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Lansell

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Death by Psychiatry: Part 2



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Through the fire



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AUGUST ISSUE

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Encore

The PHOENIX RISING Collective would like to thank all those people who responded to the request for contributions in our Spring issue: we are very grateful for all the sums that readers have so generously sent.

We are still alive, but our funding is coming to a definite end, and in order to survive we must look elsewhere. That is why we are appealing, again, to you, our readers.

Meanwhile, if not our survival at least our ability to flourish and grow, to reach people so far unaware of our issues and to tap material so far inaccessible to us—depends entirely on forces beyond our control. Those forces are—together—time and money. And anyone who can help with either will be most gratefully received.





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. ★ ★ ★ ★

Have just finished reading your Winter 1983 issue. Terrific! Everything it should be. I'm impressed.

There are many relative issues blanketing ex-inmates of prisons as well as nuthouses. My specific interest for 10 years has been designing a rehabilitation program for ex-prisoners.

For instance, the term "sociopath" is the flip side of schizophrenia when the psychologists (as well as psychiatrists) use labeling criteria for convicted prisoners. I would love to see your magazine take that term on. Szasz's publications have shed light here too. All convicted prisoners in Washington State Dept. of Correction wear this label.

My personal experience has included over 25 years inside various jails, reform schools, prisons and nuthouses throughout the U.S.A. I've been ECTed in Louisiana (retribution for agitating a work strike via "cut heel strings" of 600 prisoners where 11 ringleaders were hauled to the nuthouse for "self-mutilation" and had our "pushy Yankee attitudes" leaned on by the thunderbolt mambo machine.

I've watched them kill a man named Grigsby with ECT at San Quentin prison in California during 1954. They hid his body in the crapper, for several "inspectors from the capital" were in the building inspecting.

I was there in the days of Doctor Schmidt when "treatment" and mental health programs became popular. Grants were available for ever common shyster bug doctors who, for lack of income, hustled the penal system. I watched the Thorazine fog at its birth there. I've watched electric shock in "3rd Psych (a ward on the 3rd floor of San Quentin Hospital) and a room filled (always

with insulin shock comatosed prisoners; "4th Psych" (a ward on the 4th floor.) There were always fifty or sixty brain cell wars being waged.

I've watched an MD at this prison, Wash. State Penitentiary, develop an interest in ECT and use it almost as a hobby. I've watched many experimental programs; from LSD, sterilization, and the like, to Bertillion-like measuring of physical features.

It's been as though some twisted psychological genius was at work developing a mental abyss to destroy men's minds collectively. It's an absurdity. All prisons are of the same mold. There are no good prisons. Prisons create crime just as an insane world creates crazy folks, not to mention what evil results from mental institutions. We are terminal as a race if something is not changed.

Hooray for Phoenix Rising from the ashes. Good luck in your work.

a Walla Walla Prisoner
Walla Walla, Washington



In the article about me in your Spring issue, I was pleased that you emphasized my interest in the CAT scan technique of revealing ECT brain damage, for I believe this is the trump card that is held by the critics of ECT. However, I'd like to correct a misquotation that was carried over from the *Saturday Evening Post*.

Actually I think it would be quite impractical to CAT scan patients *before* they receive ECT. I can't imagine doctors saying to patients, "We want to measure your brain size so that we can find out whether ECT shrinks it." Fortunately, no such cumbersome approach is necessary for testing whether ECT shrinks the brain. The statistically adequate method would be to CAT scan a group of persons who have had ECT at some time in the past (at least a year earlier) and compare the results with what is normal for their ages.

The point of waiting a year is that the initial effect of ECT is to cause the

brain to *swell*. To see the shrinkage caused by ECT, one has to allow time for the swelling to go down and the dead cells to be carried away by the blood.

Marilyn Rice
Arlington, Virginia



David Petterson's letter (Vol. 3, No. 4) struck home. The negative stories of horror get to be too much until someone says, "Hey, that's me!" In our case the victim is our son. Years of state "medications" have damaged the temperature control and appetite mechanisms of his brain and left him with other officially documented damage from Thorazine.

A California legislator, Dr. Filante instigated a therapeutic review after nine! hellish years of our naive, more local efforts to stop the Thorazine — 400 to 900 mgs. daily! Multiple drugs were also used for a cruel time until Prolixin put Chris in an acute ward, near death. (The minister met us at the hospital — Porterville, 1978 — though we had been informed of an infected scratch only.) Chris transferred North in 1979.

Despite the review's recommendations over a year ago to drop Thorazine, it continues — though at least at a lower dose, because the help of megavitamins for Chris was finally recognized. (In 1974 a pyridoxine — treatable enzymatic defect was found. On the whole, the information was ignored, having been ordered from outside by us and not duplicated again by either of the two hospitals. We were maybe too eager to pay for more sophisticated tests or to put them in touch with an expert.)

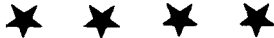
We tried very hard to carry out some good plans for our son's freedom recently. In spite of his legal right at the time to be released within 3 days of his asking out, plans were blocked and drugs upped. We are now asking for a transfer to a better ward. The answer is Chris won't "co-operate"; so again transfer is denied at Sonoma State Hospital.

One thing that has come out of this,

as far as we can see, is that the more we fight for him at the hospital level, the more they put the screws to Chris and parents like us to stop us. Being "model citizen" is what counts in and about prisons and psychiatric hospitals. So what gets people out? — Public pressure! With a sane and steady voice your Phoenix Rises on behalf of those who care, those who want to get strong enough to stop the oppression. And we thank you.

Pat Holderman
(for) Mr. & Mrs. J. Holderman
North Fork, California

P.S. The thing that is different in Chris Holderman's case from David Petterson's is the matter of abilities. Chris has a low I.Q., Mr. Petterson's is high — something that is neither here nor there when reading of their torture. The psychiatrized retarded need advocacy too, all the more since they can't ask for it.



Since its first issue, I have followed the course of this magazine with great interest. It fills a great need, which must be evident to all those who have been on the receiving end of traditional psychiatric "help." I have found your articles, in particular, to be most lucid and to the point.

Unfortunately, it and your collective seem to be rather central-Canada-based. This seems particularly sad to me, since I live on the east coast and I am not aware that the practice of psychiatry is any more enlightened or better here than it is elsewhere in Canada. Ergo, (it goes without saying) many people could use the support of a group like *On Our Own*, as well, perhaps, as a regular voice emanating from it.

I would really love to talk to you about this and about the possibility of my helping out in some way, albeit anonymously. I find myself feeling guilty about not making more obvious efforts to help others, and to warn against the dangers of prescriptive psychiatry, as opposed to preventive psychiatry, (which, I suppose, would be dedicated to its own self-destruction). It seems so obvious that systems of therapy could help people so very much more if they were to change in radical, humanistic, interactive ways.

Anonymous,
Wolfville, Nova Scotia



My renewal is anything but a sign of support for everything you're doing. Some of the things you are doing are resulting in harm to mental patients. Already the seriously mentally ill can't get treatment at all, not entirely due to your efforts but partly so: a major problem is governments taking the opportunity presented by the controversy, not to provide treatment at all. As a result of the difficulties and personal dangers, I for one after twenty five years being a psychiatrist, can't and don't treat the severely mentally ill.

You are quite wrong about ECT. In many cases the risks are far outstripped by the benefits and I reckon I've saved some thousand lives with it including my own, when I was suicidally depressed. I have a rationale in terms of brain neuro-transmitter dynamics which I'd be happy to explain to you, if you accepted contrary opinions and material.

Of course strong tranquilizers, restraints, ECT, certification have their drawbacks but without them, I for one would not be prepared to try to help the severely mentally ill, nor would you, I believe, if you really had to deal with the reality of it.

The result is already with us. These people with severe mental illness are now being neglected and not treated, all over North America. You, President Reagan, Professor Szasz, the Scientologists have a lot to answer for in terms of decreasing humanity, and increasing ignorance and fear, in spite perhaps of your intent and public stance.

Lawrence Kotkas, M.D., D.P.M.,
Lethbridge, Alberta.



On the contrary, Dr. Kotkas, we do indeed "accept contrary opinion and material;" by all means explain to us your theory of the "neuro-transmitter dynamics" of ECT. Only we hope that your explanation also includes how "the risks (of ECT) are far outstripped by the benefits" for this is where we really differ from you and, without this — we can't agree.

As for your further allegation that we have contributed to the growing trend to deny all help to the "mentally ill"—we believe that everything we have written speaks for itself—and in protest. No, we can't say that we are responsible for any "opportunities" that President Reagan or his government or any government may take. If we could, they wouldn't be so foolish, we hope.

The PHOENIX Collective



I was recently incarcerated on a psychiatric ward, here in Montreal. Luckily I'm released now. I refused "Mellaril" and all the rest of it—they didn't force the issue.

"Phoenix Rising" kept me going: kept me from going mad. As I saw old people (an old man for example who had been on the word for 3 years!) fright coursed through me—also every time I passed the "treatment?" room They told us where to sit—every day it was a different place—and what and when to eat. As for facilities—nil, and the "ward" (if you can call it that) never got any sun. The rooms were the size (this is *not* an exaggeration) of solitary confinement on death row. You got claustrophobia just entering it, and they placed two of us in each "room."

Anyways, as for your magazine, it is long overdue, and *great!!*

I still don't feel really well . . . but at least I'm no longer stuck in a dingy narrow ward that smells of feces and reeks of hopelessness.

Leora Roth
Montreal, Quebec.



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Keep WREC going! Become a member today.

With this second installment we conclude Allen Markman's investigation of eight deaths in New York State mental health facilities: the stories of two more of the South Beach Four are carefully documented, as well as the case of Allen S., AN UNDENIABLY BRUTAL

DEATH BY PSYCHIATRY*



A Preliminary Review of Eight Deaths in the New York State Psychiatric System

**Copyright 1983 Allen Markman. The author would like to thank Leonard Roy Frank and Dr. David Richman for their helpful suggestions and advice.*

ANDREW ZAMORA: A Heart of Glass?

Andrew Zamora died on August 17th, 1981, at the age of 17. Andrew is remembered by those who knew him as an intelligent, sensitive kid who had the kinds of problems faced by thousands of other young people growing up in the suburbs: conflicts with parents, anxiety over dating and sex, growing pains. Andrew was also frustrated, and sometimes he would take out these frustrations on his family.

Georgette and Gregory Zamora were troubled and hurt by Andrew's behavior, but they did not feel that psychiatry was the answer to their son's problems. When Andrew's behavior became intolerable, and his parents' pain too great to bear, psychiatric hospitalization was the last resort. Even so, his family signed him out of New York Hospital against medical advice in 1979 because they wanted him home. On December 24, 1980, Andrew, dressed only in pajamas, escaped from South Beach and ran miles in the freezing cold to spend Christmas Eve with them at home. They even lied to the hospital so that the police wouldn't pick him up. They were also very critical of the care he received there. But as critical as they were, they never could have believed that their son would die.

Andrew had been admitted to South Beach twice: the first time for four months, and the second — his last — for only three days. The first time he was released, Mr. and Mrs. Zamora signed a form promising South Beach that they would bring Andrew in for regular Prolixin injections at an outpatient clinic, but Andrew refused "aftercare" and his parents never pushed him to go.

Andrew's relationship with his parents could be described as one of escalating suspicion and hostility. In December 1980 Andrew was put in South Beach by the courts after he stabbed his father in the chest with two knives, creating a wound that took 20 stitches to close.

According to the hospital records, around the first week of August 1981, Andrew wandered around aimlessly, couldn't sleep, and told people that others were out to harm him. On the 15th his parents took him to St. Vincent's Hospital emergency room, stating that they intended to place him in the DeSisto School, a residential program in Florida for young people with emotional problems. Andrew was upset because he didn't want to go to the DeSisto School. His parents thought that he would calm down after a few days at South Beach, and then they would send him to Florida in time for the fall term.

Labelled as having an "acute paranoid disorder," he was taken away to South Beach and given 10 mg. of Navane twice a day and 5 mg. of the same drug "when needed for agitation." On August 16, he got a shot of Thorazine, 50 mg. for "aggressiveness and threatening action towards the staff," and was put in a bednet restraint from 4:30 to 8 p.m.

On August 17, the day he died, Andrew was again put in a bednet restraint at about noon. Between 1 and 1:30 p.m. the staff psychiatrist evaluated him and wrote a restraint order for 12:15 to 2:15 p.m., which he renewed from 2:15 to 4:15 p.m. In a separate note the rationale for restraint was written: "in bednet for agitation, paranoid violent toward staff." Andrew Zamora was then placed in a room near the nursing station with three others where he could be observed and checked every 15 minutes in accordance with South Beach policy.

Another thing happened on August 17th. Andrew was taken off Navane, and "antipsychotic," and put on a program of "rapid neuroleptization."⁽¹⁾ The drug to be used was Serentil, another powerful tranquilizer. In Andrew's

case, this program of "rapid neuroleptization" called for an injection of Serentil, 25 mg. every hour for six hours or until "sedated." An order for Benadryl, prn (when needed) was written to counteract possible side effects of the Serentil. Another order of Serentil was written, this one by mouth, but Andrew died before this "maintenance dose" could be administered.

The first two shots of Serentil, 25 mg. were given at 1:45 and 2:45 p.m. At 3:45, while in a bednet restraint, Andrew was given a third shot of Serentil, 25 mg., and a shot of Benadryl, 50 mg. for "extrapyramidal symptoms."⁽²⁾ His vital signs were taken: pulse rate was 100, respiration 24, blood pressure 110/70. (Normal pulse range is between 60 and 80; normal respiration is 16-18.)

At 4 p.m. Andrew Zamora, still in restraint, was described by a therapy aide as being "agitated, yelling ... remains danger to self and others." At 4:13, one of his roommates complained to staff that Andrew was verbally abusing him. (The roommate denied this when Georgette Zamora spoke to him after Andrew's death.)⁽³⁾ The aide told the roommate to get out of the bedroom, but he returned anyway and lay down on the bed.

At 4:30 p.m., an aide went into Andrew's room and noted that his pupils were dilated, he had no pulse, had foam around his mouth, and his face and nails were blue.

An attempt was made to revive him with CPR. A CPR code team was called, and his limp body was finally removed from the bednet. Two items necessary for emergencies of this sort were either broken or too far away. The suction machine from the treatment room would not work, and the "crash cart" was located on another floor, and had to be brought down.

Two safety officers⁽⁴⁾ quickly fetched a second suction machine, but the physician had to remove its tubing for use as a tourniquet to tie around Andrew's arm. The crash cart had no tourniquet, and the doctor needed one immediately so he could find a vein for an intravenous.

All attempts at reviving Andrew Zamora failed. He was pronounced dead between 4:45 and 5 p.m., a victim of too rapid neuroleptization, and too slow resuscitation.

The medical examiner's office had little difficulty in pinpointing the cause of death. It was myocarditis, an inflammation of the heart muscle. During the autopsy a focal petechial hemorrhage of the epicardium was found. This is usually an indication of myocarditis, a disease which can occur after certain infections. No such predisposing condition was identified, however.

Georgette and Gregory Zamora don't believe the autopsy. Nor do they support Mental Health Commissioner Prevost's contention that the hospital "did nothing wrong."⁽⁵⁾ They insist that Andrew was violently allergic to all phenothiazines and other major tranquilizers, and that the myocarditis was a result of the drugging. They are also angry at the Commission's report because it made Andrew look like a psychopath. It also never mentioned the fact that the Coroner found hemorrhaging and severe congestion in six organs other than the heart. The Zamoras are suing the state.

Why didn't South Beach know about Andrew's heart condition? Weren't they supposed to give him a medical check-up and blood tests? Well, they did. In fact, the blood tests were ready AFTER Andrew Zamora died. And, sure enough, they showed abnormal serum electrolytes and elevated blood enzymes at levels consistent with cardiac pathology.

The Mental Hygiene Medical Review Board wrote that the drugs given may very well have increased the stress on his damaged heart, but they added that the DOCTORS WERE NOT AT FAULT because they didn't know about his condition.

Andrew Zamora's death might well have been prevented if drugs were withheld until the results of the blood tests were ready. And he might also be alive today if the resuscitation equipment were nearby, complete, and in proper working order.

WES DORSEY: Case Pending

Charles Wesley Dorsey is the latest victim of psychiatry at South Beach. He died on October 27, 1982, at the age of 27, after being placed in a straitjacket and given sodium amytal.

In an article published by the *Staten Island Advance*,⁽⁶⁾ a local newspaper, Wes, as he was called, was described by a cousin as a "quiet, gentle man" who appeared in good health around the time he was admitted to South Beach Psychiatric Center. This same cousin reported that Wes had been making progress in combatting a "mild mental illness," but that other members of his family had complained to South Beach personnel about "overmedication."

According to hospital sources, Wes was put in a straitjacket after he became "agitated" and struck a "therapist" (who was taken to Staten Island Hospital, treated, and later released). Immediately after being placed in restraint, Wes was given a shot of sodium amytal. According to two anonymous staff members who spoke to the *Staten Island Advance*, Wes then began to hyperventilate. He died at South Beach ten minutes later, and was officially pronounced dead at Staten Island Hospital.

Only a day later, New York State Mental Health Commissioner James Prevost announced that he would convene an "independent panel of medical experts" to investigate Wes Dorsey's death.⁽⁷⁾ The panel will include an internist, a pathologist, and psychiatrist from outside the state mental health system.

The medical examiner's office has completed an autopsy which as of this writing (February, 1983) has not been released. A routine police report has been prepared, but no one has yet been charged with any wrongdoing. Additionally, the Office of Mental Health and the Commission for the Quality of Care for the Mentally Disabled will also investigate Wes' death.

Wes' parents, Charles and Minnie Dorsey, still do not know why their son died. The Dorseys and their attorneys, Peter Cooper and Steve Bamundo,⁽⁸⁾ have appeared on television to try to pressure the medical examiner to release the autopsy. They are still waiting. And so are the commissions, panels, and bureaus whose task it is to investigate psychiatric death.

Earlier, in October 1982, the Health and Human Services Administration of the federal government announced that South Beach Psychiatric Center had become ineligible for \$5 million in Medicaid and Medicare reimbursements due to "administrative deficiencies" uncovered by federal investigators after the first three of the South Beach Four died.⁽⁹⁾ Some of the deficiencies listed were inadequate controls over drugs and the use of "unqualified individuals" to run some of the units. Despite the ample time South Beach had to remedy these problems — over a year — they failed to do so. Five million dollars is one-fifth of South Beach's operating budget for a year. On November 5th, 1982, the cutoff became official⁽¹⁰⁾; but the center continued to get payments for another 30 days to cover the cost of "patients" admitted before the cutoff was announced. Wes Dorsey died only a week before the funds were cut off.

A MESSAGE TO THE CLASS OF '82 IF YOU LIKED SCHOOL...



...YOU'LL LOVE WORK

WORK: A PRISON OF MEASURED TIME

South Beach Psychiatric Center, the "jewel of the state psychiatric system," has one major flaw: the public knows what goes on there. They know about the forced druggings, the straitjackets and bed nettings, the heat, and the callous neglect. This is the legacy of the South Beach Four - public awareness. But how long will it take for the public to forget?

ALLEN S.: The Martyr of Manhattan State

The story of Allen S.⁽¹¹⁾ makes the previous seven pale by comparison. Allen wasn't "victimized" or "abused." He was **MURDERED**. The most remarkable thing is not that he died, but that it took a variety of things to kill him. An "average" individual would not have survived what Allen did for so long. Allen was extraordinary in this regard.

Allen's story begins with a degree in English literature from a college in the City University of New York, and job at the New York Public Library from 1967-1973. Not too much else has been revealed about his background except that he was never married and that he had a psychiatric history stretching back to 1965. From 1972-1978 he was an outpatient at the Vanderbilt Clinic of the Columbia-Presbyterian Medical Center. In June 1978 he was admitted to the Psychiatric Institute of Columbia-Presbyterian after being treated for self-inflicted stab wounds in the chest.

On September 13, 1978, Allen was transferred to Manhattan Psychiatric Center, a state facility, with an admission note that stated that his "assaultiveness and violence to self and others was so violent and unpredictable, that long term hospitalization was recommended." He was labelled a "paranoid schizophrenic."

Until his death, Allen S. spent seven months as an inmate in Manhattan Psychiatric Center. Records indicate that he banged his head against the walls, tried to gouge out his eyes, and assaulted staff and other inmates. For this seven month period, Allen was on "suicide precautions" and 1:1. He frequently stated that he was going to die.

Drugs

The following drugs were prescribed in the period from March 23-28, 1979:

Dilantin, 100 mg., four times daily. This was given "to determine whether it could control his behavior." Records show it was given three times a day instead of the prescribed four. (Allen S. had no seizure history and was not an epileptic. Dilantin is most often used as an anti-seizure medication.)

Aspirin, March 23-27, twice daily. Records show it was given for pains of "unknown origin" once a day instead of the prescribed two.

Haldol, 20 mg. (oral liquid), three times daily. Allen received Haldol at 5 p.m. on March 23 and at 9 a.m. and 5 p.m. from March 23 - 28.

Thorazine, 100 mg. injection, every six hours as needed for "agitation" with restraint jacket order. Records show that Allen got Thorazine on March 24 at 1 p.m. and 8 p.m. The charts also say that Allen had a "REPORTED ALLERGY TO THORAZINE."

On the day he died, March 29, 1979, Allen S. was given the following psychiatric drugs:

9:00 a.m.	Haldol	20 mg. liquid by mouth
10:45 a.m.	Thorazine	100 mg. injection
Noon	Haldol	10 mg. injection
2:45 p.m.	Haldol	10 mg. injection
5:00 p.m.	Haldol	20 mg. liquid by mouth

Restraint

From 9:30 to noon on the day of his death, Allen was in a straitjacket without a physician's authorization. At 9:30 a.m., Allen was physically restrained by four employees and placed in a straitjacket on a bed in room no. 61, and tied down to the bed with the cords of the straitjacket. His feet were bound by a sheet around his ankles, and the sheet was secured to the base of the bed. At noon a doctor arrived and signed a restraint order for noon to 2 p.m. Allen was removed from restraint at 1:45 p.m.

The Commission uncovered the fabrication of many documents, including the observation sheets. The ward charge for the day shift noted that Allen was "out of the jacket every two hours." On May 11th, 1979 this same person admitted to an investigator that he had lied on the sheet, on previous statements to that same investigator, and to his superiors. Allen was never removed from restraint between 9:30 a.m. and 1:45 p.m. on March 29.

Feeding

While confined to a straitjacket and tied down in a prone position to a bed, Allen was fed lunch by a newly-employed aide. His head was raised only six inches by a pillow. The Commission believes that this accounts for the fact that food particles were found in Allen's respiratory tract. This would also account for the aspiration pneumonia in Allen's lungs, a condition caused by aspirating food or vomit into the lungs.

More restraint . . . and a broken neck

At 2:45 p.m., the unit manager, ward charge, Therapy Aide X, and two other therapy aides restrained Allen. A

nurse was also present. The following is believed to be the true account of what happened. Aide X was "showing off" to the others on how to restrain an inmate. Allen was resisting being put into a straitjacket. He was holding onto his own feet, thereby making it impossible to get the jacket over him and his arms through the sleeves. Aide X punched Allen in the back and then, while standing behind him, applied a neck hold. The autopsy revealed that the left side of the hyoid bone was broken, and that Allen had petechial hemorrhages. During the neck hold, Allen lost consciousness and dropped to the floor. This was due to the compression of his spine. After about 20 or 30 seconds on the floor, Aide X struck him in the back again. Allen then suffered what appeared to be a brief seizure. Allen had never had a seizure before (despite the fact that Dilantin had been prescribed). He was seen to have a whitish film around his mouth. But he was not dead — yet.

Finally in a straitjacket, Allen S. began to perspire profusely, especially between 3 - 4 p.m. His voice was almost gone, reduced to a whisper because of the neck fracture. He perspired so much that cold compresses were applied to his forehead on three occasions while he was still jacketed. Even so, no effort was made to take his temperature or other vital signs.

At 4 p.m., when the restraint order expired, Allen S. was still in the jacket. The jacket wasn't removed until 8:15, when he died. Between 7-7:30 p.m., a third restraint order was signed for 7-9 p.m. by a first year psychiatric resident. Normally, patients are required by law to be removed from restraint at least every two hours. But Allen S. was in continuous restraint from 2:45 to 8:15, a total of five and a half hours. This information was obtained from the unit manager and the ward charge, who admitted to writing the false entries in the record stating the contrary.

At 4:45 p.m., Allen was served dinner by the ward charge under the same conditions as lunchtime. At 5 p.m. he got 20 mg. of liquid Haldol by mouth.

The last time anyone spoke to Allen S. was at 7:30 p.m. A nurse, the night administrator, apparently didn't notice anything awry. Allen died at 8:15, when a therapy aide discovered that he had ceased breathing, and was blue.

The medical examiner's office reported the following anatomical findings: asphyxia by compression of the neck, aspiration pneumonia, and hyperpyrexia. Thorazine derivatives were found in the liver. More Haldol than might be expected was found in the blood and liver, raising the possibility that Allen may have been given more Haldol than was recorded.

