to devote most of this issue to shock. In fact, we believe that if we did not expose this damaging information, we would be irresponsible. There is already a wealth of documentary evidence which clearly shows that shock treatment is not good for your brain. The anti-shock material we have organized for this issue is only a small sample of what is known.

We have chosen to reprint "The Shock of Your Life" by Don Weitz (originally published in Weekend in December 1979), which sparked a heated complaint by Ontario psychiatrist Dr. David Heath to the Ontario Press Council. We are also reprinting pro-shock letters from Heath and other psychiatrists, as well as anti-shock letters in defense of the article.

We also wish to point out that there is rapidly growing resistance to the use of shock in North America, especially in California. That state's NAPA (Network Against Psychiatric Assault), an independent organization of former psychiatric inmates and supportive professionals, is probably the most outspoken and militant anti-psychiatry, anti-shock group in the world. During the past five years, NAPA has organized successful protests, demonstrations and sit-ins against shock. In 1974, it was largely responsible for the enactment of the first strong anti-shock legislation in the United States.

Unfortunately, there has been no similar resistance or legislation in Canada. We believe it's time there was. We urge all our readers to speak and write out against shock; we will make a special effort to publish as many of your letters as possible. If we receive a flood of such letters, we will call a special public meeting, in co-operation with other members of ON OUR OWN, for the purpose of organizing a committee or movement against shock treatment, perhaps as early as November.

write on

Received my copy of *PHOENIX RISING* and was overjoyed with the articles. I found the magazine to be well laid out and the articles were extremely well-written.

I never realized until now that there were others who felt the same way as I do, nor did I realize that there were so many people fighting to better the lot of psychiatric patients and inmates in prisons.

I can identify with a lot of the frustra-

tions being voiced as I have certainly had my share of it since receiving a Warrant of the Lieutenant Governor. The copy of the second issue was very well received by my fellow peers here and we all look forward with anticipation to your next issue.

Everyone here wishes you the best of luck in your struggle to bring the plight of patients and inmates to light and are hoping that this struggle is successful.

--Gary L. Genereaux, St. Thomas, Ontario

I am writing in response to your request for the names of doctors who are, or have been involved in the prescription of "shock treatments" for "mental patients".

Two of these of whom I am aware are Dr. Piunick (sic?), who was with St. Joseph's Hospital in London, Ontario during the early 60s (date of encounter: 1964), and Dr. Zelanko, who was at Homewood Sanitarium in Guelph, Ontario during the 60s (encountered 1965-67).

"I must stress that force was involved..."

During periods under the care of these psychiatrists I was *forced* to submit to some 30 treatments (all but one under Zelanko's care). I was opposed to each one of these. I must stress that force was involved. As a minor (I was 14 years old at the time of the first) I was allowed no say in my "treatment".

In fact, I felt then, and still do, that these treatments were used primarily to make me more tractable rather than to ameliorate my condition (anorexia nervosa). Certainly I always regarded them as punishment for being a "bad girl".

I hope that your article on shock serves to make the public more aware of this destructive and unnatural use of force. Surely the best way to help people is not to promote brain damage.

Personally, I would like to see the use of ECT banned totally. It does not seem to me that it has a "beneficial" use, when looked at in terms of long-term effects. (Perhaps for killing rats? No, too cruel.)

As part of a campaign against it, bu documenting its ill-effects, I wish you every success. Perhaps this file will show prospective patients what psychiatrists to avoid--the Machiavellians who, through being cruel, do not make themselves kind in the long run. It was only through getting away from them that I, for one, could start to be helped sorting out the middle of my life (much of it caused by being in the hospital on and off for three years).

--Julia Schneider, Toronto

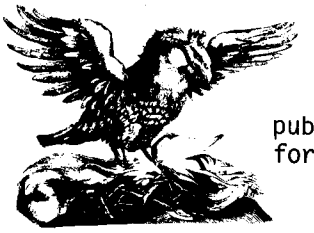
I am impressed and a bit dazzled at the sheer guts and determination it must have taken

(continued on page 37)

GIVING THEM THE BIRD

This issue's *PHOENIX PHEATHER* goes to an unknown recipient.

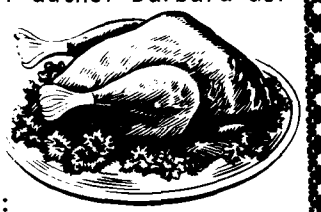
Elsewhere in this issue you will find the story of the tragic and unnecessary death of a young man named Aldo Alviani, in Toronto's Queen Street Mental Health Centre. This story would probably never have been made public, had it not been for a troubled staff member at the Centre, who mailed some of Aldo's medical records to Mike Breaugh, the NDP health critic.



Breaugh revealed the circumstances of Aldo's death, and the apparent cover-up which followed, and may have sparked a provincial investigation into overdrugging in Ontario hospitals.

To the anonymous person who found it impossible to live with the cover-up, our gratitude, and the *PHOENIX PHEATHER*.

Our second *TURKEY TAIL* goes to Dr. Morty Shulman, for his July column in the Toronto *Sun* claiming that taking women off tranquillizers could cause more harm than good, and questioning the judgment of author Barbara Gordon about her experience with Valium addiction. (Her book, I'm Dancing As Fast As I Can, was reviewed in v. 1, no. 1 of *PHOENIX RISING*.)



Wrote the good doctor:

Women tend to crumble oftener than men simply because more women than men are occupied with unfulfilling jobs and there is nothing more frustrating than the daily grind when you are unhappy. ...The simple truth of the matter is that there is no cure for these problems, but by taking tranquillizers the symptoms miraculously disappear and women are able to carry on feeling so much better.

...To suggest that a doctor sit for five hours and explain or elicit the cause of the problems is not only impractical, but ineffective. ...no explanation is going to make these women feel better, and ... the cost could be mindboggling.

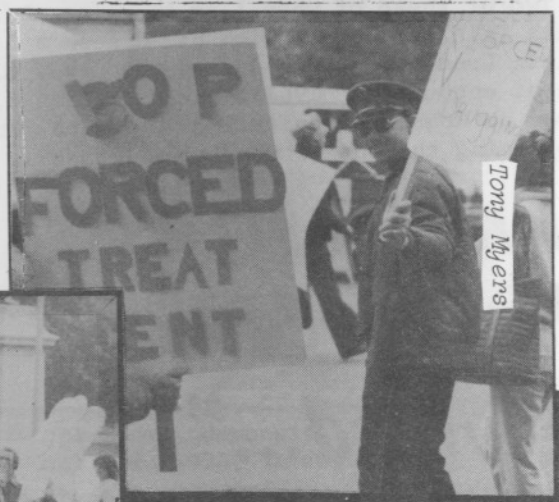
ON OUR OWN

Health Newsletter

Tony Myers

When ON OUR OWN first heard of the death of Aldo Alviani (see inside cover for details), we were horrified and enraged at his untimely death from the overadministration of drugs at the Queen Street Mental Health Centre, and the staff's subsequent cover-up.

Most of us knew someone (if not ourselves) who had routinely been given overdoses of major tranquilizers, and we all knew that many doctors administered them without any hesitation to anyone checking into an Ontario psychiatric hospital.



Tony Myers

Almost everyone had had contact with doctors who didn't bother to tell them about the side effects of the drugs they were about to give them, let alone their right to refuse treatment, whether they were voluntary or involuntary inmates.

What happened to Aldo could have happened to any of us. The issue was not only Aldo's death, but also the forced drugging that takes place instead of crisis counselling, both inside and outside Ontario's psychiatric institutions.

Aldo Alviani

What should we do about Aldo's death? At our monthly business meeting we hammered out some ideas and appointed a committee of concerned members. The committee decided to hold a rally and march a few days later, so that the issue would not die before the inquest into Aldo's death, scheduled for November 3. Members of ON OUR OWN sprang into action. It would be the first such event in Ontario organized by an ex-inmate group.

On Friday October 3, about 30 people showed up in front of the Legislative Building (the seat of the Ontario government), picketing and chanting, with security guards closely watching us. Near by, a government sign ominously read "Watch Your Step".

We were peaceful but determined as we

carried our placards and marched around chanting "ONE TWO THREE FOUR, WE DON'T WANT YOUR DRUGS NO MORE!", and "INMATES UNITED WILL NEVER BE DEFEATED!".

Some of our signs read: "STOP FORCED DRUGGING!", "QUEEN STREET KILLED ALDO ALVIANI", "WANT TO PLAY RUSSIAN ROULETTE? TRY HALDOL, THORAZINE, MELLARIL, MODITEN...", "STONE THE SHRINKS--NOT THE PATIENTS!", "STOP CHEMICAL LOBOTOMIES!", "WE REFUSE TO BE GUINEA-PIGS", and a lot more.

Mike Breaugh

Tony Myers

From *Madness Network News*

Armed with our signs, we started marching through the rain to Queen Street Mental Health Centre, escorted by two policemen who, to their credit, didn't hassle us. We were in good spirits, joking, still chanting, giving out copies of our press release and talking with reporters.

Steve Anderson
Pat Capponi,
Bill Lewis,
Don Weitz

Tony Myers

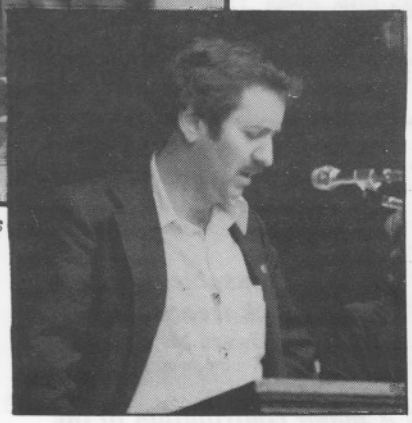
Our demonstration picked up steam as Steve Anderson read out our press release, then introduced various invited speakers: Mike Breaugh (NDP Health Critic); Ross McClellan (NDP Social Services Critic and MPP for Queen Street's riding); Pat Capponi (editor of *The Cuckoo's Nest* and an ex-inmate); Bill Lewis (an ex-prisoner and a leader in the prisoner's rights movement); and Don Weitz (ON OUR OWN's project co-ordinator).

Both Breaugh and McClellan promised they'd push for a full investigation into Aldo's death and forced drugging in psychiatric institutions.

Pat gave a rousing speech on the lack of people's rights in "mental hospitals" and the horrors of forced drugging in psychiatric institutions and in boarding and lodging houses. Bill stressed the similarities between prisoners and psychiatric inmates, claiming that forced drugging and other psychiatric abuses are common occurrences in prisons, and that prisons and psychiatric institutions are equally oppressive.

Don and Bill both added a political perspective, pointing out that drugs, shock treatment, behaviour modification and solitary confinement are used to *control* people who are too "difficult" or "uncooperative" for the authorities. They stressed the importance of knowing and exercising your rights to regain power.

Steve wrapped up the speeches with a moving rendition of "Walk a Mile in my Shoes".



Ross McClellan

On our way we made a little detour to the Sheraton Centre, where the Canadian Psychiatric Association was holding its annual convention. We gave the psychiatrists a mini-shock treatment by shouting "SHRINKS SHOULD BE SHRUNK!" and other slogans in front of the lobby. A few psychiatrists looked a bit stunned.

Forty-five minutes later and still chanting we arrived at the front doors of Queen Street Mental Health Centre. Suddenly quiet, we held a five-minute silent vigil in memory of Aldo and the hundreds of other inmates who have

been drugged to death or near-death in Queen Street and other Ontario institutions.

After the vigil, we walked slowly toward the front doors, shouting for the medical director Dr. Henry Durost, whom we had seen hovering in the corridor. A barricade of cops and institution security guards suddenly appeared and formed a solid line in front of the doors as if expecting us to storm the hospital.

Steve Anderson and a Toronto *Star* reporter went into Queen Street to invite Dr. Durost to speak to our group about Aldo's death, but he and his secretary were "out to lunch". They left a soggy copy of our press release on Durost's desk anyway for his information.

Around 3 p.m. we finally left Queen Street, drenched from the pouring rain, but happy, and convinced that we had made our presence known to Queen Street staff and to the media. Even the police were impressed; they congratulated us on being "orderly".

To celebrate our success, we went across the street to a local pub and cheered ourselves with beer, promising each other that we would be protesting at the inquest and probably holding a bigger demonstration in the future.

"OK, what'll you give me for this lovely percolator?" ON OUR OWN member Alf Jackson wrapped up our fall rummage sale with a giant auction and cut-rate extravaganza. (Bookkeeper Steve Anderson holds up the prized possession.) The sale and the dance later raised $1000 for the group. Stay tuned for future rummage sale madness!

★★In January this year, ON OUR OWN had *no* paid staff. Since then, we've been able to hire a half-time editor for *PHOENIX RISING* (Cathy McPherson), thanks to a grant from Ontario PLURA; a full-time co-ordinator (Don Weitz) and a half-time truck driver (Des Robinson) out of our Ministry of Health grant; and a half-time bookkeeper (Steve Anderson) out of the earnings from THE MAD MARKET.

Now, thanks to a City of Toronto Community Economic Development grant, we have acquired a fifth staff person. On October 15, Coreen Gilligan began work as manager of THE MAD MARKET.

We hope that Coreen's ability and experience will serve to make THE MAD MARKET a more attractive and successful endeavour, and enable us to do a better job of training ON OUR OWN members in retail sales, so that those of us who are out of work will have a better chance of finding a job.

THE MAD MARKET is now beginning to carry on consignment articles made by members of ON OUR OWN and other ex-inmates. If you would like us to consider carrying your pottery, knitting, painting, weaving or whatever, call Coreen at 363-9807.

Why not get involved with ON OUR OWN? Our only requirement for membership is past or present psychiatric treatment, in or out of hospital. We run a drop-in, a used goods store, and a flea market booth, and publish this magazine. Give us a call at 362-3193, or, if you have something you'd like to donate to the store, call THE MAD MARKET at 363-9807.

On Being Treated

by *Loura Ziolkowska*

Oh my Darling
If only I could
Get those Words
Out of my Brain.

Lock her up
Hold her down.
Hang on honey
Give it to her
Good.

Did I ask
For this
Treatment?
Fuck off Miach
you were the first to hear it from These
Chaste Lips.

PUBLICATIONS AVAILABLE FROM ON OUR OWN

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.

Myths of Mental Illness (*PHOENIX RISING* Publication #1). An exploration of common beliefs about the "mentally ill"--are they really true? $1.00.

Antipsychiatry Directory. An up-to-date list of patient-controlled groups and journals around the world. (Printed periodically in *PHOENIX RISING*.) 50¢.

On Our Own: Patient-Controlled Alternatives to the Mental Health System, by Judi Chamberlin (McGraw-Hill Ryerson). "Required reading for all 'mental health' professionals ... who still believe that 'mental patients' are too 'sick', helpless and incompetent to run their own lives." $5.00 (list price $6.95).

PHOENIX RISING, vol. 1 no. 1. Boarding homes in Toronto; Valium; legal advice; gays and psychiatry; and more. $1.50.

PHOENIX RISING, vol. 1 no. 2. Prison psychiatry; Thorazine; blindness and emotional problems; commitment; and more. $1.50.

Please send me ____ copies of **Consumer's Guide to Psychiatric Medication** @ $2.50 $____

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____ copies of **Antipsychiatry Directory** @ 50¢ $____

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ECT: WHAT THE DOCTORS DON'T TELL YOU

American Journal of Psychiatry, December 1975

In December 1979, Canadian Weekend *printed an article on ECT by Don Weitz, entitled "The Shock of Your Life." As a result of the appearance of this article, psychiatrist David S. Heath of Kitchener filed a complaint with the Ontario Press Council, claiming that* Canadian Weekend *had acted irresponsibly in publishing it.*

We are reprinting Don's article here, along with Dr. Heath's complaint, the Press Council decision, and a number of letters supporting or attacking the magazine and the Press Council. Read them--and make up your own mind.

THE SHOCK OF YOUR LIFE

It blasts away your memories, but you don't forget electroshock

BY DON WEITZ

You'd never think a loser like Ted could have had such promising beginnings. As a working-class, Catholic boy in Hamilton, Ontario he was bright and precocious, an "exceptional child" according to his teachers and guidance counsellors. He skipped Grade 4 and still remembers being strapped "three times on each hand" for reading a book more suitable for older children; he liked James Thurber and other authors not found in the library of his separate school. Ted's real love was music. At age 5 he began taking weekly piano lessons and within a year or two could read music well. At 10 he was playing Bach, Beethoven and Mozart in recitals around Hamilton; at 11 he won honorable mention at his region's annual Kiwanis International Music Festival.

"I was a bloody little marvel," he says.

Ted's training under a noted piano teacher came to an end when she developed severe arthritis and had to retire. Although he was still playing the piano when he was 12 or 13, he began to lose interest in music when he started a strict five-year academic program in a Catholic high school.

Like primary school, high school was too easy for Ted. He got Bs without really trying. He'd cram one or two hours the night before an exam and come up with 60% in a subject he didn't care about and 70% or 80% in one he enjoyed. But he was involved in extracurricular activities like the United Nations Club.

Ted's future started falling apart when he was 16. His marks dropped and he failed his Grade 12 Christmas exams. A guidance counsellor told him his IQ was 162 — genius level — and asked, "How can you be so brilliant and educably retarded?" He ran away from home; the Ontario Provincial Police picked him up in Ottawa and brought him back. "I was losing my temper over nothing," he recalls. "In a minute I'd go from doing nothing to red, roaring rage to heart-rending sobs and tears to withdrawal to doom-and-gloom depression." His parents thought he was having a "nervous breakdown." They took him to the family doctor, who gave him tranquillizers for a while then referred him to a psychiatrist. Ted was uncooperative. He was given more pills. After a few weeks he agreed to enter Hamilton's Henderson General Hospital. He was put in the psychiatric ward.

