

# phoenix rising

The Outspoken Voice of Psychiatric Inmates

*Lewis De*

Summer 1980, Vol.1 No.2

\$1.50

**PRISON PSYCHIATRY**

**THE SMITHKLINE**

**BOYCOTT**

**BLINDNESS:**

*more than meets the eye*



## ANTIPSYCHIATRY DIRECTORY

We have been informed of some changes to the directory of antipsychiatry groups and publications which appeared in the last issue of *PHOENIX RISING*. Our thanks to those who supplied this information.

If you can help us further update this list by informing us of other additions, deletions or changes, please write: Group List, *PHOENIX RISING*, Box 7251, Station A, Toronto, Ontario, Canada M5W 1X9.

The changes to date are as follows:

### DELETIONS

*AMERICAN ASSOCIATION FOR THE ABOLITION OF INVOLUNTARY MENTAL HOSPITALIZATION LAMP (Center for the Study of Legal Authority and Mental Patient Status)*

### ADDITIONS

*"A FAMILY THAT CARES"*, 1014 Cornwell Pl., Ann Arbor, MI 48104  
*AMERICANS AGAINST PSYCHIATRIC AND PSYCHOLOGICAL ABUSE*, c/o Aquilla Fitzgerald, 600 Sisalbed Ct., Seat Pleasant, MD 20027  
*ASSOCIATION FOR THE PRESERVATION OF ANTI-PSYCHIATRIC ARTIFACTS*, Box 9, Bayside, NY 11361  
*ASSOCIATION QUEBECOISE POUR LA PROMOTION DE LA SANTE*, c/o Claude Labrie, 5285 Rue Aurèle, St.-Hubert, Québec J3Y 2E8  
*CONNECTICUT LEGAL SERVICES, INC.*, 87 Main St., Box 1156, Norwich, CT 06360  
*COORDINATION INTERNATIONALE RESEAU: ALTERNATIVE A LA PSYCHIATRIE*, Ave. Louis Bertrand 39, Bruxelles, Belgium  
*ELEMENTAL-UNION FOR PSYCHIATRIC CHANGE*, Box 153, Waverley, NSW, Australia 2024  
*FREEDOM FOR ALL*, 690 Albany Ave., Hartford, CT 06112  
*LEAGUE AGAINST CRIMINALLY OPPRESSIVE PSYCHIATRY*, Florida State Hospital, Box 1000, Chattahoochee, FL 32324  
*MADNESS ADVOCACY AND DEFENSE*, Box 361, South Orange, NJ 07079  
*MENTAL PATIENTS' ALLIANCE*, 198 W. First St., Oswego, NY 13126  
*NETWORK AGAINST PSYCHIATRIC ASSAULT*, c/o Edith Schreiber, 5998 Woodland Dr., Rt. 3, Waukegan, WI 53597  
*NETWORK AGAINST PSYCHIATRIC ASSAULT/WOMEN AGAINST PSYCHIATRIC ASSAULT*, 1744 University Ave., Berkeley, CA 94703  
*NETWORK: ALTERNATIVES TO PSYCHIATRY*, c/o S. Marcos, Apdo. 698, Cuernavaca, Mexico  
*PATIENTS RIGHTS COMMITTEE (COMITE DES DROITS DES MALADES)*, c/o Civil Liberties Association, National Capital Region, 14 Metcalfe St., Suite 302, Ottawa, Ontario

*PROTECTION OF THE RIGHTS OF "MENTAL PATIENTS" IN THERAPY*, c/o 25 Seymour Bldgs., Seymour Place, London W.I., England

*PROTECTION OF THE RIGHTS OF "MENTAL PATIENTS" IN THERAPY*, 11 Ottershaw House, Horsell Rd., St. Mary Cray, Kent, England

*PSYCHIATRIC ADVOCACY AND RIGHTS ASSOCIATION*, Box 84, Leonia, NJ 07605

*QUEBEC PATIENTS' RIGHTS ASSOCIATION*, 9555 Plymouth Ave., Town of Mount Royal, Québec H4P 1B2

*WERKGROEP KRANKZINNIGENWET*, c/o stichtung 'Pandora', 2e Constantijn Huijgensstraat 77, Amsterdam, The Netherlands

### CORRECTIONS AND CHANGES (change underlined)

*ADVOCATES FOR FREEDOM IN MENTAL HEALTH*, 4448 Francis, Kansas City, KS 66103

*ALLIANCE FOR THE LIBERATION OF MENTAL PATIENTS*, 1427 Walnut St., Philadelphia, PA 19102

*BAY AREA COALITION FOR ALTERNATIVES TO PSYCHIATRY*, 944 Market St., Rm. 701, San Francisco, CA 94102

*CAMPAIGN AGAINST PSYCHIATRIC ATROCITIES*, Box 6899, Auckland, New Zealand

*MENTAL PATIENTS' LIBERATION PROJECT*, Box 158, Syracuse, NY 13201

*MENTAL PATIENTS' RIGHTS PROJECT*, 84 Fifth Ave., New York, NY 10011

*PROJECT OVERCOME*, 265 Fort Rd., St. Paul, MN 55102

*PROJECT RELEASE*, Box 396, FDR Station, New York, NY 10022

*PROJECT RENAISSANCE*, 39 Carnegie Ave., #105, Cleveland, OH 44106

*PSYCHIATRIC INMATES' RIGHTS COLLECTIVE*, Box 299, Santa Cruz, CA 95061

*STATE AND MIND*, Box 89, West Somerville, MA 02144

*SUPPORT FOR WOMEN IN MADNESS*, c/o Las Hermanas, 4003 Wabash, San Diego, CA 90405

*WASHINGTON NETWORK FOR ALTERNATIVES TO PSYCHIATRIC DEPENDENCY*, Box 23943, L'Enfant Pl. Station, Washington, D.C. 20024

# phoenix rising

The Outspoken Voice of Psychiatric Inmates



Through the fire

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

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# Being an inmate...

As promised in our first issue, we're continuing the dialogue on the meaning and experience of being an inmate, including psychiatric inmate.

An inmate, according to a recent edition of the *Random House Dictionary*, is "a person who is confined in a hospital, prison, etc.". The "etc." includes "mental hospitals and other involuntarily entered institutions in which people's daily lives are totally controlled by the authorities."

People in prison and psychiatric inmates are deprived of many of the same civil and human rights. These include freedom of movement; the right to vote; the right to communicate openly with anyone; the right of free access to public information; the right to privacy and confidentiality; the right to wear one's own clothes; the right to refuse any treatment or program; the right to be treated with dignity and respect; and the right to appeal any abuse or violation of these and other rights while locked up.

In theory and law, this right to appeal exists in some provinces and states, but long delays in the appeal procedure, difficulties in obtaining a lawyer, and lack of access to an independent ombudsman or citizens' grievance committee make this right token or non-existent.

In addition, people judged to be suffering from a "mental illness" and about to be involuntarily committed to a psychiatric institution are automatically denied the right to *due process*--more (continued over)



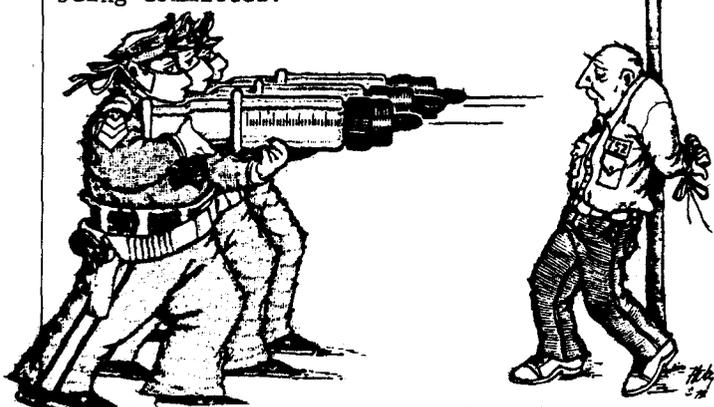
Insane asylum cell,  
circa 1880

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Cover photo by Arnold Bruner

recognized and protected in the United States than in Canada. They're denied the right to legal counsel before and during commitment procedures. Due process is the legal right to a trial or public hearing *before* loss of freedom. People accused of criminal acts are routinely given their day in court before imprisonment. However, people who have committed no crime but have been judged "insane", "psychotic", "suicidal" or "dangerous" by one or two psychiatrists are routinely denied the right to defend their sanity in court before being committed.



Prisoners are traditionally given a fixed, definite sentence; they know when they will be released. Involuntarily committed inmates generally do *not* know this. And voluntary inmates have no guarantee of being able to leave when they wish to; if they refuse to cooperate, they can be made involuntary within minutes. In these respects the psychiatric inmate has fewer legal rights than the regular prisoner.

Both prisoners and psychiatric inmates are victimized by forced "treatment". Unlike medical patients, inmates have no right to refuse *any* psychiatric treatment, many of which are dangerous and damaging (see this issue's *Phoenix Pharmacy* for one example). Refusal can easily be overridden by an appeal to a review board; it is often interpreted as just another symptom of the inmate's "mental illness". And even when the inmate does consent, it's laughable to call such consent either voluntary or informed, as required by law. Institutional staff rarely, if ever, inform the inmate of the risks of or alternatives to the treatment.

Regular prisoners are often placed in "behaviour modification" programs, some of which are described elsewhere in this issue. Some-

times prisoners, especially those judged to be rebellious, ring-leaders, or trouble-makers, are used as guinea pigs in dangerous and even life-threatening psychiatric experiments utilizing, for example, drugs such as scopolamine and anectine, or "aversive conditioning". The prisoner's refusal to cooperate can lead to longer imprisonment or doing "hard time".

The inmate who is probably the most abused and discriminated against is the person who is committed to a psychiatric institution through the criminal process, either as "unfit to stand trial" or as "not guilty by reason of insanity", under a lieutenant-governor's warrant. They share with the civilly committed psychiatric inmate the uncertainty about when, if ever, they'll be released, and with the regular prisoner the lack of protection against the routine use of damaging experimental psychiatric treatments.

To call people "patients" when they are locked up and treated against their will is not only insulting, but a lie. Euphemisms such as "mental patient", "mental hospital" and "mental illness" obscure the facts: that "mental hospitals" are in fact psychiatric prisons; that the institutional psychiatrist is actually a judge-jury-warden; that psychiatric "treatment" is a form of *social control* over uncooperative or non-conforming people whose lifestyles (usually working class) are too different from or threatening to that of the upper-class white psychiatrists; that terms such as "diagnosis" and "treatment" are



1980  
**BACK ISSUES**

In case you missed them...

**FUSE**

"4 **INUIT TV:** Inuit bring satellite communications to the north; Quebec referendum overview. The Martyrdom of "Saint Joseph Beuys; Museums and the New Media; Multilingual TV; Status of Women Artists; plus reports and reviews on books, film, video distribution & tapes, performance, and exhibitions.

"3 **WEST & EAST:** The Art of the State in East Europe and North America; Experimental Film at the Funnel Film Theatre; French high school in Ontario, English for Immigrant Workers; The Invisible Economy; Analysis of the way news-magazines wrap-up the decades; CTV: Racial attack on Asian Students; plus new records, publications, videotapes, exhibitions, books.

"2 **DEVELOPING FEMINIST RESOURCES:** The work of artists Carolee Schneemann & Martha Rosler; The Quebec Referendum & the Media; SPECIAL INSERT: The Second Independent Video Open, 1979 - Reviews & Reports on the 29 Winning Videotapes; Censorship within the Feminist community; plus Film, Music, Performance & Exhibitions.

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fraudulently applied to non-existent "mental illness"; and that psychiatric "treatment" is frequently experienced as punishment.

We are not "patients". We share with our brothers and sisters in prison the experience

of being an inmate: loss of freedom, loss of civil and human rights, loss of control over our own bodies and minds, and stigmatization for life.



# write on

Since our first issue of PHOENIX RISING hit the streets, we've had a tremendous response from people all over. Our first mail-in subscriber was Mayor John Sewell of Toronto. We already count among our subscribers such diverse groups as the Canadian Human Rights Commission, Nellie's Hostel, and--believe it or not--the Queen Street Mental Health Centre.

Space doesn't permit us to reprint all the letters that were sent to us, but we have reprinted the following ones as an indication of the range of responses we received.

Not all reaction has been favourable, however. We have included for your interest a review of our publication by ACT/ACTION, published in Syracuse, New York, and our response to it.

Congratulations on the first issue of PHOENIX RISING. We found it to be well written and attractively designed. It seems like an amazing accomplishment after only 3 months of work. In particular WCREC is pleased to see a real concern in PHOENIX RISING for the special problems women face: from over-prescription of tranquillizers to the swamping of women's hostels in Toronto.

--Women's Counselling, Referral and Education Centre, Toronto

It's great! Packed with lots of useful and titillating information as one would expect from such an elite group.

--Gail Czukar, former staff person for mental health/ontario

PHOENIX RISING is most impressive. The articles and layout are good, and the cover is excellent. The compact Anti-Psychiatry Directory is handy and we have made several photocopies. The profile piece on MPA is accurate and fair. I'm sure it will bring us a spate of new correspondence.

--Marilyn Sarti, office co-ordinator, Mental Patients Association, Vancouver

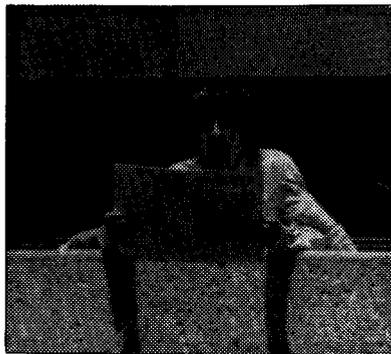
Carefully done and interesting. With a quarterly publishing schedule you should stand an excellent chance of maintaining or surpassing the early established quality.

--Barry Zwicker, publisher of Content, Toronto

Please accept my congratulations on an absolutely fantastic publication. I am extremely

impressed with the articles written, the quality of the articles, the points of view expressed, and last but not least the physical quality of the publication. I believe that this will be a most valuable publication not only to present and former psychiatric inmates but also to the community at large, both professional and non-professional. A publication like yours has been long needed and it is a joy to see that it has been accomplished.

--Carmen Scheben, administrative assistant, Parkdale Activity and Recreation Centre, Toronto



A typical enthralled and astounded PHOENIX RISING reader

Tony Myers

I read with interest the article entitled "Rights for the Handicapped: Psychiatric inmates need not apply", and there are several matters I would like to draw to your attention.

Firstly, the article states that the Minister was not at the meeting on March 24th. In fact, Dr. Elgie did attend the meeting briefly and subsequently sat down with the Coalition representatives to discuss their concerns at two other meetings which I know he found useful and productive.

Secondly, it is quite true that there was considerable discussion about the inclusion of present mental illness in the definition of "handicap", but, in my opinion, the discussion

was fruitful. As the Minister said in the Legislature last week, the definition will be expanded to include past, present and perceived physical disability, mental illness, mental retardation and learning disability.

Finally, the article was incorrect in reporting that George Ignatieff was the Assistant Deputy Minister who attended the meeting on March 24th. It was I and not my uncle, George, who was at that meeting.

--Nicholas Ignatieff, Assistant Deputy Minister, Program Analysis and Implementation, Ontario Ministry of Labour

(Our apologies to Mr. Ignatieff for confusing him with his uncle, and our thanks for pointing out our error about Dr. Elgie's brief appearance at the March 24 meeting. For an update on the situation, see the What's Happening section of this issue.)

(The following comments appeared in ACT/ACTION last month. Our response follows.)

PHOENIX RISING--the new magazine of ON OUR OWN . . . is excellent. . . . In case you are wondering On Our Own used to be the Ontario Mental Patients' Association which became the Ontario Patients' SELFHHELP Association and this new name change was inspired by Judi Chamberlin's book "On Our Own." . . . (Of course they can publish a fancy dancy magazine because they got money from some church--they didn't raise it themselves like ACT/ACTION does.)

OFF THE SHELF is another new magazine . . . . The Editor . . . has copyrighted all the material which prevents it from being disseminated by other groups through their little publications. ACT/ACTION does not copyright our material and we freely and eagerly suggest that you use and re-use our material for the benefit of all suffering people. Phoenix Rising is also copyrighted. I think this shows clearly where both of these magazines are coming from and I personally do not intend to subscribe to either one.

Dear Sister Burghard:

Thank you for commenting in ACTION that PHOENIX RISING is excellent. We certainly have no complaint about that assessment.