The Mental Hygiene Medical Review Board unanimously concluded that the causes of death were the following: "hyperpyrexia, aspiration and pneumonia while in a camisole, five and a half hours following restraint of the patient by compression of the neck which caused a fracture of the larynx." They added that two haldol injections were spaced too closely, contrary to the drug order.

The Mental Hygiene Medical Review Board felt that hyperpyrexia — dangerously high body temperature — resulted from the long period of uninterrupted restraint combined with Haldol. Just how high was Allen S.'s temperature?

At 10:15 p.m., assistant medical examiner Dr. Plank, and a visiting California medical examiner, Dr. Lawrence, arrived at South Beach Psychiatric Center and conducted a physical examination of the body. Dr. Plank found Allen's body excessively warm to the touch, so he asked Dr. Lawrence to determine the body temperature. Dr. Lawrence obtained a rectal thermometer from the unit manager and recorded a rectal temperature of 106 degrees in Dr. Plank's presence. This was Allen's temperature TWO HOURS AFTER DEATH! It is known that a body cools down about one and one-half degrees per hour following death. So Allen had an

estimated body temperature of 109 degrees or higher at the time of his death.

Coverup

The Commission encountered conflicting testimony from ward personnel on whether a neck hold was ever used. Aide X and his brother, also a hospital employee, have stuck to their story that a neck hold was never used. The unit manager and ward charge at first failed to report the neck hold, but then later did. Subsequently, the ward charge has returned to his original story that the hold never occurred. He states:

"The Unit Manager had told me that everything was going to fall on us and that they may send the police, and he told me that this is what we have to say to protect ourselves. He said, we must tell the truth about Employee X having his hands around the patient's neck and hitting the patient.

I was stunned that any employee would make a statement like that about another employee. I WAS STUNNED BECAUSE THE UNIT MANAGER WOULD TELL ON ANOTHER EMPLOYEE, NOT BECAUSE OF THE TRUTH OF WHAT HE WAS SAYING. I WOULD RATHER LIE THAN TELL ON ANY OTHER EMPLOYEE, but I was brainwashed into going along." (Emphasis added).

As of this writing, no prosecution of Aide X or anyone else has commenced. The disciplinary proceeding against Aide X was suspended pending completion of the District Attorney's investigation. Aide X was reassigned to a position involving minimal patient contact. He then returned to his native Puerto Rico.⁽¹²⁾

Concluded the Commission: "The staff charged with Allen's care on the day of his death evinced a callous indifference towards his life and safety." And, Allen S. "was the victim of indifferent medical and nursing care and gross physical abuse which may have contributed to his death."

CONCLUSION

This review is preliminary. Most of the information was extracted from the reports written by the Commission on Quality of Care, newspaper articles, and personal communications with parents of the dead. As I dug deeper into the stories of each of these individuals, I discovered that the Commission's reports concealed even more than they revealed. While the reports at first appeared very damaging, the real facts behind these cases are even more shocking.

Despite the incomplete nature of my investigations, it is possible to make the following tentative conclusions.

First, drugs are a major ingredient in psychiatric deaths. Sometimes drugs alone are sufficient to cause death. Often, other factors have to be added such as heat, pneumonia, assault, restraint, etc. When drugs are combined, the effects on the body may be unpredictable. The same is true for drugs plus the other factors. One or more of these factors combined with drugs can have unpredictable effects.

Second, the medical examiner's report is generally written in such a way that other doctors are not implicated in anyone's death. Death is attributed to natural causes whenever possible. When this is not possible, death is "unexplained." Never is the cause of death listed as "iatrogenic" (physician-caused) or "overmedication." Drs. Gross and Zugibe have made few friends in the psychiatric profession by calling attention to heat-related and pneumonia-related killings.

Third, psychiatric death is routine murder. Official agencies charged with investigating deaths at South Beach, Manhattan State, Creedmoor and other state facilities have tried to paint a picture of "abuses" of the system. If it weren't for those "bad apples," everything would be wonderful. But death is not an abuse. It is business as usual for state hospital employees. And South Beach is not special. Routine murder and institutional psychiatry are inseparable.

Finally, the murder of psychiatric inmates is not a crime. It

is not even a misdemeanor in New York State. Employees who murder are transferred. Psychiatrists who murder are lectured. Very rarely they may be demoted. The District Attorney always investigates. The families of the dead visit the offices of attorneys, and they are told the same story. We don't want this case, but we'll take it if you pay our expenses along the way. The Zamoras and the Ruggeris have the same lawyer. They have filed suits against the state. Mrs. Singer, while reluctant to talk about her daughter's death, is believed to have retained counsel, and the Dorseys, only weeks after their son was killed, sought legal help. Georgette Zamora has been especially active in attracting the attention of the news media to her son's death. Public television is currently working with her on a documentary on South Beach.

The file on psychiatric death in New York State is not closed. There are others whose stories have yet to be told: "Jason Price," "Leonard Gray," "Rita Finn," "Jeffrey Roland," "Mark Monroe," "Peter Breen" . . . The list goes on and on, and the death count mounts. A steady and logical progression of death packaged and sanitized by the state. Death by psychiatry.

NOTES

(1) Rapid Neuroleptization — A term used to describe the administration of very high doses of "antipsychotic" drugs over a one or two-day period, or longer until a peak level of drugs in the blood is reached. Gradually, the dose is lowered to a "maintenance" level.

(2) Extrapyramidal Symptoms — These may include any or all of the following: muscular rigidity, tremors, drooling, shuffling (Thorazine shuffle, parkinsonism), restlessness (akathisia), motor inertia (akinesia), and many other neurological disturbances. Caused by neuroleptic drugs.

(3) Radio interview with Georgette Zamora and Frances Ruggeri, The Madness Network, WBAI-FM, Dec. 24, 1982; Personal communication with Mrs. Zamora.

(4) Safety Officers — State-employed security force who police New York State psychiatric centers.

(5) Bruce Alpert, "Internal Probes Clear South Beach in Youth's Death," Staten Island Advance, Sept. 12, 1981, np.

(6) Bruce Alpert, "Coroner Probes Psych Center Death," Staten Island Advance, Oct. 29, 1982, pp. A1, A14.

(7) Anemona Hartocollis, "Panel to Probe Psych Center Death," Staten Island Advance, Oct. 30, 1982, pp. A1, A14; "A State Panel to Study Death of Psychiatric Patient on SI," New York Times, Oct. 31, 1982, p. 45.

(8) Radio interview with Peter Cooper, The Madness Network, WBAI-FM, January 12, 1983.

(9) Joseph B. Treaster, "Mental Patient Dies on Staten I. After a Sedation," New York Times, Oct. 29, 1982, p. 3; Bruce Alpert, "Psychiatric Center \$\$ Cut," Staten Island Advance, Oct. 15, 1982, pp. A1, A4.

(10) "Mental Center Denied U.S. Funds," New York Times, Oct. 12, 1982, p. B3; Bruce Alpert, "State Set to Move to Restore Fed \$\$ to Psychiatric Center," Staten Island Advance, Nov. 5, 1982, np.

(11) "Allen S" is the name used by the Commission on Quality of Care. His actual name is not known to this author. Information on his case was obtained largely from the death report by the Commission and from the following articles: David Seifman, "Scandal of Patient's Death in the Hospital of Horrors," New York Post, Feb. 6, 1980, p. 5; "Gross Physical Abuse' is Blamed for Manhattan Mental Patient's Death," New York Times, Feb. 7, 1980, p. B4; and Bob Keeler, "State Blames Staff in Patient Death," Newsday, nd., p. 5.

(12) This information was provided by Clarence Sundram, chairman of the Commission on Quality of Care, in an article by Bella English and Mary Ann Giordano, "Bedlam in Mental Health: Mental Care Under Analysis," Daily News, Dec. 15, 1982, p. 30. This was later confirmed by him in a radio interview with me on the Madness Network, WBAI-FM, Feb. 9, 1983.

SOUTH BEACH — A Personal Account

On December 8, 1982 Allen Markman interviewed the mothers of two of these victims of South Beach's notorious "care": Frances Ruggeri, mother of Anthony Ruggeri, and Georgette Zamora, mother of Andrew Zamora. Excerpts from the interview with Mrs. Zamora reveal the full horror of psychiatric realities grasped too late — but now courageously exposed.*

**See the last issue of PHOENIX RISING (Vol.3, No.4) for the documentation of Anthony Ruggeri's ordeal and the interview with his mother.*

A.M.: MRS. ZAMORA, HOW DID YOUR SON FIRST GET INVOLVED WITH PSYCHIATRY?

G.Z.: He was always a quiet child and very well-mannered. As a teenager, I guess he just wanted to be noticed and act a little more macho than he ordinarily was. And he wanted to change in a lot of ways, to be tough, or to act tough. It was hard for us to understand because everything was so opposite of what he was normally like. He started blasting his music. There were other signs. He said he was lonely a lot of times and that he wanted a girlfriend. It just seemed like it was a stage of his life where he was generally unhappy. We tried having private counselling, and it didn't seem to work. And at school he seemed to be drawing more attention to himself and not listening. It just seemed to be a very troubling time as an adolescent.

A.M.: HOW OLD WAS HE AT THIS TIME?

G.Z.: He was close to being 15. He'd start about 14 or 15 years of age. I had gone to New York, the Payne Valley Clinic, to get some help. There was an incident at home where he took — I don't remember what led up to it — cold cream and he spilled it all over his sister's bed. He was just really difficult. But there were other signs where I saw he was troubled. We went to Payne Whitney and we sort of convinced the doctor — I didn't know what I was getting into with Andrew — and they admitted Andrew that day. When I realized, after I saw it wasn't just like a regular hospital environment, that you couldn't just leave and that doors close behind you, I felt frightened. I know Andrew must have been terribly frightened because he was 15 years of age. And that night I found out that he said something to one of the attendants there, and he put Andrew in what they call a "seclusion room" and drugged him with Haldol. And that was Andrew's first experience — he said something like a psychedelic trip. He kept falling down, his eyes kept rolling up, his tongue was swollen. It was a very terrifying experience. After we found out, I wanted to take Andrew out immediately. I never knew such things went on. They convinced us to let Andrew stay awhile, and that while lasted two weeks. After that, it was like Andrew went downhill all the way because he was so terrified. He blamed us for putting him in a place like that. That was his first experience. And I'm sorry to say I can't go back and change anything.

A.M.: OKAY. SO WHAT WE HAVE HERE IS A PRETTY SIMILAR TYPE OF SITUATION TO THAT OF ANTHONY RUGGERI. THE PROBLEMS ARE NORMAL, EVERYDAY KINDS OF PROBLEMS KIDS HAVE. AND PARENTS THINK THAT IF THEY SEND THEIR KID TO THE HOSPITAL EVERYTHING IS GOING TO BE TAKEN CARE OF THERE BECAUSE THEY DIDN'T HAVE ANY EXPERIENCES WITH THESE KINDS OF THINGS. SO WE KNOW HOW THIS STARTED, MRS. ZAMORA. WHAT HAPPENED LATER? AFTER ANDREW GOT OUT, HOW DID HE WIND UP IN SOUTH BEACH THE NEXT TIME?

G.Z.: After that bad experience, Andrew sort of lost faith in us for bringing him to the hospital. It seemed to go downhill all the way. And then we had a very tragic experience. The three of us almost lost our lives. We had a fire in the house. It started downstairs, and we had to go live in hotels and in another apartment. All of Andrew's artwork and everything was destroyed. He had his appendix taken out; he felt he shouldn't have had. It left a terrible scar. There were several incidents where he got hostile towards us and we would call the police on him, unfortunately, because it was difficult coping with these moods. And he was at Staten Island Hospital for a short period. And leading up to the incident where he was at South Beach for three months. It was just a lot of distrust on both sides. And they had stolen Andrew's radio. We kept nagging him. He didn't want to tell us it was taken at knifepoint because this was his second expensive radio. He told us they had left it in a locker in Macy's department store, and we kept insisting that he had to get it because he couldn't leave it there. I was at work, and he had a fight with his father, and he stabbed his father. The police came and rather than having him put in a jail, we requested that he be put at South Beach. We preferred a private hospital but it doesn't work that way. He was there for three months. They continued to medicate Andrew even though we said we didn't want it because he was allergic to these medications and he felt sick. Andrew often said he had no objection to good therapy, but what he did object to was these drugs and how they made him feel and how sick he felt. And he couldn't think right. His hands trembled and everything else. When he came out of South Beach after being there for three months, we had no reason to fear because we were there all the time and they treated Andrew well. I didn't even know that such things as restraints and all that existed. He came home and he was like his old self again. He was caring, he was good, and it was like our old Andrew had come back to us. He was upset because he couldn't go to school because we didn't want him back in the same atmosphere he was in before. And we had gone to Florida. He was supposed to start in a private treatment school there that was college prep also and high school. And I think over there he was a little upset because he found out that if the need arose they would give him drugs, and that's what Andrew hated.

A.M.: AT THIS SCHOOL IN FLORIDA THAT YOU WERE PLANNING TO SEND HIM?

G.Z.: Exactly, and when he found out that if they felt he needed it he would get drugs it frightened him all again. And his distrust of us started. So when he came back home he

was very distrustful of us. We went to the hospital to ask for help. . . Once we felt he was there at that school he would like it because we liked the school, and we felt that he wouldn't be so negative about going there. He just didn't want to go. He had his doubts. He felt we were tricking him all over again. And the hospital wouldn't send anybody to help so, unfortunately, we called the police again and they sent him to South Beach. Except this time they wouldn't let us see Andrew. We found out he was tied to a bed for two and a half days.

A.M.: AND THIS WAS THE THIRD HOSPITALIZATION?

G.Z.: This was the last time. We went there the first day. They wouldn't let us see him. They said Andrew was doing well, but they didn't want us to see him. Sunday we didn't bother to go because they said that we couldn't see him until Monday. Monday my husband went. He was told Andrew was doing great, not to worry, and to come back the next day.

A.M.: THIS WAS IN AUGUST OF LAST YEAR.

G.Z.: August. He died on August 17, 1981. That same day at 11 o'clock my husband was told by a therapist he was doing great, he was going upstairs, and he would be released shortly because they knew he was starting his private school. That afternoon I was called that Andrew was dead. They lied to us.

A.M.: WHAT WERE THE CIRCUMSTANCES BEHIND THAT?

G.Z.: That hospital South Beach is notorious for not letting the parents see their children when they're doing something they shouldn't be doing, because they know darn well if any of the parents knew for one instant their children were in danger, that they had them tied down — for ten days they had Mrs. Ruggeri put off. She had no inkling or any indication that anything was wrong. And just like us. Andrew was there for two and a half days telling us how wonderful . . . I brought a bag of fruit and change of clothes. When I was told he was dead two and a half days later, I found out he never even got any of the stuff. He didn't even have a change of underwear because they had him tied down.

A.M.: HOW DID THEY TELL YOU? HOW DID YOU FIND OUT?

G.Z.: They were heartless. First of all, they didn't even want us to find out the true facts because we were called and we were told that an "incident," an "emergency situation" had arisen. At that point I got hysterical because I couldn't imagine what "emergency situation" — exact words — meant. And when I started to cry and I asked this Jonathan Kane, who was the chief psychiatrist, what he meant, he very coldly told me he couldn't tell me. I'd have to wait to get to the hospital. He was sending a police car to get me. Well, I was a nervous wreck. When I got there I hadn't even stepped a foot in the door when this man coldly told me, "I guess you know Andrew's dead." With that I got hysterical. I said, "How could I possibly imagine my 17 year old son is dead? He was so healthy." And he gave me some story. I have a witness that was with me all the time and who wouldn't believe it either. He told me that Andrew was calmly talking to a patient, the patient happened to fall asleep, and an attendant came into the room to check on them, and he found Andrew foaming at the mouth. He had just simply died. And they couldn't explain why. Somebody slipped and said something about restraints. With that, I got hysterical. I said, "My God, you didn't have my son in restraints, did you?"

A.M.: WHAT RESTRAINTS? YOU MEAN LIKE A STRAITJACKET?

G.Z.: Yes, and that's what I thought they meant. I did see people in restraints at one point, but they were able to walk

around. But never my son. And I couldn't imagine why they would ever do it to him because he was well-behaved and never any problem.

A.M.: HOW DID YOU FIND OUT THE TRUTH BEHIND IT?

G.Z.: Well, when he slipped. This male nurse slipped. Dr. Kane looked at him with one of those looks, and I said, "You didn't have Andrew in restraints, did you?" And then they quickly checked themselves and said, "No, of course not." The next day I get a telephone call from a Staten Island reporter who tells me that Andrew not only was in restraints. He was tied in a bed posey — his feet — and a netting on top.

A.M.: THAT'S LIKE A NET THEY TIE THEM DOWN TO THE BED WITH.

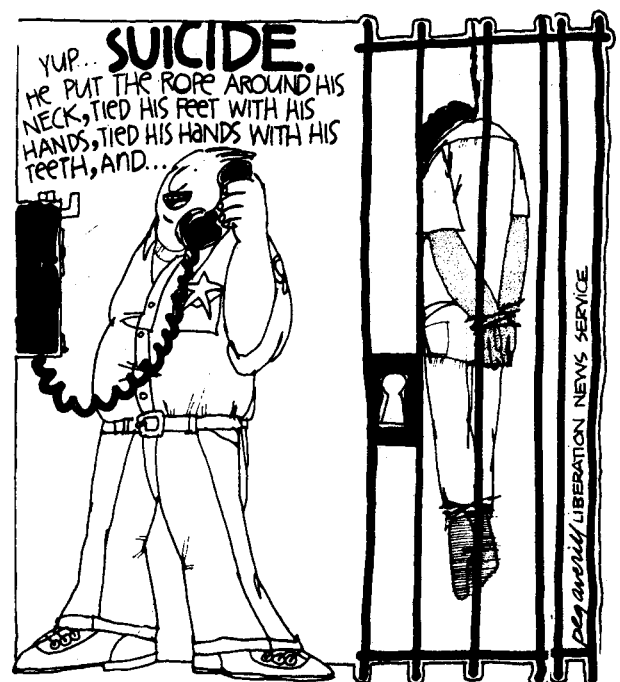
G.Z.: And a netting tied down, and then a netting up to their neck where they can't even move. I started to cry hysterically. I couldn't imagine why on earth they would do this to this child. Because one thing I can verify: Andrew had a good rapport with the staff. He listened to everybody and was very well-behaved.

A.M.: THEN WHY WOULD THEY HAVE A REASON TO RESTRAIN HIM?

G.Z.: Well, I did my own detective work about that, and I had my thoughts on that. Andrew, they knew, had allergic reactions to medications. He couldn't tolerate it. I found out later he was falling down and getting all these queer symptoms that they couldn't relate to. I managed to talk to, believe it or not, the patient who was in the room with Andrew that same day he was killed. I don't say "died." I say killed. And he told me that Andrew was getting reactions to the medication and they were afraid of him hurting himself. So what a compassionate thing these people do! Instead of calling a doctor or trying to see if these symptoms are real, they tied him into a bed posey until he's found bleeding, foaming at the mouth, and bleeding from practically every organ in his body.

A.M.: NOW, WHEN SOMETHING LIKE THIS HAPPENS, A LOT OF AGENCIES COME IN AND THEY SAY THEY'RE GOING TO DO INVESTIGATIONS.

G.Z.: Right.



A.M.: HOW MANY AGENCIES WERE INVOLVED IN INVESTIGATING THIS?

G.Z.: Well, you have to imagine. By the time Andrew died, he was the third death. You can speak to Mrs. Ruggeri. Her son was the first death. And this poor woman went to District Attorney Sullivan, who turned his back on her. She went all over and nobody listened. And if you read the report on her boy's death, it's like a horror story. Nobody cared and nobody listened. And Mrs. Ruggeri has an accent, so nobody listened even more so. Then the Singer girl died, and nobody listened.

A.M.: JUDITH SINGER.

G.Z.: Right. But when Andrew died, here was one mother who made herself very vocal. I have a brother who forced me to call every TV station and every newspaper. And, believe me, I was sad, and it was very hard for me to do. And a lot of people watched. My brother said, "Unless you bring publicity nobody's going to care and it's going to be covered under the rug like every other death there."

A.M.: WHAT YOU'RE SAYING IS THAT THE COVERUP STARTED THE MOMENT YOUR SON DIED.

G.Z.: Way before. By that time — I'm surprised that the first two reports put out by the Commission on Quality of Care were a little honest. But when it came Andrew's turn, it was complete distortion of facts.

A.M.: AND ALSO THERE'S THE MEDICAL EXAMINER'S REPORT.

G.Z.: Also a whitewash. All the way down the line. Don't forget. These are city and state commissions covering a state hospital. Nobody's going to tell me different.

A.M.: WHAT DID THE MEDICAL EXAMINER SAY WAS THE CAUSE OF DEATH?

G.Z.: Myocarditis. I can never pronounce that word ... but I know what it is. It's an inflammation of the heart muscle.

A.M.: NOW, THIS ISN'T A VERY COMMON CONDITION IN 17 YEAR OLDS.

G.Z.: A 17 year old, healthy child who had no incidence of heart condition whatsoever.

A.M.: AND NO INFECTIONS THAT COULD CAUSE THIS?

G.Z.: None whatsoever. But I'm sure if I'm sure of anything that that was due — and it can also be caused by an allergy. I'm sure as anything else that this was due — to all those medications they pumped into Andrew until he exploded...

A.M.: ONCE THEY GAVE HIM THORAZINE. THEY GAVE HIM A LOT OF SERENTIL. THEY STARTED HIM ON SOMETHING CALLED "RAPID NEUROLEPTIZATION," WHICH MEANS PUMPING SOMEBODY FULL OF A LOT OF DRUGS AND THEN TAPERING DOWN THE DOSAGE TO A MAINTENANCE LEVEL. BUT I THINK THEY NEVER GOT AROUND TO GIVING HIM THE MAINTENANCE DOSAGE BECAUSE HE DIED FIRST.

G.Z.: He exploded.

A.M.: WHAT WAS INTERESTING WAS IN THE MEDICAL EXAMINER'S REPORT THEY SAID THAT SEVEN ORGANS WERE ABNORMAL, INCLUDING THE HEART. NOT JUST THE HEART, BUT SEVEN ORGANS SHOWED A GREAT DEAL OF ABNORMALITY — HEMORRHAGING. THERE WAS CONGESTION IN THE LIVER, THE LUNGS, THE SPLEEN — YOU CAN GO THROUGH A WHOLE LIST OF THINGS. YET THE COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED NEVER MENTIONED THAT. ALL THEY MENTIONED WAS THAT ONE HEART CONDITION.

G.Z.: Isn't it strange? Every death is related to the heart in some way. And they're not going to admit that they were

wrong.

A.M.: THE MEDICAL EXAMINER CAN'T SAY THAT DOCTORS WERE RESPONSIBLE FOR THE DEATH OF SOMEBODY BECAUSE THAT VIOLATES THEIR ETHICS.

G.Z.: Of course not. You're fighting a state hospital — four deaths were in state hospitals. That's why I and Mrs. Ruggeri became so vocal. Because, first of all, nothing in this world is going to bring back our children. Our pain is so great. But I said to myself, I don't want anybody else to suffer what I'm suffering now. We're never going to have happy moments in our lives because our loved ones were taken away. And I can't conceive how their jobs could be so important that they can't admit that what they did was wrong and what they're doing to so many people out there.

A.M.: DO YOU SEE ANY WAY YOU CAN GET JUSTICE? ANY WAY AT ALL?

G.Z.: When they stop giving these medications that can kill people. And in such high dosages. They're not guinea pigs out there. They're people and they need help, and they're entitled to the best therapy they can get. And even that I'm negative about, because I really feel that these state hospitals, and even private hospitals, are just warehouses for people.

A.M.: MRS. ZAMORA, YOU WERE TELLING ME THAT YOU HAD A VISIT FROM SOME PRODUCERS TODAY FROM CHANNEL 13 PUBLIC TV. THEY'RE ... WORKING ON A FILM PROGRAM ON SOUTH BEACH. YOU SAID ORIGINALLY THEY WERE JUST GOING TO DO A PROGRAM ON...

G.Z.: On the pros and cons of adolescents and mental health. But it's mostly on South Beach now.

A.M.: AFTER THEY SPOKE TO YOU THEY THOUGHT THAT SOUTH BEACH WAS SUCH A BIG STORY THAT THEY WOULD HAVE TO COVER IT. BOTH YOU AND MRS. RUGGERI HAVE THE SAME ATTORNEY. YOU BOTH SUED THE STATE IN SEPARATE LAWSUITS. THE OTHER TWO FAMILIES ALSO HAVE ATTORNEYS. I THINK MRS. SINGER HAS SUED. WE DIDN'T MENTION THE FOURTH PERSON, CHARLES DORSEY, WHO DIED JUST A FEW WEEKS AGO. HIS FAMILY ALSO HAS AN ATTORNEY AND THEY'RE CONSIDERING A LAWSUIT. WHAT ARE THE PROBLEMS OF SUING THE STATE?

G.Z.: Nobody really wants to take the state on because they isn't a lot of money involved. But we don't care. We want justice, whatever justice. I want them to find them guilty because I know they're guilty. And this is murder. These aren't deaths. This is murder. Legalized murder they're getting away with.

A.M.: YOU BOTH WENT TO THE DISTRICT ATTORNEY, AND YOU COULDN'T GET CHARGES PRESSED.

