

On Our Own — But We're Not Alone

phoenix RISING

THE VOICE OF THE PSYCHIATRIZED

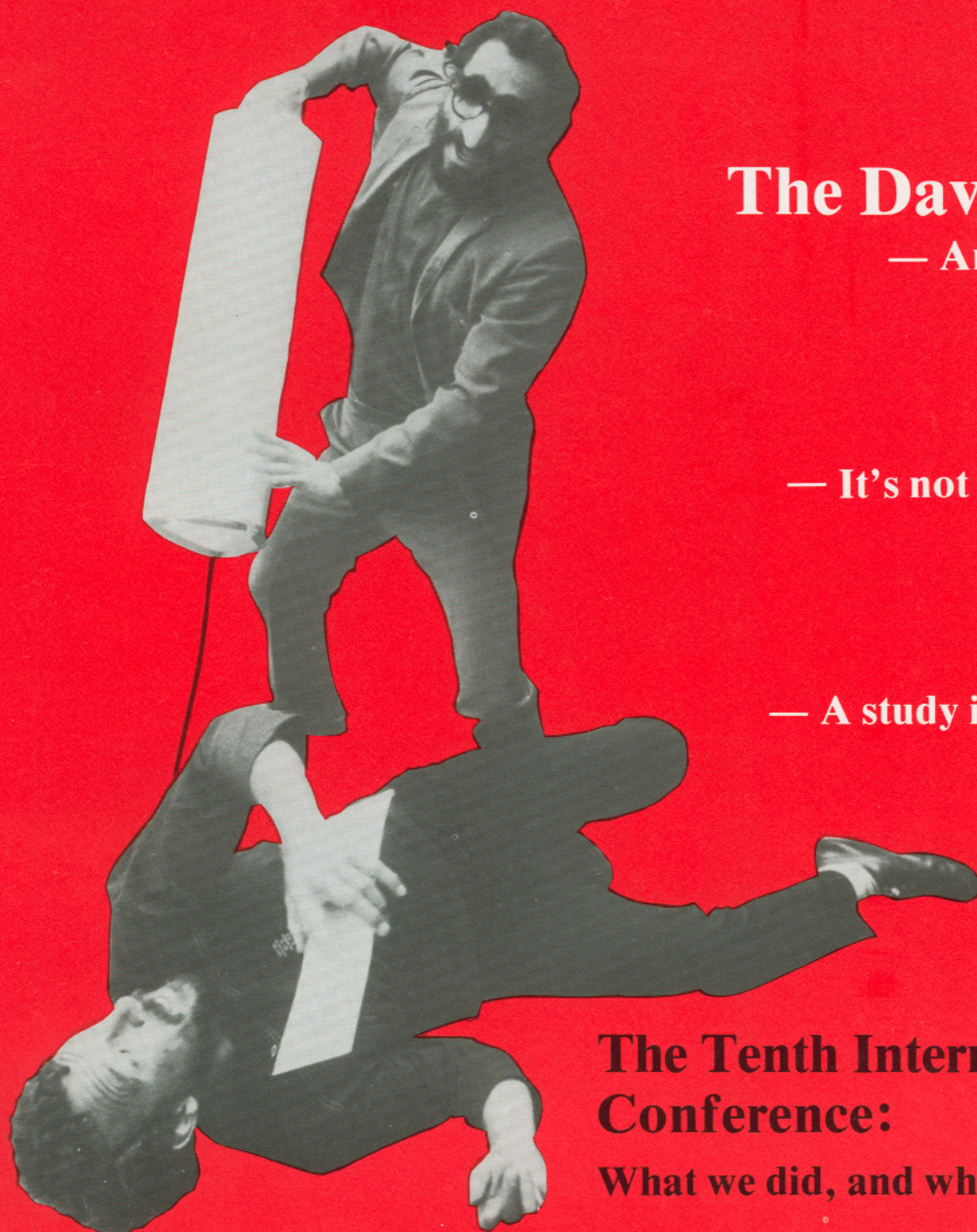


Aug.-Sept. 1982

Vol. 3 No. 1

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Thomas De



The Davis Inquest:
— Another drug death

Madness:
— It's not us, it's the system

Classes:
— A study in psychiatric bias

**The Tenth International
Conference:**
What we did, and why

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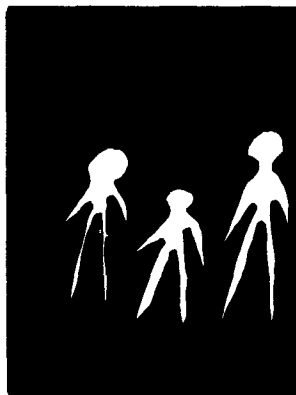
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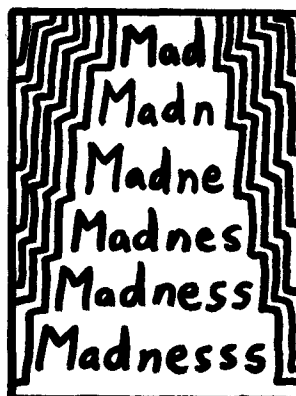
On Our Own



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Nous sommes tout le monde

We are everywhere

EDITORIAL

Toronto witnessed a unique event on May 16th. Over 100 ex-psychiatric inmates demonstrated in front of the Sheraton Centre across from city hall. South of the border this happening could have been explosive, with heads bashed and the press reinforcing myths about mental patients—myths of violence and irresponsibility. Here and at the entire Conference (see page 9), the Psychiatric Inmate Liberation Movement lent strength in numbers, experience and non-violent but outspoken clarity to the struggle to stop psychiatrists from treating people as objects.

To many it appears that institutional psychiatry is on the run, as evidenced by its defensive posture and an unwillingness to have its internal debates publicly aired. To guard against disclosure of its invalid strategies and treatment practises, psychiatry discusses problems through public relations forums and management consultants. The voices of community-oriented psychiatrists, who reject forced treatment and the medical model, are stifled, while psychologists like Norman Endler, who extol the virtues of shock treatment, have their views published in book form.

Everything considered, the public was very receptive to the messages of the Conference. The community at large is beginning to perceive that the victims of the psychiatric system, as represented by those at the Conference, have a legitimate right to be heard when they reveal how psychiatry has hurt their minds and their bodies in the name of social control. But there is still a long way to go in terms of making people aware of the Social Contract by which we all live our lives.

Simply stated, this Social Contract is an agreement by which we all agree to modify and "normalize" our behaviour OR ELSE HAVE OUR BEHAVIOUR MODIFIED FOR US. In essence, we either agree to bury all the messy, emotional feelings we experience (i.e., rage, fear, despair) underneath an exterior of "niceness" (i.e., politeness, selflessness, denial) or else be buried in a prison or psychiatric institution. Under our Social Contract, there are no provisions for healthy utterings of our innermost fears and frustrations. Either control your feelings, or others will control them for you.

One primary aim of the Conference was, in effect, to redraft the existing Social Contract and to provide psychiatric inmates with some of the rights they have been denied up until now: the right to refuse *any* psychiatric treatment; the right to remain free of incarceration in any psychiatric facility; the right to due process; the right to informed consent to treatment; and the right to decent, sanitary and humane living conditions. With self-help groups increasing rapidly in number, it is important for us to put aside social and cultural differences and to try to establish as broad a base as possible for the upcoming debate over electroshock and forced drugging. It is only through this coming together that we will build support and empowerment for ourselves and for psychiatric patients everywhere.

Empowerment produces dignity, self-respect and independence, while psychiatry produces suspicion, paranoia and hatred. We shall not allow the evils of psychiatry to triumph. NOUS SOMMES TOUT LE MONDE.

IN OUR NEXT ISSUE

The Housing Crisis

The CIA and Mind Control

Orthomolecular Therapy



write on

NOTE TO READERS: Phoenix Rising assumes any correspondence sent to us may be reprinted in our letters section unless otherwise specified. Please tell us if you would like your name withheld if your letter is printed. Letters without names and addresses will not be accepted.



In your April issue, Dr. J.J. Jeffries writes of patients "who have been helped by ECT" or "who have benefited" from it, implying that the question concerning ECT is whether patients do or don't benefit from it with respect to their illness.

ECT is a symptomatic treatment. Anyone who is emotionally ill benefits from it briefly, just as anyone who is constipated benefits from a laxative. As one patient put it, "It made me feel real good for a few days." Sometimes people stay well after ECT, but this depends on other factors in the situation, not the treatment itself.

The question concerning ECT is something else entirely: Should doctors be allowed to obtain consent to it without divulging that it will cause a great deal of permanent memory loss?

*Marilyn Rice,
Truth In Psychiatry,
Arlington, Virginia.*



I have been keeping up with all the problems that have been happening in mental health in Alberta — the cutbacks of professional help; psychiatric nurses; programmes; psychiatrists resigning, etc. The Alberta Hospital is falling apart at the seams — the institution needs repairs and is overcrowded and has a lack of services.

Why has not the Government made some improvements at the institution before now? This would have made services better for staff and patients.

Why does it take a tragedy before help comes to the people of these mental hospitals?

It makes me so angry to see the lack of communication between the Govern-

ment and the people who are concerned about the problems in the mental health clinics, who are asking for help from the Government and are not getting response.

As I myself grew up in an institution (for 15 years) for the mentally retarded, I have seen and experienced first hand, living in the institution, the lack of services and the repairs which needed to happen at the institution. I know a lot of work has been done since that time to improve living conditions at Michener Centre.

Why could not the Government have made living conditions at the Alberta Hospital Ponoka better at that time?

And why has not the Government been aware of this before now? The Government officials should spend a month living in a mental hospital as a patient and get first hand an insight of institutional living; the lack of services that are not being provided; and the over-crowded conditions.

It is the people in these mental hospitals who are suffering through not getting proper care, as well as the staff. I have been through this at Michener Centre and I know the situation. I care about people in mental hospitals as well as in the community who are suffering from mental illness, just as I care for those who are mentally retarded.

I wonder how many people in the Government ever had a loved one confined to a mental hospital, or a relative or friend? Maybe some one who is sitting in the Government could end up in a mental hospital. What would their reaction be then to poor living conditions and lack of treatment?

Unless the Government is willing to go right into mental health institutions and see the unfair conditions, they will not really understand the problems that exist in the mental health field.

As a concerned citizen, I hope the Government can learn from me what living in an institution does to people; this is why I am bringing forth my views in this whole matter of mental health problems; their solutions and getting the Government working with the professionals and public in mental health and the Alberta Hospital Ponoka living conditions. They need

upgrading — not downgrading! Just like a car that needs a tune-up, so does mental health. Not winding down.

*Doreen Befus
Red Deer, Alberta*



I was talking to Don Weitz of recent and he suggested that I inform you of some of the information I have gathered which may be of use to your magazine.

I was doing some research into the field of government spending into psychiatric services and comparing it with how much they spend on Community Mental Health Programmes and I came up with the following:

From the 1980-81 Public Accounts under the Ministry of Health it is recorded that the Ministry of Health spent \$243,583,300 into psychiatric services. A breakdown of where this money was spent in psychiatric services is listed as well. I have sent you a photocopy of the pages referred to in the Public Accounts, which can be obtained from the government book store.

From the Reference list of Health Science Research in Canada for 1981-82 which lists the grants and awards given in Canada, Ontario grants given for the purposes of some psychiatric research or treatment was picked out from the book. (The book is obtainable from the Ontario Ministry of Health Library on Overlea Blvd.). About \$419,032.00 was given out for some sort of psychiatric research or treatment in Ontario for this time period.

From the Hospital Statistics in Ontario for 1979-80 I found of interest a breakdown of Psychiatric Hospital costs. A grand total of \$166,044,521 was spent in Ont. Psychiatric Hospitals for this time period.

Now on the other side the Ontario Health Ministry spent \$8,132,032.97 (approx.) into the Adult Community Mental Health Programmes for 1979-80. A list of these Mental Health Programmes can be obtained from the bookstore or the Ministry of Health. A lot of these programmes that were granted money under this section are

operated from Hospitals or Psychiatric Hospitals or psychiatrists so as to the success of some of the programmes it is difficult to say.

I have attached some of material I have mentioned above.

I am continually doing research into the field of mental health, psychiatry, etc. and would be glad to assist you if I can in obtaining any information you may need in a certain area or concerning a certain person or group.

Sincerely,
Janet Rademacher



It is widely known, even admitted by psychiatrists themselves, that psychiatrists' predictions of people's dangerousness is far from accurate. Psychiatrists have no expertise or special skill in this area, as Carla McKague pointed out in one of her papers titled "Myths of Mental Illness."

At Penetang about ten years ago, I was locked up in the STU (Social Therapy Unit) which was run on the concept of "patient treating patient." In the STU, the "patients" were educated by the doctors and staff to recognize the "signs" or "symptoms" of "mental illness" in each other. We were then held responsible for the individual as soon as we saw the "signs." As a result, we "patients"

learned quickly and well — we had to.

From time to time, the newspapers have reported or predicted that increasing numbers of Canadians will become "mentally ill" over the next few years and will require "hospitalization." Just where or how does such a prophecy originate? Could this be some sort of long-range "programming" to justify the increase in incarcerated "sick" people?

Sometimes I can not ignore the term "iatrogenic" (doctor or medicine-caused) when recalling a commercial I've seen on TV which ran approximately three times a day for some months. The ad showed someone getting into a car and then immediately clutching and cradling his head, while an almost hypnotic voice intoned that the headache could be the cause of his tensions. Instead of telling you what the best brand of pain-reliever was to purchase, the "voice" went on to "suggest" that the suffering individual should see a psychiatrist. My reaction to this commercial was that psychiatry was subtly trying to snare more customers through the mesmerizing boob-tube. Such subliminal advertising could be interpreted as dangerous, since its intent is to influence unaware people.

Any of us who have had a lot of contact with psychiatry — especially institutional psychiatry — are all too aware of how easy it was (and still is)

for us to be seen having a mental or psychological problem while we were experiencing some common physical ailment or stress. "Psychosomatic" is the medical term for this condition. If we see a psychiatrist for a headache, we can be easily labelled as having an "emotional problem," and many of us know how easily this label can be stretched to justify certification and then involuntary commitment for our own "care and treatment" or "benefit."

Just what laws or guidelines exist to protect the unaware individual who is thinking about visiting a psychiatrist? How do you know what you are "buying" when considering the "services" of a person who is selling him/herself as a diagnostician or healer of the mind? The answer is you don't.

Psychiatrists call themselves professionals and psychiatry a science, despite the fact that psychiatry is still not a science after more than 100 years of practice and research.

Like magic or witchcraft, psychiatry has its own secret code(s) or mumbo-jumbo language which few people, except psychiatrists, can understand. As far as I'm concerned, this is simply another attempt on the part of psychiatry to confuse or mystify the average person about his or her real problem(s). Psychiatry also has the maddening ability to complicate very simple, common everyday problems or crises by transforming them into "signs" or "symptoms" of "mental illness" through the magical power of psychiatric diagnostic labels. Psychiatrists themselves can't agree with or understand their own diagnostic labels. Psychiatric labels such as "schizophrenic," "manic-depressive," "psychopathic" or "psychotic" are stigmatizing swear words; they stick to us like glue, sometimes for life. I'm convinced psychiatric language or diagnostic labels are dehumanizing; they're designed to beat most of us into submission. Unfortunately, we rarely question or challenge psychiatric diagnoses, decisions or judgements. It's time we did.

The biggest issue is PSYCHIATRIC POWER, and I am writing to provoke more serious thought and discussion about the amount and type of power we have given or allowed to be given to psychiatry: the power to diagnose or label us against our will and without our knowledge; the power to "treat" us against our will; the power to lock us up against our will; the power to control and destroy our lives.

Let's face it, psychiatric power is growing every day. It is absolutely essential that we constantly challenge and expose the power plays and abuses of psychiatry. We can be sure that they



will continue. Our freedom, our health and our lives are at stake.

Eldon Hardy
—a 10-year veteran of hell
METFORS
Queen St. Mental Health Centre



Having noticed that Dr. W. Mitchell of Niagara Falls was added to the shock doctors' list, I thought I should write to clarify the matter.

Whereas I would prefer that shock treatments not be used at all, I must also give Dr. Mitchell credit for using better than average discretion in his usage of them and also, his support for self-help and the dedicated concern he shows for his clients far outweighs any harm he may have done.

In the struggle for psychiatric reform and social freedom, good men like Dr. Mitchell should not be wasted.

Fred Serafino,
Co-ordinator, SPRED,
514 King St. E., No. 7,
Hamilton, Ontario,
L8N 1C9



I really found your issue (Vol. 2 No. 3) exciting and personally helpful to me. particularly of interest was the article about the "Lane" closing. I'm a health professional who was working at the Nova Scotia Hospital in Dartmouth and many of the people from the Lane ended up there. I think we're in a critical position here in Halifax/Dartmouth as the psychiatric facilities are overcrowded due to the closure, and there's a lot of pressure because of low staff ratios and budget cuts. I believe there's a lot of good people working in mental health, but they tend to get frustrated and leave. It's the people institutionalized who suffer most and, based on budget cuts, they're not a priority with the government.

I'm pleased to see that you're bringing these issues to public attention. I feel that self-help groups are really needed in Nova Scotia.

(Name Withheld)



Some of the things done to me in some Ontario Psychiatric hospitals were done in the name of treatment but were instead cruel and unusual punishments and crimes against humanity.

Initiation: I asked too many questions and was visited by three staff members. While two held my arms, the other proceeded to expertly work me over.

I was given shock treatments without being consulted. I was laid on a

table and given a needle. The needle paralyzed my whole nervous system. I passed out not being able to breathe. Once they pushed the button before I was unconscious. It felt like someone blowing my head off. Another time I became conscious after the shock. I couldn't move but was aware of what was going on. The attendant shoved a large wad of cotton in my mouth, saying, "Here's a big cock for you." I didn't find this very pleasant, or amusing.

I was confined with other patients to a sunroom for about six months. There were no cigarettes, reading material or games. There was no yard. We were given dexamyd and for a couple of weeks everyone was a bit hyper. A skirmish developed between a couple of the patients. It was promptly handled and the patients were put on cuffs. Someone had called the security staff, and they don't like being called for

'Cruel and unusual punishments'

anything. One of my friends whose hands and feet were cuffed was thrown to the floor while a 250 lb. staff gave him a knee drop in the chest. Tempers were flaring and one of the cuffed patients spit at a staff who was brandishing a can of the chemical mace. He had been waiting for a chance to use the chemical and he sure used it. Standing about three feet from the patient he sprayed him in the face, the ear and the neck. The stuff was dripping and running down his chest. In terms of staff patient relations this was not good.

There is another instance where mace was used. There were five of us in the capsule, better known as the box. We had been there a few days when one patient hit another. The victim's pride was hurt more than anything else and the aggressor rolled facing the wall and wouldn't communicate with anyone. Doctor B., who was in charge of the program, had observed the incident by the video equipment, and without consulting anyone he opened the trap door in the ceiling and proceeded to spray mace on the silent aggressor. Everyone in the room; we were all naked, became blinded and suffered painful burning sensations.

Patients were sometimes forced to

take a drug called scopolamine. The needles themselves were bad enough but the treatment also included sleep deprivation. The patient would be kept awake by being slapped, having his facial hair pulled and the tendons behind his ankles squeezed. After a few days the patient was in a complete delirium and at the mercy of his keepers. The drug could be given for any number of reasons. I got it for being disruptive in a ward meeting. The doctor must have thought it was a cure all.

The biggest threat was shock treatments but this was soon replaced by drugs — scopolamine, nozinan, largactol, and modatin. The modatin was the worst. It was a long term drug that a patient would probably be on for as long as he was there. Most medication was given as punishment according to the side effects that the drug produced. If anyone refused to take his medication he would be repeatedly choked until he submitted. This situation can make a person feel very helpless and I did for years. I believe that by informing the inmate patients of their rights to refuse these horrible drugs they will be spared the terrible nightmare I went through. I suggest they use discretion and consult a lawyer or the ombudsman with their intention of refusing or wanting to discontinue the medication.

Raymond T. Renaud
Ottawa, Ontario

P.S. The incidents described in this article took place at Oak Ridge Penetang. I spent a number of years at Brockville and it was the same to a lesser degree.



I have spent many fruitless hours, days, week, and months in my search for solutions to mental illness, both in and out of institutions. The fact that I have been in jail and psychiatric wards is not something I'm terribly proud of, but you seem to like it as a qualification for worthwhile opinion. So be it.