The head nurse at Henderson was remarkably similar to the iron-willed therapist in the movie *One Flew Over the Cuckoo's Nest.* Big Nurse, as she was called, didn't like young people. "She'd tell us, 'You've got no problems — you're just self-indulgent weaklings.' " She once forbade Ted to go on one of the daily walks, and he started to scream at her. As punishment, he believes, she or another staff member slipped him a dose of chloral hydrate. He's unable to remember how he was drugged, and when he woke up he didn't know where he was. He found he was in a mental hospital —the Hamilton Psychiatric. Ted recalls, "You had no privileges like making phone calls or leaving your room whenever you felt like it. I had to wear this surgical gown with three ribbons tied up in the back so that my ass hung out all the time. I usually wear prescription glasses but they took them away, too." He felt depressed, infantile and powerless. He sneaked a look at his chart and saw that the diagnosis was "paranoid-type schizophrenia." He seldom saw a doctor for more than a minute every few days; treatment again consisted mainly of drugs.

Ted repeatedly suffered severe allergic drug reactions which caused painful muscle spasms, and he frequently experienced unnerving body misperceptions — "Your arm felt like it was eight yards long and weighed 95 pounds."

More frightening by far, however, was electroshock therapy. "Electric shock wipes out your memory; I heard this and more from some of the other patients who'd had it." And the day came when Ted was informed, without warning, that he, too, was to undergo shock. He had just turned 17.

Many people are under the impression that shock is an outdated form of therapy that's no longer used. This is not true. In Ontario a total of 156,163 electroshock treatments were given during the five years ending in 1978. Reliable national statistics are hard to obtain, but in 1975, the last year for which figures are available from Statistics Canada, more than 3,000 mental patients were electroshocked; if outpatients are added, a good estimate would be that every year 100,000 shock treatments are given to about 10,000 Canadians.

Loss of memory is an undisputed effect of electroshock, often called EST or ECT (for electroconvulsive therapy), but most psychiatrists who employ it believe this lasts only a few weeks. "I have never seen a single case of permanent memory loss due to EST alone," says Dr. Barry Boyd, former medical director of Ontario's Mental Health Centre at Penetanguishene.

However, more and more patients are reporting extensive and often permanent loss of memory. A Vancouver woman who received shock in the late '60s and early '70s says, "A lot of times I'll try to recall something that happened in the morning, and my brain will feel paralyzed and just not work." A psychiatric nurse reported, three years after she received 26 shock treatments, "My long-term memory was definitely impaired. My recall for names, places and incidents had been excellent prior to

these results. Even today there are huge gaps in my past."

Ernest Hemingway, the American novelist and Nobel Prize winner, suffered major memory impairment after a series of 11 shock treatments at the world-renowned Mayo Clinic in Rochester, Minnesota in 1961. He killed himself a few days after he was released, deeply depressed over his loss of memory and inability to write. "They should make all psychiatrists take a course in creative writing so they'd know about writers," Hemingway is quoted as saying by A.E. Hotchner in his book *Papa Hemingway*. "What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business? It was a brilliant cure but we lost the patient. It's a bum turn, Hotch, terrible."

Electroshock patients find it difficult to prove memory loss, for their situations are always complicated by drugs and, of course, their illnesses. How can others be convinced that memory loss has occurred in someone who has been "out of his mind"? People find it easy to believe that mental patients are just looking for someone to blame for their condition. No patient has ever been able to win a lawsuit because of memory loss; in court judges usually believe the psychiatrist, not the patient.

Nevertheless, there are doctors who confirm the patient's experiences. In his 1976 book *Shock Treatment is Not Good for Your Brain*, the neurologist John Friedberg says he is convinced that shock therapy causes "significant brain damage and memory loss.... The evidence was all there in black and white in the late '30s and early '40s." In 1965 and 1969 two Russian psychiatrists, A. Pornov and D. Fedotov, reported jointly that shock therapy causes brain damage. Even the American Psychiatric Association, most of whose members still approve of electroshock, warned in a 1978 task force report that memory loss could extend to events "many years" in the past; not only are past events obliterated, the report said, but the ability to commit new events to memory is impaired, and the impairment is "cumulative with successive shock treatments."

In Canada, significant evidence became apparent in the work of the late D. Ewen Cameron of McGill University's Allen Memorial Institute. A president of the American and world psychiatric associations, Cameron performed shock and drug experiments on patients diagnosed as schizophrenic in the late '50s and early '60s. He subjected many of his patients to what he called "depatterning" — two or three shock treatments a day over one or two months, up to a total of 50 or 60 shocks. Two subsequent researchers, the psychologist A.E. Schwartzman and the psychiatrist P.E. Termansen, conducted a follow-up study three to five years later and found that 60% of Cameron's "depatterned" patients couldn't remember certain events from six months to 10 years in the past. Cameron himself had succinctly described the effects on a patient in a1960 article in a professional journal: "He lives in the immediate present. All schizophrenic symptoms have disappeared. There is complete amnesia for all events of his life."

From *The History of Shock Treatment*

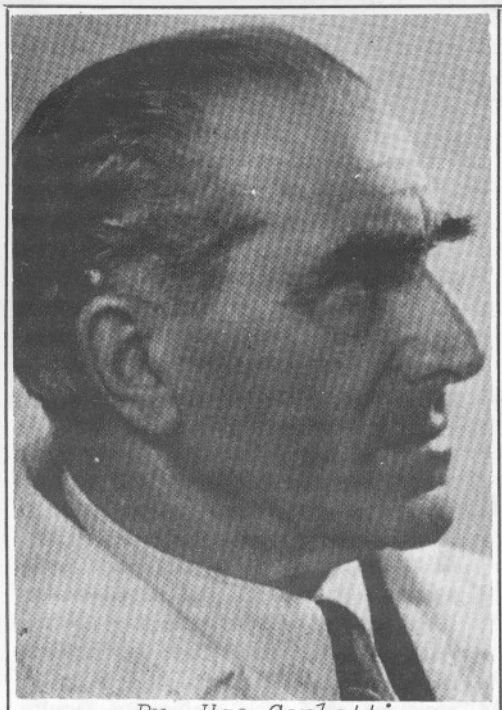
On the morning of his first shock treatment Ted was given no breakfast — the patient is not allowed to eat or drink for four hours before treatment. Instead he got a sedative. Thirty minutes beforehand he was given a drug called atropine to keep his heart going and dry up his saliva so he wouldn't choke.

"EST was never explained to me. If I was presented with a consent form I was so drugged that I couldn't possibly have given anything resembling consent. At 9 o'clock the doctor arrived. They started rolling our beds into another room. I was terrified. I didn't know exactly what would happen."

In the treatment room Ted was put on a flat padded table — a "gurney." A nurse smeared a special jelly on his temples to speed up the flow of current and prevent burns. A rubber gag was put into his mouth, and two electrodes were attached to his head.

"I felt like a cross between a guinea pig and some kind of sacrificial beast. 'Don't worry, don't worry,' I was told. I couldn't really see anything. I was just lying there rolling my head back and forth. Somebody tied a rubber hose around my right arm and gave me a needle."

Ted was one of the 10% of shock patients who, in the 1960s, were given electroshock without anesthetic—"dry shock," it was called, and it was especially terrifying. The needle Ted received gave him a dose of curare (now replaced by succinylcholine), a muscle relaxant, to prevent spasms breaking or



Dr. Ugo Cerletti
(from The History of Shock Treatment*)*

dislocating his bones. The drug paralyzes lungs and diaphragm, and the patient is unable even to breathe; a respirator with an attached oxygen mask does his breathing for him.

"I really thought I was dying," Ted recalls. "I couldn't breathe, I couldn't move a muscle. My eyes closed, and just as they closed I saw three people on either side of me move toward the bed. I saw a hand coming over which started attaching the clips to the electrodes on my forehead. That's the last thing I saw. My breath left me in a great *whoosh*. I couldn't inhale again, I couldn't twitch, I couldn't say a thing. I was terrified they were going to turn the electricity on. 'Oh, God, it didn't knock me out,' I said to myself, which is what I thought the injection was supposed to do. I wanted to move just a finger to let them know I was still there. And then the electricity was applied. That was the end."

When the psychiatrist pushes the button on a shock machine, 70 to 175 volts of electricity surge through the patient's brain for up to 1½ seconds. The result is rather like an epileptic's grand mal seizure. If the patient is given enough muscle relaxant and anesthetic, his shaking is hidden and only the toes twitch. If not, his whole body goes into a violent and uncontrollable spasm.

Ted cannot find words to describe how it felt, but the American writer Sylvia Plath described it vividly in her book *The Bell Jar*:

> *Then something bent down, and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash a great jolt drubbed me till I thought my bones would break and the sap fly out of me like a split plant.*

After an electroshock session the patient lapses into a coma lasting a few minutes. Then he sleeps for 30 minutes to two hours.

No fewer than 50 theories have been advanced to explain the precise effects of electroshock therapy, but in fact medical men know little more about it than they did 40 years ago when Dr. Ugo Cerletti, an Italian psychiatrist, first used it on a vagrant who had been supplied to him by the police. "When I saw the patient's reaction," Cerletti told a colleague later, "I thought to myself: this ought to be abolished! Ever since I have looked forward to the time when another treatment would replace electroshock."

Doctors who use electroshock say it is a valuable therapeutic tool, particularly in cases of severe depression. Dr. Gerald Shugar, chief of service at Toronto's Clarke Institute of Psychiatry, told a reporter in 1976 that shock is "remarkably effective" in treating depressed patients. "Within a few weeks of starting shock treatment, their attitudes change and they begin to enjoy life again."

Nevertheless, electroshock has never scientifically been proven effective. Four controlled, double-blind studies have been carried out, but their results were all inconclusive. An embarrassing event occurred in the early 1970s when a nurse at an English mental hospital discovered a new shock machine had never been working; for two years patients had been getting only the accompanying drugs, and the doctors hadn't noticed. A recent review on electroshock was carried out by C.G. Costello, a psychology professor at the University of Calgary, who reported in the *Canadian Psychiatric Association Journal* in 1976: "All the studies attempting to evaluate the therapeutic efficacy of EST were at fault methodologically." (Nevertheless, the Canadian Psychiatric Association issued a position paper in 1978 sanctioning the use of electroshock.) Dr. Peter Breggin, a Washington psychiatrist, says in his book *The Crazy From the Sane*, "Oh, I found one or two studies that said shock breaks up depressions, and I suppose I can believe that, but for every study that had something hopeful in it there were 20 that came out negative. Maybe even worse than that, more ugly than that, I couldn't find one study that asked, 'Is this thing evil?'"

The World Health Organization criticized the use of shock on prisoners in a 1975 paper prepared for the fifth U.N. Congress on the Prevention of Crime and the Treatment of Offenders. The paper said, "EST is an entirely empirical form of therapy having no scientific rationale, opinions within the medical profession as to its value are divided, and it is not devoid of complications...." In the United States, a start has been made toward the abolition of EST, led by groups such as California's Network Against Psychiatric Assault (NAPA). Shock restrictions are now embodied in

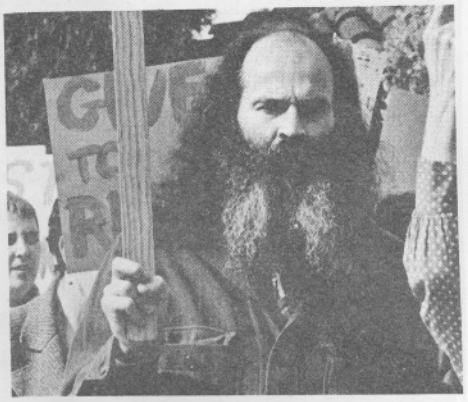
the California Welfare and Institutions Code, requiring doctors to obtain informed consent to electroshock therapy, consent that can be withdrawn by the patient at any time. In Canada, little has changed; Ontario's Mental Health Act was amended in 1978 to allow patients to refuse any psychiatric treatment, but it can still be authorized by a review board if the patient is "not mentally competent" — that is, the refusal is not binding.

One of the more eloquent voices raised against electroshock was that of the novelist Ken Kesey, who wrote of electroshock in *One Flew Over the Cuckoo's Nest*: "A device that might be said to do the work of the sleeping pill, the electric chair, *and* the torture rack." Lest this be taken as overstatement, here is the list of deleterious effects of EST, apart from memory loss, that can appear within hours or days of electroshock: breathing irregularities, confusion, delirium, dizziness, severe headache, heart irregularities, aching muscles, physical weakness, vomiting, wild excitement, fractures and dislocations, stoppage of menstruation, impotence, bizarre sexual behavior, cerebral hemorrhage, ulcers, kidney ailments and abnormalities in brain waves.

Death is another "side effect." The number of known deaths related to electroshock, based on reports in medical journals up to 1977, is listed at 384 in *The History of Shock Treatment*, edited by Leonard Roy Frank of San Francisco, himself a survivor of about 80 treatments. At least two of the deaths were in Canada. In his introduction to Frank's book, Lee Coleman, a California psychiatrist, says, "The changes one sees when electroshock is administered are completely consistent with any acute brain injury, such as a blow to the head from a hammer." Karl Pribram, the world-renowned neurologist and psychiatrist, said, "I'd rather have a small lobotomy than a series of electroconvulsive shocks.... I just know what the brain looks like after a series of shocks — and it's not very pleasant to look at."

Ted was released from Hamilton Psychiatric Hospital in the fall of 1964; he had undergone 20 shock treatments — and was suffering from severe memory loss. "During the whole 10-week period when I was getting shock," he recalls, "my memory system was just shot all to hell. I remember only single, isolated and specific incidents. There's no sequence to them, no gestalt. The time immediately preceding the shock treatments is also pretty well gone. Five or six years of my life are virtually wiped out. When I was 15 I was an usher at a wedding for a guy who grew up with me — he was like a brother, his father boarded with us for about nine years — and I have only one isolated memory of that whole thing. It was a very important event, the first time I got to participate as an adult in an adult ritual, and it's gone.

"My last year in Grade 12 is gone, the year immediately preceding my hospitalization. After my release I went back to school and tried Grade 12 four years in a row — three times at the same school. Every time it was the same story — failure, and readmission to hospital. I was still on drugs. My dosage was increased. I found it harder to study, to concentrate. Although I had never really learned how to study, I knew I could do better than that. I have to ascribe this to a combination of drugs and shock."



Leonard Frank protesting (from The History of Shock Treatment)

Frustrated at knocking his head against a stone wall, Ted began travelling. He went to Europe and North Africa in 1969 and 1973, to the Far East in 1976. He tried many jobs — as an assistant chef at a university faculty club, a management trainee, a toy demonstrator in shopping plazas, a door-to-door salesman, a floor cleaner, a file clerk. For about 10 months in 1978, he enjoyed working as an animal lab technician at the University of Toronto — "a good job," he says proudly, "a real possibility for a career" — but then was laid off in a cutback and had to go on unemployment insurance. "I'll find something that will give me a roof over my head," he says. "I'm not very materialistic and don't need what a lot of other people seem to need."

Among the things that Ted has learned to do without is music, his first love. A few years after his release from hospital he discovered that his musical ability had disappeared. "There was a piano sitting in somebody's place and I went over to play. 'Migod,' I thought to myself, 'I remember middle C, but I can't remember what goes from there. What's next to middle C? What's it called? I can't remember. Well, the hell with it — just take your fingers and play.' But I couldn't play anything I recognized. I had the mechanical dexterity to play around and sort of make chord-like sounds, but I couldn't make it happen. I couldn't duplicate anything I used to play. I couldn't play by ear. I can't play any piece or read music now."

One thing Ted does remember is his first shock treatment. He will never forget it. "Any shrink who's allowed to prescribe shock should have at least two himself," he says. "Then I don't think any more would be prescribed." ■

NUMBER OF INPATIENTS RECEIVING ECT IN CANADA (1975)

Province	Male	Female	Total	%
Nfld.	108	164	272	9
P.E.I.	0	0	0	0
N.S.	61	165	226	8
N.B.	0	0	0	0
Que.	198	445	643	21
Ont.	311	673	984	33
Man.	0	0	0	0
Sask.	73	128	201	7
Alta.	199	486	685	21
B.C.	2	1	3	0
CANADA	952 (32%)	2062 (68%)	3014	100

(Statistics Canada, "Surgical procedures and treatments--1975".)

Notes:
1. These figures are questionable. For example, an investigation by the Committee to Investigate Shock Treatment (part of the Vancouver Mental Patients Association) found that in 1974 two Vancouver hospitals gave 3,758 shock treatments to about 600 patients. But the Statistics Canada *figures for the following year show only* **three** *people in all of B.C. receiving ECT.*
2. This table makes clear that women are subjected to ECT about twice as often as men. This figure is confirmed by other studies.
3. These figures include only inpatients. *An unknown, and probably large, number of outpatients also received ECT.*
4. A conservative estimate of 10 ECT treatments per patient gives a figure of roughly 30,000 treatments to inpatients alone in 1975.

ECT ADMINISTRATIONS IN ONTARIO 1973 TO 1979

Year	Number of treatments	Number of patients	Total cost	Cost per treatment
1973-74	39,561	3,956	$781,400	$20
1974-75	37,801	3,780	$929,170	$25
1975-76	31,662	3,166	$891,436	$28
1976-77	26,228	2,623	$769,236	$29
1977-78	20,911	2,091	$646,860	$31
1978-79	18,424	1,842	$580,843	$31
TOTAL	174,587	17,458	$4,598,946	$27

Notes:
1. Figures for number of treatments and total cost provided by the Ontario Ministry of Health.
2. Figures for number of patients estimated based on an average of 10 treatments per patient.
3. Cost figures rounded to nearest dollar.

Letters to Canadian Weekend

I was distressed and angry to read Don Weitz's article on electroconvulsive therapy. In 1976 I suffered from a severe clinical depression and was a patient at the Clarke Institute of Psychiatry in Toronto for three months. I received the minimum series of six electroshock treatments, was given a general anaesthetic and suffered absolutely no discomfort before or after the treatments. The procedure was explained to me beforehand, I signed an agreement form, and I was given the very best of compassionate care.

As a result of the therapy, my recovery was dramatic, as it so often is in cases of severe but not chronic depression. I have suffered no long-term effects and I experienced only very slight and temporary loss of recent memory immediately after the first two treatments. This was, believe me, a small price to pay to alleviate the anguish I had felt.