G.Z.: Our district attorney was running for a judgeship. He doesn't want to make waves. He was just made a Supreme Court judge. Sullivan doesn't want any trouble. We've gone to him time and time again. My husband's been there many times. We've gone to the police department. We've gone all over.

A.M.: IN NEW YORK STATE, IT'S NOT REALLY A CRIME TO KILL A MENTAL PATIENT. IT'S NOT EVEN A MISDEMEANOR. SO HOW DO YOU GET JUSTICE IN A SITUATION LIKE THIS? WITH COVERUP AND IMMUNITY. THEY HAVE IMMUNITY.

G.Z.: Well, that's what I want to know. How do we get justice? You kill a dog and you're in trouble. Torturing an animal. They're torturing human beings and they're still there. And you know what's so ironic? All the people still have their same jobs. They're all still there, business as normal. No matter how beautiful it looks from the outside. It looks like a country club.

A.M.: YOU NEVER KNEW ANY OF THIS WENT ON

UNTIL YOU HAD TO LIVE THROUGH IT.

G.Z.: Do you think Mrs. Ruggeri and I — I often think, if my son could have made it to a phone. My God. They would have had to restrain my husband and I because if I had any inkling — and I know for a fact Mrs. Ruggeri too. They could never have done any of that to Andrew, because they would have had to account to me.

A.M.: ACCORDING TO THE COMMISSION ON QUALITY OF CARE, YOUR SON WAS TESTED FOR A HEART CONDITION. THEY TOOK BLOOD SAMPLES AND, TWO DAYS AFTER HE DIED, THE TESTS CAME BACK AND THEY FOUND OUT THAT HE HAD A HEART CONDITION.

G.Z.: Oh, two days after he died. Isn't that funny? Isn't that funny? From a very healthy child.

A.M.: SO IF THEY HAD WITHHELD THE MEDICATION, PERHAPS HE WOULDN'T HAVE DIED.

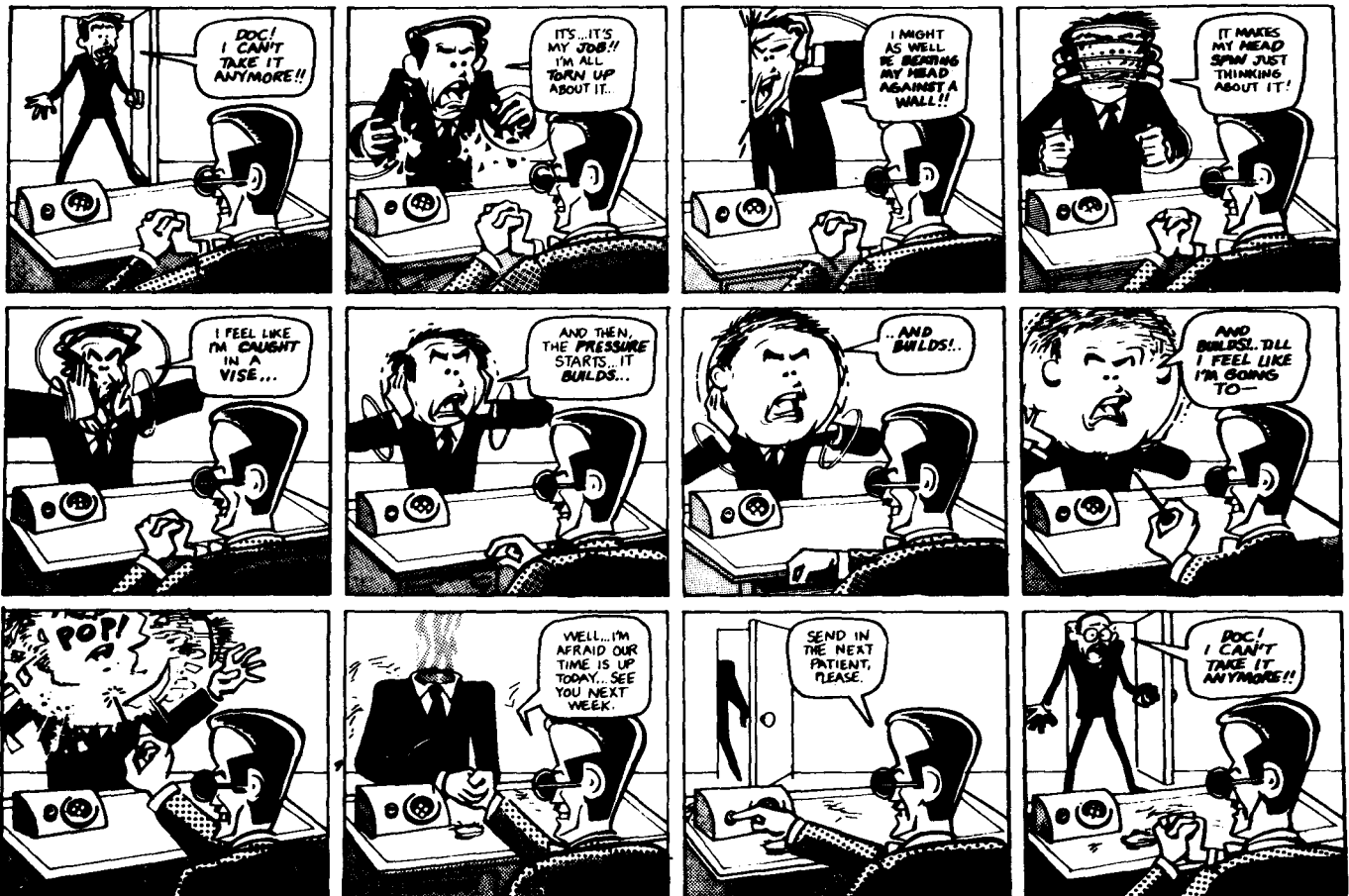
G.Z.: Yeah, that's what they're saying.

A.M.: WOULD YOU SAY THERE WAS ANYTHING FAMILIES CAN DO TO PREVENT THIS FROM HAPPENING TO THEIR CHILDREN? WHAT CAN THEY DO?

G.Z.: Let them not be fooled like Mrs. Ruggeri and I. Let them insist on seeing their children every single day. Be there. Be aware of what they're giving your children. Read up about these medications. Don't be fooled by what they're telling you. And don't let them use your children or loved ones as guinea pigs. And never, never — that's where the danger lies: when you're not allowed to see your children. South Beach is notorious for it. Because they know what they're doing is wrong and they wouldn't let any of us go in. If they weren't so frightened about what they're doing — and what they were doing to our children was very wrong — why didn't they let us go in? Because they know they were killing them. Our children were not guinea pigs. I say to all those people out there. Be aware. Ask questions. Don't let them intimidate you. You have a right as a patient, and there's nothing to be ashamed of. Mental health ... it happens to everyone. Ask questions. Don't be ashamed. Be vocal like I am, and maybe then someday there'll be changes.

A.M.: DO YOU THINK THEY WOULD ALSO BE ABLE TO PREVENT THESE KINDS OF THINGS IF PEOPLE IN THE HOSPITAL, THE PROFESSIONALS, WERE HELD RESPONSIBLE FOR THE PATIENTS?

G.Z.: Yes, yes. If criminal charges could be made against these people.



11th Annual International Conference For Human Rights And Against Psychiatric Oppression

Syracuse, New York, May 22, 1983

An Overview

BY DON WEITZ

I'm really glad I went to this year's conference in Syracuse, new York, held May 19-24. During the four days I was at the conference, I talked with many other ex-inmates and Movement activists who were at last year's conference in Toronto and new ones. Eight of us Canadians participated in the conference, five from Toronto and Hamilton, three from Quebec. It was great seeing other Canadians from Auto-Psy and Soliditairé in Québec — a renewal of friendship, strength and solidarity. *John Bedford, Connie Neil* and myself came from ON OUR OWN.

There were less people at this year's conference — about 100; there were roughly 140 last year. One reason for the traditionally small turnout is that the vast majority of ex-inmates are unemployed and forced to survive on welfare or SSI (Social Security Insurance in the US) of \$300 or less a month. Still, there was a good mix of people from many ex-inmate/anti-psychiatry groups: Network Against Psychiatric Assault (NAPA) and *Madness Network News* in California; Mental Patients Liberation Front (MPLF) in Boston; Alliance for the Liberation of Mental Patients (ALMP) in Philadelphia; Mental Patients Alliance of Central New York (MPA); Alternatives to Psychiatry Association (APA) in Florida; Project Release in New York City; Project Acceptance in Kansas; the Vermont Liberation Organization, as well as individuals from Michigan, Illinois, Maine, New Hampshire, Ohio and Texas, etc.

The conference was held at Syracuse University. The campus is located near the heart of Syracuse; it's a beautiful area with a mixture of modern and old brownstone and brick buildings and oases of green grass.

There were many exciting workshops, plenary sessions (general meetings) and

films and tapes. Some of the workshops focused on such issues as: Psychiatric Drugs; Electroshock; Military/VA psychiatry; Racism; Sexism (separate men's and women's groups); Holistic Medicine and other Alternatives; Advocacy; Fundraising; Marxist Analysis of Psychiatry — and many more.

The two workshops on racism were particularly important and attracted a lot of people. So far, our Movement has failed to attract black people and other people of colour. Virginia Raymond was excellent as the resource person for the racism workshops. The second workshop attracted over 30 people; the presence and key contributions of three black people made this workshop more credible and relevant than ones held at previous conferences. Some of the major issues discussed were: 1. Identifying major sources and reasons for racism in the Movement; (e.g. Why are only white people setting conference agendas? Why aren't we allying ourselves with other movements focused on survival issues such as the sterilization of psychiatric inmates, mentally retarded people, black and native people and Chicanos — as well as such common concerns as welfare and housing?); 2. Incorporating an anti-racist analysis into our antipsychiatry ideology and reaching out to people of colour nationally and internationally; 3. Endorsing the National Anti-Klan Coalition and encouraging people to endorse the Coalition at the next level; at the plenary on Sunday evening, we overwhelmingly passed a resolution to endorse the National Anti-Klan Coalition — one of the very few resolutions voted on at the conference. 4. Organizing the participation of ex-inmates in the Anniversary Civil Rights March in Washington, D.C. in August.

With possibly one exception, the plenary sessions were very frustrating — long-winded and upset with frequent interruptions. The 'rotating chair' method works much better in small groups than in large, plenary sessions. Besides the Anti-Klan resolution, there was a draft resolution to stage a continent-wide DAY OF PROTEST AGAINST ELECTROSHOCK this year, which we passed by consensus. This important resolution, building upon the very successful campaign by the Coalition to Stop Shock in Berkeley, California, read in part:

That a North American-wide Day of Protest (against electroshock) be declared and that major cities have individual protests in the form that is best for them. These could be demonstrations at the most prestigious facilities practicing shock, public tribunals, educational campaigns, media blitzes, marches and non-violent acts of civil disobedience. Self-help groups in all key cities are asked to take this on as a yearly project.

The resolution also called for electing an organizing committee and setting a definite date. Unfortunately, neither was accomplished.

I also attended the men's workshop on Sexism, which I found involving and in fact quite personal at times. About 20 of us in the workshop were alarmed and angry to hear that a woman ex-inmate at the conference was sexually harrassed by both another conference participant and a Syracuse University student, neither of whom were identified. This woman left the conference shortly after the incident. It was that event especially, I feel, which led us men to draft a statement denouncing the incident and all other forms of sexual harrassment and sexism. Our brief statement was not as

comprehensive, analytical or powerful as the position paper produced by the women's caucus at last year's conference ("Mental Health and Violence Against Women: A Feminist Analysis," published both in *Phoenix Rising*, winter 1983 and in *Inmates' Voice*, fall/winter 1982, spring/summer 1983.) However, our statement is a timely and important step toward a full political analysis of men's sexism in the Movement and the psychiatric system.

Highlights of the conference for me were the Press Panel and Public Tribunal on Sunday, May 22nd, our Day of Protest Against Psychiatric Injustice on Monday, and the independent Civil Disobedience Against Electroshock at Benjamin Rush Center on Monday and Tuesday. The Press Panel featured short presentations on various Movement issues by six ex-inmates elected by the conference.

The Public Tribunal on THE CRIMES OF PSYCHIATRY began at 1 o'clock and ended around 4:15. What an afternoon it was! At least 30 people, chiefly ex-psychiatric inmates together with three or four non-inmate supporters, walked in turn up to the open mike to deliver very personal, political and often moving testimony: it took courage, especially for the many new people at the conference. They spoke the truth as we have lived it. They spoke the truth about what it's really like to be forcibly incarcerated, abused and brain-damaged by psychiatrists; the truth about what it's like to lose our human and civil rights under the guise of "treatment"; the truth about how both psychiatry and psychiatric institutions humiliate and invalidate us. The personal testimony I witnessed that afternoon will stay with

me a long time.

We held our public demonstrations on Monday, May 23rd: our DAY OF PROTEST AGAINST PSYCHIATRIC INJUSTICE. There were actually four simultaneous demonstrations targeted at four different psychiatric institutions in Syracuse — the VA Hospital, one of four federal hospitals in the US where psychosurgery is *legally* performed; Benjamin Rush Center which practices electroshock treatment; St. Joseph's Hospital which practices heavy drugging, and Hutchings Psychiatric Center where we finally assembled.

After a brief meeting on campus, we split up into groups and started marching, chanting and singing. A few media people met us en route and at the psychiatric institutions for interviews. I joined the group going to Benjamin Rush Center. We handed out anti-psychiatry/anti-shock leaflets, then formed a moving picket line on the sidewalk in front of the entrance, chanted anti-psychiatry slogans and talked with the media. Around 12:30 that afternoon, we met at Hutchings, and for the next two hours we publicly denounced psychiatry and forced treatment, talked with some inmates who were glad to see us, and celebrated our survival, strength and solidarity in speeches and songs. A few of us handed a copy of the Movement's DECLARATION OF PRINCIPLES to the Medical Director and/or Administrator of Hutchings. The DECLARATION was published in *Phoenix Rising*, vol. 2, no. 4, and in *Madness Network News*, vol. 7, no. 1.

Throughout the conference, a number of fine films and videotapes were shown including "Psychiatry is gonna die" — a videotape of last year's conference in Toronto produced and

distributed by Auto-Psy in Québec.

Some of the films scheduled included: *Titticut Follies*, *One Flew Over the Cuckoo's Nest*, *Frances*, *I'm Dancing As Fast As I Can* and *Liz* (about ON OUR OWN).

The conference really ended with the Civil Disobedience Against Electroshock at Benjamin Rush Center, Syracuse's 'shock shop.' (The conference itself neither endorsed nor blocked the CD.) For roughly fifteen hours — thirteen of us ex-inmates successfully blockaded the institution's front entrance. The only violence happened when either a staff person or visitor forced his way through our chain from the inside. We were always peaceful and non-violent, which is essential for any CD. Eventually we just sat down and fell asleep in front of the entrance, while our great support people stayed awake watching over us and bringing us food and blankets to keep warm. Our CD at Benjamin Rush ended Tuesday morning with a press conference around 10:45, when three or four of us met with Dr. Dyer, Medical Director of the institution.

The final plenary scheduled for Wednesday morning never took place, I understand, because a lot of people had already left and many of those remaining stayed at Benjamin Rush to give us encouragement and support. As a result, no decisions were made about the place or date of next year's conference, and no committee was elected to organize our planned DAY OF PROTEST AGAINST ELECTROSHOCK.

Altogether it was another great conference. My congratulations to the MPA people in New York who did a magnificent job of both organizing and making us feel welcome.

Panel And Tribunal

The panel discussion held on the morning of May 22 consisted of 5-minute presentations by six ex-inmates, chosen not as leaders but because each had something different and important to say. Questions were received from other conference participants after each presentation, and from the public and the press after all the presentations. The transcript which follows includes edited sections of three of the presentations, together with one final question and reply.

JUDI CHAMBERLIN: Welcome. This Panel is to discuss the crimes of psychiatry. Virtually everyone here has been a victim of psychiatry. And I think it's very very important that we know what our history is, because like all oppressed people our history has been systematically kept from us and destroyed.

We know from brief fragmentary kinds of evidence that ex-patients have been fighting back for at least 100 years. And yet their words have been destroyed, discredited.

Sometimes you read about these things in books written by psychiatrists where they talk about these ideas as "paranoid ideas," and about this anger as "symptomatic," and so forth. But we know that these people are speaking the truth. And that's really the power of our Movement — TRUTH. We don't have a lot of money; we don't have a lot of access to the media, and from a glance I'm not sure that they're any reporters here today. We don't have the credibility, the built-in credibility that experts — especially medical experts — get in this society. So all we really have is the truth.

This Movement, the part we're all part of now, is actually only twelve years old, but there've been forerunners. As a matter of fact, one of our panelists today, *Jordan Hess*, was involved in a group called WANA (WE ARE NOT ALONE) in 1948, where ex-inmates got together and talked about their experiences and gave each other support. And that organization was taken over and subverted and has now become a large institution. And I say it's an institution, not because it's a building, a community program, but an in-

stitution in the most real sense called Fountain House, which is sometimes put forth in the liberal media as *the* model of what ex-patients need. What Fountain House does is take people's feelings of wanting to get together with other ex-inmates and subvert them into feelings that you're only well when you believe the authorized view, the staff view of "reality." So, it continues the same process in the community which the institutions force upon us when they have us totally under their power.

So, we've had to start over again and again and again and again. This Movement really started with a group called the Insane Liberation Front in Portland, Oregon in 1970. One of the people who passed through Oregon and briefly got involved in that group there later came back to New York City where he came from and — with another person — started a group called the Mental Patients Liberation Project in New York in 1971. I found out about this group a few months after it started. I saw a little announcement in the *Village Voice* in New York that said that there was a group called the Mental Patients Liberation Project who met at a certain place. I just sat there looking at that newspaper and said, "WOW! There are other people like me."

That's one of the things our Movement just keeps on doing; you see that especially at Conferences where there are always new people who have just found out about us. They always seem to feel a lot of energy and excitement and that same "WOW, there are other people like me." Our Movement has grown a tremendous amount. When the Mental Patients Liberation Project started in New York, in the same month in the same year (January, 1971), a group of ex-patients got together in Boston, Massachusetts, totally independently of anything that was happening in New York, and started the Mental Patients Liberation Front. Also in exactly the same month, a group of ex-patients and some of their supporters got together in Vancouver, Canada, and started the Mental Patients Association. These things happened totally independently, totally spontaneously among people who didn't even know that the other things had happened until months and years later. It took us a while to get in touch with one another.

The first Conference of this Movement, the Conference On Human Rights and Psychiatric Oppression, happened in Detroit in 1973. It's important for us to know that this Conference was not started by ex-inmates; it was started by a coalition of ex-inmates and liberal professionals. It's been part of our historical development and our political development that the Conference has evolved into an ex-inmate-run-and-controlled conference. Part of our political development has been recognizing when it was that the liberal professionals were helping us, and when it was that they really began to get in the way.

So since 1976, since the Boston Conference, this has been an ex-inmate Conference. It's been very satisfying and gratifying to see its growth, to see how many more groups there are. Every year, there are groups from new places, there are people here from parts of the country that have never had a Movement before. There are ideas jumping from group to group. One of the things I meant to bring with me to this Conference, but I forgot it and left it home, was some literature that just came in the mail the other day from an ex-inmate group in what I believe is Waverley, Australia. It was just like other ex-inmate literature that I've seen from all over the world saying the same things. The group is called the Coalition Against Psychiatric Injustice and Coercion. They're saying the same things we're saying. The same things ex-inmates are saying in England, in France, in Germany, in Holland, in Denmark, in Australia... The words are the same for the same reasons: It's the POWER OF THE TRUTH.

CONNIE NEIL: I'm a shock survivor. About 21 years ago, I had a baby and there was what they called a "psychotic episode" attached to it. Apparently, this happens in about one out of every three hundred births. If I'd just been left by my own, things more than likely would have just levelled out. I wasn't doing anything that was dangerous — not to myself, not to my baby, not to anybody — I wasn't threatening to, I wasn't even thinking things that were dangerous. I was going up-and-down, up-and-down. I really didn't know what was going on. I was in my in-law's house and it was all very strange for me. I didn't like what was going on.

I was taken to a psychiatrist who didn't know me in any way. After a half an hour, he recommended out-patient shock treatment, even though I asked him to see someone in Toronto or at least get records from someone I'd seen there. This wasn't done. The psychiatrist thought that I was "improved" to some extent after those three shock treatments: I was very disoriented. But they decided that I hadn't "improved" enough, as far as they were concerned, so I was committed.

Now, what I'm going to talk about is to some extent about shock treatment, and to some extent about the way rights are violated. I was *not* told I was being committed. I assumed that other people were signing papers because I really didn't feel very well. I was a little confused. I went there (hospital) voluntarily, I knew that there was something the matter with me. And I thought that this was going to be of some help. Well, it wasn't of any help whatsoever. And the way the people looked at me ... there's no feeling like when that door is slammed shut and you're in and they have the key.

They started to give me shock treatments right from the very beginning. I had the difficulties that are sometimes described with them — memory loss and disorientation. When I would wake up from each treatment, I wouldn't know who any of the people were. I wouldn't know who I was. I wouldn't know what I was doing there, or where I was supposed to go, or that I was supposed to eat, or even how to eat. I really didn't know anything.

By the time that they would tell me — because you have to have a little instruction each time — by the time that I got so that I was familiar with my surroundings, the problems that I was having would also come back. So I really don't know what they thought they were doing. I don't believe they knew what they were doing. I was told by a shrink once that they don't know what shock treatment does. They only know that in some cases it "works" — and in some it doesn't.

I think that all of us should be aware of the way that our rights are violated. Informed consent is one of the biggest issues that we try to push for when we are speaking. I think the Day of Protest that we proclaimed last night at the plenary session is probably one of the most important things that I'll be involving myself in. I'll never submit to another shock treatment. I would die first. I became involved in the Movement to speak out against these things, despite the kind of personal cost there is and also because I have lost jobs. My testimony last year appeared in *Phoenix Rising* and it was used against me at a job interview. So I want to urge you to work with us. I'm trying to arrange this Day of Protest against shock across the continent, and hopefully this intentional, sadistic procedure will never happen again.

SALLY ZINMAN: I think what everybody has been talking about in different ways is our reclaiming control over our lives — about empowering ourselves, taking control back for ourselves. The "mental health system" in various ways takes it from us just as society does, but we're here right now to talk about the "mental health system." The system is sanest;

that means it invalidates our perceptions and judgements. It says that we're "incompetent," that because we may be freaking out or having problems of living, we can not make decisions about our lives. It forces "treatment" on us. It messes with our heads, our bodies — without our consent, without information about what's being done to us. It medicalizes our social problems, and therefore takes control from us.

We have — besides talking about these things in our Movement — tried to set up alternatives that will give back control of our lives. For a second, I want to talk about alternatives the system has set up. "False alternatives" is a word Judi Chamberlin used in her book *On Our Own*, and it's a good word. Mostly, I'm going to talk about what are called "psycho-social rehabilitation centers" in the "mental health system," because they're considered *the* most progressive thing in the "mental health system" — are called *the* alternative.

We call them "false alternatives". I mean they talk good. They talk about "self-control," they talk about "empowerment," they talk about "independence." They do the opposite. It's a double message. They talk about "member control." Well, the members only control what maybe they're going to eat that day, but the staff controls the budget, staff controls the decisions, staff controls the policy-making. And we get the message. We're told, "You're important. You're wonderful. You go out and make it in this life and be independent, but don't run this program because you're not good enough." You know, there's a double message there.

They're talking about "psychosocial rehabilitation" — not talking about medicine, but don't you forget it. Their "rehabilitation" is based on the medical model. All the people from those programs are seen in the "med" clinic. They are there because they are called "schizophrenics," "manic-depressives," they are there because of their medical label. The staff is there because it's called a "school" — they're experts in what have you. The rehab centers call themselves "totally voluntary." Well, maybe 19 out of 20 people there are at least officially voluntary, but for that one person who gets sent to the state hospital — there's enough of a threat. It keeps us all in line. So, in fact, there's a double message, and *they are not real alternatives*.

Our movement has tried to set up what we call true alternatives. In Florida, we have a house and a drop-in centre. In other places, there are drop-in centres and the beginnings of houses. They are different in the sense that "patients" — members, residents, etc. — control their own service. Service recipients and service providers are one and the same. They are user-controlled. People learn autonomy by being autonomous. This undercuts sanism. I mean we're not saying, "You're going to be independent, etc. — but not here!" You are being independent *here*.

Our alternatives are not based on any medical model. You don't have to get a med appointment for your drugs. You are your own expert about your own body and your own mind. We strive to demystify our own bodies and minds. We are totally voluntary. I don't even like to use that phrase (totally voluntary) because that phrase comes from the "mental health system." Self-determination is fundamental. People have choice, and that means they can choose to go to the "mental health" centre if they choose. Unfortunately, in our house — which was designated drug-free — at least half the people at any one time choose to go. But this is their choice and we have to honor that. For each person to determine his or her answers, or no answers: that's what's significant.