I have repeatedly given your magazine the benefit of the doubt, and went on with a much less rebellious and negative life, but I respected what I thought was your legitimate search for solutions.

In my search I found a non-religious, non-medicating, non-conventional cure for mental problems, possibly the only effective one, which has been tested and unfortunately for my purposes

here, respected by your much-hated administrators and medical men. I thought the least you could do would be to print one of my letters or do a short investigative piece on such a technique. As I have told you before, Transcendental Meditation is a do-it-yourself *cure* which is available for use to any man, easy to do, natural, and is without the serious side-effects of drugs. I thought you might recognize a good thing too and share it with others. But that, I guess, is too much to expect of a self-styled rebellious movement which seems to be more negative than positive.

My disillusionment with your efforts has led me to stop subscribing to your magazine, and I will now request that you stop sending me your magazine, to save the money of whomever donates it for more constructive use. I wish you luck in your positive efforts, but I won't read any more attitudes of war.

*Brian McElhiney,
London, Ont.*



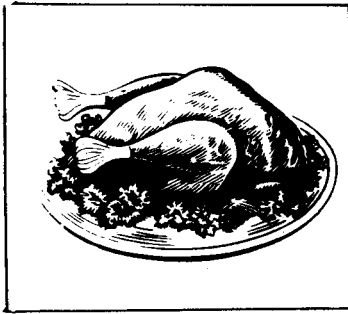
I add my voice to those readers who object to the term "inmate." If O.O.O. is truly committed to constructive change in Ontario's Mental Health Institutional Services, the use of the term "inmate" prevents many in all sectors of society from joining the Coalition on Psychiatric Services' efforts to improve services. The term is destructive not constructive! I therefore urge you to poll your readership and membership to review the use of the term "inmate", pro and con.

Could you list the postal addresses of *all* the Coalition on Psychiatric Services in a future edition, please.

Finally, you do Dr. Elliott Barker a great disservice by awarding the 'Turkey Tail' award to him. It would appear that Dr. Barker was asked by the courts to give a medical opinion on a serious matter and to the best of his ability, this is what he did. Having met Dr. Barker a couple of times and having some knowledge of his professional reputation and his personal commitment to starting the Canadian Society for the Prevention of Cruelty to Children, P.O. Box 700, Midland, Ontario, my view of those who choose to select caring professionals such as Dr. Barker for such awards is greatly diminished, to put it mildly. I ask what diagnosis would the 'presenters of the awards' give that same situation if *they* were asked to give an 'expert opinion' on the matter by the courts?

*Don Tickle,
Collingwood, Ont.*

GIVING THEM THE BIRD



We're awarding this issue's Turkey Tail to all the institutional shrinks in Ontario who are threatening to strike for a higher salary, as well as more staff. According to their spokesman, Dr. Kenneth Mesbur, the 115 shrinks employed in Ontario's ten psychiatric institutions make \$50,000 to \$60,000 per year. It seems they want a 25% increase so they'll make about as much as private shrinks, which is \$75,000 or \$80,000, if not more. While we don't object to workers going on strike because of low pay as well as intolerable or unjust working conditions, we think the shrinks don't deserve any increase in pay, since their salaries are made off the backs of human suffering, off psychiatric inmates whom they oppress in the name of "care and treatment." At the same time, the "treatment" for the inmates would significantly improve if a lot of institutionalized shrinks quit.



We are proud to award this issue's Phoenix Feather to Dr. Frederick T. Zugibe, Chief Coroner of Rockland County and Professor of Forensic Medicine at Columbia University in New York.

Through his courageous and scientific research—involving autopsy studies on approximately 200 psychiatric inmates who died in two New York State mental hospitals while on psychiatric drugs in the late 1970s—Dr. Zugibe documented the fact that the major tranquilizers (e.g. Thorazine, Stelazine, Moditen or Prolixin) are a direct cause of death. Specifically, Dr. Zugibe presented evidence from his own research and a review of the medical literature which showed that the major tranquilizers, even at "therapeutic" doses, frequently suppress the gag reflex, which results in choking or strangling on undigested food particles, particularly in the lungs and trachea (windpipe) and/or esophagus. He also presented evidence indicating that the major tranquilizers frequently mask pain and other symptoms of physical disease, which increase the risks of serious medical complications or death. Furthermore, he has made specific recommendations as to how drug-related medical emergencies, including death, can be minimized or prevented.

We salute Dr. Zugibe not only for publishing this controversial research, but for his honesty and courage in speaking out against the numerous health risks of psychiatric drugs in the face of severe criticism from New York's medical-psychiatric establishment. We wish there were many more doctors like Dr. Zugibe.

(Ed. note: See "Phenothiazine deaths" in *Phoenix Pharmacy* column of last issue and "Coroner Claims Tranquilizers Cause Inmate Deaths" on page 25 in this issue.)



ON OUR OWN

Norman Davis—another unnecessary drug death.

By Don Weitz

At 27 years of age, Norman Austin Davis should be alive today. Like many other psychiatric inmates, Davis died from forced drugging, or prescribed overdoses of dangerous psychiatric drugs.

Davis died at Queen Street Mental Health Centre on December 6, only 48 hours after admission. Davis' death marks the third *reported* drug-related death at Queen Street within an 18-month period, June 1980 to December 1981. (Reports on inquests into the drug deaths of Patricia Ellerton and Aldo Alviani appear in our Spring 1982 and Fall 1980 issues.)

Dr. Margaret Milton presided over the coroner's inquest into the Davis death; it lasted 10 days, March 23 to April 2. About forty witnesses testified including various Queen Street psychiatrists, nurses, the administrator, two pharmacologists, a toxicologist and members of the Davis family. David Baker—a lawyer, patients' rights advocate and executive director of ARCH (Advocacy Resource Centre for the Handicapped)—represented the family, and three members of COPS (Coalition On Psychiatric Services) monitored the inquest.

Some of the evidence focussed upon the three drugs found in Davis' body: paraldehyde, Nozinan and Valium. The finding of an almost fatal level of paraldehyde in a post-mortem sample of blood was most alarming (42mg% + 9mg% acetaldehyde—the lethal level is 50mg%).

Toxicologist John Kofoed testified that the high paraldehyde blood level was "close to the fatal range." Pathologist Dr. Donald Ryder agreed. In his autopsy report, Dr. Ryder claims the cause of death was a "combination of paraldehyde, acetaldehyde, bevomepromize, diazepam and non-diazepam overdose." Low or moderate amounts of Nozinan (levomepromazine, a major tranquilizer) and Valium were also found. Apparently,

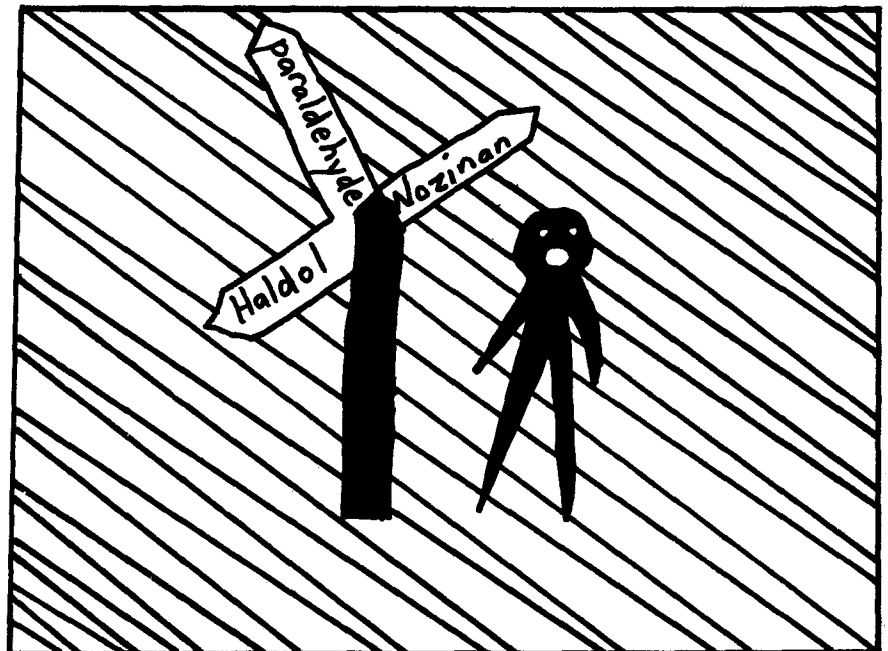
Davis obtained the Valium from another inmate or on the street, since there was evidence the drug was not prescribed.

A few hours after Davis was admitted to Queen Street last December 4th, psychiatrist Mark Lowery prescribed 24 ml of paraldehyde to be administered over a 24-hour period, in addition to a moderate dose of Nozinan. However, the medical chart showed that 32 ml. of paraldehyde were actually prescribed; a nurse misread the doctor's order and gave Davis another 8 ml., all within 16-1/2 hours. The Queen Street doctors didn't bother giving Davis a medical examination or doing blood tests *before* prescribing the drugs, an all-too-common omission in many psychiatric institutions. However, there was no evidence of alcohol or street drugs in Davis' body at the autopsy. Around 4 p.m. that Sunday on December 6, another inmate found Davis lying unconscious and dead-white in bed; he immediately called a nurse. Since Queen Street had no emergency resuscitation equipment, Davis was rushed

to Toronto Western Hospital, where he was pronounced dead.

Norman Davis was labelled "mentally ill" for many years. He'd been in and out of psychiatric institutions 34 or 35 times. He was also known to be suffering from alcoholism, heavy drug use and was suicidal. About a month before his last admission, police found him barefoot, drunk and staggering in front of a streetcar; a few hours before arriving on the ward last December, Davis had slashed his right arm with a razor. A few hours before he died, Davis had wandered off the ward and was arguing with some other inmates and staff. He also complained to two inmates that he didn't feel "alive," felt "so drugged up," and he hated being locked up in Queen Street.

The five-member coroner's jury presented their findings and recommendations on April 2. They were disappointing. The jury's verdict was that the official cause of death was "cardiac arrest;" the means or mechanism of death was listed as "unknown." Apparently, the jury was not impressed by



James Dunn

or simply unaware of the fact that paraldehyde is a very potent, unstable and dangerous drug. In fact, the drug has been medically discredited; it's been used rarely in medical or psychiatric practice during the past 10 to 15 years. When administered alone or in combination with other drugs, paraldehyde frequently causes serious medical complications including death. At the very least, the jury should have recommended its total and immediate ban in all psychiatric institutions.

Among the jury's 15 recommendations, at least 10 focussed upon staff and other internal-institutional problems; most dealt with the need for improved staff communication and training and tighter security, including the use of "limited physical restraints" on inmates. Only one recommendation dealt with paraldehyde—just to clearly date the use of any opened bottle, since

there was evidence that the bottles or ampules of the drug were old—yet medically safe.

One recommendation dealt with better "after care facilities," which might have helped Davis find sufficient support or adequate housing to stay out of psychiatric institutions; all very well, except there's been a severe shortage of community alternatives in Toronto for many years. Significantly, none of the recommendations or findings was critical of the psychiatric staff who "treated" Davis; in fact, the nurses at Queen Street and Toronto Western were praised.

The Davis family was not too pleased with these recommendations. They submitted their own to the jury, but most were not included in the jury's final recommendations. In addition to strict control over psychiatric drugs and paraldehyde, the family called for "an

independent public inquiry" to investigate "the use of chemical restraints; the mixing of several drugs in the course of psychiatric treatment," and other issues.

During the past two years, COPS, OPSEU (Ontario Public Service Employees Union), the *Toronto Star* and leaders of both opposition parties have repeatedly called for a public investigation into psychiatric treatment. How many more people must be forcibly drugged, permanently damaged or killed by psychiatry before the government acts?

FOOTNOTE: An inquest into the death of Margaret Daniel is scheduled to start on July 14. A recent press report reads: "The body of a 20-year-old patient who disappeared in mid-March from nearby Whitby Psychiatric Hospital was found in Whitby's Lake Ontario shoreline April 4." (*Toronto Star*, May 5, 1982)

These Jury Recommendations were Suggested by the Family of Norman Davis. Most of them were Ignored.

1. In light of the evidence presented, it is apparent that grave problems exist in the province's mental health system. An independent public inquiry should be conducted which would examine amongst other issues:
 - (i) the use of chemical restraints;
 - (ii) the mixing several drugs in the course of psychiatric treatment;
 - (iii) the "open-door" policy;
 - (iv) the staffing of mental health facilities; and
 - (v) the allocation of resources between institutional and community mental health care.
2. If the drug paraldehyde must be used, the patient should receive constant nursing supervision with frequent monitoring of vital signs. Both Drs. Derost and McLeod agree.
3. Where grounds exist for believing a patient has ingested unprescribed drugs prior to admission or while an inpatient at a mental health facility, a blood scan should be performed. The Addiction Research Foundation should be provided with adequate resources so this service will be available on an "as needed" basis.
4. The Ministry of Health should assume responsibility for providing supportive housing for ex-psychiatric patients. This housing should provide varying degrees of structure and encourage a person to move towards becoming independent and self-sustaining.
5. After-care services should be community based so as to reduce reliance upon the hospital. Greater efforts should be made to involve members of the family in these programs.

To date, the Coalition On Psychiatric Services (COPS) has monitored a total of three inquests into the drug-related deaths of Aldo Alviani (November 1980), Patricia Ellerton (January 1982) and Norman Davis (April 1982). After reviewing the various jury findings and recommendations, we believe the inquest process has proven itself incapable of dealing with the full range of mental health problems which can contribute to death. Essentially, there has been an almost exclusive concern with staff and institutional problems, to the relative neglect of patients' problems and rights.

The common thread running throughout these inquests has been the *routine prescribing of high doses of potent psychiatric drugs, alone or on in combination*. In the Alviana case, there was evidence that extremely high doses of Haldol were both prescribed and administered; in the Ellerton case, very high dosage of Nozinan were administered, and in the Davis inquest, there was evidence that an almost lethal level of paraldehyde was found in a post-mortem blood sample.

At the Davis inquest, family members presented a number of useful recommendations to the jury. These included: 1.) holding a public independent investigation to examine the use of chemical restraints, mixing several drugs during treatment, the "open-door policy", staffing of mental health facilities and allocation of resources between institutions and community health care; 2.) constant nursing supervision and frequent monitoring of vital signs of patients during administration of paraldehyde whenever prescribed; 3.) a blood scan to be performed on patients before and during admission whenever there is doubt or reason to believe that patients have ingested unprescribed drugs; 4.) provision of supportive housing by the Ministry of Health; and 5.) community after-care services.

The purpose of an inquest is to clear the air and alleviate public concern where death had occurred. However, in our experience, many more disturbing questions have been raised than answered. COPS will continue to press the Government of Ontario to call a public investigation. We believe that a public enquiry is essential and immediately needed to stimulate long-overdue reforms in the psychiatric system and safeguard the health and well-being of all citizens in the province.

By Judi Chamberlin

Innis College. I arrived on Friday just as the registration table was being set up, so there was time to sit in the lobby and greet other early arrivals. Old friends. New friends. Sunshine. Flowers in bloom. The almost magical feeling I get at gatherings of ex-inmates. The 10th International Conference on Human Rights and Psychiatric Oppression had begun.

We had dinner, then the first plenary session began. Innis College "Town Hall" was a room totally unsuited to our needs — it had fixed banks of risers, so that we couldn't sit in a circle or see one another, and the acoustics were awful. Fortunately, the weather cooperated so that we held almost all the other plenaries outside on the lawn. The main business of the first session — making up the workshop schedule — went smoothly, and workshops started right on time Saturday morning.

*'Oppressive
psychiatry
must be
destroyed'*

I attended two excellent workshops, one on Movement Decision-Making and another on Working with the Enemy. They were what I always want Conference workshops to be — open exchanges of ideas among people with differing opinions, but all of whom shared the basic premise that oppressive psychiatry must be destroyed.

After lunch (the meals were excellent) came another plenary. Although there were a number of items on the agenda, only one got discussed — the details of the Tribunal, planned for the next day at Toronto City Hall. Our process of participatory democracy can sometimes be agonizingly slow, and it took hours to decide that anyone who wanted to speak would have a chance, that each speaker would then recognize the next to speak (our famous "rotating chair"), that speakers would be limited to three minutes, that there would be a timekeeper with the power to cut people off, that there needed to be an election to select six panelists who

10th International Conference: *two personal accounts*

By David Oaks

Slowly but surely, more than 125 former psychiatric inmates arrived at U of T's Innis College, the conference site. They came from *Madness Network News* in San Francisco; a mutual support house in Florida; a whole, crammed van load of friendly ex-inmates from Kansas, and lots of people from Vermont, New York State and Michigan. There were also many Canadians including three French-speaking people from Quebec who arrived with an elaborate videotaping system and painstakingly recorded the whole conference.

The basic purpose of the conference was opposition to all coercive "treatment" and other forms of psychiatric assault. By the end of the conference, a three-page **DECLARATION OF PRINCIPLES** would be drafted and approved in principle by the conference, and a nine-member editorial committee elected to work on the **DECLARATION**. We also decided that the APA meeting would not drain the energy of the conference.



Connie Neil

would speak after the open Tribunal, and who would have six minutes apiece to present different facets of the movement.

But, somehow, we got through it — and Sunday's Tribunal was a powerful and moving event.

The setting was impressive — the modern, council chambers, the banks of desks, spectator seats (unfortunately not many were occupied) rising in rows. But it was the statements of the participants that were even more impressive. One after another, people introduced themselves and recited their catalogues of horrors. Atrocities in institu-

*'The power of
our words
and ideas'*

tions, "community programs," and "sheltered workshops." Forced drugging. Electrochock. Legitimate anger and pain defined as "mental illness" and forcibly "treated." And here we were, the victims, using the only power that we had, the power of our words and our ideas, to fight back.

A group went to hand out leaflets at the American Psychiatric Association's forum on nuclear war, objecting to the shrinks somehow making the bomb into a psychiatric issue, rather than a moral and political one. And then we headed back to Innis College. There was still more work to be done — planning Monday's march and demonstration at the headquarters of the APA convention. (Wasn't it convenient that they were meeting in Toronto too?)

Nearly everyone was excited about the demonstration, a chance for organized ex-inmates to confront organized psychiatrists. A chance to let out the anger and outrage that, for many of us, had been labelled as a "symptom" of our "illness."

Some people wanted to do even more — wanted to put their bodies on the line to make clear that we saw psychiatry as an evil force that must be stopped. Just as there had been civil disobedience at the 1980 APA convention in San Francisco (when the Conference also just happened to be meeting in the same city), so, we felt, there must be a similar action in Toronto. Carefully disassociated from the Conference, this group settled on

Innis College, Saturday, May 15

I felt the first workshop I went to that morning was the most important of the whole conference: organizing and networking. People talked about the techniques they used to organize new groups, building current ones and working with already established organizations. I learned that in New Jersey, for instance, ten groups have suddenly sprung up. People felt that it would be good to have one day set aside each year as an International Day of Protest Against Psychiatric Assault. It was agreed that the workshop would also propose that the Movement publish and distribute a booklet on "How To Organize Crazy Groups."

There were a lot of films, videotapes and slide shows on organizing. I saw part of the film *Liz*, a very good film highlighting an ON OUR OWN member's life in Toronto. That same afternoon, I attended a small workshop on Men Against Sexism. Initially, we were too analytical and argumentative. However, later in the meeting a few of us talked more openly and personally as we recognized that getting closer to each other was a step toward supporting each other in stopping sexism.

Some of the other workshops included: The Experience of Madness; Government Mind Control; Decision-Making For The Movement; Politics of Working With the Enemy; Alternatives; Street Theater; Publicity and Fund-Raising.

Toronto City Hall Council Chambers, Sunday, May 16

This was the site of our Public Day, which included the Tribunal and Press Panel. First, there was personal testimony. Many people related their own experiences with psychiatry, major forms of assault by the medical profession and important issues for the Movement.

My name is Sally Zinman and one thing I think I can add is to make everybody realize that this is a universal thing. There are no good hospitals. Any place with a locked door is not good. The name of the game — from the public hospitals to the private hospitals — is other people controlling your life. You're considered not competent or able to make your own decisions, to define your own self, and any way they can choose, any way they can find, they will try to control your life and make those decisions for you.

I was not given drugs, I wasn't given psychosurgery, I wasn't given shock, I wasn't given any of the more common means of control. This doctor who was so expensive, who was supposedly so progressive — he didn't use these. Nevertheless, his prime purpose was to take total control away from you, to have total control over you — in effect, to become your mind. He used his fists, he used dungeons in the bottom of old farm houses. Whether it's public or private, whether it's drugs, psychosurgery, shock treatment, fists, quiet rooms on wards or dungeons in the bottom of farm houses, it's taking control and self-definition away from you.