We do have a quarrel, though, with a couple of your other comments about the magazine. Our "fancy dancy" magazine is, so far as physical appearance goes, almost entirely the work of one unpaid typist (who fits this job into a very busy life) and one underpaid half-time editor, who is also responsible for circulation, advertising, a lot of the writing, and joe jobs in general. The "money" we got from "some church" looks after her half-time salary and our postage bills, with very little left over. And we worked damn hard to get that money, as well as the other money it takes to put out the magazine and support all the

other activities of our group. (We are not, you should be aware, just putting out a magazine.) We don't know, and it's none of our business anyway, what your financial position is, but 80% of our members are on public assistance and would have trouble kicking in enough for a few stamps, let alone the production of the magazine.

As far as the fact that we're copyrighted is concerned, what that means is that we want to have a little bit of control over who reprints our stuff, not that (as you may be implying) we intend to change anybody for reprinting it. ACTION or any other legitimate movement publication is entirely welcome to reprint anything they want--all they have to do is ask.

## GIVING THEM THE BIRD

In this issue we are instituting two awards, to be given periodically to deserving recipients.

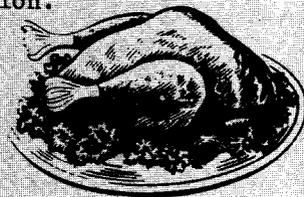
The *PHOENIX PHEATHER* will be awarded to an individual who has in our opinion made a courageous and significant contribution to bettering the lot of psychiatric inmates. The *TURKEY TAIL* will go to someone who has shown outstanding lack of understanding of the position of psychiatric inmates, or has contributed to making their situation worse.



Our *PHIRST PHOENIX PHEATHER* goes to Judge Kenneth Langdon of the Provincial Court in Brampton, Ontario. In June, Judge Langdon refused to send a man found not guilty by reason of insanity on a weapons charge to a psychiatric institution, calling such incarceration "cruel and unusual punishment" ruled out by the Canadian Bill of Rights. (The man involved had been judged not dangerous, and therefore could not be committed civilly.) His decision will be appealed to the Supreme Court of Ontario, and probably eventually to the Supreme Court of Canada. Thank you, Judge Langdon, for a brave and informed decision.

Our *FIRST TURKEY TAIL* goes to Dr. Jack Griffin, former director-general of the Canadian Mental Health Association and a strong proponent of shock therapy.

Dr. Griffin wins his *TURKEY TAIL* for his statement at this year's mental health/ontario annual meeting that giving a psychiatric inmate his choice of therapy was comparable to giving a suicidal person his choice of instruments with which to kill himself.



But there are some people we don't want using it, and a copyright is one way of protecting ourselves.

If you'd like to support the production of an "excellent" magazine, I suggest you change your mind and subscribe. If you and a lot of people like you don't, then we'll have money for the postage, but we won't have anything to put it on.

I will soon be celebrating my third year as an ex-psychiatric patient, but when I look back on my eight years of treatment, I remain disgusted with the things I have seen pass for "therapy" by "professionals".

I am certain that my experiences as a patient are not uncommon. I am also sure that mine are mild when compared with others' experiences. I hope that through this letter, others will be able to see similar things happening or having happened to them and realize that they are not alone.

I began my career as a patient at age fourteen. My parents had me referred to a school psychologist at the request of my school's vice-principal. I agreed to see this gentleman simply because I felt I needed some help and was receiving none from my family. My eldest brother had been beating me up for several years and my parents had done nothing to stop him, claiming that he couldn't be doing the things I was accusing him of. However, things had changed over the past year and my brother had begun choking me while beating me. I lived in fear of being killed while no one was listening or doing anything to change the situation.

In one and a half hours, the psychologist I saw laid seeds which were to fester and affect all treatment I received over the next eight years. He never bothered to ask what my problem was. Instead, he decided to run tests on me. Looking back, I see that his "test" was ridiculous. Based on my answers to questions such as whether I preferred blue or pink, whether I liked boys' games or girls', whether or

not I desired to go out with boys and other such things, the psychologist decided that I was a lesbian. I dislike pink, would rather play boys' games, did not have a boyfriend and was afraid of boys--no small wonder with a brother like my own.

He talked to my parents about his findings and recommended that I see him again--I refused. However, a year later, I became a psychiatric out-patient after being referred by another psychologist to the hospital. The

***“He was more fortunate... he held the power.”***

school psychologist's findings were forwarded to the hospital staff. Rather than assisting me with my brother--who was continuing to physically abuse me--the psychiatrist decided to treat my sexuality as the problem.

For seven years he "treated" the same "illness". I had never desired to sleep with women but this did not seem to matter. My psychiatrist decided, based on his observations that I wore blue jeans (like most teens my age), had straight hair, did not wear make-up and was afraid of men, that I must be assisted with becoming more "feminine".

When I resisted him, or asked him to deal with the real problem of my brother's beatings, he refused--I was hostile, resisting treatment, and needed stronger medication. Slowly, I came to doubt myself and think that perhaps I was a lesbian--after all, this doctor seemed to think I was and he should know. But I refused to discuss this topic with him because I still felt the most important topic was my brother. My refusal led to both he and I becoming angry. He was more fortunate than I--he held the power. That I was angry at him and the hospital for their inability to help and because of the control they held over patients was taken as a "symptom of my illness". I was then labelled paranoid schizophrenic--paranoid because I thought the hospital was hindering rather than helping me, and schizophrenic because I was not accepting their ideas about my problems and treatment.

My dosage of pills was also increased. My refusal to take them became a symptom of my illness, and I was threatened with withdrawal of treatment if I chose not to take them (very strange when I was supposed to be so "sick" and in need of treatment).

I took the pills like a "good patient" and was allowed to continue treatment. I continued, however, to try to get them to help

*continued page 35*

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# ON OUR OWN

"C'mon, people, buy something! Give us your MONNNEY!" That's Alf Jackson barking at customers strolling by our flea market booth in Weston. Alf's booming carny voice can be heard all over the market--the customers and vendors love it, and the many great bargains we offer.

Our flea market business has been going for two-and-a-half years, thanks to a few dedicated volunteer members such as Alf, John

Craven and John Gallagher. (All three are directors on the ON OUR OWN board.)

It all started back in November of 1977, when the group (then called the Ontario Mental Patients' Association) had no financial support and was only three months old. Alf, a founding member, had the idea of starting and managing our own flea market operation, and quickly convinced most of the members, and Bill Riordan, manager of the Sheppard Flea Market (originally at Yonge and Sheppard, now in Weston). Alf's reasons were obvious and basic: "To make money to keep the group going; to get the group involved so they'd meet the public and become aware that they're just as good as the public, and be able to communicate."

The flea market has largely succeeded in meeting these objectives. In a little over two years, working only on Saturdays and Sundays, members have raised over \$15,000. All the money has been used to pay group expenses, including expense money for the volunteers helping out in the booth. In February and March of this year we raised roughly \$2,000 selling good quality sheets and pillowcases (generously donated by Toronto's Sheraton Centre) at fantastically low prices. Alf fondly recalls, "We sold everything from soup to peanuts, except we didn't have the soup." At one time or another, our booth has sold beds and linen, electrical appliances, motors, jewellery, furniture, sports equipment, ad-

ding machines, clothes, toys, records, knick-knacks, hundreds of books and magazines, and a few antiques. Most of the stuff was donated. Nobody ever undersold us; in fact, other dealers buy from us.

John Gallagher and John Craven have been working in our booths for about two years. They've learned a lot from Alf, and from just selling and meeting people in the flea market.

John Craven remembers how he first got involved with Alf back in the winter of 1977-78. "It gave me something to do, talking with people as they came up. I enjoy dealers and wheelers, just meeting people. We've got some

pretty good stuff up there, and I hope to make a deal and money--not for myself but for the group. I feel it's better to help others than myself, but I'm also helping myself by doing

## "Give us your MONNNEY!!"



*Alf Jackson (back to camera) and John Gallagher (right) with some satisfied flea market customers.*

it." John's now helping himself and the group in his new position as Co-ordinator of Volunteers.

Shortly after John Gallagher joined the group in the spring of 1978, he wanted to "contribute to the group. I was determined to go up to the flea market and start working there. I was very nervous at the beginning. I'd never sold anything before; I'd never dealt with the public. I felt unsure of myself and lacked confidence. I missed that social contact, talking with people.

"When I first went up to the flea market, I thought I would read a book whenever I wanted, or watch other people sell. The big surprise was that it was mainly the customers who taught you the business."

One of John's surprises was a lesson in

*Members of ON OUR OWN were shocked to hear of the sudden death on May 27 of one of our members, Mary Lou Stephens.*

*Mary Lou, a good personal friend of many of our members and a caring and understanding person, was a student of social work at Ryerson Polytechnical Institute. She was a person who had a great love for children, and volunteered to teach them at a Toronto recreational centre.*

*A dedicated member of ON OUR OWN and of OUR PLACE, she will be sadly missed by members of both groups.*

financial responsibility. "I remember Alf told me a few times, 'John, whatever you do, make sure you look after the cash box.' And I said, 'OK, OK.' Then he left the booth to get a coffee or go to the washroom. All of a sudden I decided to go to another stand and talk with a dealer.

"Alf came back and hid the cash box. Then he walked away again, and I didn't know it. When I went back and looked around for the cash box, I had a heart attack 'cause the cash box wasn't there. I thought someone had stolen it. That's learning responsibility, and I'll never forget it."

John still volunteers in the booth on Saturday. He's also been holding down a steady full-time job with an electronics company for

John Gallagher, and recently Fran Ruckevina, no other members are involved. Probably the chief obstacle is fear. Alf believes most members are "still shy and afraid. They're not used to the street."

John Craven cites fear, and some members' inability to make independent decisions, as major stumbling blocks. "A lot of people are scared to talk with people. When you're



Members interested in working in our flea market booth, and people wishing to donate articles to sell, should call 362-3193.

almost a year--partly because of the greater self-confidence and self-assertiveness he developed selling in our booth. John is now President of ON OUR OWN.

Alf claims that some people who come to our stall to rap, buy or browse have also decided to become supporters or members, or even to get a job. "We've got two or three people back on the streets again; they've got jobs."

Continuing support for our flea market operation has come from manager Bill Riordan and his family, as well as from other vendors. Alf proudly recalls "the acceptance we found even during our first week with the dealers. Nobody was against us." A sharp contrast to the discrimination and rejection which most psychiatric and ex-psychiatric inmates have experienced in the community.

However, there's still the nagging problem of recruiting members to work in the flea market booth. Except for Alf, John Craven,

locked up in Queen Street or the Clarke, you're doped up all the time. It's hard for you to make decisions for yourself because you're regulated--you're told what to do, what you can't do. That's the problem with a lot of people when they come out of hospital; they haven't had the opportunity to think for themselves. You've got to want to do things for yourself, to be more active. You can't shut yourself off from the world; you've got to learn."

John Gallagher feels that if more members got involved with the flea market, they'd learn some valuable things about themselves. "If they find out they can do it, they may even want to start their own stand."

As Alf once said, "We're the ones who have faith--we've been there and back." And you better believe it.

## Cashing in

Monday, June 2nd, was a very special day--that was when we opened The Mad Market, our first non-profit used goods store and small office.

We decided, at Len Lorimer's suggestion, to name the store The Mad Market mainly to satirize the traditional "mental illness/mental patient" myths and stigmas, and also to let the public know who we are--mad like a fox.

Roughly fifty people showed up for the grand opening--members, supporters, friends, curious shoppers and the press--to browse, rap, buy some stuff, have a free cup of coffee, and wish us well. There was (and is)

A BIG THANKS TO THE FOLLOWING PEOPLE FOR MAKING THE MAD MARKET HAPPEN:

Jean Belasco	Ernie LaRose
Jody Braybrook	Cheryl Manuel
Joe Clark	Carla McKague
Nancy Connor	Cathy McPherson
John Craven	Tony Myers
Blanche Dineen	Susanne Partridge
Dave Fanning	Des Robinson
Gerard Giroux	Diane Savard
Hersel Green	Alison Sawyer
Nathan Hutchinson	Susan Steele
Alf Jackson	Glen Walters

And a special thanks to Bob Errett and Len Lorimer, who designed, made and hung our great store sign.

lots of good merchandise in the store: furniture, clothing, antiques, fine china, books and records (including many old 78s in mint condition). We made a little over \$60.00 on opening day; by the end of the second week, our total sales added up to an amazing



*Tony Myers*

\$1,560.58! In one day we earned enough to pay one month's rent and utilities. A great beginning!

The credit for the successful opening goes to a lot of people, all ON OUR OWN members. They generously volunteered to do many necessary and sometimes frustrating or backbreaking jobs: finding a suitable location; reviewing and signing the lease; building the wood frame for the washroom (the toilet finally works after a month's comedy of errors and maddening delays); building bookshelves; picking up donated goods; pricing merchandise; designing, making and hanging the store sign; selling; setting up the office; distributing flyers; and contacting the media.

The media, incidentally, played a big part (for a change) in giving us some favourable publicity. The Toronto Sun, Star and Globe & Mail all ran short articles about the store and the group; the Sun piece was a big help, since it came out on the Friday before the Monday opening. CBC-TV, CBC Radio in Winnipeg, and a Vancouver radio station all got into the act by running spot announcements and interviews. Yes, the first few days were a glorious madhouse.

Like the flea market, The Mad Market has the objective of equipping unemployed, relatively unskilled members with valuable business and social skills which can help them find and

keep jobs. Inexperienced and experienced people will be working (in fact, some already are) side by side, sharing with and learning from each other while building up their confidence, self-respect and dignity—all denied or stolen while they were in "mental hospitals" or "sheltered workshops".

But, unlike the flea market, the store will also help create real jobs for unemployed inmates out of the money raised through sales. Very shortly The Mad Market will also be

The Mad Market needs more volunteers to sell, repair appliances and furniture, clean, and help on the van. Any members interested, and anyone wishing to donate goods, should call 362-3193. Our present store hours are 10 a.m. to 7 p.m., Wednesday to Saturday.

selling merchandise produced by psychiatric and former psychiatric inmates; most of the money will go to the producer or creator. All volunteer members who work in the store, in the flea market, in the drop-in or on the van are paid expenses only. It's not a wage yet, but the expense money makes it possible for

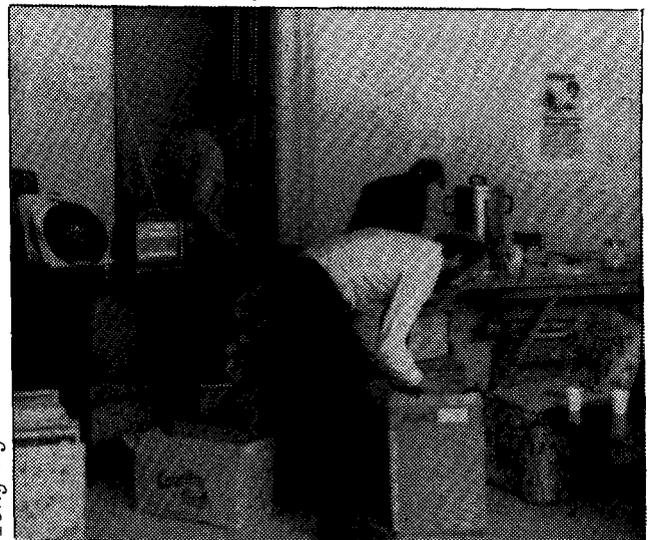
many members who are on government assistance to participate.

We're encouraged enough by store sales so far that we're already hiring someone to fill our first new job—a half-time bookkeeping position. Six of our members applied for this job, and by the time this magazine is published one of them will already be working.

In the Mad Market, you might find a



*Tony Myers*



*Tony Myers*



Hard Rock Returns to Prison  
from the Hospital for the  
Criminal Insane

by *Etheridge Knight*

*Reprinted with permission from State and Mind 6:1 (1977).*

Hard Rock was "known not to take no shit  
From nobody," and he had the scars to prove it:  
Split purple lips, lumped ears, welts above  
His yellow eyes, and one long scar that cut  
Across his temple and plowed through a thick  
Canopy of kinky hair.

The WORD was that Hard Rock wasn't a mean nigger  
Anymore, that the doctors had bored a hole in his head,  
Cut out part of his brain, and shot electricity  
Through the rest. When they brought Hard Rock back,  
Handcuffed and chained, he was turned loose,  
Like a freshly gelded stallion, to try his new status.  
And we all waited and watched, like Indians at the corral,  
To see if the WORD was true.