We strive to be non-hierarchical, which is difficult. We haven't reached our goals, because we are so used to being dependent that we have internalized the very hierarchy in the

TRY

TRY Organization is now officially incorporated and we are seeking new members to plan future activities. We are also planning a trip to New York in late fall to perform the recent production of *THE SCHIZOPHRENIC OPERA*.

If you wish to help us or learn any aspects of performance feel free to give us a try and get up on stage.

We are all trying and we are here to change the picture of the X-Psychiatric Patient.

ACTION NEEDS INPUT

So let us know what you need help towards. TRY works when you get excited. TRY works with every step you take. TRY has the contacts in all areas of culture if you want to try and go in this direction.

Ron Gillespie
Director/TRY

"mental health" system and in society into our own "system." But the beauty of a horizontal support is incredible. Somebody in a self-help group has said, "It's the invigorating support of two people reaching across, instead of reaching up or reaching down." We strive to be a democratic, collective decision-making body.

Our alternative in Florida is not complete. There's a continuum, and the continuum is not complete. We have a drop-in centre, a house. We do not have a crisis unit yet. Again, I'm using "mental health" terms. We have no place where people completely freaked out can go. And so often they fall back into the system. That work-evolving process we haven't completed yet.

But these things are occurring across the continent. Besides saying what we don't like, we are beginning to create what we want. We are beginning to empower ourselves, because only we can do so. Someone once said, "we are empowering you." That in itself is saying that we are here and you are there — and that's invalidating and dehumanizing. Thank you.

QUESTION: Could Judi talk for a couple of minutes about some of the changes she's seen in terms of strategies in the Movement in the last thirteen years?

JUDI: It's kind of a hard question to answer, because we're such an independent bunch. We don't have policies and guidelines that people have to adhere to. It's a very gradual, evolutionary process. But I have seen certain changes in the Movement, and I would certainly divide it into three phases. One is that in the beginning, the conferences were open to everybody, and there were tensions that developed between the ex-inmates and the mental health professionals. Those tensions culminated in the San Francisco Conference in 1975, when the ex-inmates there really felt invaded and taken over. The San Francisco-Berkeley area is one of the two centers in the country where radical shrinks are, and they were there in

full force, so we finally had to declare a "liberated zone" of one room for ex-inmates only. And even then, that room was invaded. But out of that came something very positive, which was the separatist trend within the Movement, which says that as ex-inmates we have a right to our own organization, our own conferences, to develop our own theory, our own ideology, our own practice. I saw that as a very positive step. To me, separatism has always meant precisely that — that we go off to develop ourselves in the way we choose. It has never meant to me that we refuse to talk with anybody who isn't an ex-inmate. And for me, that's been a rather negative aspect of separatism in that some people seem to feel that anytime you talk to somebody who isn't another ex-inmate, you're somehow compromising yourself. I think that's changed within the last couple of years — that we are reaching out, that by being separatists, we have developed our strength, developed our ideology to the point where we feel very confident in speaking out to the larger community — whether it's to the larger community on the left, as we talked about in the workshop yesterday on our relationship with the left; whether it's to the women's community as we've been talking about for a couple of years in the Women's Caucus. And last year we developed a position paper that we still have to try to disseminate into the larger women's community, giving our analysis of some of the issues we feel they've fallen down on. We're going to have an organized ex-inmates' presence this year at a National Institute of Mental Health Conference that's coming up next month which a number of us are going to. We're going to caucus now to develop what we're going to tell them there, which I think is very positive. I think it's very, very important that as a Movement, we make our voices heard to the larger community — whether it's the Left community or the women's community or some other community within what's generally known as the Movement — also to the wider society as well as the psychiatric industry. We don't go to demonstrate at the APA (American Psychiatric Association) because we suddenly think they're going to get together and say, "Hey, you folks are right. We're going to disband and stop being psychiatrists." (Laughter) We know that's not going to happen. We go there because we want them to know about our Movement, about our anger, so that even though they might not agree with it — they might poo-poo it, they might discount it — they can't say that they didn't know. They can't say, "Oh, we thought all our patients were grateful and happy," because they hear us out there yelling and screaming and telling them that we're angry. I see that as a very positive development.

WORK AND MADNESS

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Don Quixote

*The inmates went to the park
to hear the jazz concert;
deep black shadows hung
over the grass and the
sun — sinking lower and lower —
was a thief with his
pockets full.*

*The inmates did not sit
in the trees but walked,
here and there, like pigeons,
dreaming of sleeping
with full bellies,
under the eaves of a church,
where the air is free,
where they could awake
to the sound of bells.*

*As the sun slipped
down the sky,
the trumpet wailed,
the windmills whirled
on the popcorn-seller's
buggy.*

*And like Don Quixote,
one stood up, fighting
with his own shadows,
talking to himself:
unsocialized behavior,
noted, recorded;
not alive, electric,
dangerous to others.*

*Sit down. Sit down.
Do you want everyone
to know
we're crazy?*

*And as the trumpet
wailed to the bloody sky,
it sliced out the heart
of this one,
both mad,
riding their madness,
Don Quixote —
his great white horse.*

*While the others dreamt
of sleeping like pigeons
under the eaves of a church,
waking to the sound of bells,
with their bellies full.*

*Madness, not enough, never
enough madness,
charging like a great
white horse...*

*They went back to the ward
early because of him,
this one
nattering at him,
angry...*

*He did not notice:
Sharp was his pulse,
for he had ridden hard.*

Donna Lennick



personal stories

Probably

BY BUD OSBORN

we get up so fucken early to drive to the va hospital in ann arbor that we both feel like confused loose shit, & this morning first thing im sittin there eyes filled w/ laverne & shirley loud filmed live, my stomach's dyin from the coffee that's waken me up since i'd just got to sleep, & i wanted to smoke the joint id rolled the night before as soon as possible, already im thinking about world hell & pat says i finished that book on francis farmer last night & i said you did & i was thinking boom she throws hard right away sometimes i like that & Pat says yeah i read it & boy was i glad it wasnt so easy to get somebody locked up when i went crazy idda never got out & we both laugh, both shaking & chainsmoking & hunched over like inmates on the ward, poor francis farmer, that was terrible pat said, about those soldiers coming over from that army base & raping her every

weekend, yeah i said yeah, both of us having been raped at one time or another, so we finally get in the car & it's hot in december & foggy & raining & clouds & mist & full moons & dawn-lights & highway p6. 23 again, past the federal correctional institution at milan, theyre expanding that joint i told pat, oh yeah she said, past the maximum security mental health facility, prison area, dont pick up hitchhikers, past the state maximum security prison for women, & upon the bridge over the expressway, in the middle of flat desolate michigan fields, graffiti: devil children pbb acid rain they love it, & the trucks passed us & drowned the suburu & pat'd get nervous & jump each time & kick the plastic pitcher of piss she was bringing to ann arbor for tests, she said i guess im scared of trucks from the time we ran into one when i was a little girl in illinois, yeah, i

said, there's a helluva lot to be scared of from those guys, & from everything else growing up in herrin: the shelton gang, first aerial bombing in the u.s., bootleg battles, ku klux, mine riots, warfare w/ scabs, her uncle shot dead in the streets, cave-ins, black lung, pat's father going to vote & returning saying: anytime i have to walk over a dead body to vote im gonna give it up, other relatives stabbed, still others imprisoned for theft, & pat's afraid there's more warrants out for her about bad checks and im not going back to jail either she said, me neither i said,

but i probably will, you probably will pat said & we both sighed, & talked about the fbi showing up early in the morning to threaten her w/ prison if she wouldnt tell them where i was & she didnt, my sister remembers that vividly, how awful they were, how stereotypical, & how fucken nasty

Diary of a "mental patient": Street People

Anonymous

We are the hole in life's doughnut. We sit here, all six of us, over coffee. It took us seven hours collectively to beg the price of a coffee. The begging is essential or we freeze to death in the winter night. Two hookers, exhausted from the night's tricks, come in for a whore's breakfast, a cigaret and coffee. This is a gilt and neon scene. Neon announces the trade of the place in its outdoor sign. Neon shines through the artificial orange juice and grape juice that swirls and tumbles in its containers. Neon lights the place with raw colors. If our eyes weren't shut they would hurt with the reflection of so much light. This is how we sleep over a cup of coffee. The hostels were full. The churches are wall to wall bodies. There is no room for us there. We walked, begging, until we were saturated with cold. Then with fifty cents in small change we made it to the doughnut

shop where there is warmth if not life. The waitress is all of fifteen years old. Her boy friend waits patiently for her as he plays the outer space game on the neon lighted machine. We are doomed to this place until the Eaton Center opens. Then we can sit in front of one of its restaurants and listen to the jazz band inside. The music curves out of the front door and envelopes us in its opium. It is also a place to sleep sitting up and a place to dream if the dreams will come as they infrequently do. At lunch time the restaurant is filled with sales girls and salesmen, with executive type who are slumming, with old lady shoppers who are lured in by the menu that hangs in the window. The odor of food sifts out through the door as well. Our stomachs have been empty for so long that we are immune to it.

We are eventually joined by the people from the mental hospitals who are let out during the day. They spend most of their time here. If you will listen they will tell you the story of their illness. Some of the six of us who sit here are former mental patients too. But we are silent. We are sick of the story of our illness. We are too confused or too lethargic to apply for welfare. We just joined our small group at the Eaton Center and we have never left it. Half a dozen of us together always. We are welded together by illness, poverty and the necessity to belong somewhere if only in this isolated group of six. There are other groups and cliques in the crowd. They are lucky they are mostly men and girls. We are only men, barely men in age. When our eyes are open we watch the shoppers walking back and forth. They dangle highly colored plastic shopping bags from their hands. They are well

dressed; coats open because they are too warm. What must it be like to be too warm? We are familiar with what it is like to be too cold. There is a mathematical line somewhere in the body that turns into an icicle in the cold that almost cuts the life's blood out of you.

We are companions to the cold between the time the Eaton Center closes until we beg fifty cents for the nightly coffee. There is one waitress on the late shift who will hand us free doughnuts as she will only put them on sale at a cut price because they will be stale by the next day. We would like to repay her for her generosity but what would we use to pay it with? We are too numb to make the effort to ask her.

Where did street people hang out before the Eaton family built this place? We are too young to remember those days.

A drug dealer drifts in. Want any acid or grass? Up your ass. We are street people but we are too smart to go on drugs. Some of us have seen the junkies they bring in to the crisis wards of the hospital. They can vomit but there is very little else they can do.

The dealer scores, though. Someone with cash in one of the groups has enough for a joint for everyone. What would old Timothy Eaton say in the church named after him if he could see his high tech shopping plaza swirling in the odor of grass smoke? What would the old man say into his beard if he were alive and a witness to the street people of the city. They say you can buy anything on the Yonge street where the Eaton Center sits. Commerce attracts commerce. Available as merchandise are human flesh, male and female, thugs, thieves and ID cards. That wasn't the idea that built the place but it unexpectedly turned up as one of life's iron facts almost as soon as the place was open.

They say tourists come for miles around to visit this place. How do they miss the street people? How do they avoid the odor of grass? Do they know how much acid it takes to rot the brain? Hardly. They are the innocents of the world united in their ignorance of life. And they are not enlightened about these things by the tourist brochures about Toronto.

You won't find anything on Timothy Eaton's gravestone that he left the city these things in his will.

But, now it is closing time. Time for us to move among the hurrying pedestrians to beg until we have fifty cents for coffee.

Tonight there are only five of us in the doughnut shop. The sixth member of our group didn't make the fifty cents. Don't worry about him. He jumped off the Bloor Street viaduct before he froze to death.

getting culture

they troop us from a grouphouse to a play
little ducklings two by two
the social workers fresh from college heading a
delinquent and derelict procession
along dupont up to the tarragon theater for a
torpid play about the untorrid life of a
provincially straitjacketed woman
translated from the french and written by a man
a play coming at us from many removes

i sit down front row smack center knees rubbing the stage
beside doug the skinny many-weathered grizzled
bootlegger
who's got the lack-of-wine-bad-shakes
it's his very first play

and in a very early scene the girl's brother
snatches her doll stabs it and she
all-of-a-sudden SCREAMS right-at-us
jolting doug skyhigh off his chair and into that
emphysemic cement-mixer rattle in his chest
and he gasps real loud
NO WONDER MY NERVES ARE BAD

it's a play as long as life is short and every bit as
absurd with no intermission so that many
kidneys are at high tide and a million nicotined cells
are calling for help so doug clambors up clumsy cowboy
boots
stumbling coughing wheezing clattering through the small
theater's full house, and eclipses the spotlight
momentarily
and announces by way of explanation
I HAVE NEVER BEEN SO BORED IN MY LIFE

finally it ends she dies and outside
i ask doug what he thinks of his very first play
and he says, "they'll never get me to another one. i feel
like i been dragged through an asshole and fed farts for
a week."

it was the finest theatrical
criticism i've ever heard.

by bud osborn





ON OUR OWN

On Thursday, June 23, ON OUR OWN had its 1983 Annual General Meeting. A new Board of Directors was elected, which will be considering ways to improve the operations and efficiency of the Board.

ON OUR OWN was recently notified that it has received a Canada Ontario Employment Development (COED) grant for approximately \$30,000. This grant will enable us to hire two store clerks and a van driver's helper to work in the Mad Market for forty weeks,

from mid-July to April, 1984. We hope the grant will make the Mad Market even more successful in its efforts to provide both a source of income for ON OUR OWN and a place where members can develop or improve their job skills and re-integrate themselves into the competitive work force. The store will need fewer volunteers for the duration of the COED grant, but ON OUR OWN now has three new jobs to offer to eligible members or other ex-inmates.

The ON OUR OWN drop-in centre is

now open seven nights a week (Monday to Saturday, 5 to 11 p.m.; Sunday, 1 to 11 p.m.). We had hoped to hire a drop-in manager under the COED grant, but this was not possible, so the drop-in will continue to be staffed by volunteers. We will be having a picnic at Kew Beach on July 17, and another event is being planned to celebrate the sixth anniversary of the founding of ON OUR OWN, in early August. Details will be given in the August issue of our group newsletter, "The Mad Grapevine."

THE 'MAD MARKET'

is a non-profit store operated by On Our Own, a self-help group of Ex-psychiatric inmates and/or patients.

We offer items for sale at some of the cheapest prices in town!

Donations of used goods are welcome. We pick up and deliver.

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Toronto, Ontario
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20% Discount!
for member of On Our Own
and similar organizations.

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instead of "real" money.



phoenix pharmacy

At the 11th International Conference for Human Rights and Against Psychiatric Oppression, Phoenix Rising asked the drugs workshop for personal accounts of psychiatric drug problems, addiction, adverse reactions, and, most importantly, successful accounts of withdrawal.

Despite the fact that elsewhere at the Conference, I had heard four different accounts of people getting off drugs through various programs (street drugs self-help support group; women's addiction group, set up by a women's resource centre; voluntary in-clinic program; and the California Free Clinic at Berkeley (see Profile)), people who spoke at the drugs workshop presented individual efforts in withdrawing from psychiatric drugs. Comments quoted are from Conference participants in that workshop.

Aside from the discussion quoted here, it was pointed out that people in crisis who sign into institutions suddenly find their status changed from voluntary to involuntary when they refuse drugs or wish to leave. One reason for this could be that adult day care or confinement is a major industry itself, like the drug industry. Generally, people are told they must continue the drugs for their lifetime, or go/remain crazy: this, despite the indication of tardive dyskinesia and against pharmaceutical insert recommendation. The majority of those kept on drugs are from the poor, disadvantaged and desperate classes within society.

The reasonable alternative of Movement-controlled crisis management centres, the workshop felt, would make institutions as we know them obsolete.

DAVID CALLAHAN

In 1971, my wife and I had contemplated a home birthing. Someone from a community action group talked me into going to a hospital to have my child delivered. They made a condition with the hospital that I be present in the delivery room, which wasn't very well accepted at that time. When we arrived there, they refused to let me into the room. I went in anyway. While the doctor was delivering my son, he started crushing his skull with forceps. I interfered and told him I wouldn't permit him to go any further — and I finished the delivery.

In Vermont, if two physicians sign a statement, you can be incarcerated immediately in a mental institution for observation. Several State Police came and took me to the Waterbury State Mental Institution. I arrived about 5:00 p.m. and was interviewed for about ten minutes and given a large quantity of chloralhydrate which knocked me out in fifteen minutes and kept me unconscious for the duration of the night. In the morning they tried to administer Thorazine to me orally. I refused and was told they would hold me down and forcibly inject it into my veins. Not wanting to get violent over it, I took the Thorazine without knowing what it was. It threw me into a stupor. And I was there for two weeks. During those two weeks my personality changed im-

mensely. I think that anybody who knew me in my normal life who saw me acting in that way would have thought I had lost my mind. I maintain it was the side effects of those drugs. It got to the point where I was stammering and stuttering and agitated. Some people came and told me I was crazy and would never get out, never see my family again. They harrassed me several times a day, I suppose to see how I would react under the influence of the drug. I was threatened with rape several times by some of the attendants.

After two weeks I was released into my own custody by the Vermont court. The State Police and a psychiatrist were witnesses on my behalf. It was at least two-and-a-half months before I could have a normal conversation. When I encountered friends, they thought that I had lost it mentally, simply because they were observing the effect of me withdrawing from 1500 mg of Thorazine daily. I never received any physical examination whatsoever or test to determine what effect that might have on me. And as it proved out in court, they didn't have a valid reason to hold me there in the first place.

My wife and baby stayed in hospital. It wasn't the pre-arranged condition. But after the State Police arrived, the hospital took control of her. We were essentially naive in how to deal with the situation. We had no relatives in the area or means of support to accomplish getting out of there. They administered drugs to her

and other things against her will.

I'd like to form a directory of symptoms of "side effects" of psychiatric drugs, and have people correspond with me either anonymously or named. I'm interested in the differences between what is listed on inserts and what our experiences are. For those on drugs, it could be used to recognize that a lot of their symptoms are attributable to the drugs. Anyone wanting to work with me is welcome.

Write to David Callahan, Box 191, Plainfield, Vermont.

CONNIE NEIL

When I was in my last year at college, I ran into some problems and was shuffled over to a psychiatrist who put me on some drugs that were in the dexamy-dexadrein group. I'm not sure what they were supposed to be for, but I think they were to calm me down. In fact, they made my mouth dry and I used to stay awake for about seven days at a time. I now have very bad allergies, but I didn't know about them then. And I think that probably I was having opposite effects to those drugs.

Then when I was institutionalized a year or two later, they put me on a variety of drugs and I don't know to this day what they all were. When I would try to tell the nurse or the shrink or whoever you have to tell your problems — nobody wanted to hear. It's always somebody else you have to

ness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

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

There is no known effective treatment for tardive dyskinesia: antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

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(thiothixene HCl)
**Intramuscular
 For Injection
 5 mg/ml**



tell, somebody who isn't there — and you can never get to that person to say "it's making me fall down, making me go all red, making my heart race." Anybody can see somebody fall down or their skin go all red. After I was out of the institution, I was on Elavil for depression, and because I wanted to get on with my life I went to a dance class. Something about the drug doesn't allow a person to perspire. This means that if you exert yourself, you become all red. I got heat prostration with big blotches of white and red all over me. When I went to see the shrink, I told him about this, and he added another drug. Instead of taking me off Elavil, he added Librium, saying it would somehow change my muscle reaction.

I got a job with Imperial Oil as supervisor of their typesetting room. I was already on the job when I had to take their medical. They asked me what drugs I took — aspirin, Elavil, Librium — and why I took them. So I briefly told them that I'd had this problem and been told I had to take them all this time — this is about six years later. The doctor said they couldn't hire me, indicating big books above him, that it was against company policy.

I said that I was already working there, that the policy was discriminatory and that I would sue. Then I went back down to where I worked and my superior was waiting and said, "What on earth went on up there: you've got a medical rating of F — I've got a man out on the press with only one leg who has a better medical rating than you." When I tried to tell him, he said, "I don't want to hear about it." So I said, "What do you think I'm going to do, throw a fit on the floor, stab someone?" He just kept saying he didn't want to deal with it, until I said I would sue. They kept me on as a permanent, part-time, temporary employee and I had to have a yearly medical. I was still in charge of the room, but with limited benefits. They were just waiting for the time when I would lose my temper or slip up in some way. None of those things happened. Three-and-a-half years later, there was a reorganization and two departments were put together, so they put a secretary with a lot of service in charge. She hadn't my knowledge or experience and was reluctant to ask me how to do things, so conflicts developed and I was fired. They wanted me to resign because of my psychiatric record, they said it would look better on my record and I'd stand a better chance of getting a job. And I said, "No, it's going to look just as bad on your record." But that taught me that having psychiatric drugs is a way of

labeling you, so that you're not accepted for jobs, not accepted in many various ways. I decided I should get off them. I wasn't successful at first in getting off them, partly because I'd been told I'd continue to have depressions, that it was a chemical thing.

How I got off them was to take them two days, and on the third day cut down some. After a week or so, you cut down on the second day, until you're taking only one each night, then every second night, every third night, then nothing. I've been off them about three years.

I find that because I'm not taking drugs, I'm a lot clearer about what I'm doing, I can decide better. I'm a lot more agitated, so I don't really look too cool, and because I'm agitated it affects my voice and I sometimes look a little strange or nervous, which I am. But I've had periods of depression without the drugs, which I've gotten through without the drugs. What I've learned about them is that they do come and they do go, and whether you have the drugs or not, you're going to go through it anyway and the only way to get through it is to just keep doing the things you have to do every day and not give in to it. Taking drugs, I think, is a form of giving in to it. It's seeing yourself as less than human when you put yourself on them. So even though it's more difficult without them — and it is difficult — I'm glad I'm not taking them. I found no one wanted to help me go off them. Finally a shrink friend explained how you must go off them gradually and I kept track of it myself. No one monitored me.

ALLEN MARKMAN

I had never really thought of myself as having a psychiatric drug problem, thought of it as incidental, but I just made a list of all the drugs I remember being on and it's incredible how easy it is to forget them. It wasn't really a secondary, but a primary experience. A lot of times I was looking for drugs myself to knock me out and prevent me from feeling the very difficult things I was going through, the pain of going through a total disorganization of my mind, and feeling that I was going crazy, and the knowledge that I would go crazy and it would take nearly a year to go through that, and that there was nothing I could do about that but wait.

It all started when I was seventeen and having problems at college, suffering extreme anxiety, terror. I went to a psychiatrist, a very nice man, who couldn't do very much for me. He gave

me Ritalin — I don't know why — but he said it would take the bite off my depression, whatever that meant. It increased my anxiety and mental energy by about 500 percent, although I was still lethargic. I still didn't want to get up to get dressed or shaved, so it really didn't help me. About six weeks later, I wound up in the Institute of Living in Hartford, Connecticut, which is where Jean Lindsay was talking about. I had a young psychiatrist who prescribed a low dose of Mellaril. What surprised me was I didn't notice any effect except it made me impotent, which I thought was very curious. After two months, I complained and he took me off it and didn't put me on anything else. From the time I escaped from there, I was drug-free until about five years ago.

I started taking Valium — self-prescribed, got a supply of it — for similar types of anxiety. It did it temporarily, but as soon as the pill wore off I still felt I was going crazy, that my mind was coming apart, wasn't working properly. I was also in a difficult family situation so I stayed with some relatives down on Long Island and they said they understood what I was going through, but I'd have to have some professional help while staying there. So I circled some names in the telephone book and ended up with a psychiatrist who prescribed Dalmane and Elavil. The Dalmane was to make me sleep, because I hadn't slept properly in a number of weeks: I'd just lie there. The Elavil which was for depression made me "spacy". My tongue swelled up to twice its normal size and I had trouble breathing and had the problem of not being able to perspire regardless of what the temperature was outside. I would just break out in rashes. That was a very unpleasant experience. The Dalmane I enjoyed because it made me unconscious for about eight hours which is what I wanted. I wanted to be unconscious at that time permanently. I coped with my feelings by planning suicides. Should it be hanging? Should it be shooting? Jumping in the river? In front of a truck? — constantly. My condition was impossible, but I was able to mask this and people thought I was perfectly normal. Doctors thought I was okay, but I thought I was crazy — a very difficult problem. I liked this Dalmane so much, I decided to take the rest of the bottle at once and wound up in Huntington, a general hospital. The doctor there took me off all drugs, refused to give me any medication for the three weeks I was there, even though I begged for it. I wanted something to knock me out for as long as possible

because I was in such psychic pain, and with my being locked up in this psychiatric institution, there was no diversion from this pain for three weeks. Once I got out of there, about a week later, I went to a private institution for an evaluation because my family demanded it. They threatened me with an emergency commitment to Creedmore and said if I didn't come quietly, they would ship me over with guards in a locked car with bars. The doctor there admitted me as a voluntary. She gave me the choice of involuntary commitment for 15 days or voluntary, and like a fool I signed myself in and was there for four months. The doctor didn't really speak English. All he could say was endogenous depression and give me a lecture on what that was and put me on Sinequan — a high dose that left me spaced out and lethargic, and I wasn't

able to speak for a long time. Then he decided I was a psychotic, so he released me and put me on Navane and Artane. Navane again made me spaced out, and the Artane made me high. I took the Artane quite willingly because it made me happy and euphoric. Some people have that effect with the anti-parkinsonians. He gave me that because when he had me hold out my hand I had fine hand tremor, so instead of cutting the other drug he added this on top of it.