That's one thing this Movement is beginning to do. As powerless people, we are beginning to take control over our lives, to define our lives, as all powerless people are doing throughout the world . . .

After the Tribunal and panel presentations, a group of us went to leaflet an anti-nuclear war rally sponsored by the American Psychiatric Association. They're afraid of nuclear war too, in their own muddled way. We had a large peaceful presence to ask the APA to declare peace on our brains, as well as the earth. One ex-inmate, Jordan Hess, sang: "THEY SAY WE ARE CRAZY, THEY SAY WE'RE INSANE, BUT WE DON'T MAKE ATOM BOMBS OR ACID RAIN." One doctor we leafleted was Nathaniel S. Lehrman from Roslyn, New York. He pulled out his own leaflet which denounced the deaths of psychiatric inmates. He was a very rare psychiatrist, as we would find the next day when we had to deal with hundreds of unsympathetic psychiatrists. That afternoon, we returned to workshops on legal Rights, Massage, Socialism and Economic Survival.

Sheraton Hotel, Monday, May 17

Our demonstration was held in front of the Sheraton, the headquarters of the APA meeting. Lasting almost two hours, it turned out to be a very creative, successful demonstration which received a great deal of press. There was a lot of cheering, sign-waving, leafleting. Some signs read: "WE ARE PEOPLE! NOT LABELS THAT LOOK LIKE PEOPLE." "THE APA MAY CHOOSE YOU AS THEIR NEXT VICTIM???" "PSYCHIATRY OFFERS SUDDEN AND UNEXPLAINED DEATHS. WHO? HOW MANY?"

an action — an occupation of the Sheraton lobby — and a name — PILL (Psychiatric Inmates' Liberation Lobby).

The march was joyous. Holding signs: "Electroshock Kills;" "Grow, Don't Shrink;" "Stop Forced Drugging," and chanting "One two three four — We won't take your drugs no more; five six seven eight — Smash the therapeutic state," we advanced on the Sheraton and formed a picket line. A giant prop hypodermic needle was used to administer "treatment" to various demonstrators who, as they fell to the ground, raised small signs that proclaimed "Cured," as everybody cheered.

*'Smash the
therapeutic
state'*

The press was out in force, with all major newspapers, radio, and television stations represented. Only the shrinks were not very much in evidence. They avoided the demonstration as much as they could, remained safely in the lobby, or shot quickly out the doors and away from the commotion.

The psychiatrists could be easily recognized by the little colored identification cards they wore. People chanted loudly toward the shrinks: "HEY HEY, APA, HOW MANY PEOPLE DID YOU KILL TODAY?" Dr. Mad — an ex-inmate dressed up to look like a psychiatrist — carried around a huge cardboard hypodermic needle with the label "Thorazine 1000cc" on it. He shouted at some of the demonstrators, "I THINK YOU'RE AGITATED AND YOU NEED MY CURE." He injected her and she pretended to collapse on the sidewalk; a small placard which read "CURED" was placed on top of her.

I'm Joe Rogers, and I don't want to talk too much about my past. I've been on medication and in and out of treatment for a few years now. I've been very much motivated, particularly in the last year. We've been organizing other mental patients. I haven't really done so much. I've been involve din some general people organizations. As I become more and more in touch with my own feelings about what happened to me I realized that one of the big things which proved helpful was the Mental Patients' Movement, the self-help movement. I began to organize in the state I live in, which is New Jersey and I found that the most beautiful thing is the tremendous amount of resources and power to be tapped when you begin to talk to ex-patients. It's such a wonderful thing when it happens in such a brief period of time.

And in New Jersey, we have a very key issue we're organizing around: the issue of fingerprinting and mug shots. Whenever you go into a state hospital, you're automatically fingerprinted and mugshot. And these fingerprints and mug shots are sent to the New Jersey State Police, and the state police then hand them over to your police chiefs in each town, the police chief in every small town in New Jersey. This is the danger we've been organizing around . . .

There was a lot more chanting, singing and shouting: "SHRINKS HAVE KILLED, SHRINKS HAVE LIED, PSYCHIATRY IS GENOCIDE." Others sang: "FREEDOM IS STRUGGLE . . . PEOPLE GET READY, CAUSE WE'RE FIGHTING FOR OUR LIVES." A lot of people yelled over the bullhorn, "FREE ALL PSYCHIATRIC INMATES." Don Weitz, an ON OUR OWN member, shouted at the observing shrinks, "I HAVE A COUSIN WHO WAS LOBOTOMIZED IN YOUR HOSPITALS . . . YOU'RE A DISGRACE TO MEDICINE. YOU SHOULDN'T CALL YOURSELVES DOCTORS, YOU'RE BUTCHERS!" there was also a minute of silence for the deaths of psychiatric inmates at Toronto's notorious Queen Street Mental Health Centre.



Connie Neil

But the shrinks could not avoid Monday night's occupation of the Sheraton lobby. The APA had offered us use of a room at the Sheraton to hold a forum, and we used this as an entry point. As expected, only three or four psychiatrists came to the forum (which was competing with dozens of free cocktail parties sponsored by drug companies, medical schools and other bastions of the shrink establishment), but the forum was never seen by us as anything but a tool to get us inside.

From the forum, the vigilers proceeded to the large, ornate lobby and there they chose a spot and quickly sat down with their signs.

As a member of the negotiating support committee, I was deeply involved in the events of the next several hours. Of course, a crowd quickly gathered. "Who were these scruffy people," I could see the shrinks wondering, "with their outrageous signs?" A leaflet had been prepared and copies were scattered around. The APA security chief and the hotel security chief ordered us to leave. The police were called, ultimatums given. After two hours, the arrests started.

The sixteen were taken out one by one, pushed or dragged after they refused individual orders to leave. The negotiating committee called our lawyer, then we too went off to the police station to see what we could do. After much waiting around, we were allowed to join the folks who had been arrested, and through the hours of processing it took before people could be released, we were together, jubilant at the success of our action. (We still have to pay back over \$800 — \$53 per demonstrator — in fines and bail lent to us by our Canadian friends in On Our Own.)

These, then, are my impressions of the Conference — fragmented, episodic, having missed many things that perhaps were important to others. The workshops I attended were excellent. I took part in several I haven't yet mentioned, including a women's workshop on the co-optation of rape crisis centres and battered women's shelters by the mental health system. The plenaries were often slow and cumbersome, but decisions were made and acted upon.

I missed the final plenary on Tuesday morning, at which the decision was made that next year's Conference

After dinner, around 25 of us returned to the Sheraton. The American Psychiatric Association had invited us to hold a small symposium to voice our views. We filled the small room, but only a half dozen psychiatrists and members of the public came to listen.

My name is Iris Hinckle. I'm from Kansas City, Missouri. My first experience with any mental health facility was in Idaho. I wanted to lose a lot of weight, so I went on a crash diet and popped diet pills and I wouldn't eat for a while. But somehow I couldn't think anymore, so I was admitted to a hospital in Boise, and I was drugged up with so many medications that I couldn't function at all, I mean I couldn't even stand up.

I think I was on Prolixin for a number of weeks. I'm not sure of the doses, but I felt like a zombie. When I first saw a psychiatrist, he just came in and said "Hello" and then he was gone. My Mom couldn't believe the bill when it came in the mail — like \$7000 for the two weeks. Doctors can't control what you feel, but they think they can, with the medication and telling you what's wrong with you, what you should think, what you should feel. You know, everyone's their own person, and they have a right to their own thinking and feeling. And so, I just kind of go with the game and just play along with what they want me to do. I don't know what else to say, I'm kind of in a stage-fright . . .

□ □ □ □

I am Richard Stanley, from California. I want to tell about me and about others like me. I was committed by a court at the age of 12 to Capitol State Hospital. I have described at other places, including the conference last year, what it is like to receive shock treatment. The extreme physical pain and terror I have described in detail, and I will not describe it here.

What I want to point out is that on that day, the day I was changed to the ward I received the shock treatment on — there was adopted in the United Nations what is called "The Declaration of the Rights of the Child," ten brief principles, the ninth of which begins: "The child shall be protected against all forms of neglect, cruelty and exploitation." Obviously, this did not happen. Why didn't it? Why does it go on and continue — not only me but other children up to today? Because the public does not know what it is like . . .

□ □ □ □

My name is Diane Capponi. I was institutionalized in Queen Street, Toronto. One of the major rights that I almost lost was the right to my child. If I had lost my child, I would have lost my life. When I was discharged from Queen Street, I went into a boarding room, one of our infamous homes. The local Children's Aid (Society) was telling me what to do. . . and I'd like to say that something should be done to help mothers, especially single mothers in Toronto. They have a lot of tensions, a lot of stress to deal with and probably do not want to be institutionalized. If I did not have my daughter, I would not have my life right now. . .

□ □ □ □

My name is Connie Neil. I work for the City of Toronto. About twenty years ago after my daughter was born — she's up there in the taping booth — I had a post-partum depression. And after some initial talks with a friend of my husband's family, an alcoholic family doctor, and half an hour with a psychiatrist who wouldn't consult my previous history in Toronto, they put me into the Ontario Hospital in Hamilton and I was committed. And I was given a lot of shock treatments. And as a result of that, I'm missing between eight and 15 years of my life.

Before I had the shock treatment, I was awarded Best Actress across Canada. Now, I can't memorize a script. Before, I had considerable recognition as a writer. Now, all I can do is public relations because any writer works from personal experience and I don't have any experience from before the shock. And what they did was terrorize me to the point where anytime I'm threatened with anything now, I'll become very small and I'm not able to function as I should, and my intelligence is diminished. They hurt me badly by making my personality less. And I think that what should happen now is that some of us who know what is going on in the institutions should do what we can to stop people from diminishing us, and that really was done, and I think they did it on purpose. I think that was their intention.

would be sponsored by the Mental Patients' Alliance of Central New York, and which was the scene of probably the most upsetting incident of the Conference — a physical attack on one participant by another, followed by the ejection of the attacker. Although I wasn't there, I have strong feelings about what happened. Physical violence against one another is totally unacceptable to me, and I see the ejection of the perpetrator not as oppression (as some charged), but as a necessary defensive action. My sympathies lie totally with the victim of the attack.

Disruption was a problem again this year, unfortunately.

Several participants insisted on being heard every time they wanted to speak, and seemed totally uninterested in listening to anyone else. I heard some relatively new people complain that the Conference was dominated by a small number of old-timers, but what I saw was different — old and new people working enthusiastically together. Our movement is not unique — it seems there are always some people who would rather complain than do anything constructive.

Process was also a problem once again. Hours were consumed in deciding at each plenary session whether there should be a chairperson or a rotating chair, whether there should be a fixed agenda and how speakers could be held to it. Process is important — one of the basic tenets of our movement is that we all need to be heard and listened to. But process questions also detract from more substantive decision making. (I don't have a solution to this dilemma, and I don't think anyone does.)

*'A sense of
joyous
rededication'*

But out of all the disagreements, all the hassling, came (at least for me) a sense of joyous rededication. We had come together, had established a functioning community (which fought and feuded, but also produced and celebrated), had further defined our politics, had confronted our enemies. Much credit is due to On Our Own for finding such an excellent site and making (nearly) everything run smoothly.

Leonard Frank: an interview

(Following is a transcript of a broadcast aired on the "Metro Morning" show of CBL radio on May 13 in Toronto. The interviewer was Joe Coté.)

JC: *The man we're about to hear from was once diagnosed as a "chronic paranoid schizophrenic." He was subjected to oral medications, injectable tranquilizers, electro-shock and insulin coma treatment. He believes the intention was to cause permanent brain damage. Leonard Roy Frank says he was brutalized, and that it's happening to thousands of others. He's in Toronto to attend the Tenth International Conference on Human Rights and Psychiatric Oppression, and he's joined us in the studio. Good morning, Mr. Frank.*

LF: Good morning, Joe. Please call me Leonard.

JC: *It all happened when you lost your job as a real estate agent in 1961. Was business that bad, or what was wrong?*

LF: Well, it wasn't that the business was so bad, although it wasn't particularly good. I had begun to change my life style and change my values, and I became much more religiously oriented than I had been previously. And with those changes, I lost interest in what I had been doing which was being a real estate salesman. So I sort of dropped out of that and became very avid in my pursuit of knowledge and understanding and filling in some of the gaps in my education, which I felt had been neglected.

JC: *How did that lead to psychiatric treatment?*

LF: Well, my parents became very concerned about that and ultimately they sought out psychiatric treatment for me, and—they had me locked away in a psychiatric facility near the city of San Francisco in California. It was while I was there that I was subjected to all of these forcible treatments.

JC: *But it was your family that had you committed.*

LF: Yes, indeed. And they felt that my changes, my personal changes were evidence of some kind of mental disorder, and that's why they brought in the psychiatrists. And I was involuntarily committed. and underwent the shock treatment and the forced drugging.

JC: *In lay terms or straight language, you had led a normal life in your parents' eyes, I assume, and then you had opted out and found religion?*

LF: Well, that's very much what you would say, that's the way I was seeing it, but my parents didn't see it that way. They saw it as an aberration, something that had to be straightened out, and the people who straighten things like that out in our society are the psychiatrists. And the way they straighten it out is through involuntary commitment to psychiatric institutions and forced treatment. And that forced treatment is in effect a kind of brainwashing and re-programming. The shock treatment that I went through created an enormous amount of memory loss for me. It was in effect like an electrical brainwashing. As one psychiatrist who specialized in shock treatment said, that following the treatment "the patient's mind is like a clean slate upon which we can write." And that epitomizes what psychiatrists who use shock treatment are really into. A lot of people think that shock treatment is not being done on a wide scale, but the truth of the matter is that between a 100,000 and 250,000 Americans alone every year are undergoing shock treatment. But an even worse abuse is the use of forcible drugging — the use of these very powerful tranquilizers and so-called anti-depressants, which merely debilitate, de-energize and confuse people and enable them to walk around in a very fogged state of mind. That is happening to literally millions of people every year, and rarely are people told about the devastating effects that these drugs have permanently on your neurological system.

JC: *I understand the psychiatrists who administered the initial shock treatments described you as being "somewhat withdrawn and having rather unusual beliefs."*

LF: Well, that was it. In my records which I was able to get about nine to ten years subsequent to my institutionalization, it was indicated that he felt that my big problems were that I was a vegetarian, that I had grown a beard and that I had religious preoccupations. And the purpose of the shock treatment was to get me to live a more normal, adjusted life.

JC: *Did he perceive you as being dangerous potentially?*

LF: Well, he said on the basis of the strength of my beliefs, I was a dangerous individual. It wasn't that I was just 'paranoid schizophrenic', I was 'paranoid schizophrenic, chronic and severe.' This is the worst possible label that psychiatrists can hang on a human being; this is the kind of label that

Connie Neil



*We're here to talk to inmates
We know they won't be still
We're tired of psychiatry
Which says pay me & take your pill.*

*Inmates, did they tell you
That drugs would set you free
Strange how that rumor got around
That's exactly what they said to me*

*Sister woman sister
Can you still feel any pain
Or have they robbed you of your anger
While putting Thorazine in your veins*

*Sister woman Sister
Have the walls grown up so high
That you can't even dream of leaving
And you've forgotten how to fly*

they hang on the multiple murderers, the worst kinds of vicious criminals. And here, I'd never violated any law. I'd never even been charged with being a 'nuisance.' I was just taken out of my apartment, thrown into the psychiatric institution and then kept there until they thought they had me 'cured' — the cure being, of course, that I would think and be and act as I had been
JC: *I'm not a psychiatrist clearly, but I'm wondering if in the view of the psychiatrist he didn't know at the time whether or not you might perhaps do something dangerous to society. stopping a budding John Hinckley.*

LF: Well, that's frequently the argument that is used by psychiatrists to justify their interventions. But the truth of the matter is there's no way to predict what an individual will do with his life, or whether he will conduct himself in a socially approved manner, or whether he will violate the law. It's no business of the psychiatrists or anyone else to lock people up who are merely perceived as being 'dangerous'. In a free society, people have the right to be different, people have the right to be *thought* different. I mean, that's at the essence of our freedom, and when that right is violated something very precious is lost in our society and for the individual. And it should be stopped. Preventive detention, that's what it is. It's all on suspicion that you may do something wrong. In a free society, only those people who have actually violated the law should be denied their rights. But in psychiatry, there are literally hundreds of thousands of people every year who are locked away merely on the supposition that they *may* do some harm.

JC: *Tell me about the shock treatment.*

LF: Well, the shock treatment is a form of electrically-induced brain damage. Electricity is the human brain is like a bull in a china shop. The difference is that in a china shop the dishes can be mended, but brain cells once destroyed are destroyed forever. The major effect of that whole process on me was a two-year memory loss for the period immediately preceding the shock treatments. And for tens of thousands of other people, they go through the same kind of thing. The kind of shock treatment that I went through was particularly intensive, but today they do it with anywhere from six to twelve or fourteen electrically-induced convulsions, and it has a devastating effect on those people who undergo it. And rarely are these people told that they're going to suffer from brain damage, memory loss, learning disability, and they might possibly die from it, and that's especially true with elderly people.

JC: *Leonard, thank you for coming in and talking about it.*

By DON WEITZ

The sit-in at the Sheraton

The sit-in at the annual meeting of the APA (American Psychiatric Association) on May 17 in Toronto was one of many highlights of our conference. Conveniently, the shrinks were meeting about the same time (May 15-21) as we ex-inmates were (May 14-18). On May 17, 16 conference participants, all ex-psychiatric inmates from the United States, sat peacefully for over two hours in the main lobby of the huge Sheraton Centre, directly across from City Hall, where the APA was meeting. By 10 that night, all 16 of the "Psychiatric Inmates Liberation Lobby" were arrested for trespassing.

Organizing the sit-in began only a few days earlier at the conference. Although the conference previously decided by majority vote not to endorse any action beyond the planned public demonstration, people were free to plan and take personal responsibility for any other action. About 12 people started meeting to plan strategy for the sit-in, which would be peaceful, a non-violent and silent vigil. A small support group of four or five people was quickly organized to deal with legal and money matters arising from the sit-in, as well as the media and to offer whatever other support was needed. (The support group consisted of Judi Chamberlin, Sally Zinman, John Judge, myself, and one or two other people whose names, unfortunately, I forget. Sorry; it's a busy time.)

Monday, May 17, 6 p.m.: About 25 of us (conference participants) meet with a few shrinks and other mental health professionals in a Sheraton room to tell the shrinks and others about some of our immediate issues such as forced treatment and personal psychiatric abuses. (The room was reserved for us by Wes Pomeroy, APA's PR person.) Predictably, very few shrinks—only three or four—bothered showing up to listen to us.

7:15 p.m. All 16 demonstrators leave the meeting to go to a workshop on "alternatives." Actually, they troop down to the lobby to start the sit-in. The support group follows right behind.

7:30-8:00 p.m.: A small and tight circle of people are all sitting in an open area of the main lobby; our 16 brothers and sisters are sitting close to each other with arms linked. A few hundred shrinks are milling around the lobby looking stunned; some laugh nervously or make snide, sane-chauvinist remarks about those crazy "mental patients."

8:00-8:30 p.m.: David Oaks, John Judge and I are handing out copies of the conference/sit-in flyer to the shrinks and anybody else who's around or looks interested. David is also busy taping



The Globe and Mail

brief exclusive interviews with a few shrinks and other mental health professionals to get their reactions to the sit-in, drugging, electroshock or forced treatment. At the same time Wes Pomeroy, the APA press person, is telling Judi how disappointed he is in us: "You broke our agreement," he says. Actually, neither Judi nor anybody else from the conference agreed to stay out of the lobby or promised Pomeroy anything.

8:30-9:00 p.m.: Psychiatrist Milton Shabshin, APA's medical director, appears on the scene and begins talking with Judi, whom he knows. Judi fills Shabshin in about the sit-in and Shabshin starts acting somewhat understanding and also begins talking with the Sheraton manager in an effort to buy more time for the sit-in and cool things out. The manager wants to throw us all out immediately or call the police to arrest us. Judi tells Shabshin and the manager that she first must consult with all the sit-in people to find out what they want to do. Judi and Sally go around consulting with each of the 16 people. All vote to refuse to move. The Sheraton manager calls the police.