As we waited we wrapped ourselves in the cloak  
Of his exploits: "Man, the last time, it took eight  
Screws to put him in the Hole." "Yeah, remember when he  
Smacked the Captain with his dinner tray?" "He set  
The record for time in the Hole--67 straight days!"  
"Ol Hard Rock! man, that's one crazy nigger."  
And then the jewel of a myth that Hard Rock had once bit  
A screw on the thumb and poisoned him with syphilitic spit.

The testing came, to see if Hard Rock was really tame.  
A hillbilly called him a black son of a bitch  
And didn't lose his teeth, a screw who knew Hard Rock  
From before shook him down and barked in his face.  
And Hard Rock did nothing. Just grinned and looked silly,  
His eyes empty like knot holes in a fence.

And even after we discovered that it took Hard Rock  
Exactly 3 minutes to tell you his first name,  
We told ourselves that he had just wised up,  
Was being cool; but we could not fool ourselves for long,  
And we turned away, our eyes on the ground. Crushed.  
He had been our Destroyer, the doer of things  
We dreamed of doing but could not bring ourselves to do,  
The fears of years, like a biting whip,  
Had cut grooves too deeply across our backs.

# MINDS BEHIND BARS

by Carla McKague

“There are no adequate drugs to "treat" the kinds of conditions for which we send people to prison. There is, therefore, no justification for drug therapy. This does not mean that drugs may not be used for purposes of social control, but that presents a different order of question in a different argument.

What is clear is that we must not allow drugs to be used for social control while pretending that their use is therapeutic.

*Willard Gaylin and Helen Blatte, "Behavior modification in prisons", 13 American Criminal Law Review 11 (1975), p. 33.*”

Why do we have prisons? Originally, prisons were meant as punishment for people who had done something wrong. Over the years they have come to be seen in other ways as well. The names we use for them are revealing--"penitentiary", "reformatory" and "correctional centre", among others. Their main purpose, we say, is not to punish people but to rehabilitate them, and turn them into good, productive citizens who will then live happily ever after and not rob us, assault us or murder us any more.

Unfortunately, they don't work. People continue to come out of prison and merrily go on robbing us, assaulting us or murdering again. It is no secret that prison of-

posite of what it is intended to learn newer and better ways In a desperate attempt to their intended function, our and more sophisticated and habilitate offenders. New the- constantly making their appearance. that kind of environment, or elec- apy. But the proportion of people no change, no matter what tech-

There is a second problem too. What do we do with an offender who has been judged to be "insane", and thus not responsible for his criminal act? Or with one who is "unfit to stand trial"? We are not, we claim, heartless enough to send an insane person to jail. Such people belong in hospitals, where they can be cured and released--or, in the case of unfitness, sent back to stand trial now that they are capable of understanding what is going on. We even set up special hospitals for these people who are "criminally insane".

Unfortunately, they don't work either. And the consequences for the person sent to such a hospital are, in one respect at least, even worse than for the person sent to prison. The reformatory or penitentiary inmate has a fixed sentence, a date by which he knows he will be free. The prisoner adjudged "insane" or "unfit" has no assurance of ever getting out, because he is to be kept there until he is "cured", whether that be a month or fifty years.

In either situation--the prison or the hospital for the "criminally insane"--our society seems to feel that, since what we are doing is meant for the good of the inmate, no holds are barred. No technique is too bizarre or too intrusive for us to justify. Many such prisons and hospitals go much further than any ordinary hospital would dare to go with civilly committed patients;



*The Black Dragon*

us until they find themselves back in ten teaches its inmates exactly the op- teach; from one another they of committing mayhem. make the prisons perform society has developed more complex ways of trying to re- ories and methodologies are con- Perhaps this drug will work, or troshock treatment, or group ther- returning to prison shows little or nique we try.

for the criminal justice system

According to a recent story in the *Toronto Globe and Mail*, over 750 Canadians are presently being held on lieutenant-governor's warrants, about 300 of them in Ontario. (In contrast, Nova Scotia has only two people held on warrants, and Prince Edward Island has had none in the last five years.) One Saskatchewan man has been held for 42 years--since 1938--as unfit to stand trial for a killing.

this can probably be attributed to a feeling that these people are wrongdoers, and a little pain and suffering won't hurt them--a hangover of the "punishment" ethic.

Some of the most blatant excesses have taken place in the United States. Consider, for example, the Patuxent Institute in Maryland.

It was established in 1955 to treat "defective delinquents". People convicted of certain sorts of comparatively serious offences, or of any two offences punishable by imprisonment, are sent to Patuxent for assessment, and about two-thirds of them are kept there.

Patuxent works on the "graded tier" system, whereby an inmate can, through good behaviour, earn more and more "privileges" until he reaches the fourth and highest tier. The fourth tier is very pleasant. The prisoner can, for example, decorate his own cell as he pleases, and go on picnics with his family, and there is no set "lock-up" time.

However, a journalist who visited Patuxent in the early 1970s provides this description of other parts of the program: "[T]he inmate spends his first thirty--and more often sixty--days on the bottom tier, where he is deliberately subjected to the unalloyed punishment of solitary lock-up, held virtually incommunicado in a nine-by-six foot cell for almost twenty-four hours a day, denied books, letters, visitors, allowed but one shower a week. His promotion through successive levels is at the pleasure of

[A] prisoner should not be subjected, while in prison, even though willing, to ECT or any other form of medical treatment that is in the least degree controversial. ...Psychosurgery is probably the most controversial of all forms of medical treatment currently practiced, and it is therefore a method that should in no circumstances be used on prisoners. ...[I]t is not a generally accepted medical opinion that castration or hormonal demasculinization are effective treatments for sexual offenders, and... these are therefore questionable methods for dealing with prisoners.

*"Health aspects of avoidable maltreatment of prisoners and detainees". Prepared for the Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders (Toronto, September 1975).*



The Black Dragon

of the treatment staff, who may also demote him at whim." In a case which resulted from charges filed by sixteen inmates of Patuxent in 1971, the court described conditions in parts of Patuxent as "contrary to the rehabilitation of the inmates and serv[ing] no therapeutic value of any kind." As well, many of Patuxent's inmates serve longer than their original sentences.

The California Medical Facility at Vacaville has used many different sorts of procedures on its "criminal" inmates, including electroshock therapy, antitestosterone injections ("chemical castration"), major tranquillizers, and aversion therapy. In particular the facility has been criticized for its use of the drug Anectine (succinylcholine). An inmate guilty of fighting, threatening, stealing, deviant sexual behaviour, or just plain unresponsiveness to group therapy is given an injection of the drug, which produces severe physical reactions including the stopping of breathing for about two minutes. During that two minutes, while the prisoner goes through all the sensations of suffocating or drowning, he is lectured on how to behave. Dr. Arthur Nugent, the chief psychiatrist at Vacaville in the early 1970s, admitted that he "wouldn't have one treatment myself for the world", but added, "I'm at a loss as to why everybody's upset about this." Vacaville doctors have also expressed eagerness to get into psychosurgery on "violent" inmates.

Marion Federal Prison in Illinois has had some problems

### NO COMMENT

The social therapy technique developed by the Oak Ridge Division of the Ontario Mental Hospital at Penetanguishene is the most promising known for assisting offenders in self reformation. This technique should be introduced into both maximum and medium security institutions immediately to the extent that it is possible to separate entirely the inmates in social therapy from the rest of the prison population. New institutions should be built with the need for small completely contained units in mind.

*Report to Parliament of the Sub-Committee on the Penitentiary System in Canada. Ottawa: Ministry of Supply and Services Canada (1977), pp. 121-122.*

with the courts over its Control Unit Treatment Program, introduced in 1972 to deal with prisoners involved in a work stoppage. It consists of nine-by-twelve-foot solitary confinement cells, including some special cells known as "boxcars". These are concrete cells within a larger metal shell, which are almost completely sound-proof and are lit only by one sixty-

### BOXCARS

watt bulb and a little sunlight which penetrates the narrow slit in the door. They result in extreme sensory deprivation. (Experiments which have been conducted with paid volunteers in similar surroundings have shown that after only a few hours of such deprivation, begin to hallucinate and suffer extreme emotional effects--so much so that most volunteers refused to continue the experiment for more than a day or two in spite of generous pay.) The Marion inmates spend up to 23½ hours a day in these cells. Elsewhere in the unit, other behavioural techniques are used, including forced heavy drugging and electronic surveillance. In the first six years of the Control Unit, eight inmates committed suicide, and a ninth died of a heart attack after six years in solitary.

[In the psychiatric ward of Kingston Penitentiary] I was informed that I would be compelled to take shock treatments to justify my remaining a patient. If I refused, I would be transferred back to the hole to finish off my two years of solitary. Accepting what I thought might be the lesser of the two evils I ended up getting jolted into oblivion on Tuesday and Thursday each week.

*Roger Caron, Go-Boy! Memoirs of a Life Behind Bars, p. 202. Reprinted by permission of McGraw-Hill Ryerson.*

All around me [in Oak Ridge] were human vegetables rendered "tame" through the use of frontal lobotomy operations in which neurosurgical drills killed a part of the brain that was thought to trigger violence. In reality they were reduced to bona fide zombies. The more subtle method of reducing violent activity was through the use of experimental drugs which were given to the patients on the violent ward four times a day. ...The first two weeks I was made to swallow twelve pills a day, half were medication for my wound, while the rest were bug pills. The result was massive muscle spasms every thirty seconds, from the top of my head on down to the tips of my toes, so violent that I was unable to rest or even think clearly--all of which left me very shook up.

*Roger Caron, Go-Boy! Memoirs of a Life Behind Bars, p. 213. Reprinted by permission of McGraw-Hill Ryerson.*

In a 1973 case, a court described the "boxcars" as cruel and unusual punishment, and ordered them closed. Another 1978 case agreed, saying that the use of the boxcars was "unconstitutional". However, the program itself was allowed to continue.

The warden of Marion admitted that the purpose of the Control Unit was not rehabilitation, but "to control revolutionary attitudes that are prevalent in the prison and in the society at large." And an independent psychiatrist who testified at the 1973 hearing said that the program, far from doing good, actually did harm. "The setting and its organization," he said, "demeans, dehumanizes and shapes behavior so that violent behavior is the result rather than the cause... the organization and operation of the setting produces or accentuates frustration, rage, and helplessness."

In 1975, the U.S. Bureau of Prisons halted behaviour modification programs in all prisons under its control. What happened, however, was that the programs, including the one at Marion, went right on operating; the operators just stopped calling them "behaviour modification".

### THE CANADIAN STORY

It would be nice to think that all these problems are south of the border, and that we in Canada are more enlightened. But unfortunately that is not the case. We have our own horror stories here.



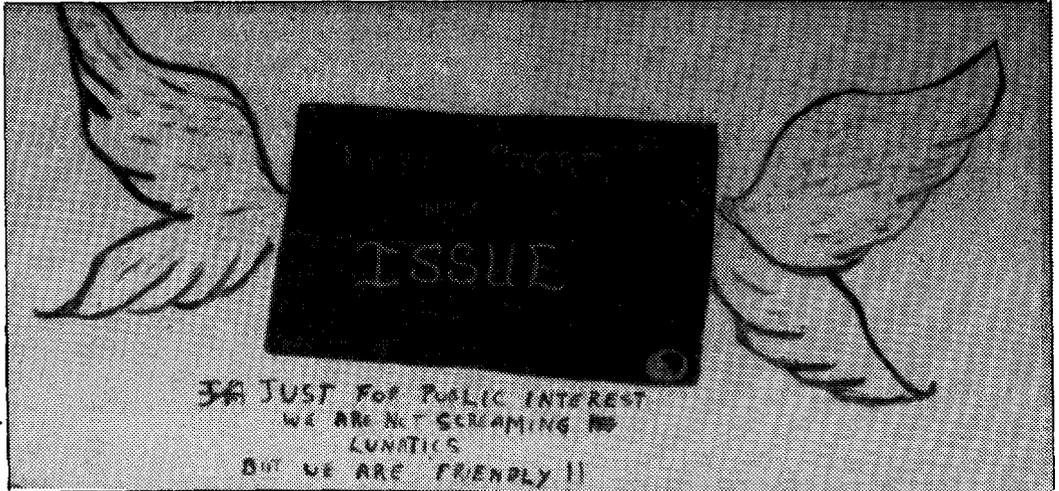
*The Black Dragon*



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Take Kingston Penitentiary, for example. Kingston has a staff of six full-time and part-time psychiatrists, six psychologists, eighteen social workers and twelve nurses. Of these, two psychologists have the task of dealing with the problems of the general prison population of over 350 inmates. The remaining psychologists and all of the psychiatrists, social workers and nurses spend almost all of their time dealing with a small handful of violent sexual offenders in something called the Special Treatment Service. The techniques used vary, but they include aversive conditioning--for example, the applying of an electric shock to the leg of an inmate who becomes sexually aroused by a picture of a naked child.

Or how about the Oak Ridge Division of the Ontario Hospital at Penetanguishene? Oak Ridge is a hospital for the "criminally insane" which in 1972 introduced a massive experiment--the Social Therapy Unit. It consists of three wards arranged in a hierarchy. On the first



Sign painted over a door at Oak Ridge.

Arnold Bruner

ward, newcomers are subjected to an intensive introduction to psychological concepts, and are not allowed to speak. Once indoctrinated, they move on to a highly structured program at the next level. Refusal to participate results in the inmate's being sent to the MAP program (Motivation, Attitude and Participation) until he shapes up.

At the top of the heap is F Ward, a setting designed to work on the inmate twenty-four hours a day. According to the originators of the program, mental illness is "essentially an inability to communicate", and everything is done that can be to encourage communication. Methods involve dyads or triads (locking inmates up together in twos or threes and ordering them to talk to one another), drugs such as alcohol, LSD and scopolamine, the deliberate inducement of "freak-outs", and, above all, the Total Encounter Capsule.

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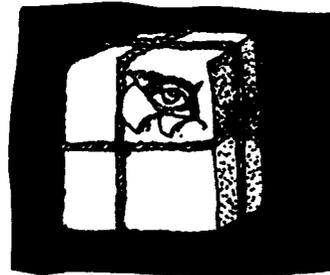
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The Black Dragon

### THE TOTAL ENCOUNTER CAPSULE

The Capsule is a small, windowless room, equipped only with a sink, a toilet, and a television monitor for playing back

videotapes of what goes on in the room. Small groups of patients spend up to two weeks naked in this room, eating from straws pushed through the door. The Capsule is often used in conjunction with drugs in an effort to force inmates into breaking down communication barriers.

Some of the Oak Ridge techniques, such as the psychological indoctrination and the MAP program, are also used at St. Thomas Psychiatric Hospital in a special ward there. One big difference is that the St. Thomas program is co-educational, while Oak Ridge takes only men. The program is limited to violent people, and, like Oak Ridge, sets out to be "therapeutic" twenty-four hours a day. Inmates spend almost all their time in ward meetings, group therapy sessions, or dyads. Those in the MAP program, who are being disciplined for non-cooperation, according to a recent newspaper report pass most of their day "sitting side-by-side on the floor of a small room, backs against the wall, feet straight out in front of them, and hands by their sides--many of them staring blankly, and silent." When they escape from this immobility into therapy sessions, they are deliberately badgered and provoked into discussing their behaviour.

The plight of civilly committed inmates in Canada is often bad enough, but many of the techniques used on our "criminally insane", or just plain "criminal", would not be tolerated by the public for a moment if they were employed in public hospitals. Somehow the fact that prison psychiatrists are dealing with "bad" people seems to be taken as justification for almost anything.

The time is long overdue for a serious consideration of what goes on in the psychiatric wards of our prisons and hospitals for the "criminally insane". There is no evidence that treatment programs work, and there is clear evidence that they violate almost every human right of the participants. They are seldom voluntary, and at best voluntary in name only; how much choice does a prisoner really have when he is told that if he doesn't participate in a particular program, he probably won't get out for a long, long time? They are often highly experimental and dangerous.

The fact that someone has committed a crime, particularly a violent crime, gives society a perfect right to protect itself against that person by incarcerating him. But it does not give us a licence to play dangerous and ineffectual games with his mind for an indefinite period of time, and call it "therapy".