When I wound up back in the hospital — the clinic wanted me back because they said I was regressing — I spent another three months on the Navane and Artane. A couple of weeks after my release, I stopped taking the drugs, didn't go back to the clinic, and my depression disappeared entirely. There was a period of about four months of euphoria and then I felt

exactly like I did before these problems. I think I'm prone to depression, and when I get into a stressful situation where I try to fit into what people think I should be — like having a job, wearing a suit, doing what my family wants, what everyone else in my type of culture or neighbourhood want, what people I went to school with do — it causes such a conflict that it drives me crazy. Some people can handle it, some drink, but me — it drives me crazy. I have to be myself. I like to do what I'm doing now, involved with the Movement, this work, helping others who have gone through the same things, preventing others from going through it.

I don't think the drugs caused my problems, although they may have contributed, but I don't see that they are any kind of solution for my problems. They're very soft solutions.



DISEASE NOW, DISEASE THEN, DISEASE AGAIN AND AGAIN AND AGAIN . . .

DEPRESSION IN PRE-COLUMBIAN ART

“While undertaking a larger study dealing with representations of disease in pre-Columbian ceramic figures, the authors found four figures in which depression was clearly depicted. Their findings prove that psychiatric disorders did not go unnoticed by the people who inhabited the American continent before the arrival of the Spanish.”

FIGURE 1
Illustration of Postpartum Depression from the Shaft-Tomb Complex Culture (100 B.C. to A.D. 250), Nayarit, Western Mexico^a

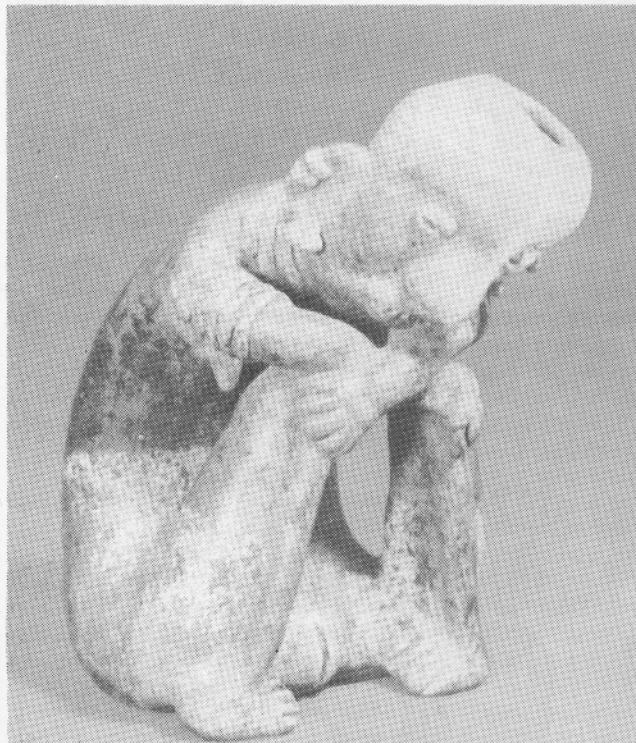


FIGURE 2
Representation of Apparent Agitated Depression from the Late Classic Mayan Culture (A.D. 600 to 900), Jaina, Campeche, Mexico^a

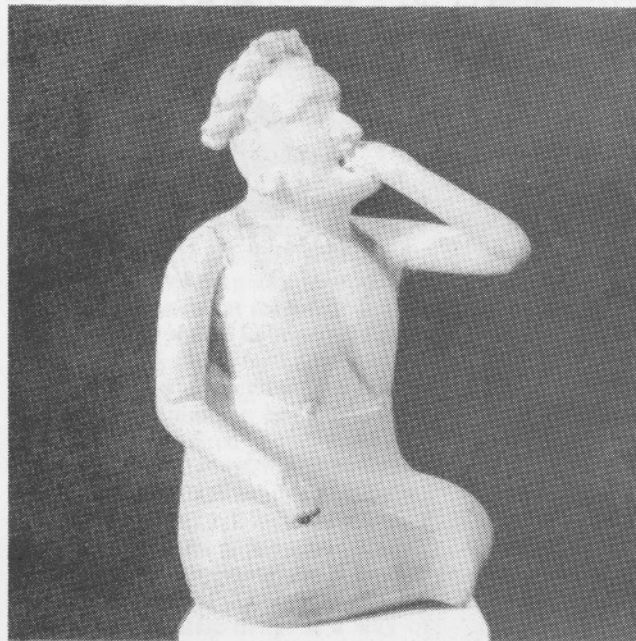


FIGURE 3
Illustration of Apparent Retarded Depression from the Shaft-Tomb Complex Culture (about A.D. 100), Colima, Mexico^a

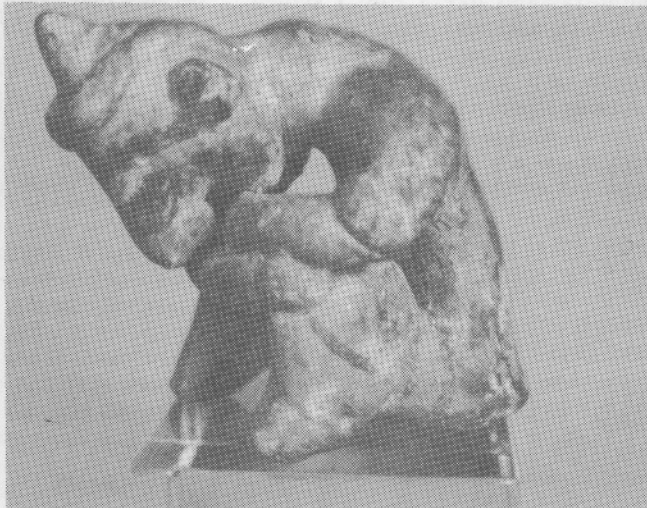
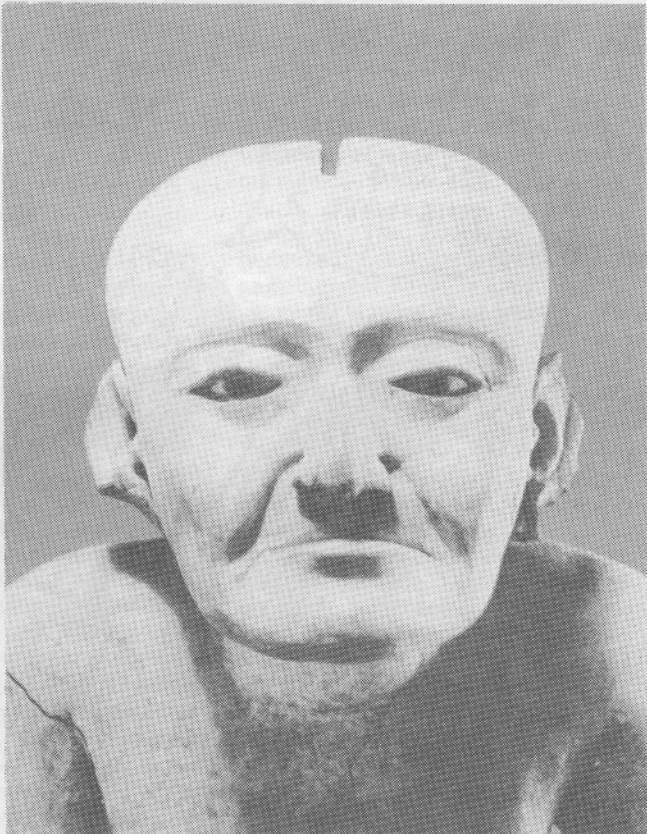


FIGURE 4
Representation of Depression of Senescence from the Late Classic Period of the Gulf Coast Culture (A.D. 550 to 950), Central Veracruz^a



PSYCHIATRIC PATIENTS' RIGHTS IN ONTARIO: An Explanation of the Mental Health Act

BY BONNIE BURSTOW

Coming to Write this Article

A number of incidents culminated in my writing this article. First and most important, a number of "psychiatric patients," "ex-psychiatric patients," and psychiatric hospital staff asked me questions about psychiatric patients' rights which I could not answer. Ex-psychiatric patients asked me questions like: Can I require a mental hospital to release my files to my present outside therapist? Staff asked questions like: Am I breaking the law when I help 'restrain' an informal or voluntary patient? Though I had considered myself fairly well-informed on this sort of issue, as often as not I did not know the answers to the questions asked. I began asking other seemingly well-informed people — polite patients and politicized therapists. I soon found that generally they too did not know the answers to these and similar questions. My response was to get a copy of the 1980 Mental Health Act can go through its laborious phrasing very, very carefully.

As I read through it, I was surprised by much of what I found. I came to realize that our conceptions of it are somewhat off: the rights contained in the Act are not nearly as straightforward as is generally assumed. Most of the rights are accompanied by a long list of exceptions, often to the point of making the right itself ineffectual. There are rights that are generally assumed to be there *which are not there*. There are rights *that are there* that most people do not know about. There are detailed avenues of appeal that most of us have had only a vague sense of. There are rights that have *not yet* come into effect but *allegedly will* come into effect. Thinking about it and realizing that I had just given myself a good grounding in the Act, I considered writing something on it. My next thought was: there's no need. When the advocacy offices come into effect, they'll do the clarifying necessary. I soon identified this as a cop-out. The point is:

1. The existence of psychiatric advocacy offices is no guarantee that people will be adequately familiarized with their rights.

*I am using terms like "psychiatric patients" in this article only because the relevant legislation is written in this language. I am in no way suggesting that you are or should be "patient." Far more offensive terminology will be coming up later. I am not changing it because I cannot do so without giving a confusing rendering of the act. This is just another example of the sort of dilemma that insensitive and inappropriate wording puts us in.

2. The advocacy offices may well not act in the patient's best interests.

3. The vast majority of psychiatric patients are not in provincial mental health centres so will have no direct access to an advocate. (Advocacy offices will be in provincial mental health centres only.)

So reasoning, I picked up my pen and began to write.

The Purpose of this Article

The first and primary purpose of this article is to do some essential clarifying. My intent is to clarify:

- 1) What people's rights really are according to (a) legislation now in effect, (b) legislation soon to come into effect.
- 2) What avenues for appeal and redress (a) are now available, (b) will become available.
- 3) How to access these avenues.

A secondary purpose is to:

- 1) Identify areas where violation tends to occur and prosecution, accordingly, is in order.
- 2) Identify deficiencies in the present Act which I think the government might be talked into addressing.

Rights Under the 1980 Mental Health Act and Avenues for Exercising Them

There is no section in the Mental Health Act called "rights." What I have done is identify what are in effect rights, select the most significant of these, and list them under general headings, together with methods for assessing them. The identifying, categorizing, and numbering are my own. I have also used a lot of my own wording, as the Act is cumbersome, though I retained the legal wording where this seemed important.

I have affixed the term "unproclaimed legislation" to some of the rights I have listed. This term is intended to distinguish a right contained in an amendment which has been passed by the legislature but has not yet been proclaimed by the Lieutenant-Governor. Rights so classified are in the process of materializing. Supposedly, they soon will though they have not yet come into being. Insistence on them and prosecution of violations of them will be possible once and only once proclamation has occurred. Watch for these. Ask about them. They have been a long while in the offing, however, so don't hold your breath.

Rights *Vis-à-vis* Admission

1. A person may not be involuntarily committed to a psychiatric facility unless first:

- a) he is given a psychiatric assessment (examination culminating in a judgment) by a physician attendant at the facility, and
- b) the physician signs a certificate of involuntary commitment which specifies that the person is of danger to self or others.

EXCEPTION: There is one and only one exception. If a magistrate suspects that a person appearing before him is "mentally incompetent," he may have the person examined by a doctor not connected with a psychiatric facility. If, in the doctor's opinion the person fits the criterion for commitment listed above, the magistrate may then order the person to be confined to a psychiatric facility for a period not exceeding two months.

2. A policeman may not have someone picked up and taken for an assessment unless *either*:

- a) a physician has made out and signed an application for a psychiatric assessment of the person in question. (For this application to be valid, the physician must have personally seen the 'patient' no longer than seven days before submitting it.);
- or b) A Justice of the Peace has issued an order for the person to be picked up for assessment (The procedure is: One or more persons meet with the Justice of the Peace and request that the order be issued. The Justice of the Peace listens to the evidence. If he is convinced that there is at least reason to suspect that the person's being at large itself constitutes some sort of danger, he issues the order);
- or c) A judge or magistrate orders an assessment;
- or d) The police officer himself *personally witnesses* the person acting in a way that suggests he is a danger to self or others and/or is not able to take care of himself.

Length of Involuntary Commitment

1. A person may be detained for no longer than two weeks under the original certificate of involuntary admission.
2. A certificate of renewal may be submitted by the physician; this will allow the patient to be retained an additional month.
3. A second certificate of renewal may be made, allowing for two additional months of detention.
4. For each three subsequent months of detention, a new certificate of renewal is required.

Rights to Review and Appeal

1. The patient or anyone connected with him has the right to require a review board to meet and reassess the original certificate of involuntary admission, each subsequent renewal of it, and any certificate which changes his status from voluntary to involuntary. (To set the review process in motion, ask for, fill out, and hand in "Form 16," which is called "APPLICATION TO REGIONAL REVIEW BOARD UNDER SECTION 31 OF THE ACT." See Form 16 in the Appendix.

Shortly after you have submitted it, a regional review board will meet to consider the case.)

2. The patient *must be*:

- a) informed when the original certificate of involuntary admission is completed, when a certificate changing his status from voluntary to involuntary is completed, and when any certificate renewing his involuntary admission is completed; (UNPROCLAIMED AMENDMENT)
- b) informed of his rights to have each of the above reviewed. (UNPROCLAIMED AMENDMENT)
3. Either the patient or a representative of the patient must be allowed to attend the review board hearing.
4. Prior to the beginning of the hearing, the patient or his representative must be shown and allowed to copy all written documents which will be presented at the review. (UNPROCLAIMED AMENDMENT)
5. The patient or his representative must be allowed to present his own testimony and to call witnesses.
6. The patient or his representative *may* be allowed to cross-examine witnesses, though this is subject to the discretion of the review board chairman.
7. Upon the completion of the 4th certificate of renewal (six and a half months after the original commitment), the patient will be given an automatic review whether he requests it or not; he will also be given an automatic review on every subsequent 4th renewal thereafter (every 12 months).
8. The patient and/or his representative should have the right to appeal the decision of the review board to the county or district court. (Get a lawyer for this one.) (UNPROCLAIMED AMENDMENT)

Right to Personal Correspondence

1. Under no condition may correspondence between a patient and either his lawyer or a member of the assembly, or a member of the review board be interfered with.
2. Other correspondence may not be interfered with unless the officer of the facility or his designate has reasonable cause to believe "a) that the content of the communication written by the patient would,
 - i) be unreasonably offensive to the addressee; or
 - ii) prejudice the best interests of the patient; orb) that the contents of a communication sent to a patient would,
 - i) interfere with the treatment of the patient; or
 - ii) cause the patient unnecessary distress." (*Mental Health Act*, Section 20)

Rights to Confidentiality of Files

- 1) A patient's files may not be shown or released to anyone other than a staff member of the facility which owns the files unless *either*:
 - 1) the patient, being of the age of majority, gives his consent;
 - or 2) where the patient is not of the age of majority, the nearest relative gives his consent;
 - or 3) the files are subpoenaed or otherwise ordered by a judge;
 - or 4) they are needed because of a medical emergency directly involving the patient;
 - or 5) the chief medical officer of the facility where the patient is now being treated submits a written request for the files;
 - or 6) they are needed for academic research and/or statistical purposes. (Where this is the case all means of identifying the patient *must* be removed before the file is shown or transmitted.)

The Right to Refuse Psychiatric Treatment and Psychosurgery

1. A course of psychiatric treatment may not be given the patient without either his consent or — where he has not reached the age of majority or he is not mentally competent — the consent of his next of kin *unless*:

a) a resident doctor applies to the review board for treatment authorization on the grounds that the patient will improve with this specific treatment and will not improve without it; and b) the review board authorizes the psychiatric treatment. (In such an event, the patient must be notified of the hearing; the patient or his representative must be allowed to attend the hearing and present witnesses of their own, etc. And, as with other review hearings, any party will be allowed to appeal the decision of the review board to the district or county court once the amendment allowing for such appeals comes into effect.)

CLARIFICATION

While the patient or, where applicable, his next of kin, can refuse consent to a psychiatric treatment and this refusal must be honoured unless a review board gives independent authorization, this in no way restricts the use of 'minimal constraint' on the patient. With no consent whatever, the patient may be subjected to 'minimal constraint.' 'Minimal constraint' is so defined that it includes the use of drugs.

QUALIFICATION

While a review board *may authorize* other forms of psychiatric treatment without the consent of the patient or his next of kin, it *may not authorize* the use of psychosurgery. Consent is absolutely needed for psychosurgery.

The Right to Re-examination and Review Where Your Estate Has Been Put in the Hands of a Public Trustee

An attending physician may examine a patient or ex-patient at any time to assess if he is capable of managing his own estate and in fact must do this examination and assessment upon admission. If the assessment is negative, he issues a certificate of incompetence. The management of the estate is thereby put in the hands of a public trustee. A patient whose estate is in the hands of a public trustee has rights of re-examination and review as follows:

1. Upon discharge, the physician must re-examine the patient to assess if he is now competent to manage his own estate. If the assessment is positive, the certificate of incompetence must be cancelled and management of the estate returned to the patient. If it is negative, a certificate of renewal is issued.

2. If any six month period goes by without a new certificate of renewal being issued, the certificate of incompetence must be cancelled and management of the estate returned to the patient.

3. Every six months, a patient may appeal a certificate of incompetence or a renewal and require a review board to convene for purposes of hearing the appeal. (To set this appeal procedure in motion, you must fill out and submit Form 18, which is called 'APPLICATION TO THE REGIONAL REVIEW BOARD UNDER SECTION 43 OF THE ACT.' See Appendix, Form 18.

4. The patient has the same rights at the meeting of this hearing as he has at the hearing *vis-à-vis* involuntary admission — i.e., he or his representative must be allowed to attend; they may call witnesses, etc. In this case as well, like every other participant to the hearing, he will be able to appeal the decision of the review board to the county or district court once the amendment allowing for this appeal comes into effect.

Rights — Fact and Fiction

I noted earlier that there are many popular misconceptions about psychiatric patients' rights. Below is a list of misconceptions I have often heard, together with a matching list of what the facts are. Some of the issues on the list have already been touched on — some not.

Misconception

- 1) If I am an informal patient — restraints may not be used on me.
- 2) If I am an informal patient, I can always get myself discharged and go home.
- 3) If I escape from a psychiatric facility, I must stay in hiding forever because I can always be picked up and taken back.
- 4) My doctor can always pick up the phone and have me taken for a psychiatric treatment.
- 5) My nonmedical psychotherapist can always have me picked up and taken for an assessment.

Fact

- 1) The same restraints that are used on involuntary patients may be used on informal patients.
- 2) Your status may be changed at any time, including the time when you decide to go home.
- 3) If you are not picked up within 30 days, you will be deemed discharged. You then have the rights of any other citizen. (Incidentally, as nice as this sounds, it is good to remember that if you advise someone to escape, you are guilty of an offence.)
- 4) If he has not seen you in seven days — and he does not fill out the appropriate form, a doctor cannot legally have you picked up.
- 5) In this regard, nonmedical therapists have no more rights than the average citizen. Their only recourse is to give testimony before a Justice of the Peace.

(Misconception)

- 6) If I want a psychiatric facility I was in to give a copy of my files to my present therapist or my lawyer, I have only to ask.
- 7) If a violation of the Act has occurred, charges may be laid at any time.
- 8) There is no point appealing to a review board. They are stacked with doctors — I won't have a chance.

(Fact)

- 6) You may request to have a copy of your files sent to your therapist or your lawyer. You do this by filling out and submitting Form 14, called "CONSENT TO THE DISCLOSURE AND TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD." Psychiatric facilities are *allowed* to release your files when they receive this form — and they generally do — though they are not *obliged* to release them. See Appendix, Form 14.
- 7) Most of the offences are subject to fines only (up to \$10,000). In the case of offences which can be fined, charges must be laid within six months of the alleged offence.
- 8) Patients often do win reviews. As for the composition of the board, it is composed of at least one and not more than two doctors, at least one and not more than two lawyers, and one person who is neither a doctor nor a lawyer.

Areas Where Violation Often Occurs and Prosecution is in Order

There may well be others. At the very least, however, I would suggest people be on the lookout for the following:

1. *The use of more than the 'minimal restraints necessary' to 'subdue' a 'patient.'* Such practices as leaving people strapped in stretchers and administering extremely high levels of drugs constitute more than 'reasonable restraint' and, accordingly, cases of this nature may — at least occasionally — be successfully prosecuted.
2. *Police picking people up for assessment just because a doctor has called and asked them to.* This happens fairly often and is unquestionably a violation of the act.
3. *Not notifying patients when times for possible appeals roll around.* As this right is still unproclaimed, of course, I cannot say that violations have occurred or will occur, but I predict they will. The prediction is based on what is happening in provinces where rights of notification are now operant.
4. *Undue interference with personal correspondence.*
5. *Undue disclosure of files.*
6. *Administering a course of psychiatric treatment where no consent has been given and no authorization provided by a review board.* This happens often.
7. *Involuntary commitment without due examination by a resident physician.* (People have claimed that this has happened to them: it is a clear violation.)

Places Where Changes Might Be Argued For

There are many places where I disagree with the present Act, and no doubt many more where you disagree. This is not my concern in the present section. My concern is to identify areas where I think the government might be convinced to make changes and where the launching of cam-

paigns is accordingly in order. My identification of these areas is in no way to be taken as occurrence with the legislation in other areas.

1. Phrases like "reasonable restraint" leave too much discretion to the staff. Sections dealing with the issue of restraint should be clearly worded to exclude such measures as leaving people strapped in stretchers, administering dangerous levels of drugs, etc.
2. Clauses should be introduced which exclude long term dosages of drugs which are in excess of the guidelines provided in the Compendium of Pharmaceutical Specialties. Clauses should be introduced spelling out and prohibiting combinations of drugs which are incompatible. Clauses should be introduced prohibiting levels and combinations that lead to tardive dyskinesia, blindness, etc.
3. Few if any exceptions should be made on the issue of private correspondence. (I.e., correspondence from a patient to somebody else should not be intercepted and withheld just because it is unduly rude: People have the right to be rude.)
4. Clear guidelines should be provided as to what constitutes a course of psychiatric treatment. Until these guidelines are provided, the patient's right to refuse psychiatric treatment is severely compromised. Until such guidelines are provided, drugs can be administered for a prolonged period and called "restraint," without either the patient or his next of kin, or the review board having authorized it, etc.
5. Institutions should be required to release files to therapists, lawyers and legal workers when the patient wishes it.
6. Patients should have the right to see what is in their own files.
7. Patients should always be allowed to at least appear at their own reviews.
8. Both the patient or his representative should have the right to hear and cross-examine witnesses at a review hearing. This should not be left up to the discretion of the review board chairman. If the government is worried about improper cross-examination, they can always establish rules concerning it.
9. Where an assessment is being made and the patient does not speak fluent English and the attendant doctor does not speak the language of the patient, it should be mandatory that a competent translator be present.
10. A competent translator should be a necessary participant of all review hearings where either the patient or his/her representative does not speak fluent English.

Additional and Most Unusual Changes to Have to Argue For

The changes I am referring to are the changes contained in the unproclaimed amendments. Pressure should be put on the government (a) to account for the delay in proclaiming the unproclaimed amendments and (b) to proclaim these amendments. The amendments have been lying on the books inoperant for a couple of years now. Every one I talked to at the Ministry assured me that it was "very, very unusual" indeed, "quite irregular", for amendments to "just lie around like that." "Everything is up in the air," I was told. No explanation was offered for the delay or for the seemingly confused state of affairs. An inquiry into it and the setting of proclamation dates is in order: and the government, I suspect, can be brought to appreciate this. There are very, very critical rights here — rights which would significantly improve the position of psychiatric patients in this province. Just to remind you of some of them, they include: the right to see copies of all written material that will be presented in a review hearing, the right to be informed when the time for possible hearings comes around, and, most significantly of all, **THE RIGHT TO APPEAL A DECISION OF A REVIEW BOARD TO A COUNTY OR DISTRICT COURT.** I am glad that the legislature saw fit to affirm these rights, to pass this legislation. **RIGHTS, HOWEVER, THAT HAVE NOT BEEN PROCLAIMED AND SO CANNOT BE EXERCISED ARE NO RIGHTS AT ALL.**

Where to Get Help When Your Rights Have Been Violated

There are a number of societies which can advise you and which can give you the names of reliable lawyers. There are lawyers, correspondingly, who have a sense of commitment in this area and handle these cases for nothing. As lawyer Carla McKague puts it, however, there are "damned few" free lawyers around: so I wouldn't count on getting one. What *will* open doors is a legal aid certificate. Most psychiatric and ex-psychiatric patients qualify for legal aid, and there are a lot of lawyers who will not only take psychiatric cases where the person has a legal aid certificate but will help people obtain the certificate where they don't. Don't just choose any lawyer, though. To quote Carla again, "There are many lawyers who take on mental health cases, but most of them are poorly informed and subject to many biases." Get the names of lawyers from self-help or other societies who understand what you are up against and who know which lawyers are reliable. Societies you could safely turn to in Toronto include: On Our Own (699-3192), Friends and Advocates (247-6116) and Advocacy Resource Centre for the Handicapped (482-8255). Helpful Ontario societies outside of Toronto include: Psychiatric Association of Timmins (705-233-2814), Self-Esteem Through Independence (London) (519-434-9178), and Society for the Preservation of the Rights of the Emotionally Distraught (Hamilton) (561-2118). While I cannot include it in my list of 'reliables,' I would point out that if you are currently in a provincial mental health centre, another place you can turn to is the official advocacy office therein. A word of

caution, though: while the advocacy office may well be helpful if you simply want your drugs changed, it is not clear that it will be of much help if you are intending anything more radical. The advocacy officers are directly responsible to officials in the Ministry of Health. *Ergo*, the advocacy offices have an inherent conflict of interest. This flaw, this weakness appears to be intentional. My own opinion?