--Name and address withheld

From one who flew over the cuckoo's nest and made a safe landing, thank you for your exposé on the dangers of electroshock. Had I known 13 years ago that my signature was legally required, I would have been spared the terrors, indignities and possible brain damage caused by this barbaric treatment.

--Name withheld, St. John's, Newfoundland

My mother was one of the 10% of shock patients in the 1960s given electroshock without anaesthetic. Seventeen years later, she is still receiving treatments but is knocked out with Pentothal beforehand. The only aftereffect is memory loss, with which she has learned to cope. My family and I have nothing but praise for electroshock. It kept us together when my mother's depression was unbearable for all, herself included.

--Name withheld, Hamilton, Ontario

We want to emphasize that patients have the right to treatment as much as they have the right to refuse treatment, and that a consent must always be obtained prior to treatment. Electroconvulsive therapy is used principally for patients suffering from severe depression, especially those who are very agitated, suicidal or who have failed to respond to antidepressant drugs. It can be lifesaving in these instances.

ECT is akin to a minor operation with a

general anaesthetic and muscle relaxant being given by an anaesthetist. The patient is awake in 10 minutes and walking in 30 minutes. On average, recovery from the depression occurs after 10 treatments given over three weeks. Deaths rarely occur, no more than for inpatient dental surgery, and side effects such as drowsiness, headaches and confusion are short-lived. Today, only small amounts of electrical energy are transmitted by the modern pulsewave form machine, and the majority is absorbed by skin and bone. There is no sound psychological or neurological evidence to show that ECT causes brain damage or permanent memory loss.

To publicly attack and sensationalize this treatment serves to deny needy people of a potential benefit.

--M.R. Eastwood, M.D., F.R.C.P.(C.), F.R.C.Psych., Head, ECT Program
--S.K. Littmann, M.B.,Ch.B., F.R.C.P.(C.), Chairman, Medical Advisory Committee
Clarke Institute of Psychiatry, Toronto, Ontario

I have been on the receiving end and have watched others being "manhandled" by everyone from the Children's Aid to the Clarke. I say to anyone, despite the inconvenience to anyone, the right to know and approve without duress any and all medical treatment, and to know its probable and possible effects.

--Alan Parton, Conn, Ontario

(reprinted from Off the Shelf, *v. 1, no. 4, July 1980)*

On July 9, 1980 a Beaumont jury awarded Jack Lawrence $75,000 damages for impaired mental ability and reduced earning capacity resulting from electroconvulsive treatment. Seven years ago Lawrence was involuntarily administered 42 ECTs, sometimes twice a day, over a 74-day period by Dr. Lewis M. Williams. The ECT began over Lawrence's vehement objections the day after he was committed to the Captist Hospital of Southwest Texas in Beaumont. His protests continued until they were silenced several weeks later by the cumulative effects of the ECT. While undergoing ECT, Lawrence complained of memory loss. He continues to suffer extensive amnesia covering a period of several years prior to ECT. Shortly before the shock treatment he had taken a leave-of-absence from law school, but never returned.

Lawrence v. Williams is the first known case in which a CT Scan (Computerized Tomography) was used to support a claim of ECT-caused brain damage. Berkeley neurologist Dr. John Friedberg, in testimony based on the CT Scan, described the severely atrophied condition of the 30-year-old Lawrence's brain, likening it to that of a 75-year-old man. Counsel for Lawrence was Barney L. McCoy of Houston.

Marjlyn Rice once worked as a statistical analyst for the United States government. She was considered an expert on gross national product--until 1973. That was the year she had eight shock treatments, following a year of incompetent dental work which permanently disfigured her and left her deeply depressed.

In 1974, Ms. Rice launched a million-dolla lawsuit against her shock doctor. Part of her complaint read:

As a result of the electric shock treatments ... the plaintiff has suffered what appears to be a permanent amnesia ... which prevents the plaintiff from carrying out her occupation .... The plaintiff has, as a result of her memory impairment, been forced to retire from her position and has suffered a substantial drop in income. The defendant, Dr. Nardini, did not ... inform the plaintiff of the prospect of memory impairment resulting from the shock treatment.

Subsequent independent neurological examinations, including a CT scan, recealed conclusive evidence of brain damage.

Nevertheless, Ms. Rice lost the 1977 case.

A full account of Ms. Rice's experiences has been published as "The Rice Papers". See this issue's Annotated Antipsychiatry Bibliography.

Electroconvulsive therapy has made it impossible for me to lead a normal life. Within three years of receiving my first set of treatments (possibly 12) and two years of my second set, my physical health has deteriorated so badly that in self-defence it was necessary for me to leave my home and family and begin to fend for myself, handicapped by brain damage. At home, my physical problems were always assumed to be psychological, and shock treatments were considered to be the "cure". After each "cure", I was much sicker physically.

During the last eleven years, I have held three very responsible positions, albeit alternated with not-so-good positions and periods on welfare. Physical health problems terminated two of these positions, and the third ended when management was told I had had shock treatments and had brain damage. My established intellectual and organizational ability were disregarded.

I hope I have not reached the end of the line. I am presently increasing my educational qualifications and looking for work. With continued self-disciplining perhaps I will not be a write-off.

--Catherine Furtenbacher, Toronto

I had 11 ECT treatments in 1967 when I was 17 years old in Nova Scotia, the reason being that I was suffering from depression and considered apparently helpless.

(condensed from the S.F. Examiner, *Jan. 8, 1979)*

The CIA in 1951 apparently conducted human experiments using electroshock techniques despite warnings from an expert that they were "extremely painful and could reduce subjects to the vegetable level."

The CIA carried out human-behaviour and mind-control projects, including the use of unwitting subjects, from 1951 until they were ordered discontinued in 1973.

Some previously secret memos on the subject included a Dec. 3, 1951 memo on the conversation a CIA officer had with a psychologist on the use of electroshock in interrogations and for other purposes.

Names were blacked out in copies of released material.

After saying the techniques "might be of considerable interest" to the agency's program, the memo explained the expert's explanation of how it worked.

"He stated that the standard electric-shock machine could be used in two ways. One setting of this machine produced the normal electric-shock treatment (including convulsion) with amnesia after a number of treatments."

The expert said that by using the machine as an electroshock device with the convulsive treatment, "he felt he could guarantee amnesia for certain periods of time and particularly he could guarantee amnesia for any knowledge of use of the convulsive shock."

The expert said there were dramatic reactions at other settings of the machine--for instance, a lower setting "had the effect of making a man talk."

This type of shock is prohibited in normal medical practice because it produces excruciating pain, the expert said.

I consider ECT treatments to be irresponsible, but a definite improvement over the barbaric inhumane ways mentally ill people have been treated in the past--especially during the Middle Ages.

"The only treatment that a doctor can use for severe depression apart from ECT is antidepressant drugs"--says who? So if somebody is sad, you lock him up, try to blow out his brain and make him as dopey as possible?! Instead of barred windows and a jail atmosphere I would suggest a colourful and cheerful library. Also a gymnasium.

David S. Heath says that "most people who commit suicide are suffering from depression". What a brilliant deduction! How many courses of Freud did he take to come to that tremendously astute observation? Am I wrong when I say that doctors are not immune to suicidal attacks?

Heath's paragraph on the side effects of aspirin is an apogee of distorted thinking. I am sure lobotomy cases do not commit suicide. Would this be an argument in favour of lobotomy? What about the "quality of life"?

Suicide rates may be going up but, God help us, ECT is not the answer. Let's get to the *root* of these problems.

To attempt to defend the merits of ECT is like trying to defend the virtues of the chastity belt. Doctors who recommend ECT treatment should be given about ten shots to see if their outlook on life is improved.

--David Boudreau, Montreal

I recently had the honour of being asked by the CBC to discuss electroshock on "Take Thirty" with Dr. M.R. Eastwood, head of the electroshock program at the Clarke Institute, and as a result I became acquainted with the current controversy over electroshock taking place in the pages of your magazine. Since

In the late 1950s and early 1960s, D. Ewen Cameron headed McGill University's famed Allen Memorial Institute. Dr. Cameron was a former president of the American Psychiatric Association, and first president of the World Psychiatric Association.

At McGill, Cameron performed shock and drug experiments on many "schizophrenic" patients. (As the press reported in 1979, one of his guinea pigs was Valerie Orlikow, wife of MP David Orlikow--Cameron repeatedly drugged and immobilized her with LSD.)

It was not unusual for Cameron to give his patient-subjects two or three shock treatments a day over a one or two month period, up to a total of fifty or sixty shocks.

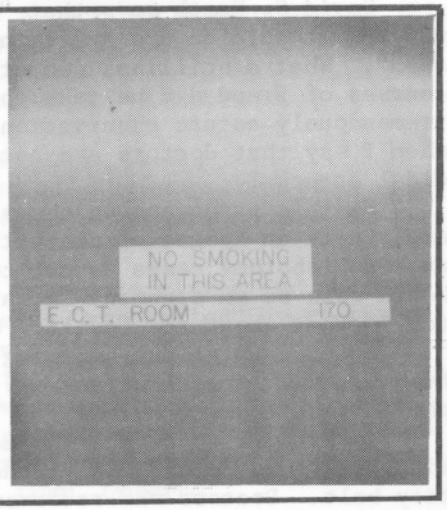
Cameron admitted that his "treatments" caused massive memory loss in his patients after the "third stage of depatterning". His description of a typical "depatterned" patient read: "He lives in the immediate present. All schizophrenic symptoms have disappeared. There is complete amnesia for all events of his life."

In his shocking expose of CIA-controlled behaviour modification experiments, *The Search for the "Manchurian Candidate"*, John Marks quotes Professor Donald Hebb (head of McGill's psychology department when Cameron was head of its psychiatry department) as saying, "Look, Cameron was no good as a researcher...he was eminent because of politics."

Much of Cameron's work at McGill was financially supported by the CIA through a front group called The Society for the Investigation of Human Ecology, or The Human Ecology Fund.

both Dr. Eastwood and Dr. David Heath have written letters lending their medical authority to a severe criticism of Don Weitz's "The Shock of Your Life", I hope you will allow me at this late date to offer an opinion by a psychiatrist in favour of Mr. Weitz's viewpoint.

In my recent scientific publication Electroshock: Its Brain-Disabling Effects, I document six cases of permanent, severe memory loss following electroconvulsive treatment, including cases in which the losses reach back many years into the individual's past. In some cases, the mental dysfunction continued into the present, making it more difficult for the individual to learn or remember new facts and life experiences. Each of the individuals felt humiliated and terrorized by the effects of the treatment.



The entrance to the ECT room at the Queen Street Mental Health Centre in Toronto

The detailed review of the scientific literature in Electroshock: Its Brain-Disabling Effects gives little support to the claims made in defense of the treatment by Dr. Eastwood and Dr. Heath. It is ridiculous to dismiss the subjective experience of memory loss when there is additional evidence of brain damage in animal studies, human autopsy reports, brain wave tests, neurological evaluations and psychological tests. The original animal studies demonstrating brain damage used less electric current than routinely used today for the simple reason that the use of anaesthesia now makes it more difficult to bring about a convulsion. Studies claiming to show less memory loss from unilateral shock treatment fail to mention that many psychiatrists believe that a greater number of treatments is required, ending with the same devastating result. Furthermore, concentrating all the electrical current on one side of the head may cause more severe localized brain damage.

Claims that electroshock treatment is an effective treatment have no more substance than claims that it is safe. Studies used to defend the treatment are poorly done and highly biased. The weight of evidence also shows that shock treatment does not prevent suicide; and in my clinical experience, it may encourage suicide at times by adding brain damage to the patient's pre-existing personal problems. Again, I refer the interested reader to my detailed analysis in my book.

Psychiatrists who claim that patients will be robbed of a much needed treatment if shock is criticized fail to acknowledge that many psychiatrists and many psychiatric hospitals have functioned for years without using electroshock treatment. If shock is so desperately needed, how is it that a recent American Psychiatric Association survey showed that only 16% of psychiatrists had administered the treatment in the previous six months, and that only 22% had administered or even recommended its use during the same period?

At the least, anyone undergoing electroshock treatment should be told that it is very controversial within the profession, that many patients complain of permanent memory loss, that a variety of studies indicate the possibility of permanent brain damage, and that the evidence for its efficacy is flimsy and biased.

--*Peter R. Breggin, M.D., Executive Director, Center for the Study of Psychiatry, Washington, D.C.*

(Dr. Breggin's book Electroshock: Its Brain-Disabling Effects *is reviewed in this issue.)*

The Complaint

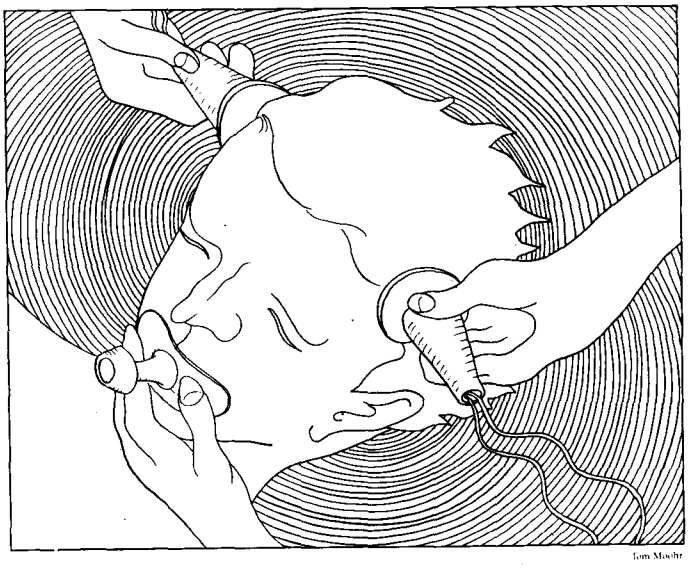
While I agree that Ted, the paranoid schizophrenic who was given electroconvulsive therapy in the 1960s without anaesthetic, sounds a most unfortunate fellow and may have been treated unkindly, his experience is irrelevant in an article on ECT today. But the sections on Ted take up half the article. First, ECT is not given now without anaesthetic. Second, it is rarely given for schizophrenia; psychiatrists think that its efficacy for this condition is equivocal, and it is used only in cases where drug treatment fails and the patient still remains very ill. It is clear from the story that Ted does not do very well in life and has deteriorated in his functioning. I would think that the lay reader is left assuming that this is due to ECT. It is not made clear, however, that schizophrenia is a malignant mental illness, which in some 10% to 30% of cases leads to the kind of deterioration that Ted underwent, and often much worse, whether they have treatment or not.

Almost another complete page is taken up by a picture of a man who appears to be undergoing ECT while fully awake. Understandably, he looks terrified. However, as I have men-

tioned, ECT is no longer given without an anaesthetic, so this picture seems to be about as fair as illustrating an article on dentistry with a picture of a patient having his teeth yanked out without any anaesthetic.

The author, Don Weitz, is fond of quoting phrases out of context. He cites a recent American Psychiatric Association report as warning that "memory loss could extend to events 'many years' in the past; not only are past events obliterated, the report said, but the ability to commit new events to memory is impaired, and the impairment is 'cumulative with successive shock treatments.'" If one reads the whole of this report, it says that memory changes are reversible, but that some patients do complain of permanent memory loss and at the moment this possibility cannot be ruled out.

Dr. Larry Squire, a psychologist with the Veterans' Administration Hospital in San Diego, California, recently published a study in the *American Psychiatric Journal*, attempting to answer the question of permanent memory loss. He took depressed patients, some of whom had had ECT and some of whom had not, and measured their performance on different memory tests six to nine months after they had been in hospital. There was *no difference* between the two groups.



From *The History of Shock Treatment*

The patients who had had ECT, however, *complained* of memory loss, although none was detected. Maybe the tests are not sensitive enough to detect memory loss, or maybe patients having had a temporary memory loss with ECT are then made more sensitive to their normal memory lapses. Another possibility is that the patients who had received ECT were the more severely depressed patients. The issue is further complicated by the fact that severe depression, for which ECT is usually given, can play havoc with one's memory. Some depressed patients even appear demented, their memory is so poor. In fact, their memory function *improves* with ECT.

When Weitz states that ECT has never scientifically been proved effective, this is just downright wrong. There are research studies in which ECT has been proved to be superior to antidepressant drugs, and the same American Psychiatric Association report that Weitz quotes from says, "In summarizing the comparison studies, electroconvulsive therapy procedure is an effective treatment in severe depressive illness." ECT was also studied by the British Royal College of Psychiatrists. Its memorandum says, "There is substantial and incontrovertible evidence that the electroconvulsive therapy procedure is an effective treatment in severe depressive illness."

Weitz quotes the book by the neurologist John Friedberg with regard to ECT causing significant brain damage. Friedberg's work has been heavily criticized by a number of people, including Dr. Fred Frankel, head of adult psychiatry at Beth Israel Hospital in Boston, and an associate professor of psychiatry at Harvard --because much of his evidence comes from animal studies in which the animals were given multiple shocks and high voltages that would just never be given to human patients.

All treatments have risks and side effects, and the job of any doctor is to weigh the benefits the patient would receive against the risks. Just to list the deleterious side effects of ECT is misleading. Look at this list of side effects: nausea, vomiting, diarrhea, gastrointestinal bleeding, gastrointestinal ulceration, tinnitus (ringing in the ears), vertigo, hearing loss, leukopenia (reduction of the number of white blood cells), purpura (haemorrhaging into the skin tissues), asthma, anaphylaxis (a potentially fatal allergic reaction), acute reversible liver damage and mental confusion. What treatment could possibly cause all of these side effects? Simple aspirin.

Weitz is even more misleading when he talks about death due to ECT. *Any* treatment requiring an anaesthetic will inevitably cause a certain number of deaths. The British memorandum quoted above states that the death rate in ECT is comparable to that of patients receiving anaesthesia for dental surgery. A recent study of ECT showed a rate of four to five deaths per 100,000 treatments. In England and Wales during 1963 to 1968 the death rate for inpatient dental surgery was about six per 100,000.