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# At the lieutenant-governor's pleasure

By Kathleen Ruff

**E**merson Bonnar was 19 when he tried to snatch a purse from a woman on a street in Fredericton, New Brunswick. For that one offence he has been locked up for the past 15 years. He's now 34 and still in a maximum-security ward for the criminally insane. When I sat down with Emerson Bonnar behind double-locked doors at the Provincial Hospital, a mental institution in Campbellton, N.B., just before Christmas, his question was: "When will I be let out?" I wished I could answer that question. The truth is no one knows.

Emerson Bonnar was the youngest of eight children in a poor New Brunswick family and was receiving voluntary psychiatric treatment at the Saint John General Hospital. After the purse-snatching attempt he elected trial by magistrate and pleaded guilty. Before sentence was passed, Dr. Robert Gregory of Saint John General Hospital testified that the youth was a "moron" and "could have been suffering a delusion as a result of insanity" at the time of the offence. Dr. Gregory added: "This fellow has been of no trouble previously."

Solely on Dr. Gregory's expert testimony the magistrate ruled that Bonnar was unfit to stand trial because of insanity and ordered him held "at the pleasure of the lieutenant-governor," which means for as long as the provincial government wants to hold him—or forgets about him. The hearing took 20 minutes. Bonnar had no lawyer. He didn't even get the chance to say a word. Had he been considered sane, he would have received, at worst, a few months in jail. Because he was labelled unfit to stand trial he was locked away for the next 15 years. He is still locked up.

The piece of paper that keeps Bonnar locked up is called a lieutenant-governor's warrant. It means that a person considered unfit to stand trial, or not guilty because of insanity, is put away in a mental institution "at the pleasure of the lieutenant-governor." As Professor Hans Mohr, formerly with the Law Reform Commission of Canada, says: "The lieutenant-governor is never pleased." Several hundred Canadians are being held under lieutenant-governor's warrants across the country. Because no term is set, a person doesn't know if he'll ever get out. What's certain is he's far worse off than if he had been found guilty and received the harshest sentence the court could impose. The only way out is to get a review board of government-appointed doctors and lawyers to state that the individual has recovered and recommend release. Even then the government can reject the recommendation and refuse to rescind the warrant.

Ironically, locking up a person under such a warrant is not intended to be punishment. Supposedly it is for the good of the person and the good of society. Orville Endicott, co-ordinator of legal services with the Canadian Asso-

ciation for the Mentally Retarded, disagrees: "Locking up a person in an institution offends fundamental human rights to have, as far as possible, freedom to come and go and to have control over one's own life. It depersonalizes them and puts them at the mercy of institution employees who come to regard them as cattle."

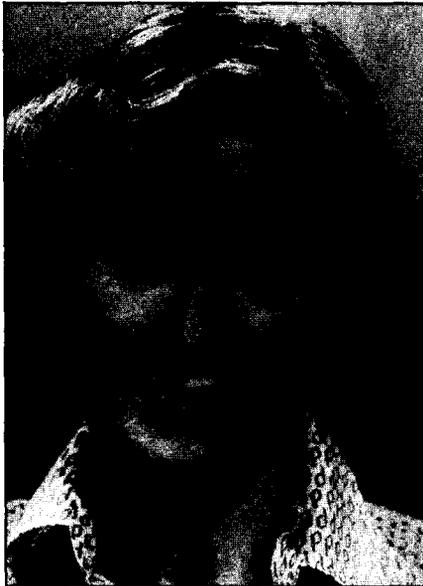
Rights the rest of us take for granted, even the right to have a say over the kind of medical treatment we will be given, do not exist for such people. Neither Bonnar nor his mother, Bessie Bonnar, is consulted or even told what drugs he is given, why he must take them, and what effects they might have.

Human beings, like Bonnar, are held under lieutenant-governor's warrants until they are re-labelled "recovered," all the while locked up in abnormal, dehumanizing circumstances. As Bessie Bonnar says, "It's a bad place to be. I couldn't survive there one day. Nobody's ever cheerful as far as I can see." To keep Bonnar there has cost at least \$500,000 in tax money. Imagine the good that much money could do to provide community support services to help people with mental problems stay with their families and live and work in their communities.

Lieutenant-governor's warrants strip mentally ill and mentally retarded persons of their legal and medical rights, their dignity and their privacy, turning them into "nonpersons." Four years ago the Law Reform Commission recommended that the federal government abolish this barbaric system. Nothing has been done. The commission recommended that mentally ill persons be returned to the regular legal system, standing trial with lawyers and advocates to protect their interests. If found not guilty, the individual would be set free. If guilty, then individual mental health would be considered in determining the appropriate penalty. But at no time would the penalty be more than that usually levied for the crime. Bessie Bonnar has used her great energy and meagre financial resources for 15 years to fight for her son's release—to no avail.

Such fights should not be left to individuals. Groups such as the Canadian Association for the Mentally Retarded and the Canadian Mental Health Association must take the advocate role for people such as Emerson Bonnar rather than continue scooping coins out of the fountain for their charitable projects. The CAMR is currently moving toward such advocacy and is trying to help Bonnar while also gathering information on like cases in other provinces. Maybe it could go further and make Bonnar's case a test in the courts to win restitution for 15 lost years from a man's life.

The question Bonnar asks will be heard elsewhere. "When will I be let out?" How will we answer?



*'Locking them up isn't supposed to be punishment'*

Reprinted by permission of the writer.

*Kathleen Ruff is a former director of the British Columbia Human Rights Commission, and the host of CBC-TV's Ombudsman until its cancellation by the CBC this spring.*



# phoenix pharmacy

## THORAZINE AND OTHER PHENOTHIAZINES

The phenothiazines--more commonly known as "major tranquilizers" or "anti-psychotic drugs"--are probably the most powerful and dangerous psychiatric drugs in existence. Some critics (inmates included) call them "chemical straitjackets", "chemical strong-arms" or "chemical lobotomies". However, their advocates--virtually all psychiatrists--prefer to call them "medication", "psychotropic drugs" or "chemotherapy".

Almost all psychiatric inmates are given these drugs, and experience their many serious effects.

Some of the most commonly prescribed phenothiazines are Thorazine (chlorpromazine); Stelazine (trifluoperazine); Mellaril (thioridazine); Moditen, Modicate or Prolixin (fluphenazine); Trilafon (perphenazine) and Etrafon (perphenazine and amitriptyline).

The "chemical revolution" in the treatment of the "mentally ill" began in the early 1950s, when Thorazine was first discovered and used. During the 1960s and 1970s, chemotherapy became psychiatry's treatment of choice.

However, these drugs are extremely dangerous, generally toxic, and sometimes fatal. When given in even low or moderate dosages for a few months, the phenothiazines exert almost total control over the person's physical and emotional life. Most people taking these drugs quickly become so weakened and apathetic that they are incapable of expressing any strong emotion or of showing spontaneity or direct action. People suffering these "side effects" may become convinced that they are really "going crazy" or "psychotic", particularly if they have not been informed that the reactions are caused by the drugs.

The phenothiazines produce many unpredictable non-muscular and muscular effects.

### Common non-muscular effects

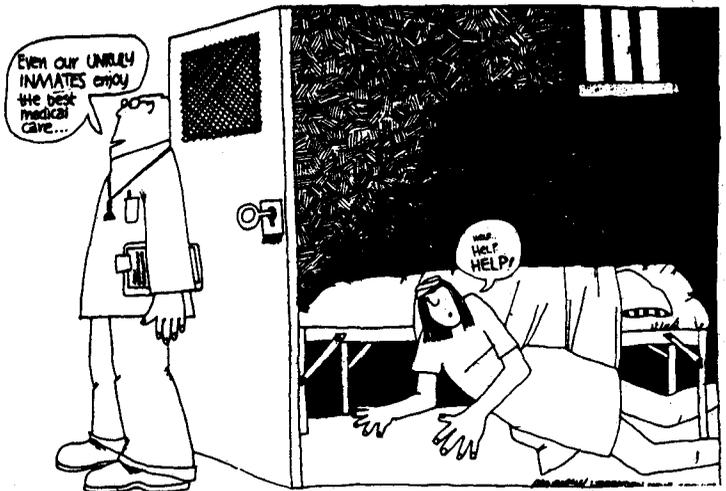
Drowsiness. Extreme fatigue, sleepiness and lethargy. This tends to be interpreted by psychiatrists as "uncooperative behaviour".

Dryness of mouth.

Blurred vision (especially near vision).

Constipation.

Weight gain. (Some people complain of increased appetite while on phenothiazines; the weight gain may be due to increased appetite or to general slowing of metabolism, which occurs with the drugs.)



Nasal congestion.

Changes in the EEG (brain wave pattern).

Orthostatic hypotension (sudden drop in blood pressure). This usually happens when the person stands up quickly from a lying-down or sitting position, with resulting dizziness and faintness. Some people pass out briefly when this occurs. It is most common at the beginning of drug "treatment" and in older persons.

Impotence or loss of sexual drive.

Sensitivity to sunlight. Severe allergic sunburn occurs when skin is exposed to sun, especially with people on high doses of Thorazine.

Impaired thought and speech.

### Less common non-muscular effects

Decrease in white blood cells (leukopenia and agranulocytosis). The latter, though rare, results in lessened resistance to infection and disease, and can be fatal.

Increased likelihood of grand mal seizures, especially in people with a history of epilepsy.

Allergic skin rash.

Difficulty urinating.

Irregularity or absence of menstrual periods.

Lactation (swelling and secretion of milk in breasts).

False pregnancy tests.

Allergic type of hepatitis.

Eye problems. Opacity of the lens or cornea of the eye because of thickening. This occurs with Thorazine.

Changes in the EKG (electrocardiogram, or heartbeat tracings).

Sudden death. People taking these drugs have died suddenly from no discernible cause. Such deaths may be due to heart failure or to asphyxiation. The number of cases reported has been small (about 25 in English-language literature), but the unreported number may be far greater.

#### Common temporary muscular effects

Akathisia. Uncontrollable constant movement of part or all of the body, with the feeling of extreme tension and of being unable to sit still, sometimes with inability to sleep.

Dystonia(s). Sudden muscle spasms of the neck, back, legs and/or face. Sometimes the eyes become painfully stuck in an upward gaze (oculogyric crisis).

Pseudo-Parkinsonism. Increase in muscle tension which leads to rigidity of body, mask-like face, shuffling walk (the "Thorazine shuffle"), hunched posture, tremors of the hands, and drooling.

#### Common permanent muscular effects

Tardive dyskinesia. A disorder of the central nervous system caused by any phenothiazine.

Symptoms of T.D. include

*slow, rhythmic and involuntary movement of the face and limbs; cheek-puffing; lip-smacking or lip-pursing; chomping or chewing of the jaws; undulation of the tongue or repeated tongue thrusts in a "fly-catcher" movement; occasional stiffening of the neck and arms; difficulty in swallowing and speaking in severe cases; rotation of the ankles and toes; or wrist and finger movements.*<sup>1</sup>

This syndrome is a definite indication of damage which is irreversible and permanent. Approximately 30% to 50% of people "maintained" on these drugs develop T.D. In one study, 43% of psychiatric outpatients developed T.D. after an average of four-and-a-half years on the drugs.<sup>2</sup> Other studies have found rates as high as 56% among institutionalized people. Some people showed signs of T.D. after only eight months of medication.

T.D. was first discovered in 1958. Fifteen years later, the psychiatric profession officially recognized this danger in a special editorial published in the April 1973 issue of the *Archives of General Psychiatry*. There is no known cure for T.D. except complete and immediate stoppage of the drug,

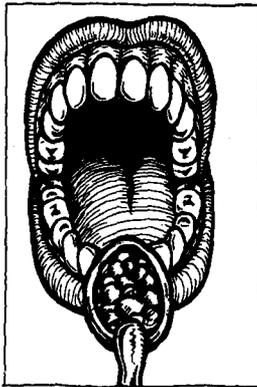
which may give only temporary relief.

To a limited extent, these "side effects" can be countered by the administration of anti-Parkinsonian drugs, which usually reduce or mask the neuromuscular effects of the phenothiazines. Some commonly prescribed anti-Parkinsonian drugs are Artane, Cogentin, Kemaprin, Akineton and Benadryl. However, these drugs have their own "side effects" as well, such as blurred vision, or confused thinking and speech. They can also be addictive.

People often develop long-term psychological and physical dependencies, or addictions, on phenothiazines. Frequently, psychiatrists have told their patients that they must take the drug for the rest of their lives. (A few members of ON OUR OWN have been told this.) As a result, many people have been conditioned to believe that if they stop taking the drug, they'll "go crazy" and end up back in hospital. Anyone who suddenly stops taking the drug(s) may find himself or herself experiencing frightening withdrawal reactions; these

may further convince the person that he or she is indeed "psychotic" and must remain on drugs.

Toronto Clarion



**WARNING: DISCONTINUING OR WITHDRAWING FROM ANY PHENOTHIAZINE, TRANQUILIZER OR ANTIDEPRESSANT SHOULD ALWAYS BE DONE GRADUALLY AND UNDER THE CLOSE SUPERVISION OF A PHYSICIAN.**

*Material on the major effects of the phenothiazines was abstracted and partially reprinted from these major sources: David H. Briggs, Consumer's Guide to Psychiatric Medication, 2nd ed., Project Release, 1978; "The Politics of Phenothiazines", Alliance for the Liberation of Mental Patients, 1979; Dr. Caligari, "Pursuing Psychiatric Pill Pushers", in S. Hirsch et al. (eds.), Madness Network News Reader, Glide Publications, 1974, and in Madness Network News, v. 5, nos. 2 and 3, 1978-79.*

#### NOTES:

<sup>1</sup> Horowitz, J. "The Hidden Cost of Mind Medicines", *Human Behavior*, May 1978, pp. 53-54.

<sup>2</sup> Asnis, G. et al. "A Survey of Tardive Dyskinesia in Psychiatric Outpatients", *American Journal of Psychiatry* 134:12 (December 1977), pp. 1367-1370.

*A neurotic is a person who builds castles in the air; a psychotic is a person who lives in them; and a psychiatrist is a person who collects the rent.*

# WHY WE'RE BOYCOTTING SMITHKLINE

Smith, Kline & French is one of the largest and most aggressive multinational drug manufacturers in the world. Its parent company, SmithKline Inc., is based in Philadelphia, Pennsylvania; other offices and plants are located in Canada, Europe, Latin America and the Far East. SmithKline makes numerous medical and cosmetic products, including many "mental health" products, including heavy, brain-damaging psychiatric drugs such as Thorazine, Stelazine, Compazine and other tranquilizers.

SK's sales and profits over the past five years have been astronomical and outrageous. For example, according to their 1979 annual report, SK's world-wide sales totalled over one billion dollars in 1978, and 1.3 billion dollars in 1979. During the five years from 1975 to 1979, SK's sales more than doubled; its profits jumped by 270% (from \$94 million in 1975 to \$344 million in 1979); and its net earnings almost quadrupled (from \$64 million to \$234 million).

SK has made a fortune selling its prescription and over-the-counter drugs. In 1973 its drug sales totalled \$789 million, or 70% of all sales. In 1979, drug sales skyrocketed to roughly \$993 million, accounting for 73% of total sales. And during the past five years drug sales more than doubled (about a 150% increase).

## stop psychiatric drug pushing

demonstrate at  
**SMITH.KLINE&  
FRENCH**

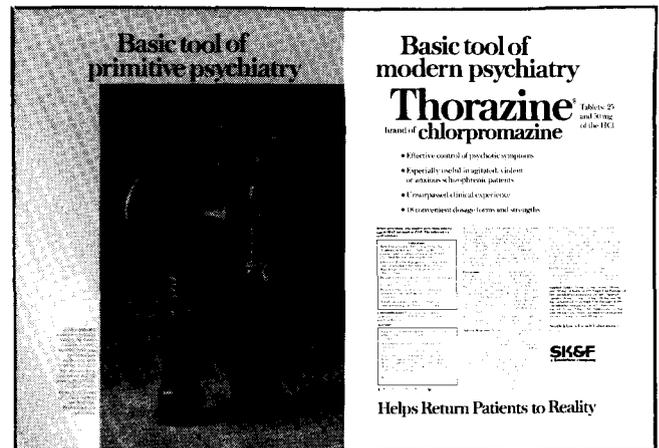
Mental Patients Unite —  
You Have Nothing to  
Lose but Your Restraints!