1. They were intended to be weak.
2. They are largely a way of circumventing proclaiming a number of the more important unproclaimed amendments.*

Concluding Remarks

This completes the article. My hope is that it will be of help to you in exercising your rights, helping protect the rights of others, arguing for changes, and challenging violations. My particular concern is that patients and ex-patients insist on the rights they have. I know that it is often terrifying to do so, especially if you are in a psychiatric facility at the time or suspect that you may be again. It must feel a bit like arguing with the surgeon over his fees as he sharpens his scalpel and wheels you off to the operating room. Many people have told me that they just can't afford to make a fuss. They would be "made to pay for it." They would be "drugged to the hilt," etc. There is no question. This occurs and, indeed, it *does* act as a deterrent. I am not suggesting that you take a risk you are genuinely convinced is dangerous or that you initiate any process you think will trigger more panic than you can deal with. Two points, though. The first is that you are not alone. If you are worried about repercussions, advise people and have them check in on you regularly. If repercussion occurs, get in touch with an advocate: a lawyer. The second is that, for the most part when punitive action does occur, the person has complained *informally*. My experience suggests that people lodging *formal* complaints are not only *not treated worse* but *tend to be treated better*. This is especially evident where 'outsiders' are involved as initiators and/or supporters (a good reason for not acting alone). In such cases, in fact, the better treatment often extends to family and friends. The Aldo Alviani incident is instructive in this regard.

Aldo Alviani received intermittent treatment at a number of different psychiatric facilities. He was often administered dosages way in excess of CPS guidelines. Aldo Alviani *never lodged a formal complaint*, though he did 'grumble' about his treatment. This grumbling was ignored if not punished. Staff got used to the idea that very high dosages 'were called

*In section 66 of the unproclaimed amendments, reference is repeatedly made to area directors. According to this section, area directors are to be informed of involuntary admission, of changes in a patient's status, and of RIGHTS OF and possible TIMES FOR review. The area director in question is "the area director for the area, in accordance with the LEGAL ACT, in which the psychiatric facility is located." What it looks like we have here is **THE BEGINNING OF AN ADVOCACY SYSTEM WHICH WOULD COME EQUIPPED WITH LAWYERS AND WOULD BE INDEPENDENT OF THE MINISTRY OF HEALTH.** My sense is that the Ministry had second thoughts about setting up the beginnings of such a system, so quickly brought in an **UNEQUIPPED AND FLAWED** system, that **IS DIRECTLY UNDER THE MINISTRY** in its stead. Dishonourable? A travesty? It sure looks like it!

Be this as it may, by all means, turn to these offices for help when you think it appropriate and use the help they give you. Just don't count on them.

for' in Aldo's case. One day at Queen Street Mental Health Centre Aldo Alviani was administered one of those very high dosages and bad combinations — and Aldo Alviani died. Later, outsiders *began lodging formal protests* about Aldo's treatment. Not long after the protests began, Aldo Alviani's brother was admitted to Queen Street Mental Health Centre. Aldo Alviani's brother was not administered high dosages of anything. He was not 'punished' for the trouble that had been caused the hospital. Rumour has it, in fact, that Aldo Alviani's brother was treated like an absolute prince!

My thanks to Robbyn Grant, Patricia Urquhart, Carla McKague, and others for their input and overall support in the writing of this article.

Form 16

Mental Health Act

APPLICATION TO REGIONAL REVIEW BOARD UNDER SECTION 31 OF THE ACT

To: The Chairman of the Review Board

RE:
(print full name of patient)

.....
(psychiatric facility)

.....
(print full name of applicant)

hereby apply for an inquiry into whether or

not
(name of patient)

is suffering from mental disorder of a nature or quality that likely will result in

(See Note)

.....
.....
unless such patient remains an involuntary patient in the custody of a psychiatric facility.

.....
(signature of applicant)

Dated the day of
19

NOTE: The criteria set out in subsection 31 (1) of the Act are as follows:

- (a) serious bodily harm to the patient;
- (b) serious bodily harm to another person; or
- (c) imminent and serious physical impairment of the patient.

Form 14

Mental Health Act

CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A CLINICAL RECORD

I,
(print full name of person)

of
(address)

hereby consent to the disclosure or transmittal to or the examination by

.....
(print name)

of the clinical record compiled in
(name

..... in respect of
of psychiatric facility)

.....
(name of patient)

(See Note 5)

.....
(witness)

.....
(signature)

Dated this day of, 19

Form 18

Mental Health Act

APPLICATION TO REGIONAL REVIEW BOARD UNDER SECTION 43 OF THE ACT

To: The Chairman of the Review Board

RE:
(full name of patient or out-patient)

of
(home address)

I,
(print full name of patient or out-patient)

hereby apply for an inquiry into whether or not I am competent to manage my estate.

.....
(signature of patient or out-patient)

Dated the day of, 19

(form 18 continued)

NOTES:

1. Consent to the disclosure, transmittal or examination of a clinical record may be given by the patient or (where the patient has not attained the age of majority or is not mentally competent) by the nearest relative of the patient.

See subsection 29 (3) of the Act.

2. Patient.

Clause 29 (1) (b) of the Act states that " 'patient' includes former patient, out-patient and former out-patient."

3. Mentally competent.

Clause 1 (h) of the Act defines "mentally competent" as "having the ability to understand the subject matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent."

4. Nearest relative.

Clause 1 (j) of the Act is as follows:

" 'nearest relative' means,

(i) the spouse who is of any age and mentally competent, or

(ii) if none or if the spouse is not available, any one of the children who has attained the age of majority and is mentally competent, or

(iii) if none or if none is available, either of the parents who is mentally competent or the guardian, or

(iv) if none or if neither is available, any one of the brothers or sisters who has attained the age of majority and is mentally competent, or

(v) if none or if none is available, any other of the next of kin who has attained the age of majority and is mentally competent".

5. Signature.

Where the consent is signed by the nearest relative, the relationship to the patient must be set out below the signature of the nearest relative.

R.R.O. 1980, Reg. 609, Form 14.



epf

Knowing Your Rights

BY PAT MURTAGH

A prime goal of many patients' rights groups has been to get legislation that requires that patients be informed of their legal rights upon admission to a mental hospital. This is analogous to the practice of having your rights read to you if you are arrested. How well do these laws work? Of what use are they?

A recent study in the *American Journal of Psychiatry* (Feb., 1983) examined the patients admitted to both the day hospital and inpatient services of the Massachusetts Mental Health Center. This institution has been the centre of controversy as patients' rights groups claimed that inmates were not receiving information as to their legal rights while authorities claimed that the law's requirements were being fulfilled. Who was right?

The delivery of legal information was in the form of a brochure to be received on admission. Survey participants were asked if they recalled receiving this material. This was crosschecked with hospital documentation of brochure distribution. According to hospital records all of the day patients received the material, but only 56% of the people who were labelled with psychotic diagnoses received any brochure. None of the criminally committed individuals were given any information. These results give proof that the complaints of the patients' advocate group were right, that despite the law the staff of this particular hospital continued to withhold information on legal rights from patients.

So far this seems like merely another example of how those in authority can pick and choose which laws are to be obeyed and which not. But then there is a twist. Strangely enough the number of people who incorrectly recalled receiving material outnumbered the number who forgot that they had been given the brochure. This undermined the case that hospital authorities had made that the reason why patients didn't recall receiving the material was that they were in too degraded a state on admission to recall much of anything.

There was another fact that came up in this study. People who did *not* receive the brochure had just as much knowledge of their rights as did those who received it. The number of people who falsely recalled receiving the information probably confused the brochure with information received from other channels. The informal in-hospital channels were just as effective in conveying knowledge of legal rights as were the legalistic actions of the hospital staff.

This is the most interesting finding. The provision of a brochure is a typically liberal response to a demand such as that for patients' rights. It is a visible bureaucratic, documentable action that can be pointed to for the "look we're doing something" effect. It may be taken as a type of probably the vast majority of reforms in any of the social service fields, not just in mental health. The object is not to do something: It is to be seen as doing something. It isn't just that these reforms are often ignored in day to day practice. It is that, even if they were to be observed, they would make little difference. Bureaucracies such as the mental health industry have evolved subtle ways of deflecting activism into unproductive channels, channels that seem superficially rational because of the pervasive bureaucratic mentality of our society. Something is not necessarily happening just because paper is being passed.

Demonstration Against APA

Another very successful, grass-roots demonstration against psychiatric oppression and violence was held in New York City over a 4 day period, May 1-4. The demonstration was aimed at the American Psychiatric Association (APA) which was holding its Annual Meeting in New York, April 3 - May 6. Previous protest demonstrations and civil disobedience organized and carried out by ex-psychiatric inmates against the APA have been held in San Francisco in 1980, at last year's 10th Annual International Conference on Human Rights and Psychiatric Oppression in Toronto (see *PHOENIX RISING*, vol. 3, No. 1), and last March 15 against electroshock at Herrick Hospital in Berkeley, California.

During the four days of protest against the APA, ex-inmates handed out leaflets inside and outside APA's convention headquarters at the New York Hilton denouncing psychiatric violence and crimes such as forced treatment, drugging, electroshock, psychosurgery and involuntary commitment. On March 2nd, over 75 people marched, chanted and sang their opposition to psychiatry and the APA. After the March and open mike Tribunal in front of the New York Hilton, over 50 people packed the Church Center of the United Nations to hear panel presentations, including two mothers of sons who recently died in New York's South Beach Psychiatric Hospital, as well as personal testimony from numerous ex-inmates. The Civil Disobedience was chiefly sparked by the announcement by the APA that it was arranging live demonstrations of electroshock on two psychiatric inmates at Gracie Square in the morning of May 4th. (Gracie Square is the "shock shop" of New York State — more shock treatments are performed there than in any other psychiatric institution in the state.)

Our report focuses on some of the testimony presented at the Tribunal together with an account of the CD at Gracie Square.

Tribunal

EX-INMATE: Asylum used to mean a haven or sanctuary, and hospitality used to mean kindness in a hospital . . . It seems to me that psychiatrists have replaced priests or exorcists in behavior modification. It's no longer the holier-than-thou attitude, it's the saner-than-thou. I think we have to trust ourselves, we have to trust our own thinking and prescribe our own behavior. Psychiatry is a state tool as exorcism was once a church tool against dissidents. I've seen psychiatry used to jail dissidents in Massachusetts.

NINA: My mother died in a state hospital; she was only 47 years young. She had six children to bring up on welfare. My mother was not a neurotic person; she was warm, loving, caring, compassionate and intelligent. However, she did suffer from depression; every two or three years being on welfare, and also as a result of being a widow. When my mother died (I was 16), I was in such shock over her death that I did not realize that her death should have been investigated, because she should not have died. All she had wrong with her was high blood pressure and an enlarged heart. If it was malpractice, it has been covered up; her records have been destroyed. Getting rid of all the records is a way of stopping research on deaths in state hospitals. My mother suffered a lot. She escaped Hitler only to find that Nazism is alive and well in the state "mental health system" in this country.

IVAN: I'm from California where I spent about twelve years in about twenty different state and local hospitals. I was given all the phenothiazines during that time until my last admission. When I had just got used to the idea of being a "schizo-affective," and I found out I was a "manic-depressive."

KALISA: It's extremely important for us to disseminate information that psychiatrists in Germany began to discuss the extermination of mental patients before Hitler had been heard from; that German psychiatrists were the first to exterminate people in Nazi Germany; that they pioneered the gas chamber and the crematorium and that they were the architects and executioners of the "Final Solution" for the Jews. Psychiatry has taken *no* responsibility for that.

JOHN PARKIN: I was given insulin sub-coma treatment or 'sub-shock' in the Army in 1945. It involved getting you into a groggy state in which they build up the dose day to day. Since they didn't know exactly how much to give me to get me into a coma, they would continue to increase the dose until I went into a coma once. Then they would inject us with sucrose (sugar) which would take us out of the coma. It's supposed to be "light coma". The effect of that "light coma" was to knock out my memory of the experience of the hospitalization and the period of up to three months before that. For twelve years, I could not recall that experience. If someone were to ask me anything associated with that . . . I would just blank that out and I would not even know what questions they asked...



EX-INMATE: I want to testify as to the harmfulness of the whole psychiatric machine — that a person can become a victim just by stepping in the wrong door. Psychiatrists say that shock treatment is a “success” if people are still breathing after the “treatment.” No person who’s ever had shock treatment can say that it’s a success. I very innocently went to a psychiatrist when I was in my senior year in college, just because I wanted to protest against the Vietnam War and couldn’t carry on in school as usual. And the minute I walked in the door, he said, “You’re depressed.” He gave me a shot of medication, and a day later I couldn’t even walk out on the street — I was so disoriented. And I got shock treatment. It was just a matter of being railroaded, being caught up in the machinery. And I have a degree in psychology and social work — it could be anybody.

Now I see that everybody is entitled to growing pains, we’re entitled to express anything we want, and we shouldn’t be punished for it. And in the hospital, all kinds of abuses occur. I was given an overdose of medication, my body was convulsing and the sadistic attendants there said, “It’s your imagination,” until a doctor came over and said, “Hey, you have too much medication.” The psychiatrist who suggested that I go into the hospital had no idea that I was going to get shock treatment by the time I came out.

I didn’t know what “depression” was until the antidepressants, and I was on them for nine years. I didn’t know what was wrong with me. It’s been eight years since I’ve had them and I haven’t been “depressed” since. Don’t go to these institutions, don’t support them. They’re a business and they really don’t know how to “cure” anybody. All they do is administer all kinds of poisons or whatever they have available to support their business. It’s no joke. I can’t blame myself now, but I just don’t want any part of their “treatment.”

EX-INMATE: The community mental health and rehabilitation programs from my personal experience have not worked right here in Manhattan. I refer specifically to Fountain House, social and prevocational rehabilitation programs which are in ‘Hell’s Kitchen’ on the West Side. And it’s (Fountain House) run by social workers, not psychiatrists, where people are exploited. I’ve had it up to here with the psychiatric social workers and rehab counsellors.

SHARON HARRIS: I’m from Baltimore, Maryland. I was hospitalized in Creedmore State Hospital (New York). First I was in hospital because I was on Haldol and I was diagnosed “catatonic schizophrenic” when I was in a coma. And I had no brain waves. I don’t know how you can be called ‘catatonic schizophrenic’ and have no brain waves — that was my “problem:” I was dead. Later on at Creedmore, I received shock treatment without the permission of my parents or myself. And I was given these shock treatments to make me forget. I was put on experimental drugs to make me remember that I was on shock treatment. I also had a lobotomy. After that, I could only cry, I couldn’t speak.



JEANNE DUMONT: I’m 31 years old today . . . Two months after my father’s death (about 20 years ago), my mother was given shock treatment. If we had been a family that had money, my mother would have been able to go through her grief somewhere else and be OK. She suddenly had to get her shit together and start taking care of things and find a job to take care of us. She voluntarily turned herself over to psychiatrists for help. They thought shock treatment was the answer, and even now my mother has only begun to start talking about that. She has memory losses. She used to play the piano, she can’t do that and other things.

Several years ago, I had the unfortunate experience of ending up in hospital six times. I went through state hospitals, private hospitals, general hospitals . . . I was mainly angry about a lot of things that I had kept quiet about when I was going through high school and college. I had been very upset by the Vietnam War. I kept in a lot of stuff, and at some point I was

given a drug that got me very high. It was a steroid, Prednisone. I had a severe reaction as lots of people do. That was enough to get my anger out and when my anger finally came out, I was pulled into hospital immediately, drugged unnecessarily at one of the fanciest hospitals. I had cardiac arrest twice. I was fortunate. I was put in a seclusion room and given massive doses of Haldol, Thorazine and all sorts of drugs at the same time; they thought I was dying and had to rush me to another hospital to pump my heart. Three days later, they did it again: they gave me the same kinds of drugs all under the guise of “sleep therapy” for my anger.

The abuses are amazing.

BATYA WEINBAUM: I feel lied to by psychiatrists. One psychiatrist said that if I came in and took these drugs and was committed for three months and changed my perceptions, my depression would be over. It’s an outright lie! It’s like I’m a survivor of an institution in the same way that people who’ve come back from wars are survivors. The readjustment back into society is so incredibly difficult. People who have been through it can identify with it. They look at you and see what’s wrong with you, and after you’ve dealt with your early problems in childhood—the fact that your mother didn’t treat you right when you were a baby—you’re supposed to come out unscathed and be recovered and be able to deal with the world. IT’S A CROCK OF SHIT! And I don’t like the condescension that I get from people once they know I’ve been in hospitals. I wish my doctor had told me that, and I wish he’d told me that he was giving me “anti-psychotic” drugs — he told me he was giving me antidepressants.

So this is just in favor of all of us finding support and the truth from each other.

Civil Disobedience at Gracie Square

A Personal Account

BY DON WEITZ

On May 2nd, we first learned that APA was planning the live shock demonstrations. At least 25-30 of us ex-inmates were incensed at the APA for continuing to support brain-damaging procedures such as electroshock, and for lying to their fellow shrinks and the public by claiming that electroshock is "safe, efficient and effective." Many of us shock victims know otherwise. Even Ramsey Clark, former U.S. Attorney General, had told the shrinks at an APA symposium on violence on May 1st that "electroshock is violence."

On May 3, less than 24 hours before the scheduled demonstrations about 15 of us began planning a non-violent Civil Disobedience against electroshock and the APA. Gracie Square was the obvious target: it is a private institution where more shock treatments are performed than in any other institution in the U.S.; Lothar Kolinowsky, a leading pro shock advocate, is on its clinical staff.

We decided we'd block only the front entrance of Gracie Square but chain-lock the front and side doors as well. We also voted in favor of chaining ourselves with metal chains, which would both dramatize the fact that we've been slaves of psychiatric oppression and show our strong solidarity.

We decided that we needed legal

advice and support. Anne Boldt found and contacted lawyer Aubrey Lees, who met with us and told us we'd probably be charged with criminal trespass or disorderly conduct and possibly arrested, and that nominal bail might be required for our release. However, she doubted whether we'd be charged with a criminal offence.

Thirteen of us ex-psychiatric inmates — about half were shock survivors — freely decided to participate in the CD: nine demonstrators and four supporters who formed the support group. The demonstrators were: **Anne Boldt** (*Madness Network News*, San Francisco); **Judi Chamberlin** (*Mental Patients Liberation Front*, Boston); **George Ebert** (*Mental Patients Alliance*, New York); **Leonard Roy Frank** (*Network Against Psychiatric Assault*, San Francisco); **Joan Goldberg** (*MPLF*, Boston); **Fred Masten** (*Project Release*, New York City); **John Parkin** (New York City); **Joe Rogers** (Newark, N.J.); and myself. (*ON OUR OWN*, Toronto). The four support people were: **Kalisa** (New York City); **Nancy Lindeman** (*Project Release*, New York City); **Phyllis Mager** (Los Angeles) and **Cynthia McCue** (*MPLF*, Boston).

Midmorning May 4: we chain ourselves firmly to one another and form a tight, small group blocking Gracie Square's front entrance. The front and side doors are locked — the

emergency entrance is clear. Over half an hour lapses before a staff member or administrator passes inside and returns with a security guard carrying a pair of chain cutters. The guard cuts the chains on the side door but leaves us alone at the front door. The front lobby starts filling up with staff and visitors. We begin singing protest songs.

Kalisa and Cynthia are handing out copies of our anti-shock antipsychiatry leaflets and talking to some people who have stopped to watch, explaining the purpose of our CD and what's going on inside Gracie Square. Finally, a press reporter arrives with a camera and starts taking photographs and talks with a few of us. A TV (channel 11) cameraman and reporter arrive a few minutes later, around the time the police arrive. A sergeant questions us, then threatens us with possible arrest or a trip to the police station if we don't move. Joe Rogers explains that we need time to discuss what to do, and the sergeant agrees to give us "5 minutes" — and leaves.

Sure enough, in 5 minutes the policeman is back, followed by two more police cars. A policeman along with the sergeant approach us with chain-cutters: they proceed to cut our chains and jostle but don't really push or man-handle us.

The policemen start taking some of us to the police cars. George, Leonard, Anne, and I go limp. They drag us along one-by-one as we offer no resistance. All nine of us are taken to the 19th precinct at W. 4th Street and Lexington Avenue. Our supporters meet us there.

In a large back room of the police station all of us are together again, hugging and congratulating ourselves on our short but successful non-violent CD. We huddle together and observe a minute of silent meditation for the shock victims at Gracie Square and all other victims of psychiatric violence. During the next 40 minutes, we give our names and addresses to one of two policemen. The police fill out pink traffic tickets marked "disorderly conduct" and give them to us.

We're not arrested, so we don't need bail. At noon, we're released.

Together, all thirteen of us head for a restaurant to celebrate our release and our victorious CD.





profiles

ANNE B.

Quiet Strength

INTERVIEWED BY CONNIE NEIL

"I just loved hugging her for support at the New York demonstration this May," said Joe Rogers, a New Jersey activist. "I was the first one in the police van and felt very alone, not knowing what was going to happen. Then the door opened and Anne was thrown in beside me. It's times like that you need a friend. Also, she was instrumental in getting a lawyer before the demonstration: some of us were apprehensive about doing a civil disobedience without one."

Anne is a respected front-runner for the Movement, whose quiet strength builds trust in all who know her. Nine years ago, at 22, she moved to California from Minnesota at the invitation of her great-uncle. "There's little contact with the Minnesota family now. We write a few times a year, with me being pretty honest about what I'm doing: they tend to write back about the weather. I never got to know my younger sister as an adult; I left home when she was still a young teenager."

Anne was not always an anti-psychiatry mover. "I really bought into the system right from the start, believed I was mentally ill. I even asked for ECT (electroconvulsive therapy), but didn't get it—just mostly drugs and talk. I believed I'd spend the rest of my life and out of mental institutions.

"My first contact with shrinks was at college. My parents told me, 'Okay, you are out of our lives now: if you have any problems, don't tell us.' I was at an Iowa college on a scholarship. I felt just as glad to be rid of my parents. Then I was very unhappy, and it took a long time to admit I felt rejected. They were also overprotective, and suddenly being without protection, I didn't know how to deal with the new free-

dom. In depression I made some suicide attempts—cut my wrists—just wanted to stop the unhappiness.

"The college decided I had to see a shrink, which I didn't want to do. When I went home for Christmas break, I was on Elavil and felt uncomfortable talking with my parents about it. They said they didn't like me wearing jeans, that I was taking psychiatric drugs and not telling them about it, and not to bother coming home again. Back at school I couldn't concentrate on my studies. Now I realize a lot of these problems were the effects of this drug. I had trouble talking to people, couldn't think very clearly, and slept a lot. And all this was making me more depressed. So one day I took all the drugs the doctor had been giving me because I thought I was going crazy—and ended up in hospital.

"I made some friends there—people going through the same things—which was the only helpful thing. This institution discouraged inmates talking together. One incident I remember clearly—a young woman was talking to us about why she was there and started crying, not hysterically, and we were trying to give her support. The staff came rushing over, shot her up with some drug and dragged her off because they said she shouldn't be talking to us.

"I was there ten days until my parents took me back to Minnesota. That first shrink was a real crud: they didn't really understand what was going on, but he tore into them and said they were responsible for everything. I can't really agree with that. I think I should take some responsibility for what went wrong too.

"Back in Minnesota, I worked for about a year and went to school and got more depressed. I moved into my own place and there were a few more suicide attempts. The therapist suggested I quit my job and go into day treatment

—a three month, eight-hour-day intensive talking group program. I think I would have lost my job soon anyway. Everytime a customer in the department store would ask me for something, I would burst into tears, so I wouldn't have lasted long. Looking back on it, I think it was mostly for economic reasons I went back into hospital for a week or two each month or so. I hadn't enough money for food, was living in a dangerous neighbourhood, couldn't afford a phone, didn't have friends in and had nasty rodents in my apartment. When that program was over I still felt terrible. I didn't get anything out of it, even though they tried to harrass me into talking.