9:00-9:30 p.m. Five or six police arrive, in addition to a reporter from the *Globe and Mail* and a camera crew from City-TV who actually arrived some minutes before the police. The scene is getting tense and ugly. The manager repeats his request that we all leave immediately; the police sergeant or cop-in-charge warns the sit-in people they'll be charged and arrested for trespassing.

9:30-10:00 p.m.: The police start literally dragging all 16 sit-in demonstrators out, one by one, as everyone goes limp. Nobody resists arrest, nobody gets physically hurt. The police pile the demonstrators into a paddy wagon and police car. At the same time, Sally and I phone lawyer David Neuman, who had previously volunteered to help us with any legal hassles such as arrest and bail, to tell him what's happening and that the police are taking everybody to the police station a few blocks away. Neuman says he'll shortly call the desk sergeant at the station about arranging for people's release and bail. (He called but the police never told us; he was also trying to raise bail money.)

The people arrested are: Steve Kivari, Maria Kivari, Larry Brittan, Ann Boldt, George Ebert, Christine Beck, Clark Pennington, Sharon O'Hara-Bruce, Martha West, Leonard Roy Frank, Cindy Merrithew, Bob Harris, Lenny Lapon, Joe Rogers, Virginia Raymond and Dave Gendler. (Most people pleaded guilty, five pleaded not guilty.)

After about an hour, an ex-inmate announced that an "alternatives workshop" would now be held. Several ex-inmates promptly left the room; they had actually gone down into the middle of the Sheraton lobby and began a sit-in/vigil. As I rushed down the hallway to the lobby, I saw APA security man Wes Pomeroy talking with Judi Chamberlin and other ex-inmates. He told Judi, "You've broken the trust I though I had in you." Meanwhile, the Sheraton security head was saying something strange: "The lobby and hotel is a public area, and I don't want a demonstration there."

The Sheraton lobby is a very plush place with complicated levels and connections with stores and meeting rooms. The center of the lobby is a large carpeted square surrounded by couches with a gaudy mirrored ceiling directly above. And plopped in the middle were 16 former psychiatric inmates holding a silent protest in a large ring facing outward and holding up signs. One read: "IN MEMORY OF OUR SISTERS AND BROTHERS KILLED BY PSYCHIATRY."

I interviewed several of the hundreds of psychiatrists who were standing around and watching the sit-in. They usually spoke in unnaturally low, slow voices about the need for a "balanced" view. They would then drift off into other details or subejcts to avoid what was happening. Some psychiatrists were more blatantly interventionist. One said, "These people are sick." His colleague laughed. "Look, he needs more Haldol," the shrink said of one demonstrator. He continued: "They need more medication. They need E.C.T." I asked him, "You mean you'd like to give it to them right now?" His friend and colleague answered, "We would like them to go to the hospital to get proper treatment." I then asked them about the side effects listed for Haldol, including sudden, unexplained death. "Don't give (him) your name," said the first psychiatrist to his friends. "This guy (me) is psychotic himself." The shrink quickly covered his name tag with his hand. I told him, "You look a little paranoid, don't you, doctor?"

Back at the sit-in, the protestors continued to sit calmly, silently. A few smiled, most held signs. The casual-appearing APA security guards and the more uptight Sheraton cops drifted around the circle in the midst of the press reporters, television cameras and ex-inmate supporters who were handing out leaflets to the shrinks, talking with the press or negotiating with the authorities. In the background were hundreds of amused, puzzled or blank-faced psychiatrists.

A few psychiatrists I interviewed said they opposed the use of force in psychiatry, usually because they disliked electroshock, but most doctors were covertly in favour of coercive procedures. Some even denied the existence of any forcible psychiatric procedures! One fellow said he was "an old hippie from the sixties." He supported coercive drugging. As I argued with him, an ex-inmate stepped up: "My name is Kendra Russell. I've been forcibly drugged; I've had electroshock; I've had insulin therapy."

"Oh my God," Larry, the ex-hippie, blurted out. Kendra continued telling him about how she had been mistreated in Canada (Manitoba). Said Larry, "If it's used appropriately . . ." Kendra quickly replied, "The trouble is it is used inappropriately three-quarters of the time."

At the sit-in I asked Dr. Melvin Shabshin, medical director, and one of the top eight officers of the American Psychiatric Association, what he thought of the sit-in.

"Our reaction," he said, "is that some of the concerns are very useful questions. We've attempted to answer them in the past. We understand what they're trying to do. We sympathize. We've been more helpful than the group has acknowledged."

I asked him about forcible drugging. As he put it, "Could we say that occasionally and quite rarely when patients are committed, occasionally there is use of medication, to which the patient has not given consent." He denied that any forcible electroshock existed today.

I asked him, "Is it true that there are drug-related deaths connected with the neuroleptics such as Thorazine, Haldol, Mellaril, Prolixin?"

"Probably much less than with the use of Penicilin," he said.

"Is it true that it does occur, though?" I asked him again.

"It is true that occasionally there are deaths from almost all medications," he replied.

"Does that mean yes?" I asked.

"The answer is 'yes,'" he finally said.

Later, the police suddenly began to arrest the peaceful protestors. They pulled each one from the circle and then dragged them by their arms out the

10:30-12:30 a.m.: We anxiously wait in the police station for everybody to be released. The sergeant tells us that bail is \$53 per person or a total of \$846 for all 16 people. We don't have the money. Sally Zinman calls Mel Starkman at the conference; Mel quickly consults with a lot of conference people who unanimously decide to use the conference funds for bail money. At the same time, I call Carla McKague (a conference participant, On Our Own member and lawyer) to tell her what's happening; she says she's coming down to the police station with the conference money for bail. Carla arrives about 30 minutes later and immediately starts negotiating with the police and the Sheraton 16 with cash in hand. The bail fines are all paid, everybody is released, and we all cheer and hug each and every person as they walk out free, including Carla.

At the very least, the sit-in "demo" communicated the message that psychiatric inmates and ex-inmates will no longer be ignored and abused, that we are human beings and have rights, that we are going to keep fighting against psychiatric atrocities and for our rights.

Some of us Canadian ex-inmates plan to take that message to Montreal between Sept. 29 and Oct. 1 this year. That's when the Canadian Psychiatric Association is holding its annual meeting. We'll make sure the Canadian shrinks get our message too.

door.

After the quick arrests, I walked over to a much smaller group of suited people, including the APA and Sheraton security people.

"Who ordered the arrests? Would it be the APA or the Sheraton?" I asked.

"One of them," said Sheraton security chief Eric Robb.

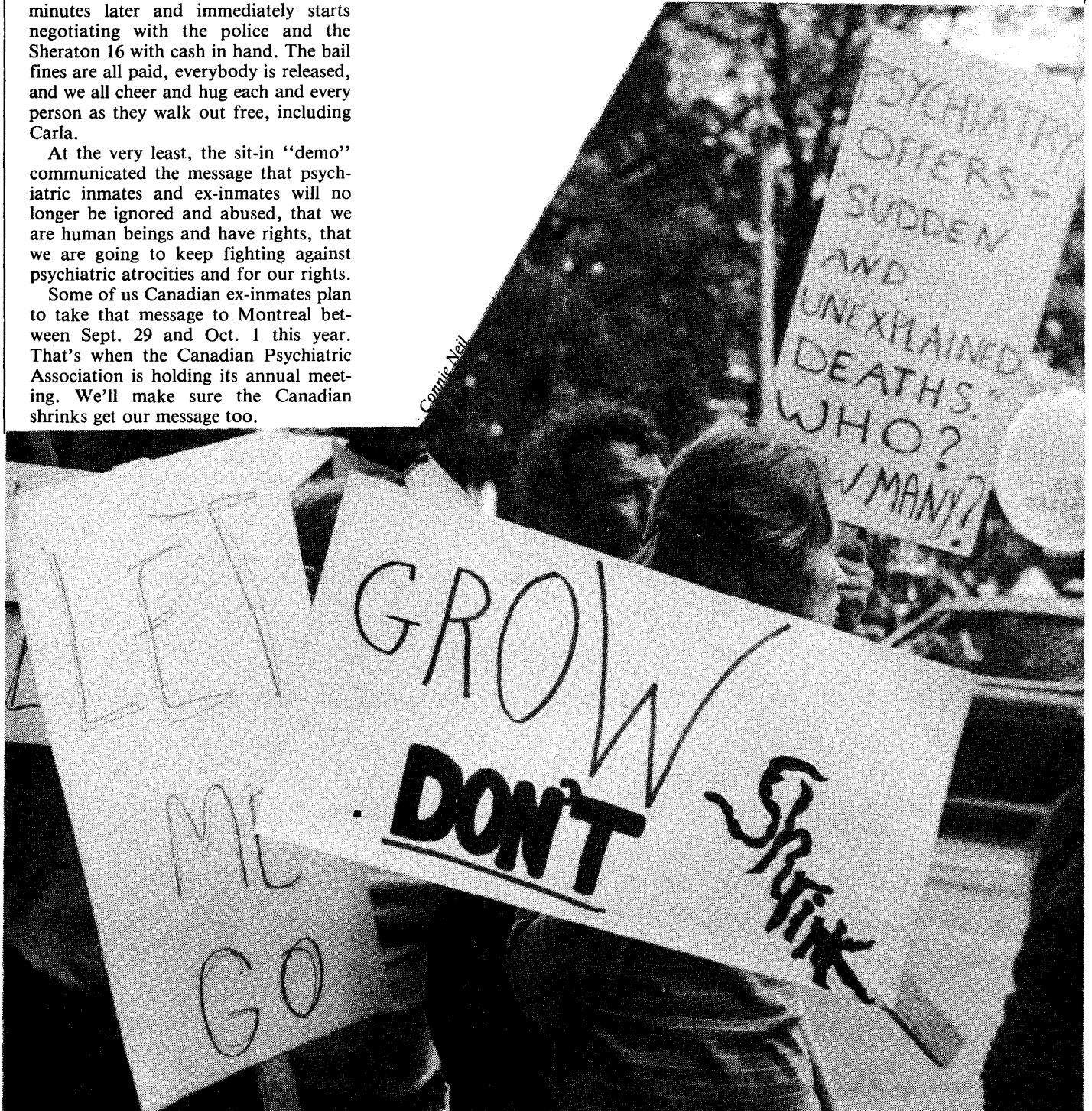
"Which one?" I asked.

"I have no idea."

"Is it a secret?" I asked.

"Call it a night," he answered.

Back at Innis College, the rest of the conference participants were very upset. They had skipped a major meeting and instead stayed glued to the TV set searching for any news about the demonstrators' fate. Later that night, after several draining hours in jail, all the ex-inmate demonstrators were released.



Why I supported the sit-in

By MEL STARKMAN

*"These are hopeless,
helpless people."*

This comment came from a psychiatrist who refused to be named on CBC-TV's early evening coverage of the demonstration in front of the Sheraton. For some time, I have been aware that some psychiatrists are merely misguided, and not elitist or lacking in moral understanding. But that demonstration opened my eyes and ears to the evils of psychiatrists.

My "mental" struggle over the last few months on the role of psychiatrists was focussed in front of this downtown hotel, where I was one of those coordinating an angry, but humorous demonstration that was peaceful and responsible. The expressed anger of the demonstrators, as seen in their signs and faces, was like a tinder-box. It could have become an ugly scene; it didn't, thanks to our good sense and that of the police officers present at our request. No thanks were due to the well-fed, well-dressed, sneering, supercilious psychiatrists who were looking on.

Throughout our march, we had received a lot of support from many passers-by. The leaflets we handed out were read with interest. One black woman broke down and cried and wished us well. She wanted to talk

about her experience and I gave her our group's address.

In front of the hotel, we met a rag-tag of what I now call the enemy. Several shrinks took off or hid their name badges. Most of their faces were stony and cold. Several young psychiatrists, acolytes to the perfidious priests, grinned. Older APA delegates were locked into their banality and their professionalism; mid-afternoon suits often covered protruding paunches.

As our people sashayed back and forth, sang anti-psychiatry songs and performed street-theatre, the hotel security chief and the attending police officers kept warning us not to commit petty trespass, i.e., sitting down, standing still or leaving our signs lying around. The media were interviewing our people; it was a good show.

I was tired, sad, and anxious; worried that our anger might invalidate the message we were trying to deliver: i.e., that society cannot deal with the free expression of opinion and life style; that psychiatry serves as a social control, using damaging powers and instruments of their pseudo-science; and that we must resort to confrontation to be heard.

A microphone and TV camera were thrust in front of me. I was one of the delegated spokespersons for the Canadian contingent. The interviewer asked me why we were here and I felt like lashing out with verbal violence—"because you won't listen to us unless we put on a good show to entertain your viewers." Fleeting thought, 'we're here to try to prevent you from being psychiatrized.' I felt like a bold American instead of a timid Canadian. On the streets of Toronto, a little bit of Americana was being played out. Our Movement, which bridges the gap between the anger and beauty of the sixties and the call to moral responsibility of the eighties, had brought its grass-roots, here-and-now struggle to Canada.

We left at our scheduled time. I was proud of us. I was pleased that, in this instance, Toronto had done well—our demonstration had not been goaded into violence.

Later that evening, the sit-in at the hotel took place. I heard about the sixteen Americans who were arrested for trespassing on private property to protest the ongoing invasion of our minds and bodies. In balancing the profits of hotel keepers against the despair of those who are now illegally and forcibly incarcerated in asylums across the continent, I could not but support the sit-in. We shall be free.

THANK YOU TO CONFERENCE ORGANIZERS AND PARTICIPANTS

A lot of people helped make this year's Conference in Toronto a huge success. Without your presence and support, the Conference wouldn't have happened. So, we want to thank everyone who helped some of us ON OUR OWN members to organize the Conference back in January. The people from the United States and Quebec who attended the first planning meeting of the Conference Committee were: Jean Dumont (Ithaca, N.Y.); Fred Masten (Staten Island, N.Y.); Renée Bostick (Columbus, Ohio); Judi Chamberlin (Somerville, Mass.); Su Budd (Kansas City, Ka.); Paul Morin (Quebec City, Que.). And we thank those people who came to Toronto a few days before the Conference to help us with many important, last minutes details: Leonard Roy Frank (San Francisco, Ca.); David Oaks (Chicago, Ill. and other places); Steve Stapelton (Regina, Saskatchewan); Judi Chamberlin. And our special thanks and deep appreciation to all the ON OUR OWN members who worked long and hard on various sub-committees or task groups to make it happen: Carla McKague; Mel Starkman; Coreen Gilligan; Connie Neil; Nancy Connor; Susanne Partridge; Jane Bowden; Mike Mallon; Don Weitz; and Alf Jackson.

We won't forget; neither will the APA shrinks. ON TO SYRACUSE OR SOMEWHERE IN NEW YORK NEXT YEAR!



profiles

Montrealers film the Conference

By CONNIE NEIL

Three members from Auto-Psy, in Montreal, shot about 300 minutes of video tape recording during the Conference which will be edited to a 45-50 minute video.

Paul Morin, 31, a Board member of Auto-Psy (short for Autonomie-psychiatrie), said the edited video would be ready in English first in September, and a little later with French subtitles.

"We taped in entirety the personal tribunal and press panel—about 90-100 minutes—and 20-minute tapes will be available for \$35 a cassette to cover cassette cost and duplicating and mailing. The panel at the end took about 30 minutes. For the Movement they are valuable materials: the testimonies are mostly very articulate. If a group took these to show to their own group, it would be very educational. The finished film will be available to the Movement at half the rental cost. If we rent it to a hospital for \$100, it will be \$50 for Movement groups. That's what we plan, but we might make some change in that," said Morin.

The Autonomie-psychiatrie name, coined by the French movement in Quebec to denote people who have been psychiatrized, has been shortened to AutoPsy as a pun on their performing an autopsy on the dead psychiatric system.

In explaining how they developed as a filming group, Morin said, "I met Helen Doyle in February 1981 when they showed AutoPsy the film she made with another woman about women and madness, titled 'Ce pas le pays des merveilles?' or 'This Isn't Wonderland.' We hoped to show it at the Conference, but the equipment wasn't compatible. It had a \$200,000 budget as it is 16mm and a fiction, so

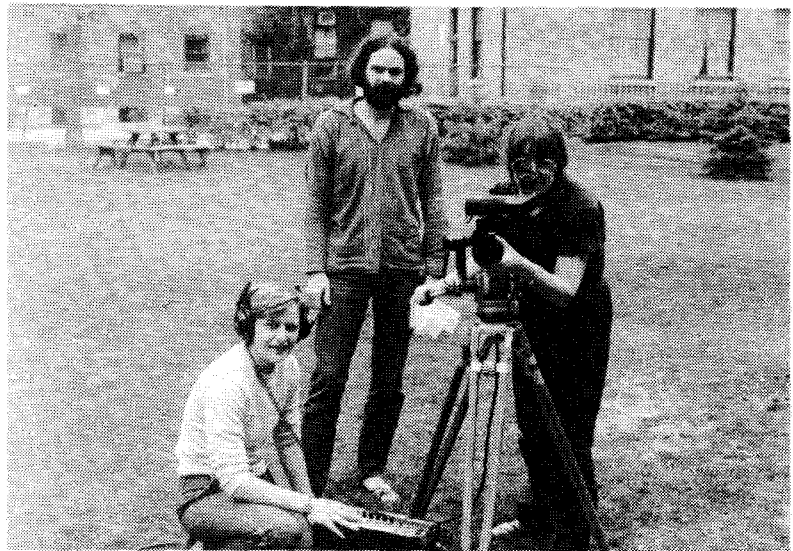
you use actors from the Institut du Québécois du Cinema. It had good reviews. Helen has eight years professional work as a camerawoman, is a founder of Video Femme, made many movies, and a video on rape. She's very talented, very much an activist, and certainly not there for money. Although not an ex-psychiatric inmate, as an adolescent she tried to commit suicide, is an asthmatic, and spent about a year in hospital for health problems."

The Conference film is the first one Christine Gourgue has worked on for AutoPsy. She had been in a Montreal psychiatric hospital and is moving to Quebec to work with the group.

"I worked with Helen before this," said Morin, "making the 88-minute video shown in Quebec and Montreal about psychiatry in Quebec. We inter-

viewed in August/September '81 and finished editing in March '82 when it was shown at the National Film Board office in Quebec for three days for 300-400 people, with good reviews in our main newspaper in Quebec. We have shown it at a meeting at the end of April of all the ex-psychiatric Quebec groups in Montreal. They liked it. This is a loose alliance or federation of ex-inmate groups, half-way houses, alternative psychiatric groups and semi-professionals who have banded together for emotional support.

"We also showed it at Robert Gaffard, the main psychiatric hospital in Quebec. Possibly they will buy it as the administrator is progressive, so we want to steer him the right way. With their readmission rate at 85 per cent, and with them getting less and less money, he realizes it will save money for him to cut readmissions. It's possible the group will get some money from that hospital to start a drop-in centre and it will be given without therapeutic or administrative control. Of course there will be an evaluation, but only as con-



Connie Neil

ABOVE: Montreal film-makers Paul Morin, Helen Doyle and Christine Gourgue brought their videotape equipment to the Conference, representing the Quebec group Autonomie-Psychiatrie. Their 50-minute documentary will be available in September.

cerns the money given and how it is spent."

Financing for that film is from a \$5,000 grant from the Quebec Disabled Persons Office who had originally given \$3,000 for a start-up fund for AutoPsy for the International Year of the Disabled.

"And now," said Morin, "we were given an additional \$15,000 because we went province-wide in 1982.

"We decided to use part of the \$15,000 we got this year to cover this conference because it is a good educational piece and shows a sense of life. The grant money is to educate and organize people with disabilities, to fight for disabled persons' rights, so I think it's a good idea to use some of that money to film the conference."

Paul Morin received his university degree in communications in 1974, but didn't really use it—except for two years as a professor—until last year.

"I'm mostly the researcher because I'm not personally involved in any group. For instance, I was in Boston in '76 at the International Conference—there were no groups in Quebec at that time—on my own because I was interested. Lots of information and research from that conference was used for the 88-minute video we finished in March to show that psychiatry is not a science. It's not very visual, mostly interviews for which research is very important. You must use good research and arguments to show it is not a science.

"Although Auto-Psy is just two years old, it is ascending because we use much research, so it's easier to show our arguments and get funding. We are probably the only group involved in patients' rights. Solidarité-Psychiatrie is more a support group, while ours is more a research group trying to fight for people's rights. We don't have a drop-in or things like that now," said Morin.

