phoenix RISING

THE VOICE OF THE PSYCHIATRIZED

October 1988
Vol. 8 No. 1
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- Patients' Day at the American Psychiatric Association annual meeting
- Report from the Fourteenth International Congress on Law and Mental Health
- What they say versus what we know

A close-up look at the enemy

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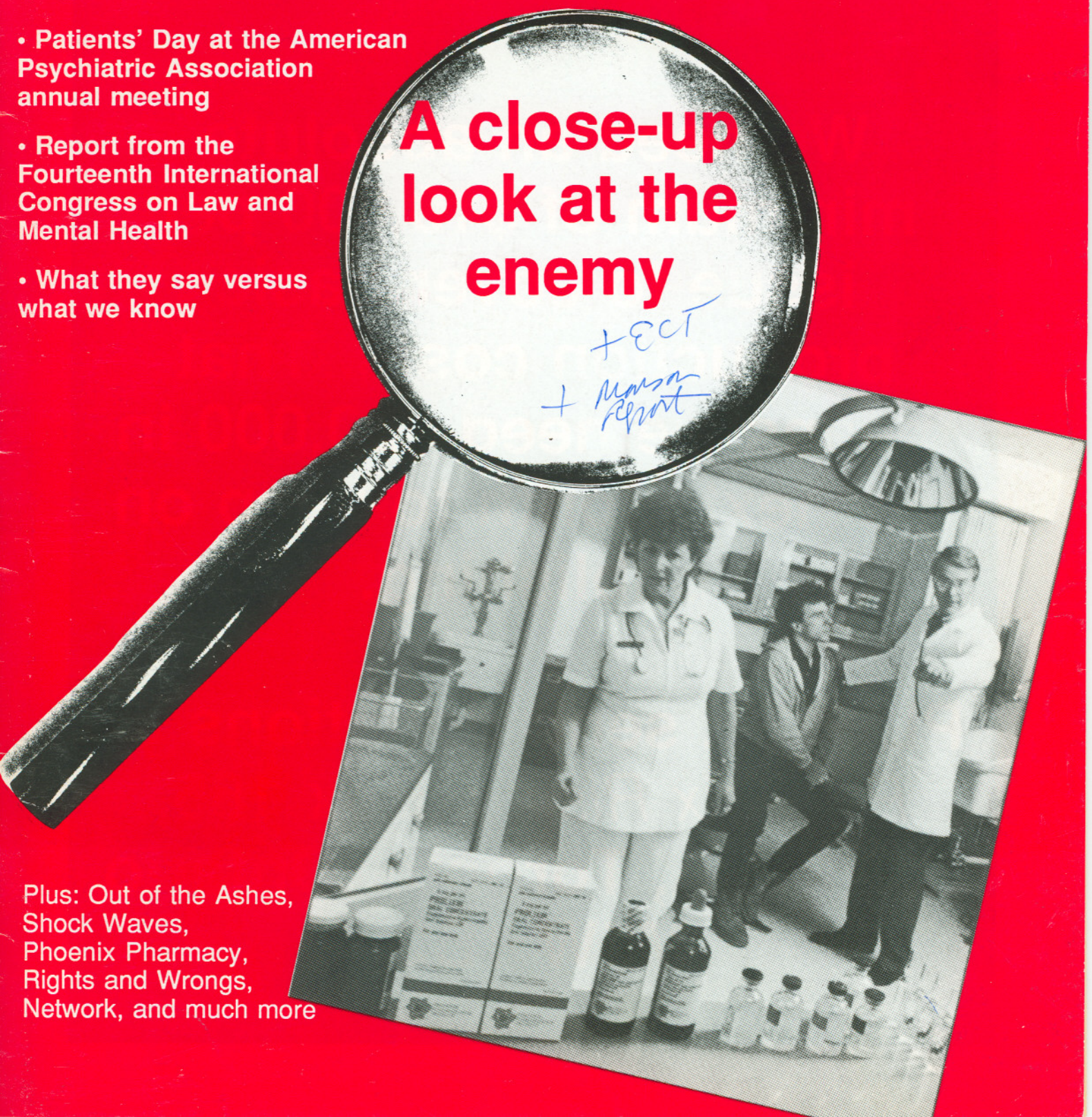

Plus: Out of the Ashes, Shock Waves, Phoenix Pharmacy, Rights and Wrongs, Network, and much more

HELP!

We need an absolute minimum of $10,000 per issue to cover basic production costs. That means we need $20,000 in the next month to keep on publishing.

PLEASE send donations to *Phoenix Rising*, Box 165, Station A, Toronto, Ontario M5W 1B2.

A close-up look at the enemy

ABOLISH FORCED PSYCHIATRIC TREATMENT

EDITORIAL

Shrinks are bad news. It would be nice not to have to think about what they're up to, since it's generally something awful. But it's important to keep tabs on them when we get the opportunity to do so. The more we know about how they operate, the easier it is to keep out of their clutches and explain to others why it's not our "paranoia" that makes us distrust them.

That's why this issue of *Phoenix Rising* is dedicated to "a close-up look at the enemy" – what the professionals are saying to each other about us and about their work. Irit Shimrat reports on the Fourteenth International Congress on Law and Mental Health (which took place in Montreal last June), where shrinks, lawyers, and "social service" professionals got together to pat each other on the back, tell each other what a great job they're doing, and pay lip service to the notion that their "services" should be geared to what the "consumer" wants. Was a single "consumer" invited to speak at this shindig? No.

Also in this issue, Bill Cliadakis of the U.S. National Committee for Preventing Psychotherapy Abuse examines the kinds – and extent – of damage caused by psychiatry. George Ebert of The Alliance explains why it's wrong to call the victims of psychiatry "consumers" in the first place. Don Weitz tells what happened on "Patients' Day" at the Annual Meeting of the American Psychiatric Association. Barbara Hudspith tells about her encounter with the "closed circle" formed by the psychiatric and medical professions. And Marilyn Rice provides the latest scoop on the classification of shock machines by the U.S. Food and Drug Administration.

As you can see, we need more Canadian content! We especially want to hear from readers in parts of Canada other than Ontario, and in Quebec.

Please note our **new mailing address and phone number.** We can now be reached at:

Phoenix Rising
Box 165, Station A, Toronto Ontario
M5W 1B2

(416) 465-3883

Corrections

Linda Macdonald, whose story appears on Page 26 of *Phoenix Rising*, Vol. 7 No. 4, in fact had five children in four years, not four children in five years. On Page 22 of the same issue, the election statistics for individual institutions in Don Weitz's story, "Everyone has the right to vote . . . well, almost everyone," actually refer to elections held on September 10, 1987, not May 2, 1985. Apologies to Linda and Don.

phoenix rising

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The opinions of the editorial collective are expressed in the editorial and in unsigned articles. Otherwise, articles, stories and letters reflect the views of the writer. We will not accept advertising which in any way supports forced drugging, electroshock, involuntary confinement, or psychiatry's medical model of mental illness. **Phoenix Rising** reserves the right to edit material submitted. Material should be submitted typed and double-spaced. Persons wishing to have material returned must enclose a stamped, self-addressed envelope. **Phoenix Rising** is published quarterly by On Our Own, and may be contacted at Box 165, Station A, Toronto, ON M5W 1B2, or by telephone at (416) 465-3883. Second-class postage number 5342. Copyright 1988 On Our Own. October issue. ISSN 0710-1457.

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Phoenix Rising *assumes that any correspondence sent to us may be printed in "Write On" unless otherwise specified. Please let us know whether you would like your name withheld if your letter is printed.*

WRITE ON

Beaten by staff

My name is Elliott Garel. Here is my story. In 1973 I came to Penetang on an assault charge, and I spent five and a half years unfit to stand trial. I went to court and got three years' probation. In February 1978, I was transferred to Whitby Hospital. One month later I came back to Penetang. In 1982, I was again transferred to Whitby, and I hurt one staff – a female. I went to court and was sentenced to five years in prison. When I was in court, I assaulted a male and got a Warrant of the Lieutenant Governor.

I was on Ward 07 in 1973, and the staff almost killed me. I was walking down the hallway and two staff grabbed me, and three more staff punched me in the head and chest. After they got done beating me up, the nurse gave me a needle of Nozinan.

I would be glad if you put my story in *Phoenix Rising*. I want to thank you for considering their crime and looking into the matter.

Your friend,

Elliott Garel
Oak Ridge
Penetanguishene, Ontario

My Brother's Place revisited

I am writing in response to Howard Davidson's letter to *Phoenix Rising* in Vol. 7 No. 4 (which refers to Irit Shimrat's article, "Big Brother's Place?" – Vol. 7 No. 1 – about conflicts at a Toronto halfway house). I worked full-time for two years at My Brother's Place (MBP), and was among the "radical eight" who resigned.

In his letter, Howard questions how and even *if* MBP changed substantially. He criticizes *Phoenix* for not taking the role of "critical outsider" (whatever that means). He attacks the article, saying it's "hopelessly naive" to think a radical halfway house could be funded by Corrections without "serious confrontations." He assumes that the residents were the conservative or reactionary elements at MBP, and that the staff and director found it difficult to turn theory into practice. Finally, he asks how the difficulties *he* has identified can be overcome in the future.

First of all, *Phoenix* makes no pretence of being an "outsider" to issues or events that it covers. Quite the opposite; it is the voice of the "insider." Secondly, more investigatory research went into Irit Shimrat's article than went into Howard's letter.

In his letter, Howard implies that some of the troubles at MBP were due to maintaining Corrections' funding, and responding to their demands or policies while maintaining a radical philosophy. Untrue. We – particularly Bonnie Burstow – confronted this issue, *and* we had a radical halfway house for two years. This issue did not lead to the problems at MBP. However, it was often used as a red herring.

Howard further suggests we had difficulty turning theory into practice. Again, not true. We were damn good at it! (For our pioneering work with Freirian principles, see the upcoming article by Bonnie, "Conscientization: A New Direction for Ex-Inmate Education," *International Journal of Lifelong Education*, January 1989.) Unfortunately, there still exist numerous false perceptions about what we actually did at MBP, and Howard's letter just adds to these. And, contrary to his analysis, many times the residents were more radical than some of the staff and board members. It was an exciting period.

Our greatest obstacle was certain board members who not only wanted to gain power over the staff and residents, but also wanted glory in the process. Sexism, heterosexism, racism, and classism did play some part in our struggle. A more substantial problem was some board and staff members' growing acceptance of psychiatry. But the biggest problem was hierarchy. The chairperson, in particular, wanted overriding control (although wanting to appear democratic). She took over, with the help of some board members who were essentially followers. Those who did not follow resigned. This is the unpleasant truth that many of us did not want to publicize, out of consideration for the chairperson.

I think Howard would benefit from talking with staff and board members who resigned. He sounds like a principled human being; had he been there, he probably would have resigned too. As it is, he cannot expect *Phoenix* or Irit to provide a justification for him being on a board for which there is no justification.

Kali Grower
Toronto, Ontario

Related by our bonds

For the first time your magazine has reached me, touched me, angered me, depressed me, and affected me

very deeply. But most of all, it has shown me a way to express myself, and has guided me to my "relatives." We (all of us who have been called "insane" at worst, "abnormal" at best) are all related by our bonds and bondages.

I am akin to your pain, your exploitation, your degradation, your separation, your segregation, your loneliness, and your fears. I am reaching out to gently caress your extended fingers that search, and ache, and long for understanding and companionship. But I know that these delicate fingers are also clenched in anger, raised in defiance, twisted and crippled by our interior torments and exterior tormentors.

Perhaps I appear to be overly dramatic. Perhaps I am not being dramatic enough. What one sees as "treatment" another perceives to be torture. But then I guess it all depends what side of the fence we're on.

My name is Theresa Giagnacovo. I'm 32 years old, and am being held captive in Kingston Prison for Women. I'm not going to say that I don't *deserve* to be here, and needless to say, I don't *want* to be here. But, while I *am* here, I would like to contribute to your publication.

Most of my life I've been a loner, out of touch with people. I've spent most of my time in self-absorbed thought. Since I was abducted three years ago and thrown into the harsh realities of the masses, I've acquired some amazing capabilities which I wasn't even aware were within me. I've met kindred spirits and, through this kinship, I have discovered a desire to help wherever I am able.

Being in prison and having limited freedom of movement, it was difficult to meet with those I would have liked to – but I have recently discovered a way to make this possible: becoming a member of the Prisoners' Committee. This allows me easier access to people, but has its limitations. Being committee secretary demands most of my time for committee-related functions. Therefore, I have a limited amount of time to devote my energies to my quest for fair treatment of the mentally/emotionally "imbalanced," support groups for those so unfortunately labeled, and public awareness.

Your magazine is my first actual attempt at contact with those directly involved in this area. Though my intentions have been good, direct action has never been my forté. But I am working hard at changing this. I am very impressed with your publication; it is refreshing to see that "people with labels" are getting the chance to speak out and express themselves, and it is encouraging to know that steps are being taken. I am also thankful for the help and support you give.

Though I have already served more than two years of my six-year sentence and am eligible for full parole, my hearing was suspended in order that I be assessed by a psychiatrist, as my offence was one of violence which resulted in the death of another human being, and because of my extensive psychiatric history. The recommendation of this psychiatrist was that I receive treatment before being released.

As a result, I am presently awaiting transfer to Pinel Institute in Montreal. There have been many delays regarding my hospitalization, as there are no available facilities in Ontario for women who are not from this province, except in crisis situations. Mine is one of many such instances here at P4W, and it is a sad state.

I hope that my candidness has not been a detriment to the views and concerns I have tried to express. Communication is a delicate ability, which I have only recently tried to improve.

Theresa Giagnacovo
Prison for Women
Kingston, Ontario

Stress risks

Avoid stress. Learn from the sparrow. Go where you feel most comfortable; stay away from where you don't feel comfortable.
Sincerely,

Neil Daugherty
Erie, Pennsylvania, USA

Bad ad

I believe a very serious oversight took place when you accepted the advertisement which appears on Page 28 of *Phoenix Rising*, Vol. 7 No. 4, under the lead "Help break the pattern of poverty – please contribute to USC Canada."

Your readers should know that USC (founded by Dr. Lotta Hitschmanova in 1945) passed itself off as the Unitarian Service Committee (which the advertiser was careful not to include), but had absolutely nothing to do with the Unitarian Church. Many later found this to be a rather sleazy way to cash in on the fine reputation of the Unitarians. Apparently her committee was being funded in part by CIDA, a government body of the same allegedly "neutral" Canadian government whose complicity with the American war effort in Vietnam was later exposed.