Included in these figures are the sales of powerful phenothiazines such as Thorazine, Stelazine and Compazine. Sales of these and other psychiatric drugs hit \$61 million in 1978, and \$64 million in 1979.

Unfortunately, we could find no separate financial statement of SKF's pharmaceutical sales or profits in Canada; these figures are hidden in the consolidated international statement.

Thorazine, Stelazine and Compazine are dangerous, brain-damaging drugs which have many serious effects (see this issue's drug column). In moderate to heavy doses, they cause numerous physical and psychological reactions which are health-threatening and often permanent. For example, virtually all the phenothiazines are known to cause tardive dyskinesia, a most serious and permanent disorder of the central nervous system. A person with T.D. is brain-damaged.



Despite the fact that SKF knew as far back as the early 1960s that Thorazine and other phenothiazines caused T.D., they waited until 1972 before informing physicians about T.D. It's obvious that SmithKline is committed to profits, not people, which mocks their pretence of being a "good corporate citizen". And SKF knows, or should know, that its psychiatric "miracle drugs" are routinely forced upon psychiatric inmates against their will and without their informed consent. Psychiatric staff rarely, if ever, bother to tell inmates about the risks and dangers of any tranquilizer or antidepressant *beforehand*.

Furthermore, SmithKline contributes to the economic exploitation of Third World people. SK has huge investments in many laboratories and plants in South America, Puerto Rico, the Philippines, Peru, Mexico, India and Pakistan. SK's policy on the openly racist government of South Africa, which advocates and practises apartheid, was spelled out in a 1972 pamphlet titled "Corporate Responsibility". SK argued that "a pullout of companies such as SKF from South Africa would injure the very people who are supposed to benefit." (What benefit? How?)

These exploitative corporate pill pushers then had the arrogance to add, "We feel that the very nature of our business . . . contributes to the well-being of all people . . . and cannot reasonably be looked upon as contributing to the apartheid policies of the Government of South Africa."

We, the editorial collective of *PHOENIX RISING*, have decided to join the groups listed below in boycotting *all* SmithKline products because:

1. SMITHKLINE PRODUCES, ADVERTISES AND MARKETS DANGEROUS BRAIN-DAMAGING DRUGS;

2. SMITHKLINE HAS FAILED TO FULLY INFORM PHYSICIANS, PATIENTS AND THE PUBLIC ABOUT THE MANY DANGEROUS DIRECT AND PERMANENT EFFECTS OF ITS PHENOTHIAZINES;
3. SMITHKLINE MAKES HUGE PROFITS FROM THE SUFFERING OF PEOPLE; and
4. SMITHKLINE ECONOMICALLY EXPLOITS THIRD WORLD PEOPLE AND CONDONES, OR REFUSES TO PUBLICLY PROTEST AGAINST, RACISM IN THIRD WORLD COUNTRIES.

We urge all individuals and groups who support the right of all people to control their minds and bodies to join us in this boycott.

### **DON'T USE THESE PRODUCTS**

For those readers who wish to support the SmithKline boycott, we are supplying a list of SmithKline products, including cosmetic products, non-prescription drugs and prescription drugs. In the case of prescription drugs we are also supplying the *generic* (chemical) name of the drug. If your doctor prescribes an SKF drug for you, ask him to give you a generic prescription instead. Not only will it help the boycott, but it will also probably save you a substantial amount of money; generically prescribed drugs are almost always much cheaper than their brand-name equivalents.

*We cannot guarantee the completeness of this list.* As we point out elsewhere, SKF does not list all its drugs in standard reference works; although we know of some which have been omitted, there may be others of which we are unaware.

#### COSMETIC PRODUCTS AND OVER-THE-COUNTER DRUGS

Contac  
Sea and Ski  
Love Cosmetics  
Sine-Off  
Allergy Relief Medicine

#### PRESCRIPTION DRUGS AND GENERIC EQUIVALENTS

(Psychiatric drugs are marked \*.)

Acnomet (resorcinol, sulphur)  
\*Amylozine (trifluoperazine and amobarbital)  
Ancef (cefazolin sodium)  
Benedrex (propylhexedrine)  
\*Benedrine (amphetamine sulphate)  
\*Combid (isopropamide prochlorperazine)  
\*Compazine (prochlorperazine)  
Cytomet (liothyronine sodium)  
Darbid (isopropamide iodide)  
\*Dexamyl (dextroamphetamine sulphate and amobarbital)  
\*Dexedrine (dexamphetamine sulphate)  
Duatrol (aluminum hydroxide, glycine, calcium carbonate, dimethyl polysiloxane)  
Dyazide (triamterene, hydrochlorothiazide)  
Dyrenium (triamterene)  
Ecotrin (acetylsalicylic acid)

Eskabarb (phenobarbital)  
\*Eskaserp (reserpine)  
Fesofer (ferrous sulphate)  
Ornade capsules and liquid (chlorpheniramine, phenylpropanolamine hydrochloride)  
Ornade D.M. Cough Liquid (chlorpheniramine, phenylpropanolamine hydrochloride, dextromethorphan)  
Ornade Expectorant Cough Formula (chlorpheniramine, phenylpropanolamine hydrochloride, guaifenesin)  
Ornex (phenylpropanolamine hydrochloride, acetaminophen)  
\*Parnate (tranylcypromine)  
Pragmatar (cetyl alcohol-coal tar distillate, sulphur, salicylic acid)  
Quotane (dimethisoquin hydrochloride)  
\*Stelabid (isopropamide, trifluoperazine)  
\*Stelazine (trifluoperazine)  
Stoxil (idoxuridine)  
Tagamet (cimetidine)  
\*Thorazine (chlorpromazine)  
Troph-Iron (vitamin B12, thiamine, ferric pyrophosphate soluble)  
Trophite (vitamin B12, thiamine)  
Tuss-Ornade (caramiphen edisylate, chlorpheniramine maleate, phenylpropanolamine hydrochloride)  
Vontrol (diphenidol)

ALSO AVOID ANY DRUG LISTED UNDER A GENERIC NAME PRECEDED BY THE LETTERS SK, SUCH AS, FOR EXAMPLE, "SK-PENICILLIN".

**DON'T GIVE YOUR COLD TO CONTACT!**

## **BOYCOTT SUPPORTERS**

ACT/ACTION, Syracuse, N.Y.  
 ADVOCATES FOR FREEDOM IN MENTAL HEALTH,  
 Kansas  
 ALLIANCE FOR THE LIBERATION OF MENTAL PATIENTS,  
 Philadelphia  
 BERKELEY FREE CLINIC  
 BREAD & ROSES COFFEEHOUSE, Baltimore  
 CENTRO DE CAMBIO, San Francisco  
 CHRISTIAN ASSOCIATION, University of Pennsyl-  
 vania  
 COALITION AGAINST FORCED TREATMENT, San Fran-  
 cisco  
 COALITION FOR THE MEDICAL RIGHTS OF WOMEN,  
 San Francisco  
 COALITION AGAINST INSTITUTIONAL VIOLENCE,  
 Boston  
 COALITION OF WELFARE RECIPIENTS, Los Angeles  
 EMERGENCY CIVIL LIBERTIES COMMITTEE, Phila-  
 delphia  
 GAY ACTIVISTS ALLIANCE, New York  
 LAVENDER LEFT, Philadelphia  
 MADNESS NETWORK NEWS  
 MENTAL HEALTH CONSUMER CONCERNS OF ALAMEDA  
 COUNTY, California  
 MENTAL PATIENTS ASSOCIATION, Vancouver  
 MENTAL PATIENTS' LIBERATION FRONT, Boston  
 MENTAL PATIENTS' RIGHTS ASSOCIATION, Florida  
 NATIONAL COMMITTEE TO SUPPORT THE MARION BROTH-  
 ERS, St. Louis  
 NATIONAL LAWYERS GUILD, San Francisco, Phila-  
 delphia  
 NATIONAL WOMEN'S HEALTH NETWORK, Washington, D.C.  
 NETWORK AGAINST PSYCHIATRIC ASSAULT, San Fran-  
 cisco, Los Angeles  
 NYU COMMITTEE TO INVESTIGATE CORPORATE POWER,  
 New York  
 PEOPLE'S FUND, Philadelphia  
 PEOPLE'S LAW SCHOOL, San Francisco  
 PEOPLE'S RIGHTS ORGANIZATION, Santa Rosa, Cal.  
 PLEXUS  
 PRISONERS RIGHTS COUNCIL, Philadelphia  
 PRISONERS UNION, San Francisco  
 PROJECT RELEASE, New York  
 PSYCHIATRIC INMATES' RIGHTS COLLECTIVE, Santa  
 Cruz  
 SAN FRANCISCO WOMEN'S CENTRE  
 SANTA CRUZ WOMEN'S CENTRE  
 S.W.P./Y.S.A., Philadelphia  
 STATE AND MIND, Boston  
 TOM SCRIBNER PROGRESSIVE BOOKSTORE, Santa Cruz  
 WAGES FOR HOUSEWORK/WAGES DUE LESBIANS, Phila-  
 delphia  
 WIN MAGAZINE, New York  
 WOMEN AGAINST RAPE, South Carolina  
 WOMEN AGAINST GRAPHIC RAPE, Philadelphia  
 WOMEN FREE WOMEN IN PRISON, New York  
 WOMEN ORGANIZED AGAINST RAPE, Philadelphia  
 WOMEN'S HEALTH COLLECTIVE, Santa Cruz  
 WOMEN'S INFORMATION SERVICE, Media, Pa.  
 WOMEN'S MENTAL HEALTH PROJECT, Portland

WONDERFUL OLDER WOMEN, Philadelphia  
 WORKING GROUP ON BATTERED WOMEN, Philadelphia

List taken from ALMP Newsletter

### **WHAT IS SMITHKLINE HIDING?!!**

When we were researching SmithKline products for this issue, we ran into some unexpected difficulties with our reference sources. We found these difficulties so interesting that we wanted to tell you about them.

The *Compendium of Pharmaceuticals and Specialties* is a standard reference work used by pharmacists and doctors. It gives information about almost all prescription drugs available in Canada.

The first, and most important, section of the *Compendium* gives, for all those drugs which the manufacturer wishes to include, substantial information about indications for use, dosages, and effects. *Neither Compazine nor Thorazine is included in this section.*

The second section lists drugs according to the conditions for which they are prescribed. Under "Antipsychotic Agents" and "Psychosis Therapy", *neither Compazine nor Thorazine is included.*

The third section lists drugs under the name of the manufacturer. Under "Smith Kline & French", *neither Compazine nor Thorazine is included.* The fourth section lists drugs under their generic (chemical) names; most SKF drugs listed in this section are followed by the letters "SKF" to identify the manufacturer. *Compazine and Thorazine are included in this section, but with no indication that they are manufactured by Smith Kline & French.*

The fifth section lists brand names of drugs and gives their generic equivalent. Both Compazine and Thorazine are included here.

In other words, if someone wanted information about Thorazine from this book, *there is no way he or she could find out that it is manufactured by Smith Kline & French.* And in order to get information about its effects, he or she would have to go to the fifth section, find out that the generic name for Thorazine is chlorpromazine, and then look up chlorpromazine in the first section. In the case of Compazine, even that is not possible; one can discover that the generic name is prochlorperazine, but the first section has no listing for prochlorperazine.

PHOENIX RISING is very curious as to why SKF has apparently done everything possible to hide its connection with these drugs and to withhold information about their effects. They seem to be proud enough of most of their products to tell us about them and attach their name to them--why are Thorazine and Compazine an exception?



# profiles

## Linking arms in San Francisco

*Our usual practice in this section is to present profiles of a Toronto resource for inmates or ex-inmates and of a particular antipsychiatry group. In this issue we are doing the first, but departing from our pattern on the second. Instead of an individual antipsychiatry group, we are reporting on the Eighth International Conference on Human Rights and Psychiatric Oppression, which was attended by many of the groups we will be describing in future issues.*

by Dianne Jennings Walker

From May 2 to 6, 85 anti-psychiatry activists met in a secluded campground in Tilden Regional Park in Berkeley, California. Across San Francisco Bay another group, the American Psychiatric Association, convened for its 133rd annual business meeting. This year's Conference on Human Rights and Psychiatric Oppression was dominated by a single theme: anger at the APA.

Since 1973 our conference has met yearly in different U.S. cities. In 1977 we voted in Los Angeles to change our name from North American to International Conference because some participants come from Canada and Europe.

My own participation in the mental patients' liberation movement began at the 1975 conference in San Francisco. I walked into a room filled with about 45 "ex-psychiatric inmates". Upstairs in the same building some 200 proponents of radical therapy were discussing how crazy and frightening we were. While they rationalized the use of leather restraints and tried to out-Marxist each other, we huddled together and wept and spoke for hours about our pain and loneliness. My search for a better therapeutic model was over.

The main focus of the International Conferences on Human Rights and Psychiatric Oppression is opposition to all forms of psychiatric treatment which are administered by force or coercion. A secondary focus is public education about the physical and emotional effects of such procedures as drugging, elec-

troshock, behaviour modification, solitary confinement and psychosurgery. Alliances between groups and friendships between individuals form and deepen each year. We are a living, growing network of people who know that Freedom is one of the most beautiful words in any language.

Workshops were held at Tilden Park on Alternatives, ECT, Military Psychiatry, Relating to the Prisoners' Movement. Plans for demonstrating against the APA dominated the nightly general meetings. A splinter group met to plan a disruption of the psychiatrists' convention. The whole conference gave our blessing to their plan for a peaceful blockade of the main entrance to Brooks Hall where the

# PHOENIX RISING



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APA would be meeting. Fifteen of us worked on the Conference Statement in which we publicly accuse the APA of crimes against humanity.

Conferences for me are usually a time to relax with friends. This one was totally political. Some of us call ourselves "consumers"; some of us say "inmates". Some want model social services; others just want to be left alone. We *all* see the APA as the embodiment of institutional psychiatric oppression. Each conference demonstrates against a local psychiatric institution. In 1978 we marched against Smith Kline & French in Philadelphia and began a boycott against their over-the-counter products such as Contac.

May 5 began with a 9:30 a.m. Tribunal on Psychiatric Crimes at Glide Memorial Church in San Francisco. It was open to the public and well attended, as was the late afternoon public workshop also held at Glide. Speakers from the conference related personal experiences. Then several people spoke on the open mike. Vietnam veterans asked for understanding of their emotional scars.

Then fifty people marched to Brooks Hall, which is in the San Francisco Civic Center. Nineteen ex-inmates linked arms and blockaded the main entrance until nightfall. Perhaps because local police know the Network Against Psychiatric Assault is totally against violent demonstrations, there were no arrests. The cops smiled and the psychiatrists fumed.

We set up a P.A. system. The angry voices of ex-inmates and our supporters rang across the Civic Center Plaza all afternoon. A veteran anti-psychiatry activist set a serious tone for the rally by reminding us that mental patients were the first victims of Nazi Germany. He gave voice to the feelings of all our hearts when he shouted: "We're here to tell this gathering of obscene and evil people that we're not going to take it any more!"

We'll be in Cleveland next year. For more information, write Patients' Rights Organization, 2112 Payne Ave., Cleveland, OH 44118, or call Project Renaissance, (216)-523-1798.

*Dianne Jenninas Walker is a member of NAPA (Network Against Psychiatric Assault).*

## ***Ex-inmate controlled co-ops***

HouseLink Community Homes is a non-profit organization that provides co-op housing for people who have had previous psychiatric treatment. HouseLink was founded by a group of concerned citizens and mental health professionals who saw the need for alternative housing.

The initial stages in HouseLink's develop-

ment began in July of 1976. In conjunction with the Program for Revolving Door Patients at Queen Street Mental Health Centre, a co-operative house was set up and monitored as a pilot project. The success of this project led to the founding of HouseLink Community Homes. In August 1977, HouseLink became a non-profit corporation and set up its first co-operative.

At present HouseLink operates 11 co-ops--six houses and five apartments, which house three to five people per unit. The houses/apartments are rented directly from landlords, and residents are solely responsible for the management and upkeep of the premises (examples being paying the rent, payment of household bills, and cleaning).

Depending on the co-op, rents range from \$100 to \$130 per month. Each resident is required to contribute a nominal amount of money per month to their co-op's "slush fund". The basic furnishings are supplied by HouseLink.

There is no maximum stay in a HouseLink co-op. Residents may stay as long as they wish providing they don't break any of the non-negotiable rules: no physical violence, no illegal activities, and no abuse of drugs or alcohol.