The vast majority of ECT given in Canada today is for severe depression. Untreated, severe depression can last for nine months or more, and in the days before ECT (1936), severely depressed patients languished in mental

hospitals for months. The death rate for suicide and other causes was sometimes found to be as high as 36% in untreated, severely depressed patients, compared to similar patients treated with ECT who had a death rate of nearly zero. There are a number of studies now that show that depression causes people to have a higher mortality rate generally, and that adequate treatment with antidepressant drugs or ECT can reduce the mortality rate.

The only treatment that a doctor can use for severe depression apart from ECT is antidepressant drugs. However, these drugs, while effective, are not as effective as ECT and often take three weeks or more to work. That is a long time for some patients to go through the hell of depression and risk committing suicide. Also, there is a lot of evidence that a certain proportion of patients just do not respond to the antidepressant drugs and the only way that they will get better is by ECT.

One glaring omission in the article is so-called unilateral shock therapy. This is a fairly recent change in method in which the shock is given on one side of the head only; this reduces the temporary memory loss to minimal amounts and should now be a standard procedure.

In conclusion, ECT does cause reversible memory loss. Some patients do complain of permanent loss of some memories, but these have yet to be measured by objective tests. Depression itself can cause difficulties with memory.

A recent study has shown that depression is common, affecting 5% or 6% of the population at a time, and that only one-quarter of the patients seek professional help. Most people who commit suicide are suffering from depression. The suicide rate in Canada and in the United States is not decreasing, and I think this is partially due to the fact that people with depression are not coming forward for treatment. Articles such as the one by Weitz will discourage patients even more from coming forward, and will therefore leave potentially suicidal patients untreated.

--David S. Heath, M.B.,Ch.B., F.R.C.P.(C.), Kitchener-Waterloo Hospital, Kitchener, Ontario

The Decision

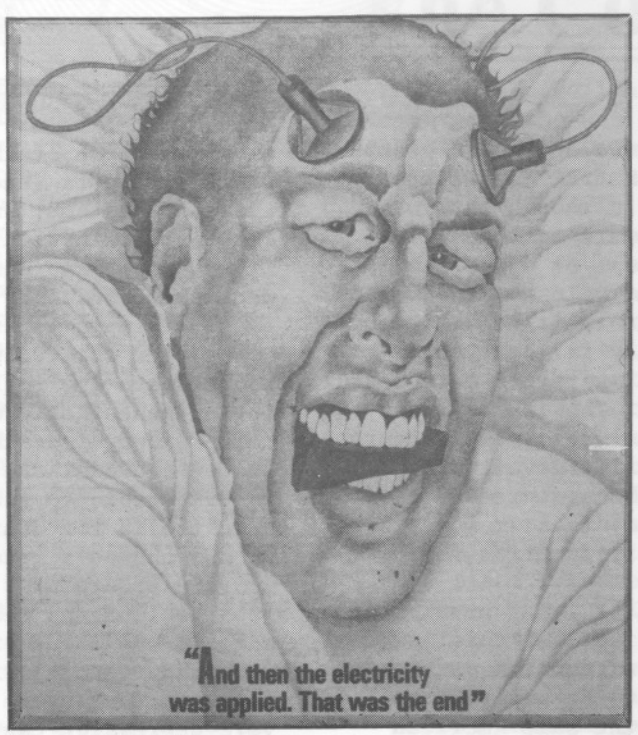
The Press Council does not believe that it should rule on the merits of any medical therapy, to say whether it is good or bad, effective or harmful. The scientific jury has yet to reach a consensus on electroshock therapy, and in examining Dr. Heath's complaint, Council members read and heard of strongly-stated conflicting opinions held by doctors, psychologists and psychiatrists.

The Council also emphasizes that it does not dispute in any way the magazine's right to publish an article expressing a point of view on any controversy. Society urgently needs full, vigorous and fair discussion of all controversial matters, certainly of any involving the functioning of the human mind, and the quality of human life.

In this case the complainant held that the article did not inform the public in a balanced way; that it could mislead or unnecessarily frighten people.

The magazine made it clear that in publishing the article it was promoting one point of view on the treatment. It also pointed out that the article did contain some reference to opposing views and that it had later published critical letters from Dr. Heath and from the Medical Advisory Committee of the Clarke Institute of Psychiatry, Toronto. The Council applauds the publication of these letters.

But the Council believes that the article erred in heavily dramatizing a case from the 1960s, including the use of an artist's very vivid picture, in basing much of its argument on treatment practices no longer followed, and in not giving a fuller picture of current practices and the opinions of many psychiatrists currently using the treatment with



The picture used in Don Weitz's article.

reported

Although the magazine had a right to take a position on the matter the Council believes that the magazine should have given more attention to evidence and views on the other side so it would inform members of the public adequately enough for them to make up their own minds.

The Council believes that on such sensitive issues all publications should endeavour to see that the public is as fully and fairly informed as possible, either by giving fair treatment to different views within the same article or in two articles published simultaneously.

In these respects the complaint is upheld.

The Ontario Press Council

The Ontario Press Council has been in existence since 1972, when, according to an early press release, it was formed to "deal with citizens' complaints" and to "work for the development of common ethical and professional standards".

The Press Council has changed little since those early founding days. It still retains as members the seven original founders (dailies owned by Southam Press Limited or Toronto Star Limited), plus one Southam-owned daily that joined after the Council was formed, and six independent weeklies.

Conspicuous by their absence continue to be the *Globe & Mail* and the Toronto *Sun*.

Weekend magazine, now called *Today*, is not a member of the Press Council. It is owned, however, by SouthStar, a company jointly controlled by Southam Press and Toronto Star Ltd.

From the first day of its existence, the Press Council has been both praised and damned for its performance and its mandate, modelled after that of the British Press Council.

"Having a press council is a mixed blessing," says Barry Zwicker, editor of *Content*, a magazine for journalists. "The existence of a press council has stimulated considerable debate, and that's good, but it may give people the impression that the press is changing the wrong when that may not be the case."

Zwicker admits that the Ontario Press Council has about as much power to enforce its judgments as the British Press Council--which is none. But giving the Press Council the power to enforce its decisions might also amount to the worst kind of censorship.

The structure of the council has also met with a great deal of criticism. At present it is composed of ten appointed members of the public, and ten representatives of the newspaper industry and member newspapers.

Hearings of complaints lodged against any newspaper are usually held behind doors closed to reporters and the public. Although there is a provision that these hearings can be held in public, none have been as of yet. Writers of articles in question can appear at the hearing and testify with the approval of the publication or of the Press Council.

Furthermore, the Council requests that the complainant sign a waiver should there be any indication of a possible suit being launched on the basis of what might be said during the hearing. This rules out any possibility of legal action by the complainant in future.

"We shouldn't expect much more from the Ontario Press Council," cautions Zwicker, "since most newspapers are owned by corporate entities. They'll engage in better journalism only if it increases their profits. We would probably have a healthier council if newspapers were owned in a variety of ways--and if the council had a preponderance of representatives from the public."

Persons wishing to register a complaint with the Press Council about its ruling concerning Don Weitz's article on shock therapy in Weekend *can write to: Fraser MacDougall, Executive Secretary, Ontario Press Council, 151 Slater St., Suite 708, Ottawa, Ontario K1P 5H3.*

California has the most stringent shock legislation of any North American state or province. The main provisions of the law are:
(1) If there is doubt about an inmate's competency to consent or refuse shock, a court hearing must be held to decide competency.
(2) The refusal of a competent inmate, or of the next of kin of an incompetent inmate, can not be overruled.
(3) The inmate must be fully informed of the nature of the "illness", the nature of the procedure, the probable effects and serious risks (including memory loss), the division of medical opinion about ECT, the reasonable alternatives, and the right to refuse. Consent must be in writing on a standard form.
(3) Consent may be withdrawn at any time.
(4) ECT may not be administered to anyone under 12 years of age, and may be given to those from 12 to 15 only if three psychiatrists unanimously testify to a review board that it is needed as a lifesaving treatment.
(5) In addition to inmate consent, two psychiatrists or neurologists (other than the treating physician) must certify that the treatment is indicated, and is the least drastic alternative available for the inmate.
(6) A doctor violating these rules may be fined up to $5,000 and/or lose his or her licence (in addition to being liable for damages to the inmate involved).

The Responses

Ann Rhodes is the editor of Today *(formerly* Canadian Weekend*). She wrote this letter to the Ontario Press Council in response to their decision.*

I have received the copy of your Executive Secretary's letter to Dr. David Heath and of the June 23 press release relating to the Council's finding in the matter of the complaint laid by Dr. Heath against the article on electroshock therapy published in *Canadian Weekend* on December 9, 1979.

Although I appreciate that OPC procedure does not allow for an appeal, I feel that I would be derelict in my duty if I did not express certain grave misgivings I have about the Council's decision and the press release.

I am most concerned about the penultimate paragraph of the press release which states that "on sensitive issues all publications should endeavour to see that the public is as fully and fairly informed as possible, either by giving fair treatment to different views within the same article or in two articles published simultaneously." This seems to me to be a virtual condemnation of advocacy jour nalism where "sensitive issues" are concerned and, given the great number of issues that could be defined as sensitive, does not bode well for the future of our craft.

The paragraph could also be said to be in conflict with an earlier statement: "The Council also emphasizes that it does not dispute in any way the magazine's right to publish an article expressing a point of view *on any controversy*." (Emphasis mine.)

The press release also does not make clear that our decision to publish the article was based on reports of *enduring* memory loss; hence the choice of Ted, who had undergone electroshock therapy 15 years earlier and who can still cite specific memory impairments.

The statement that our article "did contain some reference to opposing views" strikes me as an understatement. We directly quoted two proponents of the treatment and reported that the Canadian Psychiatric Association officially sanctioned its use while most members of the American Psychiatric Association approve of it.

Nor is it true that our article "based much of its argument on treatment practices no longer followed." It certainly described Ted's experience, but the argument was based on numerous findings following an extensive study of the literature, as our brief made clear; among the findings cited in the article were the experiences of two other patients and research done by numerous experts including Friedberg, Portnov and Fedotov, an APA task force, Schwartzman and Termansen, Cameron, Costello, Breggin, Frank, and Coleman. The findings of many of these experts are based on current or recent practice.

> I'd much rather have a small lobotomy than a series of electro-convulsive shocks. ...I just know what the brain looks like after a series of shocks--and it's not very pleasant to look at.
>
> --*Karl Pribram, M.D. "From lobotomy to physics to Freud...an interview with Karl Pribram," in* APA Monitor, *Sept.-Oct. 1974, p. 9.*

The statements in the release that (a) the central character in the article was being treated for schizophrenia and (b) Dr. Heath commented that electroshock is used only rarely for treating this illness combine to give the impression that *Canadian Weekend*, perhaps out of sheer ignorance, chose a rare occurrence to illustrate its thesis. Not so; the article made clear that the therapy is widely used in treat-

Canadian Shock Docs

In this issue, *PHOENIX RISING* is presenting its first roster of Canadian psychiatrists who administer or authorize shock treatments, along with their institutional affiliations. Listed psychiatrists who no longer use ECT, or who have mistakenly been included in the list, may notify *PHOENIX RISING* to have their names removed. Readers who know of shock doctors who are not on this list are invited to submit t their names and institutional affiliations. Names submitted by anonymous sources will *not* be listed (although we will withhold the informant's name).

Ananth, Jambur. McGill University School of Medicine, Montreal, Quebec.

Arndt, Hans. Northwestern Hospital, Toronto, Ontario.

Boyd, Barry. Penetanguishene Mental Health Centre, Penetanguishene, Ontario.

Brawley, Peter. Toronto General Hospital, Toronto, Ontario.

Eastwood, M.R. Clarke Institute of Psychiatry, Toronto, Ontario

Giles, Charles. Affiliation unknown, Edmonton, Alberta.

Heath, David S. Kitchener-Waterloo Hospital,

ing depression. The statement that we "cited current statistics about treatment of schizophrenia" is so vague as to further muddy the issue. Moreover, I believe it to be inadequate. We stated in our brief that surveys of three Metro hospitals revealed that schizophrenics formed 15.9% to 16.7% of those receiving electroshock--hardly a "rare occurrence."

In sum, apart from my main concern about the apparent condemnation of advocacy journalism per se, I feel strongly that the general impression left by the Council's press release is that *Canadian Weekend* rushed to judgement without conducting a thorough review of the evidence--a charge which I believe our written brief and oral presentation laid to rest--and that it published a far more biased, less well substantiated article than was in fact the case.

★ ★ ★ ★ ★

I am familiar with the controversy arising from the publication of "The Shock of Your Life" by Don Weitz in the *Canadian Weekend* (now known as *Today*), December 8, 1979.

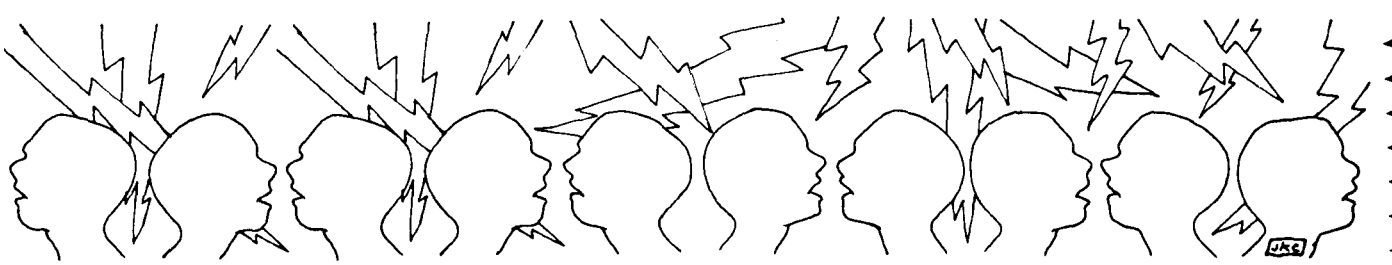
Recently Ms. Ann Rhodes, *Today*'s editor, forwarded me a copy of the Ontario Press Council's press release announcing its decision to uphold in part the complaint by Dr. David S. Heath that Mr. Weitz's article "did not inform the public in a balanced way, and as a result would mislead or unnecessarily frighten people."

My purpose in writing you now is to ask the Council to consider seriously reversing its decision in this matter for the following reasons:

1. In censuring *Today* for publishing Mr. Weitz's article, you have in effect charged Ms. Rhodes with journalistic irresponsibility. And what is the basis for this? That she has published a one-sided article on a controversial issue. The media have a clear right to publish without censure such articles, especially when an issue of vital concern to many people is grossly misunderstood by the public; indeed, the media have a responsibility to do so. Contrary to the Council's action, Ms. Rhodes and *Today* should have been praised for being among the first to bring to the public's attention certain extremely disturbing facts and opinions about electroconvulsive treatment (ECT) which the psychiatric profession has glossed over--more accurately, covered up--during the more than 40 years of use since ECT's introduction.

2. Your criticism of *Today* for not giving "different views within the same article or in two articles published simultaneously" is unfair. By providing 45 inches of space in the letters-to-the-editor section in a later issue, *Today* gave ECT proponents ample opportunity to rebut Mr. Weitz's position, thereby fulfilling its obligation to present both sides of a "sensitive issue."

3. In faulting the article for "basing much of its argument on treatment practices no longer followed," you have implied that current standard methods of ECT administration are safer and more effective. Modified ECT, as the current method is called, involves anaesthetic and muscle relaxant drugs. Some critics and proponents of ECT regard this method as more dangerous than the ones it has replaced. According to one proponent, "Although decreasing the rate of fracture complications, (muscle relaxants) unquestionably increase the chance of fatal accident." And while anaesthetics reduce pain, they raise the individual's convulsive threshold, thereby requiring a larger amount of current to produce the convulsion,



Kitchener, Ontario.
Hoffman, Brian. Clarke Institute of Psychiatry, Toronto, Ontario.
Jeffries, Joel. Clarke Institute of Psychiatry, Toronto, Ontario.
Kolivakis, Thomas. McGill University School of Medicine, Montreal, Quebec.
Lehman, Heinz. Mercy Douglas Hospital, Verdun, Quebec.
Littman, S.K. Clarke Institute of Psychiatry, Toronto, Ontario.
Piunick. St. Joseph's Hospital, London, Ontario.
Rudenburg, M. Affiliation unknown, Kingston, Ontario.
Shugar, Gerald. Clarke Institute of Psychiatry, Toronto, Ontario.
Sim, David G. Hamilton General Hospital, Hamilton, Ontario.
Solursh, Lionel. Toronto Western Hospital, Toronto, Ontario.
Zamora, Emil. St. Joseph's Hospital, Hamilton, Ontario.
Zelanko. Homewood Samitarium, Guelph, Ontario.

which in turn adds to the danger of brain damage and memory loss.

--*Leonard Roy Frank, San Francisco, California*

(Mr. Frank's book The History of Shock Treatment *is reviewed in this issue.)*

★ ★ ★ ★ ★

I have recently been made aware of the controversy surrounding the article by Don Weitz entitled "The Shock of Your Life", which was published in the *Canadian Weekend* Dec. 8, 1979. I have read the article and the letters that followed which were subsequently published, including Dr. Heath's.

Based on my personal experience and observations of the deleterious and damaging effects of ECT on numerous individuals, I believe that there is no justification for supporting the complaint of Dr. Heath and others.

In his article Mr. Weitz has presented information about ECT in a realistic and medically valid manner, even though presenting one particular point of view. He has provided an adequate amount of space in his article to opposing points of view concerning ECT and has clearly indicated the different forms of ECT (with or without anaesthetics). I believe the controversy that was raised an extremely healthy one and the complaints are invalidated more by the significant space allotted the numerous pro-ECT letters subsequently published.