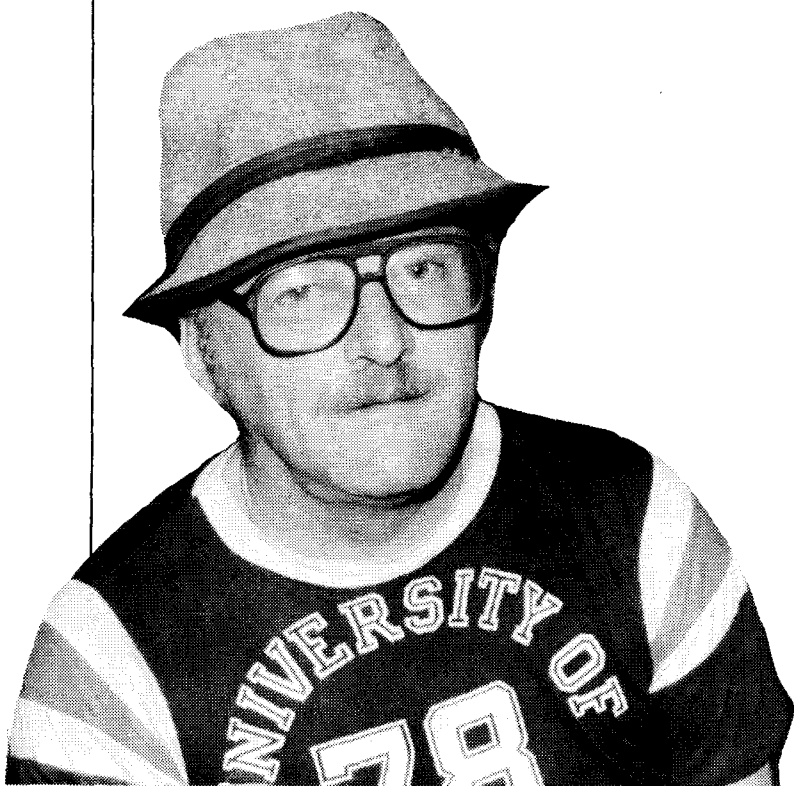
Morin realizes the political importance of ex-inmate only controlled groups, but explains, "AutoPsy is not restricted to ex-psychiatric inmates. There are also sympathizers, friends and relatives. Quebec is a small town and, if you tried to restrict it to one group, there would not be enough to be effective. It works for us. Next week we are showing our video at the psychiatric hospital for the inmates. Now, with Law 27 in Quebec that establishes in every psychiatric hospital a patient's rights committee composed of five people—two from outside—there is a good possibility Christine will be on that committee. Two will be on the Board of Directors of the hospital. I am already a member of the hospital board because the Quebec Minister chooses people from susceptible groups for the Board.

"I think it's good to have access to information at that level. It works for us," said Morin.

'I hope I learn to laugh again'

STEVE STAPLETON OF REGINA

... poetry and public speaking keep him going.



Steve Stapleton, 46, President of Regina's By Ourselves, is one of the half-dozen who came early to the Conference to help with last-minute planning details, do radio interviews to publicize the event, and to talk to *Phoenix Rising* about his involvement in the psychiatric system and his subsequent work in the Movement. Here, as told to Connie Neil, is his story . . .

"It started at about 23 years of age while living with my sister in Vancouver—although I have little recollection of the beginnings because I had shock treatment shortly afterwards. I lived in British Columbia for about 12 years.

"But what I remember is that I went to work with my brother-in-law normally one day—we had to drive about 15 miles into Vancouver—and I stopped at a little coffee shop we used to refer to as Perky's Ptomaine Palace for a package of cigarettes and, instead of going to work, I turned around and started walking home—about 15 miles. And I vaguely remember getting home and coming in the door and my sister saying, 'Where have you been? The boss was looking for you.' I have no recollection of talking to the doctors or anything. I was committed by two general practitioners in British Columbia.

"From what other people tell me, I refused to sign the paper, but once done I was quite happy about it, joking on the way over to the hospital although everybody else was just about sick. I do remember waking up on a closed ward where we were all kept in our pyjamas with the door locked and the radio blared very loudly—someone was always turning it up—and it was very noisy, a lot of patients making a lot of noise, what have you. That was my first recollection at the hospital.

"The first time I was in for about six months. Committal only lasts three months in B.C., but they talked me into voluntarily re-committing myself. In addition to shock treatment, I also got light insulin treatment. They'd quit using coma insulin but they used to give us light insulin. They'd give you a shot of insulin and you'd lie in bed for two or

three hours and sweat like a pig. When you woke up and got up they'd give you glucose, and you were in an encounter group with a psychologist in the afternoon as part of the whole program.

"This psychologist was one of these happy, happy assholes: 'Geez I'm happy, aren't you happy? Isn't everybody happy, happy-happy-happy?' He was such an idiot that I refused to talk to him. He'd put people on the hot seat and usually they'd tell their troubles and cry a little bit, but I just refused to have anything to do with him, I thought he was such a stupid ass. So that encounter group didn't do me much good.

"I was in hospital three or four times after that in B.C. and received shock treatments over a period of five years, sometimes even as an out patient. I'd take the bus out to the hospital, get zapped, have dinner and come home in the afternoon.

"But the last time I was in Essendale I was in Center Lawn, which is an acute building, and they were on the verge of putting me in West Lawn which was a men's chronic building. There were 500 men in there and 1-1/2 doctors (1 part-time), so you can imagine how long you'd be there. I would have been in for five, six, 10, 15 years, I don't know. But they decided to let me go, and I got into a very good boarding home situation, and I never went back to Essendale.

"That was in about '66-'67 and I left Vancouver in 1970. Now I'm 46. So I was in and out until I was 31 or 32. Mostly a few months at a time on four or five different occasions.

"In Regina, since '70, I was also hospitalized several times, but only received shock treatment the first time in Regina, so I haven't received any for six or seven years.

"When I first went into hospital I was very withdrawn and wouldn't talk to anybody. The doctor even gave me a sodium amyltal treatment where they stick a needle into you and you see God for about 20 minutes and talk very liberally, but I found that even in that conversation under sodium amyltal I would only say so much and then close up, wouldn't say anything else.

"As a result of the shock treatments I have whole periods that I can't remember. I didn't have much social life living with my sister—they lived away out in Burnaby, miles from downtown and I didn't drive—but just before I went in the hospital I started going to a church social group and apparently I had a girlfriend. I still remember a movie that we went to—War and Peace—I remember scenes from the movie, the carpet on the floor, the suit I was wearing, but I've no idea who that girl was, and I never saw her again afterwards. She phoned the house several times after I went in hospital, but my sister wouldn't tell her where I was, just said I was gone away for a while.

"I have a sister in Seattle, a lab technician, single; a half-sister—all quite a bit older than I am—who is a nun in Edmonton and the sister I was staying with in Vancouver died last August. She was only 57 but had a massive aneurism, and died in hospital; and I have a niece, her daughter, and my niece's little boy in Winnipeg; and that's all the family I've got. I've never been married.

"Well, I'm quite a bit better these days, although I'm still on medication—I'd like to get off it, but I'll have to do that gradually. Lithium made me violently sick; Modicade made a real zombie out of me—sleep 12 or 14 hours a day—could hardly function at all. Stelazine has worked comparatively well for about 20 years. They changed my diagnosis. Originally it was schizophrenic, and in the last 10 years it's changed to manic depressive and I was on mood levelling drugs.

"When I get sick I get very euphoric. I'll go out and tell Blakeley how to run the province, and everything is just wonderful, marvellous. The trouble is I'm not really *doing* anything, not functioning at all, just high as a kite, or else

I'll get suicidally depressed, and sometimes they alternate.

"I was one of the early members of By Ourselves in Regina, but not one who applied for the original grant, and I took over as president last July, so it's a little over a year old with 50-60 members. We have a drop-in centre in a crummy old building, but with a great location in the centre of downtown in a shopping mall at 1821 Scarth Street, but it's only \$150 a month. We have a limited budget and don't want to spend it all on rent.

"The start-up grant of \$5,600 from the International Year of the Disabled opened the clubroom, then we got \$4,000 from PLURA to help us continue, then we got \$27,000 chiefly for wages from Manpower and Immigration but also for some of the rent and office supplies.

"The one I was instrumental in getting for the club was a \$30,000 grant from the Dept. of Public Health in Saskatchewan, which keeps us in business until next April when we'll have to deal with the provincial government again. There's three paid staff, who look after the clubroom, plan sports activities, do bookkeeping, office work. It's open seven days a week.

"As president I do public relations, speaking engagements, and grant applications, which I prefer rather than being tied down to the clubroom. I also get an honorarium of \$100 a month from CMHA to supplement my disability pension, for being a liaison person. I lead a very simple life. I don't have very expensive tastes except for cigarettes.

"Another thing I have in the works is my poetry and a novel with only about 60 pages done, largely autobiographical.

"I'd have trouble getting a job because I have such a chequered work record over the past 25 years. The one place I could probably get a job if I was really desperate would be somewhere in a cheaper hotel, anything from dishwasher to porter to desk clerk to trouble man to maintenance. My life is busy and I belong to a lot of organizations. I got so caught up a couple of weeks ago campaigning in our local election for a candidate and everything just fell in like a house of cards. I got sick with flu for five or six days and there were people calling me for meetings, from the club. With all the organizations, I just over-extended myself. I have to learn to say NO, and when I leave this conference I'll be saying NO more often.

"I've been such a lot of time in hospitals but, unlike some of our members who have rather severe social disabilities and don't mix well with people, I mix well and am quite a good speaker so I can go out and address groups and clubs and organizations and that gives me a feeling of self-esteem. If I can go to the Y's Men's Club and they invite me for dinner and I talk to them, make them laugh and applaud, it makes me feel worthwhile, at the same time getting the message across about the mental health liberation movement.

"I've been speaking since I was 19, went to a seminary at a preaching order of priests and they'd have you on the stage for any excuse they could think of, reciting Shakespeare, debating, moderating. So I can go into a TV studio and it doesn't bother me a bit.

"Treatment has made me a somewhat more restless person than I was in my younger days, although I had been restless even then. I get up in the morning, have six cigarettes, four cups of coffee, pace the floor constantly, no matter what type of medication I'm on—or no medication at all. So that wasn't really a marked change, but one thing that did happen to me last time I was in hospital—since then I've just completely lost my sense of humour, in the way of being able to laugh. I haven't really laughed in three or four years, really laughed so you hurt. I don't really know what did it . . . maybe the male menopause, who knows? I'm not sure. I hope it will come back because I used to be a rather happy person."

You can learn to be free from your fears

Most of the 70 people who gathered to hear Dr. Hank Frazer, a psychologist and behavioural therapist at Toronto East General Hospital, talk on the subject of agoraphobia are complex sufferers. Many had spouse or friend accompany them because of the extreme difficulty in overcoming the multiple fears that confront them just in getting to the meeting.

The Freedom From Fear Foundation is a non-profit, self-help group of agoraphobics and friends who meet the last Monday of each month at 8 p.m. in a room at St. Rose de Lima Church in north-east Toronto.

In drawing a profile of agoraphobia—originally, “the morbid fear of open places”—Frazer had his audience volunteer from their personal experience, which convinced them they were not alone.

Many people experience nameless fears that produce anxiety attacks, causing them to be unable to act. They are usually victims of multiple fears, are highly suggestible, practice avoidance, have panic attacks, fear the attack symptoms, worry, are overly and continually responsive to stressors and stimuli. In its extremes, women don't leave their houses, men become alcoholic.

Agoraphobics grow to adulthood with low self-esteem, unskilled at responding to the stresses of today. Often they have a history of not being allowed to be a child, growing up too soon. They have high expectations, are perfectionists, afraid to make mistakes, and take life and themselves too seriously.

Who are agoraphobics? Anyone. One-third of cases are partly genetically caused, with metabolic rates that tick over a little faster to above a critical level. Once above the line and into reaction it's difficult to get under that level again.

Other causes are poor childhood environments and early separation from parent at two or three years of age.

Another factor that links phobics is

an inability to see the true cause of the attacks because of hysterical thinking—like a short-circuit in the brain. As a displaced fear, which might surface as a fear of heights to mask a fear of parents, the sufferer doesn't recognize what s/he truly fears.

They are frightened to express emotions, overreact to environmental stress and believe the reaction is externally controlled, that they can't do anything about it. That is the avoidance pattern at work.

All these patterns and attitudes are learned, and more helpful patterns can be learned to replace them.

Hospitalization is a mistake, as these highly suggestible types easily pick up others' symptoms. Psychoanalysis is too complex a treatment to be effective. And limited solutions such as addictive medication like Valium, too often prescribed with these complaints, avoids the issue by the person if s/he attributes diminished anxiety success to pills. In about one-third of cases, anti-depressant tri-cyclates are recommended.

To combat agoraphobia, you can do some things yourself or get support through the monthly meetings and lectures at the Freedom From Fear Foundation or join one of the groups run by

psychologists to pick up skills that help you relate in the present day to correction — without overreacting.

Because anxiety is governed by thoughts, Frazer has his group members keep a daily diary and thought sheet to record how you make yourself tense, to make yourself look at the trigger, understand it and alter it. These include what you think about that frightens you, what scary things you tell yourself, how you feel during an attack, its length, how you came out of it.

There are also reminders to practice deep breathing and relaxation to help you learn to talk to yourself differently, positively.

Don't run away from anxious situations; manage them. *Don't* fight the attack: practice assertiveness training techniques. *Don't* be afraid of it: relax and let go. *Don't* try to hide it: you can't.

You can contact the Foundation at (416) 221-4090. In addition, two helpful books are *Simple Effective Treatment of Agoraphobia* and *Freedom From Fear*, both written by Claire Weekes.

Connie Neil

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phoenix pharmacy

Paraldehyde— a killer drug still in use

Researched by Don Weitz, here is a breakdown on paraldehyde, the drug that helped to kill Norman Austin Davis.

1. Chemical definition and identification

- mixture of polymers of acetaldehyde, a polyether;
- chemical formula: $C_6H_{12}O_3$;
- brand names: Paral and Paral-Oral;
- manufacturer: Fellows.

2. Pharmacological properties

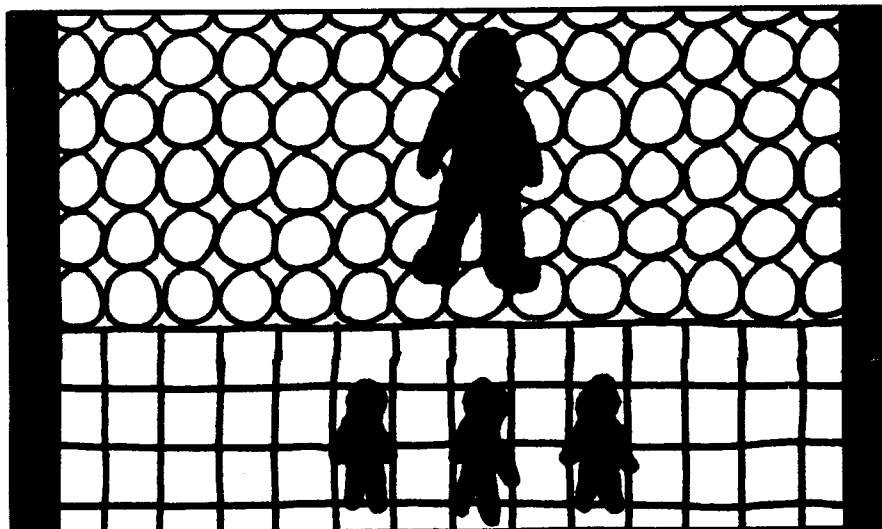
- potent hypnotic/sedative, produces sleep within 10-15 minutes after only 1 dose;
- rapidly absorbed in body, 70%-80% metabolized in liver;
- colorless, emits strong pungent odor, bitter taste;
- highly acidic.

3. Decomposition and storage

- rapidly decomposes or breaks down into glacial acetic acid, which is poisonous, upon minimal exposure (few hrs.) to light and/or air;
- decomposed paraldehyde definite health hazard;
- bottles or ampules of drug should always be stored in dark, amber bottles and kept in dark and cool place;
- only glass syringes should be used for administration (plastic syringes break easily and react with drug).

4. Dosage and administration

- dosages contained in 2 cc, 5 cc or 10 cc ampules or capsules;
- given orally, rectally, intramuscularly or intravenously;
- usual adult dose 5 cc or 5 ml;
- blood levels: normal: 5.0 mg.%; toxic: 20-40 mg.%; lethal: 50 mg.%;
- administration very risky because of drug's well-known caustic or corrosive action, which frequently causes severe irritation and burning of skin and mucosa, esp. throat, stomach, bowel or rectum.



James Dunn

5. Contraindications and precautions

- should never be given to people suffering from pneumonia or any lung disease, liver disease or stomach problems including ulcers.

6. Therapeutic uses

- epilepsy;
- convulsions;
- alcohol withdrawal and DTs;
- eclampsia (convulsions during pregnancy or delivery);
- insomnia;
- asthma.

NOTE: Since mid-1970s, the drug has been rarely used for these conditions because anti-convulsant drugs or minor tranquilizers have proved to be safer and more effective.

7. Toxic reactions and medical complications

- poisoning, acidosis;
- severe burning and irritation to skin or mucosa, especially throat, stomach and rectum;
- damage to sciatic nerve (in thigh and leg);
- tachycardia (rapid heartbeat);
- hypotension (drop in blood pressure);
- pulmonary edema (fluid and congestion in lungs);
- respiratory collapse or sudden stoppage of breathing;
- curvature of spine and total loss of equilibrium (in fish).

8. Deaths

- approx. 150 deaths reported directly caused or linked to paraldehyde since 1890s;
- over 40 deaths reported during past 25 years;
- specific causes include: overdose; decomposed paraldehyde; intoxication or poisoning; sudden stoppage of breathing or respiratory collapse.

9. Summary and conclusion

Paraldehyde has proved to be a dangerous and poisonous drug. It rapidly decomposes into highly toxic glacial acetic acid upon minimal contact with air and/or light. Oral, intramuscular, rectal and intravenous administration of the drug have caused serious medical problems. For example, the drug's corrosive action has caused severe irritation, burning and tissue damage in the throat, esophagus, stomach and bowel or rectum. In the treatment of epilepsy, seizures and convulsions as well as alcohol withdrawal and delirium tremens, paraldehyde has proved to be ineffective or inferior to safer drugs. In addition, the drug is responsible for causing or contributing to almost 150 deaths during its 100 years of clinical use.

Paraldehyde should have been taken off the market many years ago and banned. "It deserves to be retired." (Goodman and Gilman, 1980.) It also deserves to be labeled a health hazard.

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'LET ME KNOW IF THERE ARE ANY SIDE EFFECTS.'



what's happening

One million dollars for "mental health"

Ontario's Health Ministry is finally starting to wake up and do something about the many serious needs and problems of psychiatric inmates and ex-inmates in the province. On May 29th at the annual meeting of the Ontario Division of the Canadian Mental Health Association, Health Minister Larry Grossman boldly announced a package of 25 "mental health" programs to "face the challenges of mental health head-on." The whole package will cost Ontario taxpayers roughly one million dollars in the first year.

Of the eleven projects slated for Toronto, most will provide some form of housing (i.e., halfway houses, supportive homes, etc.) and various social-recreational, support services and more staff for existing programs. Although decent, low-cost housing has been a top priority issue for many years among ex-inmates and frontline workers, the Ministry is actually providing only 57 additional beds, when hundreds are needed. The 57 beds will be distributed among *and* controlled by health, social or community volunteer agencies such as HouseLink, Chai-Tikvah, Toronto East General Hospital and the Metro Branch of the CMHA. To the best of our knowledge, none of these programs and services will be run by ex-inmates, since the government (as well as most mental health professionals) won't trust us because they think we're irresponsible, stupid or "incompetent."