There are no live-in staff in any of the co-ops, but each co-op is provided with a non-professional Volunteer House Co-ordinator who acts as a house advisor and attends the weekly meetings where house problems, if any, are discussed.

When considering residence in a HouseLink co-op, you must first contact a professional worker (i.e., social worker or psychiatrist) who has known you for at least two months, to make a telephone referral to Erich Freiler (HouseLink Referral Co-ordinator). Once the initial contact has been made, an interview time is arranged. If there are no openings in any of the HouseLink co-ops, the applicant is placed on a waiting list. However, when there is a vacancy, a time is arranged for the prospective resident to meet the people living in the co-op. The co-op and the applicant decide whether to accept one another, and relay their decision back to Erich.

Open Meetings are held to discuss issues and make recommendations on policy matters pertaining to the organization. The final determination of policy is made by the HouseLink Board of Directors, which is comprised of fourteen people, seven of them ex-patients. Each year HouseLink holds its annual meeting at which the Board of Directors is elected for the coming year.

The staff assist a residents' Recreation Council in implementing a variety of social-recreational activities such as baseball or group outings. HouseLink residents also publish their own bi-monthly newsletter.

For further information, telephone (416)-968-0242.



# what's happening

## Kitchener's Snake Lady

by Ben Steidman

Society's outcasts in the Waterloo region can breathe easier--their angel of mercy is still active and interested.

Anna Kaljas, 67, may have retired to her farm north of Kitchener-Waterloo, but she continues to worry about those considered down-and-outers by society.

"I love them all...it's a waste, most people don't care about them," reflected Anna, known affectionately as the Snake Lady because she and her husband kept exotic snakes and animals at their Kitchener home.

For over twenty years her home provided a haven for people classified by social agencies as hopeless cases. She began by taking discharged youth offenders from Guelph Correctional Centre, and then adult offenders and girls from the Galt Centre. Still later she began helping ex-psychiatric patients, alcoholics and drug addicts.

At times there were as many as twenty people in her home. If her guests had money, they paid her \$35 a week for room and board.

Anna has taken five of her people to live with her on her farm. "There are about seven acres at the house where we plan to have some of the people work in the garden," she said. Anna and her husband, Eric Rosar, also rent a ten-acre farm adjacent to the house to raise horses.

Anna's work has not gone unrecognized. Recently, the Waterloo Region Knight of Columbus held a dinner, attended by provincial government officials and representatives of local social service agencies, to honour her community work. As well, the Waterloo Region Mental Health Association presented her with an award. Local agencies have plans to nominate her for the Ontario Medal for Good Cit-

izenship and the Order of Canada.

Anna's anxiety over what will happen to those she once cared for has been somewhat lessened by the opening this month of a drop-in centre at Water and Joseph Streets, sponsored by the local Mental Health Association. But she believes more is needed. So she is helping the association start a foundation to raise money for a halfway house for ex-psychiatric patients and others in need.

"They need help to become more independent," she insists, "though I wonder if the government really cares. I'm angry when I think about a government that spends \$135 a day keeping people in hospitals but won't provide money for help in the community."

## Thumbs down on community alternatives

Advocates of integration projects and community-run alternatives to "mental hospitals" shouldn't expect too much support from mental health/ontario in the near future.

The board members of that association won't be discussing a report on community alternatives until November of this year, and even then should be unsympathetic, if the reaction from provincial association delegates and three panelists on May 31 at the Holiday Inn in Toronto is any indication.

The report, prepared by staff person Gail Czukur with an advisory board of representatives from the Queen Street Mental Health Centre, the Ontario Ministry of Culture and Recreation, HouseLink Community Homes, the Ontario Association for the Mentally Retarded, and ON OUR OWN, was written in response to the Ontario government's increasing emphasis on community versus hospital care, and to the closing of Lakeshore Psychiatric Hospital in 1979.

The paper discussed community alternatives available and not available, and recommended a

call to action by mental health/ontario to support existing alternatives and establish additional ones to fill a yawning gap.

Despite the time and effort that went into preparing the report, it drew a negative response from psychiatrist and panelist Dr. Jack Griffin, former director-general of the Canadian Mental Health Association and one of the Association's original founders.

Dr. Griffin told the audience that the concept of choice of therapy by consumers was comparable to giving a suicidal person his choice of instruments to kill himself with.

Panelist Dr. Abbyann Lynch, who helped produce the 1979 report "Agenda for Action" on mental health services in the province, and who teaches Health Care Ethics at St. Michael's, told the audience that alternatives to hospital and medical care were "icing on the cake".

Ken Charlton, president of mental health/kent and third and final panelist, rounded off the discussion by sidestepping the issue altogether, choosing instead to use the platform to speak about his brain-child, preventive medicine. Charlton proposed that a campaign be launched in much the same way as Labatt's sells its beer--through advertising--to sell the concept of "mental health".

A small vocal minority, however, made a strong case for community service links with hospitals to help people just released integrate successfully back into society. They included a number of people who gave personal accounts of their frustration in attempting to provide assistance or seek help themselves where services outside the hospitals were virtually non-existent.

## No rights this summer

In the last issue of *PHOENIX RISING*, we described the confrontation last November between many handicapped/disabled groups and the Ontario government over human rights protection for the handicapped.

Since that time, a coalition of 60 to 80 groups representing consumer organizations and agencies have been meeting with the government to draft a more mutually acceptable bill.

Between March and May of 1980, six sessions took place between the Coalition and either Dr. Elgie, Minister of Labour, or other Ministry representatives. The consultation covered many aspects of the proposed legislation, focussing particularly on such difficult issues as insurance, definitions, and so forth.

We wish to applaud this process and the Ministry of Labour for working with handicapped people on this crucial matter. But it is still not clear what this proposed human rights coverage will be.

Dr. Elgie has assured the Coalition that its views and concerns have been presented to Cabinet for consideration, but as of this writing the exact nature of the legislation still remains in the hands of the Ontario Cabinet.

The Minister had expressed his hope that a bill could be brought down before the end of this session. That proved to be a false hope; no bill appeared on the Order Paper as the legislature closed up for the summer. As the end of the summer session drew near, the Coalition sent a telegram expressing some concern over the slowness with which new human rights coverage was being drawn up. A meeting at Toronto's new City Hall on the last day of the legislature, open to the press, failed to bring any action.

Shortly thereafter, Dr. Elgie announced to the press that amendments to the Human Rights Code to prohibit discrimination against the physically and mentally handicapped would be introduced in the legislature this fall.

Stay tuned . . .

## Hoffman-La Roche gets off lightly

Hoffman-La Roche, one of the world's largest manufacturers of pharmaceutical drugs and developer of Valium and Librium, has been given a light slap on the wrist for trying to reduce or eliminate competition by selling Valium at unreasonably low prices or giving it away.

The company was fined only \$50,000 by an Ontario Supreme Court judge, who justified the low fine by stating that the situation was a borderline case, and not a serious offence.

The *Canadian Combines Investigation Act*, under which Hoffman-La Roche was convicted, sets no maximum fine for predatory pricing.

## Behavior Mod French style

It appears that Alberta is not alone in its use of behavioural modification techniques for disciplining children with behavioural

problems.

In the last issue of *PHOENIX RISING*, we told readers about a group home in Peace River, Alberta, that forced children to sleep in urine-soaked sheets, eat dog food laced with hot pepper sauce, and smear menstrual blood on bathroom walls, among other things.

Now it appears that a 69-year-old Catholic priest in France has topped even that.

Rev. René Fabré, recently sentenced to ten years in prison for the suffocation death of an epileptic teenager, exercised his own brand of sadism to discipline handicapped girls in their early teens.

An unrepentant Fabré told the court that he used whips and other techniques to instill "a sense of responsibility" into the retarded

girls he was in charge of.

When one girl wet her bed, Fabré said, in order to teach her a lesson "I had to dunk her head in the toilet, while I flushed it."

Another girl was chained to a hot radiator because she was restless.

Isabelle Le Menach, 13, died under Fabré's charge in 1976 when he ordered her bound in a straitjacket and hung from a wall in a padded cell after she had interrupted his mass with incoherent sounds.

Despite Fabré's sentencing, Le Menach's parents are not impressed. Now that they've won their case against Fabré after a four-year fight to get it into the courts, they plan to lay charges against the people who knew what he was doing all along.



# commentary

## BLINDNESS:

### *more than meets the eye*

by Mike Yale

Blind people, like other handicapped or disabled people, have had to contend with outdated and peculiar public attitudes and misconceptions for centuries. Negative myths and stereotypes have proven to be the true handicaps to progress and integration, as well as a barrier to dignity for most "handicapped" persons.

Many handicapped persons have been conditioned to be quiet and respectful, to be passive and accepting of hand-outs or token rights, and apathy and resignation remain all too common today.

It is interesting that in many published surveys of people's attitudes, the public consistently considers blindness to be the most serious, loathsome and frightening of all physical handicaps. Many seem to feel that their lives will end when their sight vanishes.

As a blind man myself, I can assure you that such is not the case. But in a visually oriented society such as ours, where appearance

and beauty are over-emphasized--the perfect body--I can understand the public's misconceptions and fears. The negative public perception does, however, hinder the integration of blind people and is detrimental to their quality of life. To many in the public, "blind" implies or means clumsiness and awkwardness of movement, immobility generally, unemployment, stupidity and deafness. I have often been shouted at by someone trying to assist me.

These notions manifest themselves in strange ways. If I am in a restaurant with a sighted friend, the waitress will usually ask my companion, "What does he want?" On the street I am constantly asked, "Do you know where you are going?" Such little examples, when compounded, add up to big frustrations and lack of self-esteem among many blind (and otherwise handicapped) people. The situation is further complicated by the fact that blind people are often given the wrong kind of information, or the kind of misleading information that keeps them guessing. "There is a chair to the right." To my right or to the

Institutionalization, as we all know, has very major and negative consequences on any individual. And from the standpoint of a blind person, even long-term residential schooling may have unfortunate results, despite the quality of the education offered.

The residential school, like other established systems and institutions, often seems to suffer itself from negative or restricting attitudes about its own students. The school often has low expectations of a person's capabilities, due to the fact that the person fits into some category, like multihandicapped blind. One young blind woman with cerebral palsy told me, "The school emphasized my disabilities rather than my abilities. What I

## ***"Alcoholism is a major problem"***

needed was a stern kick in the butt, not a sympathetic pat on the shoulder."

Most blind kids attending the residential school in Ontario only go home on weekends and during vacations. Those living further away than a convenient distance may not even get home on weekends. They live with, socialize with, learn with, only blind friends for most of their time. When they do go home, they do not know or have anything in common with the sighted kids who may live right next door. Their interaction with sighted peers is therefore greatly limited.

Since dating and social customs are not a high priority at the residential school itself, many blind children are in fact virtually deprived of all social interaction. Social skills essential to eventual normalization and integration are inhibited. And at the end of perhaps twelve years in the school, the teenager is told to get out there now and be normal. The result, in some cases, is frightened and intimidated young people, often with a good education but lacking in employment skills or social training.

Blindness is, in effect, a kind of perceptual handicap, for it limits the amount and kinds of information at the disposal of the blind person. Visual information is denied. Though vision is only one out of five senses, its loss may affect seriously how a blind person thinks of and evaluates his surroundings.

Unless a blind person has had a "hands-on" demonstration of how a certain thing looks, he or she may have a false impression or no impression whatever of what a certain animal looks like, or a historical building, or even basic concepts like circles and squares. The speaker's right? What angle to the right? If I don't know the answer, I may end up sitting on a table.

Paranoia can also be a very serious element in the lives of blind people. If you cannot see who or how many are watching you, your imagination may run wild, creating, in the end, an obsession.

lack of some of these concepts may interfere with the mobility or functioning of the blind individual. The remedy ought to be fairly obvious--a hands-on approach to learning. Nevertheless, many blind persons are shy and feel at a serious disadvantage because of this conceptual deficiency.

Much public information is not available to a blind person in a usable form--i.e., in Braille or on tape. Government documents and publications, commercial leaflets or advertising, and countless other generally available pieces of information are not available. This puts the blind person again at a serious disadvantage compared with his sighted peers. Even the CNIB sends much of its material to its blind clients in print.

A general problem facing the blind, just as it also affects all handicapped people, is the lack of real life experiences, either in employment, in training, in integrative skills, and so forth. Without such experience and opportunities, many potentially productive people sit idly by, and society loses their talent and input.

The lack of experience plus a high frustration level can create an emotional time bomb in many blind individuals. It can lead to a deflated self-esteem, a sense of worthlessness, and a growing alienation which often leads to isolation.

In some cases, isolated individuals give up even on the idea of having a social life or developing normal sexual relationships. In other instances, an isolated blind person may attempt to break out of a hermetic existence by swinging to the opposite extreme--promis-

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PHOENIX RISING is available on tape for the use of blind readers. To borrow tapes, please call Jo-anne Yale during the day at (416)-364-4939.

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cuity. Though not always satisfactory, this solution will at least provide much-needed affection and some social recognition.

Alcoholism is a major problem in the blind community. Others have turned to drugs. Again, though not the best or even an advisable solution, alcohol and pills may ease the pain slightly and also lead to some social interaction. In other cases, of course, alcohol and drugs only strengthen and perpetuate the isolation.

Many blind people turn to psychiatrists or counsellors for assistance. Unfortunately, most professionals in this field tend to give advice based upon their own misconceptions and stereotypes about handicapped people. Not only have most of such professionals not dealt

previously with a handicapped person, but most have never had specialized training to counsel handicapped people in their many years of training.

Handicapped people have an absolute right to their own individuality and uniqueness. They should have opportunities corresponding with their abilities, and they should be encouraged to take responsibility for themselves rather than be treated as helpless beneficiaries of custodial care or hand-outs.

Blind people who succeed don't want to be considered exceptional or superstars. On the other hand, those that do not succeed should not be condemned as misfits or imbeciles. We want a hand up to equality, not a hand-out.

*Mike Yale has been blind for 30 years, and works as a community legal worker at ARCH. He is also one of the founding members of BOOST, a blind persons' self-help group.*



# Rights and Wrongs

## INVOLUNTARY DETENTION, PART II: IN THE HOSPITAL

by David Baker

Once a physician or justice of the peace has completed the appropriate form, or the police officer has decided that involuntary admission is appropriate, the detention process commences.

A police officer, or any other person in the case in which a physician applies for a psychiatric assessment, enforces the decision to detain. It appears safe to presume that no more force should be used than is absolutely necessary to enforce the decision.

The police must take the person who has been apprehended to a psychiatric hospital "forthwith". Formerly the police had been throwing persons in jail until it was felt to be convenient to take them to a hospital. Now they must go direct. Failure to do so probably does not make the detention order invalid (unless more than seven days have elapsed since the form was signed). However, the police officer would be guilty of a criminal offence.

Upon arrival at the hospital, a person is processed through the admissions department. Those brought to the hospital on the order of a justice of the peace or police officer are to be assessed "forthwith" by a physician "after receipt of the person at the place of assessment". Persons who have gone through the involuntary admission procedure describe it as being just as dehumanizing as this language would imply. The staff are predisposed toward believing that the person is uncontrolled, dangerous and certifiable. The person becomes a patient.

The hospital now has authority to "re-

strain, observe and examine" the person for a period of up to five days. The powers which the hospital does *not* have are as significant as those which it has. The wording of the Ontario *Mental Health Act* makes it clear that *no treatment is to take place* during this five-day period unless the person voluntarily consents to it.



Tony Myers

The hospital does, however, have the power to "restrain", defined as "keep under control by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient". Thus a person who actively attempts to escape, harm others, or harm himself or herself may be chemically prevented from doing so. Those familiar with hospital procedures will be aware of the

"Code 99", where hospital staff drop their other duties and rush to physically restrain a person while a physician injects a massive dose of a chemical sedative. This obviously should not be confused with "treatment".

The primary purpose of this five-day



Tony Myers

period is to have the person observed and examined by a physician with some expertise in psychiatry. Evidence so far indicates a real need for this procedure. As was mentioned in the previous column, the tightening of involuntary admission criteria in 1978 did not significantly alter either the number of admissions or the reasons given for detention. In other words, family physicians and the police continue to use the mental health system as a dumping ground for troublesome people.

There *has*, though, been a significant reduction in the number of people involuntarily admitted at the end of the five-day period. This may indicate that specialists in psychiatry are more familiar with the law than are family physicians and policemen. It may also reflect a changing role for involuntary detention--from forced therapy to crisis intervention (as is, for example, the case in California, where psychiatric detention is time-limited). Only experience and closer study will tell.