There is a significant minority of psychiatrists who believe that ECT is "obsolete" (to quote from one study) and more emphatically a destructive and damaging procedure. There are also many, many silent physicians of all specialties who privately condemn the creation of electrically-induced seizures. I have witnessed countless abuses of individual rights, liberties, bodies and brains at the hands of the psychiatric system and I strongly support the view that each and every electrically-induced seizure creates permanent brain damage via the massive electrical short-circuiting of the brain's neural connections, and is to be avoided at all costs as with any form of induced brain damage.

With ECT there is really no ability to use informed consent, for once you have received one shock "treatment" you are so dazed, confused and disoriented that you cannot protect yourself from further insults. Thus I think there is even more justification for the public presentation of the long-standing controversy about the validity of creating electrically-induced seizures as a "tool" of improved mental health. The Ontario Press Council has found itself grappling with a media Pandora's box, which is typical of the numerous paradoxes of psychiatry--i.e., psychiatric hospitals or psychiatric prisons? treatments or tortures? healing or hurting?.

It is not feasible or necessary to recount more studies or more statistics in persuading you to reconsider your decision. However, as one who has had his eyes painfully opened to some of the horrible realities of ECT (compared to the psychiatric rhetoric of ECT), I feel strongly that Mr. Weitz's article was appropriate, accurate and a public service. The methodology, legitimacy and ultimate effects of ECT on brain, mind and spirit should be called into question and aired for public debate.

--*David L. Richman M.D., Berkeley, California*

(Dr. Richman writes a regular column on psychiatric drugs for Madness Network News, *under the pseudonym of "Dr. Caligari".)*

★ ★ ★ ★ ★

A year-long study conducted by the Food and Drug Administration in Washington during 1978-79 resulted in electroconvulsive therapy devices being reclassified from Class I to Class III, the category denoting high risk. Acting on its mandate to protect the public, the Food and Drug Administration recognized eight health risks in the therapy:

1) Burns: Excessive electrical current or improperly designed electrodes may cause

the patient's skin under the electrodes to be burned.

2) Pain: The patient is subjected to pain if the device fails to administer sufficient current to achieve a convulsive seizure.

3) Brain damage: Excessive or improper control of the applied electrical current may produce injury to the patient's brain.

4) Self-injury during seizure: Inadequate supportive drug treatment may allow the patient to be injured from unconscious violent movements during convulsions.

5) Aspiration: The patient may inhale foreign material, such as regurgitated stomach contents, if preventive procedures are not employed.

6) Adverse drug effects: The muscle relaxing and tranquilizing drugs that are part of the procedure may hamper the patient's ability to breathe spontaneously.

7) Cardiac arrhythmia: The therapeutic convulsions may be accompanied by irregular heartbeat or cardiac arrest.

8) Memory loss: The patient may suffer amnesia after the treatment.

The public has the right to factual reporting of these serious risks, and any ruling tending towards press censorship of this information would frustrate the principle of *informed* consent to treatment.

--Claude Labrie, Vice-Président, l'Association québécoise pour la promotion de la santé, St.-Hubert, Québec

(Editor's Note: We are pleased to see the American government recognize some of the dangers of ECT. However, the sole effect of this reclassification is to require manufacturers of ECT equipment to meet stringent manufacturing standards. This is, in our opinion, akin to requiring that thumbscrews be manufactured within a specified tolerance.)

To put it bluntly, I do not believe that we can scramble brains and expect to have anything left but scrambled brains.

--Anonymous psychiatrist. Quoted in Lawrence Kolb, M.D. and Victor H. Vogel, M.D., "The use of shock therapy in 305 mental hospitals," American Journal of Psychiatry *99 (July 1942), pp. 90-93.*

phoenix pharmacy

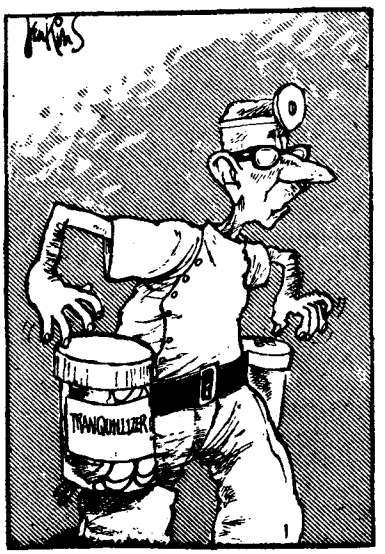
At our August business meeting, ON OUR OWN voted unanimously to support the boycott of *all* Smith Kline & French products, including the dangerous phenothiazines such as Thorazine and Stelazine. In doing so, they joined more than fifty groups already involved in the boycott (see *PHOENIX RISING*, v. 1, no. 2 for a partial list).

Other groups who wish to support the boycott should write to *PHOENIX RISING*, Box 7251, Station A, Toronto M5W 1X9, so that we can add your name to the growing list of boycott supporters. We plan to publish as complete a list as possible in our Winter 1981 issue.

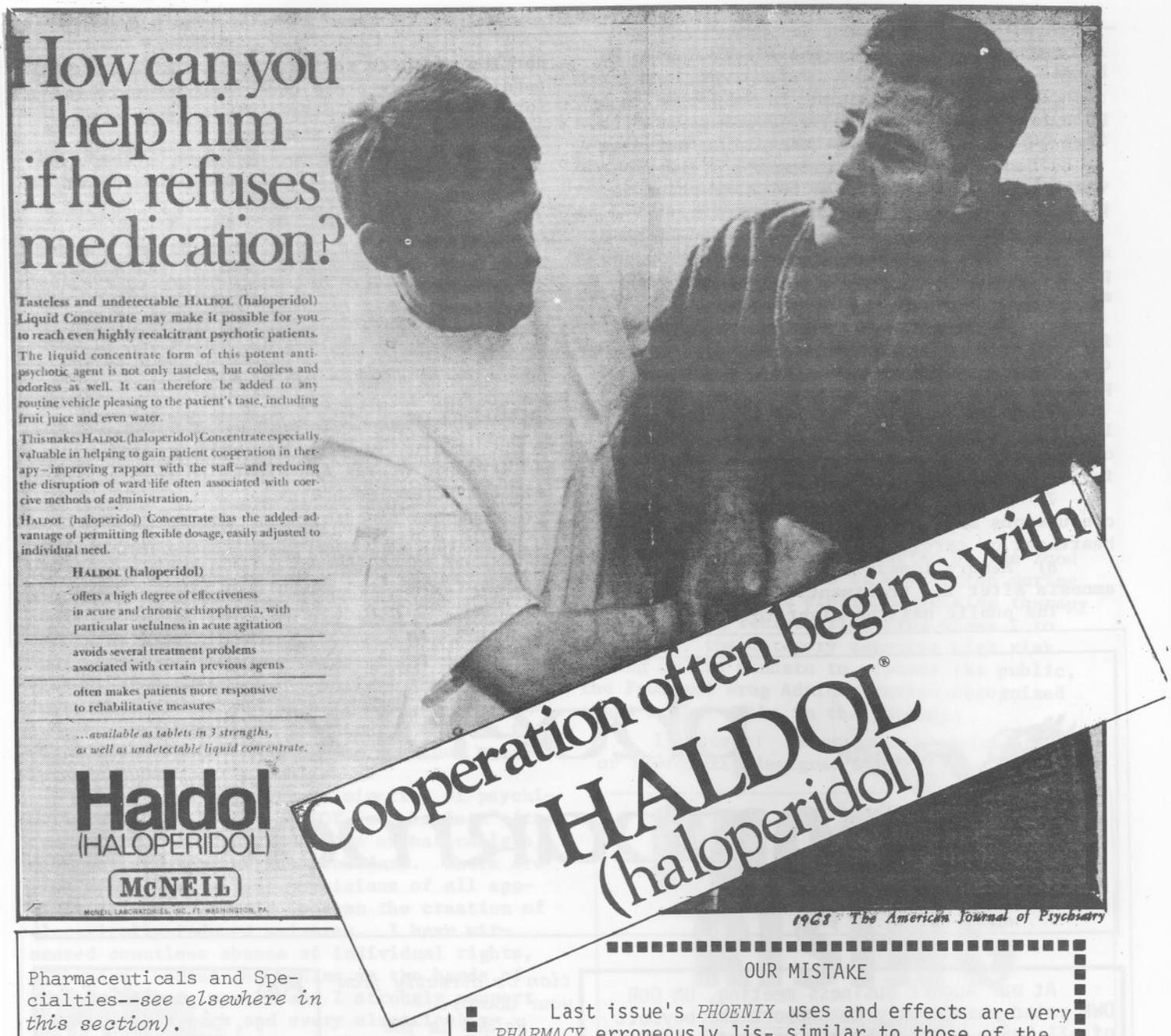
Haldol (haloperidol) has been on the North American market since 1966. Its patent is held by McNeil Laboratories. Haldol tablets, liquid or injections can be obtained on prescription or directly from your doctor.

Haldol is the drug implicated in the death of Aldo Alviani reported in this issue. Aldo's death is not the first to be associated with the drug.

As well, there is at least one clinical study showing that Haldol in large dosages (such as Aldo received) is no more "effective" than in small dosages (of the amounts recommended by the Compendium of



Tony Jenkins, The Globe & Mail, *Sept. 25, 1980.*



Pharmaceuticals and Specialties--*see elsewhere in this section).*

OUR MISTAKE

Last issue's *PHOENIX PHARMACY* erroneously listed Haldol (haloperidol) as one of the phenothiazines. Although Haldol's uses and effects are very similar to those of the phenothiazines, it is *not* a member of this chemical family.

Press reports of Aldo Alviani's death may bring other instances of drug abuse by psychiatrists into the open.

For example, the Toronto *Star* reported on October 7 that a Toronto woman, Frances Hunsley, would be examining her brother's medical files at the Queen Street Mental Health Centre in an attempt to find out why he died while on drug treatment as an outpatient.

The autopsy report on Gordon Hunsley stated that his system contained diazepam (Valium) and orphenadrine (a muscle relaxant).

Source: Compendium of Pharmaceuticals and Specialties, 12th edition, 1977 - published by Canadian Pharmaceutical Assn.

. . .

This is the official medical information Queen St. staff had when they overdrugged Aldo Alviani with Haldol on June 22-23, 1980. Aldo died of an overdose, after forcible injections of Haldol - 260 milligrams within 13 hours.

HALDOL® Ⓟ *McNeil*

Haloperidol ***Antipsychotic—Antiemetic***

Indications: The control of such target symptoms as anxiety, apprehension, hostility, mania, hallucinations, delirium, and psychomotor agitation, which, in varying degree, are commonly associated with emotional, behavioral and mental disorders such as schizophrenia, manic states and psychotic reactions or disturbed behavior in patients with chronic brain syndrome, alcoholic delirium, and mental retardation. Haloperidol has also proved effective in controlling the classic symptomatology (involuntary tics, vocal utterances, etc.) observed in patients with Gilles de la Tourette's syndrome, a rare behavioral disorder.

May also be used in obstetric patients to control nausea, vomiting, and apprehension associated with labor and delivery, and to augment the therapeutic effects of narcotic analgesics.

Contraindications: Parkinson's disease, depressive states, comatose conditions, patients with previous spastic diseases, during the first trimester of pregnancy and children under 3 years of age. Do not administer to patients known to be generally sensitive to drugs, nor to senile patients with pre-existing Parkinson-like symptoms.

Precautions: Haloperidol prolongs the hypnotic action of barbiturates and intensifies the primary effects of anesthetics and narcotics; caution should be exercised when it is used with agents of this type. Haloperidol does not potentiate the anticonvulsant properties of barbiturates, or other anticonvulsant agents, and has been reported to trigger seizures in previously controlled, known epileptics.

When instituting haloperidol therapy in patients who are also receiving anticonvulsant medication, the dose of the anticonvulsant should not be altered. Subsequent dosage adjustments may be required, particularly when haloperidol brings under control those psychotic symptoms which were responsible for precipitating the seizures.

Haloperidol has been reported to interfere with the anticoagulant properties of phenindione, and the possibility should be kept in mind of a similar effect occurring when it is used with other anticoagulants.

Elderly or debilitated patients receiving the drug should be observed for evidence of over-sedation which, unless alleviated, could result in complications, such as terminal stasis pneumonia.

Administration to patients with severe cardiac involvement should be guarded despite the fact that haloperidol is well-tolerated by patients with cardiac insufficiency and that it has been used with favorable results to maintain the cardiovascular function of patients with excitive crises. In very rare instances, it has been felt that haloperidol was contributory to the precipitation of attacks in angina-prone patients. Moderate hypotension may occur with parenteral administration or excessive oral doses of haloperidol; however, vertigo and syncope occur only rarely.

The role of haloperidol in the metabolism of cholesterol in man has as yet not been determined clearly. Mild transient decreases in serum cholesterol were reported in preliminary studies, but it has since been shown that haloperidol has no detectable effect on serum cholesterol levels in man. Haloperidol has lowered the level of cholesterol in the serum and livers of monkeys. An accumulation of 7-dehydrocholesterol has been observed in the serum of rats given repeated high doses (10 mg/kg) of haloperidol. However, 7-dehydrocholesterol was not observed in the serum of any of 45 patients examined for this intermediate sterol at an advanced stage in the chronic long-term administration of the drug. Skin and eye changes (ichthyosis and cataracts) have occurred clinically with a remotely related drug in the butyrophenone series.**. No such drug-related changes have been observed in patients receiving haloperidol. However, it is advisable that all patients receiving haloperidol for a prolonged period of time should be carefully observed for any changes in the skin and eyes. If such changes are seen the drug should be discontinued promptly.

Patients should be cautioned about the possible potentiation of alcohol by concurrent use of haloperidol.

**4-(3-azaspiro/5.5/undec-3/yl-4')-fluorobutyrophenone, a remotely related congener.

Adverse Effects: In the lower dosage range (1 to 2 mg daily), adverse effects from haloperidol have been infrequent, mild and transitory. In patients receiving higher dosages (4 to 15 mg or more daily), adverse effects are seen more frequently, as listed below:

Neurological: Neuromuscular (extrapyramidal) effects such as Parkinson-like symptoms, akathisia, dyskinesia, dystonia, hyperreflexia, opisthotonos and, occasionally, oculogyric crisis, are the most frequently reported adverse effects associated with the administration of haloperidol and appear to be more common than with the phenothiazine group of drugs. These reactions appear to be dose-related, since they subside when the dose is reduced or the drug is temporarily discontinued. However, there are considerable variations in the dose levels at which these symptoms may occur, and severe reactions may occur at low doses. Administration of an antiparkinsonian agent is usually, but not always, effective in preventing or reversing neuromuscular reactions associated with haloperidol.

Tardive dyskinesias: Tardive dyskinesia may appear in some patients on long-term antispychotic therapy or may appear after drug therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g. protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.

There is no known effective treatment for tardive dyskinesia; antiparkinsonian agents usually do not alleviate the symptoms of this syndrome. All antipsychotic agents should be discontinued if these symptoms appear. Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked. The physician may be able to reduce the risk of this syndrome by minimizing the unnecessary use of neuroleptics and reducing the dose or discontinuing the drug, if possible, when manifestations of this syndrome are recognized, particularly in patients over the age of 50. Fine vermicular movements of the tongue may be an early sign of the syndrome. If the medication is stopped at that time, the syndrome may not develop.

Behavioral: Insomnia, depressive reactions and toxic confusional states are the basic types of reactions encountered in this group. Drowsiness, lethargy, restlessness, agitation, anxiety and euphoria also have been reported.

Cardiovascular: Reports of tachycardia, hypotension and increased respiration have been rare. Severe orthostatic hypotension has not been reported. However, should it occur, supportive measures including i.v. vasopressors may be required. Epinephrine should not be used, since haloperidol may block the vasoconstrictor effects of this drug.

Allergic and toxic: The overall incidence of significant hematologic changes in patients on haloperidol has been low. Occasionally there have been reports of mild and usually transient leukopenia and leukocytosis, decreases in blood cell counts, anemia or a tendency toward lympho-monocytosis. Agranulocytosis has only rarely been reported with the use of haloperidol, and then only in association with other medication. With haloperidol, the hazard of liver toxicity is minimal. Reports of drug-induced liver dysfunction in one survey of 12,000 cases was estimated in the range of 0.1% and there was belief that this figure may have been even lower. One case of photosensitization is known and isolated cases of idiosyncratic cutaneous involvement have been observed.

Miscellaneous: Heartburn, nausea, vomiting, lactation and breast engorgement have been reported, but are rare. In early studies in which high doses were employed, anorexia and weight-loss occurred in some patients. Other untoward effects encountered include peripheral edema, salivation, blurred vision, dry mouth, constipation, dyspepsia, urinary retention, impotence, hypocholesterolemia and stasis pneumonia. A syndrome characterized by perspiration, dehydration, hyperthermia and a dazed state of mind (if this should occur the drug should be discontinued) was reported by one author.

Acute Toxicity: The oral LD_{50} of haloperidol in rats is 850 mg/kg. The lethal dose in man is not known. A 2-year-old child ingested 20 mg and recovered without ill effect.

Overdose: Diagnosis: Overdosage would most likely occur in adult psychiatric patients receiving medication for acute and chronic psychotic states or adults and adolescents receiving treatment for Gilles de la Tourette's syndrome. One should be alerted to the possibility of signs and symptoms of overdosage in patients receiving anesthetics, narcotic analgesics, CNS depressants, and anticonvulsant medications.

Symptoms: In general, the symptoms of overdosage would be an exaggeration of known pharmacologic effects and adverse reactions, the most

prominent of which would be: 1) severe extrapyramidal reactions, 2) hypotension, or 3) sedation. The patient would appear comatose with respiratory depression and hypotension which could be severe enough to produce a shock-like state. The extrapyramidal reaction would be manifested by muscular weakness or rigidity and a generalized or localized tremor as demonstrated by the akinetic or agitans types respectively. In the one case on record in which overdosage was observed in a 2-year-old child, hypertension rather than hypotension was observed.