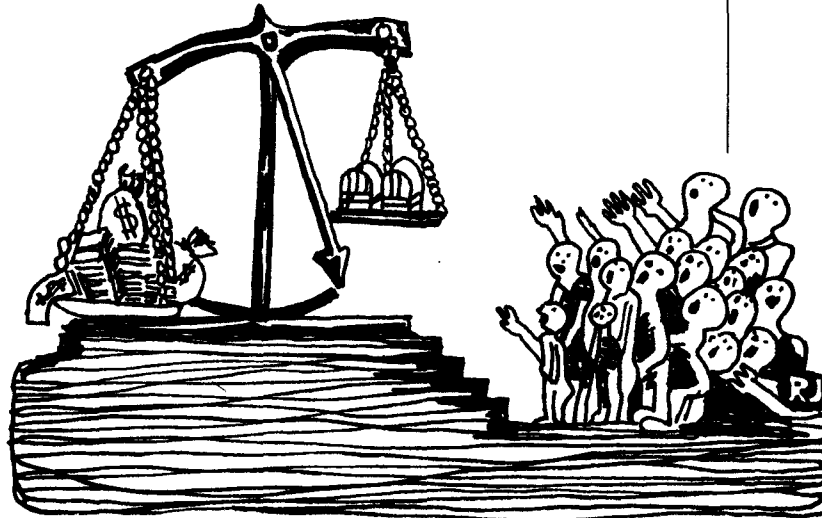
The "Patient Advocate" program announced by Grossman also sounds great and is obviously long-overdue. According to Grossman, ten advocates will be appointed (he hasn't said when or how yet), one for each of the ten psychiatric institutions in the province, including Queen Street. The Patient Advocate's duties, as outlined by Grossman, will be to: help inmates "in the use of organizational mechanisms such as the review board and legal aid;" inquire "into patients' complaints;" explore "problems and mediation with staff;" help inmates "in the understanding of rules and procedures (institutional);" and assure inmates of their "rights such as confidentiality." Grossman hopes the Patient Advocates will "facilitate problem-solving," "provide a reliable source of information about resources available to the patient" and "reinforce the image of the hospital as a *fair and humane* institution." (our emphasis).

Grossman is either in for a big disillusionment or just plain naive to expect advocates to do a PR job on psychiatric institutions which are inherently unfair, inhumane and oppressive. They're beyond hope or reform. AND while Patient Advocates are obviously needed, their hands will be tied if they have to be directly accountable to institutional administrators — who have a vested interest in preserving the "fair" and humane image" of their institutions — and/or "Community Advisory Boards," which still don't exist.

The Patient Advocates' prime (if not sole) responsibility should be to the psychiatric inmates. Otherwise, Patient

Advocates will turn out to be nothing more than government PR agents hired to whitewash illegal or unethical psychiatric abuses such as forced treatment, drugging, electroshock and behaviour modification. These abuses, together with numerous violations of people's civil and human rights, are experienced by thousands of psychiatric inmates every day, in every psychiatric institution in Ontario. Patient Advocates can and should be free to expose and act on them.

Although Grossman hasn't yet appointed any Patient Advocates, it will be interesting to see just how many, if any, are ex-psychiatric inmates. Perhaps he'll appoint one or two token inmates just to make his government look "fair" and "humane."



Raymond J. Mitchell

Coroner claims tranquilizers cause inmate deaths

In the late 1970s, Dr. Frederick Zugibe, Coroner of Rockland County in New York State, published alarming research which showed that the major tranquilizers, even at "therapeutic" doses, were a major cause of death among psychiatric inmates.

After performing autopsies on 203 inmates who died in two state mental institutions while on tranquilizers Dr. Zugibe, along with six independent pathologists, discovered that the tranquilizers frequently suppress the gag or cough reflex. As a result, undigested food particles or vomit get stuck in the lungs, esophagus or windpipe, causing internal choking or strangling.

Hundreds, if not thousands of people have strangled to death while receiving major tranquilizers. Dr. Zugibe found

“aspiration of food and vomitous materials” in 30 per cent of the autopsy cases studied. He also found evidence that the major tranquilizers can mask pain and other symptoms of physical disease, another contributing cause of inmate deaths. The mysterious, “sudden unexplained death” phenomenon reported in psychiatric literature since the 1950s was becoming less mysterious. (See “Phenothiazine Deaths” in last issue.)

New York’s psychiatric establishment was not pleased with Coroner Zugibe’s findings. In fact, they immediately tried to fire him for the heresy of publicly stating that psychiatric drugs can cause death by internal strangulation.

In *The Tranquilizing of America*, authors Richard Hughes and Robert Brewin tell us what happened to Dr. Zugibe in 1978:

When Zugibe raised the alarm in public, the New York mental health establishment reacted with anger. Even before his conclusions were investigated, Dr. James A. Prevost, commissioner of mental health, and Thomas A. Coughlin, commissioner of mental retardation, attacked Zugibe as “totally irresponsible.” When the State Mental Hygiene Medical Review Board completed its investigation eight months later, it elected to attack Zugibe’s personal integrity rather than address the issues he presented. Although the review board accepted the finding of aspiration of death in 29 cases presented by Zugibe and said it could not confirm or refute 13 others because of inadequate microscopic slides, it dismissed the statistical link as comparing “apples and oranges” and demanded that Zugibe apologize to the mental health community. Zugibe refused to back away, and the review board exerted political pressure to have him removed from his job. (pp. 158-159)

In a recent phone conversation, Dr. Zugibe told *Phoenix Rising* he resigned at first to protest this injustice, but quickly changed his mind and was promptly reinstated as coroner. Dr. Zugibe successfully rebutted all the accusations hurled at him by the government-paid doctors in a 75-page paper (unpublished) titled “Death Is An Unacceptable Side Effect.” He has also received many awards from professional and consumer groups, and has made numerous media appearances.

Too bad there aren’t more coroners or doctors like Dr. Frederick Zugibe. We salute you, Dr. Zugibe, for your honesty, courage and research which, we hope, will prevent many more needless deaths caused by psychiatry’s “miracle drugs.”

Cages aren’t for people

There is a new addition to the Queen Street Mental Health Center—a 17-foot high hurricane fence with sharp points on top to prohibit anyone from going over. On May 19, 1982, people from the Parkdale community, the Lower Ossington community, OPSEU, Park Community Legal Services, P A R C, as well as ex-patients of the hospital, and various other community groups, demonstrated against the installment of the fence. Pat Capponi of P A R C says the demonstration was a milestone in that it was the first time in Ontario that both staff and patients were united in a demonstration.

The fence, or “the cage” as the containment area is called, is there to enable Queen Street to accept the overflow from the Penetanguishene and St. Thomas institutions for the criminally insane. The airing court enclosed by the fence is a medium security unit. Obviously the community does not want a medium security unit in its neighbourhood. People

ask, “What’s a medium security unit doing in a residential area or in an open door hospital anyway?” They say they don’t want people in pajamas wandering out in front of street cars, but that the answer is to give them care; not to lock them up. Even the staff at Queen Street is against it.

But the cage has greater-reaching effects for use than just to absorb the overflow from the psychiatric prisons. Inherent in its existence is the potential for misuse as a form of behaviour modification of the Queen Street patients as well.



Any patient who doesn’t “behave” can have the threat of the cage levied against him/her. In other words, the cage has its own abuse built right into it. For instance, at a recent Center staff meeting it was suggested that geriatric patients be put into it, since fewer staff are needed when old people are in an enclosed area. It is difficult enough to prove sanity or justify anger when you are a psychiatric patient. The cause for everything you do can be construed as coming from your “illness.” Ordinary acts like shouting can be considered violent in this context. If THEY don’t listen and you raise your voice, you could find yourself in the cage. It takes less time to deal with you that way, and anything you do or say can be turned against you because you are “crazy” in the first place.

The fence—or even the threat of it—leaves no recourse for argument or assertion of a patient’s rights. It becomes a kind of mind control. The punishment for getting out of line is banishment to the cage, where you are cut off from any means of supportive human contact and subjected to the further threats and abuses of criminally dangerous people. So a hospital becomes a prison.

In short, the effect of the fence is to further take power and autonomy away from patients by the simple fact of its existence. The effects of being incarcerated are emotionally and psychologically debilitating and undermining. The 17-foot-high fence is a real and physical reminder to those behind it that they are indeed incarcerated.

Cages aren’t for people. Hospitals are for care—not imprisonment.

How Québec shut down the exploiters of the handicapped

The only people making money out of the handicapped in Québec these days are the handicapped themselves. It is a situation unique in all of Canada.

Ever since 1978 Québec, alone among Canada's 10 provinces, has required all handicapped workers be paid at least the \$4-an-hour minimum wage. This requirement put every sheltered workshop for the handicapped in Québec out of business.

Outside Québec, sheltered workshops where handicapped people can be legally employed at rates as low as 25 cents an hour continue to exist. Patty Holmes, research director for the National Coalition of Provincial Organizations of the Handicapped, says sheltered workshops still bring "big bucks" to employers who pay low wages to handicapped workers.

The vulnerability of sheltered workshop workers was demonstrated in 1979, says Holmes, when employees at a workshop run by the Canadian National Institute for the Blind in Edmonton went on strike to win an increase in their 40-cent-per-hour pay. The CNIB response was to close the workshop.

The Québec decision replaced the private workshops with 28 fully subsidized Centre de Travail Adaptés where many of the same workers from the workshops now earn the minimum wage to produce goods such as fiberglass boats, furniture, fishing flies and ceramic lapel pins.

The province will pay the full salaries of all the handicapped workers as well as some start-up costs for a CTA. In return, the operators of the CTA must have a majority of handicapped workers on staff and must produce goods that can be sold to eventually make the project self-supporting. The CTA's cannot make a profit but must make enough to pay the salaries of the able-bodied staff.

While the aim of the centres is not to move the handicapped into the mainstream of the workforce, it has happened.

Patty Holmes says the Canadian Council of Rehabilitation Workshops, the national organization of sheltered workshops, is beginning to react to the pressure about exploitation of the handicapped. They have asked COPHO to comment on the current internal review of the council's constitution.

Medical files treated as garbage

According to a recent story in Toronto's *Globe and Mail* (18/2/82), "confidential medical and psychological files on clients of the Ministry of Community and Social Services" were found in a garbage bag in the garage of a provincial government building in Hamilton. An alert and caring citizen found them and gave the unshredded files to a reporter.

Among other things, the files contained "complete medical records, including patient histories, drug prescriptions, drug administration charts, information on drug addiction and alcoholism and letters from doctors; two OHIP cards; dental records; detailed psychological records including psychologi-



James Dunn

cal assessments and case histories; two psychologists' 1980 appointment lists for 115 clients in the Hamilton-Oakville area; references to clients' criminal records, including the prisons or training schools they had been in; records of the ministry's vocational rehabilitation service . . ." as well as letters to and from some prominent lawyers and a letter from Stephen Lewis, former leader of the Ontario New Democratic Party.

Task force plea

Reprinted from an article in the *Edmonton Journal* by Agnes Butner.

It is estimated that one in eight Canadians will experience mental health problems at some time or another. Now they have the opportunity to ask for changes in the mental health legislation in Alberta.

The task force appointed by Social Services Minister Bob Bogle earlier this year to review Alberta's Mental Health Act is looking for suggestions for changes to the act. They want to hear from the general public as well as interested groups and professionals.

"I think unless the task force gets consumer input they could miss the boat," said Canadian Mental Health Association executive director Ron LaJeunesse.

"All too often professionals design something for people rather than with them. But until people are aware of the act they don't know what's happening in it.

"We want input from people who have experienced mental illness or families of people going through mental illness.

"We urge these people to write to the task force directly, or if they are worried about the confidentiality of their submissions, they may send them to us with the request they be kept confidential."

The association is prepared to review these submissions and summarize them before passing them to the task force, said Mr. LaJeunesse.

Some of the controversial issues in the present act that are causing concern were outlined by Mr. LaJeunesse.

•"Mental disorder" is not adequately defined. The Mental Health Act, copies of which are obtainable from the Queen's Printer, says "mental disorder" means lack of reason or lack of control of behavior.

A physician may write a certificate admitting a person to a facility for detention and examination if he believes the person is (a) suffering from mental disorder and (b) in a condition presenting a danger to himself or others.

•“Dangerousness” is not defined. Some people believe what might be a danger to one person may not be a danger to another.

•When should a person be committed? Should there be more general hospital settings for people who refuse to recognize they have mental health problems? Is there a lack of designated facilities where patients may be involuntarily confined?

•Should there be a change in the legislation prohibiting a person who voluntarily enters either of the two facilities going before a review panel to request release?

•Should psychiatric patients confined against their will be allowed more access to review panels despite their doctors' opposition?

•Are people who need treatment finding it difficult to get?

•An adequate treatment plan should be developed for people confined in large institutions so that their length of stay could be shortened.

•The rights of patients should not be violated by government, which has authority to delve into records “for any purpose considered . . . to be in the public interest.”

•Should patients be allowed to see their files? Some psychiatrists argue if patients have access to their files they would not understand the terms used and could assume the worst.

•Should people confined in mental institutions have the right to vote in federal elections?

•Is there evidence that patients' mail is being tampered with?

“Somehow we have to have some sort of system that allows us to provide answers,” said Mr. LaJeunesse.

“I would hope that members of the public with their very own personal experiences or those of family members will come forward.”

Written submissions should be directed before Oct. 1 to: The Task Force to Review The Mental Health Act, 2nd Floor, Centre West Building, 10035 109 St., Edmonton, T5J 3L1.

Submissions may also be sent to Ron LaJeunesse, Executive Director, Canadian Mental Health Association, 201B, 19711 107 Ave., Edmonton, T5H 0W6.

Moving out, moving on

With this issue, *Phoenix Rising* loses — at least as full-time workers — two of the magazine's founders and most dedicated participants.

Cathy McPherson has been Editor from the very first issue. In those early days laying out and paste-up of the pages was done on the kitchen floor of Carla McKague's apartment, that being — so office legend has it — the biggest uncluttered flat space they could find. She brought much to the job, as everyone did, and every new issue showed an increasing professionalism. Cathy resigned as Editor last March.

With her also departed Annegret Lamure, Business and Circulation Manager. Three months later, promotions she began are still bringing in new subscriptions.

Their contribution to the growth of *Phoenix Rising* has been immeasurable. In leaving the magazine, however, they have not left the Movement; and we will always welcome their further contributions.

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Here is *Phoenix Rising's* revised and updated list of Canadian psychiatrists who administer or authorize shock treatments. Listed psychiatrists who no longer use ECT, or who have been mistakenly included in the list, may ask *Phoenix Rising* to remove their names.

If you, a member of your family, or a friend, have been shocked by a Canadian doctor and want his/her name added to our list, please send us the doctor's name and hospital affiliation. We will of course withhold the informant's name, but doctors' names submitted anonymously will *not* be included.

Allodi, Federico. Toronto Western Hospital, Toronto, Ont.

Ananth, Jambur. McGill University School of Medicine, Montreal, P.Q.

Arndt, Hans. Northwestern Hospital, Toronto, Ont.

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

Brawley, Peter. Toronto General Hospital, Toronto, Ont.

Conn, Bert. Belleville General Hospital, Belleville, Ont.

Cornish, David. Alberta Hospital, Edmonton, Alta.

Eades, B. Riverview Hospital, Port Coquitlam, B.C.

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

Furlong, F.W. Sunnybrook Medical Centre, Toronto, Ont.

Shock doctors up to date

Giles, Charles. Alberta College of Physicians & Surgeons, Edmonton, Alta.

Gray, Trevor A. St. Michael's Hospital, Toronto, Ont.

Gulens, Vlademars, Jr. Chodoke-McMaster Hospital and St. Joseph's Hospital, Hamilton, Ont.

Haden, Philip. Kingston Psychiatric Hospital, Kingston, Ont.

Heath, David S. Kitchener-Waterloo Hospital, Kitchener, Ont.

Hoffman, Brian. Clarke Institute of Psychiatry, Toronto, Ont.

Jeffries, Joel. Clarke Institute of Psychiatry, Toronto, Ont.

Jenney, Leslie. St. Joseph's Health Centre, Toronto, Ont.

Kolivakis, Thomas. McGill University School of Medicine, Montreal, P.Q.

Lehmann, Heinz. Foothills Hospital, Calgary, Alta.

Littman, S.K. Clarke Institute of Psychiatry, Toronto, Ont.

McFarlane, W.J.G. Riverview Hospital, Port Coquitlam, B.C.

Mitchell, Wallace. Greater Niagara General Hospital, Niagara Falls, Ont.

Pankrantz, Werner John. Lions Gate Hospital, North Vancouver, B.C.

Peacocke, J.E. Clarke Institute of Psychiatry, Toronto, Ont.

Pivnick, Bernard E. St. Joseph's & University Hospital, London, Ont.

Plumb, Lois. Women's College Hospital, Toronto, Ont.

Rapp, Morton S. Sunnybrook Medical Centre, Toronto, Ont.

Rejskind, Mojzesz. Clarke Institute of Psychiatry, Toronto, Ont.

Rodenberg, Martin. Kingston Psychiatric Hospital, Kingston, Ont.

Roper, Peter. Douglas Hospital, Montreal, P.Q.

Shugar, Gerald. Clarke Institute of Psychiatry, Toronto, Ont.

Sim, David G. Hamilton General Hospital, Hamilton, Ont.

Solursh, Lionel. Toronto East General Hospital, Toronto, Ont.

Stevenson, Cameron M. Kingston Psychiatric Hospital, Kingston, Ont.

Zamora, Emil. St. Joseph's Hospital, Hamilton, Ont.

Zielonko, Walter. Guelph General & St. Joseph's Hospital, Guelph, Ont.

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the Book worm turns

The Therapy Kit, by Norm Forman,
Toronto: Norm Forman, 1982. \$8.00.

Reviewed by **Bonnie Burstow**

The Therapy Kit is intended to help clients and would-be clients choose a therapy and a therapist and negotiate a therapy contract. Like the directory produced by the Women's Counselling Referral and Education Centre (WCR-EC), this book is a landmark in the movement to foster a consumer's approach to therapy.

The movement itself strikes me as being compatible with the major values and principles of the anti-psychiatric movement and indeed, as a "sister" movement. It puts the client in the driver's seat (and where else should he be? It's his life we are talking about!). It sees the client as a human being with capabilities and rights. It reduces the likelihood of "terrible" and/or inadequate therapy experiences. And it sets the stage for an adult-adult relationship.

The Therapy Kit is more comprehensive than most books of this nature. It provides an overview of the major types of therapy, commenting on their philosophies, modes of operation and shortcomings. It distinguishes different types of therapy training. It gives pointers on how to choose the right type of therapy, how to conduct the initial interview, how to ensure you get what you want, and how and when to terminate. It does all this and does it well. I have no trouble recommending it. At the same time, I would like to offer some qualifications, call attention to some problems, and correct some possible misunderstandings.

Most of the problems relate to the section on the modalities, or types of therapy. Commenting on how psychoanalysis operates, Norman states that the analyst sees the client about five times a week. When I first read this, I was confused. Then I remembered that

Norman came from New York. In Europe and in New York, analysis often does work this way. In Canada, it is almost always the same once-a-week affair as the other therapies.

He also states that psychoanalysts discourage their clients from reading about therapy. Let me qualify this. Some do. There are others, though, who actively encourage it. If you want an analyst who encourages reading, you won't have much trouble finding one.

Commenting on Rogerian or client-centred therapy, Norman notes that people often find it superficial. Here we are into subjective impressions, of course. My sense is, though, that this is an atypical reaction. More common are such complaints as: "There's not enough direction given," or "I don't feel it's going anywhere."

These are but relatively minor problems. For me, at any rate, a major problem arises with Norman's inclusion of primal therapy. I react to its inclusion much as I would react to the inclusion of shock therapy. Some of the therapies included, of course, are not as "nice" as others. This one, however, is completely beyond the pale.

I believe primal therapy is blatantly incompatible with client power, or even with the simple human respect the kit supports. The working assumption of primal therapy is that the values and beliefs of the client are essentially nothing but part of a "neurotic system" designed to protect the person from pain. Talking to this neurotic system, negotiating a contract with this neurotic system, and listening to the objections of this neurotic system are considered a waste of time. What primal therapy does instead is to *bombard* the system, *crack* the system, and *reunite* the person with his pain.

If it seems as if I am going out of my way to make primal scream therapy sound violent, I would point out that violence is its method and language. Janov, the founder, is forthright about

it. "The only way to eliminate neurosis," he writes, "is to overthrow by force and violence."

The "overthrow" is accomplished by intensive high-level confrontation—confrontation which often goes on for many hours, day after day. It is accompanied by sensory deprivation. In classical Janovian primal—the type Norman has included—the first day and often the first two weeks are also accompanied by isolation, and sometimes by sleeplessness.



I can't stomach this. This is not therapy, but torture; not growth, but regression. I can't see including it in a book of this sort, except maybe to warn people against it. I am glad it is not as popular as it was five years ago. I can understand, of course, why a desperate person would consider it. There is a lot of propaganda to the effect that nothing else works; and desperate people, of course, are willing to take desperate steps. I would strongly recommend anyone in this position, though, to ask himself:

- 1) Does he agree with the philosophy?
- 2) Has he considered enough of the other options?
- 3) Does he have some friends he can talk it over with?
- 4) Would one of the milder forms of primal suit him better? ("Mild" is a comparative term here. None of them are all that mild.) Would, perhaps, a hybrid form like Transactional Analysis be primal?