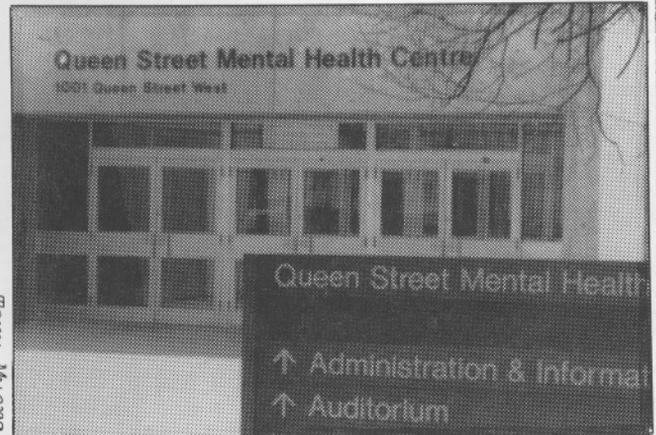
The criteria for involuntary admission after the five-day period are somewhat different from those used to make the initial decision. There is no longer any obligation to assess whether actual danger existed some time in the past. The physician need only: (1) make a medical diagnosis; (2) predict future dangerousness; and (3) consider the availability of alternatives. This is an obvious time for a person to outline a willingness to seek other forms of treatment or assistance and to make the necessary arrangements. It would be a mistake to rely upon hospital staff for this kind of effort.

The certificate of involuntary admission is to be reviewed "forthwith" by the hospital administrator. I am not aware of any case in which this review has resulted in the release

of a detainee. It appears rather to be an effort on the part of the government to ensure that "t's" are crossed and "i's" dotted on the forms. The Canadian Civil Liberties Association embarrassed the government in 1977 by conducting an independent review of whether certificates conformed with the law; 70% were found to be illegal. Arguably, the person has a right to present his or her case to the administrator; however, to date the review has always taken place in the person's absence.

Despite the obvious conclusion that a person held involuntarily wants to be released, the onus of initiating a review of the detention is placed on the detainee. There are essentially two options.

The most commonly used route is an application to the regional Mental Health Review Board. A person may apply to the Board after the certificate of involuntary admission has been completed, and the Board must hear the case and make a decision within thirty days. Procedure throughout is informal. By law the hospital staff must have applications for review readily available. A person need only sign the form and return it to a staff person, who will ensure the form is forwarded to the Board as soon as possible. The application need not be made by the person who has been detained; anybody may summon the Board.



Tony Myers

The merits of the system are that: (1) it is informal and does not require the services of a lawyer (though a lawyer can be helpful); (2) since there are psychiatrists on the Board, expert evidence is not essential (again, a report from an expert who disagrees with the decision to detain can be invaluable); and (3) it is the mechanism which the law provides for all but exceptional cases.

There are many problems with the Review Board, too numerous to list here. Suffice it to say the most important are regional inconsistency (the Board in the north-west of the province grants approximately 50% of all applications, while that in the central region grants less than 5%) and secrecy (a person

never knows the case which must be met, nor does he or she receive reasons for the Board's eventual decision).

The alternative to the Review Board is an application to the Supreme Court of Ontario for a writ of *habeas corpus*. In practice this procedure would probably require the services of a lawyer. If the Court's review is to extend beyond what has been written on the form, it would be advisable to secure a supportive medical report.

*Habeas corpus* has been available since the time of Magna Carta to secure the release of persons who have been unjustly detained by the state. Despite its proud history, a

judge would certainly expect an explanation as to why the statutory course of applying to the Review Board was not selected. Perhaps because it has not been properly utilized, it has not been a significant factor in securing the release of persons detained in psychiatric hospitals. However, in the proper case, particularly where speed is of the essence, and with the assistance of an experienced lawyer, it can be a very effective remedy and should not be overlooked.

Next issue: Consent to Treatment for Involuntary Patients.

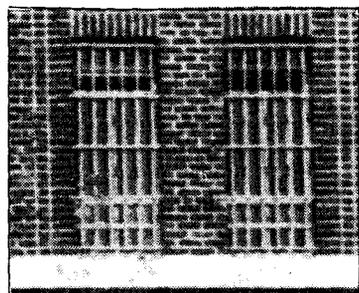
*David Baker is a Toronto lawyer.*



# the Book worm turns

Go-Boy! Memoirs of a Life Behind Bars, by Roger Caron. McGraw-Hill Ryerson, 1978, hard cover 264 pages, \$10.95, paper 317 pages, \$2.95.

Reviewed by *Don Weitz*



Going "stir-crazy" in prison is just a matter of time. It usually results in inmates doing more "hard time", or getting sent to a psych ward to be experimented on like a guinea pig or rat.

Prisons, like "mental hospitals", are classic Catch-22s. To survive years in the punishing, dehumanizing prison environment and retain one's sanity and humanity takes incredible strength and courage. Few of us have it.

Roger Caron has both--awesome physical strength and sheer guts. He's a genuine survivor of the Canadian prison system. Now 42, Caron has spent over half his life, almost a quarter century, in no less than thirteen jails and prisons. He's sampled some of the toughest: Guelph Reformatory, Kingston Penitentiary, Millhaven and "Penetang" (Penetanguishene Mental Health Centre for the "criminally insane"). Finally, in 1979, Caron was released from medium-security Collins Bay Penitentiary in Ontario.

Caron started his prison career at 16, when he was convicted for a "B & E" (breaking

and entering). He has seldom been free for more than a few weeks or months at a time. Thefts, armed robberies and escapes inevitably led to doing more "hard time" in the Big Joint.

It's amazing that Caron has survived this long with his sanity intact. But what's even more amazing is that, while locked up, Caron wrote *GO-BOY!*, an autobiographical account covering roughly twenty-two years of his prison experiences. Undoubtedly the act of writing the book helped Caron stay human:

*Through it all I was reborn: I found out all about myself not stretched out on a shrink's couch but rather through the inner therapy of writing my life story . . . . I really do think I would have gone crazy if I hadn't been permitted to scribble away . . . .*

*Go-Boy!*, as the book jacket explains, is "prison slang for a runner and the prisoners' chant of encouragement to those who make the



desperate break for freedom." Caron escaped six times from about as many prisons. His vivid descriptions of these daring and ingenious but futile breakouts surpasses almost anything on TV or in film. Caron's keen sense of the dramatic is tempered by his compelling heed to stick to what happened to him, to tell it like it was--which was horrible enough: guards beating and gassing inmates in cells and corridors; near-fatal fights with other prisoners; the brutal and maddening experiences of solitary confinement in "maximum deadlock", where sewer rats sometimes emerged through open toilets; the terrifying psychiatric "treatments" he was forced to endure in the psycho ward; and the flesh-cutting torture of ten strokes of the "paddle" with which prison guards used to beat him till he bled.

Caron's account of forced treatment with gas (Indoklon, I believe) administered while he was in a strait-jacket is equally horrifying. Caron was subjected to this torture by the prison psychiatrist, Dr. Bonin, as an alternative to the "paddle":

*The mask clamped firmly over my mouth and nose and suddenly I found that I could not breathe! . . . Then I heard the ominous hissing of gas . . . Horror-stricken, I started thrashing about while the hands that were gripping me squeezed more tightly than ever. There was an eerie buzzing in my ears like an angry horde of wasps trying to chew their way into my brain. And I still couldn't breathe . . . Now the faces of the doctor and Miss Carter were getting all hairy and the room was spinning around in a maddening circle and I was being engulfed by a big wave as thick and dark as molasses, a wave that was carrying me off into a shadowy world full of lurking horrors, a universe of flashing lights and buzzing sounds, sounds that were getting louder and louder until I was being consumed!*

In his supportive foreword to the book, Pierre Berton writes:

*It is not good enough for Canadians to say that they did not know these things were going on inside our prisons. They did know.*

Photos of Oak Ridge  
by Arnold Bruner



*They were told about it over and over again. Some of us have tried over the years to protest; but the Canadian public, in spite of the clear knowledge that physical torture of the most painful kind was part of official policy, continued to accept it, and indeed, in some cases applaud it. One of the reasons that the Canadian penal system has yet to emerge from the dark ages is because the people continue to demand revenge rather than rehabilitation.*

Like much concentration camp literature, *Go-Boy!* can be read as a forceful witness to survival in hell, as well as a major contribution to prison literature and criminology. Caron and *Go-Boy!* are winners. In 1979, Caron won the Governor-General's Award for *Go-Boy!*, which was judged the best non-fiction work in Canada for 1978. Caron is free now, and working on his next book, which deals with the Kingston Riot. It's titled *Bingo!*; if it's anything like *Go-Boy!*, *Bingo!* should hit the jackpot.

*Kind and Usual Punishment*, by Jessica Mitford. Vintage Books, 1973, paper \$2.45.

Reviewed by Cathy McPherson



Ask any person on the street what his opinion about crime and prisons is, and the answers might range from "Lock them up and throw away the key!" to "Prisons shouldn't exist."

Canada has been having Royal Commissions and studies of one sort or another on the problem since the 1930s.

There's no doubt about it, prisons are a controversial topic; so it's not surprising that America's best-known investigative reporter, Jessica Mitford, would have a crack at them.

Although the information in Mitford's investigation into the penal system dates back

to the early seventies and deals almost entirely with American prisons, the book is well worth reading if only for the questions Mitford poses and the horror stories she so vividly documents. At the time this book was written it publicized serious problems in the American penal system and inspired a number of reform; thus it has become an important



Isolation cell in Notre Dame Prison

Cruel and Unusual

reader on the subject.

Mitford begins *Kind and Usual Punishment* by tracing the history of prisons to their conception by the Quakers 200 years ago as a more humane form of punishment for poor law-breakers than the common practices of death, decapitation, and so on. Only the rich could afford the luxury of being imprisoned for long periods of time.

The Quakers' not-so-original form of solitary confinement and prolonged Bible study was replaced by hard labour when it was discovered that most of the criminals were going insane as a result of the isolation. At about the same time a movement for reform sprang up, and for the next hundred-some years the two groups sparred over the proper punishment of criminals.

Time and again differences in treatment between rich and poor, black and white crop up in Mitford's book. She points an accusing finger at a society that considers crimes such as corporate pollution and embezzlement to be less serious than petty theft and mugging. Mitford draws attention to the disproportionate number of poor people and black people in prisons--a point which has a familiar ring in Canada when one compares the prison rates of Indians and whites.

Much of what Mitford talks about either doesn't apply in Canada or is carried out here only to a limited degree. Definite indefinite sentences are uncommon here, and experimentation by drug companies on prisoners in Canada is minimal (it has been under stronger supervision in the States since this book was written). Prison industries are not nearly the big business in Canada that they are in the States. As well, Canadian prisons seldom house more than 400 inmates, while American prisons lock people up by the thousands.

Those differences aside, however, much of what Mitford says strikes close to home. Her discovery that more money is spent on administration than on actual programs for convicts is applicable here, as is her comment that prisons do not act as deterrents and end up corrupting people more often than they do in curing them of law-breaking. All this in light of the fact that more, not fewer, big prisons are being built in Canada despite innumerable committees and studies recommending the opposite.

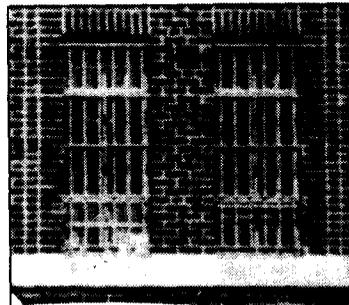
As for her criticisms of the American parole system, these too find strong parallels here. Although prisoners are convicted and sentenced to imprisonment for a certain number of years, they are often kept in prison longer than their original sentence because of the peculiarities of the Parole Act and the incredible sweeping powers of the Parole Board itself.

But Mitford doesn't let us off easily. Although she rages about the uselessness of prisons, she cautions would-be crusaders that small changes in the penal system are not enough. The attitudes of society toward people and criminals must be changed.

And just how that might be done she leaves up to the reader.

Cruel and Unusual, by Gerard McNeil with Sharon Vance. Deneau and Greenberg, 1978, paper \$6.95.

Reviewed by *Cathy McPherson*



You've read Jessica Mitford's book. Now you want to know more about the Canadian prison scene.

Start with *Cruel and Unusual*, written by a reporter and a researcher who followed the Commons Subcommittee on the

Penitentiary System in Canada on a cross-country tour of jails in 1976.

Gerard McNeil and Sharon Vance combine the testimony of guards, prisoners and offi-

cials with facts and figures about the Canadian penal system that will leave you unnerved by the injustices that still exist in our country.

In the words of the subcommittee, "Imprisonment in Canada is not simply inhumane, it is the most individually destructive, psychologically crippling and socially alienating experience that could conceivably exist within the borders of this country."

Because of this book, along with pressure from the subcommittee and community groups over the mediaeval conditions in the B.C. Penitentiary, that prison has finally been closed down--for now. Apart from that and a few other small changes, conditions remain pretty well the same as when this book was published in 1978, according to people at the John Howard Society.

The subcommittee's proposal that prisons be limited to 200 people has not been adopted, and, from all accounts by people in the know, only one smaller regional centre dealing specifically with psychiatric problems has been built since the committee took their tour. Reviews of that centre (in Saskatchewan) are now trickling through the grapevine. There appear to be serious doubts about its therapeutic qualities, because of the prison's custodial nature.

McNeil and Vance's book gives a lucid view of the system, and along the way provides substantial evidence of the need for change.

## SUICIDE

by Diane Savard

Suicidal feelings creeping over me  
like worms crawling over leftover pumpkin guts  
rotting in the street.  
Now I have everything in the world a person  
could want or need, to be content.  
But these suicidal feelings are still creeping  
over me.

I try but I live so I try again  
to kill myself.  
But I live and these feelings keep coming.

Now I don't know why I want to kill myself,  
don't have a clue why I want to die,  
but as long as these feelings keep coming  
again and again I'll try.  
Could it be the full moon  
or rings around the sun?

Maybe I should start a little club.  
Members would have to be suicidal 'cause  
I know I'm not the only one who gets  
suicidal feelings creeping over me  
like worms crawling over leftover pumpkin guts  
rotting in the street.....

### ANNOTATED ANTIPSYCHIATRY BIBLIOGRAPHY (SECOND INSTALLMENT). Prepared by Cathy McPherson.

- Braly, Malcolm. *False Starts*. Penguin (1976), paper \$1.95. The true story of a man who "made a career out of serving time" in American prisons and lived to tell it all in a very entertaining manner.
- Culhane, Claire. *Barred from Prison: A Personal Account*. Pulp Press (1979), paper \$5.95. Deals with the author's experiences between 1976 and 1978 as a member of the Citizens' Advisory Committee attempting to improve conditions at the B.C. Penitentiary. Largely because of the efforts of the CAC, the notorious "B.C. Pen" has been closed, and is now a tourist attraction.
- Helwig, David. *A Book About Billie*. Oberon Press (1972), paper \$2.95. Literary anthologist, writer and editor Helwig chronicles the tragic story of a 37-year-old man who was on his own at a very early age and ended up in and out of institutions and prisons for the remainder of his life. The inside story of a "professional" criminal.
- Klass, Alan. *There's Gold in Them Thar Pills*. Penguin (1975), paper \$2.25. The international drug companies get a run for their money in this book, which examines the amount of money spent on research (too often on developing similar drugs under different patent names) and advertising, and the way the two affect consumers and doctors alike. Mandatory reading for those who have been following the Hoffman-La Roche case in Ontario.
- Leonard, Gerald. *The Canadian Consumer Guide to Prescription Drugs*. Wiley (1979), paper \$6.95. An easy-to-read publication on 500 of Canada's most commonly prescribed drugs (including Largactil and Moditen), what they should be prescribed for, precautions in use, and possible side-effects.
- Richmond, Dr. Guy. *Prison Doctor*. Nunaga (1975), paper \$4.50. Spans the forty years a doctor spent working with "cons" and "delinquent" people in England and B.C. Doesn't rank among the best, but does provide some insight.
- Schroeder, Andreas. *Shaking it Rough: A Prison Memoir*. Doubleday Canada Ltd. (1976), cloth \$9.95. A personal account of the author's experiences for eight months in the B.C. correctional system after being sentenced for possession of hashish for the purpose of trafficking. Some parts of this book were published in *Weekend Magazine* before it became *Today*.