Treatment: Gastric lavage or induction of emesis should be carried out immediately followed by administration of the universal antidote. Since there is no specific antidote, treatment is primarily supportive. Establish a patent airway by use of an oropharyngeal airway or endotracheal tube or, in prolonged cases of coma, by tracheostomy. Respiratory depression may be counteracted by artificial respiration and mechanical respirators. Hypotension and circulatory collapse may be counteracted by use of i.v. fluids, plasma, or concentrated albumin, and vasopressor agents such as norepinephrine. **Epinephrine should not be used.** In case of severe extrapyramidal reactions, administer antiparkinsonian medication. Diphenhydramine, 25 to 50 mg, administered intramuscularly, may be used to reverse dystonic reactions.

Dosage: To achieve optimal results and to avoid unnecessary adverse effects, the dosage should be based on the patient's age and physical condition, the severity of his symptoms, and his response to treatment. The lowest recommended dose should be used initially.

Oral: Dosages (given either in tablet form or by Haldol Concentrate in drop form in juices, milk, food or water) should be individually titrated in accordance with patient's response.** Initiate dosage based on severity of symptomatology (2 or 3 times daily) as follows: moderate, 0.5 to 1.5 mg; moderate to severe, 1.5 to 3 mg; very severe, 3 to 5 mg. Doses in excess of the above are seldom required. After a therapeutic response has been achieved, dosages should be gradually adjusted downward until a schedule providing adequate maintenance is reached.

Parenteral: When symptoms are severe or their rapid control is desired, haloperidol should be administered intramuscularly. Dosages in the range of 2.5 to 5 mg are recommended generally, and should be employed on a p.r.n. basis (but not more frequently than once every 4 to 6 hours) until the desired effect is achieved.** Thereafter, oral administration should be initiated in dosages described above.

**If adverse effects are encountered before the desired psychotherapeutic effect is obtained, one of the following courses of action may be taken:

(a) Maintain or reduce dose and initiate specific measures to counteract adverse effects. In the case of extrapyramidal reactions, the counter measure should consist of the administration of anti-parkinsonian drugs.

(b) Reduce dose and subsequently increase more gradually.

(c) Temporarily discontinue the drug; reinstitute therapy at a lower dose, and increase more gradually.

Children, debilitated and geriatric patients: Lower doses may be used in these patients since they may be more sensitive to the drug. Initial daily doses ranging from 0.5 to 1.5 mg (0.25 to 0.5 mg, 2 or 3 times a day) should be employed. Upward adjustment of these doses should be made gradually; maximum and maintenance doses should be individualized and are lower generally than those used for healthy and/or nongeriatric adults.

Obstetrics: A single i.m. dose of 2.5 to 5 mg administered during the first stage of labor with a narcotic analgesic usually provides adequate control of pain, apprehension, nausea and vomiting in most patients; occasional patients may require one or more additional doses of analgesics.

It should be remembered that haloperidol prolongs the hypnotic action of barbiturates and intensifies the primary effects of anesthetics and narcotics, hence caution should be exercised when it is used with agents of this type.

Supplied: Ampoules: Each 1 ml ampoule contains: haloperidol 5 mg, methylparaben 0.5 mg, propylparaben 0.05 mg, lactic acid sufficient to adjust the pH within the range of 3.2 to 3.5 and water for injection U.S.P. Should not be diluted with sterile saline. Available in boxes of 10 and 100 ampoules.

Drops: Each ml of colorless, odorless, tasteless solution contains: haloperidol 2 mg. Available in 15 and 120 ml dropper bottles.

Tablets: Each round, scored, uncoated tablet, biconcave with beveled edges, with diameter of 7.2 mm and thickness of 2.1 mm contains: haloperidol 0.5 mg (white), 1 mg (yellow), 2 mg (pink) or 5 mg (green). The 0.5 mg tablets are available in bottles of 100 and 1,000; other strengths are available in bottles of 100, 1,000 and 5,000.

(Tablets shown in Product Recognition Section)

profiles

Friends and Advocates

by *Pat Black* and *Cathy McPherson*

Recent studies in the field of psychiatry tend to show that people who cope well with crises have one important thing in common--a *friend or confidant*. This factor, along with a good social support system, reduces depression and maintains good mental health.

Friends and Advocates has been operating under these guidelines for nearly four years. Located in Etobicoke (a borough of Metropolitan Toronto), and funded by the Ministry of Health, the United Way, Metro Social Services, and the borough, the program offers support to people recovering from emotional and mental distress.

Volunteers and partners (those referred to the program) offer support through friendship to one another by caring, and by sharing fun and recreational activities. Most volunteers have had some experience with the problem of "mental illness" or have been psychiatric inmates themselves, although volunteers are not asked about their past history.

Volunteers are given orientation sessions before being matched with a partner. Pat Black (the co-ordinator) and two other community workers employed by Friends and Advocates then match up volunteers with people who have had psychiatric problems. They take into consideration the needs, interests and personalities of those involved. In some cases, partners end up becoming volunteers in another match.

Once volunteers and partners join, there is no differentiation between them in making their voices heard. The policies and direction of the program are decided by the group, both partners and volunteers, and the executive body is elected from this group at an annual meeting.

Friends and Advocates also has an Advisory Board, made up of two politicians, one community worker, a lawyer, and the co-ordinator of the Social Services Program at Humber College. They meet twice a year to give Friends and Advocates feedback on how they are perceived by the community, and to advise on fundraising. During the year they serve as resource persons.

While most members of Friends and Advocates come from Etobicoke or the west Toronto area (referred by hospitals, psychiatrists, social workers and acquaintances), people from any area of Toronto can join.

A word of caution, however. Friends and Advocates is presently swamped with partners in need of volunteers, and cannot take on any more people in that capacity at this time. Volunteers, on the other hand, are urgently needed to match up with the waiting list of partners.

Thos interested in joining Friends and Advocates, or wishing to learn more about it, can call 247-6116, or write to: Friends and Advocates, 25 Poynter Drive, Weston, Ontario M9R 1K8.

In last issue's article about the Eighth International Conference on Human Rights and Psychiatric Oppression, we reported that fifty people took part in the march on the San Francisco Civic Centre. This should have read a hundred and fifty people.

MPLF

(Information compiled from Acting Out *and* Madness Network News.*)*

The Mental Patients' Liberation Front (MPLF) of Boston is a grassroots group composed of present and former psychiatric inmates, along with those who have experienced the "community mental health" system and "outpatient care".

MPLF began about nine years ago when a few psychiatric inmates got together in Boston. One of their first projects was a legal handbook entitled *Your Rights as a Mental Patient in Massachusetts*. To distribute this handbook, MPLF visited many institutions. They also helped

begin inmates' rights groups, and continue to do so to this day. They have recently been attempting to get an ex-inmate group started in Concord, New Hampshire.

Since their founding meeting, they've published newsletters, organized demonstrations, and spoken openly about their own lives. They have had a drop-in centre, support groups, and a women's group. Sunday night meetings have

Ellen Shub

been held since their earliest days. MPLF also holds "Friends of MPLF" meetings open to the public, to create a dialogue between "mental health" workers and those who have experienced psychiatric treatment.

Members take shifts to staff their office, which is shared with the Disabled People's Liberation Front (DPLF), and co-ordinate time spent answering people's questions, working on projects, gathering information, and so on. Much of what they do is true advocacy work. People call up to find out about their rights, to complain, or to ask for practical assistance.

However, two deaths have recently devastated MPLF. David Regan, an active member, was killed by a hit and run driver while he was riding his bicycle to the occupation of the Seabrook Nuclear Power Plant in New Hampshire. (MPLF sent an affinity group to the attempted Seabrook occupation on May 24.) David had worked on MPLF's paper *Acting Out*, doing a lot of the layout and editing.

Another member, John Aleksiuk, died in April in very suspicious circumstances. Aleksiuk had done a lot of drug research for MPLF and had found some medical studies linking the phenothiazines to heart attacks. He was apparently taken to a private hospital in the Boston area by police with a court order, and was given at least one dose of Thorazine (a phenothiazine) because he was uncooperative. Within hours of his admission he was found dead in his isolation cell, with bloodstains on his head and on the wall beside the mattress on the floor.

MPLF has demanded an investigation into John's death, but as of yet none of the police, the district attorney or the attorney general's office has done anything. Private sources within the hospital have said that police bru-

(continued on page 40)

Rights and Wrongs

CONSENT TO TREATMENT IN PSYCHIATRIC SETTINGS

by *David Baker*

The power to treat someone in a psychiatric setting will be the most hotly disputed issue in mental health law for years to come. Doctors take the position that hospitals are places for treating the sick. According to their logic, a person in hospital is therefore to be treated.

This presumption of treatability conflicts sharply with the traditional civil liberty assuring an individual control over his or her body. In short, an unconsented-to medical treatment constitutes an assault.

For a consent to be valid, four preconditions must exist.

1. The consent must be given by a person who is considered legally competent to do so. Competency is an issue which is left up to the medical practitioner to determine. A substituted consent may be given by the person's next of kin should the doctor make a

finding of incompetency.

2. The consent must be specific. While the consent need not be in writing--indeed, it may be implied from the patient's actions--it must relate to a specific procedure and be performed within a specific time frame.

3. A consent must be informed. To be informed, the person giving the consent must be advised of the diagnosis, have the medical procedure explained, have possible risks and benefits outlined, and have alternate procedures described. In other words, all the facts necessary for an intelligent decision must be available.

4. Finally, the consent must be voluntarily given. While true voluntariness is difficult for persons who are incarcerated in prisons or psychiatric facilities, our law continues to assume that it is possible. Clearly, consents which are given as a result of inducements (e.g., "If you take this, you can leave the hospital") or threats (e.g., "Take this, or we will give you electroshock") are not valid. The dividing line, however, is difficult to describe in general terms.

There are three general exceptions to the rule that doctors must secure a valid consent prior to administering treatment:

1. A "medical privilege" emerged to protect the doctor who came upon an unconscious accident victim who would die if he did not receive immediate medical attention. The law assumes a person will be grateful for having been saved from death or serious physical impairment once he regains consciousness. It appears possible that courts would extend this principle to include people who are temporarily incompetent in cases of extreme medical emergency.

2. Under the *Mental Health Act*, a medical practitioner can "restrain" an involuntary patient. Restrain means "keep under control", so in theory restraint is quite distinct from treatment. However, the law clearly contemplates the use of chemical restraints, leading to the blurring of the distinction in practice.

3. Under the new *Mental Health Act*, psychiatrists can apply to the Mental Health Review Board to have a competent person treated against his or her will. The Board must be satisfied (a) that the mental condition of the patient will be or is likely to be substantially improved by the specific psychiatric treatment or course of treatment for the providing of which authority is sought; and (b) that the mental condition of the patient will not or is not likely to improve without the specific psychiatric treatment or course of treatment. Arguments about the validity of psychiatric treatment in general are probably doomed to failure, because psychiatrists sit on the Board.

As can be seen from the foregoing, psychiatrists possess large and increasing powers to treat people against their will. A person seeking freedom of choice in these matters should exercise his or her rights very carefully.

If you reject *any* psychiatric treatment, then the most appropriate remedy is to challenge your involuntary admission. For persons who are unhappy with the *prescribed course of therapy*, the following tactics might be explored: ask for more information about the therapy; explore all alternatives with the attending physician; request a second opinion from a doctor outside the hospital; make it clear you are not rejecting *all* forms of assistance; and if possible have a realistic alternative in mind. Be careful not to react violently, or the physician will exercise his power to restrain you. If the restraint power is being relied upon, ask for witnesses to be present, and indicate to these witnesses that you are resisting the *treatment* and not the *custody* of the physician.

Once you have given your consent to a procedure, remember that it can be withdrawn at any time up until treatment is administered.

If you can contact a lawyer, he or she might intercede on your behalf with the physician and, if necessary, the hospital administration. If this proves unsuccessful, then an application might be made to the court for an injunction to prevent the physician from treating you.

Finally, it should be remembered that once the treatment has been performed, this is not necessarily the end of the matter. If you maintain that the treatment was illegally performed, you might have a damages action against the attending physician and the hospital. It should be remembered that the law in this area is very unclear. Historically, courts have been hesitant to intervene in what are considered to be areas of medical expertise. Therefore, the likelihood of being successful against a doctor in such an action is small in any but the clearest of cases.

David Baker is a Toronto lawyer.

what's happening

Penalty box gets misconduct

Board of Education members in Halton were shocked to learn in early September of the practice of confining emotionally disturbed children in a dimly-lit four-foot-square "penalty box".

The time-out isolation room has been used as a form of behaviour modification by the George Kennedy Public School in Georgetown to control children between the ages of 7 and 12, with some success and much parental approval.

According to C.S. Lavender, the Director of Education for Halton, stays in the box averaged five minutes, with an adult supervisor immediately outside the door, and were done in consultation with a Board psychologist.

But, while Board members approved of the concept of separating children from their classmates when they are unruly, they decided to discontinue the use of the "penalty box". Use of the strap is no longer permitted in that school system.

Editor's Note: As we were going to press, we learned that the Ontario Ministry of Community and Social Services has banned corporal punishment and the placing of a child in a locked room as methods of discipline in group homes for children under their jurisdiction. The ruling applies to homes for children with emotional problems or physical handicaps, homes for the retarded, and children's "mental health" centres.

Investigating the MAP-makers

An investigation is being held by the Ontario Ministry of Health into allegations by the Church of Scientology and five inmates of St. Thomas Psychiatric Hospital that the institution is subjecting its inmates to harsh and untherapeutic treatment. At least four other hospitals have undergone such reviews in the past two years.

The inmates have sworn out affidavits that patients have been spending up to a year in a small crowded room, and were assaulted, kicked, hit and spat upon as part of their treatment in the MAP (Motivation, Attitude, Participation) program for the criminally insane. (See v. 1, no. 2 of *PHOENIX RISING* for a more in-depth treatment of this program.)

According to a story written by Toronto *Globe & Mail* reporter Douglas Yonson, they said that inmates were being punished for inappropriate behaviour by being kept for long periods of time on their knees, being bound hand and foot and tied to a mattress overnight or longer, or being subjected to "hours of confrontation".

The St. Thomas program is modelled after the

intensive therapy program for the criminally insane at Oak Ridge in Penetanguishene, and has been in existence for four years. Inmates committed to either institution under a Lieutenant Governor's Warrant can stay there indefinitely unless they agree to take part in the intensive therapy program.

Dr. Robert Coulthard, Chief of Forensic Service at the Clarke Institute of Psychiatry, has been given the job of conducting the independent (?) investigation. His report will remain confidential to protect the identities of the inmates who made the charges, according to a Ministry of Health spokesman, but will be rewritten and presented to the public in its altered form some time this fall.

Staff of the institution say they welcome the investigation because they feel that what they are doing is appropriate and medically correct.

CHUM exposes pill-pushing MD's

An undercover radio investigation team has revealed that two doctors in Parkdale have been handing out prescription drugs without question and with little or no medical examination.

CHUM-FM broadcast the results of its eight-month investigation in late August. The two doctors named in that broadcast were Dr. Dennis Kanhai and Dr. Abraham Skorbinski. One of the drugs most frequently handed out was diazepam (Valium).

CHUM reporters Tim Laing and Jeff Anderson began their investigation when a woman complained to them that her common-law husband had died of an overdose of prescription drugs.

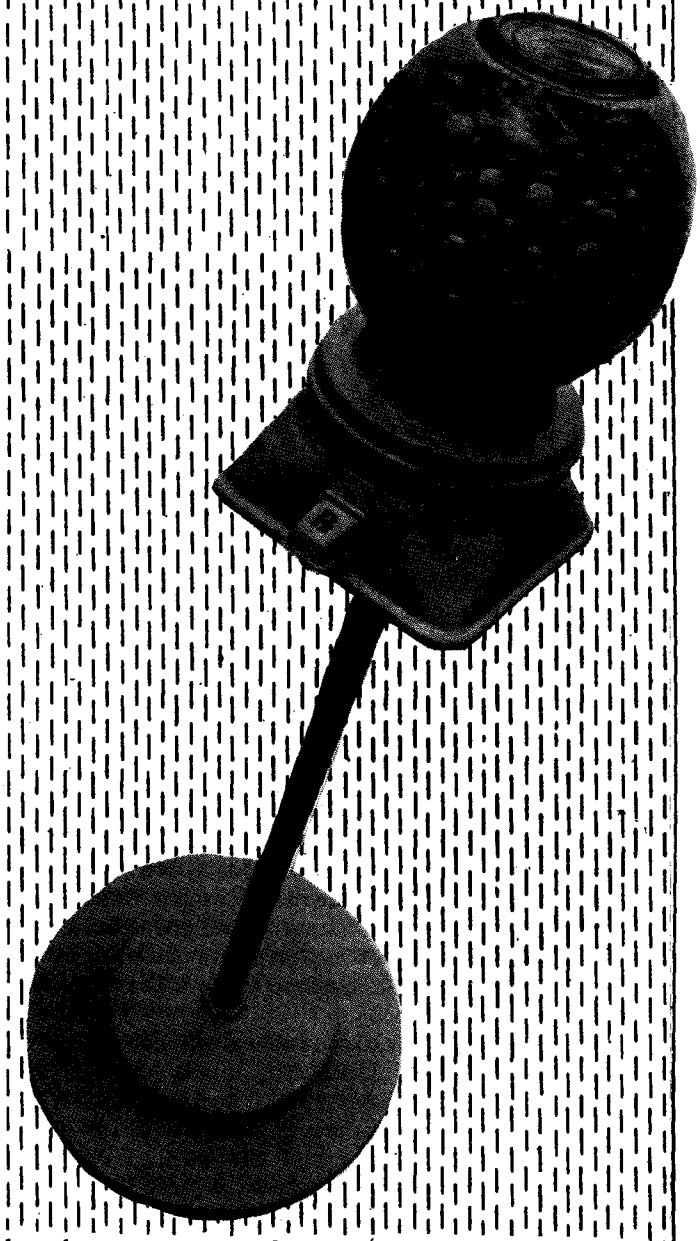
"The story went beyond just an overdose," says Laing. "It was a horror story of drug abuse and the ease with which he was able to get them that could have happened anywhere."

According to Laing, when the two reporters probed more deeply they found that he was seeing more than two doctors, but they decided to concentrate their investigation on the two because he was seeing them more often than the others.