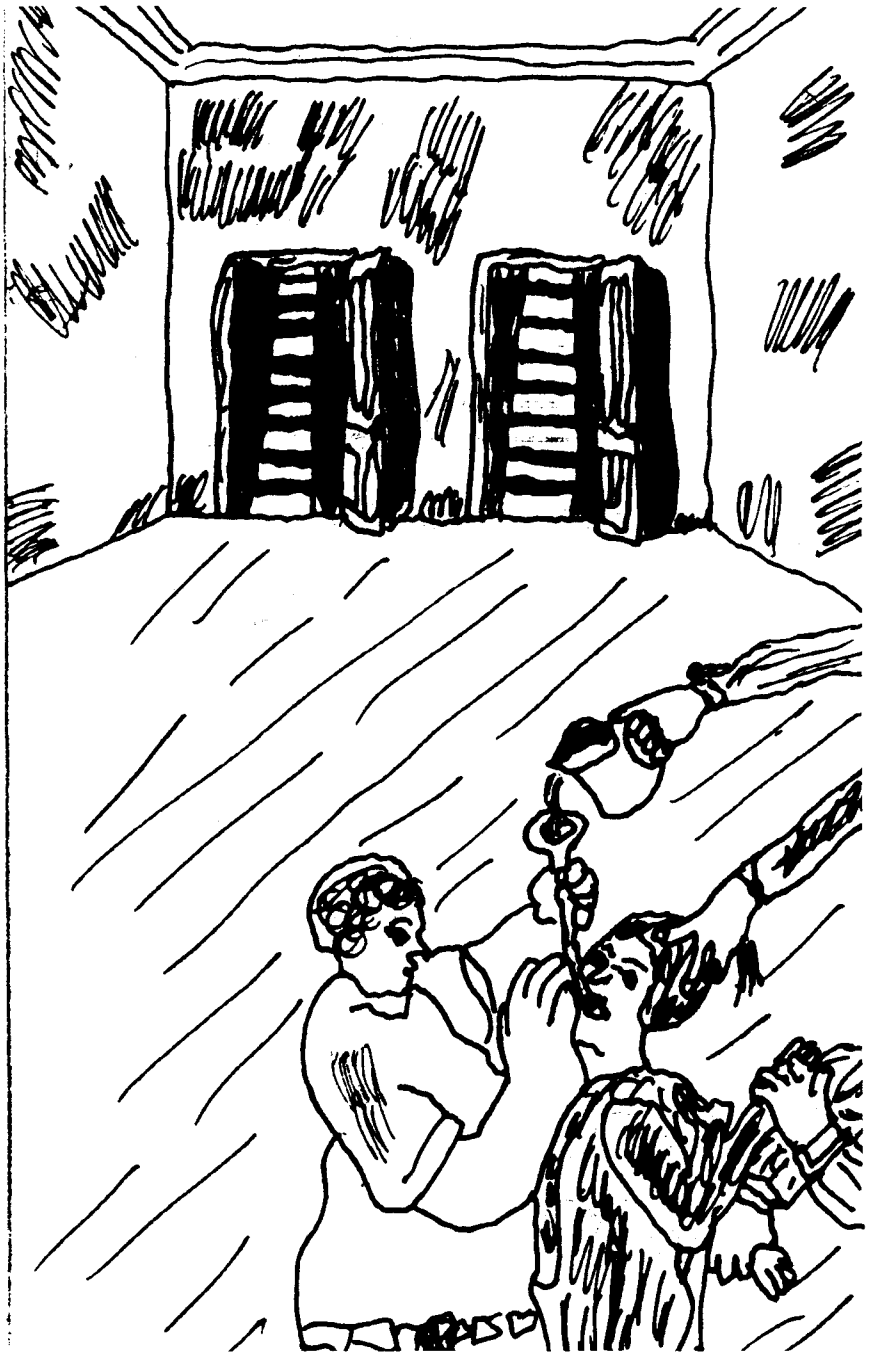
Dr. Hitschmanova, to the best of my knowledge, never did verify the source of her doctorate title, nor the strange uniform she constantly wore. I see now that a "C.C." has been added to her title (sic), meaning what?

Dr. Hitschmanova was known for her efforts to set up homes for destitute, war-orphaned children in the post-second-world-war period, and claimed to be a Czechoslovakian (I believe) refugee herself. She approached me on my return from Vietnam in 1968 to solicit my help to set up such a children's home in South Vietnam during the war. I challenged her as to the timing of such an effort – whether she would have considered doing the same in Hitler's Germany, rather than waiting till the war was over. If not, why consider working with the fascist Thieu government in South Vietnam? No answer.

I'll end here, on the note of recommending that you check out more carefully such organizations.

Claire Culhane
Prisoners' Rights Group
Vancouver, British Columbia

OUT OF THE ASHES



Drawing by Douglas Robinson

Crease Clinic

In Crease Clinic,
in October of 1974,
I saw Heydrich
Protector of Prague
descending the main
staircase
and visualized
the whole building
as a Gestapo
headquarters
where, in silent cells,
the doctors
tortured
the sick

Al Todd

The Closed Circle

Barbara Hudspith's true story has a message for women who've been abused by the medical/psychiatric system: It's not "all in your head"!

I couldn't have written this two years ago. The pain was too raw and the words would have spilled over with rage. The fear was still close to the surface, and setting pen to paper would have ripped open a tender wound. I think I'm ready now.

I could still kick myself for trying to have another baby. I should have known better. My first two pregnancies had been fraught with problems, but a new babe in arms to cuddle and enjoy was a persistent desire, and it was with only mild hesitation that I decided to give it a go.

The first month was full of foreboding. My exhaustion was intense and there was unusual pressure on my pelvis. But I was 36, and had never been an energetic amazon, so I accepted the trials with calm endurance, seeing my doctor for a stubborn bladder infection that seemed to be the cause of my malady.

Things took a sudden turn for the worse as my ability to urinate dwindled, and I spent long, agonizing nights straining and squeezing out the few drops that would come between fevered bouts of restless sleep. But, not to fear, I told myself. You have been here before and it's a matter easily rectified.

I returned to my doctor, a quiet and gentle lady who was not easily roused to activity but clearly empathetic, and presented my case. She offered to try to obtain an appointment with a specialist within the next few weeks. "The next few weeks!" I gasped in disbelief. I couldn't pee! What was I supposed to do for the next few weeks? I hoped she was joking. I pleaded my cause with renewed fervour. I even explained in simple terms what was happening. My womb was stuck low in the pelvis and, as it grew in size, it cut off my bladder. It had happened just this way in my last pregnancy, three years earlier. But – woe betide me – that had happened in another city with another doctor and was just not valid. My knowledge of my own body and how it malfunctions was simply irrelevant. She was kind and sympathetic, but unmoved. She ushered me out. It took several desperate phone calls and persistent visits before she suggested that I might be allowed a quick visit to the local emergency department for an opinion on whether it was really that pressing.

Once I was on the table, the young female resident was horrified that I had waited so long and not sought help for my condition before this. Not passing your water was a very serious matter, she scolded. The kidneys could back up and poison your system, and I had better hope it hadn't happened to me! She immediately had me hospitalized, catheterized, and closely watched. Finally, an ally!

Then began long, gruelling days of "holding the position." This consisted of minutes that turned into hours with my bum in the air and my shoulders touching the bed, arms tucked under, and head twisted uncomfortably to the side or buried in the pillow. This was prescribed with the hope that it would cause my uterus to drop into the correct position and stay there. It relieved the tremendous pressure on my bladder momentarily, but seemed so simple a remedy as to be futile.

Interspersed with this treatment were agonizing bouts of the chief of staff trying to push my womb into position manually. A charming man with a great sense of humour and deft hands, he was, however, a giant – well over six feet – and I a tiny individual, just over five feet and with barely enough space for a baby to grow, much less tumble. The ordeal was agonizing; the woman resident was quick to offer her hand and all the emotional support I needed as this huge man pushed me quite literally to the wall in his attempts to rearrange my uterus.

Suddenly, one day, I was examined and sent home. "You've done it!" they cried. "Holding the position worked. Your problems are over."

I returned in agony at three a.m., and was readmitted to my old bed. The doctor, I was told, would be in at seven a.m. to relieve my pain and decide what to do next. The resident who admitted me couldn't believe that I had been sent home to "hold the position" for the next six months. She was incredulous and annoyed, and let it be known. I never saw her again.

Seven a.m. turned into noon and still no doctor. I writhed and moaned. The resident on duty offered painkillers and apologies. Noon turned into night, and still no sign of her. Nothing could be done because "my" doctor hadn't come, they told me. The nurse on duty was herself three months pregnant. I saw her wince with every cry I made, picturing herself in my predicament. More pills turned my agony into a hazy oblivion. I didn't eat, confident that a simple surgical procedure would be forthcoming – the same one I'd had in that other city. It was all so simple. My womb had been pushed into place under anesthetic. Six months later, a beautiful little redhead had emerged unscathed.

Ten p.m. arrived and my doctor, in evening dress, stepped hurriedly to my bedside and demanded to know what all the fuss was about. No operation was necessary, she stated authoritatively. She would see if a

more effective drug would quieten me. Clearly my bladder was going into spasm. She left for her party and hours passed before the new resident on night duty came to tell me that the hospital couldn't locate the drug – perhaps by morning. I was beginning to lose confidence.

I spent days wandering the halls and measuring my urine. I made fourteen or more trips a day, plotting my progress in murky yellow millilitres. The nurses were impatient, annoyed at the added nuisance of adding up my output. No notice was taken of my frequency. The tally was simply input and output, and my long and conscientiously kept list of painful trips was pitched in the garbage.

An ultrasound was ordered. To anyone who has had one under normal conditions, it is a painless and often joyful procedure. Seeing the shape of your baby on the screen overshadows any minor discomfort. In my case, it was a form of slow and prolonged torture. My bladder, already acutely sensitive, was forced to hold a quart of liquid and then

subjected to half an hour of repeated pressure. No one seemed aware of my problem, and my agonized distress was a mystery to the technicians who perform these tests by the dozens on healthy pregnant women.

The aftermath was as frightening as the test. My outraged bladder would not release its burden; the liquid stayed locked securely inside for the next full day. Long hours of squeezing and pacing resumed and, finally, relief!

I had the choice, they told me afterwards, of being catheterized, but the mere thought gave me nightmares. As a one-time event it was an unpleasant process, but I was beginning to lose count of the times, and squeezing clearly won out over that pain.

After the ultrasound had been duly administered and read, the doctor returned to my bedside with a solemn face and began to substitute the words "blighted ovum" for "baby." It took me several startled minutes to follow her as the new phrase slowly took effect, and a blacker dilemma enveloped me. Now we were fearing for the wellbeing of the child. A sickening sense of doom began to spread.

Later that afternoon, as my husband and son and I shared the sad news, I began to have violent cramps, and blood started to gush out of me. My husband ran to the nursing station for assistance, and was received by a callous young aide who refused to interrupt her coffee break, assuring him that it was much less serious than he imagined. Angered, he made a scene, and the doctor came rushing. Bleeding profusely, I gave birth to a tiny fetus in her hand as she attempted to examine me. The doctor was obviously startled at what lay in her palm, but she remained in quiet control.

I was rushed to the operating room and cleaned out with amazing rapidity, more because it was suppertime than for any medical reason. At the door of the operating theatre, the charming chief, in his "greens," counselled my husband to wait at least a month before resuming marital relations with me. And I, feeling very much the bystander at my own cleansing, had an inexplicable sense of justification. Surely now they could understand that I had been in pain, that something had been wrong. Later findings revealed that my child had died quite some time before the miscarriage, and had been a Downs Syndrome baby.

Despite my complaints that urinating was still difficult and great pressure plagued me when I stood up, I was duly sent home to recuperate from what was termed "a routine abortion."

My entire pelvis became tender to the touch and I could not endure any clothing but a loose skirt. I could only sleep sporadically, since lying prone caused great pain. I couldn't walk to the corner without feeling that my bladder would explode. I couldn't cuddle my children, or ride in a car. The discomfort spread. I thought my insides were falling out.

I returned to my resident, who could find nothing but a tipped uterus, and tried but failed to insert a pessary to hold it in place. The chief, with a winning smile, nonchalantly explained that the pain would subside, and that there was no need for worry. "But she can't even ride in a car, or wear clothes," the resident persisted. "She's housebound, and can't function." He smiled me out of the office. As a last resort, the resident sent me to a urinary specialist.

I arrived trembling and tearful with the post-partum blues. He was clearly annoyed. I tried to explain, but he was curt, uninterested. My husband, who had been advised to come with me for support, was barred at the door, and I was left to face the man alone. He examined my bladder internally, and paid no heed to my pained response. "Pregnancy does not continue to affect the bladder after an abortion," he announced. "There's nothing wrong. You'll just have to learn to control yourself."

The pain was beginning to creep in. I knew what was in store. "What will I do about the discomfort when I get home?" I asked apologetically. He shoved a couple of tablets into my hand and declined to discuss it.

I writhed on the waiting room couch for all to see as the taxi driver hunted for the right door. He seemed years in coming. I needed an ambulance, not a cab. There was no position that wasn't pure torture. I moaned and cried through the streets as the car swayed and jolted. Stoplights were a personal affront. The neighbourhood children watched me drag myself into the house.

It was such a private, embarrassing pain. If I had had the chance, I would gladly have shot myself. Yet another call to a local doctor netted my husband some potent painkillers and a local anesthetic. This doctor was a woman, and she knew. I buried myself under the bedclothes and vowed never to go near another hospital.

And then my faith was restored. I found a new man. He showed a cocky sense of self-assurance when he said flat out that my uterus was clearly prolapsed, falling right out, in fact – hadn't I noticed it? Of course I was in distress; it pushed against my

If it had not been for a few people who believed in my sanity and integrity, I would probably have buckled under and become a passive victim, mesmerized by anti-depressants.

bladder at every step and aggravated the problem. Furthermore, my vagina was full of warts and infection, and needed immediate attention. His solution in the long term would be a hysterectomy. The news was a happy respite in the midst of such disbelief and unconcern. I would have skipped home if I'd been able to walk; my hopes soared. The next visit was a long, tedious wait away, but I was hopeful. Once I got there, however, he hedged on the hysterectomy and told me that a pain control clinic was my first step, so that I could learn to live with the discomfort in case some of it remained after the surgery.

The pain control clinic turned out to be a psychiatrist who clearly had other things in mind. He had decided that my real problem was depression caused by the loss of my child. After all, didn't those mysterious physical symptoms of mine bear a suspicious resemblance to the symptoms of depression? I didn't go out; I couldn't cuddle my children or touch myself without pain. Was this not a thinly disguised emotional problem? He had me. Drugs were the answer, to deal with my depression. I had been set up.

He was a kind man, and obviously concerned. But we were not there to discuss my pain. He had his own agenda, and the more I talked, the more I hung myself. Had I ever been depressed before? Well, of course. Who hasn't? Was there a history of mental problems in my family? I knew where I was being led.

Meanwhile, the bladder spasms came on with renewed vigour and, finding that my doctor was out of town, I was forced to return to the hospital and the chief. He was cool. He disagreed with my new doctor's theory. After all, he said, "If it was something as simple as a prolapse, wouldn't I have noticed it?" Testily, he offered to do a laproscopy, thinking all the while that adhesions from past surgery were to blame for all the pain. I was clearly a nuisance by now, and allowing me this exploratory surgery was a major concession.