Other qualifications and comments on the kit? Someone reading it quickly could get the impression that most therapists operate out of one modality. These days, most therapists are eclectic. So it is not modalities in isolation that the consumer must be able to judge, but *combinations*. Correspondingly, it is easy to get the impression that there is a "right modality" for a person. It's more a matter of timing, or what you are up to. If you are just beginning and feel you need support, a confrontation type like gestalt is inadvisable. Later on, you might feel you would benefit from more confrontations. Some are okay with gestalt right off. It's a question of going with what feels right at the moment, and keeping in touch with your emergent needs and directions.

Where do consumers generally err? Norman identifies a number of common errors. I like this section and highly recommend it. My own sense is that the most common error is taking on a more confrontational type of therapy than you are "okay" with. This error is often compounded by staying with the choice out of the conviction that if the therapy is hurting, it must be good for you. There are many therapists who buy and encourage this pain/cure equation. As with everything else, you have to make up your own mind. Personally, I find the formula woefully simplistic. While a certain amount of discomfort does occur in a change process, I see no reason why therapy can't be a fairly tender and loving experience.

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John Marshall. *Madness: An Indictment of the Mental Health Care System in Ontario*. Based on the public inquiry commissioned by the Ontario Public Service Employees Union. 1982. 255 pages. \$7.50.

Reviewed by Mel Starkman

At a press conference in Toronto's Park Plaza Hotel on May 20, 1982, OPSEU released John Marshall's *Madness*. This book should be **must** reading for anyone concerned about one of the most aggravated social issues in our province—the treatment of people with emotional problems, and those who do not fit the norms established by society. As one observer at the Toronto hearings cried, "I'm ashamed to be a Canadian . . . Find a way of propping that rock to get our legislators to look under it."

The union-sponsored public inquiry provided the raw material for Marshall's book. This inquiry had been undertaken by OPSEU in the absence of a public inquiry by the Ontario government, in spite of repeated requests by opposition parties, many organizations, individuals and newspaper editorials. ON OUR OWN, *Phoenix Rising* and the Coalition on Psychiatric Services (COP.S.) had been among the earliest in the field asking for such an inquiry.

The blue-ribbon panel was unacceptable to many ex-inmates. Because there were no consumers on the commission, ON OUR OWN boycotted the hearings, which were advertised in thirty-eight (38) newspapers. Besides being a legitimate voice of psychiatric consumers, ON OUR OWN was concerned that this commission would serve first the interests of direct care workers, union members and only incidentally, if at all, the victims of Ontario's ill-conceived "mental health system."

John Marshall, a journalist of insight and concern, with access to limited information, has detailed a horror story in readable form.

MADNESS takes us on a journey—a packaged tour of Ontario's "mental health system" from All-Saints hostel, through the ex-inmate ghetto of Parkdale, to the urban and rural remains of the institutions (such as Brockville) that haunt our collective memories. Along the way we get a blurred snapshot of Oak Ridge (Penetanguishene Mental Health Centre) where psychiatry, criminality and violence interact in a bear

pit. That story still remains hidden from an Ontario public who likely would not want to know, but should.

"The day of patients' rights to a say in the system is, or should be, here; but those rights should coincide with the rights of the direct-care staff to have a similar input. When their mutual interests humanely coincide, it will mean the system has been brought to its efficient and caring potential." (p. 96).

Included in the book are two research studies, "Summary of Research Studies on Mental Health" by Francine Solitar, and "Summary of Research Studies on the Mentally Handicapped" by Catherine Farrell. While informative and interesting, particularly on the biases of direct-care workers, there is no evidence that the researchers consulted ex-inmate literature and documentation, although much is available.

MADNESS probes beneath the anger, the frustration and the lack of communication to lift the lid on a story that needs to be told. Marshall bridges the chasm between victims and direct care workers, each locked into institutional psychiatry's ill-founded treatment patterns and strategies. Marshall sees the need to rethink how to care for patients in and out of hospital, and that this should involve consumers.

Other appendices include statistics and overviews on mental health issues, such as housing, social assistance rates, aftercare analyses, and a sample *assaults*

on staff form. *Assaults on patients* statistics were not gathered.

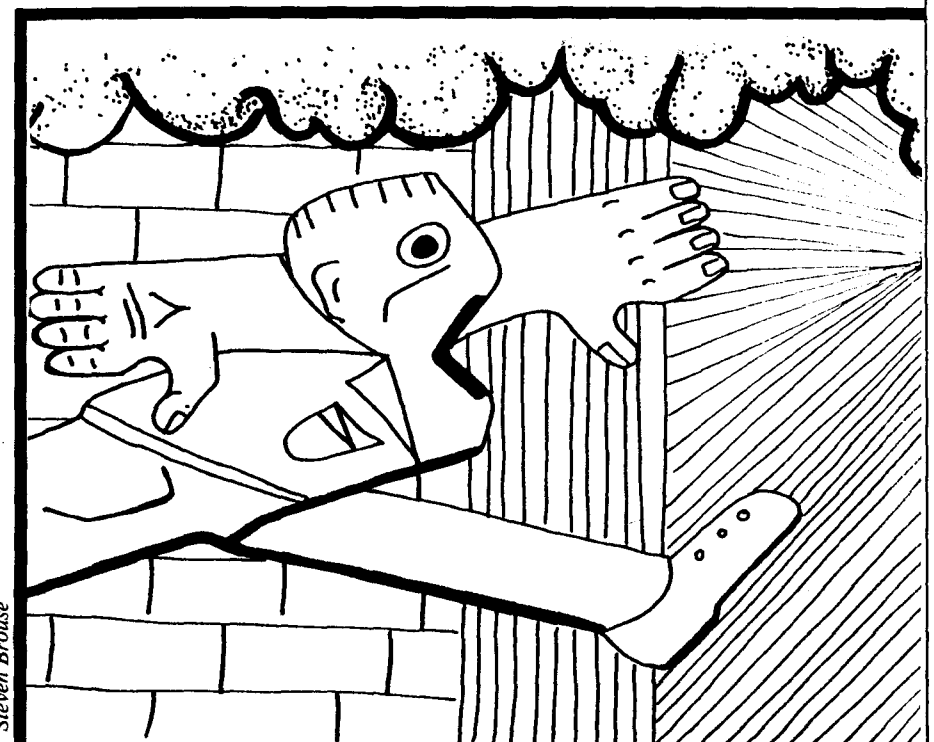
An important inclusion in the book is the Commission's 54 recommendations, which range from the calling of a Royal Commission or public inquiry; to decent care in the community—housing, employment and dignity; and to "scrutinize medication policies with a view to reducing undue reliance on drugs."

Patient input is recommended regarding the Mental Health Act and full cooperation with ex-patient organizations, including, if they ask it, meeting rooms at institutions. Finally, increases of and safeguards for staff are requested.

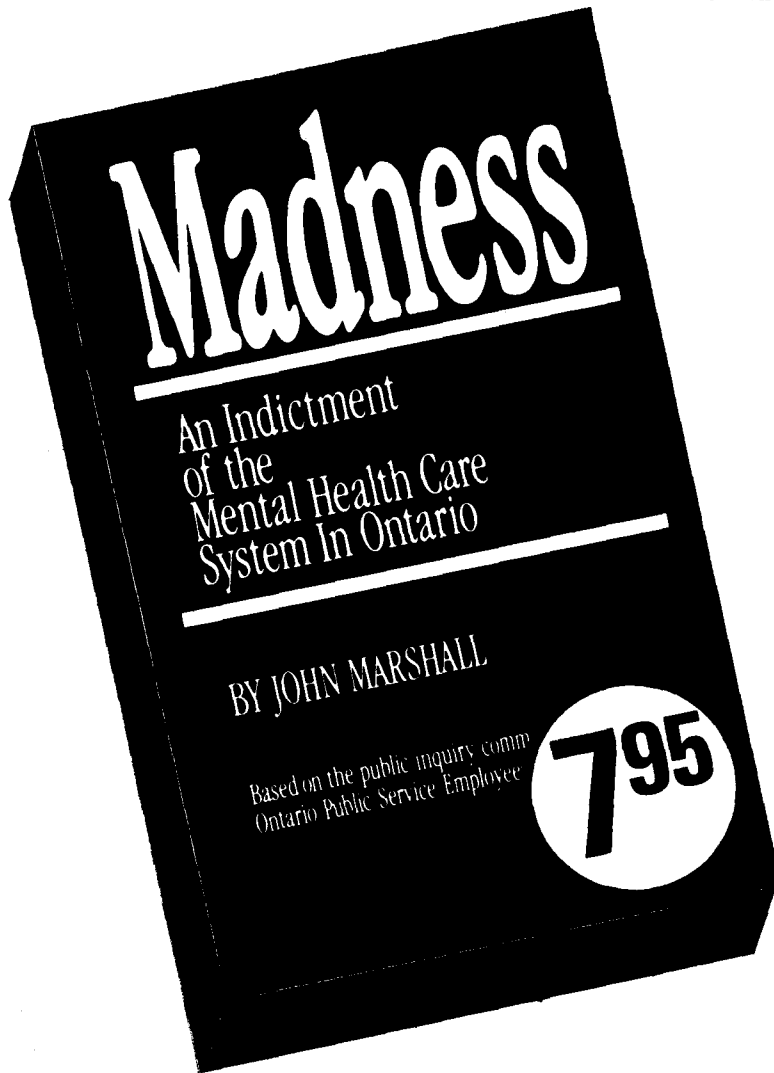
The final recommendation does admit that an ex-patient representative on the commission "would have been helpful." Since this report is only one step in a long process, OPSEU and other decision-makers can rectify their errors before, and not after, the fact.

MADNESS is a public document, conducted in public. There can only be health in this process. In the best tradition of the press, Marshall has illuminated the debate between the governed and the governors. Everyone has had enough of statistics and rhetoric. Society now needs action on problems we have aggravated by leaving care to experts whose validity is open to question.

As a document for the present, Marshall's book is of great value. But let us hope today's book will be yesterday's news; not tomorrow's agenda.



Steven Brouse



Madness

An indictment of the mental health care system in Ontario

“The public hears too little from the people who actually provide the care required by the mentally handicapped and emotionally ill. The public hears virtually not at all from the people who receive that care or who are close to those who do. It is time that their voices were heard. It is time that their story was told.”

EXECUTIVE BOARD, LABOUR COUNCIL OF METROPOLITAN TORONTO

Here, from *Madness*, are some of those voices:

- “Mental illness is rapidly becoming a fatal disease.”
AN EX-PATIENT
- “Prisoners in jails have more rights than mental patients.”
A REPRESENTATIVE OF UNION STAFF IN A MENTAL INSTITUTION
- “Society at large has not seen fit to hear the cries of the victims.”
AN EX-PATIENT
- “Some don’t make it back to hospital. They’re suicide statistics.”
A PSYCHIATRIC HOSPITAL NURSE
- “A cycle of human misery unworthy of our community or this province.”
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The new Constitution — and the right to treatment

By ELAINE NEWMAN

Is there a right, in Canada, to obtain psychiatric treatment? Is there anything written in our laws, or stated by our Courts, which promises that one who is involuntarily committed to a psychiatric facility must receive therapy or treatment? Does anyone have to make an effort to help that person, to encourage his recovery or rehabilitation, so that he may be discharged within a reasonable period of time? Must anyone make available to an institutionalized patient, the means to recover, and to be discharged? Is there a right to obtain psychiatric treatment on an outpatient basis?

The knowledge that we live in a fair and just society tells us that we surely must have this basic right. And we assume, or hope, that in individual cases, patients, their families and their lawyers are dealing effectively with hospitals to ensure that treatment, and appropriate treatment, is performed. But it continues to come as a surprise to lawyers and law students that in this area we operate in a complete legal vacuum. There have been no such written or proclaimed guarantees or protections in Canada. Most of the literature in this country dealing with the rights of psychiatric patients doesn't even touch upon the issue. We are unaware of any case brought before the Canadian courts in which a judge has been asked to decide the point.

It may be, however, that Mr. Trudeau's new Charter of Rights and Freedoms, which became law in Canada on April 17, 1982, may add something new to the legal picture. The Charter may bring us closer to the American scene, in which the right to treatment has been actively discussed by the Courts in the context of the protections given by the U.S. Constitution, and its amendments.

In the U.S., the Courts have approached the question from many different directions, which result from the various applications of certain constitutional guarantees. Some of these are presented here, together with the sections of the Canadian Charter of Rights which may prove to be similar.

1. Liberty and Due Process of Law:

The U.S. Constitution requires that no one be deprived of liberty without the application of due process of law. Some U.S. Courts have held that this guarantee applies to the commitment of involuntary patients, and that "due process" requires that the nature and duration of the commitment (being the deprivation of liberty) must bear some relation to the purpose for which one was committed. Therefore, it follows that appropriate treatment must be provided during the hospital stay, aimed at reducing or eliminating the need for hospitalization.

In the Canadian Charter of Rights and Freedoms, now contained in the Constitution Act, there are two sections which might be applied to produce a similar kind of reasoning in Canada. Section 7 of the Charter states:

"Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

Section 9 of the Charter states:

"Everyone has the right not to be arbitrarily detained or imprisoned."

2. Cruel and Unusual Punishment:

The U.S. Constitution requires that no one be subjected to cruel and unusual punishment. It has been argued in the American Courts that this guarantee applies to the right to treatment, and that commitment without treatment may amount to cruel and unusual "punishment" for having a mental illness.

In the new Canadian Charter, section 12 states:

"Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."

3. Equal Protection Before and Under the Law:

The U.S. Constitution guarantees equal protection before the law, and it has been argued in the American Courts that this guarantee also applies to the right to treatment. For example, the law must be applied equally to those incarcerated in prison and those who end up in psychiatric facilities, particularly when the people involved may have committed the same crime.

The Canadian Charter now provides, in Section 15 (1) that:

"Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

(This section will come into force on April 17, 1985.)

It would be naive for us to announce that these sections of the new Canadian Constitution guarantee the right to treatment in this country. The Charter of Rights and Freedoms is a new-born infant, and we frankly have no idea of how it will grow; how it will be applied and interpreted by the Courts. Of course, we can draw similarities between it and the U.S. Constitution, and we can borrow from the arguments used in the U.S. Courts. But Canadian society, history and constitutional law are all very different from those of the U.S., and interpretation of our constitution might move in a very different direction from that of its southern counterpart.

At this point, the Canadian Charter of Rights and Freedoms is barely one month old, and some sections of it will not come into force for another three years. Right now, we can only say that it is likely that with the help of energetic and imaginative lawyers, arguments such as those so briefly outlined here, will soon be presented in the Canadian Courts in their full form. Everyone interested in the mental health field anxiously anticipates the publication of those first few decisions, and looks forward to the evolution of what could be new law in the coming years.

There is also the even more important right to *refuse* treatment, which is equally vital in some circumstances. But that is for another article, and it requires a different approach.

While the right to treatment is important to many, the right to refuse treatment is a priority issue with our Editorial Collective. In regards to treatment, we are more concerned with quality than availability. (Ed. note)



commentary

Psychiatry's assumptions are biased and unscientific

Bonnie Burstow, who wrote this pioneering study in social class and psychiatric attitudes, is a Toronto therapist and long-time critic of orthodox treatments.

Many years ago a Victorian doctor wrote:

The necessities of our existence limit our work to the well-to-do classes . . . At present we can do nothing for the crowded ranks of people who suffer exceedingly . . . One may reasonably expect that at some time or other the conscience of the community will awaken and admonish it that the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving his life. . . This treatment will be free. It may be a long time before the State regards this as an urgent duty. . . Some time or other, however, it must come.

The doctor was Sigmund Freud, and he addressed a serious societal problem. The poor man leads a more difficult life and so may be more in need of therapeutic assistance; yet he actually gets less. Freud looked to a time when the community will recognize its responsibility and remedy the problem. The solution he envisioned was more therapeutic helpers, free therapy, and the adaptation of techniques to fit the needs of the lower classes.

We are more fortunate in Canada in

the 80s. There *are* more helpers. Our lower classes *do* have access to psychological help. The full awakening which Freud envisioned, however, has not happened. There is still a greater prevalence of mental disturbance in the lower classes. Help is still less available to them. And the treatment that *is* offered tends to be insensitive to their needs and their values. Generally it is not adapted to them at all, or when it is adapted, adaptation is based on class stereotypes. The result is less therapy, inferior therapy—a biased mental “health” system.

‘This disturbs me as a therapist’

Only one really thorough North American study has been done on class bias. It was conducted in New Haven in the late Fifties by Hollingshead and Redlich. The New Haven study excited people and led to further studies. They were relatively minor, though, and interest was on the decline by 1970. It has declined ever since.

September ’81, Ross McClellan asked, “Will the minister of health table any studies undertaken by either ministry staff or Queen Street Mental Health officials on the correlation between class or ethnic status and resultant treatment?” The minister looked into the matter. Two months later the minister reported, “The ministry is unaware of any such studies.” That was it. A question had been asked. Timbrell had answered. The issue was closed.

This disturbs me as a therapist and a human being. I would like to see more interest shown, more attention given, more research done. The purpose of this article is to clarify just what *is* indicated, to interpret the findings, and to suggest solutions. The paucity of Canadian material forces me to rely on American research to some extent. I will comment on its application to the Canadian scene, however, and will draw heavily on the few Canadian studies which *do* exist.

The Hollingshead study indicates that the lower the social class, the greater the prevalence of mental disturbances.

A STUDY IN SOCIAL STATUS AND THE STATUS QUO

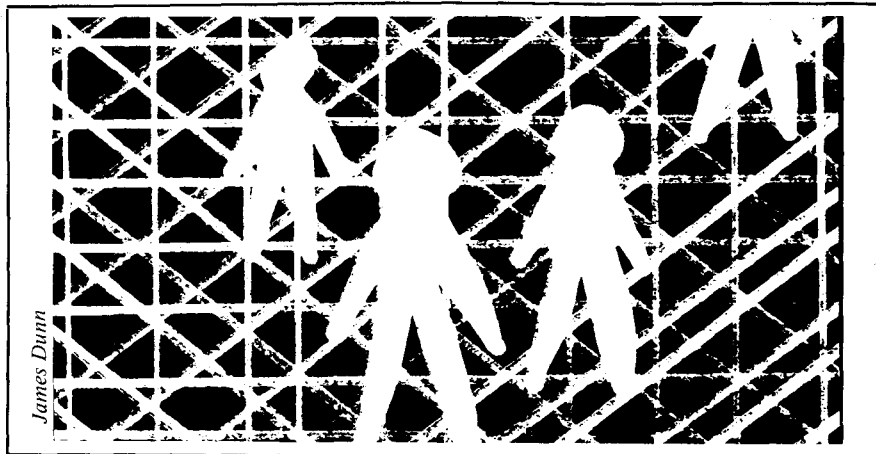
The situation is worse in Canada itself. There are very few Canadian studies. Our governments have not commissioned studies, have not kept relevant statistics. Typical of their reaction is the response given by then Ontario Minister of Health—Dennis Timbrell—to an NDP probe. In De-

Correspondingly, a study on social and mental health done in Montreal contains the same findings.

‘The treatment is inadequate’

As Freud noted, one factor which seems

to account for the prevalence is the hard life the lower classes lead. There are, however, two other important factors. The first is that the lower classes are appreciably less willing to hospitalize self, friends, or family. Consequently, the disturbed person is likely to remain disturbed and to continue getting worse until the state intervenes.



Attempting to account for this reluctance, researchers have suggested that people from the lower classes are more tolerant of "odd" behaviour and less likely to see it as serious. When I was working at Queen Street Mental Health Centre, I was aware of a second factor—pride. The lower classes tend to look on mental disturbances as something shameful, something to be hidden.

A final factor is the perceived inadequacy of the treatment available. Here a multiplying effect enters in. Given that treatment is likely to be unsatisfactory and s/he knows this, the lower class person shies away from treatment. The tendency is to get worse and finally be brought in by agencies, the police, etc. The treatment afforded this more disturbed person is likely to be less effective than the treatment afforded the "less disturbed" middle class counterpart who came in earlier, since the more disturbed the client, the worse the prognosis. This ineffectiveness in turn reinforces the reluctance to hospitalize.