"It was five years later I finally broke out of the system. They told me they really couldn't do anything more, that I had to go to the State hospital. I went voluntarily for five months, and left against medical advice. Then I was hospitalized in a general hospital where a psychologist gathered all the tests I'd been given and said, 'Okay, I'm going to tell you what your life is going to be like: you can expect to spend the rest of your life in institutions, always unhappy, always nervous, never able to relate to people in any kind of normal way.' I felt pretty discouraged. I'd been through all the programs this county offered and this was their long-term prognosis. I started freaking out, got angry, although I didn't admit it—this is actually the first time I've thought this—but I was probably angry at what he told me.

"I decided the world was such an awful place I was going to kill a lot of people and then kill myself and we'd all be safe from this awful world. So I sort of tried to kill this friend of mine—actually I knew he was a lot stronger than me, a street fighter who could really defend himself, that's probably why I picked him—and I went at him with a knife while he was sleeping. Of

course it didn't work. I looked at it as a favour, removing him from this awful world. But it really scared me that I'd end up locked up in the State hospital again.

"Just then my mother's uncle called from California and invited me to live there. My parents were very angry when I went. I got a letter from my sister months later who wrote that our dad wouldn't let any letters out of the house to me, and that when asked about me he would say, 'I don't have a daughter named Anne.'

"It turned out to be a good move although the first couple of months were rough because my uncle had sexually abused me as a child, and recently his wife had died, and he wanted a replacement. But I was desperate. I didn't even really think about it until I got out there and problems started with him. It was a sudden weekend decision. Of course, when I was little I didn't really know what was going on. By the time I realized, I didn't have it really clear in my mind. I moved out as soon as I was able to.

"I moved to a half-way house run by ex-inmates. But they were also alcoholics, and about every week the police would be there about a fight or fire breakout, or one of the house parents overdosing. The people who lived there were just out of institutions and pretty heavily drugged and shaky: they didn't stay around too long. After taking a clerical course, which helped with my confidence, I got a job. My first job lasted one day—with an insurance company. When they discovered I was taking psychiatric drugs, they fired me.

"I ended up in hospital again, and it was much worse than any of the bad ones I'd been in before: people were literally in chains. There weren't enough beds—I didn't have one. It shocked me. I realized for the past five years I'd been taking these drugs, in and out of places like this, and I decided I wasn't ever going to come back again. It wasn't good for me. So I got in contact with the Berkeley Free Clinic (2339 Durant Ave., Berkeley, California), which is where I first became aware of how psychiatry abuses people, and the addictive power of the drugs. They help people get off psychiatric drugs, if that's what they want. I've never been in an institution since.

"I was mostly lonely, but this woman at the clinic asked if I was taking psychiatric drugs and suggested some of my problems were because of the drugs. I had tried to get off them before and not been able to. She said if I went down there, there were other people to talk to and help me get off the drugs. I got off them, and she asked if I'd like to work there because they really need

ed people who had been through the system as they were the only ones who could really help other people. For me, successfully getting off the drugs, and feeling for the first time in my life that I didn't have to be afraid around people, that they respected me for my experience as an ex-inmate, it really made the difference. There weren't any professionals at the clinic.

"I started out on the switchboard—a 24-hour information and referral line. While I was doing this people became aware I had ex-inmate experience and certain skills and encouraged me to take psych emergency training so I could do crisis intervention and drug overdose management. I did a lot of that. You mostly let the people talk and give some suggestions about what has worked for you. In drug overdose management, except in rare instances, people don't have to go to hospital. We find out what shape they're in, whether they're alone, maybe go to their home and bring them to the clinic and keep an eye on their pulse, blood pressure and respiration, but only on the graveyard shift. It wasn't an in-patient facility. There were a couple of pillow rooms—quiet, dim—where they would lay down. People who go to hospital usually end up locked up in psych wards. It's a terrible idea to give people coffee and walk them around, which is what you see depicted in movies: that gets the drug in their system faster. Coffee causes you to vomit even more later, and possibly obstruct your lungs and windpipe. Caffeine is just another drug which will react with the drug

already in your system, who know how. The best thing generally is to lay on your side, head propped, and have someone check vital signs for twelve hours every 15 minutes: you check skin color and sensation to pain for coma by pressing the chest. I worked there for 5 years.

"Then I went through a real bad period for almost a year in a half-way house. While still with the Clinic I also had a very stressful job at a library and was getting migraine headaches. A neurologist was giving me medication, but told me he didn't think drugs were good for me and suggested instead that I swim two miles a day. I started that and it made the headaches go away. I kept it up, because it's relaxing for me—a time to be alone. I also enjoy reading, movies, cooking and riding my bike."

"Anne is quite an athlete," said Sally Zinman, a Florida woman with the client-run alternative house there. "Her physical fitness is awing, and I believe it's responsible for the good state of health she enjoys. It's so easy to work with her: she has a low-key, calming effect on others. I was most impressed by her bravery in chaining herself to the doors at this May's New York demonstration. For some, this is an easy thing to do. But Anne was so upset by being arrested in Toronto last year, she doubted she'd do another demonstration. For her, it was a great sacrifice."

"While at this half-way house," said Anne, "we got a letter from Philadelphia about the 6th International Conference asking for donations. At the

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general meeting they decided instead of donating money, they would send me, because of my interest (with other money from the Free Clinic and individuals). So in Philadelphia, I decided to get involved in the Movement. There were a couple of people there from *Madness Network News* and Network Against Psychiatric Assault (NAPA) which are in the same building. NAPA is both political and a support group. Even before I got involved with them I was aware of the politics of hospitals, drugs and psychiatry.

"I have worked with both groups for the past five years, on and off. They are two separate groups with some members overlapping. For *Madness* I do some editorial work, bookkeeping, layout, and approving for inclusion. Right now there are six or seven on the collective, with each person having one vote: it varies. There is no paid editor. Our money is entirely from the sale of the newspaper and donations: there is no funding or grants.

"In 1980, the International Conference was in Berkeley. We worked on it for a year. It was hard, because it was a coalition and some were not ex-inmate groups, and the Coalition Against Forced Treatment was not incorporated. I was concerned because the previous conference in that region had been dominated by professionals. After a lot of discussion, we decided on the 15 percent non-ex-inmate figure.

"Working on the Berkeley Conference I learned a lot—but it was also a real burnout. I left to travel and visit Movement groups in Europe for a few months after the Conference," said Anne.

Since so much effort was spent on the Berkeley Ban on Electroshock in late 1982, and the New York demonstration, Anne decided to cycle to the Syracuse Conference. From there she plans to cycle to Boston, Montreal and Toronto to visit Movement groups.

"We miss her a lot," said Leonard Roy Frank, who works with Anne at

Berkeley. "She is a tremendous source of moral support to all in the Movement, constantly giving of herself, without ever imposing herself. She's one of my favourite people. I never met anyone who had a bad thing to say about Anne. To know Anne is to like her. That sounds trite, but with Anne it's simply true.

"Anne is very strong. That vital force, mixed with good judgement, good vibes and good ideas, just smooths things out when difficulties arise. She has a point of view everyone in the Movement can relate to.

"I care for her so much. With her humanity, intelligence and genuine caring about people, Anne most represents what our Movement is all about," said Leonard.

So say we all.



HAS PSYCHIATRY GONE TO THE DOGS?

By Rev. Kenneth J. Whitman

A recent *New York Times* story stated that "in treating certain forms of schizophrenia, it has been found that dogs can be used successfully where human therapists have failed."

This canine "barkthrough" was pioneered by Dr. Samuel A. Corson at Ohio State University.

The prime qualification of a psychiatric dog is warmth and friendliness. A medical degree is not required.

In a report, Dr. Corson describes the case of Marsha, allegedly brought to the University hospital screaming and disoriented and was diagnosed as a "catatonic schizophrenic" by a human psychiatrist. Marsha was given drugs but did not respond. Next, 25 sessions of electric shock were administered with the result that Marsha became "withdrawn, frozen and almost mute."

Traditional psychiatric methods having not only failed but having made things worse, a psychiatric dog was assigned to the case. The report says that Marsha "soon began to show signs of recovery, leading ultimately to discharge from the hospital." Said Corson, "The dogs offer the kind of love a psychiatrically sick person needs."

All this is certainly a step up the social ladder for animals who were formerly employed as domestic pets,

but it is not much of a testimony for the efficacy of modern psychiatric care.

It would seem Dr. Corson has missed the important point which evolved from his experiment — that warmth and friendliness can do a lot more for someone experiencing difficulties in living than can drugs and shock treatment.

The experience also indicates that human psychiatrists have lost touch with their patients as thinking, feeling individuals. Perhaps due to their medical training and the status medicine has achieved in our society, psychiatrists have developed a penchant for things medical: the use of facilities called "hospitals", drugs, physical treatments and even surgery. These trappings are part of what is known as the "medical model" which is simply an attempted *analogy* between physical illness and mental conditions.

The main point that usually gets missed is that the general practitioner or medical specialist is treating largely organic, observable illnesses and the psychiatrist is not.

The human psychiatrist *calls* problems in living "illness" and has many impressive (and intimidating) diagnostic terms, but these do not help achieve results. This is one big advantage that psychiatric dogs have — they don't

"know" that an individual is a "patient" or that he "has schizophrenia of the paranoid type." The dog just relates to a person. People do this too — friends talk problems out with friends and marital partners talk things over with each other, often to great benefit and relief.

If human psychiatrists don't change their methods of dealing with troubled individuals, they may well be replaced by canine therapists. Dogs don't charge \$50.00 an hour, they are faster to train and they have the simple ability to relate to people which many psychiatrists have neglected. After all, no one ever said that man's best friend was a psychiatrist.

Reprinted from
Madness Network News





movement news

“Stop Shock” Demonstrators Arrested

On Tuesday, March 15, nineteen people were arrested for blocking the entrances to the administration building of Berkeley's Herrick Hospital in a protest against the resumption of electroshock treatment at Herrick. An additional 150 demonstrators formed a picket line and acted as legal observers while the civil disobedience action was in progress. Electroshock in Berkeley had been banned by Measure T, a ballot initiative passed by Berkeley voters last November. Several psychiatric associations subsequently filed suit against the ordinance. In January a Superior Court judge issued an injunction permitting the continued use of electroshock until the legality of the ordinance can be determined at a future hearing. Massive media coverage of the March 15 demonstration alerted many Berkeley voters who were not aware that electroshock had been resumed. The ballot initiative campaign and the civil disobedience protest were organized by the Coalition to Stop Electroshock.

The ten women and nine men who were arrested at the demonstration were held in jail for about 7 hours and then released on their own recognizance. Several women were strip-searched while in jail. The blockaders were arraigned the following day in Berkeley Municipal Court before Judge Julie Conger. Since the Berkeley Court is not wheelchair accessible, and one of the arrestees, CeCe Weeks, was in a wheelchair and refused to be carried into the courtroom, the group demanded that they all be arraigned in the downstairs hallway along with Weeks. Blockader Barbara Quigley announced the group's decision to Conger, who responded by trans-

ferring the arraignment to the accessible city council chambers in a nearby building. Berkeley mayor Gus Newport and school board member Barbara Lubin, both supporters of Measure T, attended the arraignment. The charges against most of the blockaders were reduced from a misdemeanor to an infraction with a sentence of “time served” (the previous day in jail), in exchange for pleas of “no contest.” Several arrestees chose to be sentenced for the original misdemeanor charge and also received a sentence of “time served.” Two blockaders, Trudy Rogers and Maureen Bei, pled “not guilty” to the misdemeanor, and requested a jury trial. The date of their trial is not yet scheduled and they are looking for attorneys willing to represent them at no cost.

Following the sentencing, Judge Conger permitted the demonstrators to make brief statements of their reasons for getting arrested. One said her mother had died of a cerebral hemorrhage following shock treatment, one said that a close relative had committed suicide following shock, one said that someone he grew up with is currently receiving shock at Herrick, one said that she had been damaged by shock treatment herself. Several stated that the shock doctors were the real criminals.

According to the Department of Mental Health, two-thirds of all people receiving shock in California are women and two-thirds are over 45 years of age. The rate now being charged for each shock treatment, a nurse who formerly worked at Herrick Hospital (who was one of those arrested at the March 15 action) stated that inmates are not informed of the likelihood of permanent brain damage and memory loss. According to hospital reports, a small percentage of those receiving shock have not consented to it because a judge has ruled that they were incapable of giving consent.

One of the blockaders, Trudy Rogers, who described herself as a former mental patient, explained that she pled not guilty because “I did nothing wrong. Electroshock is not a treatment. It is

barbaric, like rape. There are people in Herrick who don't have a voice. We are their voice.”

For more information about electroshock, the Measure T campaign, and the international anti-psychiatry movement, send \$1 US to *Madness Network News*, 2054 University Ave., room 405, Berkeley, CA 94704, with a request for the Spring issue.

Therapy Abuse

Several groups in the United States have started up what promises to be a network of protection, advocacy and support for people abused in private — usually nonmedical — therapy. In January, 1982 four people founded the Association of Psychologically Abused Patients in Fort Worth, Texas: the response they received to leafletting at a week-end single's fair and a small ad in *Psychology Today* was overwhelming. Inquiries from coast-to-coast led to a network of self-help groups of abused therapy consumers. Sexual abuse in therapy and drug abuse by therapists are issues most often confronted, although others — overcharging, false advertising, misdiagnosis, abandonment, sadism, dependency/cult — are of equal concern.

Also in January, 1982, an advertisement that William Cliadakis placed in *The Village Voice* in N.Y.C. elicited a similar response: phone calls from as far away as San Francisco resulted in the setting up of a core group of concerned therapy consumers who have undertaken — among other responsibilities — to investigate various mental health committees, to look into past records and procedures of the various redress systems, to formulate research questions, to set up peer-support groups, to plan joint projects with other self-help organizations and to try to raise funds for ongoing work.

The N.Y.C. group publishes a newsletter, available for \$10.00/yr. (U.S.) from NCPPA, 60 W. 57th St., N.Y.

N.Y., U.S.A. 10019, (212) 663-1595. A statement in the initial newsletter indicates the group's commitments and some avenues they intend to pursue:

"There is little doubt in our view that no other profession-to-client relationship has the potential for emotional damage to the client that therapy does. Yet there is almost no recourse for the victim of psychotherapy abuse. At present the consumer is allowed only a token role in redress and standards systems. It is because of this imbalance of power and the extent of harm done that we are dedicated to protecting, helping, and educating the therapy consumer and reforming the profession.

... Self-policing has proved a failure, and it is a mark of shame on the psychology profession. In a helping profession where openness, honesty and ethics are such important words in conducting business, the lack of these qualities in the profession's self-criticism stands out.

The unusual position of trust and vulnerability in which the psychotherapy client is placed requires an exceptionally strong system of accountability and protection. 'Snitch' laws, as prescribed in the state of Florida, would be helpful. Another useful step would be immunity in third-person complaints — introduced in California with respect to

child abuse cases (therapists themselves stress the parallel of the parent-to-child relation in therapy). Also needed is a change in the absurdly weak rules on professional misconduct so that abuse would become a felony. Perhaps most important, however, is a means for increased meaningful participation by informed, responsible consumers."

The groups together hosted the First national Conference on Psychotherapy Abuse and Consumer Protection in New York on November 15, 1982. Sylvia Diamond of the Texas-based group (APAP) was instrumental in founding the national network, The National Federation of Therapy Abuse.

Schizophrenic Opera

The almost full house attendance for the *Schizophrenic Opera* let our small group celebrate a bold attempt at entering the cultural world. Thanks to *A Space* and John Crawford at the Joseph Workman Auditorium in particular, we were able to handle a very difficult production. The time we had to actually produce the entire Opera was less than six weeks, so that the workload was enormous. Without the assistance of James McLeod and Costa Ferreo from the Toronto Art Community we could have not made everything work on time. The production crew of Silvio Cerusi and Wild Bill plus the help of Penny Gillier and Kathy Czuma all made the Opera a success. The major contributions of Artists Lily Eng and Susan McKay were also major factors in achieving our ambitious project. The cast in the production were all basically newcomers (except for Ron Gillespie and Warren Moore) so we had to have a team effort by all concerned; people like Martin Greenspan, Sid Williams, Dan Anten and Anna Gruda were invaluable. The witty pronouncements of Tony Ferguson from the start helped our humour tremendously — with Tony's great humour we were always laughing at our inexperience, and playing like we were on top of the world.

The script evolved from over 1000 pages of my writings from 1978 to 1983: satire, diaries, notes, poems and essays had to be rigorously edited. Tony Ferguson, Warren Moore and myself spent long hours trying to understand my mind — and to cut out the obscurities in the work which wouldn't make sense to a wider audience.

We decided the best tactic would be to emphasize the humour and colour in the writings rather than the entraneous philosophical writings that are far too difficult to put into an Opera. Once the writings were edited down we produced a fairly rough text of sayings that offered different meanings to all levels of social contact. Some of the text, for example, refers to "voices" and other text real street material picked up living hand-to-mouth after serious illness. The script became rather bizarre, but our intention was not to be explicit. Rather, we intended to keep a safe distance from easy interpretation. We did not want people to think "Schizophrenia" was a simple act anyone could understand. So we thus purposely kept our distance and instead we made people think a bit. We hope in so doing we opened a few eyes to the special curves and road switches a "schizo" mind can take very swiftly indeed.

Once the script was pulled together we invented acts that were familiar to us all: especially volleyball and cigarettes which we all had in common. We also chose acts with a lot of our own humour and thus tried to stay close to what we knew so that we could understand our actions better. As we arranged a Performance, tried to keep our natural skills strong and pre-conditions at a minimum: meaning 'theatre'.

With the great help of Joane Deane in dance and movement we carefully worked on simple selections that we all could follow. So we once again worked more on natural experience rather than pre-formed ideas about movement.

The entire production was rehearsed during the final day and everyone made a great effort to put the Opera into reasonable shape for the evening. Despite many last minute problems, we finally went on stage as scheduled, and all of us came through with wonderful ease. Special assistance came from

Videocast of Toronto who provided expert communication help. Of course the audience's encouragement made the entire event a really positive act that we will all remember. Lastly we did our best on all levels and, we hope, put on a Production Performance that will some day show other Ex-Psych patients what can be done with determination.

We must thank Dr. O'Farrell from London, Ted Weir from Toronto and all the supporters who came to see the Opera. Graphic Alliance and Don Sibley did the posters and all of the TRY organization took part in making our's a Professional Production.

As TRY is awaiting Charitable Status, we are still living on welfare. But our hopes are high and we are planning a new production for either the Fall or early Winter. If anyone saw the Opera and would like to help our next production — please call us at 531-3498 during the Summer months.

Ron Gillespie/Director, TRY,
Toronto

P.S. Funding came from C.M.H.A., *A Space*, Ted Weir, Dr. O'Farrell, (Cultural Initiative, New York) and friends of TRY as well as from ticket sales.

P.P.S. The piece by Bridgette Eng was worked in during the last few minutes before going on stage: her performance was truly outstanding for her first time on stage.

Cast: Bridgette Eng, Lily Eng, Anna Gruda, Kathy Czuma, Susan McKay, Joane Deane, Warren Moore, Tony Ferguson, Martin Greenspan, Dan Anten, Ron Gillespie, Sid Williams.

Crew: Silvio Cerusi, Wild Bill, Don Sibley, Penny Gillier, James McLeod, Costa Ferreo, Videocast.

Music provided by Gordon W., Ron Gillespie.

Special thanks to NOW magazine, June La Rochelle, Don Sibley, C.B.C., John Crawford, Barbara Fulghum, and Sertia Bopana.

European and North American Self-Help Movements: Some Contrasts

by GUSTAVE A. DE COCQ

As members of a self-help group of ex-psychiatric inmates, we have been baffled by the extent to which not only our own efforts as a group but those of many other groups sympathetic to us, are ignored, rendered ineffective and discredited — if not simply co-opted. Now and again by some nice twist in understanding we are even “credited” with causing or furthering the very injustices and inhumanities which we work to expose and ameliorate! (See the letter by Dr. Lawrence Kotkas in our “Write On” section.)

When we have tried to understand what has frustrated us as a group, we have become conscious again of — what is hardly news to us — those same forces at work that have so frustrated us as individuals. Above all, we see the high value placed on conformity in our culture, the many mechanisms and sanctions reinforcing it, and — correlative with this — the very low level of tolerance for any sign of “difference” or, in fact, change in either individuals or small groups. Ruth Cooperstock, for example, commented in her study of the social rationale for providing sedative drugs in such massive quantities, especially to women,

Clearly many of the anxieties and stresses brought to physicians today are the result of work pressures, poor marriages, inadequate housing, underemployment and the like. By defining these problems as inherent in the individual, we tend to see pharmacological solutions as acceptable, and certainly easier than long term social solutions.

*We suspect that the same onus — and denial and isolation — is placed on small self-help groups such as ours in this society. And with the same lack of broader understanding — or long-term benefit to either individuals or groups or the society itself. We are reprinting the following excerpted chapter from *The Strength In Us: Self-Help Groups In The Modern World** in an effort to encourage further discussion of these issues. We welcome all comments, criticisms and other ideas.*

**Reprinted from *The Strength In us: Self-Help Groups In The Modern World*, with the permission of the authors Alfred H. Katz and Eugene I. Bender, *New View Points*, a Division of Franklin Watts, New York, 1976. Copies of the book are available — for \$2.50 U.S./paperback or \$5.00 U.S./cloth — from: Dr. Alfred H. Katz, School of Public Health, University of California, Los Angeles, California, U.S.A. 90024; or Dr. Eugene I. Bender, Faculty of Social Welfare, University of Calgary, 2500 University Drive N.W., Calgary, Alberta, Canada, T2N 1N4.*

“Normal” vs. “Deviant” Functioning

In the prevailing North American view, social welfare, like health, is dichotomized; “normal” social functioning becomes a cutoff point *below* which people are assisted to return to independence and competence, but *above* which people are thought to be able to maintain themselves and to grow and develop through their own resources. In the Western European view, on the other hand, social welfare is

seen as an open-ended continuum, on which any individual may at some time need to draw for his own level of creative and abundant life.

Thus, it may be said that the European *Weltanschauung* is comprehensive and concerns itself with the total structure of society. It includes the following ideas: (1) social welfare, as a state of social well-being, is viewed as an open-ended ideal, applicable to the population as a whole; (2) social services are seen as society’s obligation to itself, and hence, as comprehensive and universal; (3) social work practice stresses the human and compassionate approach of letting people grow to develop their own potentials, rather than the intervention of professional experts. In contrast, in North America the dominant approach is that professional “experts” should help people cope, to attain or regain a “normal” level of functioning.

Related to these themes are contrasting North American and Western European views of the nature of public-voluntary relationships. Broadly speaking, in North America the welfare activities of government are seen as antithetical to those in the private or nongovernmental sector. In consequence, voluntary citizen participation is viewed as an ideological necessity, one that preserves a particular way of life, or shores up a particular political system. But in Western Europe this relationship is seen as essentially cooperative and complementary; voluntary citizen participation is evaluated in terms of the pragmatic benefits that might accrue.

The American view is predicated on a value orientation that holds the individual and his family responsible for the social ills that befall them. These ills must be cured, alleviated, or ameliorated primarily by the individual himself; by his relatives and friends only to the extent that the individual cannot cope. Society, through its agents in the public sector, may intervene only when other means have failed. If one looks at self-help organizations in North America from this perspective, it is not surprising that they have been essentially individually oriented, have not traditionally secured state or public support, and are considered essentially antithetical to government ventures.

On the other hand, in Western Europe it is held that the social ills befalling the individual arise from a faulty societal structure, thus placing the burden of responsibility for ameliorating or curing these ills on society as a whole. If the phenomenon of self-help is viewed from this perspective, it is not surprising that in *Western European countries much of the self-help undertaking is not only sanctioned by government, but is actually encouraged and in many ways incorporated into the existing political structure.*

The self-help group of Europe is able to concentrate on the way in which social programs can best be carried out: there is little conflict over goals or what is conducive to people’s

well-being. In contrast, self-help groups in North America have to concentrate on changing social values and public attitudes in order to establish the validity of their programs in the first place. This results in a continuous battle; the achievement of a particular piece of legislation does not necessarily mean a change in social values and attitudes, but only a reluctant giving way on one point and a concomitant stiffening on others. It may be that in a pluralistic society — as both countries on the North American continent claim to be — agreement on the principles of a social philosophy for general well-being cannot be reached. But it is tragic and wasteful that much effort is spent on winning hard-fought singular campaigns, while the total victory remains elusive. This point may be illustrated further by a different type of self-help organization: the political activist.

In the last several decades the leading countries of Western Europe — the Netherlands, the Federal Republic of Germany, Denmark, and Great Britain, among them — have all experienced tremendous changes starting with the economic crisis of the thirties and followed by World War II and its massive consequences. In each of these countries the pressure of events necessitated the creation of far more enlightened and far-reaching social policies than had existed previously.

The degree to which social *policy* has been translated into social *services*, as well as the kind and extent of professionalism in social practice, varies in each country. Yet there can be no doubt that the concept of *social welfare*, as a guarantee of well-being for all citizens, is much more firmly established in these Western European societies than in North America. For diverse reasons — including the initial processes of immigration and the Protestant ethic that emphasizes the individual's responsibility for achievement through his own efforts — the state in North America has been seen as essentially antithetical, or at best neutral, in the individual's striving to achieve "the good life."