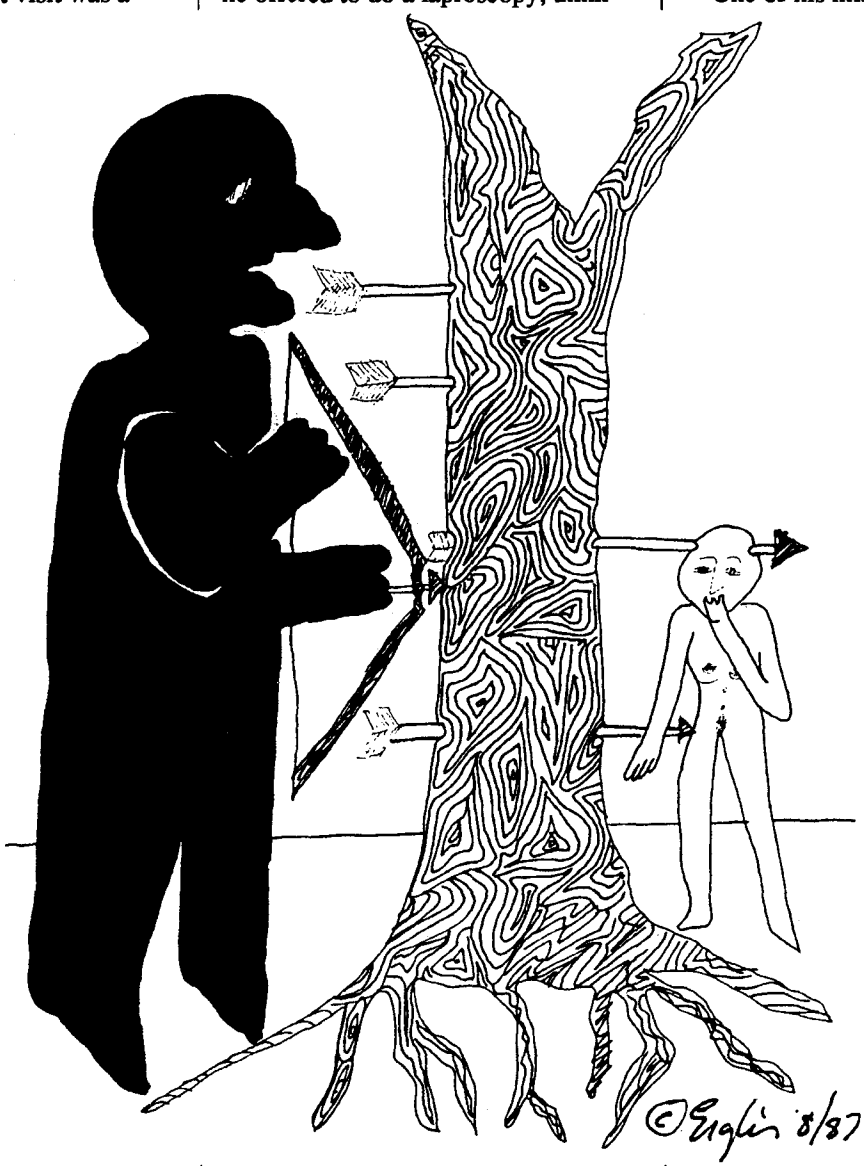
Through an anesthetized haze, I learned that my new doctor had been right. Not only was my uterus prolapsed, I also had a bad case of pelvic varicose veins. There was no treatment recommended, because these are major veins and cannot be stripped. And last, but not least, I was not in pain. Neither of these conditions caused pain, according to the chief. The implication was clear. It was all in my head. The chief promised to return when I was lucid, and discuss the problem. I never saw him again.

One of his minions saw me the next morning and discharged me. She grudgingly handed me a few painkillers for the day – until my new doctor returned. My husband had thought I was overly sensitive, but when he met this woman, he knew I was right.

I phoned my new man for help as soon as he returned. His reply via the nurse was strangely aloof: "Take an aspirin and use a hot water bottle in bed, and I'll see you in a few months." The nurse was unhelpful. Despite a raging vaginal infection, I was told to stick a couple of Tampax in, to push my uterus into place.

The date for a hysterectomy had been set simply to placate me and to ward off my husband's persistent questions about the delay. Now the doctor refused to see me. His initial diagnosis, it seemed, had changed mysteriously from prolapse to emotional instability. I wondered why.

It became clear shortly afterwards, when I realized that I was dealing with a closed circle. My new doctor, I found, had a close friendship with the chief, and they had obviously discussed me.



At one time I had possession of my own medical file, so that I could transfer it quickly from one doctor to another, but it was neatly sealed, and the law prevented me from opening it. I had been told I had a prolapse. I had been told I didn't. I had been told I had bladder problems. I had been told I didn't. I had been told I had an infection. I had been told it didn't matter. I had been told I had no pain, and I knew I did.

I wrote the new doctor a letter. It was tactful, polite and to the point. It expressed my surprise at his response to my pain, and questioned the basis upon which he had sent me for psychiatric counselling.

His answer was curt, merciless. He had cancelled my surgery. I was clearly in need of more psychiatric help, and he would not see me as a patient unless I underwent more treatment. He had seen me numerous times, and felt his judgement justified.

In fact, he had seen me twice, and had made this decision between the first and second visits. My questions regarding his decisions made it clear that I was not giving "informed consent" to surgery, and might make him liable. His tone was angry, defensive. I wanted to die. I was in acute pain, unable to function as a wife, mother, or person. I was depressed, for very good reason. My deliverance had been in sight, or so I'd thought, and now it was gone.

I had no courage left. I knew the medical profession was a closed system, and I was too vulnerable to fight. If it had not been for my husband, my family, and a few close friends who believed in my sanity and integrity, I would probably have buckled under and become a passive victim, mesmerized by anti-depressants.

Instead, through a chance meeting with new neighbours from Tibet, I met an acupuncturist who gave me new hope. After one treatment, I fell asleep in my supper. I hadn't slept like that for six months. And what was even better, he believed me! He took my pain seriously and proposed his own theory of what was happening inside me. The treatments helped, but didn't cure me. They needed to be frequent and intense. He wanted to work side by side with my doctors, but all they could muster were raised eyebrows.

He felt uneasy charging for such long-term therapy, and we soon went to barter. My husband taught him woodworking in exchange for his services. He came to my home and I went to his; the clinic was the living room couch or, often, the carpet. My children loved him. And we were people together, not doctor and patient. A treatment meant a quiet cup of tea and conversation, as well as "being stuck." Compared to the many tests I had undergone, being pricked with needles was gentle.

From acupuncture I found my way into chiropractic and homeopathy. Again I found caring human beings who never once hinted that the problem was in my head. They were interested in each and every symptom as a unique piece in the puzzle of my pain. I was introduced to herbs and vitamins and exercises. The closed circle came to have less importance.

I have no miracle cures to report – no wonderful testimonial to the effectiveness of holistic medicine. Would that I did. But I do carry with me a lasting appreciation for, and a confidence in, *bona fide* holistic healers. They gave me back my confidence and taught me new ways to diagnose and deal with pain. When the circle closed against me, I found a road that led out.

Another significant milestone came in the shape of a doctor who was outside the circle. He was my mother's gynecologist – a truly compassionate man who took me at my word. After several months of experimenting with pessaries and bladder relaxants, he did a hysterectomy, and things took a permanent change for the better.

I am not "cured," but I have returned to a normal life. I can enjoy a long walk in the autumn woods, and my little red-head can cuddle up quite comfortably on my knees. I can even manage an occasional canter on our old horse. But my problems persist in a subdued form (a troublesome bladder and a tender pelvis) and intrude upon my joy.

I know now that doctors are only people, not gods. I know that they tire and make mistakes. I also know that many, many women are diagnosed as having emotional problems when the medical profession cannot or will not find the cause of their pain. I no longer feel like *the* victim; I know I am just one of many.

I am over my bitterness, but it has taken a long time. I know that I am not depressed, in the clinical sense. I also know that I have been through a period of very necessary mourning – a mourning that included the loss of my usefulness as a person, as well as the loss of my child. Psychiatry would have denied me that grieving or, at best, delayed it.

My resources in time of trouble have widened considerably, and the closed circle no longer frightens me. I now number my family, my acupuncturist, my chiropractor, and my homeopath among those at the top of my list.

I know now that many, many women are diagnosed as having emotional problems when the medical profession cannot or will not find the cause of their pain.

Images from Inside: These black and white photographs by Mary Ellen Mark and Lonny Shavelson were featured in the exhibition *Inside Out*, curated by Chris Johnson in May 1988 at Presentation House Gallery, 333 Chesterfield Avenue, North Vancouver, British Columbia.

Left: from the book *Ward 81* (Simon and Schuster, 1979: photos by Mary Ellen Mark, text by Karen Folger Jacobs).

Below: Brandie Johnson. from the book *I'm Not Crazy, I Just Lost My Glasses:* photos by Lonny Shavelson (available for $12.95 + $1.00 for shipping [U.S. funds]; write to De Novo Press, Berkeley, California, USA, 94705).

Professional Opinions

Irit Shimrat reports on some of the goings on at the Fourteenth International Congress on Law and Mental Health

Have you ever noticed how shrinks use language? They can't talk about what they do without using big, scary phrases like "neuroleptic agent," "anti-psychotic medication," "electroconvulsive therapy," "bipolar affective disorder," "manic depressive psychosis." You and I can get a lot more said in fewer and much shorter words, such as "dope," "poison," "shit," "shock," "torture," "crazy," "nuts."

We usually use words to say something; to convey meaning. Shrinks often use them to obscure meaning. They make a lot of money – and get a lot of status, prestige, and power over other people – from the idea of "mental illness," and the notion that shock and drugs keep the "symptoms" of such illness under control. And they get away with it partly by monkeying around with words and meanings in order to scare the shit out of "consumers," while reassuring our families.

We who misbehave are told, "You have a dreadful illness – chronic schizophrenia, paranoid type – but don't worry. You'll be safe here; the door is locked. Now take these drugs and lie down."

Our families (or whoever has been putting up with our unacceptable behaviour) have gotten rid of us, but do not have to feel guilty, since we are getting "professional help." They are told that we have this "illness," but that everything will be okay because we're in hospital now. And the "anti-psychotic medication" they have us on will keep us from "acting out" (being angry).

Meanwhile, the disease cannot be proved to exist; the symptoms are things we say or do, not things that are wrong with our bodies; the "medications" (or shock "treatments") damage our brains and screw up our lives, and we are locked up on no charge, with no trial.

Can this be legal?

You bet. Law and psychiatry have been cozy bedfellows for as long as psychiatry has existed. Courts use psychiatrists to have people declared insane, or unfit to stand trial. Shrinks use police to pick us up and bring us to them.

The Fourteenth International Congress on Law and Mental Health (held at the Ritz Carlton Hotel in Montreal, June 15 to 18, 1988) was a gathering of some of the people who influence, make, and use mental health laws. There were almost 200 presenters from all over the world – many from the United States, most associated with universities or psychiatric institutions.

Besides shrinks and lawyers, there were professors, researchers, government mental health officials, social work bureaucrats, criminologists, and people who work for things with names like "Centre for Health and Human Resources Policy." There was also a handful of "psychiatric

patient advocates" and Bill Stapley, president of The National Association for the Mentally Ill, a group for the families of "consumers" (see Page 18 for details).

There were sessions on "Workers' Compensation and Stress Claims in North American Law," "Legal System Etiology in Non-Organic Disablement," "Psychosocial and Legal Dimensions of Violence," "Psychosocial Problems in the Work Place," "Profiles on the Mentally Disordered Homicide," "Intoxication, Criminality and Forensic Psychiatry," and "Multimodal Behavioural Therapy," to name just a few.

Some of the presentations sounded promising, but weren't. "Women, Law, and Psychiatry" was about isolating two major types of patients who have murdered children, the "psychotic" and the "personality disorder" – not the way law and psychiatry keep women down.

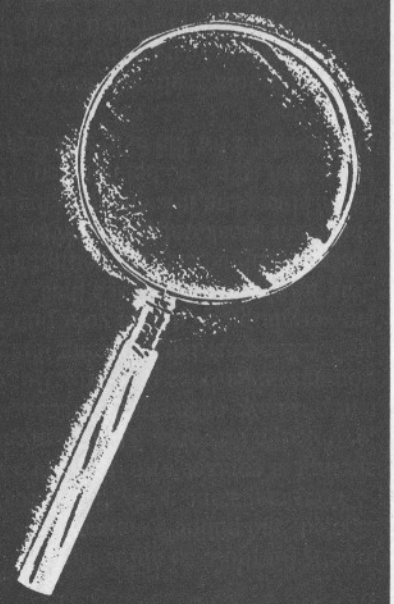
"Law and the Regulation of Mental Health Professionals" dealt with shrinks' obligation to report child abuse and "professional relations among mental health professionals" – not keeping shrinks' power under control.

"Economic Issues and Mental Health Systems" was about psychiatric malpractice claims and how hard it is to get licensed as a psychologist – not how drug companies make billions of dollars through "mental health care" scams. (Among the sponsors of this conference, by the way, were the drug companies Mead Johnson, Squibb Canada Inc., and Merrell Dow.)

"Models of Advocacy for Mental Patients" praised the "quasi-independent" Ontario Psychiatric Patient Advocate Office – but failed to admit that professional advocacy for psychiatric "patients" is a farce. (For a critique of the Patient Advocate Office, see Page 27.)

"The Right to Refuse Treatment" was about "clinical characteristics of refusers," "philosophical implications of the clinical research model" and "medicating incompetent mental patients" – not the right to refuse treatment.

The session called "The Right to Refuse Treatment" was actually about "clinical characteristics of refusers."



A Richer Autonomy

Good examples of the kind of doubletalk celebrated in this event came up whenever "competence" was discussed. This was the topic of Alan Weisbard of the New Jersey Bioethics Commission. His contribution to a session called "Law, Psychiatry and Politics" focused on "deciding when you will respect the wishes of a patient to consent to or refuse medical treatment and when you will not."

Right off the bat, Weisbard announced that he would not be talking about "treatments in a mental health setting." He gave no explanation for avoiding the subject of psychiatry.

Weisbard doesn't know what competence is. He just knows how it's used: "The concept or construct [idea] of competence is substantially theoretically incoherent [a mess], and is used to avoid or obfuscate [hide] political, social, and moral choices about decision-making."

A doctor should "try to determine whether the individual's decision-making capacity is sufficient to justify societal and professional respect" [decide if the person thinks enough like the doctor to deserve to have any rights]. It is probably okay to assume a person is competent "where a particular choice for which the patient expresses a preference is consistent with professional and societal views of the patient's good" [if the person agrees to the treatment].

However, "when the patient is inclined to express a preference for a choice that has serious deleterious consequences as they would be viewed by others in some objective universe, there is a greater disjunction among the elements of autonomy" [if the person refuses treatment, their right to make a decision should be taken away].

The dictionary says autonomy is self-government. In Weisbard's head, however, autonomy is something much more complicated. One of its elements is the desire to have one's wishes fulfilled. But then there is "some sense of autonomy that looks to values and objectives, and would accept that others better understand and apply the patient's values

at this time."