One of the doctors in question had already been called before a disciplinary hearing of the College of Physicians and Surgeons of Ontario in 1978, and had been found guilty by that body of professional misconduct. He appealed that decision, however, and under College rules may continue his practice until the appeal is heard.

Since the broadcast, a number of agencies have contacted the reporters. The College of Physicians and Surgeons of Ontario and the College of Pharmacists of Ontario have asked for information and transcripts of the program for their own investigations. The Ministry of Health is having a check run on OHIP to find areas "where tightening can be done", according to Laing.

The police have also expressed interest,



but have not yet officially announced an investigation of the subject.

"We'll be continuing to do research and follow-up based on the contacts we made," says Laing, "and to follow the progress of the various agencies who have contacted us."

Feds warn Meds

Canadian doctors have been warned by the federal department of Health and Welfare that if they don't stop needlessly prescribing tranquilizers they will be forced by law to do so.

A directive orders doctors to reserve tranquilizers for only unusual high-stress periods, and then only for short periods--a week at the most.

The order came in September, after a study prepared for the department by eight top psychiatrists and pharmacologists found that Canadian doctors are too inclined to pass out the pills.

The cross-Canada committee was set up two years ago to look into the problem of over-prescribing.

Low cost housing for high profits

Low-cost housing in Parkdale for ex-psychiatric patients and other low-income people may become a thing of the past if the city takes a hard line against boarding and lodging house owners who are not meeting city standards.

Watchers of speculation buying predict that these owners will sell out to "white painters" or upwardly mobile professionals who want to live closer to the city core if they are taken to court to upgrade their properties.

"Damn right," says Anne Mason-Apps, journalist and long-time investigator of white-collar crime. "Certainly that was the pattern in South St. James Town and Cabbagetown."

Investigation by Alderman Gordon Cressy's boarding and lodging house committee last spring revealed the interesting point that operators running such establishments were close to making no profit at all.

"Until we do title searches on the properties and find out who's financing them, we can't say for sure," says Mason-Apps. But she has a strong hunch that the buying and selling of properties in the area and the rental of boarding and lodging houses follow a familiar pattern.

"A mortgage foreclosure, the properties go up on the block and are auctioned off by the sheriff. The trick is to have enough cash flow to float until you can resell for a profit," says Mason-Apps.

"Since the bachelorette cleanup, housing prices in the area have been depressed. Fortunes have been made on land in times of depression."

Bachelorette conversions of big old houses in the area drained Parkdale some years ago of much of its low-cost housing. What has remained has been largely small room rentals in the form of boarding, lodging or rooming houses.

But Cressy says his committee's recommendations for the cleanup of boarding and lodging houses in the area have repeatedly used the word "encourage" rather than "coerce".

"Certainly our goal is not to close houses; it is to get better programs going. The issue of enforcement will be left up to the city."

Cressy's cleanup campaign will be contingent, however, on whether he can get funding for the project from Metro or the province. Nowhere in the final recommendations is there mention of financial assistance in helping operators bring their houses up to city standards.

An implementation program will be put together some time in October. With city elections on the agenda for November, it seems unlikely that much of the above scenario will take place before spring.

No place like home?

The operator of a boarding home housing 24 former psychiatric patients in Whitby has been charged with common assault after allegedly hitting a woman in the home across the arm with metal stripping from a door.

Charges were laid when a worker in the home complained to a local health officer about the actions of operator Hildegard Kahl. But, despite a subsequent 4½-hour surprise raid by York Regional Police, officials say there is little they can do to close down the home. There is no provincial legislation to regulate boarding or rest homes in Ontario; municipalities are responsible for setting standards.

Baldwin Rest Home lost its licence under Ontario's Homes for Special Care program several years ago. Since 1973, two residents have died at the home, and relatives have complained of the unusual abuse residents have received.

During the raid officials found open unlabelled drug containers, several mistakes in medication, and fire and health infractions.

Low quality food was being served to residents.

Despite the home's bad record, one worker at Baldwin said that Whitby Psychiatric Hospital had been sending it patients on a regular basis. Owen Slingerland, Officer of Health from York Region, met last spring with Michael O'Keefe (then Whitby's administrator) and an official from the Ministry of Health to talk about conditions at the home, but neither believed him.

O'Keefe is now administrator of North Bay Psychiatric Hospital.

Residents had been paying up to $14 a day to stay at the home, and were given $3 a week by the operator as pin money. Mrs. Kohl charged residents for coffee at coffee breaks.

Drug victim wins half million

(reprinted from On the Edge, *v. 1 no. 4)*

Henry Tucker, a Virginia prisoner, who will be confined to a wheelchair for the rest of his life, was awarded $518,000 in January 1979 as settlement in a suit he brought against 19 officials for medical and psychiatric malpractice and mistreatment. Large doses of Prolixin Decanoate administered to him during the last half of 1976 resulted in "permanent paralysis of his arms and legs as well as other irreversible physical problems". *(Prolixin is known in Canada as Moditen.)*

Kate Thompson, *Women's Press*, July/August 1976

Bonnar "unfit" for what?

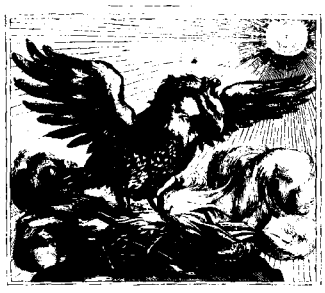
There have been some developments in the case of Emerson Bonnar, reported in v. 1 no. 2 of *PHOENIX RISING*. Mr. Bonnar, at the age of 19, was incarcerated in a maximum-security mental institution in 1964, after being found unfit to stand trial on a purse-snatching charge. He is still being held, 16 years later.

In February, two independent psychiatric assessments of Mr. Bonnar were carried out, one by the New Brunswick government and one by the Canadian Association for the Mentally Retarded (CAMR). Both assessments concluded that: (1) there were errors in the original finding of unfitness; (2) he is not a dangerous person, but, because of being treated as dangerous, he has become "severely institutionalized"; (3) the Review Board has consistently confused the question of dangerousness with the question they are *supposed* to be considering--his fitness to stand trial; (4) an intensive rehabilitation program should be provided, instead of the total lack of stimulating treatment he has been receiving (his "treatment" has consisted of medication, isolation, and the opportunity to sweep the floor once a day); and (5) he is fit to stand trial. They recommended that the warrant should be vacated, and that Mr. Bonnar should be civilly committed near his home during a rehabilitation period before being released.

The Board of Review rejected many of these findings, although agreeing with the recommendation for rehabilitative treatment. A new warrant has been signed, authorizing temporary transfer to another institution with the permission of the Administrator.

The provincial Minister of Justice issued a public statement that Mr. Bonnar was not yet fit to stand trial, and that the warrant would therefore not be discharged. He admitted on questioning that there was no longer any point in trying him, since after 16 years they would be unable to produce the necessary evidence.

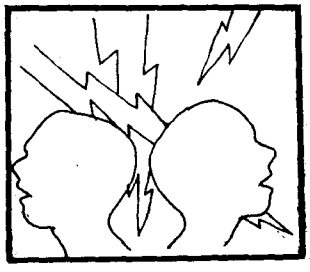
In other words, Emerson Bonnar is still being held--on the grounds that he is not fit to participate in a trial that will never be held, and in disregard of the findings of two different independent psychiatrists that he is fit, and that his problems are largely the result of being imprisoned for 16 years.



the Book-Worm turns

Shock Treatment Is Not Good for Your Brain, by John Friedberg. San Francisco: Glide Publications, 1976, 176 pages, paper $6.95.

Reviewed by *Jo-anne Yale*



During the term of his residency in neurology at the Pacific Medical Centre, John Friedberg placed an ad in two of the local newspapers which basically stated that shock treatment is not good for the brain, and that he would like anyone who had undergone such treatment to contact him. He had previously been present while shock treatment was being administered to psychiatric inmates, and he was becoming increasingly suspicious of ECT (electroconvulsive therapy). He questioned the usefulness of such treatment, and when he researched ECT further he uncovered information which substantiated his claim.

The results of Friedberg's ad were twofold.

First, he was able to glean very valuable information from several people who permitted him to interview them on their experiences as recipients of ECT. Chapters Four to Ten of his book are comprised of seven interviews, which were very personal in nature. One of the people interviewed thought that ECT had really helped her, in that it relieved her from the stress and guilt she had felt previously. The other six people believed that their shock treatment experiences had left them with varying degrees of memory loss, inexpressibly severe headaches, confusion, and the need to re-learn various skills, along with other disturbing side effects. And, with regard to the fear of shock treatment itself, one person said:

> *EST is a cruel if not unusual punishment for which there has been no crime. ...It is a series of death sentences, each of which is almost, but not entirely, carried out. There is no trial, no jury; there is merely an executioner, one who is excellent at near killing. There is the anticipation of death, the terrible wait and sound while others are punished, and finally your own turn. In that eternally long fraction of a second while electricity is ripping apart your being, the searing pain begins in your temples but quickly disperses to every nerve-ending in the body. You pray that you will die quickly.*

Second, his public statement against ECT led him to learn, very quickly, that challenging the usefulness and effectiveness of ECT is like attacking the sacred cow. In fact, many psychiatrists used ECT, not because they found sufficient evidence of its tangible positive results, but rather because it had been a recognized method of treatment for a substantial number of years. He learned that

> *doctors fight with the weapons they are taught to use, and psychiatrists often instinctively wield the stigmata of mental illness against those they dislike or with whom they disagree, and they usually succeed because defining craziness is their business.*

Shortly after his ad appeared, John Friedberg was urged to discontinue his research, and was given the ultimatum that he either go into psychotherapy or be dismissed from his position at the Medical Centre. He refused to back down, and instead, after his dismissal, he fought for what he believed in, and sought more and more evidence to prove his point. The first two chapters of his book talk about his struggle, and the many hardships he underwent as a person black-listed by several very powerful people.

Doctor ECT's Treatments

by *June Bassett*
(one of Dr. ECT's victims)
contributed toward the battle

A simple, efficient, lucrative way
to eliminate gradually a troublesome brain
while retaining good public relations
and remaining unpunished for same.

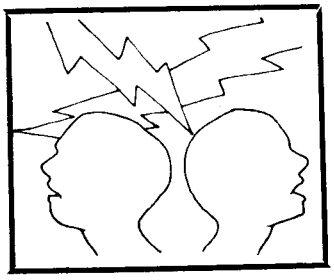
Needless to say, if you're looking for well-documented material on ECT, it's all there in the book; if you're looking for personal opinions and experiences, you'll find plenty of those as well.

Usually non-fiction books do not hold my attention. However, John Friedberg's courageous efforts to fight against a treatment on which much of psychiatry is based won me over. I felt an ability to identify with him, and if *you* are striving for an equal position and a voice in society, you would most likely share our common bond.

I strongly recommend that you read this book, and that, in fact, it should be required reading for those people entering the field of psychiatry.

The History of Shock Treatment, edited by Leonard Roy Frank. San Francisco, 1978, 206 pages, paper $6.00.

Reviewed by *Don Weitz*



Leonard Frank has earned credibility the hard way. As a former psychiatric inmate and shock victim, he has survived roughly 80 electric shock and insulin coma treatments in California.

Frank is a co-founder of NAPA (Network Against Psychiatric Assault) and BACAP (Bay Area Committee for Alternatives to Psychiatry) and a prolific and articulate writer on the abuses of shock treatment and other forced psychiatric "treatment". His History of Shock Treatment is a compelling and brilliant exposé of the psychiatric punishment or atrocity commonly called electroconvulsive therapy (ECT).

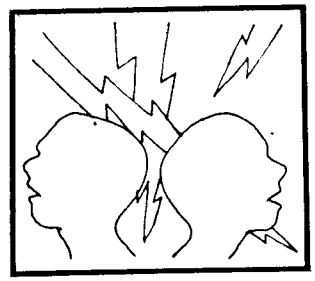
Frank has organized a wealth of documentary evidence on electric shock from 47 A.D. right up to 1977. It's all here: the bland but chilling clinical accounts from medical and psychiatric journals; the pompous, self-righteous statements by pro-shock doctors extolling the "benefits" of ECT, which in themselves are condemning; painfully personal accounts of what electric shock felt like and what it did to them from scores of victims; consciousness-raising cartoons, illustrations and photographs; poems by ex-inmates; obscene ads pushing the latest and most "effective" shock machines, anti-convulsant drugs and muscle relaxants; an "ECT Death Chronology" listing reports of 384 deaths related to ECT as of 1977; a partial "Shock Doctor List", which includes the names and hospital affiliations of 265 doctors who have used shock; a 35-page glossary clearly defining many key psychiatric terms; and two bibliographies.

Remember the shock scene in One Flew Over the Cuckoo's Nest? Frank's book is even more horrifying, and forces the reader to take a stand.

Copies available from ON OUR OWN or directly from Leonard Frank (see notice elsewhere in this issue). Also on sale at the Bob Miller Bookstore in Toronto.

Electroshock: Its Brain-Disabling Effects, by Peter Roger Breggin, M.D. New York: Springer, 1979, 244 pages, about $22.50.

Reviewed by *Carla McKague*



Peter Breggin is one of a rare breed--a psychiatrist with an abiding concern not only for the well-being of psychiatric inmates but also for their human rights. For a number of years he has been a leader in the fight against psychosurgery in the United States.

More recently, Dr. Breggin has turned his attention to another evil of psychiatry--shock treatment. One of the results is Electroshock: Its Brain-Disabling Effects.

Breggin's book lacks the personal touch of John Friedberg's Shock Treatment Is Not Good For Your Brain, and the gripping immediacy of Leonard Frank's patchwork quilt of words and

George Bjorgen, *Minneapolis Star*

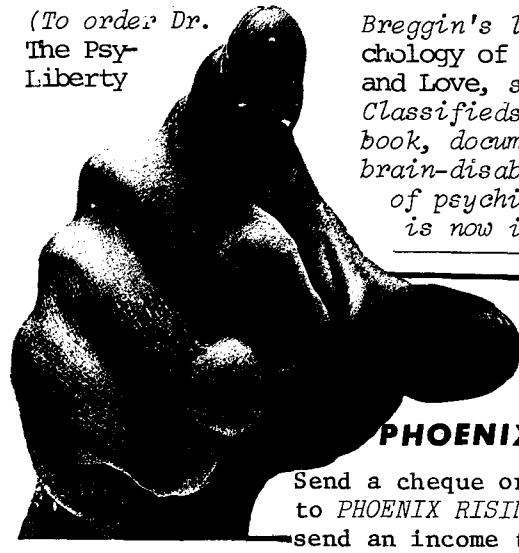
pictures, The History of Shock Treatment. But it more than compensates for these lacks with its thoroughness and authority.

Breggin provides masses of information on ECT, citing and discussing virtually every study ever done on the subject. Animal studies, human autopsy studies, neurological studies, memory loss studies--all are examined in detail to substantiate his claim that ECT, far from doing good, disables the human brain. He also talks about the victims' fear of ECT and other psychological reactions to the treatment.

Breggin is at his best in the chapter devoted to six case studies of the effects of ECT. He describes vividly the subjects' memory losses and loss of intellectual functioning, and the "shame and anguish" they feel as a result of this impairment.

Perhaps the strongest evidence that proponents of shock have to support their claims that ECT is virtually harmless is a study by psychologist Larry Squire which purports to show that ECT does not cause long-term memory loss. Squire's work has been attacked by a number of people, but never more devastatingly than by Breggin. Breggin was involved in the examination by a number of specialists of an ECT victim in whom Squire had found no memory loss. He details the massive brain damage and intellectual and emotional losses suffered by the victim, and the conclusions of the examiners that there appeared to be no explanation for this damage other than ECT.

Anyone seriously interested in understanding what ECT does to the human brain and body cannot do without this book. It is a long-needed and priceless contribution to the cause of abolishing ECT from the repertoire of psychiatric control techniques.



(To order Dr. Breggin's latest book, The Psychology of Freedom: Liberty and Love, *see our Classifieds. Another book, documenting the brain-disabling effects of psychiatric drugs, is now in manuscript.*

ANNOTATED ANTIPSYCHIATRY BIBLIOGRAPHY (THIRD INSTALMENT). Prepared by *Don Weitz*.

Breggin, Peter Roger. *Electroshock: Its Brain-Disabling Effects*. Springer (1979). See review in this issue.

Coleman, Lee. "Introduction" in Leonard Roy Frank (ed.), *The History of Shock Treatment* (see below). A powerful denunciation of shock treatment in particular, and forced psychiatric treatment and institutional psychiatry in general, by a psychiatrist who is co-founder of the Committee Opposing Abuse of Psychiatry in California.

Frank, Leonard Roy. "The Frank Papers" in John Friedberg, *Shock Treatment Is Not Good For Your Brain* (see below), pp. 62-81, and in *Madness Network News*, December 1974, pp. 12-17. A victim of roughly 80 insulin and electric shock treatments, Frank exposes the biased and fraudulent nature of institutional psychiatry by publishing his own medical records and notes on his forced treatments.

The History of Shock Treatment. Self-published. San Francisco (1978). See review in this issue.

Friedberg, John. "Electroshock therapy: let's stop blasting the brain," in *Psychology Today*, August 1975, pp. 18-24. A US neurologist's opening blast against the "effectiveness" of shock treatment. A good and brief introduction to this controversial issue.

--. *Shock Treatment Is Not Good For Your Brain*. San Francisco: Glide (1976). See review in this issue.

Janis, Irving L. "Psychological effects of electric convulsive treatment," in 3 *Journal of Nervous and Mental Diseases* (1950), 359-382. One of the most carefully controlled follow-up studies by an outstanding psychologist, clearly showing the massive memory loss 2½ to 3½ months after treatment. A classic--destroys the psychiatric myth of temporary memory loss after ECT. Required reading for shock researchers.

Mental Patients Association. *In A Nutshell* (shock issues: v. 4 no. 1 (Feb. 1976) and v. 6 no. 5 (1979)). Consciousness-raising information put together by MPA's Committee to Investigate Shock Treatment.