The story I am telling, then, is a story about an initial inadequacy—an initial insensitivity to and bias against the lower classes. It is of a reluctance on the part of the lower classes. And it is how the two combine together to create further inadequacy and further bias.

The story will become clearer as I discuss the avenues open to the lower classes. I will begin with what is available to the person who is not yet severely disturbed, who is simply looking for some sort of assistance.

Here we find social work agencies, community clinics, and the like. Most of these were specifically designed with

the two lower classes in mind. This notwithstanding, even here the client is likely to encounter a class bias.

An interesting qualitative study was done in Toronto in 1979 in this regard. The researcher was Evy Boyd. She interviewed social workers on the class factor, and perceptions of the social workers were:

1. The lower the social status of the client, the less agreement between the worker and the client on the nature of the client's problem.
2. The lower the social status, the shorter the treatment.
3. The lower the social status of the client, the worse their prognosis.

Agreement in problem identification has been established as a significant factor in the success of treatment. The lower the social class, the less the agreement and correspondingly, the worse the prognosis.

'The professional lack of insight'

To some extent the difference in problem identification can be accredited to the lower class client's misunderstanding of psychotherapy. The literature suggests that the lower class client tends to see her or his problems as medical and comes expecting pills. Another factor is the professional's lack of insight into the client's situation and what is called for in it; and the client's dissatisfaction with this. The lower class client has a problem with the professional's "sublime detachment" at the best of times. If s/he has just been fired and does not know how s/he is going to feed her/his children, this "detachment" can be intolerable.

What is involved here is a mismatch. It is a mismatch, however, with one of the "partners" in the power position. The result is, the other "partner"—the lower class client—suffers the effects of inadequate treatment. S/He is rushed through and s/he is often rejected outright. Asked about this, one of Boyd's interviewees described the situation this

way:

"The lower class person gets shuffled through faster . . . If I call for someone, chances are 100% improved that the person will get some help, where they get nowhere on their own. The difference is that the middle class person is more articulate, more assertive, more knowledgeable of her rights. The lower class person doesn't know her rights, doesn't know the rules of the system, doesn't know how to ask the right questions or get the right information, and doesn't speak the same language."

Lower class inability is one side of the coin. Professional "inability" is the other. The professional does not know the questions to ask, does not understand. He tends to see the lower class client as simply undeserving. The rapport, the empathy which is the foundation of a helping relationship is missing. The price the professional pays for this is intermittent frustration. The client pays the more formidable price of despair and aloneness. As one of Boyd's interviewees put it, "The lower class person after contact with an agency often feels, 'I don't feel recognized. I don't feel acknowledged. Nobody cares.'"

The same problem exists in the clinic, with the psychiatrist as helper. Here, in fact, the problem is greater, for as Hollingshead notes, the psychiatrist tends to come from the upper or upper middle class; so there is greater social distance between him and the client. The greater the social distance, the worse the prognosis. In line with this, with the psychiatrist as helper, there is likely to be a greater disagreement on the nature of the problem and still more "aloofness."

'Bias is not the only factor'

Compounding the problem is the psychiatrist's preference for well-educated, articulate, middle-class clients. The psychiatrist prefers such a client, and acts out of this preference. If he is in private practice, he can actively discourage the would-be working class client by overcharging. And whether in private practice or in an institution, he can and does exercise a measure of selection. The result is, the lower the social class, the lower the percentage of clients seeing a psychiatrist, and what is even more telling, the lower the social class, the less often the client gets to feel s/he is being understood.

Personal bias is not the only factor which contributes to the differential. Another factor is that the psychiatrist, like most people, works in the daytime

only. While this limitation poses no problem for the "welfare" client, it poses a very serious problem for the employed working class client. The working class client is less able to get off work than the middle class client. The upshot is, even those psychiatrists who are sympathetic to working class clients are likely to see less of them and to see them less often.

The result of this is the reluctance to seek out professional help, a deepening of the problem, and a greater prevalence of mental "illness."

The differences in referral and attitude culminate in a further difference—a difference in "place referred to." Given any diagnosis, the higher the class, the greater the likelihood that the client will be referred to a private psychiatrist, private hospitals, or general hospitals. The lower the class, the great-

er the likelihood that the client will be referred to a provincial or state hospital. The Hollingshead study strongly suggests that this is so in the States.

This is important—vitaly important. Referral to the Clarke is referral to a place which is reasonably staffed, relatively safe, and a place where meaningful therapy is at least possible. Referral to Queen Street is referral to a place which is badly understaffed, and where overdrugging, accordingly, is resorted to. This is the hospital—don't forget—where Alviani and Davis died from overdose. In saying this, I would like to point out that I am not complimenting the Clarke nor criticizing Queen Street. The Clarke too relies more heavily on drugs than I am comfortable with. It is largely luck that it is sufficiently staffed. Queen Street, I am sure, would dearly love more staff.

What's more, while the Clarke is clearly a smoother operation, it is largely so because of discriminatory policies. The morality of these policies is open to question. To be more explicit, it is hardly to the Clarke's credit that it turns away people more readily, that it decides that there are "no beds available" when beds can be found, that it selects the less troublesome client—the educated, "interesting," middle class client. It is hardly to the Clarke's credit that police bring their "pickups" to Queen Street, not the Clarke, because Queen Street and only Queen Street can be relied on to admit them. I do not wish to single out the Clarke. It is hardly alone in these policies. And I am sure that we are all of us tempted to avoid "problem cases."

'Queen Street is a mess'

The point I am making is that if Queen Street is a mess, it is so because the policies of other mental hospitals make it so. And indeed, it is a mess. In a confidential psychiatric report dated Dec. 1980, a psychiatrist at Queen Street acknowledged that the psychiatric workload was reaching a point where it was "meaningless or of questionable quality." Not only has the situation not improved, there have been further cut-backs. If treatment in Queen Street was meaningless in 1980, it is downright dangerous today. And it is to this hospital where the care is inadequate and dangerous that we consign the lower classes.

Bias enters in once again when it comes to diagnosis. The image of mental "health" is itself class-lined. In an American study by Gurrslin, Hunt and Roach on mental health pamphlets, it was found, in fact, that the descriptors used to depict the mentally healthy person were actually descriptors of middle-class virtues. This casts some doubt on the reliability of the prevalent findings. While mental problems may be more prevalent in the lower classes, it may not be nearly as prevalent as the middle class professional assumes and as middle class research "proves." It also suggests:

1. A "healthy" person who is from the lower class stands a greater chance of being diagnosed as "mentally ill" than his middle class counterpart.
2. Therapy as a movement serves the purpose of reinforcing whatever is middle class. To quote from Gurrslin, Hunt, and Roach here, "The mental health movement is unwittingly propagating a middle class ethics under the guise of science."

The lower class person's "referral" is likely to come from the police, the courts, or other government agencies. Here the figures are staggering, especially the figures on clients labelled 'psychotic.' In the Hollingshead study, the referral breakdown for upper and upper middle class "psychotics" is:

referral by family, friends, and self.....	88.6%
referral by private physicians.....	21.4%
referral by agencies.....	0 %
referral by police and courts.....	0 %

The corresponding breakdown for lower class "psychotics" is:

referral by family, friends, and self.....	2 %
referral by physicians.....	22 %
referral by agencies and other professionals.....	23.8%
referral by police and courts.....	52.2%

Hollingshead comes up with a similar, although less dramatic, differential in the cases of the "neurotic" and the "alcoholic." And research done in Toronto at the Addiction Research Foundation confirms the findings on alcoholic referral.

A 1981 report by Community Resources and the Clarke Institute of Psychiatry gives figures on education level and occupation level for aftercare patients from four different psychiatric centres. Two are identified as general hospitals, one is the Clarke, and the last is Queen Street. The corresponding figures for the Clarke and Queen Street are:

	Hospital 1 (The Clarke)	Hospital 2 (Queen Street)
<i>Educational Class</i>		
Some University	28%	6%
Some High School	60%	52%
Less than Grade 9	11%	42%
<i>Occupational Class</i>		
Professional	12%	2%
Clerical	28%	12%
Skilled or Semi-Skilled	30%	24%
Unskilled or Unemployed	30%	54%
Housewife	1%	7%

The figures on the other hospitals are similar to Clarke's. The point is clear. The lower the educational and occupational status, the lower the class status. The lower the class status, the greater the likelihood of being referred to Queen Street.

Just as the lower class client is more likely to be seen as ill, he is more likely to be seen as *severely* ill. In this regard, Riessman and Miller report an interesting study done with psychograms. Sets of matching psychograms were invented. Each set consisted of a psychogram of a hypothetical lower class client and a matching psychogram of a hypothetical middle class client. For any given set, the psychograms were identical except for the class differential. The sets were broken up. The psychograms were individually given to a number of psychiatrist-appraisers. Each appraiser was asked to give an appraisal of each of the "clients." In each case, the hypothetical lower class client was seen as more severely disturbed than the "matching" hypothetical middle class client *despite the fact that the psychograms were identical*. This is frightening, but there it is.

The next stage—choice of treatment—is equally biased against the lower classes. Now it is to be expected that a lower class person wrongly diagnosed as "psychotic" would receive different treatment than his middle class counterpart diagnosed as "neurotic." The problem, however, does not stop here. *The lower and middle class clients given the same diagnosis do not receive the same treatment*. Here, once again, the Hollingshead findings are interesting. It was found that for each diagnostic category, the lower the class, the greater the probability that organic therapy and/or custodial care will be the principal form of therapy given, and the lower the chance that psychotherapy will be the therapy of choice.

So it is that, regardless of the diagnosis, if you are from the lower class, there is a greater likelihood that confinement in an institute and/or drug therapy and/or shock therapy will be the principal mode of therapy you receive. In fact, if you come from the lower class and you are to receive treatment, the likelihood of it not being drugs, shock, or confinement is very small. As I am sure you will agree, this is a high price to pay for class affiliation.

My hope is that people who have suffered from the present system, groups like On Our Own who are committed to changing it, assume the initiative in raising public awareness, planning, and asking for change. As I see it, it is not enough that the government be "asked." It is not enough that you or I or the NDP ask. As long as the public feels okay and/or is relatively quiet about the present state of affairs, the

status quo will continue.

As Freud put it, we need to awaken the conscience of the community. To awaken it, we need the help of the media. At this point, I see interesting the media as priority number one. Care must be taken, however, to sensitize the media to what is involved. If the press overdramatizes, blames, sets up an "us-them" situation, we lose more than we gain. To some extent, this is what happened with the Queen Street deaths.

What was the result? Staff feared for their jobs. Security was tightened, and authoritarianism encouraged.

There are problems here—difficult human problems. Moreover, there are complex systemic problems. I am asking that we face them without scapegoating. Contradictory though this may seem, I am asking that we point out, that we protest, that we confront, but that we do so with good will and with a commitment to dialogue.

What can be done?

A number of recommendations are implicit in what I have written. I will not go into any in depth. I will, however, highlight those measures which strike me as particularly important.

Essentially, what I propose is:

1. Therapy clinics keeping evening hours be made available.
2. The education of all professionals in the mental health field include:
 - a. consciousness raising *vis a vis* class issues.
 - b. training in bridging the therapist-client gap.
 - c. practicums involving lower class clients and settings.
 - d. emphasis on psychotherapeutic techniques other than psychoanalysis.
3. The overreliance on drugs and custodial "care" be corrected; the use of shock discontinued; and reliance on psychotherapy increased.
4. More attention be given the client's immediate life situation and life problems.
5. Modes of psychotherapy that are interactive and action-oriented be emphasized when working with clients from the lower classes.
6. The therapist assume the responsibility for explaining the nature of therapy to the client and joining the client in working out a therapeutic contract which is acceptable to both parties.
7. An ongoing education campaign be launched for purposes of:
 - a. alerting people to signs of mental disturbance.
 - b. weakening the association of disturbance with shame.
 - c. informing the public what might be expected from psychotherapy.
 - d. advising the public of their rights and of avenues for protest.
8. Therapists assume more responsibility for informing clients of their rights and encouraging clients to protest against any treatment they feel violates those rights and/or is insensitive to them.
9. More therapy with lower class clients take place at the client's home or in other environments in which they feel comfortable.
10. Therapeutic modalities involving role-playing be used more with lower-class clients, since:
 - a. this helps reduce the formality which alienates the lower class client.
 - b. it is in keeping with their action and interaction orientation.
11. Grants be provided to encourage the lower and lower middle class to pursue careers in the helping professions.
12. People from the medical professions and people from the 'middle' middle class upward form a smaller percentage of the therapeutic and administrative staff at hospitals and clinics.
13. Educators and staff developers be hired to sensitize the staff to the needs of the lower classes, to familiarize them with nonmedical modes of psychotherapy.
14. Therapeutic ombudsmen be employed.
15. Hospitals and clinics be adequately staffed.
16. Those organizations not under provincial jurisdiction be encouraged to examine their biases and to address the systemic problems to which they are contributing.
17. Ongoing research be done on the relationship between social status and mental 'illness.'
18. Community based alternatives be morally and financially encouraged.
19. Community based organizations be invited to examine their own middle class biases.
20. The lower classes be centrally involved in planning and instituting these and related measures.

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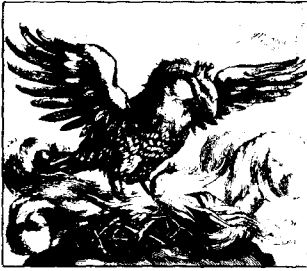
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community news

Since the last issue of *Phoenix Rising*, ON OUR OWN has gone through some changes. The move to our new location at Woodbine and Queen St. has been completed and we are grateful to all members, staff and volunteers in the community who helped to get the new space in working order.

On June 25th an open house and party was held to celebrate. Over 100 people drifted in and out through the day in what proved to be a colourful and exciting event. A dance was held in the evening for ON OUR OWN members. We had the pleasure of sharing our accomplishment with many members, and again, thanks to all who helped to organize it.

Since the open house, the drop-in centre has been busy and the Social Rec Committee has even more plans for the future. A schedule of activities for the summer months has been put together and plans for fall and winter are underway. Although we have not yet received any money to hire our drop-in manager he continues to volunteer and we have managed to expand the hours a great deal. During July and August on Thursdays, Fridays, Saturdays, and Mondays, the hours will be from 6 p.m.-11 p.m.; on Sundays from 1 p.m.-6 p.m. Also, from 1 p.m.-3 p.m. on Sundays the newly formed softball team will play.

There will be a film night every second Tuesday from 7-9 p.m. and on every second Wednesday at the same time we will be having guest speakers. Starting July 16th, the drop-in will feature a coffee house with live entertainment, every second Friday. Everyone is welcome to attend and perform.

Special events coming up include a self-defense course for women to be held on July 31 and August 1. It is a two-day course costing \$30.00, which can be subsidized if needed. Day care will be provided.

Also, on July 25th the ON OUR OWN Picnic in the Park and Barbeque will be held; people and donations are both welcome. On August 29th there will be a summer wrap-up party, which will mark our fifth anniversary.

The Social Rec Committee is meeting every second Tuesday from 6-7 p.m., just before the films start. Anyone wishing to help plan programs for the fall or help put out our newsletter, *The Mad Grapevine*, is urged to attend. For further information, call the office at 699-3192.

The annual general meeting will be held on August 26th. The agenda includes elections to our board of directors and a summing up of the past year's business. We feel confident this will be our best year and that you will be part of it.

Persons United for Self-Help

On June 26th, over fifty persons with varying visible and invisible handicaps met in an all day meeting in the Council Chamber of Toronto's City Hall. It was a moving experience to witness these highly articulate and motivated individuals join in a common effort to elect a ten (10) member Central Regional Council.

PUSH-Ontario is a newly formed, grass-roots consumer association with an elected Provincial Council from six Ontario regions. The Council will be meeting in Toronto July 24-25 to prepare for a September Conference. On the national level PUSH-Ontario forms part of COPOH (Coalition of Provincial Organizations of the Handicapped). In the year of Canada's new Constitution, a large number of Canadian citizens will be spoken for *by* consumers—not on *behalf* of them.

Ex-psychiatric inmates are represented by Mel Starkman of ON OUR OWN, who was elected to the Central Regional Council and subsequently as Secretary of the region, and Cathy McPherson, the former editor of *Phoenix Rising*, who was also elected and became the Treasurer.

The new cross-disability concept brings strength in numbers, mutual understanding and insight into concrete needs, as more and more hitherto institutionalized or otherwise isolated from the mainstream persons with handicaps begin to fulfill themselves to the limits of their potential. Self-determination, shared responsibility and dignity are empowering goals for persons with deafness, blindness, emotional, developmental and mobility handicaps as well as invisible handicaps such as epilepsy or dyslexia.

The other members of the Central Regional Council are David Heatherington (Chairperson), Beryl Potter (Vice-Chairperson), Pat Israel and David Graham (Provincial Council representatives), Lynne Fournier (Issues Co-ordinator), assisted by Kazumi Tsuruoka, Steve McCahon (Public Relations Co-ordinator), and Bill Carroll. The Central region will hold a day-long seminar on October 16.

Flea Market

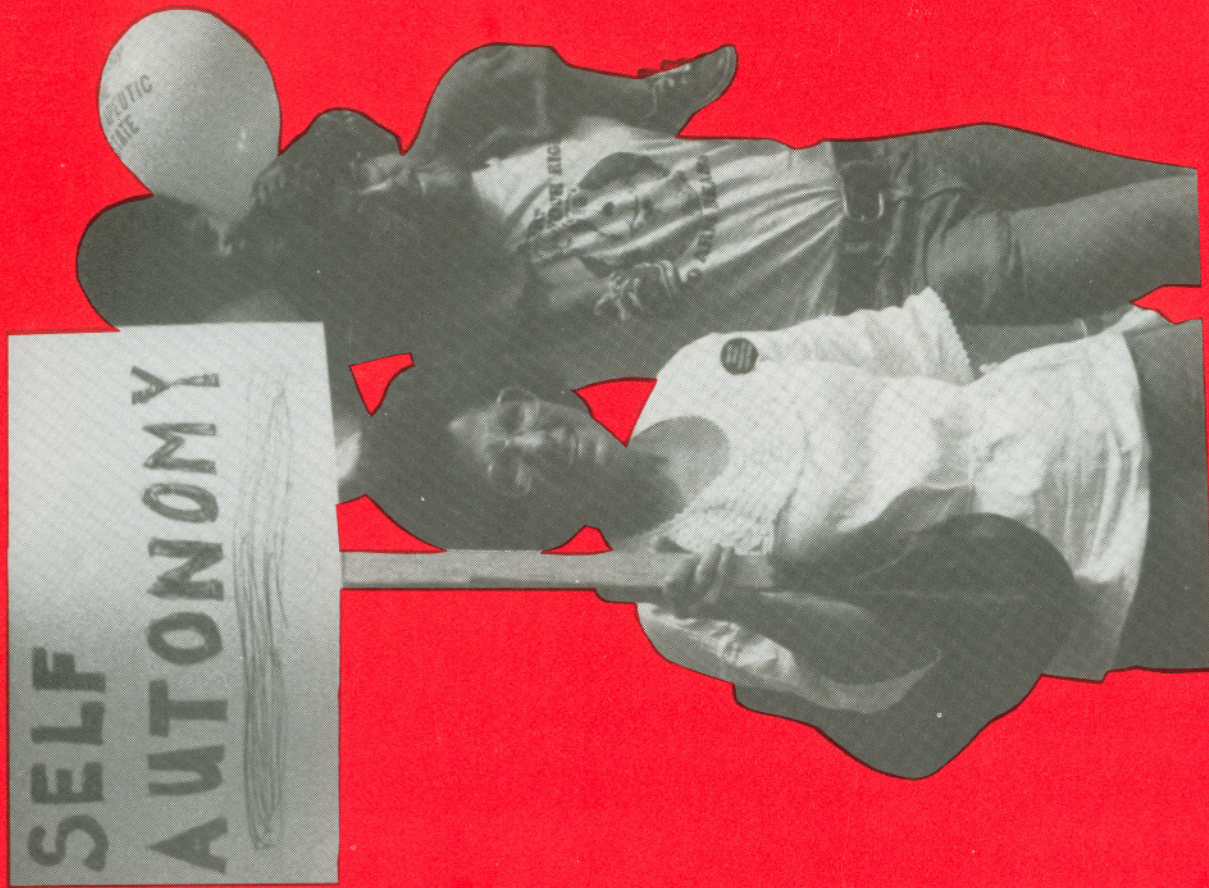
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