Weisbard claims that "a patient might be competent to say yes, but not competent to say no." He recommends to doctors "not to say that one immediately rejects the patient's preference, but rather that one engage in conversation and in dialogue, if possible, to understand what's going on, or why it is that the patient is making that choice. If forced treatment is justified, it's justified either on paternalistic grounds or, I want to claim here, on grounds of respect for a second, richer and more satisfying sense of autonomy itself."

Weisbard was weaving a shining web of big words around a whole lot of hot air. What he was really saying is, instead of ignoring and then forcibly treating the "incompetent patient" [who must be incompetent or else wouldn't be refusing], the doctor should listen to what the "patient" has to say, and *then* proceed with the treatment anyway.

Leaving certain things out

Loretta Koppelman of the Department of Medical Humanities, East Carolina University School of Medicine, spoke about "Why Competency Decisions Can Be So Difficult."

"One attack on the way competency decisions are made is to maintain that these are merely conventions of social approval or mores, which, if true, would undercut the rationality of the judgements.

"Researchers have identified the core meaning of these judgements as the ability to do a certain task well enough for a certain purpose. Of course, in many cases we would be hard pressed to say just what tasks or purposes or thresholds we had in mind when we made a competency decision.

"So to some extent these are elliptical judgements – that is, they leave certain things out: namely, the specific tasks or purposes or thresholds that we have in mind, that are nonetheless entailed by making these judgements."

In other words, a decision can be made that you are not competent, without saying what you're not competent for, why you have to be competent, or how competent you have to be.

"Competency or capacity determinations are sometimes done by authorities to benefit the person – either to make certain programs available to them [lock them up], or to excuse them from blame [lock them up in a mental hospital indefinitely rather than in prison for a fixed term].

"These decisions are sometimes made to benefit society. Obviously, there is sometimes a need to restrict the freedom of others for the sake of social utility" [lock people up so they don't get in the way].

Treatment with psychiatric drugs "cannot be judged as cruel and unusual punishment where the intent is therapeutic."

Therapeutic intent

Donald H.J. Hermann of DePaul University College of Law continued Weisbard and Koppelman's line of non-thought in a presentation called "Privacy and Autonomy in Treatment Refusal." Hermann pointed out that it would be "illogical to hospitalize a patient and then allow the patient to refuse treatment."

Some people, he said, have claimed that "freedom of thought and mind are interfered with by [psychiatric] drugs." But this is wrong, claims Hermann, since the drugs are "not administered to prevent thinking."

"Patients," said Hermann, "have claimed that psychiatric drugs were used to punish them, but courts have ruled that there was no evidence" of this. Hermann admitted that treatment with these drugs has been recognized as cruel and unusual punishment in correctional (prison) facilities. But the very same treatment "cannot be judged as cruel and unusual punishment where the intent is therapeutic."

TD – a legal hot potato

Two sessions at the conference dealt with Tardive Dyskinesia, a debilitating disease characterized by permanent brain damage and suffered by many "patients" as the result of the "anti-psychotic medication" shrinks prescribe for people who are not behaving.

The reason TD came up at all, of course, is that it costs shrinks money: "Several malpractice cases have been decided for large sums based mainly on the failure of clinicians [shrinks or other doctors] to warn patients and their families about the risks of TD."

It was noted that shrinks resist taking "measures aimed at the prevention and management of TD," even though "many patients improved when massive dosages of neuroleptics were removed."

There wasn't even one presentation on electroshock at this conference, since there haven't been any big, successful lawsuits against shock.

Making up the Rules

One of the scariest parts of the Congress on Law and Mental Health was the session called "Mental Health Policy: New Directions," opened by Paul Fink of the Philadelphia Psychiatric Centre.

According to Fink, "We need to standardize training for all professions around all issues related to mental illness. There are programs in America that are purely biological, and there are programs in America that are purely psychological in their organization, in a time when the biopsychosocial paradigm must be preeminent."

"The biopsychosocial paradigm," also known as the "medical model of mental illness," is the excuse for saying that **psychos** who cause **social** problems have a **biological** disease that can be taken care of by drugging them.

"During this year I'm hopeful that all the major organizations in mental health will get together to put on a major television extravaganza . . . I also hope to establish once and for all the biopsychosocial paradigm."

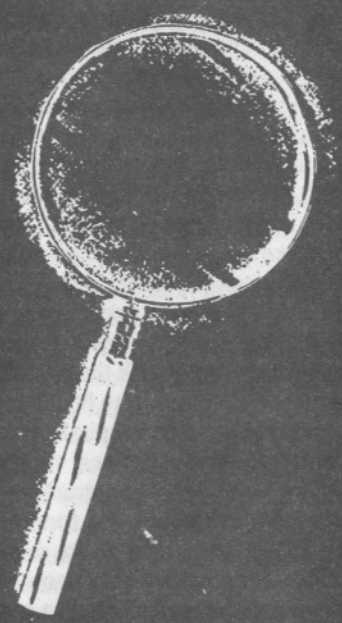
That is, Fink hopes to encourage all the millions of people who watch T.V. to believe that people who act weird are sick and need drugs.

Also presenting at this session was Richard Surles, New York State's Commissioner of Mental Health (see Page 16 for details).

Fink, Surles, and Stapley all paid lip service to the involvement of the "consumer" in the shaping of mental health policy.

Asked about why there was no apparent effort to get a "consumer" to make a presentation at this event, Fink told *Phoenix Rising*, "I think that in having Bill Stapley you have the best advocate and spokesman for consumers you could have had. The consumer movement is the youngest of the movements. We don't think to include consumers."

Our families and friends sign the papers and hope for the best as we are locked up, forcibly drugged, and transformed into zombies.



Psychiatry controls and destroys people's lives, and the law helps it happen. "Professional help" is a profitable game; the "service providers" have all the cards, and the "consumer" always loses.

Many of us have been fooled by fast-talking professionals. Our families and friends have signed the papers and hoped for the best as we were locked up, physically restrained, forcibly drugged, and transformed into zombies. We have kept taking our pills, even though they made us feel terrible, because we've been told we'll become "psychotic" again if we ever stop.

Fear and ignorance allow people to fall under the power of the "mental health" priesthood. Those of us who get out from under can learn a lot by looking at what the professionals are saying, and what they're doing while they say it. By learning how and why they've lied to us, we can reject the idea that we are, or ever were, "sick" – and shed our inmates' pyjamas for good.

Look for details from sessions on tardive dyskinesia, predicting dangerousness, psychiatric research on the "the criminally insane," and "competency and freedom of choice in forensic practice" in future issues of Phoenix Rising *(if we can afford any future issues).*

Richard Surles on "Continuity of Care for the Chronically Mentally Ill"

Excerpts from an address by New York State's Mental Health Commissioner to the International Congress on Law and Mental Health

It is not clear what we mean by "mental health"; it is not clear who the clients are, or what the services are. Every day I see the casualties that our current mental health policy has created.

We started saying, "What is happening in our psychiatric emergency system? Who were the people coming into the psychiatric emergency room repeatedly?"

They were more male than female. Most were between seventeen and 35 years old. Most had a diagnosis of schizophrenia. Most had not been in a state psychiatric hospital.

This was not a group of unknown patients. These patients were well known by the system. Many of them had their names posted in inpatient units, on notices saying "Do not admit." Many of them would not accept services being offered, nor, in most cases, were they wanted.

We identified the same principle in inpatient care, but in large part for a different group of patients. Interestingly enough, the majority of people who turned up in the emergency room, if they were admitted, stayed a fair bit of time – especially young, black males.

> ***We have to wait for people to collapse and become casualties in order to treat them.***

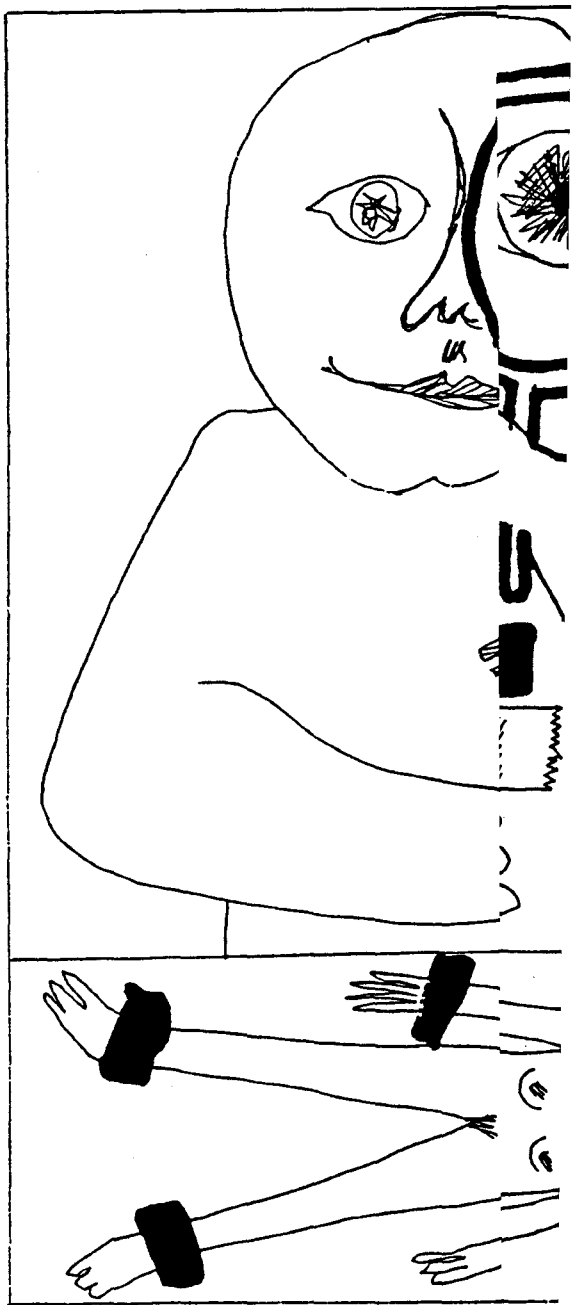
We asked a series of questions around sex, age, diagnosis. We are coming to a point where we think that we can identify some of the factors associated with relapse and the need for hospitalization. And that has tremendous implications for the way we organize services.

I was shocked to find that less than one percent of our budget is spent on emergency services. We have no control over the gates into the mental health care system. We have no way of saying "How do we get access to patients that need us the most [How can we lock up the people who scare us most]?"

There are going to be some serious implications for some of the providers that have been living off the mental health system for years.

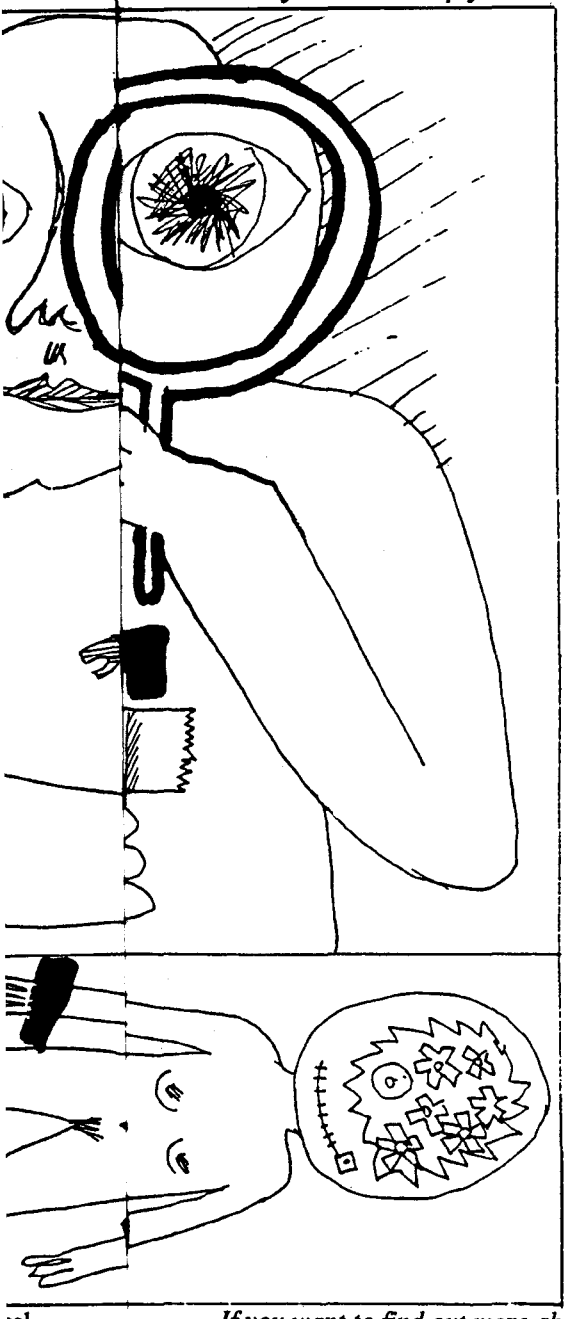
We're going to ask these preferred providers – community health centres, acute care hospitals, psychiatric emergency services, vocational services, residential programs, a rehabilitation centre – to form a network. And to basically take responsibility for a cohort of patients. So that when the person needs a place to go during the day, one of the network of preferred providers takes that responsibility. And when there is a crisis, there is the availability of rapid emergency services [we are going to watch these people 24 hours a day, and if they misbehave, we're going to lock them right up].

And by the way, one of the things that I think we have to watch out for is our police state mentality – the idea that we can use law to solve mental health problems in this or any other country – when in fact, using the law calls on a mental health system that is so rigid and so inflexible that we have to wait for people to collapse and become casualties in order to treat them [mental health law needs to be changed so we can lock people up before they get "sick"].



William C. Cliadakis on "Abuse in the New York State Mental Health System"

Excerpts from a presentation by the National Committee for the Prevention of Psychotherapy Abuse to the State-City Commission on Integrity in Government



If you want to find out more about the National Committee for Preventing Psychotherapy Abuse, contact: NCPPA, 60 West 57th Street, New York, New York, USA, 10019, or call (212) 663-1595.

In 1985, 2,661 inpatients and outpatients in New York's mental hygiene system died. (There were 21,000 inpatients in state psychiatric centres in that year.) That toll underestimates the number of deaths, since those associated with psychiatrists in private practice are not recorded. And psychiatrically induced deaths are not counted as such when the person is transferred to a regular hospital to die.

Seventy-seven percent of those deaths were reported as being from "natural" causes. There was no indication that any of the deaths were caused by mismedication or prescribed overdose. Yet it is no secret that this type of death is common. Such information is suspect.

Since 1985, the system has stopped reporting numbers of deaths.

This commission, which was appointed by Governor Mario Cuomo and Mayor Edward Koch, decided that 422 of these deaths required further investigation "because of some possibility that the cause, manner, or issues related to the death of the individuals may have presented lessons which could contribute to the improvement of quality of life for those who are still in the State's mental hygiene system."

The National Committee for Preventing Psychotherapy Abuse (NCPPA) decided to conduct a spot check of your screening process. We requested information about one typical, suspicious death that we were very familiar with, to see if it was under investigation. It was not listed among the 422 deaths in the 'suspicious" category.