Plath, Sylvia. *The Bell Jar*. New York: Harper & Row (1971). A painfully personal and sensitive novel based on the author's own experiences with breakdown, shock treatments and other institutional experiences. (Plath later committed suicide.)

Rice, Marilyn. "The Rice Papers," in *Madness Network News*, April 1975, pp. 4-8, and in Leonard Roy Frank (ed.), *The History of Shock Treatment* (see above). A personal and tragic account of a brilliant woman's intellectual and memory losses after shock treatment, and her losing court battle against her shock doctor.

letters cont.

to get a project like the *PHOENIX* from the dream stage to its present shape. You have my complete respect and admiration because you've done a fantastic job, not to mention a great service to the men and women who carry the burden of EX-MENTAL-PATIENT about with them like some poor poisoned thing. It's now the turn of the SHRINKS to bow their heads in shame.

--Roger Caron, Hull, Quebec

(Roger Caron's Governor-General's-Award-winning book, Go-Boy!, *was reviewed in* PHOENIX RISING, *v. 1, no. 2.)*

I have finally managed to read all of Vol. 1 No. 2 of *PHOENIX RISING* and was very much impressed with it. You have a superb magazine.

I told you in my last letter that from all that I've heard from friends, psychiatric hospitals were probably worse than prisons. Your magazine has convinced me that what I thought was true.

In fact, it kind of made me embarrassed for calling them psychiatric hospitals. A better term would be psychiatric or mind prisons. Certainly the same type of people run both.

Some of their methods might be different but the result they are looking for is identical. Total control and dependence. I attempted to call the people running prisons "crime pimps" but had the term censored from my correspondence. "Mind" or "brain pimps" would be a very good description or title for the people living off the avails of people's minds.

It is kind of strange that all of them use the term "rehabilitate" to justify their existence. Goering also used the same term when he opened the concentration camps in Germany. "I instructed the controllers of the camps that they should be used not just to deprive men and women of their liberty, but to re-educate and rehabilitate them."

That type of statement must be very familiar to you. In the time I've been in prison I think I've heard a similar statement from just about every crime pimp in the country. Judges, Wardens, Parole Officers, Psychiatrists, Psychologists, Social Workers, you name them; they've said it.

It is for that reason that prisoners have so very much to learn from ON OUR OWN. Only by ourselves will we be able to get rid of the shackles, whether it be of the mind or physical. For sure, the parasites aren't going to work themselves out of a job.

I don't have to wish you luck. You already have it all together.

--Tommy Smith, Odyssey Group, Millhaven Penitentiary

"As the debts have mounted so has the desperation."

Ten years ago I was teaching, enjoying a fair amount of success, when the stress and pressure built up to a point where I crashed headlong into a hospital with an emotional crackup.

I recovered after a long battle and entered a new phase of my life. I began writing for the print media; my marriage got better, and my wife in the space of three years presented me with two healthy daughters.

I continued to take medication as needed and to see a doctor when I felt it necessary. But largely, needless to say, my life and my outlook improved. Gone were the doubts about myself, the gnawing fears, the doom and gloom, the negative feelings and thoughts, the hostility, the pain, and the hiding.

Then the firm I worked for went bankrupt. Because of my age (40), education (university degree), experience (12 years of work), or whatever, no one was interested in hiring me or even interested in listening to me.

My wife has a physical disability; she's unable to work. My unemployment insurance ran out. I now and then was able to obtain temporary jobs at minimum wages. We even went on welfare twice. Tensions and stress mounted, and I have grown more irritable and defeatist. Yet I have clung to a belief that everything will turn out right in the end.

My friends deserted me, as did my relatives; my former colleagues in the print media turned their backs on me. As the debts have mounted, at times so has the desperation.

Compounding all this is the disaster governments at the provincial and federal levels have created with the economy, making jobs scarcer.

--Name withheld

In his article "Blindness: More Than Meets the Eye" (v. 1, no. 2), Mike Yale comments: "Many handicapped persons are conditioned to be quiet and respectful, to be passive and accepting of hand-outs or token rights, and apathy and resignation remain all too common today."

Despite these impediments, the 1970s saw the establishment and growth of many self-help groups "of" the disabled, including BOOST (Blind Organization of Ontario with Self-Help Tactics), ON OUR OWN, COPOH (Coalition of Provincial Organizations of the Handicapped), and many others. These organizations have provided many disabled citizens with their first opportunity for self-expression and to be directly involved in decisions which affect their daily lives and overall quality of life.

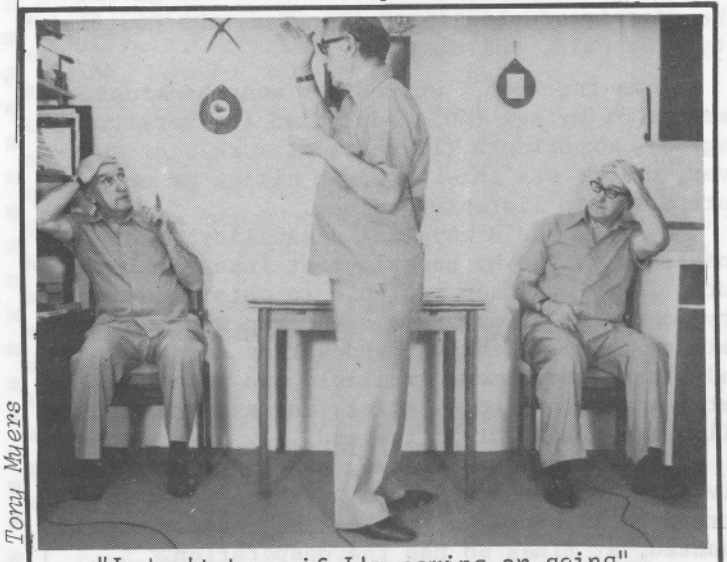
dirge for a manic depressive schizophrenic

anonymous

In the midnight of my mind,
I am in a box, with the lid nailed down,
There is no grass to grasp
Or air to breathe,
Only a pulse

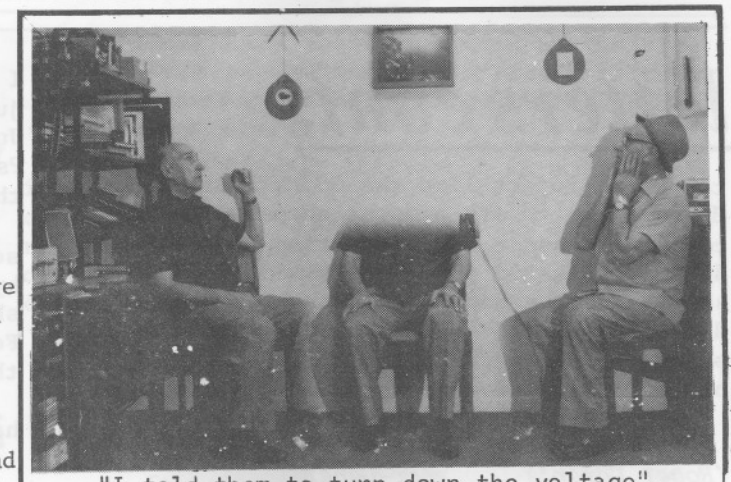
Life, radiating life,
Fill, all, the hollows
With pure pure gold,
Pinks and blues, chiffon and silks, fragrance and petals, violets and daffodils
and let me live a time again.

While many groups of disabled Canadians must confront their own particular part of the unrepresentative Agency System, this disenfranchisement is being increasingly resisted by the blind. We must deal with the CNIB--supposedly "our Agency"--a national, monopoly service-provider which is perceived as one of our society's major "sacred cows" by too large a segment of our population.



Tony Myers

"I don't know if I'm coming or going".



Tony Myers

"I told them to turn down the voltage".

BOOST has recently released a comprehensive 289-page report entitled "Self-Help and Government Commitment: A Call to Action", which contains over 325 separate recommendations and a detailed plan for their implementation. The report's recommendations include: establishment of a quota scheme for the hiring of qualified handicapped people; introduction of a comprehensive national employment strategy; provision of reliable core funding to the self-help movement; entrenchment of rights for the disabled in a new Canadian constitution; the enactment of comprehensive human rights protection at both the federal and provincial levels; a gradual ten-year phase-out of the CNIB; and greatly expanded involvement of disabled consumers in the planning and execution of all policies and programs which affect our daily lives.

For too long, agencies "for" the disabled have raised countless millions of dollars in our names, have provided services to us, but have failed to involve us in determining Agency priorities. We are no longer prepared to stand for this blatant denial of our civil and human rights. If disabled Canadians are to achieve true integration during the 1980s, we must become far more outspoken and begin by demanding the return of our civil and human rights which the Agency System has stolen from us. Only through the direct involvement of disabled citizens in all aspects of regular community life, including the planning process, will disabled Canadians achieve our goal of true integration. It's up to us. Waiting for others to do it for us has woefully failed.

--John Rae, Toronto

(John Rae is past president of BOOST.)

My Psychotherapy

by *Delana Munroe*

You said I was sick because I went to MIT when only forty-five women did so
And you thought there was hope because I breast fed my son for eight months, encouraged him to become a doctor and did exquisite needlepoint
You said I was sick when I fainted from anemia
And you encouraged me to donate blood to the Red Cross
You said I was sick and a clever cheat when psychological tests said I was normal
And you hospitalized me against my will
You said I was sick because my husband was impotent
And you propositioned me and later became a family therapist
You said I was sick and a rebellious wife when I refused to repair a TV for fear of being electrocuted
And you recommended shock treatments for discontented wives
You said I was sick because my psychopathic husband beat me
And you tore the clothes from my body and locked me in a room without furniture when I cried
You said I was sick and should confide in you because you were trustworthy
And you violated the Nuremberg Code and the Mental Health Act
You said I was sick because I did volunteer work
And you charged forty dollars an hour because you were a dedicated doctor
You said I was sick and depressed
And you ordered me to stop joking
You said I was sick and abused chemicals because I had one drink when twelve others each had three
And you prescribed twenty-five different drugs
You said I was sick because I had an IQ of 170 and was studying psychology
And you borrowed my books
You said I was cured when I got a degree in psychology and a divorce
I said I was cured when I encouraged my son to become an architect
And refused to work for you because
Freud was a fraud
Jung was a Yahoo
Adler was addled
Sullivan was schizophrenic
Reich was randy
Maslow was maudlin
Perls was a pushover
and
You were fascists
Of course, I was speaking strictly as a professional

CLASSIFIEDS

We invite the public and members of ON OUR OWN to submit ads for this section. Rates are $2.50 for each 25 words or less. Members of ON OUR OWN may advertise FREE up to 25 words. Cash, cheque or money order must be received before advertisements are published. Mail your ad with payment to: Classified, *PHOENIX RISING*, Box 7251, Station A, Toronto, Ontario M5W 1X9.

PUBLICATIONS & FILMS

BULLDOZER. "The Only Effective Vehicle for Prison Reform."
Prisoners Solidarity Collective, a self-help group of ex-prisoners and supporters, has just published a newsletter with the above title. The contents are all (except the editorial) written by prisoners fighting the state's use of Special Handling Units, skin frisks, involuntary transfers, and other efforts to control prisoners and disrupt organizing activities. Letters, comments and donations welcome. Write for a copy. $1. Free to prisoners, including psychiatric prisoners.

A new film is available from DEC--it's called *Alternatives to Hysteria*, and it examines aspects of psychiatric care in Canada, dramatizing the experiences of a woman in Sudbury and a traditional psychiatrist. Call 964-6560 for information on rentals.

PUBLICATIONS & FILMS

The Psychology of Freedom: Liberty and Love, by Peter Roger Breggin, M.D., a leading critic for the movement, is now available for $12.95 plus mailing. Send your cheque or money order to: Lake House Books, Box 5919, Washington, DC 20014, USA.

A booklet titled *Mental Health and the Law* is now available. To order, send $4.10 to Community Legal Education Ontario, 111 Queen St. E., Suite 310, Toronto M5C 1S2.

Cinofrenic, a controversial new film that deals with insanity as seen by an insane punk rock star, is available for rentals. Contact Harry at Shandel Productions. 968-0563.

VOLUNTEERS

Volunteers needed to relieve receptionist. Call Advocacy Resource Centre for the Handicapped, 482-8255.

HELP WANTED

ADVERTISING SALESPERSON

Person wanted part-time to solicit advertising for *PHOENIX RISING* on commission basis. Call Cathy at 362-3193.

FRIENDS

Young man, 36, 5'3", seeking matrimony. Age no barrier. Photo & phone number a must. Janos Krakoczi, 42 Bellview Ave., Toronto.

BACAP (Bay Area Committee for Alternatives to Psychiatry) has started an On Our Own Pen Pal Club. They will be distributing the names of those insterested in joining to all psychiatric inmate liberation movement publications (including *PHOENIX RISING*). Those interested in joining should write to: On Our Own Pen Pal Club, c/o BACAP, 944 Market St., Rm. 701, San Francisco, CA 94102, USA. Include your name, address, postal code, and interests in 10 words or less.

(continued from page 28)

tality was responsible for the death, but according to the medical examiner it could take years to get an autopsy.

At last count MPLF had held a successful demonstration in front of Glenside Hospital, where Aleksiuk died, and litigation had not been ruled out by Aleksiuk's family.

Those interested in giving MPLF much-needed financial and spiritual support can write to them at: 230 Boylston St., Room 204, Boston, MA 02116.

★Congratulations to two *PHOENIX RISING* collective members, Mike and Jo-anne Yale, on the publication of their first book, No Dogs Allowed, which was published last month. It's an autobiographical account of the Yales, a blind couple, travelling through Europe with only the assistance of their seeing-eye dogs. (Methuen, $13.95)

Interested in joining ON OUR OWN, or in finding out more about it? Call us at 362-3193, or write to: ON OUR OWN, Box 7251, Station A, Toronto M5W 1X9.

The *Commentary* section will be returning to *PHOENIX RISING* next month with Harry Beatty's viewpoint on how insurance companies treat clients with a psychiatric history. Persons who have experienced problems in this area are invited to send their information to Harry at: *PHOENIX RISING*, Box 7251, Station A, Toronto M5W 1X9.

ON OUR OWN's store, THE MAD MARKET, is located at 754 Queen Street West. The store is open Wednesday to Saturday from 10 a.m. to 7 p.m. The phone number is 363-9807. Drop in or call us if you are looking for something special to buy, or if you have a donation for us.

(continued from inside front cover)

These facts, and perhaps more to come, raise many disturbing questions. We raise only a few of them here:

(1) Why didn't Queen Street staff bother to do routine blood and urine tests on Aldo before drugging him?
(2) Why did Queen Street staff administer massive doses of Haldol to Aldo, especially when he was apparently calm on arrival?
(3) Why did Queen Street staff and the Coroner's Office wait almost three months before informing Aldo's family of the autopsy results?
(4) What happened to the missing medical chart for the morning of June 23rd, the day Aldo died?

* * *

ON OUR OWN members, all former psychiatric inmates, wish to make some specific recommendations to Minister of Health Dennis Timbrell in the light of these disturbing facts and questions. We choose to express them as demands:

1. WE DEMAND THE IMMEDIATE RESIGNATION OR FIRING OF ALL THOSE QUEEN STREET MENTAL HEALTH CENTRE STAFF RESPONSIBLE FOR THE TREATMENT AND DEATH OF ALDO ALVIANI AND THE COVER-UP OF HIS DEATH.

2. WE DEMAND THAT CRIMINAL CHARGES BE LAID AGAINST ALL THOSE PROFESSIONAL STAFF RESPONSIBLE FOR THE DEATH OF ALDO ALVIANI.

3. WE DEMAND THAT FORCED PSYCHIATRIC TREATMENT, INCLUDING FORCED DRUGGING, BE IMMEDIATELY STOPPED IN ALL PSYCHIATRIC INSTITUTIONS IN ONTARIO.

4. WE DEMAND THAT SECTION 8(5) OF THE MENTAL HEALTH ACT, WHICH GIVES THE STAFF OF PSYCHIATRIC HOSPITALS THE AUTHORITY TO "RESTRAIN" PERSONS ADMITTED FOR PSYCHIATRIC ASSESSMENT, BE AMENDED TO FORBID RESTRAINT BY CHEMICAL MEANS.

5. WE DEMAND AN INDEPENDENT PUBLIC INVESTIGATION INTO ALL ASPECTS OF PSYCHIATRIC TREATMENT IN ALL PSYCHIATRIC INSTITUTIONS AND PRISONS IN ONTARIO. THIS INVESTIGATION SHOULD START THIS YEAR.

6. WE DEMAND THAT PERSONAL TESTIMONY FROM PRESENT AND FORMER PSYCHIATRIC INMATES AND PRISONERS BE AN ESSENTIAL PART OF THIS INVESTIGATION.

7. WE DEMAND THAT PSYCHIATRIC INMATES AND THE PUBLIC BE FULLY INFORMED ABOUT THE DANGERS OF PSYCHATRIC DRUGS.

* * *

Forced drugging and overdosing occur daily in virtually all psychiatric institutions in Ontario and other provinces. Many other psychiatric inmates have, unlike Aldo, survived this drugging, but have been permanently damaged. And, like Aldo, many of our brothers and sisters have been overdosed to death. How many other deaths from drug overdoses have occurred in Ontario's psychiatric institutions and been covered up?

As present and former psychiatric inmates, we will be closely watching the developments of the November 3rd inquest into Aldo's death, and what action, if any, the Ministry of Health takes in response to the recommendations of the coroner's jury.

This press release was distributed by ON OUR OWN at a demonstration and march held on October 3. See story in the ON OUR OWN section of this issue. For more information about Haldol, see this issue's PHOENIX PHARMACY.

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.

STOP 86, 86 Madison Ave., 922-3271. Women 16-25. 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. Emergency beds free. 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. 7:00-10:30. 977-9835. (Gays.)

TORONTO AREA GAYS. Mon.-Thurs. 7:00-10:30. 964-6600.

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.

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