# tongue in cheek

by Len Lorimer

Once beneath a time there was a scientist whose research grant was not renewed. He had been studying to determine the life span of the average tapeworm. The government did not think this was important.

Looking about for a project that would interest the government, the scientist hit upon the idea of an Optiman. An Optiman would be human, but with genetic characteristics carefully selected and modified, so that he would be the best possible citizen--that is, the optimum citizen.



Madness Network News

OPTIMAN

The government approved the project. With many assistants and large funds, the scientist produced an Optiman.

The Optiman was developed in a large bottle and emerged fully grown--requiring no childhood care. Basic linguistic and other cultural information was genetically implanted as instinctive. Optiman had four prominent characteristics making for good citizenship. Optiman was loyal, intelligent, stable, and conservative. Also there were other genetic modifications. Optiman could smoke cigarettes and drink Coca-Cola constantly without lung problems or tooth decay. Optiman could function efficiently for about forty years, after which he grew old and died in fifteen minutes (no need for geriatric care). So as to avoid inconvenient unforeseen interruption of services, six hours before age-death Optiman turned blue.

The government was pleased.

The scientist turned his attention to developing an Optiwoman. She hatched looking remarkably like Jane Fonda, and the scientist

tested her moral reactions immediately. However, she was frustratingly conservative.

By this time the original Optiman had himself applied for a government grant. Pointing out his personal genetic qualifications and his innate experience with bottled life, he offered to take over future Optiman development at half the salary of the scientist.

Optiman's application was accepted.

The scientist, again out of a job, was disgusted. He complained that neither his degrees nor his name had been mentioned. Muttering about high employability and living happily ever after, he climbed upon a nearby slab of time and went looking for a conventional short story.

Optiman carried on. With persistence and enthusiasm, he developed a more agreeable Optiwoman. Then he worked on the genetic elimination of various health problems. Since Optiman had no childhood, he had no emotional needs. He did not spend money on status symbols. Instead he invested wisely.

Then one day Optiman turned blue. He immediately went to a cupboard and took some pills. Shortly thereafter he turned light brown.

The government has been unable to locate Optiman. (Investigators finally assumed that he had died in some unlikely place where he fell into a river and was washed out to sea.)

However, if you go to Miami Beach, there is a chance that you may see Optiman. He is light brown, loyal, intelligent, stable and conservative; drinks lots of Coca-Cola; smokes cigarettes; and reads the stock market reports every day.

The *Toronto Clarion*, a courageous and outspoken newspaper, is in serious financial difficulties. Because of the rising cost of publication, they have been forced to cut back temporarily to once-a-month publication rather than every two weeks, and may not survive without help.

Anyone wishing to make a contribution to the continued existence of a badly-needed newspaper may do so by writing to: *Toronto Clarion*, 73 Bathurst St., Toronto, Ontario M5V 2P6.

## On Our Own cont.

be a heavily used, intramuscularly injected drug called Thorazine, one of the strongest tranquilizers around. (Its effects are described in this month's *Phoenix Pharmacy*.)

A panel of ex-psychiatric patients (Carla McKague, Alf Jackson, Pat Capponi and myself) discussed the legal rights of patients, boarding homes, co-operative housing and life after hospitalization. Because all of the panelists had received psychiatric help at one time or another, they were able to give a bird's eye view into the system and textbook "professionals".

Most of the participants left the forum convinced that the psychiatric system needed not just a tune-up but an overhaul, and possibly even a total restructuring--which doesn't seem likely in the near future.

### **STAY TUNED FOR TAKE THIRTY**

Stay tuned this September for a special program on sterilization of the mentally retarded on CBC's "Take Thirty".

PHOENIX RISING's editor was one of a number of interested people in a studio audience who threw questions at three panelists on this

issue: Dr. Katherine Chalin, psychologist and associate professor of behavioural science at the University of Toronto; Orville Endicott, coordinator of national legal services for the Canadian Association for the Mentally Retarded; and Mary Van Stolk, founder and president of the Tree Foundation of Canada, which concerns itself with child abuse and family violence.

Sterilization of the retarded has been temporarily halted in Ontario until the government can decide its policy on protection of the retarded who are, or could be, subjected to this operation. The issue is one that is being hotly debated, as witness the Take Thirty program.

Viewers who want to see this show can contact the CBC at 925-3311, extension 4524. They should have the exact time and date set by August.

ON OUR OWN's drop-in is now officially open at St. Christopher House, 761 Queen St. W. in Toronto. We offer people who have had psychiatric treatment an opportunity for companionship, and a variety of programs including arts and crafts, bingo evenings, dances and rap groups.

We're open every Thursday, Friday and Saturday night from 6 p.m. to 11 p.m. We're just getting daytime programs started; for up-to-date information on these programs, call 362-3193.

## letters cont.

me with the problem I thought I had. Finally, I realized it was a losing battle and saw that I could not agree with many activities and treatments done to patients by psychiatric professionals. They were controlling me, not helping me to grow, slowly killing my desire to live. I became angrier. My psychiatrist felt out-patient treatment was no longer suitable and recommended intensive psychotherapy--institutionalization for a "short time" would be good. I thanked him for his efforts and left, never to see him again.

I never received shock treatments, was never institutionalized and physically restrained only once, and attempted suicide only once. Like most patients, I was in and out of treatment several times during eight years because I had been taught to depend on my psychiatrist to cure my "illness".

When I left treatment, I made a decision never to return. At first I lived in fear that perhaps they had been right about my illness. Any time I felt depressed for a few days I was terrified I would become "sick" again and need to be hospitalized.

As time has passed, I have had these fears less and less. I have had a great deal of help

from my family, but especially from friends and fellow patients who have helped me through times when I've felt "sick" and really wasn't, with care and understanding--the things I had hoped to receive from psychiatric professionals.

Finally I am free to grow and free to be myself. Everyone must have this freedom and understanding from others. This can happen only amongst friends, only amongst equals who do not hold power over each other. Rarely is this possible in psychiatric treatment since it is based on the power of the psychiatrist over his patient.

--Name withheld

I attended the Ortho-Molecular Conference on June 7 and 8 at the Park Plaza Hotel with another ON OUR OWN member, and I thought you might be interested in my impressions of the weekend.

At most conferences, there are some speakers whose words expand in your mind and seem better and more important than they did at the time they were spoken. My own reaction to the Ortho-Molecular Conference was just the opposite--the whole thing keeps shrinking as time goes by. In my opinion the entire conference was nothing more than a stage for the Canadian Schizophrenic Association (CSA) to boost Dr. Hoffer and vice versa.

The lectures began to go wrong when it was Hoffer's turn to speak. His speech, "Schizophrenia in General Practice", was one of the least attractive aspects of the conference simply because he didn't make any sense.

"We wouldn't have to use so much shock therapy if they'd only take their vitamins," he said at one point, when in fact we all know doctors shouldn't be using shock at all because of the brain cell damage and memory loss that goes with such treatment.

Unfortunately, we didn't get a chance to question any of the speakers about our objections or to talk to Hoffer personally. Hoffer told the audience at the end of the conference that although he'd like to discuss everything individually he just didn't have time. Would we please be understanding?

Not all was bad, however. Dr. Pheiffer was the purest, most disciplined and austere of all the speakers and clearly overshadowed the rest. He attempted to bring into focus some of the blurred myths surrounding psychiatry and vitamin therapy, and outlined a program that he claims could be a way of life for anyone suffering from "mental" problems. He suggests eliminating as many chemicals as possible from the food we eat and reducing our intake of meat, along with taking different vitamins.

A major disappointment was the apparent opinion of most speakers who seemed to think we "mental patients" could be cured by vitamins alone. We know what we need, and each of us probably has their own formula that works for our own "mental" well being.

Of the token statements we did receive, the comments we got from Mrs. May, president of the Toronto branch of CSA, stand out the most. "I want to get involved with you *poor* people," she told us.

Well, Mrs. May, your kind of help we don't need: We're surviving on our own just fine, thank you, and we certainly don't need your sympathy. And another thing you may find useful to know is that we aren't "poor". Most of us just don't have much money.

--Nancy Connor, Toronto

*(Editor's note: CSA advocates the use of vitamins as a virtual cure-all for "schizophrenia". Dr. Hoffer, a Saskatchewan psychiatrist, is president of this association.)*

As a veteran of the mental hospital and prison route, I'd like to relate some stories that have happened to me along the way.

I'm 39 years old. I was in my first mental institution at the age of 12 or 13. All total, I think I've spent 15 years on the street. It all began when I was put into reform school at 10 years of age because the courts had labelled me an unmanageable child.

My mother, separated from my father, just couldn't cope with bringing up a young boy.

When my time was finished at reform school, I was bumped into Lakeshore Psychiatric Hospital (at 12) because they had nowhere else to put me. From that point on I went from one institution to another because I didn't fit anywhere.

## ***"Police passed on my records to hospital staff"***

About 14 years ago I was in the Ponoka Mental Institution in Alberta--three times the size of the Queen Street Mental Health Centre. I was taken there from the Foothills Hospital because I was being "emotional". Although I had signed myself in as a voluntary patient, I ended up in the jail ward as an involuntary patient when the police passed on my criminal record and information about myself to the hospital staff.

During my stay at Ponoka I was forcibly put on Moditen in the jail ward. (For those who don't know what this is, I'll explain. This is a drug compound mixed with an oil for the purpose of breaking down within the system over a period of time. It is injected intramuscularly.)

Everyone's nervous system is different depending on that person's size, weight, etc. In my case, being a hyper type of person, I had strong side-effects that came out in the form of Parkinsonian reactions.

Although the doctors knew that Cogentin, Nozinan and a variety of other drugs could be used to fight these side effects, I was never given any. I was told, when I complained, that I was making it up.

In another incident I was incarcerated in a penitentiary and was unable to get counselling of any kind regarding my marital problems at that time. While my wife was capable of getting counselling on the street, I was denied counselling in prison, and felt so badly I attempted to take my life.

The extent of my wife's counselling involved the authorities' attempt to convince her to leave me. They succeeded--which leaves her with two kids on welfare until they grow up. Now my five-year-old son is in the same rut I was in when I was five years old.

The cycle continues.

--Fred Dobson, Toronto

THANK YOU TO ...

Benjy Wolfe, for research on SmithKline products.

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## CLASSIFIEDS

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

FOR TRADE	HELP WANTED	JOBS WANTED
Foreign and Canadian coins are better in my collection than in your trunks in the basement. Let me buy your coins from you at catalogue prices. Call Edmund Kuch at 767-8159.	Person wanted part-time to solicit advertising for <i>PHOENIX RISING</i> on commission basis. Call Cathy at 362-3193.	ON OUR OWN's Mad Market, 754 Queen St. W., has set up a job opportunity/jobs wanted board. Ex-psychiatric inmates and businesses are urged to drop by and put up notices or call us at 362-3193.
Members of ON OUR OWN wanted to help out at ON OUR OWN's flea market. Lively company and good experience. Call ON OUR OWN at 362-3193.	Part-time typing and/or filing job needed one or two days a week, flexible hours. Can type 55 words per minute and have experience. Call Cathy, 463-6990, around supper or before 9:00 a.m.	AGENCIES
		Women's Counselling, Referral and Education Centre. Provides referral for women who are seeking non-sexist counselling. 924-0766 in the afternoons.
Volunteer bookkeeping help needed ½ day/week. Also volunteers to read legal material onto tape for blind staff. Call Advocacy Resource Centre for the Handicapped (ARCH), 482-8255.	CUPBOARDS MADE. Example: Display cupboards 6' x 49½" x 14" deep, 6 shelves, centre dividers, recessed backing, unpainted, \$105 plus tax. 362-3193. Leave message for Len Lorimer.	Are you handicapped in some way and feel treatment of you has violated your legal rights? Phone Advocacy Resource Centre for the Handicapped, 482-8255.

### COMING SOON IN PHOENIX RISING

- Electroshock treatment, freedom of speech and the Ontario Press Council.
- Sexism in psychiatry.
- Psychiatry and children.
- Psychiatric treatment: Do you have the right to refuse?
- Book reviews, poetry, letters to the editor.
- Much, much more!

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

### SPECIAL ANNOUNCEMENT!

The Mad Market is beginning to handle on consignment handicrafts, etc., produced by psychiatric inmates and ex-inmates. If you are an inmate or ex-inmate and would like us to consider handling your weaving, pottery, woodwork, jewellery or whatever, call us at 362-3193.

The Mad Market has already, in its first month of operation, produced its first new job! ★ Congratulations to Steve Anderson, ON OUR OWN's new trainee bookkeeper, who started work on July 15.

### SHOCK VICTIMS!!

Issue number 3 of *PHOENIX RISING* will be a special issue devoted largely to the subject of electroconvulsive therapy ("shock treatment"). As part of this issue, we intend to include a list of Canadian doctors who administer or authorize ECT.

If you, a member of your family or a friend has been subjected to shock by a doctor in Canada, we would appreciate your sending us the following information: the doctor's name; his hospital affiliation (name of hospital and name of city); and the year of treatment.

Please sign your letter; otherwise we will not be able to use your information. We will, of course, keep your name confidential.

The information should be sent to: Shock Doctor List, *PHOENIX RISING*, Box 7251, Station A, Toronto, Ontario M5W 1X9.

## METROPOLITAN TORONTO EMERGENCY RESOURCES LIST

### Emergency Accommodation: Men

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

### Emergency Accommodation: Women

- ANDUHYAUN*, 106 Spadina Rd., 920-1492. Native women. 24-hr. admission. 12:00 curfew. Meals. \$40/wk. if you can pay.
- INTERVAL HOUSE*, 596 Huron St., 924-1491. Priority battered women (& children). 24-hr. admission. Free.
- NELLIES*, 275A Broadview Ave., 461-1084. 24-hr. admission Mon.-Fri., weekends after 4 p.m. if possible. 2-week maximum stay. Free--donations if possible.
- STOP 86*, 86 Madison Ave., 922-3271. Women 16-25. Free--donations if possible.
- STREETHAVEN*, 87 Pembroke St., 967-6060. 24-hr. admission. Light lunch, dinner. 2-week maximum stay. Free.
- TORONTO COMMUNITY HOSTEL*, 191 Spadina Rd., 925-4431. Checkin by midnight, out by 9 a.m. Meals. Maximum stay 5 days (extension possible). Free--donations if possible.
- WOMEN IN TRANSITION*, 143 Spadina Rd., 967-5227. Women with children. 24-hr. admission--phone first. Meals. 1-6 week stay. Free.
- EVANGELINE RESIDENCE*, 2809 Dundas St. W., 762-9636. 24-hr. admission. Meals. \$40/wk. if you can pay.
- WOODLAWN RESIDENCE*, 80 Woodlawn Ave. E., 923-8454. Checkin after 1, out by 12. Emergency beds free. Meals.

### Emergency Accommodation: Families

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

### Detox Centres

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

### Emergency Welfare

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

### Crisis Counselling

- DISTRESS CENTRE 1* (24 hours), 598-1121.
- DISTRESS CENTRE 2* (24 hours), 486-1456.
- TORONTO EAST GENERAL CRISIS INTERVENTION UNIT*. Weekdays 9-5, 461-0311. Weekends, after hours, 461-8272, Ext. 220.
- SALVATION ARMY EMERGENCY COUNSELLING AND SUICIDE PREVENTION BUREAU* (24 hours), 368-3111.
- TEEN CHALLENGE* (24 hours), 463-4900.
- YOUTHLINE*. Sun.-Thurs. 4:30-1:00, Fri.-Sat. 4:30-3:00. 922-1700.
- RAPE CRISIS CENTRE* (24 hours), 964-8080.
- PARENTS ANONYMOUS* (24 hours), 967-7227. (For abusing parents.)
- ADDICTION RESEARCH FOUNDATION* (24 hours), 595-6128. (Drugs, alcohol.)
- STREET HAVEN AT THE CROSSROADS* (24 hours), 967-6060. (Women--drugs, alcohol.)
- METROPOLITAN COMMUNITY CHURCH*. Mon.-Thurs. 7-10:30. 364-9835. (Gays.)
- TORONTO AREA GAYS*. Mon.-Thurs. 7-10:30. 964-6600.
- LESBIAN ORGANIZATION OF TORONTO*. Tues. 7-11, Fri. 7-12. 960-3249.

*These lines are often busy. Keep trying; you will get through eventually.*

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