The death toll alone does not show the extent of victimization and abuse in the mental hygiene system. One 1985 study documented 136 assaults by staff in one month in three facilities with a total patient population of 1,845. Sixteen of these assaults were described as causing major injury. Only two of them were reported to the district attorney or to the police. Many assaults are never reported to anyone.

Mental abuse and institutionalization can be just as debilitating as physical assault. Consider a system that takes away from its recipients the constitutional rights granted even to convicted criminals. Consider a system that drugs virtually anyone who comes into it, lies about the permanent central nervous system damage done by the drugs, and threatens outpatients with rehospitalization if they refuse to take the drugs. Consider the Office of Mental Health stating that electroshock is "underutilized," but refusing to conduct the most basic physical tests on people receiving shock, such as before-and-after CAT-scans that would determine the damage to brain cells. Consider the fact that lobotomies have never been banned.

One of the largest areas of abuse is in psychotherapy, particularly in the private office setting. NCPPA has interviewed about 1,000 people who have been abused in psychotherapy. It is not just sexual abuse. In a preliminary study, sexual abuse ranked fifth behind dependency, misdiagnosis with failure to correct, abandonment, and mismedication, in that order. The experiences of the victims who were interviewed were often devastating.

Bill Stapley on "NAMI: The Emerging Family Movement"

Excerpts from a presentation by the president of the National Alliance for the Mentally Ill to the International Congress on Law and Mental Health

I have a 31-year-old son diagnosed as a chronic paranoid schizophrenic. He has had difficulties from before he learned to speak, throughout his lifetime. He's been through all kinds of psychiatric facilities, psychiatric testing, and diagnosis over a period of 28 years.

We did not know what schizophrenia was, if you can believe it, till about eight years ago. And until we got that diagnosis – we had no inkling, we were told nothing about the possibility that he might have a serious mental illness.

This colours the thinking and reaction that families have with regard to their interface with the mental health system, and their inability to become informed as to what illness is all about, and how they can contribute to helping their family member cope with the illness [keeping their family member medicated].

I'm talking from the family perspective. And I do not share the optimistic view that we're making great progress. Not that there's no progress being made. But I want to stress result. We have all kinds of activity programming, but are we getting a result for the individual, for the families, who are the persons who are affected?

All we know is how the services [drugs, civil commitment orders] are delivered. Whether we're getting them or whether we're not. Whether our family member is being taken care of or getting excluded. Whether our own lives are being assisted by the clinicians or we're being excluded.

NAMI is made up of families, each of whom has a seriously mentally ill family member [a member whose behaviour scares them because they can't understand it].

Our basic purpose is to seek an eradication of serious mental illness [make our family member normal] and, secondly, to improve the quality of life of those people whose lives are affected by serious mental illness [get our family member off our backs].

We need to know what these illnesses are, what science tells us, treatment opportunities, the necessity to recognize the psychosocial orientation and restore the person to their level of functioning. We have to get control of active symptoms of illness [get the family member to lie down and shut up]. There's no use discussing all these things we're going to do to improve functionality if the person isn't functioning [behaving].

Medication is the treatment of choice, according to science and our own experience, for persons who have these kinds of illnesses [drugs are the only way to get them to behave].

Stigma is the extension of the historical perspective that persons with mental illness were regarded as untrustworthy, as fools, as people to be ridiculed. They were devalued persons in our society. That hasn't changed.

Another area is the whole question of normalizing treatment for the mentally ill. Why do we have all the special rules? Why do we have the intrusion of the legal system into nearly all facets of the mental health delivery system?

If I had a family member who was diabetic and they had a seizure, and I called emergency, they would transport the individual to an emergency room; they would decide what ought to be done.

If I have a psychiatric member in my family and I call, what's likely to arrive is the police. They usually put them in handcuffs, and they may take them to a facility which is not a clinical facility but which may be a jail. Why is it different?

And when you talk about legal advocacy – I can have people that are going to jail for literally nine, ten, twelve weeks, and there's not a single lawyer that shows up for those individuals. But if I have a two-day detention order for commitment evaluation, I'll have lawyers trying to keep them from being evaluated and committed so they can get treatment. I ask you, where is the fairness in that system [why can't I get my son locked up in a hospital whenever I want to]?

Finally, there's a whole array of rights issues having to do with confidentiality, commitment, medication, treatment, protection and advocacy, and commitment. Talk about the legal application of rights seems to be focused in on solely the question of choice. People are not concerned, apparently, about treatment neglect and abuse as represented by the kind of facility we have, the type of training, the qualifications of the staff, the overuse of restraint – the whole advocacy of treatment. Where is the advocacy in those areas?

George Ebert on "Breaking the Silence: Barriers to Abuse and Neglect Reporting"

Excerpts from a presentation by a psychiatric survivor, and member of The Alliance, to the Symposium on Abuse and Neglect

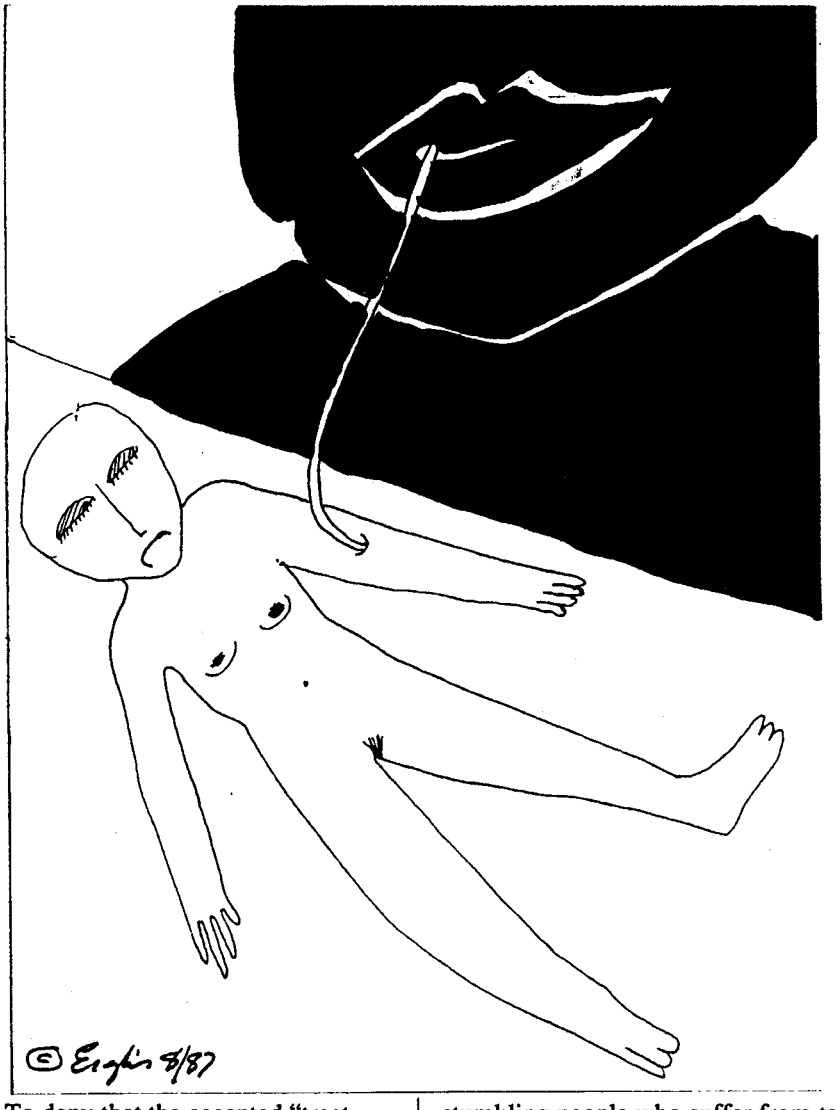
A recent Star Trek re-run told a tale about a sub-class of people who were kept underground and in darkness. It was a story about their struggle to gain the same things that other people need – equality, kindness, and justice. A question about the treatment of these people was posed at a council meeting of the ruling class: "Are we so sure of our methods that we never question what we do?"

I was silenced in the name of mental health, because I could be certified "mentally ill." I know what can happen when a person questions authority, or challenges conformity or normality. I know that people are fragile and can be broken. I know what phenothiazine drugs do to your ability to express yourself. I have no doubt that shock treatment causes memory loss. I know what being caged, prodded, and provoked can do to your spirit.

To victimize us by isolation, lobotomies, shock treatment, toxic drugs, behaviour modification, and experimentation, and then to call us "mentally ill," adds insult to our injuries. Our "no hope" diagnosis – the idea that we are sick and will always be sick and that, while our symptoms may possibly go away, we will never be well or whole – is an abuse.

It's not fair to refer to people who are locked up in institutions, lied to, lied about, and incapacitated as "consumers." "Consumer" sounds terrifyingly close to "useless eater." Except that now we are seen as a valuable commodity that can be used by someone else, for profit.

The annual cost of the psychiatric system in New York State is more than five billion dollars. Imagine if that much money was used to provide an opportunity for equality.



To deny that the accepted "treatment" causes damage is an abuse. To threaten with further "treatment" people who have been so hurt that the streets offer more hope and refuge than the present system is an abuse.

See us. See the people burned out by shock treatment and wiped out by psychosurgery. See the tens of thousands of trembling, drooling, stumbling people who suffer from tardive dyskinesia, a disease caused by psychiatric drugs. See the reality of neuroleptic malignant syndrome, a disease caused by psychiatric drugs, and the thousands of deaths it causes.

Hear us. We are usually not what you call us or what you expect us to be.

For information about The Alliance, see Network, Page 32.

Ex-inmates challenge the APA

More than 30 ex-inmate activists from the United States and Canada attended the Annual Meeting of the American Psychiatric Association (APA) in Montreal May 7-13, 1988. Some of us were there to speak out against psychiatry on May 10, which the APA's program described as a day for "Dialogue with Patients: Differing Perspectives."

In fact, there was little dialogue. There were three low-key, polite panel sessions: "Homelessness and Mental Illness," "Patient Advocacy and Psychiatry," and "Self-Help/Alternative Care Models." There was also a workshop on "How to Build a Collaborative Care/Advocacy Program with Consumers," which many of us avoided, rather than cooperating with our oppressors.

Each panel was chaired by a psychiatrist, and featured five or six ex-inmates. According to APA public relations officer John Blamphin, this year's "panel dialogue" format was deemed "more appropriate" by the APA executive than debates, which the APA has occasionally had with ex-inmates in recent years. Obviously, the APA wants to defuse further criticism of its policies and practices. It was largely successful at this conference. Aside from Suzanne Osgoode's distribution of free anti-psychiatry literature outside the convention centre, and a small public demonstration against drugging kids with Ritalin, there was no real opposition.

A press release condemning the APA and the Canadian Psychiatric Association (CPA) for their complicity in and 30-year silence on Ewen Cameron's brainwashing experiments was distributed. The experiments, conducted at Montreal's Allan Memorial Institute, were funded by the Canadian government and the CIA (see *Phoenix Rising*, Vol. 6 Nos. 1 and 2). The APA told us we couldn't hold a press conference after the panel discussions, since there wasn't space or time for one.

Judi Chamberlin, who spoke on the panel on homelessness, told *Phoenix* that "the APA puts on these presentations about homelessness as if it's some form of psychiatric diagnosis, and as if psychiatrists have the major role to play in solving the problem of homelessness."

We'd do a lot better if we just gave the patients the money and forgot the middlemen.

"Homelessness is not a mental illness," she explained. "People who are poor are caught in a trap that's not at all of their own making. Rents are rising in the United States, yet the Reagan Administration has cut off funds for subsidized housing. Areas that used to be occupied by deteriorating rooming houses and small apartments, which are not ideal living situations, have now been remodeled into expensive condominiums.

"Certainly there are ex-patients who are homeless. They can't find work. They come from families that won't support them. They're on public benefits. In a city like Boston, where I'm from, the average monthly benefit cheque is less than the average rent on an apartment.

"When you're homeless, your behaviour often appears bizarre to others. You have to wear every piece of clothing you own, because you have no place to put it. Your clothes are dirty, because you have no place to wash them. You can't afford clothes that are 'appropriate' for the season.

"Living on the street or in shelters is dangerous; you're afraid of having things stolen. If somebody takes you out of context and administers psychological tests on you, you'll come out looking kind of pathological. If psychiatrists gave these tests to people living in concentration camps, they'd look pathological too. But psychiatric treatment is not the answer."

Rae Unzicker, an ex-inmate activist with the National Association of Mental Patients (Sioux Falls, South Dakota), had this to say on the advocacy panel: "That the question of what advocacy is – and who is a legitimate advocate – is being discussed at this meeting is troubling to me, both as an advocate and as a former mental patient. It's a bit like asking the dogcatcher to consider the rights of animals to run free. Any semi-intelligent cocker spaniel knows

that the local dogcatcher is not her friend, but is indeed her natural enemy.

"When your psychiatrist retains the right to have you committed against your will, that does not lend itself to free and open communication by either person. More services, more staff, and more money has never made for a better mental health system. Personally, I think we'd do a lot better if we just gave the patients the money and forgot the middlemen. The *only* goal of the mental health system should be to put itself out of business.

"Parents and family members are a powerful force, and they would have you believe that they represent the wishes of 'the patient.' This is based on the false assumption that the wishes of mental patients and the wishes of their families are the same. Family members have often advocated to loosen commitment laws and make it easier to force their adult children to receive treatment.

"If you are truly an advocate, you will advocate for what your patient wants – even if you think it's wrong, stupid, or irrational. Because everybody gets a chance to be wrong, stupid, or irrational – including psychiatrists. Psychiatrists are not advocates, and cannot be advocates for their patients. Asking the fox to guard the henhouse – and to do it in a responsible manner – is asking for a Kentucky Fried Chicken dinner."

Between ten and 20 shrinks and a handful of other mental health professionals showed up at each of these "patient" panels. Their questions and comments were stupid, patronizing, and offensive.

Also offensive were the crassly commercial drug exhibits that dominated the conference. The chemical lobotomy experts – multinational drug companies, which always endorse, and largely fund, APA conventions, seminars, and journals – trumpeted propaganda about the "effectiveness" and "therapeutic value" of Haldol, Thorazine, Prolixin (Modecate), and Lithium.

The Thymatron Corporation was also on the brain-damage bandwagon, pushing its shock machine.

Several of the activists decided that we were never going to another APA or CPA event as panelists because, as far as dialogue is concerned, such panels are a farce. If we attend such an event again, it will be to publicly debate about the murderous policies and practices of the psychiatric industry – or to demonstrate against them, out on the street.