Conversely, in Western Europe the reciprocal relationship *cepted social services in the countries of Western Europe* in urban transportation, poverty, and so on. It marshals a

In contrast, "multi-concern" or "multi-focus" self-help group goals toward internal maintenance. Groups of this type reflected in all social institutions.

Thus we find sweeping, comprehensive, and generally accepted social services in the countries of Western Europe in contrast to those of North America. The climate of opinion in the United States and Canada is geared to the acceptance and provision of social services where there has been a clear breakdown of social functioning according to preconceived norms; to intervene in those cases where the individual, as a result of misfortune or accident, is not reaching his potential by his own efforts. *In contrast, Western European programs generally address individuals or groups who may have suffered a breakdown in social functioning.* Western European societies accept the responsibility to provide opportunities for the individual to develop his potentials, rather than reluctantly picking up the pieces when all other efforts have failed.

In spite of widespread social changes in the 1960's the countries of North America still view the individual as responsible for his own destiny and development. It is true that the social welfare measures in North America had their roots in Great Britain, in a penal code that protected the property rights of the non-poor, was severe in its punishment, and was rarely tempted by mercy. Thus, social service programs in the United States and Canada are often punitive in nature, e.g.: restrictive residence laws; emphasis on retribution in correctional and penal institutions; the belief that the unmarried mother should relinquish her child; cutting of allowances to unmarried mothers who have a second or third "illegitimate" child; close scrutiny of public assistance

recipients; the encirclement of minority groups either on rural reservations or in urban ghettos.

Drawing this contrast does not imply that there are no restrictions on social welfare services in Europe, or that in North America there is no support for the reform and liberalization of welfare programs. But it seems clear that the climate of opinion in Western Europe encourages the development of comprehensive services, which aim to support the potential of people in general, rather than at salvaging particular groups of the underprivileged or unfortunate.

A distinction can be made between the self-help group more or less homogeneous in its membership, which focuses on a single concern, and the heterogeneously composed self-help group, which may have many focuses of concern. The former concentrates on separate issues such as racial discrimination, housing, the war in Vietnam, air pollution, urban transportation, poverty, and so on. It marshals a good deal of commitment around its goal and often displays an initial spurt of energy and activity which rapidly peaks, then may diminish considerably. The diminution does not necessarily spell the disappearance of the group, but often results in a lessening of the initial drives and a shifting of group goals toward internal maintenance. Groups of this type seem more prevalent on the North American continent than in Western Europe.

In contrast, "multi-concern" or "multi-focus" self-help groups have broader social-philosophical goals, under which numerous issues can be subsumed. Such goals might include improving the quality of life or the humanization of a technocratically oriented society. Many self-help groups of this type are found in Europe. Both the earlier Provo and the present Kabouter movement in the Netherlands are cases in point. These Dutch groups started as protest movements against the dehumanization of society, but in contrast to the Hippie and Yippie movements in North America, which seem to have withdrawn from the political scene, the Kabouter movement has remained politically active to the extent that it now has members elected on both the local and national levels of government.

On the North American continent, the single-focus self-help groups often become isolated as social deviants. In contrast, in Western Europe, where the band on what is considered "normalcy" is broader, the single-focus groups are not considered as outcasts. Male homosexuality is an example. Despite Prime Minister Trudeau's comment that "government does not have a place in the bedrooms of the nation," there is still a vast gulf between the social acceptance of homophile organizations in North America and in Europe. For example, the Dutch homophile group requested — and was granted — a royal charter for the society! In Western Europe, such self-help groups as homosexuals or ex-alcoholics, ex-drug addicts or ex-criminals, war protesters or anti-royalists are less stigmatized as "crackpots" or "social deviants," and consequently are less alienated from prevailing political organizations and structures than in North America. Disadvantaged groups in Western Europe have more access to social policy formulation and social planning processes than do their counterparts in North America.

In a milieu where basic social responsibility for the well-being of all members of society is not controversial, the self-help groups in Western Europe seem able to achieve the changes needed for the fulfillment of their goals. Visible and external protest activities do not seem essential to attainment of their goals. In North America, where a social philosophy that asserts society's responsibility for public well-being is still debatable, the self-help groups continue to be seen as gadflies, annoying to be sure, but in the long run, easily dealt with by co-optation or suppression.



the Book worm turns

SCREW — A Guard's View of Bridgewater State Hospital, by Tom Ryan with Bob Casey, 1981, South End Press, Boston, MA. 161 pgs., \$7.00.

REVIEWED BY CONNIE NEIL

Screw has been well reviewed recently in the alternative press. We add *PHOENIX's* voice in praise of this scathing indictment of the Bridgewater, Massachusetts prison. This book is a strong reminder that public complacency allows hell-holes like this to exist. Anyone who saw the shocking 1967 film *Titicut Follies* (see *Phoenix*, Vol. 3, No. 2) knows reforms are needed in institutions — and Bridgewater is only one of several mentioned in Judi Chamberlin's epilogue.

As a result of the savage abuses that came to light in *Titicut Follies*, a new "hospital" was built. Tom Ryan tells his experiences at the State Hospital as a student volunteer and then guard between 1972 and 1975 working in both the old and new "hospital." As the inhumane treatment was built into the system and not a result of inhabiting a particular building, the abuses continued with several new sadistic wrinkles — using the intercom in cells to simulate "hearing voices", making prisoners locked up without toilet facilities wait for the three-man "piss call" detail to come from another building (at least the old building provided piss pots)... In any case, the new trendy facilities designed to provide relief and training to inmates were unequipped — and only opened for public tours.

Regardless of what crimes or deviant behaviour were committed to cause these men to be locked away from society — and many records were missing — the brutal treatment made no pretense at rehabilitation, except in public speeches to the effect that "Everyone helps to put the men back on the street in good shape."

What Ryan relates in blunt, unembellished style are inmates' stories and incidents he witnessed which moved him to try to make changes — to

treat inmates humanely, tell visitors how the superintendents' tours were snow jobs, lecturing to college psych classes, suggest better systems—all to no avail. His stories have the ring of truth that plain talk has, and they're filled with atrocities. One guard goaded a naive fellow into gouging out first one eye, then the other. Not satisfied with mere blindness, he suggested — when the inmate complained that he couldn't see — that the glass replacements were in backwards and (you guessed it) he dug them out again with a small bloodied branch.

Well, you say, "Those are the guards, who only need a high school diploma to qualify for employment. What of the professional staff?" No therapy was observed to take place. Inept nurses didn't care if their bandages for pus-swollen wounds hit the mark or not. Doctors with bloodshot eyes and jittery hands took an hour to crudely stitch a palm wound. The chief doctor was not licensed to practice psychiatry or even general medicine in Massachusetts. Lawyers at transfer hearings went through the motions of defense without even consulting with their inmate clients.

Any attempt to inform inmates of their rights, like the Mental Patients Liberation Front pamphlet given out by a volunteer teacher, found the teacher barred and search parties formed to remove any remaining pamphlets. The rights information was considered the work of outside agitators. Memos were posted warning staff of outside "Hitlerian techniques" of "sociopathic individuals outside" and suggesting bloodshed as their aim — and embarrassment to the "hospital."

Because Ryan "fraternized" — read, spoke to — the inmates and refused to savage them, he was exposed to dis-

crimination by other staff: notes on his personal record; a guard's vehicle speeding down on him — on foot — one dark night; false accusations of sleeping on duty; harrasing calls by a teenage girl to compromise him. When finally he was suckered into "helping" in a brutal inmate beating, Ryan resigned.

It is important to point out that the responsibility for unhealthy buildings, forced drugging and sadism lies with each and every one of us. The disproportionate number of poor and black people imprisoned indefinitely — sometimes for no crime, but for "observation" — point to the necessity for radical reforms in a system that uses catch phrases like "law and order" and "public safety" to destroy people. With stress, or under certain sets of circumstances — you could be next.



The Mind Manipulators

By Alan W. Shefflin and
Edward M. Opton, Jr.
New York: Paddington Press, 1978.
539 pp.

REVIEWED BY

DAVID L. RICHMAN, M.D.

Can we control the controllers???

"Lobotomy, psychosurgery, electrical stimulation of the brain, castration, brainwashing, hypnosis, behavior modification—the list of techniques for gaining control of the mind of another is quite substantial. Left unchecked, the list will continue to expand, and the techniques already on it will reach a higher degree of efficiency. It is against that possibility that we have written this book." (p. 10)

The basic issue of control is of paramount importance in all aspects of human existence; whether it be the internal "self," or of a prison. Over the last three hundred years Institutional Psychiatry has become the final tool of enforced control over those who do not tow the socially-approved line and demonstrate "appropriate" self-control. Paralleling this "war" against the socially different is the seemingly endless political/economic/military struggle for power via control over natural and human resources (power=control=power). In this domain of might-versus-might and spy-versus-spy the ability to brak the self-control of one's enemy—both individual and in mass—for purposes of gaining mental and physical dominance is a highly prized objective and dovetails with similar goals basic to the coercive and crushing nature of psychiatry.

Alan Schefflin and Edward Opton have done an invaluable job in collecting a wealth of relatively obscure information that clearly documents the vile abuses of human beings by the military-intelligence-psychiatric axis. The general subject of mind control, the relationship between brain function and the powers of mind-spirit-individual, and such issues as brainwashing, hypnotic (whether concerning Jonestown, Patty Hearst, or prisoners-of-war or of psychiatry) is not an easy task to tackle. The authors specifically choose not to deal with the at least equally sinister and even more ubiquitous psychotropic drugs (tranquilizers/depressants, such as Thorazine, Prolixin, Haldol, Valium, and lithium) or behaviour modification (for example, token economy and aversion "therapy").

Under the chapter heading, "Laundering the Mind," the authors debunk the concept of "brainwashing," its basic mythology and cold-war roots, and then examine American POWs in Korea, the Manson "family," Patty Hearst, religious cults, and the government's interest in these phenomena. After a slow start (to me anyway), they move on to an engrossing documentation of the rise of Psychochemical Warfare ("Tampering with the Mind") via CIA-psychiatric covert operations, such as Bluebird, Artichoke, MK Ultra, MK Naomi, involving the administration of various exotic psychoactive drugs (such as LSD, mescaline, belladonna, cannabis) to unwilling, often unsuspecting, individuals. The authors combine the tragic personal stories of some of the victims, including Harold Bauer, Dr. Frank Olson, and James Christensen, with detailed evidence exposing the ties between CIA-military operators and institutional psychiatrists, including the notorious "Jolly" West, Sidney Gottlieb, and Robert Heath.

The book contains well-thought-out chapters on psychosurgery ("Amputating the Mind"), electroshock ("Blowing the Mind"), electrical stimulation of the brain ("Re-wiring the Mind"), sexual-control drugs ("Castrating the Mind"), hypnotic control for political purposes, as popularized in the novel *THE MANCHURIAN CANDIDATE* ("Robotizing the Mind"), and concludes on an up-beat note with a positive vision for the future ("Asserting the Mind").

While the authors clearly expose the despicable involvement of psychiatry in all these mind-control/brain-destruction nightmares, they sometimes espouse attitudes consistent with the psychiatric party-line that rationalizes these activities. They write, for example, "schizophrenia was then, as it still is, one of the most malignant and resistant conditions known to man." Thus, they demythologize the concepts of brainwashing and hypnotic control, but reinforce current attitudes toward "schizophrenia" and "mental illness," of which the public also needs to be disabused.

Minor criticisms aside, this book is of great importance for it sheds much light on the politics and technology of "the mind manipulators." Without such exposure, effective resistance to their growing power can never be developed. The loosening of governmental restrictions on the use of psychosurgery is bound to encourage future brain-mutilating atrocities. Reading one nurse's description of America's leading lobotomist, Dr. Walter Freeman, demon-

strating his technique in a hospital amphitheater crowded with doctors and nurses should make us realize the urgency of controlling the controllers:

"As each patient was brought in, Dr. Freeman would shout at him that he was going to do something that would make him feel a lot better. The patients had been given electroshock just before they were brought in . . . He gave nothing for the pain, no anesthesia, no muscle relaxant . . .

"His main interest during the entire series of lobotomies seemed to be on getting good photographic angles. He had each operation photographed with the icepick in place.

"When all was ready, he would plunge it in . . . He lifted up the eyelid and slid the icepick-like instrument over the eyeball. Then he would stab it in suddenly, check to be sure the pictures were being made, and move the pick from side to side to cut the brain.

"Dr. Freeman worked with one hand and no surgical gloves, no gown, no mask . . .

"After Dr. Freeman had lobotomized eight or nine people making photographs from all possible angles, he seemed to feel that we were getting restive, so he said he would show us two at once! He stuck one pick in each eye at the same time! It was like a bullfight, watching the picadore stick two spears in the bull's hump, one on each side. It was just unbelievable, because he started with his hands way up at his shoulders and just plunged them in! Then he looked up at us, smiling . . . It astonished me that he was so gay, so high, so 'up.' For him it was a performance. I don't know how the others felt, but we watched in dead silence from beginning to end. For me it was like a nightmare." (pp. 248-249)

Reprinted from Madness Network News.

WHAT NEXT!?

The following ad closes out the 'classified' section of July 1983's *The Progressive* magazine:

SERVICES SOLD

JONATHAN SHAY M.D., BUSINESS-SEASONED PSYCHIATRIST. Specialist in troubled family business relationships and transactions, work-outs, bankruptcies. Consults to individuals, banks, law firms, accountants. 141 Cedar Street, Newton, MA 02159. (617) 595-6655.



Rights and Wrongs

CLAIR

CLAIR, the Canadian Legal Advocacy Information and Research Association of the Disabled, is a national, voluntary and consumer-controlled organization. It was established in 1982 to respond to the legal needs and concerns of people with disabilities.

CLAIR has two major objectives: 1. To ensure that the Canadian legal system more effectively meets the legal needs of disabled people, and 2. To promote greater understanding of legal issues of importance to disabled people among organizations of disabled people, legal service professionals and organizations providing services to disabled people.

Since the spring of 1982, CLAIR has had a board of directors which consists of disabled people. There are currently fourteen board members from every province and territory in Canada. These members represent six major disability groupings: invisible disabilities (e.g., epilepsy, diabetes, etc.); mental disabilities (e.g. "mental retardation"); psychiatric disabilities; mobility disabilities (e.g., cerebral palsy, paraplegia); visual disabilities (blindness); hearing disabilities (deafness, hard-of-hearing).

CLAIR is committed to seven major priorities: 1. Human Rights (focus on provincial and federal human rights codes and Charter of Rights and Freedoms); 2. Right to Self-Determination (legal guarantees of our right to make our own choices or decisions); 3. Access to Legal Information and Services; 4. Health Care Rights (e.g., right to refuse or consent to treatment); 5. Rights of People in Institutions (e.g., psychiatric inmates, "mentally retarded", etc.); 6. Employment Rights, and 7. Housing.

CLAIR has become increasingly active in public education and research focused upon the needs and issues of disabled people. During the last year, some board members have been researching major briefs, including one on the Charter and its impact on the

disabled. CLAIR also publishes a quarterly magazine, JUST CAUSE. The first issue came out last February and features a number of interesting articles on rights issues, as well as a special section called "Fighting Back" which discusses some legal victories won by disabled people such as Justin Clark.

For any disabled person or group of disabled people, one year's subscription to JUST CAUSE and dues for membership in CLAIR costs \$10. For professionals and professional organizations, service organizations or institutions, the total cost is \$22. JUST CAUSE is free to disabled people who cannot afford the cost.

There are three types of membership open to any person or group who supports CLAIR's objectives: Regular — open to any disabled citizen; Supporting — open to any person, and Organizational — open to any organization.

For more information, please write or call CLAIR: 147 Wilbrod St., Ottawa, Ont. K1N 6N5, phone (613) 231-3367, or call Don Weitz, (416) 596-1079.

Abuse in High Places

A U.S. psychiatrist whose clients have included members of such prominent American families as the Rockefellers and the Lindberghs has finally been forced to give up his medical license in response to numerous accusations that he physically and sexually abused his "patients." In a hearing in March before the Pennsylvania Board of Medical Licensure, Dr. John Rosen, 79, pleaded guilty to three of 102 alleged violations of the Medical Practices Act, surrendered his license, and agreed to release the four inmates who remained in his custody.

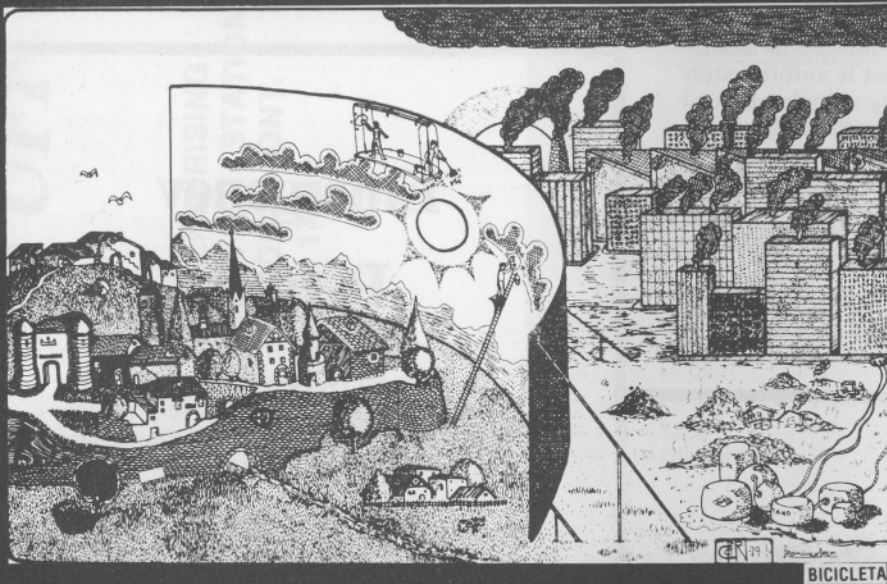
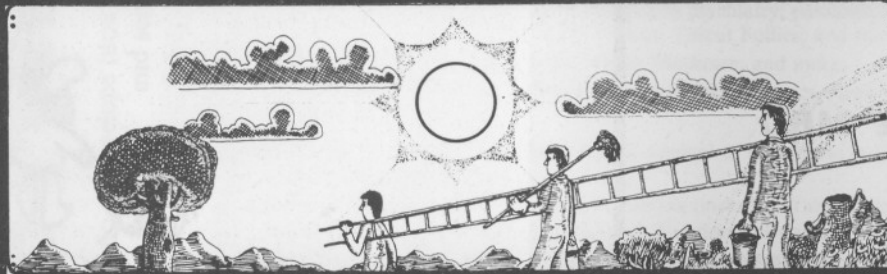
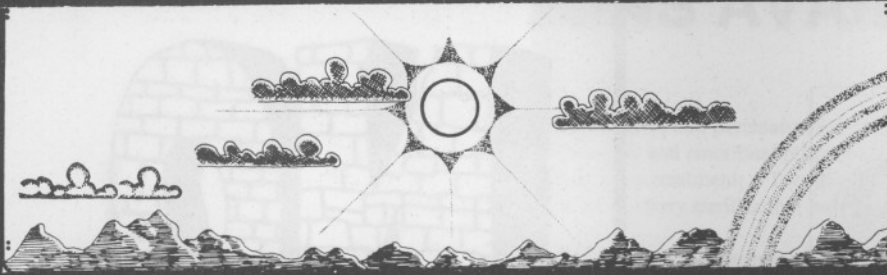
According to the charges, Rosen's "aggressive approach to psychiatry" (as the Miami Herald euphemistically called it) included forcing people in his "care" to perform various sexual acts,

assaulting them and imprisoning them in a basement "security room." Rosen pleaded guilty to abandoning a 31-year-old mentally retarded woman, Gay Claudia Ermann, in a Florida home where she was subsequently beaten to death in November, 1979. Two of Rosen's aides were convicted of criminal charges in connection with Ermann's death. Rosen also admitted that he failed to provide "proper supervision or regular treatment" for Michael Hallinan, who—bound and shackled—was kept in the basement of Rosen's "clinic" in Gardenville, Pennsylvania.

The investigation of Rosen was the result of many years of effort by some of the inmates abused by him. Sally Zinman, director of the Mental Patients Rights Association of Palm Beach County, Florida and one of the people who led the fight to hold Rosen accountable for his actions, was also kept locked up in Rosen's damp, poorly ventilated basement. "Half of me was knowing this was a joke. People didn't do this to other people," she told a Miami newspaper. "But then I also kept thinking that (Rosen and his aides) must know what they're doing. I kept trying to think of the good reason for it . . . My whole world was turned around to where the nightmare seemed like the normal thing." She stated she finally tricked Rosen into releasing her, after he had physically and sexually mistreated her over a two year period, from January 1971 to February 1973. Rosen denied these charges.

Rosen told the board looking into the accusations which concern abuses done to eleven Florida and Pennsylvania inmates over many years, that he was now "unable to practice medicine with reasonable skill and safety to patients because of (his own) illness." He informed the Miami Herald that he was just too old to be able to fight the investigation. "I'm not in the mood at my age to bother with it."

"It takes just one patient to stand up," Sally Zinman concluded after her 12-year fight to expose her psychiatrist's abuses and wrongdoings. But she also added, "It's not a perfect justice. It's too little and too late."



Symptoms of Life

*In her bathrobe and slippers,
she went to the department store
to buy rat poison.*

*Strange, there was no thought
about selling her the rat poison,
just ring up the sale,
and let the lady out into the street
into the traffic and heat,
in her bathrobe and slippers,
with her rat poison.*

*She was unaware
of how her belly burned,
how her body had been violated.
She hung like a trapeze artist
by her fingers
high above the earth.*

*The rows of clay pots
sat like birds at a fair
waiting to be shot down.*

*As her eye flickered,
and the light settled,
she simply said:*

“Why did you save me?”

*And then fell asleep
like a child with
gnarled toes and pale skin,
strangely old,
as if she had passed
through a lifetime.*

*In her cupboards,
dresses and vests
from Morocco,
and a blue satin robe
like Garbo’s,
and other symptoms
of life.*

Donna Lennick

“The people who really understand the way psychiatry operates know that it’s a political situation. A good example: Earl Long, the governor of Louisiana some years back, was acting in a bizarre and very grandiose fashion, making bizarre speeches and there was a group of important politicians who wanted him disposed of. What they did was institutionalize him. His wife had him committed to Louisiana state hospital. He knew how psychiatry worked. This man was a consummate politician. He fired the head of the hospital system and installed his own person. He was immediately released.”

Samuel Delaney in an interview with Allan Markman for WBAI Radio, N.Y.

Correction:

ATLA is not Atlanta Trial Lawyers’ Association, but American Trial Lawyers’ Association.

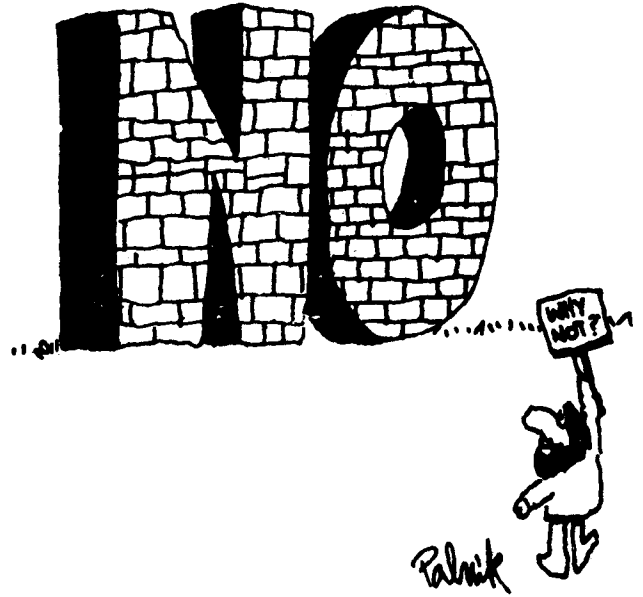


GIVING THEM THE BIRD

An unknown psychiatrist in Toronto made the following comment at a special meeting or conference held in Queen St. Mental Health Centre on the Anglican Church and Ontario Government's plan to provide soup kitchen-type drop-ins and/or halfway houses for expsychiatric inmates in Parkdale:

"I've heard of soup-to-nuts. Now I know what it means."

Although this psychiatrist has not come forward to identify him/herself, we think this gross statement is unfortunately typical of the contemptuous and degrading attitude which all too many psychiatrists and other mental health professionals exhibit toward psychiatric inmates and ex-inmates. We therefore are awarding a Turkey Tail to this unknown shrink and all the other shrinks who have such attitudes.



Emergency Request

Madness Network News in California is going through a very heavy funding crisis right now. The crisis is so serious that *MNN* may have to stop publishing this year or next. If that happens, the loss of *MNN* would be a severe blow to psychiatric inmates, former inmates and the International Psychiatric Inmates Liberation Movement. *MNN* is one of the most outstanding, ex-inmate-controlled magazines in the Movement; it's roughly 9 years old. We ask you, our readers, to offer whatever support you can to *MNN* to help it survive. Cheque or money orders should be made payable to *Madness Network News* and mailed to: *Madness Network News, Inc.*, P.O. Box 684, San Francisco, CA 94101. THANKS!



"We understand you tore the little tag
off your pillow."

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*“The mental health business is
the only profit-making business
in the world where the customer
is always wrong.”*

—Doris Wells