Left to right: Nurse Nancy Sheff, activists Don Weitz, Marlene Disher, Ron Disher, and psychiatrist Harold Eist, at the Self-Help: Alternative Care Models workshop. Photo by Brian McKinnon

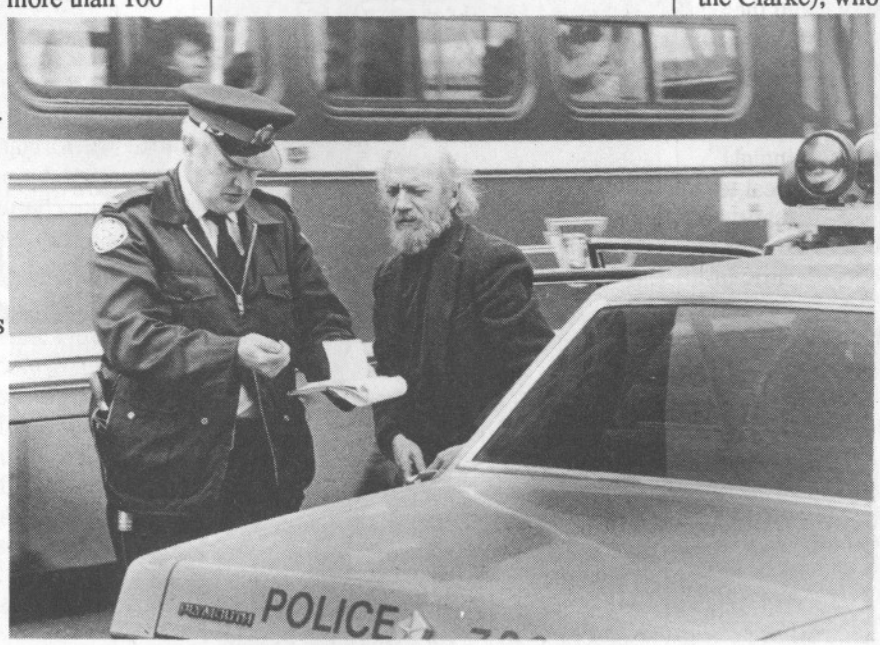
SHOCK WAVES

Toronto Protesters Arrested for Trying to Distribute Shock Information

The Ontario Coalition to Stop Electroshock, On Our Own, and *Phoenix Rising* staged an anti-shock demonstration in front of the Clarke Institute of Psychiatry in Toronto on May 2, 1988.

The Clarke shocks more than 100 inmates every year. As a research centre for biological psychiatry, the Clarke consistently lies to inmates and ex-inmates, our families, and anyone else who will listen about the alleged safety, effectiveness, and benefits of ECT (shock). In their ECT handout for "manic-depressive patients" and their families, the Clarke psychiatrists falsely claim that shock is "no longer frightening," that "there is little if any memory loss," that the "treatment can be lifesaving," and that "ECT is particularly helpful if you are suicidal."

In the past year, Ontario's Ministry of Health has produced three drafts of *ECT: A Guide to Understanding*. The Ministry's "objective and balanced" third draft skips the fact that shock victims suffer brain damage and permanent memory loss. It doesn't even mention that electroshock is a "controversial treatment," even though the Ontario government's ECT Review Committee (1985) said this information was necessary for "informed consent."



Don Weitz gets ticketed for "trespassing." Photo by Konnie Reich

The "guide" also doesn't say that shock is mostly used on women (twice as many women as men are shocked) and elderly people. It claims that "unilateral ECT" (electrodes placed on only one side of the head) "causes less memory loss than bilateral" (electrodes on both sides). In fact, the kind of memory loss suffered may be different, but the severity is the same. The purpose of the "guide" is clearly not to inform, but to ensure "patient compliance."

At the May 2 demonstration, protestors handed out literature on the truth about shock to passersby, many of whom were "patients" or employees at the Clarke and didn't want to hear about it.

One protester approached a bearded man and tried to give him a piece of paper, explaining that the demonstration was against the use of ECT. "I wouldn't read that," he replied. "You are doing a great deal of harm. You are depriving people of a way out of the deepest pain and suffering." It was none other than Dr. Vivian Rakoff (chief psychiatrist at the Clarke), who went on to explain that his father had been stricken with a deep depression last fall and had greatly benefited from shock. Unfortunately, Rakoff's father wasn't there to comment.

Armed with about 30 copies of the pamphlet *Electroshock Facts: Your Right to Know the Truth About ECT*, Jack Wild and Don Weitz – who have both survived shock "therapy" – went up to the eleventh floor of the Clarke, which houses many shock candidates. They approached the head nurse and politely asked her if they could hand out information about shock to some of the "patients." She refused, saying that

doing this would be "against hospital policy." When asked why "patients" couldn't decide for themselves whether they wanted to see the information, she threatened to "call security if you don't leave."

Telling the nurse they wouldn't leave until they'd talked with some "patients," the two sat down in front of the ward elevators, arms linked. Two security guards arrived to deal with this act of non-violent civil disobedience. One called the police, at the head nurse's instructions.

About half an hour later, the police arrived, arrested the two, and charged them with "trespassing" and with "refusing to leave premises when directed." Twenty minutes after being led, unresisting, to the police car, they were released. Each was given a $53.75 ticket.

Weitz and Wild (whose trial was originally set for July 27 but has twice been postponed, and is now set for November 2) will plead "not guilty," and will challenge part of Ontario's Trespass to Property Act as being unconstitutional under the Charter of Rights and Freedoms. They plan to tell the judge that the Clarke violated their rights, and the inmates' rights of freedom of expression and freedom of association, by denying them the opportunity to meet inmates and share information about shock. If they lose in the provincial offences court, they plan to appeal to the District Court and, if necessary, to the Court of Appeal.

Psychiatrists deceive psychiatric inmates, the public, and the media about the destructiveness of shock. No psychiatric inmate in Ontario can give informed consent to electroshock, because none is truthfully informed about it. When "mental health" authorities can – and do – call in the law if someone tries to give inmates real information, it's time to challenge the law.

If you want a copy of Electroshock Facts: Your Right to Know the Truth About ECT, *please send a cheque or money order, payable to* Phoenix Rising, *in the amount of $2 (which includes postage) to: Phoenix Rising, Box 165, Station A, Toronto, Ontario, M5W 1B2.*

The Status of Shock Machines

Marilyn Rice of the Committee for Truth in Psychiatry looks at Classification of the "ECT Device"

The following is excerpted from Marilyn Rice's presentation at a workshop on the Food and Drug Administration at the annual conference of the National Association of Protection and Advocacy Systems, Bethesda, Maryland, June 10, 1988.

In 1976, through the Medical Device Amendments to the Federal Food, Drug and Cosmetic Act, the Food and Drug Administration (FDA) became responsible for assuring the safety and effectiveness of medical devices. The purpose of this legislation may have been to strengthen the hand of organized medicine in putting down "alternative therapies." Certainly it wasn't expected to empower patients to rise up against organized medicine. Yet that is what has happened in the unique case of the "ECT device" (shock machine), to the consternation of the American Psychiatric Association (APA).

Ever since shocking began, patients who have had this treatment have been reporting permanent memory loss, and describing a pattern of loss that is produced only by brain damage. All the while, psychiatrists have been shouting us down and unabashedly assuring the next patient that shock does no permanent harm to memory or to the brain.

The new legislation dropped this long-standing conflict into the lap of the FDA to be settled. Shock had already been a subject of contention in state governments, but now, for the first time, the federal government was involved, and patients had an opportunity to take their case to the top.

The law was only supposed to deal with medical devices, but it is impossible to consider a device separately from the treatment in which it is used. In the case of the shock machine, the treatment was the whole thing.

The doctors say shock is safe, the patients say it's not safe, and the FDA has been trying to duck the issue by proclaiming the particular diagnoses for which it considers shock to be effective.

The Medical Device Amendments of 1976 required a review of all types of medical devices on the market at the time of passage of the law. These already-existing devices were called "pre-amendment devices," and, of course, the shock machine was one of them.

These devices were to be divided into three classes. Class I meant no-risk; Class II, low-risk; and Class III, high-risk. The next step would be to subject each class of device to a different set of control procedures. The actual names of the classes referred to these procedures.

Class I was called "General Controls," meaning that these devices would be subject only to generally applicable laws concerning good manufacturing practices. Class II was called "Performance Standards." These devices were basically safe, but could be harmful if they were out of order or not used correctly. They would therefore be subject to "performance standards" to be developed under the auspices of the FDA, which would assure their safety in operation.

Class III was called "Pre-market Approval." These devices were under a cloud of suspicion that they might be basically *un*safe, and were to go through the same "pre-market approval" scrutiny as devices introduced after 1976.

Nearly two-thirds of the pre-amendment devices went to Class II, nearly a third to Class I. Only a few went to Class III. There was a great deal of tugging and hauling over the shock machine but, to make a long story short, it ended up in Class III.

There was no follow-up to the classification. To this day, performance

standards have not been established for Class II devices, and pre-market approval procedures have not been carried out for Class III devices. Perhaps the original scheme was impossibly over-ambitious. At any rate, there is a bill in Congress right now that would largely absolve the FDA of its unmet responsibilities regarding pre-amendment devices.

Despite the general picture of lack of results of classification, the issue of the classification of the shock machine has remained white-hot, with the APA petitioning for reclassification to Class II, the FDA publishing an official "notice of intent" to reclassify, and patients hanging on like bulldogs to Class III. This struggle continues unabated (see *Phoenix Rising*, Vol. 7 No. 2).

I have been asked why this is so important to patients, since it doesn't seem to have any practical significance. I responded by asking why the questioner thought it was so important to the APA. The answer to both questions is that the backing of the FDA is at stake. The FDA is the United States' highest authority in medical controversies, and the public believes what it says. Neither side is going to let go and let the other side win by default. If the APA can get the shock machine into Class II, or even if the FDA makes a further step in that direction, the APA can blare through the media that the FDA agrees that shock is a safe treatment, harmless to memory and to the brain.

If patients can keep the shock machine in Class III, then we can look forward to a pre-market approval investigation for safety, to establish whether shock is inherently brain damaging. If it is, our objective is truthfully informed consent.

I might point out that if the APA did not think shock was brain damaging, it would allow the shock machine to stay in Class III and let a pre-market approval investigation take place.

You may be thinking that there is no real possibility of such an investigation, since none has taken place for any other pre-amendment Class III device, and since the bill in Congress would allow the FDA to knock all these devices down to Class I. But there *is* a possibility, because patients have fought for and won an exception to the bill: the shock machine is to continue to be regulated by the 1976 law in its original form.

We would have liked the bill to say that the shock machine has to stay in Class III, period.

But a staff member on the relevant committee says they couldn't go that far, because the APA would never permit it. Certainly the psychiatric profession has far more influence with Congress than patients do.

Now, the FDA has a new draft of its "proposal to reclassify" the shock machine, and is expecting to publish the proposal in the *Federal Register*.

A task force of six men was convened to "review scientific publications for the period of 1982 through 1988 to determine if enough scientific evidence exists to cause the FDA to change its initial decision to reclassify." Of course, all the published literature was written by shock doctors or people who get grants from the National Institute of Mental Health (the governmental subsidiary of the APA), and is therefore 100 percent supportive of the APA's safety contentions. So the task force was able to reach its foregone conclusion with the speed of lightning.

I asked the chairperson of the task force, James McCue, whether they considered any evidence on the other side. He said no. I pointed out that the FDA's own files on shock – especially the many first-hand reports of its effects – constitute a fine collection of evidence against the safety of this procedure. He didn't dispute what I said. When I asked specifically whether they had reviewed their own shock files, he again said no. He also said that the wording of this new draft was meant to mollify patients, and told me it was "more supportive of your side than theirs."

But what matters to the APA, and to us, is that publication of the "proposal" means that the FDA is willing to be used by the APA in its campaign to sell shock.

The Class II rating would mean that the FDA is pretending to believe that adherence to performance standards – such as specifications concerning strength of current and size of electrodes – makes shock safe.

For 50 years, shock patients have reported permanent memory loss. In this time, psychiatric journals have run thousands of articles about shock, with brain damage and memory loss as constant themes. In an APA poll published in 1978, psychiatrists were asked whether they thought shock was brain damaging. Most said yes. Still, the public position of the psychiatric profession has always been that shock is harmless.

As one psychiatrist recently explained to a Committee for Truth in Psychiatry member, "If you tell everyone what it will do to their memory, the people who really need it might refuse it."

The FDA should not be collaborating with the doctors in their policy of lying to us "for our own good." Write your views to: John Villforth, Director (HFZ-1), Centre for Devices and Radiological Health, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland, USA, 20857.

The Committee for Truth in Psychiatry can be contacted at Box 76925, Washington, D.C., USA, 20013, or at (703) 979-5398.

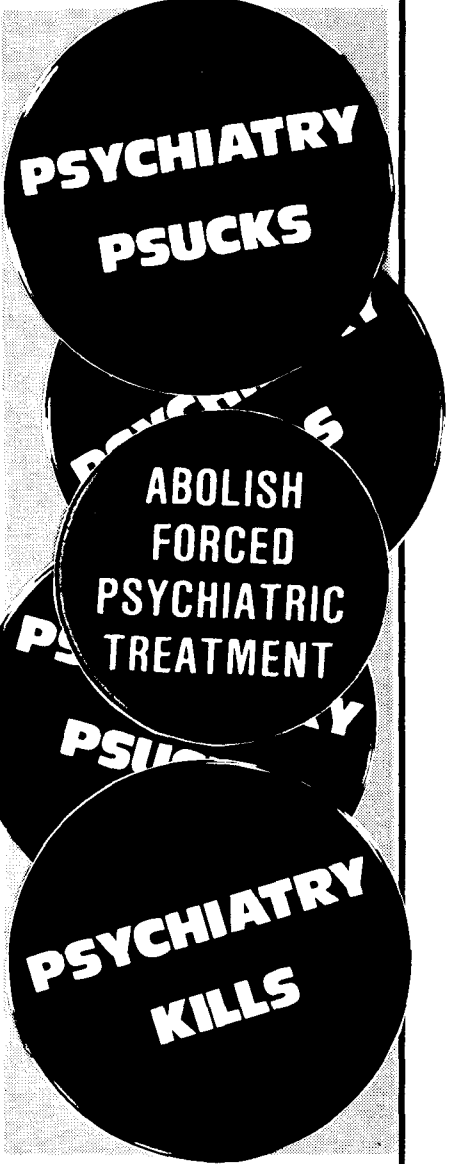
Shocking Stats from Ontario

According to the Information Resources and Services Branch of the Ministry of Health, between April 1, 1986 and March 31, 1987, 355 "patients" in Ontario psychiatric hospitals were given 1,834 electroshock "treatments."

Here's what they got it for: 738 were shocked for "psychosis," 151 for "neurosis," 147 for other (unspecified) psychiatric diagnoses, nine for "organic brain syndrome," and six for "substance abuse."

Only 27 "patients" in general hospitals were reported as having been given shock for "secondary psychiatric diagnoses," but general hospitals are not obliged to report the number of "patients" given shock, so this figure is low.

Let 'em know how you feel!



To order, please send cheque or money order for $2 per button to *Phoenix Rising*, Box 165, Station A, Toronto, Ontario M5W 1B2 . Specify how many of which button(s) you want.

PHOENIX PHARMACY

Propaganda from Merrell Dow

Critique by Irit Shimrat

Merrell Dow Pharmaceuticals is the publisher of *Schizophrenia: Returning Home* – a recent pamphlet on what to do if the black sheep of the family happens to be released from the loony bin.

Here is what Merrell Dow has to say about "side effects" of the precious substance that will keep the Family Member passive and obedient (note the classic ruse of blaming the drug effects on the "illness"):

"Drowsiness tends to be the biggest problem. It is hard to know if the drowsiness is really from medicine or whether it is simply easier to nap most of the day than to face the problems of schizophrenia."

Of course, the really troublesome "side effects" are those that embarrass the folks at home. The answer is simple – either reduce the drugs, or add more drugs:

"Perhaps the most distressing side-effect for families is the 'zombie-like' look that patients on anti-psychotic drugs sometimes develop. It is a combination of slow movements, expressionless face and stiff arms and legs. It goes away when the dose of anti-psychotic drugs is lowered or when 'anti-parkinsonian drugs,' are added. Although the stiffness temporarily looks strange to others, it is not uncomfortable for the patient." Those of us who have taken these drugs (and can still talk) could tell Merrell Dow a few things about this.

"The most worried-about side-effects are the loss of spontaneity and creativity. These may be more side-effects of illness than of drugs. Nevertheless, patients often feel that these empty feelings are due to the drugs they are taking. It is important to realize that these feelings may be, temporarily, a necessary price to pay for staying free of the fear of psychosis. It is important to keep on with the drugs at this stage, to correct those side-effects which are correctable and to endure those which are not."

The price many, many "patients" have to pay to be "free of the fear of psychosis" is being disabled by tardive dyskinesia. How does this pamphlet deal with TD? It doesn't:

"Tardive dyskinesia – a possible late effect of anti-psychotic drug treatment – will be discussed later in this series [of pamphlets]."

Eventually, *Schizophrenia: Returning Home* gets down to brass tacks, recommending coercion:

"Even when not fully stable, a patient can understand that if he constantly disregards family rules, his parents will eventually be forced to act: asking him to move, calling the police, or arranging readmission to hospital.

"Each family will have different guidelines and consequences, but if they are to have any meaning, promises or threats must be followed through. When a patient is out of touch with reality, his intimates must ensure that he receives treatment. Upon discharge from hospital, when the treatment has stabilized the patient's condition, the patient is again in a position to more fully assume responsibility for himself. At this point, what if the patient decides to terminate treatment prematurely because 'There's nothing wrong with me'? One is forced to wait until the person deteriorates before further action can be taken, unless persuasion or bargaining ('If you take your medication, then you can live at home') is effective."

Merrell Dow, of course, makes buckets of money on drugs that cause grave disability, brain damage, and death. *Schizophrenia: Returning Home* clearly means to let The Family off the hook. It does this by promoting the absurd idea that the only way to keep The Patient safe and out of hospital is through the permanent use of Merrell Dow products.

The Truth About NMS

Neuroleptic Malignant Syndrome (NMS) can kill you. It is caused by "anti-psychotic" drugs. It can hit anyone taking these drugs, at any time during the "treatment." NMS is not a rare problem, and it is important to recognize it as soon as possible.

The symptoms of NMS are: fever; stiff, painful muscles; difficulty with swallowing; tremors; jerky movements; sweating; irregular pulse; rapid breathing; raised blood pressure; shivering; dehydration; decreased alertness; tiredness; confusion; loss of consciousness; and kidney failure.

Temperatures of up to 42 degrees Celsius (107 Fahrenheit), are often an early sign of NMS. (See "Neuroleptic Malignant Syndrome," *Phoenix Rising*, Vol. 7 No. 1.)

Tardive Dyskinesia

Tardive Dyskinesia is a major public health crisis. This disabling condition affects many people on anti-psychotic medication, but psychiatrists and the drug industry don't want you to know the real story. For more information, write to: Tardive Dyskinesia-Tardive Dystonia National Association, 600 East Pine Street, Seattle, Washington, USA, 98122, or call (206) 522-3166.

RIGHTS & WRONGS

Advocacy in Psychiatric Hospitals

Don Weitz looks at The Manson Report: Another Ministry of Health Scam

In February 1988, Ontario Health Minister Elinor Caplan announced the release of "Advocacy in Psychiatric Hospitals: Evaluation of the Psychiatric Patient Advocate Office" (1987). This Ministry of Health report on Ontario's five-year-old Psychiatric Patient Advocate program was prepared by a non-government research group, the Centre for Research and Education in Human Services, and a government-appointed Evaluation Committee for the Psychiatric Patient Advocate Office.

Three of the twelve committee members were ex-psychiatric inmates. In 1986 and 1987, the committee received more than 100 submissions, interviewed many mental health professionals, inmates' relatives, and advocates, and held community meetings, which some ex-inmates attended. Right now, there are twelve advocates working in Ontario's ten provincial psychiatric institutions. Only one is an ex-psychiatric inmate. There are no advocates in the province's many other psychiatric facilities.

The 198-page Manson Report's liberal, "balanced" tone prevents it from asserting strong or radical positions. The report favours "non-confrontational" advocacy – gentle persuasion, information-sharing and "conflict resolution," mostly with nurses, social workers and psychiatrists – rather than real, client-oriented advocacy. The few militant advocates who are committed to informing inmates about their civil and legal rights, and helping them assert these rights, are seen as less effective than those who wish to develop cozy relationships with hospital staff. Talk about being out of touch with reality!

The report admits that there is a conflict of interest when advocates who are supposed to be defending inmates of Ministry of Health institutions are accountable to the Ministry. It recommends that advocates report to an independent, "consumer-controlled" board, but goes on to say that advocates should continue to be funded by the Ministry of Health. So the attempt to support independent advocacy (as recommended in On Our Own's 1987 brief "What Advocacy? A Critique of the Psychiatric Patient Advocacy Program") is extremely superficial.

The few psychiatric inmates quoted in the report make it clear that exercising your rights in a psychiatric institution is all but impossible, even where there are Patient Advocates: "You have the right to refuse treatment or to refuse medication, but if you do, staff will often coerce you or say, 'You'll stay here forever.'" "Use [advocacy] as much as you can, but be prepared to be punished if you do." "The staff say you're an informer, a rat, if you go to the advocate." "Sometimes people are afraid; after I went, they gave me ECT; an advocate tried to stop it but couldn't."

The report notes that fewer than half of the advocates now working actually educate inmates about their legal rights. This means that thousands of people locked up in Ontario institutions that have advocates don't know about basic rights, such

as the right to refuse any psychiatric procedure if you are "competent"; the right to sue staff for abuse or assault – including forced drugging and electroshock without consent; the right to leave the hospital at any time if you are "voluntary"; and the right to see and copy your medical records. ("Rights advisors" should be informing all inmates about these rights, but in fact only tell involuntary inmates about their legal status and right to a review board hearing.)

The report recommends expanding the advocacy program to the Homewood Sanitarium in Guelph, the Royal Ottawa Hospital, the Sudbury Algoma Hospital, and Toronto's Clarke Institute. But it doesn't push for advocates on psychiatric wards in the general hospitals, as recommended in On Our Own's brief.

The other recommendations from On Our Own that are ignored in the Manson Report are: that advocates immediately and fully inform psychiatric inmates of their legal rights under Canadian legislation and of the regulations of the institution they are in; that new advocates not be hired before consulting with inmates, ex-inmates, advocacy groups, or coalitions of people with disabilities; and that the term "psychiatric patient advocate" be replaced by the term "psychiatric inmates' rights advocate."

The Psychiatric Patient Advocate Office will probably come under the umbrella of the larger, independent advocacy system proposed for "vulnerable adults" in the 1987 O'Sullivan Report (see "You've Got an Advocate . . . Maybe," *Phoenix Rising*, Vol. 7 No. 2). If this happens, psychiatric inmates should theoretically get stronger, more independent advocacy while locked up or after being released into the community. But don't bet on it. The Ministry of Health and the psychiatrists it employs will do their best to see that the only right advocated for is our "right to treatment" – our right to be brain-damaged, oppressed, and invalidated. Rights advocacy, of course, will be seen as "interference with treatment."

What we need now is self-advocacy, which can raise our consciousness, empower us, respect our right to control our own lives, and support our struggle to be free from psychiatry.

For a free copy of "Advocacy in Psychiatric Hospitals," write to: Communications Branch, Ministry of Health, 80 Grosvenor Street, 9th Floor, Queen's Park, Toronto, Ontario, M7A 1S2. Or, in Toronto, call 965-3101; elsewhere in Ontario call toll free at 1 (800) 268-7540. If you want to phone and you are hearing-impaired, call 965-5130 in Toronto, or toll-free at 1 (800) 268-7095 elsewhere in Ontario.

For a copy of "What Advocacy? A Critique of the Psychiatric Patient Advocacy Program," please send $1.50 (which includes postage) to: On Our Own, Box 7251, Station A, Toronto, Ontario, M5W 1X9, or call (416) 699-3192.

Alberta Amendments

According to the May 14, 1988 *Red Deer Advocate*, a new provincial advocate will help Alberta's "mental health patients" deal with complaints about their treatment. Hospitals Minister Marvin Moore said Alberta's amended mental health act increases the rights of involuntary "patients" and recognizes the Charter of Rights and Freedoms.

"Mentally competent patients" will be allowed to refuse treatment, and a review panel will review their cases. Some people, however, will be treated against their will while the panel reviews their cases. Access to medical records will be improved, but it "won't be easy," says Moore, since "there are many things in a patient's records that may be harmful to the patients themselves." Letters from a family who committed someone, for instance, might "affect a patient's recovery."

MAD NEWS

Ontario Auditor Documents Psychiatric System Mess

A bad situation that's getting worse

According to the "mental health care" section of the 1987 Annual Report of the Provincial Auditor of Ontario, the use of restraints, confinement, and one-to-one observation is on the increase, and the situation is getting worse.

In Ontario, as elsewhere, "mental health" is big business. There are ten provincial psychiatric hospitals, 64 psych wards, 111 other psychiatric facilities, 243 organizations delivering 375 community-based "services," and 466 Homes for Special Care that house 5,000 residents.

Studies cited in the report found that eight percent of Ontario residents received medical services for a psychiatric diagnosis every year, and that 43 percent of the inmates at the provincial institution in North Bay and 25 percent in three other provincial hospitals (not named) "could have been released" if adequate housing and support facilities had been available.

The Ministry of Health employs about 8,200 "mental health" staff. There are about 1,200 psychiatrists in private practice in the community. There are 4,237 hospital beds in psychiatric hospitals, and 2,274 psychiatric beds in general hospitals. In the 1987 fiscal year, $254 million was spent on salaries and employee benefits for workers in psychiatric hospitals.

Apparently, psychiatric hospitals treated "more difficult patients" than previously, and the report noted a "feeling of hopelessness experienced by the staff because of the high readmission rates" and "inadequate staff training related to the management of disturbed behaviour." Furthermore, people are staying locked up longer: the average length of a stint at the Queen Street Mental Health Centre (which is unfortunately not specified) has "increased by eighteen days in the last five years."

Many psychiatric facilities provide an environment which contributes to patient instability.

The report found that many psychiatric hospital facilities were physically sub-standard, with inadequate washroom facilities, temperature control, ventilation, and "patient privacy," and that they provided "an uncomfortable environment which contributed to patient instability and disturbed behaviour."

"The situation," says the report, "is likely to deteriorate further in the near future. . . . The reality of inadequate meals, unsanitary conditions and overcrowding in low standard boarding homes has been a major cause of relapse, leading to high readmission rates in the psychiatric hospitals."

Killing Us Off in Droves

Statistics revealed by Glen Simpson (Manager of Information Consulting Services for the Information Resources and Services Branch of the Ontario Ministry of Health) show that, between April 1, 1986 and March 31, 1987, there were 207 deaths in provincial psychiatric hospitals in Ontario. One hundred and forty men and 67 women died. Fifty-six were less than 65 years old; seventeen were less than 44 years old. Twenty "patient" deaths were reported in psychiatric wards of general hospitals – fourteen men and eleven women. Ten of these people were under 44.

Horny Shrink Exposed

Dr. John Orpin, a psychotherapist, lost a bid not to be named in reporting about his professional misconduct in having sexual relations with a woman "patient." During sessions in his office, Orpin stroked the woman and encouraged her to pull her panties down, hit her buttocks with a belt and with his hand, and ejaculated while she lay on top of him. According to the January 16, 1988 *Toronto Star*, the complainant said he had told her that, for the therapy to work, she had to "fall in love with the therapist." Orpin is allowed to practise while his appeal is pending.

Do-it-yourself Lobotomy

The Hartford Courant of February 24, 1988 reported that doctors said a Los Angeles man who was obsessed with washing his hands cured himself of his phobia by shooting himself in the head. The man was "egged into a suicide attempt by his mother." His own doctor said that the bullet "destroyed the section of his brain responsible for his disabling obsessive-compulsive behaviour without causing any brain damage to the man, a straight-A student." *Physician's Weekly* called the suicide attempt "successful radical surgery."

COPOH

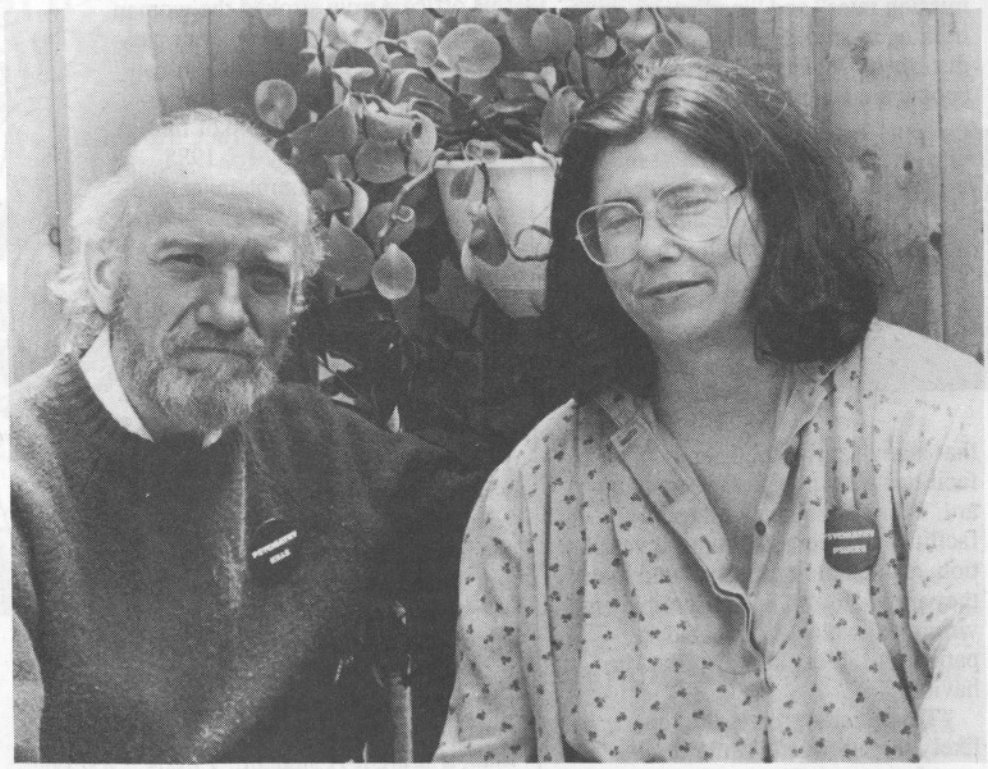
The Coalition of Provincial Organizations of the Handicapped (COPOH) began in 1977, thanks to a handful of super-dedicated people working in the new cross-disability organizations of the four western provinces. (We have resisted the temptation to become just another speck in the turbulence of Ottawa and have remained headquartered in Winnipeg.) As it has grown to encompass the rest of the country (except New Brunswick), COPOH's membership and orientation have also expanded. Many COPOH affiliates find themselves dealing with far-reaching, government-proposed amendments to human rights legislation.

Looking beyond physical disability has helped raise consciousness about other kinds of disabilities. In particular, it has forced us to look at prejudice against the psychiatrized. In the struggle to make discrimination against all disabled people illegal under federal jurisdiction, COPOH-member provincial councils were shocked to hear that a major stumbling block was an objection from the Federal Department of Finance, which was concerned that hiring a psychiatrized employee might jeopardize its security.

When Rehabilitation International met in Canada in 1980, COPOH took a decisive role in helping to form a new, less conservative, United Nations-sponsored organization: Disabled Persons International. During the International Year of the Disabled, we fought to remove the word "physical" from the term "physical disability" in the Canadian Human Rights Code, and to get "disability" included in the Equality Rights Section of the Charter of Rights and Freedoms.

Over the years, our reputation as advocates and our broadly based composition have made COPOH a major influence, and a touchstone for disability groups, service deliverers, and politicians. Our function ranges from supportive efforts to ensuring that the Charter's "equality before and under the law" provision applies to all citizens, and, in particular, that the due process of law be available to those who are not tried or sentenced due to a "mental condition."

For more information about COPOH and our publications – our bulletin, *Info COPOH*, and our new quarterly journal, *Compass*, please write to: COPOH, 924 - 296 Portage Avenue, Winnipeg, Manitoba, R3C 0B9.



***Shrink Resistant* editors Weitz and Burstow. Photo by Konnie Reich**

Shrink Resistant

Shrink-Resistant: The Struggle Against Psychiatry in Canada, will be available in Canadian bookstores very shortly. This collection of anti-psychiatry writings, edited by Bonnie Burstow and Don Weitz, has just been published by New Star Books in Vancouver.

Burstow and Weitz are also planning to produce a book about the struggle against electroshock in Canada. If you have had shock and are opposed to it (or if someone you know is in this situation), please send (or ask them to send) relevant personal stories, statements, poems, or pictures to Don Weitz, 100 Bain Avenue, #27 The Maples, Toronto, Ontario, M4K 1E8.

PAL

Project PAL is a non-profit self-help organization for ex-psychiatric inmates in the area of Verdun, Quebec. PAL's membership includes sympathetic professionals. The group produces pamphlets with information about the civil rights of psychiatric inmates, and arranges social activities organized by ex-inmates. PAL has also initiated a service that will help ex-psychiatric inmates find somewhere to live after being released from institutions. The Lodging Search and Follow-up Resource Program offers to sensitize landlords to the positive qualities of ex-psychiatric inmates as tenants. The program plans to meet with landlords and enquire into their lodgings; to

provide access to information on such resources as used furniture stores; to distribute donated household items; to assist people who need to relocate; to offer courses on household maintenance; and to provide domestic follow-up, as needed. It will serve those who live in Verdun, Ville Emard, Pt. St. Charles, or Côte St. Paul. For further information, contact Lodging Search and Follow-up Resource, Project PAL, 3957 Wellington, Verdun, P.Q., H4G 1V6 (or, in Verdun, phone 767-4701).

OAPP

Ottawa Advocates for Psychiatric Patients (OAPP) is a non-profit organization formed in February 1988. OAPP informs inmates of their rights, acts as an advocate if they have concerns about treatment, and refers homeless or jobless ex-inmates to drop-ins, self-help groups, food banks, grocery programs, sources of free clothes, the Welfare and Family Benefits department, etc. OAPP provides information on getting a social insurance card, a birth certificate, disability pension, free reading and writing classes in English or French, free basic education, and student loans for inmates who want to attend college or university. It also provides referrals to the Unemployment Insurance Commission and to various shelters and agencies.

OAPP is working together with the Ontario Coalition to Stop Electroshock, and corresponds with organizations of ex-psychiatric inmates in Canada and all over the world. It also lobbies the regional, provincial, and federal governments. Finally, OAPP provides confidential consulting services to individuals and organizations, as well as public education workshops on life on the psychiatric ward, the misuse of tranquillizers, special needs and concerns of psychiatric inmates, and how employers and others can better relate to people having emotional problems. If you would like to donate office supplies or money to OAPP, or if you want to find out more, contact Sue Clark at OAPP, 1406 - 1485 Caldwell Avenue, Ottawa, Ontario, K1Z 5L6.

Dendron

For $20 U.S. ($10 for one year, or $5 for six months, if you have very low – or no – income), you can get a year's subscription to *Dendron*, Oregon's radical newsletter about psychiatric abuses, human rights, and alternatives. The rate for agencies, libraries, and organizations with paid staff is $40 for a year's sub. Please make cheques payable to: Clearinghouse on Human Rights and Psychiatry.

Dendron would like to know what you think of the publication, and also wants to know what rights campaigns you think would be a good idea, what strategies have worked for you, and what alternative to coercive psychiatry has been helpful for you or for people you know. Two hundred concerned people eagerly wait for your reply! Write to *Dendron*, Box 11284, Eugene, Oregon, USA, 97440.

The Commitment Papers

The Commitment Papers is a quarterly newsletter published by the Coalition Against Psychiatric Abuse (CAPA). The first issue (Summer 1988) looks at the horrors of shock "therapy," gives advice on how to fight for your rights and how to keep going in the face of conflict, explains who "the brain police" are, and discusses "alternatives to zombie pills." Subscriptions are $12 (U.S.) a year, but no one will be denied for lack of money.

The Commitment Papers is looking for articles, letters, poetry, and artwork. Any submissions should be sent in a stamped, self-addressed envelope. All writing is subject to editing, since space is limited. Donations are gratefully accepted. Please address submissions, donations, subscription orders, or inquiries about CAPA to: Coalition Against Psychiatric Abuse, Box 170407, Atlanta, Georgia, USA, 30317-0407.

CAPE

A new Pennsylvania-based advocacy group, the Committee for Abolition of Psychiatric Experimentation

(CAPE), has been formed by Jocelyn Hollis, Pennsylvania representative of the Committee for Truth in Psychiatry, to stop government-funded experiments on "patients" in mental institutions. The address is Box 2013, Upper Darby, Pennsylvania, USA, 19082.

NARPA conference

The National Association of Rights Protection and Advocacy (NARPA) is holding its 1988 conference in Portland, Oregon, October 26 to 29. The main issues to be discussed are electroshock (ECT), implementation of the U.S. Protection and Advocacy law, and outpatient commitment. Canadian ex-inmate activists Carla McKague, Linda Macdonald, and Don Weitz – all shock survivors – will participate in the conference together with several U.S. activists, and dissident psychiatrists Peter Breggin and Thomas Szasz. For more information, write to: Lynda Wright, NARPA, c/o Oregon Advocacy Centre, 310 SW 4th Avenue, Suite 625, Portland, Oregon, USA, 97204, or phone (503) 243-2081.

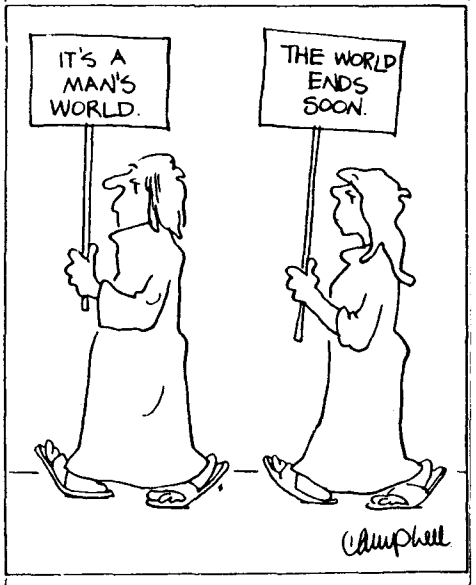
Broads on Bay Street

The Alliance for Non-Violent Action (ANVA) is a coalition of progressive groups and individuals in Ontario and Quebec who are committed to non-violent civil resistance as an important means to confront injustice and oppression. The ANVA Women's Caucus is planning a day of non-violent resistance called "Broads on Bay Street" for International Women's Week (March 1989).

Who are we? "Broad" is a word used by men to degrade us. We take back the word. We are strong women. We are angry women. We are Broads. Bay Street is the emotional heartland of Canadian capitalism – a home to many businesses whose primary interest and function is to maintain a *status quo* that translates into poverty, pollution, and war. The act of shutting down Bay Street will do much more than stop traffic. It will give us a space to raise our voices against women's oppression. If there is a particular issue you would like to focus on, please feel welcome to do that. We are working on research, putting together educational materials, and getting the word around that the action is happening. We are also seeking endorsements from groups and individuals.

Come join us. When lots of women act together, we can move mountains – and men.

For more information, to endorse the women's day of resistance, or to make a financial contribution, please write to: The ANVA Women's Caucus, Box 235, 253 College Street, Toronto, Ontario, M5T 1R5, or phone (416) 533-9507, 469-4736, or 533-0819.



The Alliance

In January 1987, the Alliance (formerly the Mental Patients' Liberation Project) received a grant from the state legislature to open an Advocacy, Education, and Social Centre in Syracuse, New York. We recently formalized a long-standing agreement with Hutchings Psychiatric Centre to give its inmates access to advocacy.

The Alliance Peer Advocacy Service provides client-centred, rights-oriented, confidential, free advocacy to people in Hutchings. We deal with involuntary treatment, public benefits, housing, employment, education, and alternatives to civil commitment. We help people speak out, and we offer advice, assistance, companionship, information, referral, and representation.

We are reaching out to the larger community to recruit and train lay advocates. We hope to create such services at other facilities in our area, and to train advocates to reach agreements with other institutions.

You can contact the Alliance at 826 Euclid Avenue, Syracuse, New York, USA, 13210, or at (315) 475-4120.

Activists for Alternatives

The mental health system is responding to the increasing evidence of its failure with a concerted effort to consolidate and expand its power. Homeless people in New York City are being taken to Bellevue and psychiatrically "treated" against their will and in violation of their rights. Many are sent to a special unit at Creedmoor Hospital for long-term warehousing. The Office of Mental Health in New York State is in the process of re-introducing electroshock into the state mental hospitals, without any public discussion.

Activists for Alternatives rejects the idea of "mental illness," opposes any kind of involuntary psychiatric "treatment," and calls for the immediate abolition of electroshock. We are ex-psychiatric inmates, commonly known as "mental patients," as well as professionals and others who support ex-inmates.

We want to be a networking forum and clearinghouse for self-help and advocacy groups and to let ex-inmates rediscover their power through social activism.

To find out more, contact Dr. Seth Farber at (212) 799-9026, or write to: Activists for Alternatives, Box 20651, Columbus Circle, New York, New York, USA, 10023.

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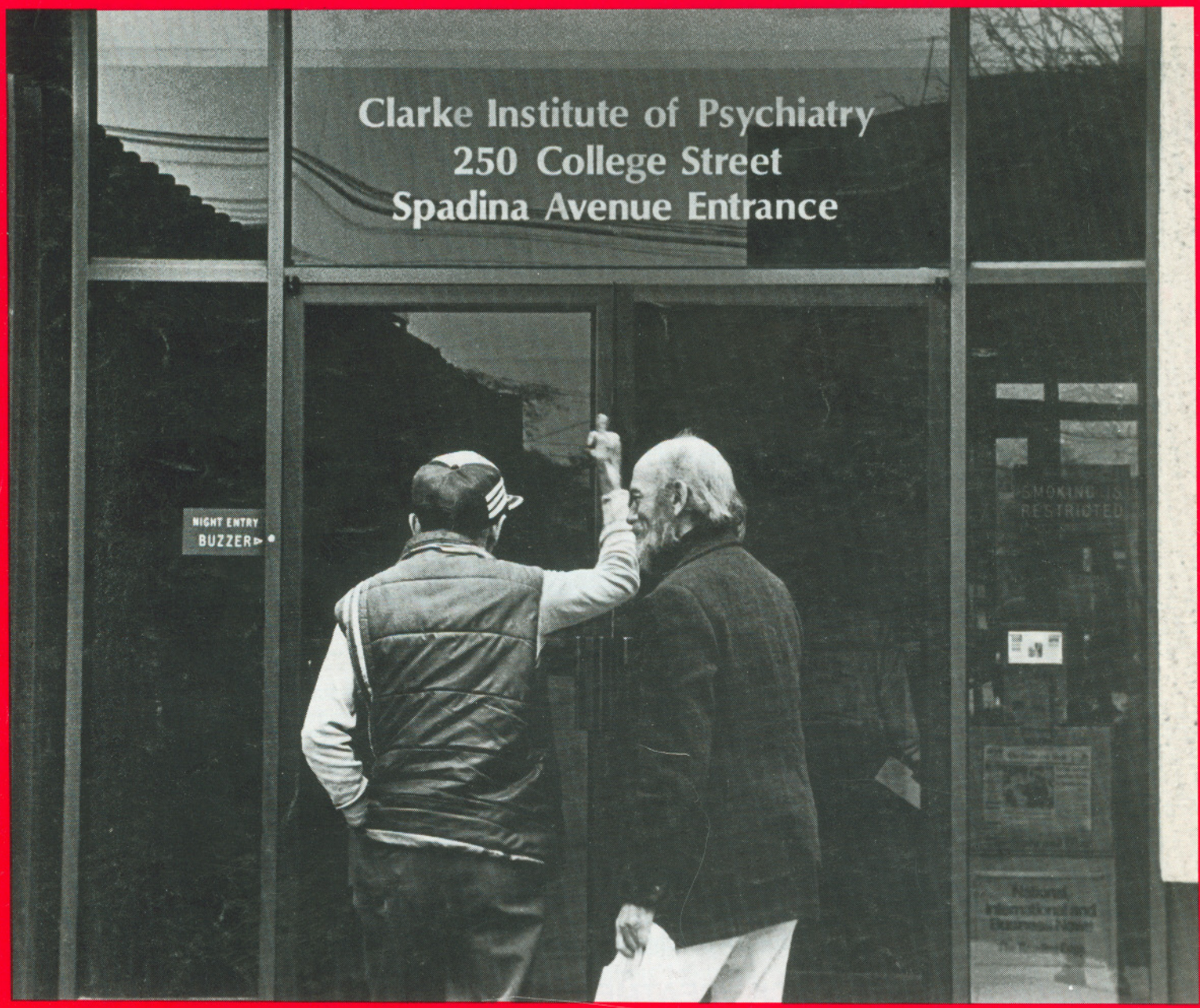
In the heart of enemy territory . . .



Ex-inmate activists set out to tell the terrible truth about shock at Ontario's most prestigious psychiatric institution. See story on Page 22. Photo by Konnie Reich